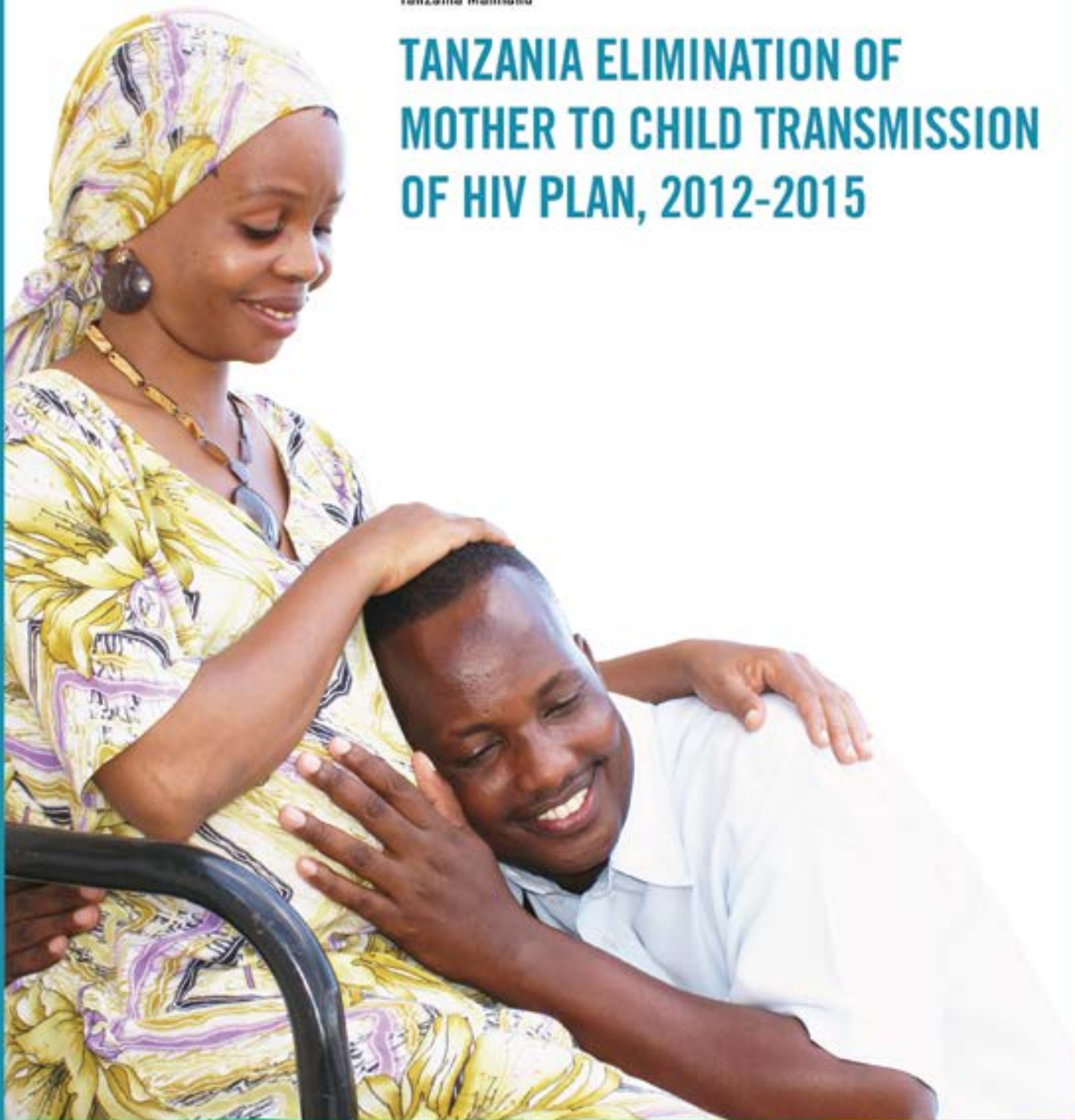




THE UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH AND SOCIAL WELFARE
Tanzania Mainland

