TANZANIA AIDS PROJECT
MIDTERM REVIEW REPORT

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The observations, conclusions, and recommendations set forth in this document are those of the authors alone and do not represent the views or opinions of POPTECH, BHM International, The Futures Group International, or the staffs of these organizations.

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ACKNOWLEDGMENTS

For their tolerance and support throughout our assignment in Tanzania, the Tanzania AIDS Project Midterm Review Team (MTR) would like to express our appreciation to the following:

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- To the NGO cluster members and our many other respondents for their time, patience, and cooperation during our review and for having shared with us their aspirations and thoughts, making it possible for the MTR team to contribute, to whatever small degree, to the challenging task associated with the prevention and control of HIV/AIDS in Tanzania.

We would also like to take this opportunity to acknowledge the contribution of our team member Dr. Ephraim Kipuyo, whose untimely death during the MTR's final days in Dar es Salaam was greeted with the greatest regret by all who knew him and worked with him. At the time of his death, Dr. Kipuyo was the Deputy Director of the Government of Tanzania's (GOT) NACP and

had served for many years as the NACP's senior epidemiologist. As such, Dr. Kipuyo was an invaluable technical resource on HIV/AIDS both to the nation and to the international HIV/AIDS control effort. With our acknowledgment of Dr. Kipuyo's substantial contribution to our team’s findings and to his unfailing goodwill and courage, we dedicate this report in his honor.

We are certain that Dr. Kipuyo would join with us in offering to all of the above organizations and persons our very real encouragement for continued success and progress toward the goal of total control and prevention of HIV/AIDS in Tanzania.

ABBREVIATIONS

AIDS	acquired immunodeficiency syndrome
AIDSCAP	AIDS Control and Prevention Project
AIDSTECH	AIDS Technical Support Project
AIM	AIDS impact model
AMREF	African Medical and Research Foundation/Kenya
BC	birth control
BCC	behavioral change communication
BHR	Bureau of Human Response
BP	British Petroleum
CA	cooperating agency
CBO	community based organization
CEDHA	Centre for Educational Development in Health/Arusha
CSM	contraceptive social marketing
DACC	district AIDS control coordinator
DANIDA	Danish International Development Agency
DHS	demographic and health surveys
DMO	district medical officer
EEC	European Economic Community
EEU	European Economic Union
EG	economic growth
FAMS	financial administrative management system
FHI	Family Health International
FP	family planning
GOT	Government of Tanzania
GTZ	Association of Technical Cooperation/Germany

HIV	human immunodeficiency virus
HMIS	health management information system
IDC	Infectious Disease Clinic
IEC	information education communication
KABP	knowledge, attitudes, beliefs and practices
M&E	monitoring and evaluation
MCH	maternal and child health
MOE	Ministry of Education
MOH	Ministry of Health
MSD	Medical Store Department
MTPIII	third mid-term plan
MTR	mid-term review
MVU	Mobile Video Unit
NAC	National AIDS Committee
NACP	National Aids Control Program/Tanzania
MTP	*National HIV/AIDS/STD Policy*
NGO	nongovernmental organization
OD	organizational development
PIF	process information form
PHC	primary health care
PHCI	Primary Health Care Institute
PLWH/A	people living with HIV/AIDS
PSA	public service announcement
PSI	Population Services International
PSU	Project Services Unit
PWA	person with AIDS
RACC	regional AIDS control coordinator
RAS	regional administrative secretary

RC	regional commissioner
RDO	regional development officer
REO	regional education officer
RH	reproductive health
RMO	regional medical officer
SHDEPHA+	Society for Persons with AIDS
SMU	social marketing unit
SO	support organization
SOW	scope of work
STD	sexually transmitted disease
STI	sexually transmitted infection
TA	technical assistance
TACOSODE	Tanzania Council of Social Development
TAP	Tanzania AIDS Project
TBA	traditional birth attendant
TFTU	Tanzania Federation of Trade Unions
TOT	training of trainers
TPC	Tanganika Planting Company
TRC	Tanzanian Railway Corporation
TS	Tanzanian unit of currency
UNAIDS	United Nations Joint Programme on AIDS
USAID	United States Agency for International Development
USAID/T	USAID/Tanzania
USIS	United States Information Service
VHW	village health worker
WHO	World Health Organization
YPWA	young person with AIDS

EXECUTIVE SUMMARY

The principal goal of the Tanzania AIDS Project (TAP) is to build the capacity of indigenous nongovernmental organizations (NGO) to implement HIV/AIDS preventive education activities and to provide a source of support to people with HIV/AIDS. The Midterm Review (MTR) of TAP, carried out at the request of the Office of Population, Health and Nutrition of USAID's Mission in Tanzania, responds to USAID/Tanzania's (USAID/T) defined need to ". . . periodically examine and review the extent to which the Project (TAP) is functioning according to its prescribed goals and objectives . . . .' and to assess TAP's progress related to *Intermediate Result Two* of USAID/T's strategic plan: "*Increased knowledge of and access to HIV/AIDS information and services*."

TAP was initiated in June 1993 as a five-year project (1993 to 1998). It was supported by a USAID budget of US$20 million and a core budget of US$1.6 million from Family Health International's (FHI) initial AIDS Control and Prevention Project (AIDSCAP) cooperative agreement. This cooperative agreement was later incorporated into the AIDSCAP contract to support activities from September 1, 1994 to April 1997. TAP's central Dar es Salaam management office consisted of a Project Services Unit (PSU) and a Social Marketing Unit (SMU). PSU activities were managed by FHI; SMU activities were largely under the direction of Population Services International (PSI), a subcontract under the larger FHI/AIDSCAP Project. TAP also included a bilateral grant to the National AIDS Control Program (NACP) to assist with condom distribution and the overall coordination of the NACP.

The evaluation conducted by the MTR team responds to USAID/T's Scope of Work (SOW) that focuses on a review of TAP's progress in eight technical areas:

(1) NGO Cluster Development. In just over 18 months, TAP has organized 189 NGOs into accomplishments have been significant. Yet, there is still much to be done to ensure the sustainability, continuity, and effectiveness of the cluster program.

(2) Business or "Worksite" Development. Cluster worksite programs includetraining employee peer health educators, providing information education communication (IEC)/behavior change communication (BCC) materials and programs for use in the workplace, and promoting condoms. Although there have been some successful worksite interventions, the clusters have not actively recruited worksite partners. Therefore, the clusters have not been able to recruit the anticipated 100 worksites.

(3) Support of Orphans. TAP's efforts to assist orphans have been hampered from the outset b identify orphans as a significant, growing problem in their regions and are attempting to implement interventions to assist them. These efforts are, however, modest and largely ineffectual.

(4) IEC/BCC. IEC is a critical component of TAP and is the principal mandate/mode of intervention of member NGOs. However, the IEC interventions have been developed individually with no reference to each other. The impact of these efforts could be strengthened by developing a common theme or symbol to unite the interventions so that they convey a single, clear message.

(5) Sexually Transmitted Disease (STD) Prevention and Control. The outcome of earlier USAID support under AIDS Technical Support Project (AIDSTECH) and African Medical and Research Foundation (AMREF) has led to increased donor support for STD prevention and control in Tanzania. At times activities supported by different donors have not been well coordinated and, as a result, opportunities for coordination have been missed. Nevertheless, the program is recognized as having made significant contributions

to STD prevention and control in Tanzania in training providers in the private and NGO sector. To better target its STD prevention and control activities, TAP needs to establish a health management system to track epidemiologic data. In addition, TAP should strengthen its activities designed to improve the integration of STD and family planning (FP) activities.

(6) Contraceptive Social Marketing (CSM). During the three years since TAP's launch, PSI has sold more than 26 million condoms into the trade in Tanzania: it sold 11.9 million condoms in 1996 alone. The communications efforts connected with this activity have been good, but these efforts have been directed toward marketing the Salama condom rather than promoting HIV/AIDS prevention. To raise awareness of HIV/AIDS prevention, a consistent strategy and an identifiable symbol or tag line is needed to link the advertising of Salama and other TAP-produced media.

(7) Policy. Since TAP began, many policy-related issues have emerged. To develop a country-specific approach to the promotion of HIV/AIDS-related policy, USAID should focus on (1) strengthening NACP's institutional capacity by supporting capacity-building activities and by supporting the finalization of the draft *National AIDS Policy* (NAP), (2) supporting the use of the AIDS Impact Model (AIM) to develop a proactive constituency for HIV/AIDS prevention and control, and (3) building consensus for support of HIV/AIDS/STD activities among Tanzania's key policy makers.

(8) TAP Project Management. TAP needs to establish a flexible financial management process and strengthen the capability of personnel responsible for management of the NGOs and the NGO clusters. This process should provide maximum efficiency, flexibility, and transparency in funding NGO activities. Furthermore, full authority should be vested in the TAP resident manager to approve NGO work plans and to disburse funds.

This report addresses three aspects of the TAP program: (1) a "snapshot" of TAP's current stage of development in the TAP's eight technical areas, (2) suggestions for ways in which TAP and USAID/T can build on TAP's progress in the 17-month period from May 1997 through the September 1998 project extension, and (3) recommendations for initiatives that USAID/T might consider to support HIV/AIDS prevention and control for the five-year period from 1998 through 2003. These three aspects are addressed in the body of the report. To summarize, the MTR team's recommendations for future initiatives that address general cross-cutting issues are listed below:

- CSM/IEC Coordination. Assuming that PSI continues its condom marketing efforts, it will be important that the PSI staff work as fully integrated members of USAID/T's assistance team.

- NGO Strengthening. An initiative should be designed to continue the development of TAP's work with the Tanzanian NGO cluster network. Furthermore, to support the field operations, a central office should be established in Dar es Salaam to provide overall coordination and management support to respond to requests from the NGO clusters.

- NACP Management Support. Dedicated support should be provided to the NACP to enhance its management skills and help it develop into an effective advocate for national action in response to the increased incidence of HIV/AIDS in Tanzania.

- Operations Research. Technical assistance should be provided to the Government of Tanzania (GOT) in terms of expertise and funding for operations research. Appendix G lists suggested areas for such operations research.

- Technical Assistance to the Ministry of Health (MOH). USAID should consider supporting the GOT's HIV/AIDS/STDs control and prevention activities.

RECOMMENDATIONS

The MTR team has provided the following recommendations to respond to USAID/T's interest in a forward-looking perspective for continued support to the GOT's program of HIV/AIDS control and prevention. Although the majority of these recommendations refer to the MTR's specific technical areas, some of the recommendations are categorized as those that would have a cross-cutting effect on the direction of the HIV/AIDS program. All recommendations are listed in order of priority for the appropriate topic.

Cross-cutting Issues

The following recommendations focus on the USAID support initiatives that are, in the opinion of the MTR team, essential to the HIV/AIDS control and prevention program's continued progress.

Strengthening the NACP: USAID/T should provide the NACP with technical assistance targeted to strengthen NACP senior management skills. An institutional audit would indicate the needed duration and content of this assistance.

HIV/AIDS/STD and FP/Reproductive Health (RH) Program Integration: As a major focus of TAP and its successor, USAID should support, through seminars and training, the integration of HIV/AIDS/STD services with those of FP/RH.

NGO/GOT Regional/District Collaboration: USAID/T should ensure that technical assistance to NGOs supports the continued growth of collaboration between the regional and district NGOs and the government sector. Developing the program planning capacity

of both NGOs and their local government counterparts should be a key element of this assistance.

Donor Coordination: Rather than including orphans as an element in its support to HIV/AIDS activities, USAID/T should work with other donors to ensure that efforts on behalf of orphans are included in programs such as those focused on poverty alleviation, women in development, community development, or compulsory education.

NGO Cluster Development

In order for the NGO cluster concept to continue to be viable and effective, cluster development activities should focus on ways in which USAID can further support clusters as recognized operational entities.

TAP Extension Period (1997 to 1998): During the extension period, TAP should assess each cluster's managerial deficiencies. Once these deficiencies are identified, TAP should define a short-term strategy and a supporting budget to respond to each cluster's specific internal development priorities. In a related action, TAP's staffing profile should be evaluated and, if necessary, reorganized to focus on the NGOs' internal capacity development needs.

Beyond TAP Extension (1998 to 2003): USAID/T and its successor should focus on the following activities:

- Define and adopt precise selection criteria for an NGO's inclusion in a cluster.

- Build on TAP's internal capacity-building initiatives by providing technical assistance to NGOs for the following:

  - Decentralization and devolution of responsibility,
  - Monitoring and evaluation,
  - Management of demand for services, and
  - Design and management of local research initiatives.

- Reaffirm the importance of recruiting cluster worksites and developing these worksites for greater coverage and increased cost-effectiveness.

- Underwrite opportunities to promote public sector political support for the NGOs by supporting activities such as joint-review workshops, press releases, and observational travel.

Information, Education, and Communication/Behavioral Change Communication

The following recommendations focus on ways in which the disparate elements of TAP's current IEC/BCC program could be brought together.

- Develop a national campaign theme and symbol (tag line and logo),

- Extend public knowledge of HIV/AIDS prevention and control issues by developing an IEC/BCC program to advise people of the risks inherent in ordinary social and sexual conduct,

- Develop an initiative designed to monitor behavioral change with respect to HIV/AIDS and STDs, and

- Design "instructions" and evaluation sheets to be included in each shipment of IEC materials.

