

Combating HIV/AIDS in Tanzania: Aligning PEPFAR and the National Multi-Sectoral Strategic Framework

Kevin Croke

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Leadership, Management and Sustainability Program
Management Sciences for Health
784 Memorial Drive
Cambridge, MA 02139
Telephone: (617) 250-9500
www.msh.org/lms

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EXECUTIVE SUMMARY

This report examines the degree of alignment between the US Government's PEPFAR programming in Tanzania, and the Government of Tanzania's forthcoming National Multi-sectoral Strategic Framework 2008-2012 (NMSF). It finds that there is in general strong convergence between the NMSF and PEPFAR, although with significant areas of disjuncture. PEPFAR programming supports a majority of the NMSF's 175 strategies, and in a number of PEPFAR's activity areas - such as ARV procurement and services, counseling and testing, orphan and vulnerable children care, prevention of mother-to-child transmission, laboratory infrastructure, blood safety, and basic palliative care - all or nearly all NMSF strategies are matched by PEPFAR programming. These areas of strong convergence account for 71.4% of total PEPFAR funding for Tanzania in 2006 (or 82.0% of PEPFAR's "prevention, care, and treatment" subtotal.) The strongest area of alignment is with the NMSF's "care and treatment" section, but the "impact mitigation" and "enabling environment" categories are also marked by substantial agreement between the NMSF and PEPFAR.

However, there are also significant differences, above all in the area of prevention. The NMSF makes clear that prevention is the Government of Tanzania's highest priority, and suggests that donors shift resources in that direction. PEPFAR, in contrast, devotes by far the largest percentage of its budget to treatment. In addition, PEPFAR does not have extensive programming in two of the NMSF's nine prevention focus areas: the prevention and treatment of sexually-transmitted infections other than HIV, and the expansion of workplace prevention interventions. PEPFAR and the government of Tanzania also differ on the relative weight placed on the three sexual transmission prevention strategies of abstinence, fidelity, and condom use. Finally, feedback from stakeholder interviews points towards differences between the NMSF and PEPFAR on the degree of emphasis on system strengthening and capacity-building contained in PEPFAR programming.

I. Introduction

Through the President's Emergency Plan for AIDS Relief (PEPFAR), the US government provides extensive support for HIV/AIDS programming in Tanzania. In US fiscal year 2006, PEPFAR funding for Tanzania totaled just under \$130 million; in 2007 the amount increased to \$173 million.¹ Given both the absolute size of the PEPFAR contribution, and its magnitude relative to other sources of HIV/AIDS funding in Tanzania, every effort should be made to ensure that PEPFAR funds are supportive of the Tanzanian national strategy for HIV/AIDS.

This report will examine the degree of convergence between PEPFAR and the Government of Tanzania's (GoT) forthcoming National Multi-Sectoral Framework on HIV/AIDS 2008-2012 (NMSF).² This convergence is of interest because "country ownership" is widely recognized as a key determinant of aid effectiveness, and because both the US and Tanzania have committed to it as a matter of policy. This report will analyze how well the coordination that both sides endorse in theory is occurring in practice, by examining whether PEPFAR programming is consistent with the NMSF's strategic choices and priorities. As a secondary matter, it will also examine PEPFAR's "fit" with the Government of Tanzania's Health Sector HIV/AIDS Strategic Plan 2008-2012 (HSHSP), which outlines the health sector's contribution to the national HIV/AIDS campaign.

This report finds that there is in general strong convergence between the NMSF and PEPFAR, although with significant areas of disjuncture. PEPFAR programming supports a majority of the NMSF's 175 strategies. More important, in a number of PEPFAR's activity areas - such as ARV procurement and services, counseling and testing, orphan and vulnerable children care, prevention of mother-to-child transmission, laboratory infrastructure, blood safety, and basic palliative care - all or nearly all NMSF strategies are matched by PEPFAR programming. These areas of strong convergence account for 71.4% of total PEPFAR funding for Tanzania in 2006 (or 82.0% of PEPFAR's "prevention, care, and treatment" subtotal.)

However, there are also significant differences. The largest gaps are found among strategies for prevention. The NMSF makes clear that prevention is the government of Tanzania's highest priority. PEPFAR, in contrast, devotes by far the largest percentage of its budget to treatment (in 2007, 48% of the total, or 55% of the "prevention, care and treatment" subtotal). PEPFAR also has minimal programming to match two of the NMSF's nine prevention focus areas: the prevention and treatment of sexually-

¹ US Government fiscal year begins on October 1 and ends on September 30.

² This new NMSF (2008-2012) has not yet been approved in final form. Upon its approval it will replace Tanzania's first National Multi-Sectoral Strategic Framework, which covered the time period of 2003-2007.

transmitted infections other than HIV, and the expansion of workplace prevention interventions. PEPFAR and the NMSF also disagree on the relative weight placed on the three sexual transmission prevention strategies of abstinence, fidelity, and condom use: The NMSF appears to favor a greater emphasis on condom promotion than PEPFAR, which by law must spend 1/3 of its total prevention funding on abstinence programming. This disagreement about sexual transmission prevention is significant because approximately 80% of new HIV infections in Tanzania occur via heterosexual contact.³

Beyond these broad areas, there are numerous smaller instances where the NMSF and PEPFAR both agree and differ; many of these are described in the sections below. A table found in the appendix also shows this information graphically.

II. Methodology

The methodology of this report was primarily desk review of PEPFAR and NMSF documents. The report was also informed by consultations with Management Sciences for Health and US government staff, and structured interviews with other stakeholders including GoT officials, non-USG donors, and PEPFAR implementing partners. The author also participated in a PEPFAR site visit on July 17-18 to the Southern Highlands HIV Care and Treatment Program. Information about the content of PEPFAR programs was drawn principally from two documents: “Summary of Activities and Targets by Program Area, Fiscal Year 2007,” and a PEPFAR “program area context” document provided by US government staff. Judgments about the content of individual PEPFAR programs (and accordingly, their relationship to the NMSF) were based on the descriptions in these documents. The “5th and Final Draft” of the NMSF 2008-2012 was used; the document was awaiting final approval by the GoT during the time period of this consultancy. See Appendix II-III for a full list of documents reviewed and people interviewed. This study was conducted between June 19 and August 10, 2007.