TANZANIA ELIMINATION OF MOTHER TO CHILD TRANSMISSION OF HIV PLAN, 2012-2015



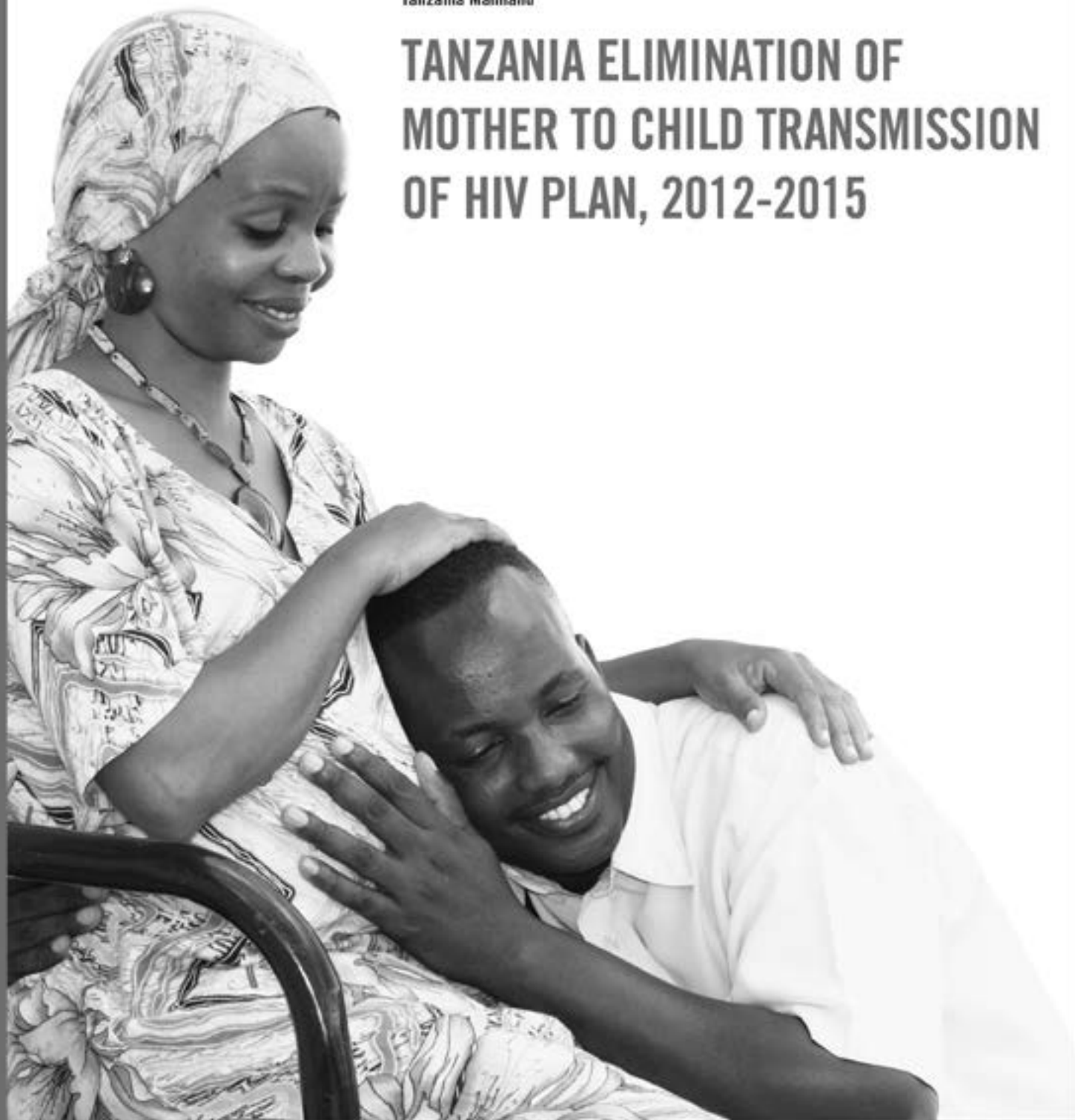






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FOREWORD

It is with pleasure that I present the Tanzania elimination of Mother To Child Transmission of HIV (eMTCT) plan for 2012 - 2015.

At the High level meeting on AIDS in New York in June 2011, Governments noted with deep concern that despite substantial progress over the three decades since AIDS was first reported, the HIV epidemic remains an unprecedented human catastrophe inflicting immense suffering on countries, communities and families throughout the world. As such, Governments Reaffirmed that prevention of HIV must be the cornerstone of national, regional, and international responses to the HIV epidemic and Committed to working towards the elimination of mother-to-child transmission of HIV by 2015 and substantially reducing AIDS-related maternal deaths. Tanzania was represented in this meeting by the Vice President His Excellence Honorable Mohamed Gharib Bilal. His excellence endorsed the declaration and committed to making elimination of mother-to-child transmission of HIV a reality in Tanzania.