Sexually Transmitted Diseases

The following recommendations ensure that the current progress in addressing STD issues is continued:

- Continue to support the Muhimbili testing and counseling center,

- Continue to support coordinated and integrated public/private sector training in STDs,

- Provide technical assistance centered on monitoring and maintaining standards in the training institutes,

- Explore the feasibility of USAID supporting the regular supply of drugs by paying selected distribution costs and by ensuring the availability of free or affordable STD drugs in critical locations that have high patient visitation.

- Provide support for the following country-specific research issues:

    - Collection, analysis, and application of epidemiological and behavioral data;

- Integration of additional categories of health agents, such as traditional healers and birth attendants, into the program;

- Contact tracing and treatment of the partners of persons with HIV/AIDS/STDs;

- Promotion of the increased visibility, acceptance, and access to female-controlled HIV/AIDS prevention methods; and

- Inclusion of pharmacists and patent medicine dealers in STD syndromic management training.

Contraceptive Social Marketing

The following recommendations focus on ways in which to both maintain PSI's considerable progress in condom distribution and to increase its contribution to public knowledge of HIV/AIDS prevention and control.

· Use the existing sales force to carry out more public demonstrations promoting the use of condoms against HIV/AIDS;

· Actively collaborate with NGO clusters to support sales training, the development

of materials, and the continuation of favorable terms for condom sales;

- Expand condom distribution to general merchandise outlets; and
- Promote an increased acceptance of distributing family planning products from Tanzanian medical services and associations.

Policy

The following recommendations focus on potential USAID/T support for a country-specific approach to promoting HIV/AIDS-related policy.

- Support the use of the AIDS Impact Model (AIM) methodology for Tanzania to develop a proactive constituency for HIV/AIDs prevention and control;
- Support the NACP—through workshops, technical assistance (TA), or other means—to finalize and disseminate the National HIV/AIDS/STD policy;
- Support a thorough review of Tanzania's HIV testing policy and associated regulatory framework;
- Support the use of USAID's private sector AIDS prevention methodology to assist employers in assessing the potential impact of HIV/AIDS on their workplace, as well as to identify policy options and prevention programs; and
- Support journalist workshops focused on HIV/AIDS/STD issues.

Project Management

The following recommendations focus on ensuring that TAP and its successor have the flexibility and knowledge to respond to cluster-specific management capacities.

- Invest full authority in TAP's resident manager—and in all managers of future NGO-related management projects—to approve workplans and disperse funding;

- Define a financial management process for the project that will provide maximum flexibility and transparency in the funding of NGO activities;

- Define a supervisory structure for the clusters that is divided into the following four regional zones:

  Zone 1. Dar es Salaam and Tanga,
  Zone 2. Moshi and Arusha,
  Zone 3. Shinyanga and Tabora, and
  Zone 4. Dodoma, Morogoro, and Iringa;

- Promote the concept (initially on a trial basis) of a few performance-based grants for those clusters with a capacity to manage such a grant.

1. INTRODUCTION

1.1 Background

The principal goal of the Tanzania Aids Project (TAP) is to build the capacity of indigenous nongovernmental organizations (NGOs) to implement HIV/AIDS preventive education activities and to provide support to people with HIV/AIDS. The Midterm Review (MTR) of TAP, carried out at the request of the Office of Population, Health and Nutrition of United States Agency for International Development's (USAID) Mission in Tanzania, responds to USAID/Tanzania's (USAID/T) defined need to ". . . periodically examine and review the extent to which the Project (TAP) is functioning according to its prescribed goals and objectives . . . ." and to assess TAP's progress related to *Intermediate Result Two* of USAID/T's strategic plan: "*Increased knowledge of and access to HIV/AIDS information and services*."

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Beyond responding to these two objectives, this report provides an overview of lessons learned from TAP's approach to maximizing the resources of disparate NGOs by consolidating these NGOs into "clusters."

The evaluation conducted by the MTR team responds to USAID/T's specific Scope of Work (SOW) that focuses on a review of TAP's progress in eight specific technical areas:

- NGO cluster development;
- Business or "worksite" development;
- Support of orphans;
- Information, education, and communication/behavioral change communication (IEC/BCC);
- Sexually transmitted disease (STD) prevention and control;
- Contraceptive social marketing (CSM);
- Policy; and
- TAP program management.

The MTR team's findings address three aspects of the TAP program: (1) a "snapshot" of TAP's current stage of development, (2) suggestions for ways in which TAP and USAID/T can build on TAP's progress in the 17-month period from May 1997 through the September 1998 project

extension, and (3) recommendations for initiatives that USAID/T might consider to support HIV/AIDS prevention and control for the five-year period from 1998 through 2003.

1.2 Methodology

This review was conducted in Tanzania in February and March of 1997 by an eight-person team of professionals from a variety of disciplines who were able to view the relevant issues from a wide perspective. The evaluation team consisted of representatives from USAID/Washington's Global and Africa Bureaus, USAID's technical bureaus for HIV/AIDS in Africa, National AIDS Control Program/Tanzania, and related private sector organizations.

The MTR team actively solicited input from as many members of the nine clusters as was feasible within the team's five-week in-country schedule. Assisted by TAP's central office and USAID/T's support staff, the MTR team used several methods to review activities of the NGO cluster network. Team members conducted field visits to the nine regions in which NGO cluster activities are occurring. The team analyzed subagreements; quarterly reports; narrative reports; process information forms (PIF); and knowledge, attitudes, beliefs, and practices (KABP) studies. In addition, the team interviewed TAP staff, cluster management, steering committee members, NGO members and leaders, beneficiaries and participants, and current and prospective donors.

2. TAP'S CURRENT STAGE OF DEVELOPMENT: REVIEW OF TECHNICAL AREAS

2.1 NGO Cluster Development

In just over 18 months, TAP organized 189 NGOs into nine regional clusters that have provided an entry point for a variety of private sector HIV/AIDS intervention activities. Dispersed throughout the country, NGOs in TAP's clusters have initiated interventions to develop HIV/AIDS awareness and prevention messages, to work with regional and district government authorities to stimulate behavior change, and to provide services to AIDS victims and survivors. Monthly reports by each of the nine clusters indicate that the clusters have distributed many promotional posters, facilitated more than 500 well-attended regional sensitization sessions, trained 189 trainers and more than 1,500 peer educators, and established information centers. Starting in late 1995 and budgeted at $850,000, support activities are location in nine region.

It is not easy to specify the number of NGOs allowed to join a cluster. Cluster recruitment has no limit provided that the potential NGO member (1) is conducting activities based in the community within the geographic area in question, (2) is a registered NGO, and (3) is willing to collaborate with other NGOs within the cluster in HIV/AIDS intervention activities. A lead or "anchor" NGO is selected by the NGO cluster members based on the following criteria:

- Status as a registered NGO;
- Ability to lead and coordinate the efforts of other NGOs;
- Previous implementation of activities within the community in question, including experience managing funds from other donors; and

- Sound financial management experience, including possession of a bank account.

In addition, each cluster recruited a basic management staff that is typically composed of a cluster manager, a secretary, and an accountant. In most cases, this administrative staff is associated with the anchor NGO.

Because of the variety of organizational structures of individual NGOs in a specific cluster, some clusters have been more effective than others at creating a cluster organization and at fostering an environment that builds on that organizational model. TAP project paper, recognizing this variety of NGO structures, envisioned that five to seven international NGOs, approximately fifteen national organizations, and 100 "micro" NGOs would, ultimately, become involved in TAP's efforts. NGO participation has clearly exceeded these expectations; 200 NGOs—almost twice the anticipated number—are now involved in cluster activities.

While some member NGOs are international organizations that do not necessarily have a local focus and approach, others are genuinely community-oriented organizations that have developed in direct response to locally identified needs, including HIV/AIDS. In addition to the relative scopes of the individual NGOs—and, therefore, their ability to call on their membership and non-TAP resources—the levels of commitment and participation vary substantially among the NGOs. Quasi-political organizations are generally less involved than either the national independent NGOs or the local/community-based NGOs.

The articulation of goals, objectives, or missions statements varies among clusters and NGOs. Most of the nine clusters appear to have developed mission statements and specific goals and objectives while developing their project subagreements. Some of these statements are clearly articulated, others are not. Several clusters' mission statements are realistic, and focused; others are diffuse and beyond the management capacity of the cluster or individual NGO. A cluster's

established targets are frequently the sum of the targets identified by the larger, more established NGOs; the smaller NGOs do not necessarily agree with their cluster's targets.

TAP's delivery of technical assistance (TA) to the cluster, the NGOs, and the communities has been hindered by funding delays and logistical problems. Most of the TA provided by TAP has focused on developing the capacity of individuals rather than of the NGOs or clusters. In other words, cluster have not adopted a strategic plan for capacity building and have chosen to train participants in a fairly ad hoc manner.

Decentralization efforts are proceeding; the clusters are implementing activities in selected districts in all nine regions. In these districts the participating NGOs seem to function effectively as "subclusters" or "miniclusters." They are still connected to the cluster organizations at the regional level, but the relationship seems to be more a supervisory one than a collaborative one. The districts have no funds of their own and are closely supervised by the regional steering committee. Thus, decentralization, if at all workable in the absence of appropriate capacity-building and management training, is still in its early stages.

After a somewhat lengthy period during the development of its systems, TAP now routinely uses monthly financial reports and reports on outputs to manage cluster activities. Although this financial, quantitative, and situational data has its place in program management, TAP needs to devote immediate attention to improving the NGOs' capacity to generate and use monitoring and evaluation information to improve their program performance.

RECOMMENDATIONS: In order for the NGO cluster concept to continue to be viable and effective, cluster development activities should focus on ways in which USAID can further support clusters as recognized operational entities.

TAP Extension Period (1997 to 1998): During the extension period, TAP should assess each cluster's managerial deficiencies. Once these deficiencies are identified, TAP should define a short-term strategy and a supporting budget to respond to each cluster's specific internal development priorities. In a related action, TAP's staffing profile should be evaluated and, if necessary, reorganized to focus on the NGOs' internal capacity development needs.

Beyond TAP Extension (1998 to 2003): USAID/T and its successor should focus on the following activities:

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    - Design and management of local research initiatives.

- Reaffirm the importance of recruiting cluster worksites and developing these worksites for greater coverage and increased cost-effectiveness.

- Underwrite opportunities to promote public sector political support for the NGOs by supporting activities such as joint-review workshops, press releases, and observational travel.

2.2 Business or Worksite Development

TAP will eventually fully incorporate worksite programs into its regional cluster programming; it has already taken steps to introduce cost-sharing programs in the clusters. The worksite programs include training employee peer health educators, providing IEC/BCC materials and programs for use in the workplace, and promoting condoms. Since 1988, TAP has supported three worksite programs, based largely with Dar es Salaam employers. These worksites were set up outside the cluster framework by three collaborating institutions: the African Medical and Research Foundation (AMREF), the Tanzanian Council of Social Development (TACOSODE), and the Tanzanian Federation of Trade Unions (TFTU). The AMREF program, for example, works with 14 employers, including British Petroleum (BP) Tanzania, Tanzania Breweries, transportation companies, sugar and tea estates, and parastatal companies.

The management of most companies is willing to buy into these programs, their economic status permitting. As new companies are added to a program, cost-sharing is made a condition from the outset. However, despite the companies' willingness to participate in the worksite program, a lack of commitment from top management coupled with poor supervision of peer educators have been major constraints to the effectiveness of these programs. Recognizing that part of the problem with using peer educators in the worksite program is that they are volunteers, some companies have arranged for the peer educators to keep some proceeds from the Salama condom sales as an incentive to stay involved in the program.

The Tanganyika Planting Company (TPC), a large sugar estate near Moshi, is a Moshi cluster member and provides an example of a worksite program incorporated into and implemented through a cluster. The program began in 1995 and includes peer educators (both male and female, although the vast majority of the estate employees are men), a drama group, films, and a primary school educational program. Although the program targets the population of the

residential community camps on the estate, many educational activities are also provided in villages and communities off the estate—particularly the performances of the drama troupe. The worksite team intends to build community involvement, because many employees do not live on the estate and there are many formal and informal links between estate residents and nonresidents. In addition, the worksite team will train more peer educators to provide counseling expertise and to conduct a regular program of seminars in the estate communities.

Some types of worksites present serious challenges to developing suitable interventions. A case in point is the casual mining sites in the Tabora and the Shinyanga Regions. These mines attract thousands of itinerant prospectors. The Matinje site, for example, has over 2,000 miners living in nine different camps. The miners, mostly young men, stay in the area for different lengths of time depending on the success of their efforts. Therefore, providing worksite services to these itinerant miners is complicated. The Tabora cluster has trained five peer educators at mining sites in the Nzega District, but three have already left the area; since they cannot be traced, there is no way of knowing if these peer educators are providing educational services in their new locations.

Some clusters have not actively recruited worksite partners. The clusters often rely on the TFTU, which may be a weak link. Although the TFTU is ostensibly a member in many clusters, their representatives were largely unavailable during the team's visits to the regions. Furthermore, some regions (most notably Tabora and Shinyanga) have relatively few large employers that would make worksite programs more efficient and cost-effective. Thus, the clusters have not be able to recruit the anticipated 100 worksites.

2.3 Orphans

In its initial stages, TAP emphasized assisting AIDS orphans as a programming element that was of equal significance to HIV/AIDS prevention and control. However, TAP's implementation of this orphan component depended on the transfer of resources from other USAID-supported program areas, predominantly the Finance and Enterprise Development Program into a Social Action Trust Fund. To date, this private sector strategic objective has not been able to generate the anticipated support for AIDS orphans activities. TAP's efforts to assist orphans have been hampered from the outset, and TAP has had to use existing program funds—rather than the anticipated substantial resources from the Social Action Trust Fund—to help a very small number of orphans in the cluster areas.