III. Analysis

A simple first test of the relationship between the NMSF and PEPFAR is to examine whether the NMSF’s strategies are translated into PEPFAR programs. The NMSF addresses four major themes – prevention, care and treatment, impact mitigation, and cross-cutting “enabling environment” issues. For each area, the NMSF identifies “strategic issues” that hinder action, and proposes strategies to overcome them.⁴ Examining whether NMSF strategies are matched by PEPFAR programs and vice versa

³ Health Sector HIV/AIDS Strategic Plan (HSHSP), p. 11

⁴ This organizational scheme broadly corresponds to PEPFAR’s categories of prevention, care, treatment, and other (strategic information and policy analysis/system strengthening).

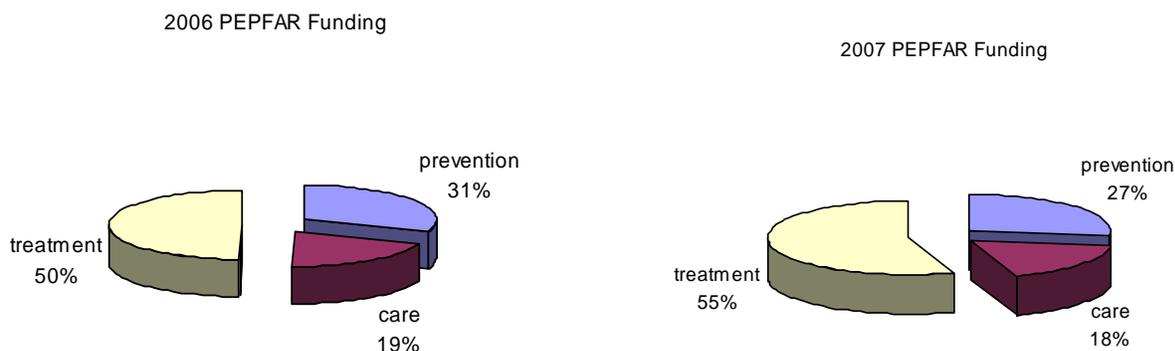
is a useful “first cut” analysis, pointing towards the major areas of convergence and disjuncture.

A simple listing of the NMSF strategies and PEPFAR programs that match them does not tell the whole story, however. Not all 175 strategies in the NMSF are equally important, so PEPFAR’s degree of “fit” with the NMSF is less determined by the absolute number of NMSF strategies that it matches than by the degree to which its major funding commitments correspond to the NMSF’s priorities.⁵ Yet comparing prioritization with precision is impossible because unlike PEPFAR, whose priorities are indicated by funding levels, the NMSF is by design not a prioritized or costed document. This points to the need for qualitative rather than quantitative analysis, based primarily on the very broad prioritization that the NMSF does provide: It states that prevention is the top priority, followed by care, treatment and impact mitigation as equal second priorities. But within those categories, the 175 strategies are not ranked or prioritized. (The NMSF emphasizes that it is not intended to be an operational plan, but rather a guide for implementers as they create their own prioritized operational plans.) In addition, prioritization can be discerned to some degree from the report narrative, and from structured interviews with GoT officials and PEPFAR partners.

This report does not presume that gaps between PEPFAR and the NMSF are necessarily problematic, since these gaps could simply reflect division of labor among donors. The extent to which this is the case could not be determined, since it was not within the scope of this report to examine all donor activities addressing HIV/AIDS. However, it is hoped that a clearer understanding of PEPFAR’s alignment with the NMSF will assist the broader donor community in its efforts to coordinate with the Government of Tanzania.

A. Prevention

The NMSF states clearly that “the number one priority...is to increase HIV prevention efforts.”⁶ Yet as the charts below show, PEPFAR’s 2007 prevention, care and treatment budget is dominated by treatment, with prevention accounting for just over one-quarter of the total, and this trend has increased over time. (The percentages below differ from the prevention, care, and treatment percentages provided on PEPFAR’s website because they follow the NMSF’s classification system, which counts counseling and testing under prevention, not under care as PEPFAR does).



PEPFAR's authorizing legislation mandates that it spend 20% of its overall funds on prevention, which allows for only limited variation from country to country.⁷ This is not *prima facie* evidence of disagreement: As one interviewee pointed out, the cost-intensive nature of ARV treatment means that it will almost inevitably dominate budgets; prevention is intrinsically a less expensive activity.⁸ However, the NMSF does not just state that prevention is the top priority; it also clearly indicates a difference of opinion with donors about prioritization, stating that "a balance must be reached which may compromise the needs of the 7% of the population who are HIV positive, with...the 93% of the uninfected population...[p]ractically speaking, this means scaling up prevention and impact mitigation."⁹ In addition, feedback from interviews (including with GoT officials) generally supported the view that the GoT would prefer greater resources devoted to prevention.¹⁰

There are further similarities and differences in each of the NMSF's nine prevention sub-categories, with the greatest areas of divergence occurring with respect to "ABC" sexual transmission prevention strategies, STI prevention and treatment, and workplace interventions, and the greatest convergence occurring in the categories of PMTCT, counseling and testing, and blood safety.

Youth abstinence, sexual delay, partner reduction, and consistent condom use/Promotion and distribution of condoms. These two NMSF subcategories, which address the "sexual transmission" prevention strategies of abstinence, sexual delay, fidelity/partner reduction, and condom distribution and use (ABC) coincide with PEPFAR in the sense that most NMSF interventions are matched by at least some PEPFAR programming. They appear to disagree, however, on the relative emphasis that they place on each of these three strategies. Much of PEPFAR's "AB" programming supports the NMSF's emphasis on youth-focused prevention education, including programs for curriculum development and teacher training, involving youth in HIV education through peer-to-peer education and formation of youth clubs, engagement with parents and other "gatekeepers," community and faith-based education, and development of "edutainment" and other forms of behavior change communications at both the community and mass media level. The NMSF also stresses norms of responsible male sexual behavior, which is matched by PEPFAR's significant increase in "male faithfulness" programming for 2007. NMSF and PEPFAR also coincide in

⁷ For a details on PEPFAR compliance with its authorizing legislation vis-à-vis prevention see GAO report GAO-06-396 "Global Health: Spending Requirements Present Challenges for Allocating Prevention Funding Under PEPFAR," <http://www.gao.gov/new.items/d06395.pdf>

⁸ This interlocutor also argued that insufficient knowledge about prevention effectiveness is a further reason to favor investing in treatment.