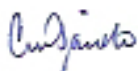
To align to the global commitments and virtual elimination of new infections among children and keeping their mothers alive, Ministry of Health and Social Welfare recommended the need to revise the current PMTCT scale up Plan (2009 – 2013) and align it to the elimination agenda hence the development of this elimination of mother to child transmission of HIV plan.

PMTCT services have been implemented in Tanzania since 2000 and a lot of progress has been made since then. By 2010, 94% of all Reproductive and Child Health facilities were providing PMTCT services reaching about 70% of the pregnant women with ARV prophylaxis. Undoubtedly, Tanzania has seen major progress in the prevention of HIV transmission from mother to child. Such progress however, has often been uneven, not reached all women and children in need and not addressed all the major interventions that will contribute to eMTCT.

In quest to accelerate progress in achieving virtual elimination of new infections in children, this plan has been developed to provide guidance on critical interventions, targets and resources required at all level. The plan has been developed based on an equity focused bottleneck analysis of the PMTCT programme.

This plan highlights the current status of implementation of the PMTCT programme and areas where progress has been made towards achievement of eMTCT targets. Also, it identifies areas where progress has stalled or lagging behind. It sheds light on some of the major bottlenecks that have affected programme implementation and proposes targets, strategies and resources that will facilitate achievement of virtual elimination of new infection among children in Tanzania.

We are confident that this plan will inform the equity focused programming for eMTCT and guide priority setting for cost efficient interventions that will lead to elimination of new infections among children and keep their mothers alive. We are also confident that plan will guide the Government, Partners and stakeholders of resource allocation for sustained impact.



Dr. Donan W. Mmbando,
Ag. Chief Medical Officer
Ministry of Health and Social Welfare

ACKNOWLEDGEMENTS

The elimination of Mother to Child Transmission of HIV (eMTCT) plan is a result of joint collaboration between the Government of the United Republic of Tanzania through the Ministry of Health and Social Welfare (MOHSW) and partners supporting Prevention of Mother to Child Transmission (PMTCT) programmes in Tanzania. Given its scope and breadth, the plan would not have been possible without the strong commitment, guidance and support of members of the National Task Team for elimination of mother to child transmission of HIV.

The Ministry of Health and Social Welfare (MOHSW) wishes to thank all who took part in the task team, eMTCT sub teams and the consultations carried out over the course of several months. Among those who took part were representatives from the following institutions: Ministry of Health and Social Welfare, Centres for Disease control and Prevention (CDC), the United States Agency for International Development (USAID), United Nations Children Fund (UNICEF), United Nations Joint Team in AIDS (UNAIDS), United Nations Population Fund (UNFPA), World Health Organisation (WHO), Elizabeth Glaser Paediatric AIDS Foundation (EGPAF), Clinton Health Access Initiative (CHAI), Pathfinder International, JHPIEGO, ICAP, Family Health International (FHI), Mother2mother (m2m), Tanzania Commission for AIDS (TACAIDS), AMREF, Walter Reed, Millennium Village Project (MVP), Supply Chain Management System (SCMS), Association of Tanzania Private Employees (ATPE), Engender Health, Population Service International (PSI), AIDS Relief, Management Development for Health (MDH), National Council of People Living with HIV/AIDS (NACOPHA) and Municipal Medical Officer of Health Temeke.

The MOHSW would also like to acknowledge Dr. Dorothy Mboori-Ngacha, Senior PMTCT Specialist, UNICEF Eastern and Southern African Region and Dr. Priscilla Idele, Senior Advisor Statistics and Monitoring in UNICEF HQ for their participation and technical guidance during the consultative meetings that led to the development of the plan.

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Finally, the MOHSW acknowledges the exemplary work done by PMTCT unit under the leadership of Dr. Neema Rusibamayila Assistant Director RCHS, Dr. Mwikemo Deborah Kajoka PMTCT Programme Coordinator and Ms. Joyce Mphaya (UNICEF) in coordinating the various activities leading to the publishing of this plan.