Part of the difficulty of implementing the AIDS orphan program element stems from the definition of orphans at the policy level in the Ministry of Labor and Youth Development. In Tanzania, an orphan is defined as any child of 18 years or under who has lost one or both parents. In this context, an orphan is not necessarily considered either socially or economically disadvantaged; the orphan might be living in a "complete" household with a surviving parent who has remarried. There is an overwhelming cultural preference for all orphans (those having lost either one or both parents) to remain in their original communities and to receive support through their kinship network. All of the clusters now identify AIDS orphans as a significant, growing problem in their regions and are attempting to carry out some interventions to help them. However, these efforts are modest and, as recognized by TAP, largely ineffectual.

The HIV/AIDS epidemic has caused an increase in Tanzania's orphan population. Responding to the socioeconomic burden associated with caring for and nurturing orphans, however, extends beyond the purview of the targeted HIV/AIDS prevention and control program. Although eliminating HIV/AIDS in Tanzania would eliminate future AIDS orphans, eradicating HIV/AIDS in Tanzania will not address the needs of current orphans which result

from poverty, poor health standards, neglect, abandonment, or lack of education. Further, in order to affectively address the problem of orphans, efforts and resources should be incorporated into programs that currently address broader issues such as poverty alleviation, community development, women in development, and compulsory education. Dedicating HIV/AIDS program resources to alleviating orphans as a socioeconomic problem will not alleviate the problem of orphans: it will only reduce the already limited resources that are dedicated to the targeted control and prevention of HIV/AIDS.

2.4 Information, Education, and Communication/Behavior Change Communication

Information, education, and communication (IEC) is a critical component of TAP and is the principal mandate/mode of intervention of member NGOs. The design of the IEC component involves two tiers; one to conduct IEC/behavior change communication (BCC) activities at the national level and a second to conduct activities at the community level.

This two-tiered design was developed in response to technical and practical concerns. The NGO clusters were not formed until mid-1995, over a year after the start of TAP. Until the clusters were ready for action, the IEC/BCC units implemented preparatory activities such as workshops to inform and sensitize national-level leaders and journalists and developed mass media interventions including radio spots, TV programs, and newspaper columns and cartoons.

TAP's IEC/BCC strategy is to take a quality, sophisticated approach. TAP has used the results of two formal "lessons learned" exercises, as well as the reports from cluster members, to focus its print media productions. These cluster reports suggested that Tanzanians are having trouble with the complex dilemmas raised by HIV/AIDS. The IEC/BCC unit continues to fund a weekly radio program on HIV/AIDS (AIDS and the Community), and a music program on the popular new private station during which the public service announcements (PSA) are aired. In addition, the IEC/BCC unit recently produced three items that focus on the complex HIV/AIDS dilemmas. These items are as follows:

- A wall calendar with the "Fleet of Hope" or "three boats" message;
- The *Sema Wazi*/Straight Talk newspaper insert presenting sexuality and HIV/AIDS experiences of youths; and
- *Tuzungumze,* a newspaper insert for adults.

All three items acknowledge the complexities of HIV/AIDS and STD prevention, care, and support; they also suggest "options" instead of directives on what to do. These IEC/BCC activities represent substantial achievements for a program that has been operating for less than two years. However, there are also some problems with these activities:

- Of these materials, the only one that appears to have reached the cluster level in adequate supply is the Fleet of Hope poster.
- TAP's pamphlets that provide basic information on AIDS need to be updated to reflect current thinking about the prevention-care continuum, to explain the basics of personal risk assessment, and to explain the importance of support (or at least tolerance) for people living with AIDS/HIV (PLWA/H).

- The materials are sent to the clusters without guidance on their specific uses. They often focus less on specific local needs and more on the larger, general needs of a national program. As a result, the special relevance of *Sema Wazi Wazi* for youth and *Tuzungumza*'s uses for parents was not always recognized.

- The limited attention to the timely and systematic production of TAP's publications, especially the *Sema Wazi Wazi*, has resulted in missing opportunities to use the publications as a principal medium of education on HIV/AIDS prevention and control.

TAP's training seminars have expanded the knowledge and imagination of most participating community-based organizations (CBO) regarding the range of available intervention methods. Still, the quality of IEC/BCC interventions varies greatly and the technical skill and understanding of IEC/BCC in clusters that are farther away from TAP/Headquarters(HQ) is lower than in clusters that are closer to HQ. All informants requested "refresher courses" and "more follow-up" from TAP/HQ to improve the quality of their work.

In summary, the quality of the national-level IEC/BCC program is very good—especially given the time line and budget. However, each program stands alone and makes no reference to the others. There is no common theme or symbol to help audiences combine the messages from different channels into a strong, unified message, as called for in the strategy.

RECOMMENDATIONS: The following recommendations focus on ways in which the disparate elements of TAP's current IEC/BCC program could be unified.

- Develop a national campaign theme and symbol (tag line and logo),

- Extend public knowledge of HIV/AIDS prevention and control issues by developing an IEC/BCC program to advise people of the risks inherent in ordinary social and sexual conduct,

- Develop an initiative designed to monitor behavioral change with respect to HIV/AIDS and STDs, and

- Design "instructions" and evaluation sheets to be included in each shipment of IEC materials.

2.5 Sexually Transmitted Diseases

2.5.1 National Program Coordination

USAID, in collaboration with the AIDS Technical Support Project (AIDSTECH) and the AMREF-directed education programs for truck drivers and sex workers, assisted in upgrading and training the personnel of four occupational clinics and selected primary health care (PHC) facilities along the major truck routes. The outcome of these joint initiatives has led to increased donor support for STD prevention and control in Tanzania.

In the early 1990s, NACP recognized the importance of STD prevention and control and designated a national STD coordinator who is assisted by an STD expert. The European

Economic Union (EEU) provided funding to develop and implement a national STD prevention and control program. Significant progress has been made including:

- The first worldwide randomized trial by AMREF demonstrating that improved STD treatment reduced HIV incidence by 40 percent;
- Development of a national policy and strategies on HIV/AIDS/STD for the Ministry of Health (MOH)/NACP;
- National STD treatment guidelines;
- Revision of the essential drug list to include cost-effective STD drugs;
- Consensus on the need to promote the syndromic management of STDs and agreement on related algorithms;
- Establishment of a system for distribution of European Economic Community (EEC)-purchased STD drugs to selected health facilities by the Medical Store Department (MSD); and
- An improved HIV/AIDS/STD surveillance system, including the monthly reporting of STD episodes and drug use from about 54 public sector STD centers.

Although their current working relationship has reportedly improved over the past year, the NACP and USAID/TAP have had problems because of the following issues:

- Changes in the senior staff of the NACP have led to several misunderstandings with TAP senior management on issues such as coordination, planning, policy development, and supervision;

- Slow implementation of the EEC-funded STD training program in the public sector coupled with USAID/TAP's focused support of STD training, prevention, and control in the private sector has led the NACP to assume that USAID/TAP had only a limited interest in collaborating with the public sector; and

- Relatively limited communication and collaboration among donors has led to duplication of effort and lapses in nationwide coverage.

Because of these difficulties, private facilities with staff trained under TAP have not taken advantage of EEU funding for STD drugs. At the same time, the NACP has not been able to benefit from USAID/TAP's experience in delivering training on STD syndromic management. There is often a disconnection between the facilities that have trained providers in syndromic management and the availablity of drugs.

The lack of collaboration among implementing agencies such as TAP, AMREF, and Germany's Association of Technical Cooperation (GTZ) has resulted in missed opportunities. Each of these organizations has developed unique experiences, tools/materials, and approaches that could help identify best practices. For example, GTZ and AMREF's work to establish post-training supervision of STD case management could serve as a model for other training programs and supervisory approaches. If the nation's response to HIV/AIDS/STDs is to improve, donor collaboration to share lessons learned must also improve.

Although TAP has experienced difficulties in coordinating the efforts of program participants and has, therefore, missed opportunities for collaboration, TAP's program is recognized as

having made significant contributions to STD prevention and control in Tanzania. TAP's contributions include the following:

- Mobilizing and supporting new partners in HIV/AIDS/STD prevention and control;

- Empowering three training governmental institutions—the Primary Health Care Institute (PHCI), the Centre for Educational Development in Health in Arusha (CEDHA), and the Infectious Disease Clinic (IDC)—by developing their training and supervisory capabilities in STD;

- Developing STD treatment guidelines for the NGOs;

- Training (in 15 months) more than 600 health providers in the syndromic management of STDs; and

- Developing evaluation procedures to assess the effectiveness of TAP's training strategies on syndromic management of STDs. The interim report prepared by TAP in July 1996 on "Quality of Post-training STD Case Management" of 1101 patients suggested that correct use of the national guidelines for syndromic management was high: 70 percent of patients received either the first line of recommended drugs for the diagnosed syndrome or approved alternate treatments. Furthermore, risk assessment was used correctly in most cases to manage vaginal discharge in women.

Despite these contributions, TAP's training of more than 700 health providers represents training for less than 5 percent of the 18,000 professional and other medical personnel in Tanzania's health care system. In addition, supervision of these trainees has not continued as

planned because of organizational and administrative issues, as well as limited resources. Nevertheless, TAP has played a significant role in the progress made so far and has demonstrated a comparative advantage in planning and delivering training activities on STDs. If TAP and USAID are to continue making a contribution to STD training activities, they should recognize that current donor programs do not make the best use of donors' skills and experiences and do not facilitate the development of linkages and partnerships for investing resources in the most relevant locations. The sectoral and regional approach used by donors needs to be reviewed in the context of STD epidemiological and behavioral data, in-country institutional capabilities, and opportunities for effective interventions. In addition, as recognized by the MOH, there are limits to the training and supervisory approaches and their ability to address the enormous training needs of all health and family planning programs. Still, the donors and the government agree on most of the critical issues regarding the delivery of an effective STD prevention and control program in Tanzania. With proven interventions and with the approaches and materials developed by key players in STD prevention and control, it is the right time to implement a coordinated effort.

2.5.2 Service Accessibility

TAP has not undertaken specific activities to improve service accessibility, except for its training of service providers. The critical service accessibility components that are missing from the program include:

- Coordination with the government sector,
- Promotion of "new and improved" services,
- Improved integration with current health care delivery points,

- Development and maintenance of infrastructure, and
- A consistent and appropriate drug supply.

In addition, since much of the HIV/AIDS program emphasizes the use of the male condom as the single most effective means—other than abstinence and partner fidelity—of preventing the transmission of HIV/AIDS and STDs, the value of the female condom and the diaphragm has been ignored. Although neither of these methods has achieved widespread recognition and use within any national HIV/AIDS program, they could be introduced on a trial basis as methods that provide Tanzanian women with some ability to prevent HIV/AIDS transmission.

Without surveillance data, it is difficult to determine the number of patients that have been seen by trained providers and the extent to which services are being used. Many trained providers work at sites with few STD patients (e.g., two per month or less). Generally, more women than men are seen—possibly because the inadequate drug supply in the public sector may have resulted in increased utilization of pharmacies, especially by men. An inconsistent drug supply reduces demand for services because, even though trained clinicians staff the facility, patients choose to avoid sites where drugs are not available. Finally, epidemiologic data—including any available sentinel surveillance data—are not being used to plan or to make decisions.

2.5.3 IEC/BCC Activities

IEC/BCC (specific to STDs) to develop and promote messages to prevent HIV transmission has not been a major project component. NGOs, both individually and in clusters, do not appear to understand the importance of linking birth control (BC) messages to STD

management. Materials developed by other groups—such as AMREF and GTZ—are not widely distributed by TAP.

2.5.4 Case Management of STDs

Among TAP's NGO clusters, the control of STDs as a significant HIV/AIDS control and prevention mechanism has not been given the attention it deserves. In 1995 alone, nearly 30,000 STD episodes were reported to the NACP from 54 public sector health facilities across Tanzania. Also, the frequently cited Mwanza study estimates that the HIV transmission rate can be reduced by as much as 42 percent through early diagnosis and prompt treatment of STDs. In TAP's nine regions, the expression "HIV/AIDS/STD" is used even when only HIV/AIDS issues are addressed. As a result, it is extremely difficult to determine when STDs specifically have been addressed. Many NGO cluster members often "forget" to mention their specific efforts in STD prevention when they discuss their activities and achievements; when they "remember," STDs are presented as being relatively unrelated to HIV/AIDS. STDs are often portrayed as "freestanding" diseases; the link between STD and HIV transmission is not made or emphasized.

The integration of STD programs into family planning (FP)/reproductive health (RH) programs has occurred to the extent that those NGO cluster members—and their community outreach workers, such as village health workers (VHW) and traditional birth attendants (TBA)—that traditionally provide FP/RH services have been educated on STD prevention and, occasionally, syndromic management. Such STD programs include training of peer educators in HIV/AIDS/STD interventions, training of trainers (TOT) in HIV/AIDS/STD community-based IEC/BCC interventions, and TOTs in STD syndromic management. The application of these newly acquired HIV/AIDS/STD skills to FP/RH is left to the discretion of the NGOs. Moreover, the current policy prohibits maternal and child health (MCH) aides and nurses who

are trained in syndromic management from prescribing STD drug treatment and represents a missed opportunity to improve quality of care and potential impact of STD programs.