⁹ NMSF, p. 108

¹⁰ This does not appear to be a problem just with PEPFAR: On p. 108 the NMSF cites a 2006 Deloitte and Touche study which found that 64% of all donor HIV/AIDS resources was devoted to care and treatment, with only 14% allocated for prevention.

prevention programs targeting vulnerable populations, such as intravenous drug users, refugees, and mobile and migrant workers. The only NMSF AB strategy without clear PEPFAR programmatic support is the call for increased programs against drug and alcohol abuse, although this may be covered in part by PEPFAR “life skills” programming. PEPFAR also appears to place greater emphasis on mass media strategies than the NMSF.¹¹ For the “C” component of ABC, the NMSF and PEPFAR also both support the promotion of condoms for high-risk populations, behavior change communications to promote condom use, and condom procurement and distribution, with the only apparent difference being that PEPFAR programming does not incorporate the NMSF’s strategy of advocacy about condoms with religious leaders.¹²

However, this agreement on strategies is not matched by equal agreement on priorities. In accordance with its authorizing legislation, PEPFAR must spend one-third of its prevention funds on abstinence programming. Since it is not a prioritized document, it is unclear whether the NMSF would allocate prevention resources in this proportion. However the balance of evidence suggests that it would not. First, the NMSF states that “messages on condoms and their effectiveness in the prevention of HIV infection have been highly unbalanced, leaving [a] majority of prospective users in total confusion”; that “male condoms are one of the most effective and easy-to-use barriers preventing the transmission of HIV”; and that messages for sexually active youth must include consistent condom use in addition to partner reduction and sexual negotiating skills.¹³ These statements suggest that the GoT places greater emphasis on condoms than PEPFAR does. This impression was strongly backed by feedback from interviewees.

Risk reduction for vulnerable populations. In addressing gender issues, the NMSF advocates increased education about gender inequality, better access to reproductive health and HIV/AIDS services and education, promotion of positive social norms for males, and challenging of gender-biased Tanzanian laws. PEPFAR matches these strategies to some extent, by incorporating advocacy for gender equity into “AB” prevention education, promoting male social norms of responsibility and gender equity, supporting income-generating activities for female-headed households, and supporting a program that seeks to reduce the incidence of sexual coercion and exploitation. However, the role of gender inequality in HIV transmission is one of the NMSF’s principle themes; it does not appear to have equal emphasis in PEPFAR programming.

The NMSF also focuses on highly vulnerable populations such as intravenous drug users (IDUs), commercial sex workers (CSWs), prisoners, victims of gender-based violence, and men who have sex with men. Here PEPFAR supports programs to reduce transmission among IDUs and CSWs, to expand counseling and testing in high-risk locations, and to reduce gender-based violence. PEPFAR does not appear to support the

¹¹ The NMSF addresses mass media strategies in the “enabling environment” section.

¹² FY 2006 PEPFAR funding was used to procure over 35 million condoms (program area context document.)

¹³ NMSF, p. 68, p. 58.

NMSF strategies of providing condoms to prisoners, providing services (including post-exposure prophylaxis, emergency contraception, and counseling) to rape and sexual abuse victims, although it is possible that these activities are covered to some extent in a way that was not apparent from PEPFAR program descriptions. PEPFAR does not support the NMSF strategy of advocating for the decriminalization of commercial sex work.

Workplace Interventions. The NMSF prevention subcategory that advocates expansion of workplace interventions is not matched by significant PEPFAR programming. Of the eight strategies proposed by the NMSF, only two have corresponding PEPFAR grants. The strategy of making information and condoms available to all mobile and migrant workers is addressed in part by PEPFAR's prevention and counseling and testing programs targeted at the Tanzania-Zambia transport corridor. PEPFAR's prevention programming for the Tanzanian military is also a workplace intervention. In addition, a PEPFAR program in the Kilombero region seeks to use the private sector to link counseling and testing with ARV services. However, there is no PEPFAR programming addressing NMSF prevention strategies for the public sector workplace, the informal sector, Tanzanian labor laws, or outreach to families through workplace interventions.

Sexually Transmitted Infections. Another significant gap can be found in the NMSF subsection on sexually transmitted infections (STIs). The NMSF states that "STI prevention and control has proven to be one of the major prevention strategies in reducing HIV transmission. The Mwanza trial of 1994 has convincingly demonstrated the contribution of STIs and their control to the epidemic."¹⁴ Yet PEPFAR does not have programming for any of the seven NMSF strategies in this area.

Counseling and testing. Counseling and testing is an area of strong convergence between the NMSF and PEPFAR. Both focus on the maintenance and expansion of testing services, through grants to local service providers, use of mobile labs to reach underserved communities, demand creation activities, and establishment of new testing sites. In addition, a key sub-focus for both is the roll-out of provider-initiated testing and counseling: PEPFAR is providing technical assistance for this to the MOHSW, while also integrating it into counseling and testing projects. PEPFAR programs also support other NMSF strategies such as increasing integration of counseling and testing with broader HIV/AIDS and health services, strengthening confidentiality, and implementation of Tanzania's National Testing Day.¹⁵ However, PEPFAR appears to have only one program in support of the NMSF strategy of increasing the use of non-health care workers in testing, and PEPFAR programming only partially supports the NMSF strategy of increasing testing of children and couples and seeking to reduce the legal age for parental consent for testing.

¹⁴ NMSF p. 64

¹⁵ National Testing Day is not in the NMSF; however the PEPFAR "Program Area Context" document states that the idea originated with the GoT and was subsequently support for PEPFAR. It took place on July 14th 2007.