Dr. Peter Mmbuji

Ag. Director Preventive Services
Ministry of Health and Social Welfare

List of abbreviations and acronyms

AIDS	Acquired Immune Deficiency Syndrome
AMREF	African Medical and Research Foundation
ANC	Antenatal Clinic
ART	Antiretroviral Treatment
BCC	Behavior Change Clinic
BFHI	Baby Friendly Hospital Initiative
CARF	Community AIDS Response Fund
CBO	Community Based Organization
CCHP	Comprehensive Council Health Plan
CMAC	Council Multisectoral AIDS Committee
CME	Continuing Medical Education
CMO	Chief Medical Officer
CO	Clinical Officer
CORP	Community Owned Resource Persons
CPL	Central Pathology Laboratory
CTC	Care and Treatment Clinic
DACC	District AIDS Control Coordinator
DBS	Dry Blood Spots
DHHS	Department of Health and Human Services (US)
DMO	District Medical Officer
DOT	Directly Observed Therapy
EID	Early Infant Diagnosis
FBO	Faith Based Organization
FP	Family Planning
FTE	Full Time Equivalent
GDP	Gross Domestic Product
GOT	Government of Tanzania
GTZ	German Agency for International Development
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
IATT	Inter-Agency Technical Team
IEC	Information, Education and Communication
ILS	Integrated Logistic System
IYCN	Infant and Young Child Nutrition
KCMC	Kilimanjaro Christian Medical Centre
MAP	Multi-Sectoral AIDS Project
MNCH	Maternal, Newbon and Child Health

List of abbreviations and acronyms

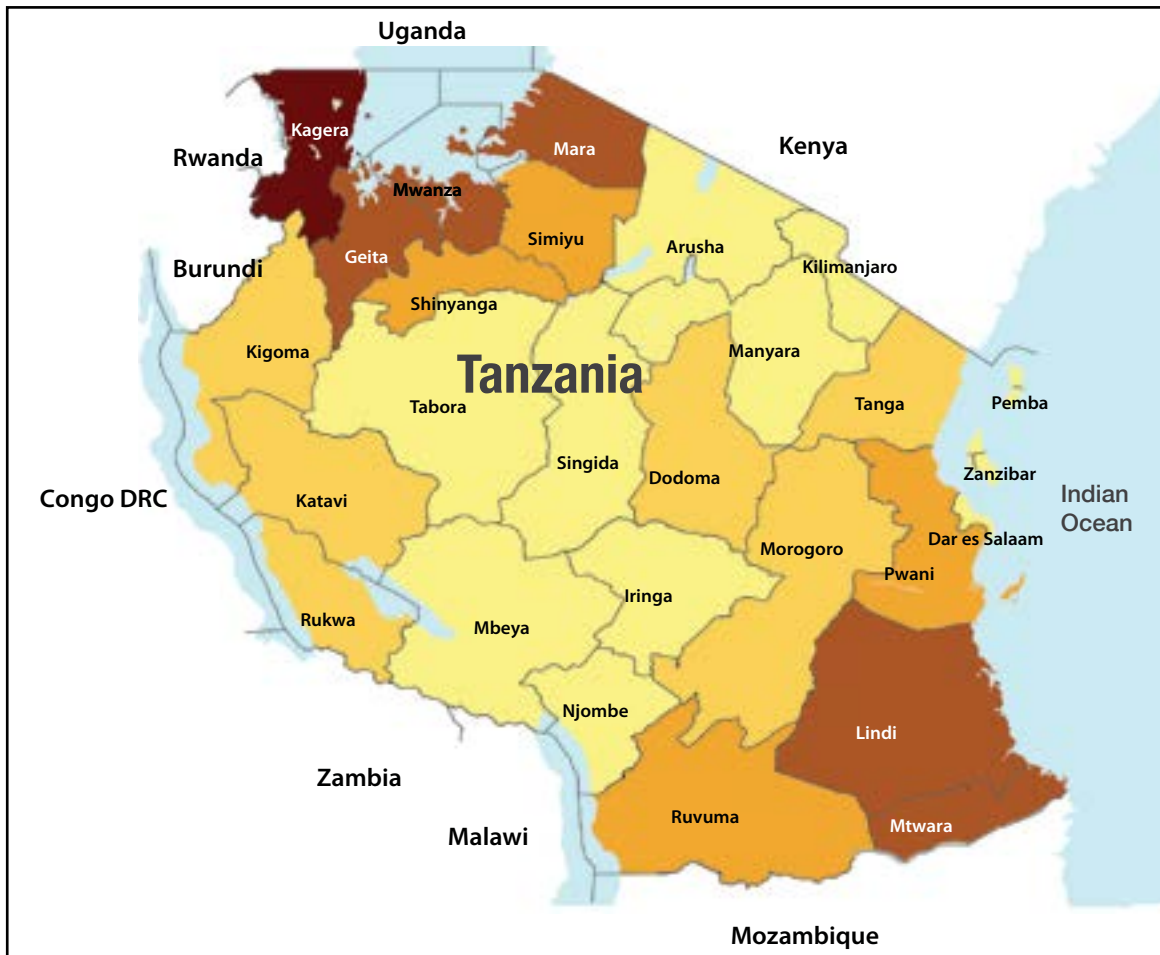
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MNH	Muhimbili National Hospital
MoHSW	Ministry of Health and Social Welfare
MSD	Medical Stores Department
MST	Marie Stopes Tanzania
MTEF	Mid Term Expenditure Framework
NACP	National AIDS Control Programme
NGO	Non Governmental Organization
NHLS	National Health Laboratory Services
NMSF	National Multi-Sectoral Framework
OI	Opportunistic Infection
PEP	Post-Exposure Prophylaxis
PITC	Provider Initiated Testing and Counseling
PLHIV	Person(s) Living with HIV
PMO	Prime Ministers' Office
PMO-RALG	PMO-Regional Administration and Local Government
PMTCT	Prevention of Mother to Child Transmission of HIV
QA	Quality Assurance
RAS	Regional Administrative Secretary
RCH	Reproductive and Child Health
RMO	Regional Medical Officer
RNO	Regional Nursing Officer
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TACAIDS	Tanzania Commission for AIDS
TB	Tuberculosis
TDHS	Tanzania Demographic and Health Survey
TFDA	Tanzania Food and Drug Authority
TFNC	Tanzania Food and Nutrition Centre
THIS	Tanzania HIV Indicator Survey
THMIS	Tanzania HIV and Malaria Indicator Survey
TOT	Training of Trainers
UMATI	Chama cha Uzazi na Malezi Bora Tanzania
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