2.5.5 Training of Clinicians

TAP's effort to train clinicians in service provision is highly commendable. So far, 656 clinicians—including medical officers, assistant medical officers, medical assistants, and clinical officers in the NGO and private sectors—have been trained in the syndromic management of STDs based on the World Health Organization's (WHO) guidelines. In addition to its private sector focus, TAP should be commended for its efforts and vision in developing and strengthening the institutional capacity of three public training institutes—CEDHA, Primary Health Care Institute/Iringa (PHCI), and Infectious Disease Clinic/Dar es Salaam (IDC)—to train clinicians in the syndromic management of STDs.

However, the training institutes' self-evaluation mechanisms and their supervision of trained clinicians should be strengthened. Out of a total of 243 clinicians trained by PHCI/Iringa in the syndromic management of STDs, only 91 have received supervisory or follow-up visits since training started in July 1995. The 168 IDC-trained clinicians have not had follow-up visits of any sort since that training started in May 1995. The reasons given by these institutions for their irregular or non-existent follow-ups range from funding constraints to lack of the necessary staff and time.

One lesson learned from the GTZ project in the Mbeya Region is that, unless training in syndromic management of STDs is followed up immediately with supervisory visits, the clinicians often revert to the etiologic approach of STD management once they are confronted with problems applying their newly acquired skills. One of GTZ's best practices has been to visit newly trained clinicians within one week of their return to duty to guide them through

these initial problems. Once the clinicians are through the initial problem stage, they tend to continue to use the syndromic approach to STDs. Another best practice of the GTZ project is the delegation of supervision of the trained clinicians to trained district medical officers (DMO) and district AIDS control coordinators (DACC). As a result, each clinician receives supervision at least twice a month. This regular supervision to ensure that clinicians continue to provide quality STD services is clearly a model on which other projects should base their supervision requirements.

When evaluating the success of clinician training, partner notification and treatment are always difficult issues since their success or failure largely depends on the patients and their contacts. With little success, trained clinicians continue to counsel patients and give them partner notification slips.

In addition, correct antibiotic treatment depends on the sensitivity pattern of the causative organisms and the correct application of highly sensitive and specific treatment algorithms by trained clinicians. Thus, the algorithms will require regular assessments and updates.
One highly commendable practice of the GTZ in the Mbeya Region is its continuing effort in operations and biomedical research initiatives and application of research findings to service delivery operations. Following the outcome of such efforts, kanamycin replaced septrin in GTZ-supported health facilities in the Mbeya Region as one of the first-line drugs used to manage urethral discharge.

2.5.6 Policy Issues

The United Republic of Tanzania has a draft policy on HIV/AIDS/STD that clearly articulates the right of all Tanzanians to have access to IEC on HIV/AIDS/STD; the draft also states the GOT's intention to provide free STD services. This approach, although well intentioned, may not be sustainable. Findings suggest that currently all patients (including STD patients) are required to make "contributions" toward the services that they receive. Contact tracing and treatment continues to be a difficult issue. Considering the public health benefits of partner notification and treatment, the GOT should consider providing free treatment (including a consultation fee) to any patient who presents a valid contact/notification slip at a public health facility.

Community members, religious leaders, traditional rulers, and parent and teacher committees should be sensitized to the need to introduce HIV/AIDS/STD and reproductive health education into the formal and informal school systems. There is increasing anecdotal evidence of a problem with adult males seducing underage females, often school girls, in an attempt to avoid being infected by "exposed and experienced" adult females. This practice has led to an increasing prevalence of HIV infection among youth in their early teens. NACP and the presidency should be encouraged to further facilitate this sensitization process through dialogue with the Ministry of Education (MOE).

Finally, to improve and maintain the highest standards of STD services, senior medical practitioners, such as regional medical officers (RMO) and DMOs, should be trained in the syndromic management of STDs and given competency-based supervisory responsibilities over clinicians in their regions or districts.

RECOMMENDATIONS: The following recommendations would ensure that the current progress in addressing STD issues is continued:

- Continue to support the Muhimbili testing and counseling center;

- Continue to support coordinated and integrated public/private sector training in STDs;

- Provide TA centered on monitoring and maintaining standards in the training institutes;

- Explore the feasibility of USAID supporting the regular supply of drugs by paying selected distribution costs and by ensuring the availability of free or affordable STD drugs in critical locations that have high patient utilization; and

- Provide support for the following country-specific research issues:

    - Collection, analysis, and application of epidemiological and behavioral data;

    - Integration of additional categories of health agents, such as traditional healers and birth attendants, into the program;

    - Contact tracing and treatment of the partners of persons with HIV/AIDS/STDs;

    - Promotion of the increased visibility, acceptance, and access to female-controlled HIV/AIDS prevention methods; and

- Inclusion of pharmacists and patent medicine dealers in STD syndromic management training.

2.6 Condom Social Marketing

During the three years since the start of the project, PSI has sold more than 26 million condoms into the trade in Tanzania; it sold 11.9 million in 1996 alone. Apart from the minimal cross-border traffic to Malawi and Burundi, it is believed that most Salama condoms stay in Tanzania. PSI's promotion of the use of the Salama condom is commendable and, after three years of sales, compares favorably with other PSI Africa programs. There were some stock outs in Tanzania during 1996, which may have hampered sales and per capita rates slightly. Prior to the Salama condom's introduction, some consumer demand was already being addressed by NACP condoms. In addition, about 3.75 million condoms issued to the MOH and distributed to FP units are being used per year. In total, Tanzanians are using about 25 million condoms annually, and clearly the launch of the Salama condom has been successful in switching users from using free condoms to paying for condoms.

PSI has sold many more Salama condoms than it budgeted in the initial three year contract, and since volumes of free condoms were in the system when PSI started operating—presumably catering to an existing consumer demand—its performance is even more commendable. The condoms have been well distributed in the pharmacy and drug store sectors, but less so than in the non-traditional markets in other PSI programs, where PSI has had more responsibility for the whole marketing program. Condom distribution in general merchandise outlets is weak.

Consumer awareness of HIV/AIDS is widespread among Tanzanians, although this is not entirely because of PSI's activities. Awareness of the Salama condom as a condom brand is

also widespread and, since it is the only major branded product in the market, its name is becoming generic. The communications efforts connected with this activity have been good, but these efforts have been directed toward marketing the Salama condom rather than promoting the HIV/AIDS program. To promote the HIV/AIDS program, a consistent strategy and an identifiable symbol or tag line is needed in both the advertising of Salama and other TAP-produced media.

PSI has had productive relationships with some of the individual NGO's, but for other NGOs within the clusters, PSI has been responsive rather than proactive. When approached, PSI has carried out effective CSM training and has provided materials and condoms with favorable payment terms. Within a rather limited budget and with constraints on media availability, PSI's activities on the ground have been effective using the Mobil Video Unit (MVU), often in conjunction with other NGO activities. However, these activities have been less visible here than in other PSI programs.

PSI's use of local packaging facilities and existing distribution networks has made the Tanzania project more sustainable—in sales and distribution—than in other markets. The price margins seem acceptable to all sectors of the trade and well controlled at wholesale and semi-wholesale levels. Despite having a recommended retail value of 50/TS, retailers determined the retail price of the condom based on the highest price that they think consumers will pay. Nonetheless, prices within a locality seem stable.

RECOMMENDATIONS: The following recommendations focus on ways in which to both maintain PSI's considerable progress in condom distribution and to increase its contribution to public knowledge of HIV/AIDS prevention and control.

- Use the existing sales force to carry out more public demonstrations promoting the use of condoms against HIV/AIDS;

- Actively collaborate with NGO clusters to support sales training, the development of materials, and the continuation of favorable terms for condom sales;

- Expand condom distribution to general merchandise outlets; and

- Promote an increased acceptance of distributing family planning products from Tanzanian medical services and associations.

2.7 Policy

In any nation, the development of policy is a strong indicator of commitment to HIV/AIDS control and prevention. In Tanzania, there are several indicators of movement on HIV/AIDS-related policy at both the central and the regional/district levels. At the same time, several factors appear to represent policy constraints to developing a positive environment in which to build an effective national and regional response to HIV/AIDS prevention and control. From the perspective of a midterm review and within the context of USAID's results framework, several opportunities exist for USAID's support of policy development based on its experience in assisting other nations in the promotion of HIV/AIDS-related policy.

2.7.1 Description of the Policy Environment

The following enabling factors exist in the policy environment in Tanzania.

(1) Enabling Factors.

- Progressive *National AIDS Policy* Draft. The draft *National AIDS Policy* (NAP), issued in September 1995, is a progressive document that supports a favorable environment for responding to HIV/AIDS/STDs. This policy embraces a multisectoral approach to HIV/AIDS/STD prevention, care, and control and clearly vests authority for the coordination of policy development with the NACP in the MOH. It also refers to the need to create multisectoral committees to coordinate a national response to HIV/AIDS.

- National AIDS Committee Potential. The National AIDS Committee (NAC), located in the prime minister's office, is an interministerial body that has the prime minister's permanent secretary as its chair. In forming the NAC, the GOT is acknowledging that an effective response to HIV/AIDS requires coordinated cross-ministerial action. However, the NAC has met only once and is, therefore, not yet a functional committee.

- Forward-Looking Policy Papers. The NACP has produced several thoughtful policy-related reports over the years. NACP staff and respondents feel that an opportunity now exists for a more systematic approach to transforming these reports into supportive policy action.

- Donor Support. Donor assistance is a potential means of support for the HIV/AIDS policy environment. For example, the Danish International

Development Agency (DANIDA) is leading the donor health reform effort, along with the primary health care secretariat in the MOH. The following efforts will have significant implications for the country and its health system:

- Redefining the role of the district and that of the MOH;

- Developing and carrying out cost-sharing policies;

- Fostering decentralization and the development of a health management information system (HMIS) and financial administrative management system (FAMS); and

- Redefining public sector delivery of HIV/AIDS/STD services, the role of the private sector (including NGOs), and the future of the NACP.

In addition, the EEC and USAID are supporting policy development initiatives that seek to maximize the use of resources to respond to the HIV/AIDS/STD challenge. These initiatives include the EEC's support for STD drugs and USAID's support of the NGO's work to train public and private sector health workers in STD treatment and to encourage cost-sharing by small businesses.

· Regional Collaboration. At the regional level, the regional AIDS control coordinator (RACC) and the RMOs to which they report represent the key HIV/AIDS/STD policy team. Encouraged by their respective regional commissioners, the RACCs and the DACCs actively collaborate with the majority of NGO clusters, frequently serving as members of the cluster committees, advising the clusters, and acting as resources for coordination between the clusters and the local government. In addition, under TAP's

leadership, each cluster has sponsored a one-day sensitization training session on HIV/AIDS/STD issues for regional decision makers and leaders, including the regional commissioner (RC), regional administrative secretary (RAS), regional development officer (RDO), RPO, regional education officer (REO), leaders of the religious communities, and other key decision makers.

- Progressive De Facto Regional Policy. While the NAP may still be in draft form, there are repeated instances of de facto HIV/AIDS-related policy development at both the regional and district levels. For example, the government provides free medical care in hospitals and health clinics for HIV-positive and AIDS-infected persons. Most RC's are not only engaged in responding to the HIV/AIDS challenge, but are also willing to commit resources—personnel, space, transportation, and gasoline—to support the NGO clusters' activities. In addition, even when no policy existed at the central level, most RCs were eager to promote the increased exposure to HIV/AIDS/STD issues within their government-supported schools.

The following constraints exist in the policy environment in Tanzania.

(2) Constraints.

- Delay in Finalizing HIV/AIDS Policy. As of this midterm review, the NAP remains in draft form with no date targeted for its finalization. The draft status of the NAP impedes the effectiveness of the NACP by limiting its ability to proceed with implementation of an unequivocal policy. However, the United Nations Joint Program on AIDS (UNAIDS) is supposedly prepared, as part of the third mid-term plan (MTP III) process, to assist the NACP in the NAP's completion. If such action is planned, it should be encouraged.

- Need to Clarify NACP Role and Function. The documents explaining the plans for national health reform are unclear on the role and function of the NACP. Because of this lack of clarity, the managerial skills required for the NACP to fulfill its role as the central-level coordinator of HIV/AIDS policy formulation and promotion remain undeveloped.

- Religious and Social Constraints. Tanzania appears to be a deeply spiritual and traditional country. In many cases, its religious institutions support a wide array of health and social services. In several exceptional cases, religious leaders—Catholic, Protestant, and Muslim—serve as key members of NGO clusters. At the same time, some religious communities are ideologically opposed to having frank discussions of sexual relations and to using condoms to reduce HIV/AIDS/STD transmission, two of the key elements in the GOT's HIV/AIDS program.

  With regard to traditional beliefs, practices such as female genital mutilation, use of incisions in traditional medicine, male circumcision, and associating the transmission of HIV/AIDS with witchcraft inhibit the public's understanding of HIV/AIDS control and prevention. In addition, the continued stigma associated with HIV/AIDS leads to significant levels of denial, especially at the central level, of the high incidence of HIV/AIDS and of its emergence into every segment of Tanzanian society.
  Bringing about a change in these traditional values and beliefs requires an enormous, time-consuming effort. The first step in implementing any behavior change must be taken by the government. The government must commit to a policy of working with decision makers and opinion leaders at all levels to develop a constituency for change. Building on this policy, the constituency can

then collaborate with the public and private sectors to formulate a policy focused on creating a climate for behavioral change.

- Need for Resource Coordination. Although there is evidence of considerable donor support—actual and potential—for Tanzania's HIV/AIDS/STD control and prevention program, the identification and application of program-related resources is largely undocumented and uncontrolled; there is no policy directed at coordinating these resources and use of the available resources is often duplicative. Although the NACP's potential role as a coordinator of HIV/AIDS/STD policy and resources—both technical and financial—is noted, the NACP needs assistance to translate its potential into reality. This assistance could be provided by funding initiatives focused on formulating policy directives and by conducting targeted internal capacity building.