PMTCT. Prevention of mother-to-child transmission (PMTCT) is also an area of strong agreement between the NMSF and PEPFAR. In addition to working with the MOHSW to develop a national PMTCT strategic plan, PEPFAR is directly supporting scale-up of treatment, increasing follow-up and drug uptake for those testing positive, increasing male involvement, strengthening referral systems to link PMTCT to ARV services and broader health care services, utilizing new research, and training health workers for PMTCT implementation, all in line with corresponding NMSF strategies. The only NMSF strategy which PEPFAR does not appear to support is that of promoting family planning for PLHIVs.

Blood/injection safety. In line with NMSF strategies, PEPFAR provides technical assistance to the MOHSW to strengthen Tanzania's blood safety and blood transfusion systems, and it supports injection safety through assistance with training, policy formation, procurement, supportive supervision, and monitoring and evaluation. PEPFAR programming does not support the NMSF strategy of training home-based caregivers to avoid infection in the course of care-giving, or the strategy of training communities to avoid HIV transmission in the course of traditional practices such as circumcision.

New prevention interventions. The NMSF "new prevention strategies" are circumcision, study of vaccines and microbicides, and self-testing. According to the 2007 PEPFAR annual report, PEPFAR is "awaiting normative guidance from international organizations or other normative bodies" for circumcision and microbicides, after which it will begin programming based on country requests.¹⁶ The US government does fund HIV/AIDS vaccine research, but not through PEPFAR, and PEPFAR is funding a study of barriers to "self-disclosure" but not to self-testing.

B. Care and Treatment

The categories of care and treatment are marked by strong convergence between PEPFAR and the NMSF. PEPFAR addresses 19 of the NMSF's 20 strategies for care and treatment, with varying levels of programming.

Strengthening the continuum of care, treatment and support. PEPFAR's single biggest program area of ARV services falls under this NMSF strategy.¹⁷ This is a significant area of overlap: PEPFAR in 2007 will fund 39 ARV services projects; at \$83,968,275 this accounts for over half of PEPFAR's 2007 care, prevention and treatment budget for

¹⁶ PEPFAR 3rd Annual Report to Congress (2007), p. 31. The Annual Report also states that PEPFAR is a member of a WHO/UNAIDS steering committee on the issue, and has been funding preparatory assessments in several countries.

¹⁷ This full NMSF section title is "Enhancing the capacity at regional and district level to plan, implement, coordinate, monitor, and evaluate a quality continuum of care, treatment, and support services."

Tanzania. In addition, many of the sub-components of ARV services projects correspond to NMSF strategies, including two-way referrals, opportunistic infection care, training, and ARV adherence support. Also falling under this sub-category is the NMSF “strategic issue” of inadequate health infrastructure. PEPFAR’s lab equipment programming addresses this by building or renovating labs, buying lab equipment, training lab staff, and implementing quality assurance programs.

Human resources. PEPFAR programming aimed at addressing what the NMSF calls the “massive human resources crisis” is woven into a number of different issues areas.¹⁸ In the care and treatment section, the biggest initiative is support for the National AIDS Control Program (NACP) to hire between 1,000-2,000 new health care workers. Care and treatment programs also include funding to re-hire retired health care workers, and train people living with HIV/AIDS (PLHIVs) as ARV adherence counselors, as well as individual programs in support of nursing education, “pre-service” HIV education for health care workers, WHO training in integrated management of adult and adolescent diseases (IMAI), and technical assistance to GoT for HR issues, including for the Emergency “Human Resources for Health” Hiring Plan. In addition, most ARV services projects, laboratory services projects, and many palliative care projects include a training component.

Supply Chain/Procurement. A third NMSF care and treatment strategy that is matched by PEPFAR support is the strengthening of procurement and supply management systems. PEPFAR partners work with the Medical Stores Department and Regional Health Management Teams to procure drugs, monitor drug stocks and to implement an “integrated logistics system.” They also work with the Tanzania Food and Drug Administration to turn informal drug sellers into Accredited Drug Dispensing Outlets (ADDOs) and to assess the possibility of using these ADDOs as distribution points for other HIV/AIDS-related products.¹⁹

Home-based care. The NMSF’s “home-based care” subsection is matched by PEPFAR programming in the “palliative care” category.²⁰ PEPFAR follows the NMSF in its focus on scaling up home-based care (HBC), including provision of a “basic package” of cotrimoxazole, safe water, and bed nets, as well as increased training of community-based HBC providers. PEPFAR also matches the second NMSF strategy of strengthening HBC linkages with care, treatment, and testing facilities by improving referral systems, and the third NMSF strategy of increasing PLHIV involvement in care.

¹⁸ NMSF p. 73.

¹⁹ Despite this programming, two care and treatment interviewees identified the supply chain system, and specifically PEPFAR’s requirement that projects receive all of their drugs through the MSD supply system, as a major barrier to expansion of treatment.

²⁰ PEPFAR has a category of “palliative care,” with a subcategory of “basic health care and support,” while the NMSF refers to “home-based care.”

The TB/HIV “dual epidemic.” PEPFAR is also well-aligned with NMSF strategies for treatment of the “dual epidemic” of TB/HIV co-infections. The NMSF emphasizes that although 60% of TB patients are co-infected with HIV, coordination between the two treatment programs is currently weak. PEPFAR programs for scale up of TB/HIV services include screening of HIV patients for TB as well as HIV counseling and testing for TB patients, improved referral systems between TB and HIV clinics, support for national TB/HIV policy formulation and coordination, and procurement support. These activities all support NMSF strategies.

Along with these strong similarities between NMSF and PEPFAR care and treatment strategies, there are also minor areas of divergence. The only NMSF strategy that has no PEPFAR counterpart is the call for increased cooperation with traditional healers.²¹ In addition, the NMSF strategy of scaling up private sector involvement in care provision is matched by only one program sub-component, involving outreach to the AIDS Business Coalition of Tanzania.