- Limited Use of Data. There are substantial inconsistencies in the policies related to the collection of HIV/AIDS data and in the accuracy, timeliness, and use of available information. In addition, although the nation's health information system figures prominently in its health reform plans, little attention has been given to practical and ethical policy issues associated with defining and maintaining an HIV/AIDS surveillance system. Although the NACP is interested in revitalizing its largely dormant surveillance system, NACP respondents were unable to define ways in which information would be collected, analyzed, or applied.

- Minimal Regional/District Multisectoral Collaboration. With a few notable exceptions, regional- and district-level officials have acknowledged the mounting health and socioeconomic burden associated with the increased nationwide incidence of HIV/AIDS. However, there is little evidence of any

systematic approach to implementing a policy promoting a coordinated, multisectoral regional/district response to HIV/AIDS.

2.7.2 USAID's Comparative Advantage in Supporting a Positive Policy Environment

From the perspective of USAID/T's results framework calling for ". . . increased knowledge of and access to HIV/AIDS information and services . . . ," there are significant opportunities for USAID to use its comparative advantages to support a positive policy environment in Tanzania. In order of priority and timing, these opportunities are as follows:

(1) Constituency Development. As discussed in Section 1.7.1, many of Tanzania's public and private sector decision makers and opinion leaders view transmission of HIV/AIDS as an isolated event that mostly affects a discrete portion of Tanzanian society. By applying its AIDS Impact Modeling process (AIM), USAID has succeeded in a variety of countries (most notably and most recently in Kenya) in sensitizing national decision makers and opinion leaders to the current and potential impact of continued high-level transmission of HIV/AIDS in their countries. As a result, most of these nations have developed HIV/AIDS-related policies that reflect a clear understanding of the importance of a proactive response to HIV/AIDS. With proper preparation and sufficient dedication of resources, the AIM process should produce similar benefits in Tanzania.

(2) Capacity Building within the NACP. Since the GOT continues to view the NACP as its coordinating body for HIV/AIDS control and prevention initiatives, USAID's experience in developing the managerial capacities of disparate government entities could be applied directly to the expressed needs of the NACP's senior management. Although the NACP may not now have the managerial capacity to define policy needs and to design and implement strategies to respond to these needs, with

USAID's targeted TA, the skills of the NACP senior staff could be strengthened to focus on the NACP's role as a coordinator of HIV/AIDS-related initiatives.

(3) Information Systems Development. As discussed, revitalization of Tanzania's HMIS figures prominently in the nation's health reform plans. Although USAID support for a separate HIV/AIDS information/surveillance system would be inappropriate, USAID should use its experience in developing information systems and building capacity to use data for decision-making to implement a MOH/donor-coordinated approach to developing an information system. Accordingly, USAID should provide support (with other donors) to ensure that Tanzania's information system is responsive to the needs of the HIV/AIDS program and to ensure that regional and district program directors have sufficient technical capacity to effectively interpret and use the available data.

(4) Public/Private Sector Integration. As noted in several sections of this report, TAP has been successful in promoting the coordination and integration of public and private resources to respond to regional and district HIV/AIDS program needs. While TAP's success is significant, USAID consistently supports similar initiatives throughout the world. USAID/T should, therefore, use its knowledge and experience to work with TAP and its successor to promote a positive policy environment where public and private sector resources will continue to be integrated in such areas as training, IEC/BCC message development, information systems, and community mobilization.

(5) Research. Over the past twenty years, USAID has developed a considerable comparative advantage in two principal areas of research: quality improvement and improved operations management. USAID support in both of these areas is important for developing a country-specific policy for HIV/AIDS prevention and control in Tanzania. Specific areas for this research include:

- The quality of HIV/AIDS counseling provided by the nation's health services,

- The importance of developing a policy that would make traditional healers and midwives key actors in the response to HIV/AIDS in Tanzania, and

- The current policy that prohibits MCH aides and nurses from prescribing drugs in the treatment of STDs.

USAID support for technical research assistance on these and other key issues would provide Tanzania with the ability to develop and implement research protocols the results of which could be applied to defining a policy for HIV/AIDS prevention and control.

RECOMMENDATIONS: The following recommendations focus on potential USAID/T support for a country-specific approach to promoting HIV/AIDS-related policy.

- Support the use of the AIM methodology in Tanzania to develop a proactive constituency for HIV/AIDS prevention and control;

- Support the NACP—through workshops, TA, or other means—to finalize and disseminate the NAP;

- Support a thorough review of Tanzania's HIV testing policy and associated regulatory framework;

- Support the use of USAID's private sector AIDS prevention methodology to assist employers in assessing the potential impact of HIV/AIDS in their workplace, as well as to identify policy options and prevention programs; and

- Support journalist workshops focused on HIV/AIDS/STD issues.

2.8 Management

2.8.1 TAP Management Issues

TAP's senior management is very interested in ensuring the financial accountability of each of its nine clusters. Although financial reports suggest that most clusters initially experienced difficulty in responding to TAP's accounting requirements, TAP's emphasis on financial training for cluster managers has enabled the clusters to consistently and accurately account for financial disbursements. The financial reporting from selected clusters was occasionally delayed, but TAP/Dar es Salaam's financial staff of three accountants were able to reduce such delays to an acceptable minimum. Finally, there is no evidence to suggest that the time allocated to financial management adversely affected technical areas of project oversight.

However, TAP's emphasis on financial accountability appears to have created a misperception among the clusters that TAP's primary purpose was to facilitate financial support, rather than to provide TA. In all fairness, much of this emphasis appears to have originated in AIDSCAP's Washington office and, more recently, in AIDSCAP's regional office in Nairobi. Nevertheless, this misperception detracts from TAP's ability to have a more effective, proactive dialogue with the clusters to address the clusters' needs and requirements for capacity building in areas other than financial management. Even in the many cases where other training was provided to the

clusters, providing a set number of training activities and accounting for the number of persons trained was emphasized, rather than periodically assessing the value or application of the training received.

2.8.2 TAP's Funding Disbursement Mechanisms

TAP's disbursement of funds to the clusters tends to be erratic. It can best be characterized as total gaps in funding for periods of as long as two to three months, followed by sudden and unexplained disbursement of funds. Much of the responsibility for the delay in funding can be traced back to Nairobi's AIDSCAP office and from Nairobi to Washington's AIDSCAP office. It should also be acknowledged that Tanzania's underdeveloped distribution of banking institutions has contributed to TAP's difficulties in disbursing funds on time. Although the reason for the external delays in the disbursement of funds and for the erratic availability in funding could not be assessed in this review, there does not appear to be a value-added benefit to having AIDSCAP's Washington or Nairobi offices centrally manage the funding mechanism.

In reviewing TAP's funding disbursement mechanisms with each cluster's financial manager, the MTR found that no allowances were made for mail delivery delays resulting in further delays of the transfer of funds. In addition, TAP's erratic disbursement of funds has had an adverse effect on the clusters' ability to plan and initiate activities. Without exception, the clusters were frustrated by their inability to link TAP's eventual disbursement of funds with their approved and budgeted work plans. Most clusters, therefore, had prolonged periods of inactivity while they were waiting for their funds, followed by accelerated efforts when their funding was received. Finally, there was limited evidence of any mechanism for clusters to request specific funding to respond to emerging opportunities. (See Appendix D for an example of the TAP/cluster funding distribution mechanism.)

2.8.3 TAP's Supervision of Cluster Activities

Under TAP's guidance, all clusters have produced work plans. Bringing together all of the NGOs within one work plan creates a valuable starting point for increased collaboration and sharing of scarce resources. However, it appears that because of TAP's emphasis on financial accountability, the clusters attach importance to achievements such as the amount of posters produced or the number of persons trained, rather than to the utility of those activities. At the same time, TAP's use of cluster work plans to budget financial support linked to work plan activities or to provide technical feedback appears to have been negligible. Furthermore, with the exception of clusters organized in Morogoro, Iringa, and Moshi, which have uniquely self-motivated senior management staff, clusters show little understanding of objective-setting or of the importance of conducting results-oriented evaluations. In addition, when asked to comment on the extent to which TAP senior management had responded to a cluster's monthly PIF, no cluster could cite a situation where TAP's management responded to any issue other than a financial one. Finally, little evidence exists of a systematic TAP strategy to ensure effective technical, post-training follow-up, support, and evaluation of the project's many training initiatives. With regard to the clusters' ability to supervise their own activities, clusters noted two principal difficulties: the lack of transportation and the erratic movement of funds.

2.8.4 TAP's Staffing Profile

TAP's staffing profile has enabled the project to respond to many of its immediate implementation needs. Under the guidance of an energetic resident adviser, TAP has succeeded in uniting 189 separate, and often disparate, NGOs into nine clusters. In just over two years, TAP's cluster concept has gained nationwide recognition, with growing potential. With guidance from TAP's technical staff, most clusters have effectively incorporated regional and district government officials into their steering committees so that there is a remarkable, if not unique, level of collaboration between the government and resident NGOs. In addition, TAP's staff has responded well to the often burdensome demands from AIDSCAP's Washington and Nairobi offices to produce documentation, to provide support to numerous external evaluations, and to assist in a seemingly endless list of seminars, meetings, and consultations.

At the same time, the cluster steering committee members agree that a more proactive and independent TAP-like management entity is needed; this entity should be capable of eliciting and responding to the expressed technical needs of the clusters without undue interference from external forces. This review did not focus on whether the current staff has the requisite background and technical experience to respond to this challenge. However, TAP's future staffing profile must be capable of responding to the challenge of managing hands-on a unified, empowered NGO cluster network.

2.8.5 Public/Private Sector Mix

The MTR team reviewed USAID's extended experience in Tanzania and in Africa in effectively responding to specific technical support requirements. As a result of that review and of discussions with the respondents, the team recommends the following technical areas as viable opportunities for USAID's future support to Tanzania's HIV/AIDS prevention and control program.

(1) Strengthening the NACP's Institutional Capacity. The NACP is moving away from its former role as an implementing agency towards an increased understanding of its role as a coordinating body that will develop and promote policy. The NACP also progressively envisions itself as responsible for targeted TA supporting regional- and district-level HIV/AIDS programs. In encouraging the NACP's development of both roles, USAID, with its experience in assisting national governments in managing programs and in analyzing and developing program policy, can provide targeted assistance to the NACP. Consequently, to support the NACP's development of its MTPIII, USAID might collaborate with the NACP to sponsor an institutional audit that, beyond identifying the ways that the NACP's personnel structure might be enhanced and maintained, would establish the parameters of longer-term institutional support for the NACP. Once established, these parameters could serve to guide USAID/T, the GOT, and the NACP in defining a package for prioritized TA, with an initial focus on NACP's evolution as a secretariat for policy development. Furthermore, although strengthening NACP's managerial and policy-making capacity will lead to its emergence as the focal point for HIV/AIDS-related resource coordination and allocation, USAID/T should take the lead to support the NACP in its initial steps to improve coordination and use of the many potential sources of support for Tanzania's HIV/AIDS control and prevention initiatives.

(2) Sensitizing Senior GOT Officials. Sensitization of senior-level GOT officials is the area in HIV/AIDS control and prevention that is most in need of targeted USAID assistance. Although there is ample evidence of regional- and district-level support for localized HIV/AIDS control and prevention, there is not a corresponding level of concern or action for a unified response to the increase in HIV/AIDS across all segments of Tanzanian society.

(3) Providing Assistance to the MOH in Public Sector STD Training. As noted, TAP's strengthening of the institutional capacity of three public training institutes—CEDHA, PHCI, and IDC—and its subsequent support of STD syndromic management training for 656 private sector clinicians represent credible project achievements.

2.8.6 USAID Support Package to Public and Private Sector NGO AIDS/STDs Activities

As mentioned, TAP clusters have had notable success in facilitating proactive collaboration between their NGOs and the regional and district governmental health and administrative authorities. In comparison to other national health-related programs, TAP's success in this area represents a country-specific comparative advantage for USAID's continued support.

2.8.7 USAID Support to Operations Research Initiatives

In exploring research initiatives, the MTR team focused on those cluster-specific research initiatives that would reinforce the clusters' ability to respond to the needs of their populations. Such demand driven research initiatives will produce findings that can be applied to resolve critical issues. In addition, by focusing on providing support, including technical research

methodology training for cluster-managed research, USAID will build the capacity of cluster NGOs and their governmental counterparts to conduct research.

Suggestions for HIV/AIDS-related research initiatives can be found in Appendix G.

2.8.8 Integrating Family Planning and HIV/AIDS Efforts into TAP's Five-year Strategy

There is considerable acknowledgement of the benefit of promoting integration of family planning and HIV/AIDS initiatives. Integrating these two key components of Tanzania's national public health program would increase the strength and the outreach of both programs. The following two key activities would be essential elements in the movement's success:

(1) A Policy Initiative. Support for development of a policy initiative that permits the reproductive health cadre to provide STD treatment. With the clearly documented linkage between treatment of STDs and the control and prevention of HIV/AIDS, revising this policy to permit RH workers to prescribe treatment for STDs is an essential first step in effectively integrating the two initiatives.

(2) A Training Program. Support for a training program for RH workers. To further strengthen the linkage between RH programs and the control of HIV/AIDS, an in-service (and eventually a pre-service) training program for RH workers should be introduced. This training program would emphasize the following:

- Treatment of STDs,
- Counseling in HIV/AIDS/STDs prevention, and

- Integration of FP and HIV/AIDS/STDs as a "one-stop" client encounter activity.

RECOMMENDATIONS: The following recommendations focus on ensuring that TAP and its successor have the flexibility and knowledge to respond to cluster-specific management capacities.

- Invest full authority in TAP's resident manager—and in all managers of future NGO-related management projects—to approve workplans and disperse funding;

- Define a financial management process for the project that will provide maximum flexibility and transparency in the funding of NGO activities;

- Define a supervisory structure for the clusters that is divided into the following four regional zones:

  Zone 1. Dar es Salaam and Tanga,
  Zone 2. Moshi and Arusha,
  Zone 3. Shinyanga and Tabora, and
  Zone 4. Dodoma, Morogoro, and Iringa;

- Promote the concept (initially on a trial basis) of a few performance-based grants for those clusters with a capacity to manage such a grant.

CROSS-CUTTING RECOMMENDATIONS: The following recommendations focus on the USAID support initiatives that are, in the opinion of the MTR team, essential to the HIV/AIDS control and prevention program's continued progress.

Strengthening the NACP: USAID/T should provide the NACP with technical assistance targeted to strengthen NACP senior management skills. An institutional audit would indicate the needed duration and content of this assistance.

HIV/AIDS/STD and FP/RH Program Integration: As a major focus of TAP and its successor, USAID should support, through seminars and training, the integration of HIV/AIDS/STD services with those of FP/RH.

NGO/GOT Regional/District Collaboration: USAID/T should ensure that technical assistance to NGOs supports the continued growth of collaboration between the regional and district NGOs and the government sector. Developing the program planning capacity of both NGOs and their local government counterparts should be a key element of this assistance.

Donor Coordination: Rather than including orphans as an element in its support to HIV/AIDS activities, USAID/T should work with other donors to ensure that efforts on behalf of orphans are included in programs such as those focused on poverty alleviation, women in development, community development, or compulsory education.

3. FUTURE SCENARIO FOR USAID SUPPORT FOR HIV/AIDS/STD CONTROL AND PREVENTION ACTIVITIES IN TANZANIA FOR 1997 to 1998

Responding to the SOW for this evaluation, the MTR team considered ways in which TAP can continue to respond to the urgency of HIV/AIDS control in Tanzania during its project extension through September 1998. The MTR team concluded that activities planned for 1997 to 1998 should build on TAP's progress to date and establish the necessary foundation for the subsequent five-year period of USAID support to Tanzania's HIV/AIDS/STD control and prevention program. As such, for the period from 1997 to 1998, TAP should focus on the following four principal activities:

(1) Policy Dialogue. With assistance from USAID/T, levels of dialogue on HIV/AIDS could be increased through the following interventions:

- Applying the AIM,
- Sensitization training of Tanzanian "policy agents" using AIM and other advocacy techniques,
- Interacting with religious leaders with support from U.S.-based religious networks that address HIV/AIDS, and
- Conducting study tours to neighboring countries to study the lessons learned in reaching senior government leaders and the consequences of inaction.

(2) Resource Coordination. As the first step in the resource coordination process, USAID would provide a short-term mission consultant to catalog, assess, and plan the use of resources for HIV/AIDS prevention and control activities in Tanzania. The assessment would include not only a review of donor community resources, but also a review of the resources of the GOT and of other private and public organizations operating in Tanzania.

As the second step in the resource coordination process, USAID would assist the NACP in sponsoring a resource coordination workshop designed to accomplish the following:

- Share the results of the resource assessment;

- Arrive at a consensus on the operational needs and procedures of the resource coordination process;
- Provide participants with an overview of USAID's re-engineering and upcoming results framework design process. Other donors would also be encouraged to review their processes for responding to Tanzania's HIV/AIDS support needs; and

- Establish the framework for NACP's role as coordinator of HIV/AIDS resources.

(3) Contraceptive Social Marketing under PSI. In addition to marketing the expansion of condom sales, PSI should renew its emphasis on the following activities:

- Promoting the social marketing aspect of the relationship between using a condom and preventing and controlling HIV/AIDS and STDs.

- Coordinating the IEC effort. PSI, with its experience and established reputation in Tanzania, is well placed to take the lead in promoting a coordinated approach to developing IEC messages. Specific attention should be placed on helping TAP facilitate the development of a national campaign theme and symbol (tag line and logo) that will integrate the diverse intervention strategies and messages of the HIV/AID/STDs control and prevention program.

- Increasing collaboration with NGO's. PSI has been less than successful in reaching out to NGOs who did not seek out PSI. PSI should promote increased collaboration with all NGOs (not just those in TAP clusters) to expand the condom market at the village level and to orient NGOs to the benefits and technique of effective social marketing.

(4) Cluster Capacity Building under FHI. This capacity-building activity would focus on consolidating the progress achieved during the past 2 years and establishing a foundation for future USAID TA with an emphasis on a smooth transition to the 1998 to 2003 program. Assuming that USAID will continue to support clusters in its upcoming five-year program, capacity-building activities in the next year should focus on strengthening the clusters internally rather than expanding cluster activities. Access to external TA should continue, but only if this TA is clearly linked to the objective of one of the following activities:

- Capacity Building: FHI should designate a person who is responsible for managing the capacity-building process. FHI must vest full authority in the country office to make programmatic and financial decisions.

- IEC: FHI should review and expand the content of IEC interventions so that they focus on the prevention and care continuum, gender issues, and enabling interventions.

- Monitoring and Evaluation: FHI should work with clusters in the field, as well as with program components, on capacity building that is focused on developing a monitoring and evaluation (M&E) process, testing methodologies, and increasing skills. Emphasis should be given to work at the cluster level.

- Organization Development: FHI should address organizational issues and dynamics at the cluster level. It should question how clusters can and do work together. FHI should emphasize recognizing different NGO strengths and agendas, and identifying why NGOs agree and disagree.

- Microenterprise Development/Income Generation: USAID should respond to the identified needs of the clusters to develop their capacity to generate income. This activity should involve USAID assistance to develop linkages between various USAID-supported activities across support organizations (SO) (i.e., HIV/AIDS/STD activities and microenterprise activities). It should emphasize the ability of cluster NGOs to develop income-generating activities to improve financial sustainability and to address the issue of orphans. There are no expectations that this activity will become operational in the very short term, but it could be implemented through a series of operations research initiatives.

- Financial Management Team: FHI should increase the transparency within the clusters. Emphasis should be placed on increasing TAP's flexibility and transparency in working with the clusters. Emphasis should also be placed on improving the reliability of the disbursement of funds according to approved budgets and expenditure reports. Given the tight budget control in TAP/Dar es Salaam, management should work closely with the senior accountant to regularly supervise field operations to achieve controlled empowerment of the clusters.

4. FUTURE SCENARIO FOR USAID SUPPORT FOR HIV/AIDS/STD CONTROL AND PREVENTION ACTIVITIES IN TANZANIA FOR 1998 to 2003

To build on the foundation established during the first 3 years of the program, over the next five years TAP should emphasize the continued strengthening of Tanzania's ability to define and manage an effective, sustainable, cost-effective program of nationally-coordinated HIV/AIDS prevention and control activities. In order for this activity to succeed, all parties will need to have an increased capacity to assess the impact of their actions and to take relevant corrective action within the context of targeted strategic planning.

Accordingly, building on the activities taking place in 1997 to 1998, USAID would be well placed to continue to assist Tanzania's response to HIV/AIDS/STD prevention and control through the following six interventions (See also Figure 1):

(1) CSM/IEC Coordination. Assuming that USAID continues to support social marketing of condoms, it will be important to fully integrate social marketing with a national IEC campaign.

(2) NGO Strengthening. Building on the efforts of TAP/FHI's team in 1997 to 1998, an initiative should be designed to continue the development of the Tanzanian NGO cluster network. This new initiative would focus on developing new cluster working relationships that emphasize the strengths of various NGOs (technical and geographic) and that pay more attention to the dynamics of the cluster and to leadership skills. An increased emphasis should be placed on building skills and implementing monitoring and evaluation, strategic management, planning, and evaluation in the individual NGOs using the cluster as a coordinating body. There should be a re-evaluation of the anchor concept

to balance the positive and negative consequences of choosing a larger, more established NGO (e.g., a health care organization or church-based group) with an institutional back-up instead of a smaller NGO. The NGOs could be organized into zones with Zonal offices that serve
three regions each and have roles in supervision, information sharing, hands-on mentoring, and training.

To support the field operations, a central office should be established in Dar es Salaam to provide overall coordination and management support—financial and technical, development of supervisory tools, educational, financial management, monitoring and evaluation, etc.—to respond to requests from the NGO clusters. Moreover, the central office would oversee and facilitate capacity-building training programs as dictated by periodic needs assessments carried out in conjunction with cluster NGOs. In addition, the central office would provide technical backup to the field with an emphasis on solving problems at the field level.

Figure 1, Proposed Interventions for USAID Support: 1998-2003, available in hard copy only

(3) NACP Management Support. To address the need for increased coordination in and continued policy dialogue on the control and prevention of HIV/AID/STDs, dedicated support should be provided to the NACP to enhance its management skills and to develop it into an effective advocate for national action in response to the increased incidence of HIV/AIDS in Tanzania. This targeted approach would focus on developing the NACP's capacity to formulate and support policy and to develop linkages that will effectively coordinate Tanzania's response to HIV/AIDS. While it is beyond the MTR team's mandate to suggest Tanzanian Government policy, we urge USAID/T to consider ways in which it might promote the concept of the NACP as the secretariat of the NAC with its locus in the prime minister's office and with direct responsibility to the principal secretary of the prime minister's office.

(4) Operations Research. Under this intervention, TA would be provided to the GOT in terms of expertise and funding for operations research directed at issues raised earlier in this report.

(5) Technical Assistance to the MOH. Under this intervention, USAID should consider supporting the GOT's HIV/AIDS/STDs control and prevention activities in the following additional areas:

- TA to the MOH in STD training;
- Coordination of private/public STD training;
- TA in surveillance; and
- TA to district-level public sector AIDS efforts. As health reform evolves, the mission should maintain the flexibility to provide this type of assistance (depending on the future definition of the role).

The extent of USAID/T's support in the above areas—all of which are critical elements in the reduction of HIV/AIDS transmission—would be largely dependent on the results of future needs assessments and on the evolution of the current movement toward health reform.

APPENDICES

Appendix A, Scope of Work, available in hard copy

APPENDIX B

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APPENDIX C

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Kamenga, Dr. Munkolenkole	Research Officer, AIDSCAP/Washington
Kapalale, Ambrose	Cluster manager, Tabora
Kapufi, B. J.	DCCO, Bariadi
Karibu, Mr.	RAS, Morogoro
Kassano, Mr.	Zonal Manager, World Vision, Shinyanga
Kato, John	Chairman, Dar cluster, and SHDEPHA+
Kato, Margaret	Administrative Manager, PSI
Kawiche, Lucas	DACC, Moshi
Kibe, Abe	Pharmacy owner, Iringa
Kikuli, L.	Administrative Officer, NACP
Kikuti, Edda	WWT, Iringa
Kilagula, Paschal	Accountant, Tabora cluster
Kilibika, Dr. Marcos	Private physician, Iringa
Kindole, Patricia	UWT, Iringa

Kinyunyi, John	Vice-chair, Iringa cluster
Kissamo, Rachel	Counsellor, Nkinga Hospital, Tabora
Kissui, Mary	RACC, Dar es Salaam
Kitomari, Aisha	Program Manager, Moshi Cluster
Kiwelu, Major General	RC, Shinyanga
Koshuma, Yunusi	IEC specialist, GTZ/Mbeya
Kusenha, Mrs.	Chair, UMATI, Dodoma
Kwimbere, Josephine	Program Manager, Dar es Salaam cluster
Liduke, Bathsheba	TANWAT Hospital, Njombe
Lobulu, William	Publisher, The Arusha Times
Loire, Fr. George	PASADA
Luande, Josephine	PHE, Koshika Women's Group
Ludeleko, Barnabas	Youth Alive, Bariadi
Lukindo, Monica	Peer Educator, EMAU
Lushino, Dr. O.	RMO, Iringa
Lushino, Sarah	Private Clinic Director, Iringa
Lusukine, Mr.	Program Manager, Morogoro Cluster
Lutwaza, Gilbert	NGO Officer, TAP
Lyamu, Mary	IDC, Dar es Salaam
MacNeil, Dr. Joan	Research Officer, AIDSCAP/Washington
Majeshi, Ramadhani	PHE, Koshika Women's Group
Mabele, Sos Roberth	ESAO, Shinyanga
Mabula, Hamis	TLC Officer, Nkinga Hospital, Tabora
Mabula, Joachim	Youth Alive, Bariadi
Mafuru, Lediana	Program Manager, Iringa Cluster
Magalla, Alfred	Training Officer, TAP
Mageni, Right Rev. Dudley C.	Bishop, Morogoro Diocese
Magullu, Wilfred S.	DACC, Bariadi