C. Impact Mitigation

There is significant agreement between PEPFAR and the NMSF in the area of impact mitigation. Both focus on care for vulnerable children (referred to as “orphans and vulnerable children” by PEPFAR, and “most vulnerable children” by the NMSF), as well as support to the families and community or religious groups that provide care.

Most Vulnerable Children. NMSF and PEPFAR strategies are well-aligned with respect to vulnerable children care. All eight NMSF OVC strategies are matched by PEPFAR, including support for caregiver groups that provide educational and nutritional services, vocational and life-skills training, rental assistance, support for orphan-headed households, psychosocial support, linkages of OVC services to HIV prevention and care, and training of social workers and other caregivers. PEPFAR also supports the NMSF by providing technical support for the GoT’s National OVC Plan of Action and Data Management System, as well as funding for district-level government capacity building for OVC care. Also in accordance with the NMSF, PEPFAR supports advocacy for community mobilization, protection of children’s rights and stigma reduction, and monitoring and evaluation of national OVC efforts. The only NMSF sub-strategies not directly matched are those of “strengthening the decision-making influence of caregiver households,” and expansion of “community justice interventions.” These strategies are somewhat vague, and it is unclear if PEPFAR programs should be interpreted as supporting them. In addition, one OVC care provider raised the issue that while PEPFAR programming relies heavily on the OVC National Plan of Action, it is only

²¹ PEPFAR PMTCT programming does involve sensitization for “traditional birth attendants.”

mentioned once in the NMSF OVC section, and it is not a component of any of the strategies. This may be indicative of a gap between NMSF and PEPFAR.

The Affected. The NMSF advocates eleven strategies to support “the affected,” which it defines primarily as caregivers and other family members of PLHIVs. PEPFAR supports the strategies aimed at strengthening local caregiver organizations, bolstering the economic security of caregivers (especially female and child-headed households), providing psychosocial support, and fighting stigma. PEPFAR does not appear to have specific programming in support of the NMSF strategies to link caregivers most in need to health services, or to quantify the impact of HIV on affected households. It is also unclear whether PEPFAR programming should be seen as in support of the NMSF strategies of “support for community justice interventions,” and “strengthening solidarity systems.”

People Living with HIV/AIDS. The NMSF subsection deals primarily with non-medical issues facing people living with HIV/AIDS (PLHIVs). Several strategies deal with the political and institutional environment facing PLHIVs, which are also discussed in the “Enabling Environment” section below. Other strategies in this section, such as support for PLHIV nutrition, strengthening of referral systems for PLHIVs, and psychosocial support services for PLHIVs, are matched by PEPFAR activities discussed in the care and treatment section. However, PEPFAR programming does not specifically support several strategies proposed by the NMSF in this section, such as support for the establishment of national PLHIV “umbrella” group, investigation of the provision of insurance for PLHIVs working in the formal sector, and the strengthening of human rights mechanisms for PLHIVs.

D. Enabling Environment

In the “enabling environment” category, the NMSF advocates strategies of political advocacy, fighting stigma and discrimination, mobilizing regional, district, and community responses, mainstreaming HIV/AIDS, and integrating HIV/AIDS into national strategy documents. Many of these issues are matched by PEPFAR programs that fall under the previously-discussed categories of care and treatment, prevention or impact mitigation. Others, such as political advocacy, coincide with activities classed under PEPFAR’s own cross-cutting “strategic information/policy analysis/system strengthening/other” category.

Advocacy and Political Commitment. The NMSF calls for political and legislative advocacy vis-à-vis HIV/AIDS policy, and for working with government and media to disseminate accurate HIV information to the public. Three PEPFAR programs align with these strategies. Through both the “Health Policy Initiative” and the “Sensitization of Parliamentarians” project, PEPFAR seeks to work with Tanzanian political and civil

society leaders to facilitate sound AIDS policy. PEPFAR also supports a group of “strategic radio” programs for public HIV/AIDS education, including the creation of a radio “center of excellence” for HIV/AIDS programming.

Fighting Stigma, Denial and Discrimination. PEPFAR programs support this NMSF strategy through anti-stigma programs for health care workers, anti-stigma components of OVC programming, anti-stigma radio and other behavior change programming, and through a youth anti-stigma pilot program in Mbeya.

Regional, District and Community Response. Assessing PEPFAR’s alignment with the NMSF strategy of building regional, district, and local capacity is complex. PEPFAR attempts to build local capacity by using local community and faith-based groups as implementing partners, and through specific capacity-building programs such as technical assistance, training, financial capacity building, and grant management services. For the public sector, PEPFAR programming directly supports regional health authority capacity building, and many ARV services contracts also include RHMT capacity-building components. A number of OVC and prevention programs include “community strengthening” elements directed at CBOs and FBOs as well as support for district governments to coordinate them. Despite this programming, the issue of local capacity-building was frequently raised in the course of interviews, and it is also raised by the Health Sector HIV/AIDS Strategic Plan (HSHSP). A broader discussion of this issue can be found in the HSHSP section of this report.

Mainstreaming HIV/AIDS/ Incorporating HIV/AIDS into National Strategies. The final set of NMSF “enabling environment” strategies address the mainstreaming of HIV/AIDS activities and their incorporation within Tanzanian national documents such as the Poverty Reduction Support Paper (“Mkukuta”). PEPFAR does not appear to support programming of this nature.

E. Monitoring and Evaluation

Although it is not one of the four main sections of the NMSF, monitoring and evaluation (M&E) is addressed at some length, with a focus on increasing GoT M&E capacity, harmonizing data systems, improving data quality, and integrating M&E data into the policymaking process. PEPFAR initiatives that align with NMSF strategies include support for: increased M&E staff, M&E training for NACP and MOHSW staff, surveillance surveys of at-risk and antenatal populations, coordination of Tanzania’s HIV/AIDS monitoring systems, and dissemination of the results of previous HIV/AIDS surveys. The US also supports technical assistance for national efforts such as the Tanzania HIV/AIDS Information Survey (THIS), the National ART Monitoring System, and the OVC Data Management System, as well as support for upgrading of health management information systems (HMIS). The NMSF emphasizes the need for

increased M&E capacity at the local government level, which is matched by PEPFAR's support for local government training through the NACP. The US also funds operational research in areas including ARV services, OVC care, most at-risk populations, and anti-stigma programming, in line with NMSF strategies. The NMSF strategy proposes spending 2.5% of HIV/AIDS funding on M&E, while PEPFAR is spending 3.2% on "strategic information" in 2007.

NMSF strategies with no direct PEPFAR support include developing M&E communications and advocacy capacity, building local research capacity, tailoring operational research to local governments, strengthening research ethics, the creation of a national HIV data resource center, and engaging service delivery organizations to conduct operational research.

F. The Health Sector HIV/AIDS Strategic Plan

In contrast to the NMSF's multi-sector view, the Health Sector HIV/AIDS Strategy outlines Tanzania's HIV/AIDS strategy from the point of view of the main implementing sector. In large part, the degree of convergence between the HSHSP and PEPFAR mirrors the level of agreement between the NMSF and PEPFAR. There is similarly strong convergence on care, treatment and cross-cutting issues, and there are also significant gaps in the prevention section.²² As with the NMSF, major disagreements within prevention center on STI prevention/treatment, and on the prevention of sexual transmission through ABC. Overall, the similarities between the NMSF's and the HSHSP's relationship to PEPFAR are striking, down to the level of individual strategic items. Most differences between these two relationships stem from the fact that the HSHSP is both more detailed and specialized than the NMSF.

The HSHSP does highlight one area of potential difference with PEPFAR that is not emphasized in the NMSF: the issue of "vertical" versus "horizontal" approaches, and the related tradeoff between short-term impact and long-term sustainability. This issue of sustainability also emerged consistently in interviews as a major difference between PEPFAR and GoT strategy. The following concerns with respect to sustainability were raised most frequently by interviewees:

- PEPFAR's decision to provide project-based aid rather than budget support runs the risk of hindering the institutional development of the Tanzanian health system, through the creation of a parallel and competing health sector;
- PEPFAR's inability to provide program and budget information in time for Tanzania's budgetary process results in less effective public sector planning and increased transaction costs in general, especially at the district and local level;

²² The HSHSP does not have an "impact mitigation" category.

- PEPFAR training and capacity building may be too concentrated within project staff rather than on broader health workforce expansion;
- Interviewees identified a strong need for more capacity-building at the district and local government levels.

III. Conclusion

The NMSF and PEPFAR are in substantial agreement with respect to Tanzania's strategy against HIV/AIDS. The majority of PEPFAR programs are in line with NMSF strategies, and most NMSF strategies have PEPFAR counterparts. In particular, the area of care and treatment is marked by very strong alignment between the NMSF and PEPFAR. The areas of impact mitigation (including OVC care) and the cross-cutting "enabling environment" category also are generally marked by agreement. However, there are major gaps within the category of prevention. The NMSF's strong emphasis on prevention as the top priority is at odds with PEPFAR's prioritization of treatment. Other gaps on prevention include disagreement over the relative weight of ABC prevention strategies, and the lack of PEPFAR programming for the NMSF strategies of STI prevention and treatment and workplace prevention interventions.

Beyond this, both feedback from structured interviews with stakeholders and examination of the Health Sector HIV/AIDS Strategy suggest significant differences with respect to the nature and magnitude of PEPFAR efforts at "system strengthening." Both the HSHSP and a majority of interviewees suggested that PEPFAR's relationship to the Tanzanian health sector is overly "vertical," with insufficient attention to "horizontal" challenge of strengthening the broader health system. Symptoms of this problem include incomplete information sharing with government of Tanzania stakeholders, and insufficient attention to expansion of the health sector workforce. However, there was also agreement that PEPFAR has made significant improvements in this area, and that the general trend is positive.

Gaps between NMSF strategies and PEPFAR programming need not be problematic, if such gaps are the result of donor division of labor and specialization. However, as the NMSF points out in its discussion of prioritization, the coordination of the entire donor community as a whole with the NMSF is far from complete. It is hoped that this report has highlighted areas of alignment as well as gaps between PEPFAR and the government of Tanzania's National Multi-Sector Strategic Framework, thus enabling donors to better coordinate their programming in search of genuine partnership with Tanzania in the fight against HIV/AIDS in Tanzania.

APPENDIX

CARE AND TREATMENT		
NMSF Category	NMSF Strategy	PEPFAR Response
Continuum of care	Enhance capacity at regional and district level to plan implement, coordinate, monitor and evaluate a continuum of care	General ARV provision, regional health authorities capacity building, quality improvement/assurance, coordination of ARV expansion, lab infrastructure, training
	Increase the number of qualified service providers	ARV services training; hiring retired health care workers; NACP training; IMAI training, lab training, HR research support, productivity and retention interventions, nurse training, twinning, mentoring, technical assistance for HR management; pre-service education, curriculum standardization/improvement
	Strengthen procurement and supply management systems	ARV procurement, supply chain strengthening, support for MSD, ADDO accreditation, ILS roll-out
	Expand access to prophylaxis and treatment for opportunistic infections	Supply chain strengthening, OI management as component of ARV services
	Scale up private sector involvement in care	Working with ABCT to promote public-private partnerships
	Promote gender sensitive research and its application to clinical management of AIDS clients	Exit interviews of men to identify barriers to treatment
	Build partnerships with traditional healers	
	Enhance linkages between care, treatment, support and prevention	"Two way referrals" included in ARV services
	Strengthen IEC and BCC for care, treatment, and support	Community sensitization in ARV services, creation of low literacy adherence materials
	Incorporate nutrition counseling and support in care	Component of some ARV services projects, "Play pumps," component of home-based care
Ensure PLWHAs are involved in adherence counseling	Selian, Kihumbe projects	
The dual epidemic	Improve cooperation, share best practices b/w Tb and HIV care	Scale up of TB/HIV services, RPM, work with NTLP, TPDF.
	Strengthen screening of PLHIVs for TB; for prophylaxis and early treatment;	Included in TB/HIV services
	Expand provider-initiated HIV testing and counseling in TB services	Included in TB/HIV services
Home-based care (HBC) and support	Strengthen linkages and referrals b/w health facilities and HBC	HBC services including "basic package"; faith-based HBC, quality control/advocacy/best practices, procurement
	Train adequate number of HBC providers/make sure they know rights to care/treatment/support according to Nat'l HBC Guidelines*	Training for caregivers, Mildmay training, NACP training
	Greater involvement of PLHIVs	Selian Hospital project
	Promote advocacy and education in communities to make them respond effectively to needs of PLHIVs	Training of caregivers, RPM education component, Strategic Radio Communications

* An asterisk (*) indicates that more than one NMSF strategy has been condensed into a single cell; the different strategies are separated by a backslash (/). Strategies have also been condensed to fit the available space.