Name	Title/Organization
Majiji, W. B.	Red Cross, Shinyanga
Makoyo, Kheziah	Chair, Koshika Women's Group, Dar es Salaam
Makulla, Erastus	Church elder, Nkinga Hospital, Tabora
Makundi, Mr.	Chair, Dodoma Cluster
Male-Mukasa, John	Country Director, AMREF
Manchester, Tim	Project Director, PSI
Manyama, E.	UWT, Shinyanga
Manyange, Joseph	WAZAZI, Bariadi
Manyiwa, Hosea S.	PHE, VIJANA, Bariadi
Manyama, S. K.	DAS, Nzega
Manyambo, J. A.	DC, Nzega
Marsden, Andy	Logistics advisor, JSI
Masam, Steven	IDC, Dar es Salaam
Masanja, Gabriel	Cluster chairperson, Tabora
Masawe, Mr.	Tanzania Bureau of Standards, Dar es Salaam
Mashishanga, S. J.	RC, Tabora
Masinde, Barnabas	Sikonge Hospital, Tabora
Masonde, Mrs.	Secretary, SWAAT, Muheza
Massawe, Joyce	Information Center Volunteer, Arusha
Massawe, Raphael	AIDS Committe, Nzega
Massem, Dr.	RACC, Kilimanjaro
Massi, Dr. Meshack	RMO, Dodoma
Matembele, Daniel	Temeke Theatre Group
Materu, Bertha	HIV/AIDS coordinator, Nkinga Hospital
Matoro, Jacqueline	PHE, Koshika Women's Group
Mawazo, A. S.	RACC, Shinyanga

Name	Title/Organization
Mazora, Nuru	CCBRT and Steering Committee, Dar cluster
Mberesero, Dr.	Chairperson, Tanga cluster
Mboya, Dr. Benny	Tutor, CEDHA
Mbughuni, Dr. Shamani S.	RACC, Tanga
Mburu, Francis	Family Planning Advisor, USAID/Dar es Salaam
Mbwiliza, Prof. J.	RC, Kilimanjaro
Meta, Victor	TRAWU, Tabora
Meza, John	KAUNAI, Tabora
Mganga, F.	RAS, Tanga
Mguko, Agnes	Chair, SWAAT, Pangani
Mhando, Lucy	Scouts, Iringa
Minja, Dr. Frederick	RMO, Mbeya
Mjema, Nakiete	RACC, Police Medical Services, Tanga
Mkagishe, Dr.	DACC, Moshi
Mkanga, Grace	DC, Makete
Mlayi, Marcel	Igawilo Health Center, Mbeya
Mmbugu, Trufina	Majengo STD Clinic, Moshi
Mohammed, Dr.	Coordinator, Tanga Cluster
Momburi, Dr. R. B.	Deputy Director, PHCI
Mpangile, Dunstan	RACC, Iringa
Mruk, Charlotte	Health Program Officer, EU
Mselem, Abdul	BAKWATA, Iringa
Mseti, Baraka	PHE, Koshika Women's Group, Dar es Salaam
Mshana, Billy	Chairman, MECA, Morogoro
Mshana, Asha	TAHEA, Moshi
Mshana, Margaret	Coordinator, KIWAKKUKI, Kilimanjaro

Name	Title/Organization
Mshana, Mary	Assistant STD Coordinator, NACP
Msobi, N.	Research Coordinator, NACP
Msuya, Pastor H.	Religious Network on AIDS Control, Dodoma
Mtasiwa, Deo	STD Consultant, TAP
Mtwewe, Germana	BACAWA, Iringa
Mulay, Mr.	Freelancer, IEC
Mukama, Shukrani	SDA, Dodoma
Munuo, Mr.	Chair, Moshi Cluster, and TAHEA
Mushi, Rose	Majengo STD clinic, Moshi
Musola, Juliet	Mt. Meru Hospital, Arusha
Mwabangale, Mr.	Testing Manager, TBS
Mwakalile, E.	TAHEA, Iringa
Mwakanyamala, Florence	Counsellor, GTZ, Mbeya
Mwakapalale, Dr.	DMO, Kyela
Mwakitange, R.	AIDS Officer, AMREF
Mwakyelu, Joshua	Clinical Officer, Igawilo Health Center, Mbeya
Mwalupindi, W. A.	TSWDF, Iringa
Mwambu, Wandoa	Upendo AIDS Centre
Mwamjati, Dr. A.	Medical Officer, AIC, Iringa
Mwange, Mr.	Pharmacist, Iringa
Mwasikili, Atupokile	Ruaha Diocese, Iringa
Mwijage, Dr. L. A.	ABC, Bariadi
Mwingira, V. A.	AAC, Tabora
Mwinuka, Andrea	Clinical Officer, Iringa
Mwizarubi, Blastus	AMREF
Myonga, W. J. P.	Red Cross, Iringa

Name	Title/Organization
Nchimbi, Grace	Igawilo Health Center, Mbeya
Ndaku, Dr. B. T.	Director, PHCI
Ndeki, Dr.	Principal, CEDHA
Nduvambo, E.	DACC, Makete
Ndyetabura, Dr. E. F.	National Program Officer, UNDP
Nesje, Ruth	Project Coordinator, MEUSTA, Tanga
Neukom, Josselyn	Population Fellow, USAID/Dar es Salaam
Ngalawa, Adam	VIJANA, Tabora
Ngelula, Mr.	Kay's Hygiene Ltd., Dar es Salaam
Ngerea, Perpetua	UWT, Tabora
Ngirwamungu, Dr. E.	FP/IEC Coordinator, MOH
Nguma, Justin	IEC/BCC Officer, TAP
Njen, Ms.	RAC, Police Force
Nkini, Wilhelm	Sales Manager, PSI
Nkya, Dr. C.	Regional STD Manager, Kilimanjaro
Ntibangisa, Joel D.	Health Education Officer, Nkinga Hospital, Tabora
Nyahore, Anceth	Secretary, MP, Shinyanga Urban
Nyakuni, G.	CDO, Bariadi
Nyambo, Mary	Accountant, Dar Cluster
Nyamwihula, Geoffrey	Accountant, Shinyanga Cluster
Nyang'anyi, Dr. M.	Head, STD/Clinical Unit, NACP
Nyato, Rosemary	TAHEA, Iringa
Nzowa, Omari	BAKWATA, Iringa
Ochola, Penina	Program Manager, TAP
Over, Dr. Mead	Senior Economist, The World Bank

Name	Title/Organization
Patrick, Anne	Chair, SWAAT, Tanga
Pattni, K.	J. D. Pharmacy, Dar es Salaam
Perry, Steve	Consultant, JSI
Rutta, Justin	VIJANA, Iringa
Rwezaura, F.	Kemi Pharmacy, Moshi
Sabiyumva, Cornelius	Deputy Matron, Nkinga Hospital, Tabora
Safari, Cecilia	TAHEA, Dodoma
Saguiwa, Dr. Gitima	Director, Testing and Counseling Study, TAP
Salilo, Martin	Clinical Officer, AIC, Iringa
Saluti, D.	CDO, Bariadi
Samuel, Dr. J.	RMO, Tanga
Sanga, Lucy	Red Cross, Iringa
Sayi, Justine	BAHAMA, Bariadi
Scheinman, David	TAWG
Shilla, Dr. A.	DMO, Nzega
Shayo, Mrs.	Secretary, Maranju Information Center
Shirima, Mrs.	RAS, Iringa
Shirima, Isidore	RC, Dodoma
Simba, Kay	Kay's Hygiene Ltd., Dar es Salaam
Sitima, Esha	MP, UWT/CCM, and Vice-chair, Shinyanga Cluster
Sitta, Eliza	UMATI, Shinyanga
Sizya, James	Accountant, Iringa Cluster
Sowoki, Clotilda	Urambo ACC, Tabora
Soto, Mr.	TP Leader, Pangani
Suleman, Zulfikar	Twiga Paper Products, Dar es Salaam

Name	Title/Organization
Swai, Eliza	Matron, Nkinga Hospital, Tabora
Swai, Lucy	Red Cross
Swai, Mike	Peer Educator, Moshi
Swai, Dr. R.	Program Manager, NACP
Swebe, M. M.	TSWDF, Iringa
Tawale, Neema	Health Services Coordinator, Nkinga Hospital, Tabora
Temu, Christopher	Majengo STD Clinic, Moshi
Tengg, Thomas	Private Sector Advisor, USAID/Dar es Salaam
Tennagashaw, Mulunesh	Country Program Advisor, UNAIDS
Thaw, Abraham	RCO, Dodoma
Tillya, Sophia	Majengo STD clinic, Moshi
Timberlake, Janis	AIDS Sector Advisor, USAID/Dar es Salaam
Tibakweitira, G.	WAMATA and Project Coordinator, Dar cluster
Ulomi, Dr.	RMO, Kilimanjaro
Urasa, Peris	SWAAT, Kilimanjaro
Vittuko, Abdallah	Secretary, AAC, Nzega
Wangberg, Dr. Harold	Doctor in Charge, Medical Ward, Nkinga Hospital, Tabora
Warning, Dr.	Country Representative, WHO
Woollen, Charles	DANIDA, Dar es Salaam
Yunus, Habiba	AIC, Iringa

APPENDIX D

Tanga Budget Review

An illustrative example of the TAP Cluster Funding Process

The budget was developed in collaboration with TAP, and reviewed and approved by TAP country office.

During the first year of project activity (FY 1996) the cluster received the following disbursements:

September 1995:	Received $9,614
October 1995:	Nothing
November 1995:	Received $5,863
December 1995:	Nothing
January 1996:	Nothing
February 1996:	Nothing
March 1996:	Nothing
April 1996:	Nothing
May 1996:	Received $8,255
June 1996:	Received $4,924
July 1996:	Nothing
August 1996:	Nothing

Balance on hand at the end of August 1996: $124.75

The same pattern has obtained so far during fiscal year 1997:

Month	Budgeted	Received	Balance Forward
September	$1,054	$0	$124.75
October	$13,176	$0	$124.75
November	$15,340	$7,741	N/A
December	$11,384	$0	$6548 (12/4)
January	$4,535	$5,777	$2041 (1/4)
February	$5,498	$13,937	$6919 (2/4)

Expenditures during February 1997: $1,982

Balance on March 4, 1997: $18,847

A TA accountant from Dar es Salaam came to Tanga in September and October and told the cluster to continue waiting for the funds, without any explanation. Similarly, during those months, the chairperson traveled to Dar es Salaam to request funding and was told to wait. Because the funds were not disbursed as agreed, several activities were cancelled. Half of the peer education sessions (three out of six) were cancelled. In addition, the cluster had been granted approval to purchase a motorbike. Yet, by the time the funding finally arrived, the motorbike's initial price of TS 2.5 million had tripled and the cluster could not afford it.

APPENDIX E

Attendance at the TAP MTR Stakeholder Debriefing
Kilimanjaro Hotel, March 25, 1997

Name	Organization
Rob Cunnane	USAID/Tanzania
Vicky Chuwa	TAP
Bill Emmet	Team Leader, TAP/MTR, POPTECH/FUTURES
Anne Fleuret	G/WID, USAID/W
Dr. A. Jorgensen	NACP
Dr. Gina Ka-Gina	AMREF
Virginia Kainaniula	AMREF
Anne Kamande	TAP
Victor Lihendeko	TAP
Gilbert Lutwaza	TAP
Anne Mahendeka	AMREF
Mwamini Masasi	PSI
Justin Mbonde	AMREF
F. M. Mburu	USAID/T
Alfred Magalla	TAP
Martin S. Mkuye	AMREF
Tim Manchester	PSI
Elizabeth Mosha	Pathfinder
Mary Mshana	NACP

Nancy Msobi	NACP
Zebina Msumi	NACP
Mukami Mugo	PSI/Kenya
Rosemary Mwakitwage	PSI
Blastus Mwizarubi	AMREF
Josselyn Neukom	USAID/Tanzania
Oswald Ngadutta	PSI
Dr. E. Ngiwanungu	FPU, MOH
Justin Nguma	TAP
Wilhelm Nkini	PSI
Sakina Othman	Netherlands Embassy
Alex Ross	AFR/SD, USAID/W
Edith C. Ruhumbika	TAP
Dr. G. Sangiwa	MMC, HIV C&T Centre
Sophie Ngahyona Shauri	NACP
Godfrey Sikipa	AIDSCAP/AFRO
Dr. C. Simbakalia	FPU, MOH
Name	**Organization**
Dr. R. Swai	NACP
Eban Taban	AIDSCAP/AFRO
Mulunesh Tennagashaw	UNAIDS
Charles Thube	Pathfinder
Janis Timberlake	USAID/Tanzania
Charles Woollen	Danish Embassy

APPENDIX F

Cluster Member NGOs in Nine Regions

Name of NGO	Region(s)	Comments
CHAWAKUA	Arusha	Four district branches
DOHOCE	Arusha	Two branches
ELCT (KKKT)	Arusha, Iringa, Kilimanjaro, Morogoro	Anchor NGO. Three districts in Iringa, one in other regions
IEM	Arusha	
KEUL	Arusha	
KINNAPA	Arusha	
KIPOC	Arusha	
MFP	Arusha	
NAT	Arusha	

OIPSP	Arusha	
OSOTWA	Arusha	
Pentecostal Assemblies of God	Arusha	
PIWGT	Arusha	
Seventh-Day Adventists	Arusha, Dodoma, Tanga	
SWAA(T)	Arusha, Dar es Salaam, Dodoma, Iringa, Kilimanjaro, Tanga	
TAHEATAMICO	Arusha, Dodoma, Iringa, Kilimanjaro, Shinyanga	Two districts in Iringa
	Arusha	
TTU	Arusha	
TUICO	Arusha	
UMATI	Arusha, Dodoma, Iringa, Kilimanjaro, Morogoro, Shinyanga	