PREVENTION		
NMSF Category	NMSF Strategy	PEPFAR Response
AB	Provide more youth and gender sensitive sexual health info and services, tie it to income generation issues	Peer youth health educators
	Support parents and school-based HIV ed/train enough teachers to cover all schools and every level/expand HIV education at all levels, curriculum development, peer-based education and counseling*	Prevention through curriculum-based interventions, skills-based prevention, primary school life skills education, prevention training for RACC and DACCs, teacher and trainer training
	Expand peer education and counselor training for out of school youth	Peer-to-peer programs, skills-based HIV education, NACP helpline, rural outreach, mass media programming, community and faith-based programs.
	Encourage youth to develop their own interventions	Peer to peer counseling, youth club formation
	Challenge gender norms of male dominance	"Sikia Kengele" program for male fidelity, study of factors influencing multiple partnering, youth social norm promotion.
	Strengthen advocacy with gatekeepers	Reinforcement of parents and teachers, outreach to religious leaders
	Programs against drug/alcohol abuse	
Risk reduction with vulnerable populations	Promote wider discussion and awareness of gender inequality and HIV	Incorporated in some AB programming
	Empower women through better sexual and reproductive health education, better life skills	PMTCT/ANC programming, also skills training for female-headed households under OVC care
	Promote responsible social norms for men (reduce male dominance, gender-based violence)	"Sikia Kengele" campaign, multiple partnering study
	Have influential men advocate gender equity	See above
	Advocate repeal of laws and cultural practices that violate women's social protection	
	Provide PEP, emergency contraception, counseling, other services to rape victims, abused children and women	
	Identify determinants of vulnerability, support programs against them	
	Partnerships between government and vulnerable population CSOs for advocacy, best practice exchange	
	Increased access to HIV prevention info and services for vulnerable populations	Counseling and testing for vulnerable populations, condom provision and prevention education for CSWs and other MARPS
	Revise law that condones early marriage/doesn't recognize rape in marriage	

	Make condoms available for female prisoners, address sexual abuse of male and female prisoners	
	Strategy to reduce HIV transmission among intravenous drug users (IDUs), including education, condom provision, harm reduction measures, and rehab	Interventions with IDUs and CSWs including assessment, implementation manual, community outreach, and referral services
Expansion of workplace interventions	Public sector HIV training/standardize for quality	
	Increase public sector interventions; share practices through ABCT	Kilombero program to link VCT with care and treatment
	Ensure legal regime protecting HIV-positive workers/strengthen labor regulations	
	Special programs for informal sector	
	Outreach programs to include families into workplace programs	
	Info and condoms available for workplace programs	Prevention on the Tan-Zam corridor, education and condom distribution for the military
Prevention/treatment/control of other STIs	Expand STI services to all health facilities, make them youth and gender friendly, maintain and improve quality	
	Keep treatment up to date w/ research, especially with HSV-2	
	Ensure continuous drug supplies	
	Strengthen public-private partnerships	
	STI services for vulnerable populations especially CSWs	
	Empower health workers to provide counseling for individuals with STIs	
Promotion and expansion of counseling and testing	Expand testing	General testing scale up, testing through FBOs and NGOs, fund NACP for 25 new sites, mobile services, home-based testing, technical assistance to GoT, National Testing Day, supplies, demand creation
	Introduce provider-initiated counseling and testing (PICT) at all sites gradually	Assist GoT in phasing in PICT, support MOHSW, implement through testing partners
	Explore use of non-health workers	Selian Lutheran Hospital
	Link testing to all other care and services	Referral services within counseling and testing programs
	Ensure confidentiality	Support NACP, ZACP to strengthen confidentiality
	Expand testing for sero-discordant couples, youth, reduce parental consent age	
PMTCT	Expand further through opt-out testing in antenatal care	General services expansion, introduce opt-out testing
	Get males involved to stimulate responsible behavior vis-à-vis PMTCT/public sensitization and anti-stigma*	Male involvement components of EngenderHealth and Columbia PMTCT projects, public sensitization through social marketing
	Link PMTCT with care and treatment	Incorporated in PMTCT programming

	Keep PMTCT treatment up to date in line with new research findings	University Research Corporation study
	Promote access to family planning for HIV positive women	
	Train health workers for PMTCT	Component of PMTCT programs, also FX Bagnoud Center training program
Promotion and distribution of condoms	Include condom issues in the revised National HIV/AIDS Policy and Guidelines	
	Make female condoms more accessible	Distribution of Lady Pepeta female condom
	Expand availability through social marketing, better distribution, free provision	Condom procurement, marketing, and distribution in high risk areas; limited condom distribution to TPDF
	Increase knowledge and skills for condom use, correct misperceptions	Behavior change campaign for condom use
	Advocate with religious leaders	
	Address gender and cultural barriers to use	Condom promotion behavior change campaign
Blood safety	Expand National Blood Transfusion Center/provide quality screening/screen donated blood/supply lab supplies for screening/expand availability of PEP/educate about it*	Strengthening blood safety services, support to MHSW for broader system strengthening
	Educate communities to avoid transmission through traditional practices	
	Intensify advocacy and train health workers on contamination issues	Injection safety programs (3 programs)
	Train home care-givers so they don't contract HIV through contamination	
New prevention interventions	Scale up male circumcision	
	Access acceptability and demand for self testing	
	Research new interventions, such as microbicides or vaccine	US research takes places in non-PEPFAR programming