Uwakumo	Arusha	
CCBRT	Dar es Salaam	
EMAU	Dar es Salaam	
JIEPUSHE	Dar es Salaam	
Koshika Women's Group	Dar es Salaam	
Kwetu Counseling Centre	Dar es Salaam	
MAF	Dar es Salaam	
PASADA	Dar es Salaam	Prospective member
SHIDEPHA+	Dar es Salaam	
Temeke Theatre Group	Dar es Salaam	
Upendo	Dar es Salaam	
WAMATA	Dar es Salaam	Anchor NGO
DCT	Dodoma	

DEMAJ	Dodoma	
EGAJ	Dodoma	
Mvumi Hospital	Dodoma	
World Vision	Dodoma, Kilimanjaro, Shinyanga	Anchor NGO
UWT	Dodoma, Iringa, Kilimanjaro, Morogoro, Shinyanga	Three districts in Iringa, three in Morogoro
WAZAZI	Dodoma, Morogoro, Shinyanga, Tabora	Three districts in Morogoro
World Vision	Dodoma, Kilimanjaro, Shinyanga	Anchor NGO
Anglican Church	Iringa, Morogoro, Tabora	Anchor NGO. Three districts in Morogoro, two in Iringa
BACAWA	Iringa	
BAKWATA	Iringa, Morogoro	
CHAMATA	Iringa	

Concern	Iringa	Two districts
MET	Iringa	
Red Cross	Iringa, Shinyanga	
Roman Catholic Church	Iringa, Kilimanjaro	
Ruaha Diocese	Iringa	
Scouts	Iringa, Morogoro	Two districts in Iringa, three in Morogoro
Southern Tanganyika Diocese	Iringa	
TARENA	Iringa	Three districts
Tosamaganga Orphanage	Iringa	
TSWDF	Iringa	
VIJANA	Iringa, Morogoro, Shinyanga, Tabora	Three districts in Iringa, three in Morogoro
Ambassador Foundation	Kilimanjaro	

AMREF	Kilimanjaro	
FARAJA	Kilimanjaro	Unofficially dropped out
KIWAKKUKI	Kilimanjaro	Anchor NGO
MKUKI	Kilimanjaro	
TFTU	Kilimanjaro, Morogoro, Shinyanga, Tabora, Tanga	
TPC	Kilimanjaro	
YMCA	Kilimanjaro	
BAWATA	Morogoro	Two districts
Kilosa Mission to the Needy	Morogoro	
Malihai Club	Morogoro	
Mazimbu Development Group	Morogoro	
MECA	Morogoro	

Mji Mpya	Morogoro	
MODOCO	Morogoro	
MPWA	Morogoro	
MWAP	Morogoro	
Poverty Africa	Morogoro	Two districts
Uluguru Mali Hai	Morogoro	
Ushirika	Morogoro	
Africa Inland Church	Shinyanga	
ESAO	Shinyanga	
SHACO	Shinyanga	
YADEC	Shinyanga	
Anti-AIDS Club	Tabora	Two districts
Archdiocesan AIDS Committee	Tabora	Dropped out

Caritas	Tabora	Dropped out
MARTEA	Tabora	
Ndala Hospital	Tabora	Dropped out
Nkinga Hospital	Tabora	
Sikonge Hospital	Tabora	
Urambo AIDS Control Committee	Tabora	
VIWAWA	Tabora	
Tanzania Christian Health Board	Tanga	
TAWG	Tanga	Anchor NGO
TWAWG	Tanga	

APPENDIX G

HIV/AIDS-related Research Issues

A study of the practices of traditional healer/traditional birth attendants followed by training of traditional healers/traditional birth attendants in home-based care and in orientation to STD treatment

Rationale: A significant level of health care is provided by village-based traditional healers and birth attendants. In many cases, the health care (especially in the case of sexually transmitted infections [STI] and their contribution to the transmission of HIV/AIDS) is inappropriate and harmful.

In addition, hospital-based treatment of persons with AIDS (PWA) is fast becoming an unmanageable burden for health facilities where home-based care represents an alternative response for PWAs who are between crises. However, the health services' emphasis on certified health care workers as the source for acceptable quality home-based care is an equally onerous burden, in terms of both financial and human resource training and support needs.

Overview: Under this proposed operations research initiative, traditional healers or birth attendants would be selected for training that is focused on referring clients with STIs and providing home-based health care to PWAs. Villagers would nominate persons to be trained and indicate their willingness to support trained traditional health workers by paying for the health care provided to PWAs. After receiving training, the traditional health workers would agree to refer clients with STIs to

their local health facilities and to accept the agreed-upon payment. Training would be provided at the health center to which the traditional health workers would later refer the persons with STIs. The effectiveness of this program would be evaluated by assessing STI-related health center statistics and surveying villages after the training.

Application: If proven viable, the training of traditional village health workers in referral of STIs and home-based care for PWAs would be a major contribution to developing a village-based approach to prevention and control of HIV/AIDS.

Needs assessment STD drug counseling followed by STD orientation for pharmacists

Rationale: Strong anecdotal evidence suggests that pharmacists are counseling and prescribing treatment to many people with STIs. However, these pharmacists receive no formal training in STI counseling and are forbidden by law to prescribe treatment for STIs. As with the practice of traditional health workers, the pharmacists' incorrect and ineffective treatment of STIs contributes to the transmission of HIV/AIDS.

Overview: Related operations research would be carried out in two phases. Phase one would consist of a field evaluation of the suspected problem. If the anecdotal evidence of the pharmacists' prescribing habits is confirmed, phase two of the protocol would consist of training selected pharmacists to recognize the importance of referring persons with STDs to trained health workers. The training would give pharmacists an appropriately technical orientation to syndromic treatment of STDs. The effectiveness of the program will be

evaluated through focus groups, post-training provider interviews, and through mystery client visits to pharmacies.

Application: This proposed research will confirm the extent of the problem of pharmacists' prescribing habits. If the pharmacist training appears to assist in increased referrals or in more reliable counseling, this research initiative will give policy makers an increased incentive to review the current policy regarding the training of pharmacists in STIs.

Assessment of counseling needs for PWAs

Rationale: The quality of counseling for PWAs is largely dependent on the good will and compassion of the provider. No counseling protocols exist to address the specific counseling needs of Tanzanian PWAs. As a result, PWAs are commonly left with few options other than to continue their existing behavior patterns that will transmit HIV/AIDS to others and that will result in their own reinfection and, thus, an increased severity of their illness.

Overview: This proposed operations research will proceed on two levels. The first level will consist of focus group sessions with PWAs to define the most effective counseling guidelines to provide PWAs with sufficient behavior modification incentives. Following the definition of such counseling guidelines, investigators will develop and test protocols using feedback from PWAs to determine their effectiveness.

Application: If proven effective, these tested counseling protocols can serve as essential HIV/AIDS prevention and control training and service delivery instruments.

Community mobilization

Rationale: The 1996 Demographic and Health Survey (DHS) confirms that Tanzanians know much about HIV/AIDS, its transmission, and its prevention. Nevertheless, health surveillance data and health service reporting confirms that HIV/AIDS in Tanzania is rapidly extending beyond its urban confines to peri-urban populations and beyond, to rural areas. The evidence from other national programs suggests that IEC programs based on joint prevention and control initiatives through community/health center workers could be an effective means of combating the spread of HIV/AIDS.

Overview: Employing TAP's NGO cluster structure as a framework for an IEC operations research initiative, investigators will define a program of education focused on developing control and prevention program linkages between selected villages and their respective health facilities. Under the management of selected TAP NGOs, villagers and health centers will work together on activities such as developing posters, having educational contests for students, organizing theater groups, volunteering at health centers, and implementing village-based health orientation sessions by health service workers. The effectiveness of this program will be evaluated by surveying village households and assessing health center data.

Application: If proven effective, documentation of these initiatives can serve as guidelines for support of the NGOs that are working with rural areas on HIV/AIDS control and prevention activities.

School education program employing PWAs

Rationale: Tanzania's MOE has resisted the introduction of HIV/AIDS-related discussions at the primary and secondary school levels. However, there is considerable support for proactive, innovative HIV/AIDS preventive education programs. In addition, other countries that benefit from USAID support for HIV/AIDS school education programs have remarkably effective programs that use school-age or relatively young "school-leaver" PWAs as group facilitators for the pilot school education programs.

Overview: Collaborating with the Society for Persons with AIDS (SHDEPHA+), cluster NGOs will organize a public speaking education program for volunteer young people with AIDS (YPWA) that will train the self-selected YPWAs to facilitate HIV/AIDS preventive health discussions at primary and secondary schools. After being trained at SHDEPHA+ headquarters in Dar es Salaam, the YPWAs will travel throughout the country (travel costs, stipends, and per diem will be paid) to facilitate discussions at selected primary and secondary schools. Beyond enlisting interested schools, selected cluster members will provide support to the YWPAs by providing them with lodging in their cluster areas and by monitoring the YPWAs' discussions at their area schools. This program, geared toward primary and secondary school students, will increase students' awareness of at-risk behavior and of their own risk as potential targets for the

HIV virus. The effectiveness of this program will be documented and evaluated through a combination of structured on-site monitoring and pre- and post-discussion focus groups with the students.

Application: If this pilot program is successful, its documented results could be a key instrument for forming a committed senior-level governmental constituency who could then support the development of a proactive, school-based HIV/AIDS preventive education program.

Assessment of the capacity of church groups to support the HIV/AIDS program

Rationale: Some Tanzanian church groups actively resist public education programs focused on control and prevention of HIV/AIDS. Although much of this resistance appears to be toward open discussion of condoms as an effective preventive measure, resistance extends well beyond this one issue. Much of the resistance may be more deep-seated and based on a moral stand against an open discussion of human sexuality in general. As a result, the resistance of these church groups to proactive and effective HIV/AIDS prevention and control initiatives tends to exacerbate Tanzania's climate of denial and the stigma associated with the nation's HIV/AIDS crisis and with those who have the virus.

Overview: Under this suggested research initiative, there would be a two-part protocol. The first part would center on focus group discussions with senior members of the resistant church groups. The aim of these focus groups would be to establish a more comprehensive understanding of the basis of this resistance. At the same

time, the focus group leaders would work with their respondents to define those HIV/AIDS control and prevention initiatives that would address the concerns of the church groups. Using the defined initiatives, the second part of the research agenda would focus on developing, testing, and selectively introducing pilot education and information protocols in direct collaboration with participating church groups. The effectiveness of this program would be assessed through both follow-up focus group discussions with church leaders and pre- and post-protocol focus group discussions with randomly selected church members.

Application: If successful, the information and education protocols developed under this initiative could serve as the basis for a nationwide church-oriented HIV/AIDS control and prevention program.

Promotion of the women's condom and the diaphragm

Rationale: In the majority of HIV/AIDS-related programs, the male condom is the single method used for preventing infection from one's partner. However, in administering these same programs, all program directors acknowledge the very real difficulty in building such a prevention initiative around the concept of the male partner being willing to use a condom to prevent infecting his female partner. By contrast, both the women's condom and the diaphragm represent proven methods for a woman to protect herself against HIV. For female sex workers, use of the women's condom is advantageous because not only does it protect the worker herself and her partner, but it is easy to use and it does not require any action by her partner. For other women, such as spouses or women with an occasional partner who may not be sure of their partners' freedom from infection, the diaphragm has the added advantage of being a discrete method; the woman is the only one who knows that she is using it. Although both of these methods are highly effective in preventing the transmission of HIV, both are relatively unknown and virtually untested as HIV-preventive measures.

Overview: Given the relative newness of women's condoms and diaphragms among HIV/AIDS prevention and control programs, this proposed research initiative would introduce both of these methods on a pilot basis within the structure of active health facility programs. As a first step, the pilot program would support the development of educational materials for health workers that, after appropriate testing, would be the basis for an educational program for health workers at a few self-selected collaborating health centers. Once they were oriented on how to use the two contraceptive methods and how to introduce them to the client, the collaborating health workers would be asked to promote

the methods' use within a defined trial period and to record the degree to which they succeeded in promoting method use. At the end of this trial period, the participating health workers would be asked to take part in focus groups to document the utility of the educational material, their attitude toward promoting the methods, and their approaches to introducing the methods to their clients.

Application: If the results of the pilot program indicate that introducing the women's condom or the diaphragm as an alternative to current HIV preventive methods is feasible, suitably modified educational material would be distributed among an expanded health worker audience. In addition, once a critical number of Tanzania's health workers were oriented to these methods, the next logical step would be to develop educational campaigns that increase the public's awareness of these two methods.

Family planning/reproductive health workers integration of STD treatment

Rationale: Nurses and aides associated with FP/RH programs cannot prescribe treatment for STDs. However, because of what these workers do, they represent, perhaps, the greatest potential for a first-line defense against STDs among women and against HIV transmission.

Overview: Given the current legal restraints that prohibit FP/RH workers from prescribing and providing treatment for STDs, this pilot research initiative would focus on providing documented evidence of FP/RH workers' ability to accurately, effectively respond to the technical requirements of providing and prescribing treatment for STDs. The first step in this proposed research protocol would be to provide selected FP/RH workers with the standard clinical orientation to syndromic management of STDs. After their training, the practices of these workers would be closely monitored, supported, and supervised by qualified technicians. At the end of the trial period, the supervising technicians would facilitate a focus group debriefing session with participating FP/RH workers. The aim of the focus groups would be to review the supervising technicians' observations and to solicit observations from the FP/RH workers on their continuing to be included as the cadre who prescribe and treat STDs.

Application: If this trial is successful in its aim of training FP/RH workers to competently provide treatment and prescriptions for STDs, documentation could be submitted to the GOT to support modification of the government's current policy on this issue.