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IMPACT MITIGATION		
NMSF Category	NMSF Strategy	PEPFAR response
MVCs	Strengthen families and communities to protect MVC through economic, psycho-social, health and nutrition, and early childhood development support, also skills-training and protection from abuse	General OVC services scale up, training social workers and other counselors, PSS services, support to orphan-headed households, housing rental/renovation, vocational training, grants/economic training, nutritional support.
	Work with local governments, community groups; support care-giving households and increase their decision-making influence	Support for community care groups, community "kids clubs," local capacity-building for OVC care, support for OVC caregiver network
	Support MVC education, health services, HIV treatment, counseling, and rights	See first MVC strategy, also linking OVC to care, treatment, and prevention services, train HIV-positive OVCs in adherence counseling
	Policy: implement Children's Act, prepare MVC policy, care and support guidelines, recognize differing needs of boys and girls	Support scale-up of OVC plan of action and data management system, advocacy for OVC rights, technical assistance to DSW for guidelines and policy
	Recognize issues facing child and elderly-headed households	Support for orphan-headed households in high-risk areas, support to grandmother-headed households
	Strengthen national/regional/local institutional capacity for MVC response	Enhance district community capacity, technical support to DSW for national OVC guidelines, policy
	Use advocacy and social mobilization to reduce stigma, promote MVC participation, be gender-aware, promote child participation	Media and faith community advocacy, incorporation of anti-stigma into OVC programs
	Monitor and evaluate MVC activities	MEASURE monitoring and evaluation project, support for MVC Data Management System
	The Affected	Quantify and understand differential impact on caregivers, recommend means for mitigation
Special attention for caregivers in need including elderly and children		Support for child- and elderly-headed households including through grants and skills training
Engage local partners and groups to support caregivers		General OVC services scale up
Empower and build capacity of formal and informal groups to implement MVC care		General OVC services scale up, training social workers and other counselors, PSS services, support to orphan-headed households, vocational training, grants/economic training
Link caregivers in need with health and social services		
Strengthen referral systems for caregivers to services		
Strengthen volunteer support networks		Formation of caregiver network
Provide psycho-social support/strengthen solidarity systems for caregivers*		Incorporated in general OVC programming
Roll out community justice interventions		
Reduce stigma against caregiving households		See stigma reduction programming above

PLHIVs	Advocate for strong national PLHIV "umbrella" association	
	Assess policy environment, make recommendations	Health Policy Initiative
	Strengthen influence of PLHIVs in national policy decisions	
	Strengthen human rights mechanisms for PLHIVs	
	Engage local institutions to support PLHIVs	See treatment section
	Increase membership in PLHIV groups	
	Strengthen community referral networks to get help to most vulnerable, community psycho-social support networks	See referral system programming in treatment section
	Support enforcement of HIV/AIDS act	Parliamentary Sensitization, Health Policy Initiative
	Investigate possibility of insurance coverage for PLHIVs in formal sector	
	Community-based nutrition initiatives	Nutrition counseling, home gardening initiative

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ENABLING ENVIRONMENT		
NMSF Category	NMSF Strategy	PEPFAR Response
Advocacy and political commitment	Advocate for legislation for HIV response; accountability for implementation (with a human rights and gender-sensitive approach)/mobilize political commitment at all levels of response	Health Policy Initiative, MP Sensitization
	Work with the Ministry of Culture and Information, media, other stakeholders to disseminate HIV/AIDS information	VOA, Radio "Center of Excellence"
Fighting stigma, denial, discrimination	Promote a rights-based, gender sensitive HIV campaign/address stigma, denial, discrimination	Anti-Stigma Pilot-Mbeya, Strategic Radio and other BCC, stigma reduction for HCWs, anti-stigma in OVC programs
	Create an environment where sexuality issues can be openly discussed	Anti-stigma programming, HIV education
	Greater involvement of PLHIVs in HIV responses through self-organization and advocacy	pilot program
	Review and enact laws and regulations to ensure gender & human rights-sensitive approach to those affected by the epidemic	Health Policy Initiative
Regional, district, community response	Promote models of community mobilization/build on the strengths of communities to find their own solutions	community strengthening as component of OVC programming
	Strengthen local capacity for planning, coordination, monitoring and evaluation, and financial management/mobilize local political leadership and CSOs/capacity building especially focused on VMACs and WMACs*	capacity building to regional health authorities, to RACCs and DACCs, to CBOs and FBOs for AB, RFE, local government capacity bldg as part of ARV services, OVC programming, program and fiscal capacity building for public sector grantees
Mainstreaming HIV/AIDS	Strengthen capacity for HIV mainstreaming interventions	
HIV/AIDS, Development, and Poverty reduction policy	Assess major documents like MKUKUTA, JAS, and Vision 2025 to make sure they include HIV/AIDS	
	Build capacity of GoT planners to incorporate HIV policy	

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Appendix B: Interview list:

Dr. Joseph Temba, TACAIDS
Dr. Emmanuel Malangalila, World Bank
Dr. Paul Waibale, AMREF
Dan Craun-Selka, PACT
Dr. Ilana Lapidus-Salaiz, Deloitte
Dr. Erik van Praag, FHI
Dr. Bennet Fimbo, NACP

The author also participated in a PEPFAR site visit to the Southern Highlands HIV Care and Treatment Program on July 17-18.

Appendix C: Document list:

National Multi-Sectoral Strategic Framework 2008-2012 (Fifth and Final Draft)
National Multi-Sectoral Strategic Framework 2003-2007
PEPFAR Summary of Activities and Targets by Program Area, 2007
Health Sector HIV/AIDS Strategic Plan 2008-2012
PEPFAR “Program Area Context” document
PEPFAR 3rd Annual Report to Congress (2007)
US Government Accountability Office report GAO-06-396 “Global Health: Spending Requirements Present Challenges for Allocating Prevention Funding under PEPFAR.”
Tanzania Poverty Reduction Strategy Paper (“MKUKUTA”)
3rd Joint Technical Review of the NMSF (2003-2007): Technical Review Meeting Proceedings