1.0 Background

1.1 Country Demographic and epidemiological profile

The United Republic of Tanzania is composed of Tanzania Mainland and Zanzibar. The health services in country follow the administrative structures of government and as such in the mainland there are 21 regions, 113 districts and 148 local authorities whilst in Zanzibar there are 2 health zones with 10 districts.

Tanzania with administrative boundaries



The country's population is relatively young with 44% being under the age of 15 years. Fertility rates are high at 5.7 given the low contraceptive prevalence and relatively high unmet needs for family planning (22% and 31% for Tanzania Mainland and Zanzibar respectively).

HIV prevalence among the 15-49 age group has shown a significant decline from 7% in 2003, to 5.7% in 2007/2008 in Tanzania Mainland (Tanzania HIV and malaria indicator survey), whilst prevalence in Zanzibar has remained below 1% in the general population.

The table 1 below summarizes the country demographic and epidemiological profile

Table1: Tanzania demographic and epidemiological profile	
Demographic Data <ul style="list-style-type: none"> • Total population (43.2m) • Estimated number of annual births(1.7m) • Maternal mortality rate (454) • ANC coverage 1st visit (96%) • ANC coverage ≥ 4th visit (43%) • Skilled attendant deliveries (50%) • Population under 15 years (46.6%) • Population under 5 years (21.3%) • Under 5 and infant mortality (81 per 1000 live births and 51 per 1000 live births) • DPT1 coverage (86%) • Measles immunization coverage (91%) • DPT3 coverage (86%) • Syphilis testing coverage at 1st ANC visit (%) • Rates of exclusive breastfeeding at 6m (50%) • Rates of stunting/wasting among <5yrs (42%) • Mean duration of breastfeeding (21 months) • General FP unmet need (25%) 	HIV/AIDS data^{2,3} <ul style="list-style-type: none"> • Number of people living with HIV/AIDS(2.4m) • Estimated number of people needing ART (660,000) (including subset of #/% pregnant women needing ART) • Unmet ART need (48%) • HIV prevalence among pregnant women (6.9%) • Syphilis prevalence among pregnant women (4.2%) • Estimated HIV positive pregnant women giving birth per year (119,000⁴) • HIV positive pregnant women receiving ARVs for PMTCT (disaggregated by regimen)(70%) • HIV positive pregnant women accessing ART for their own health(13,444) • Estimated number of new pediatric HIV infections per year (43,050) • Estimated transmission rate(25%) • Estimated number of children (<15 years) living with HIV (160,000) • AIDS attributable under 5 mortality (18.6%) • AIDS attributable maternal mortality(11%)

¹ TDHS 2010

² THMIS 2007-08

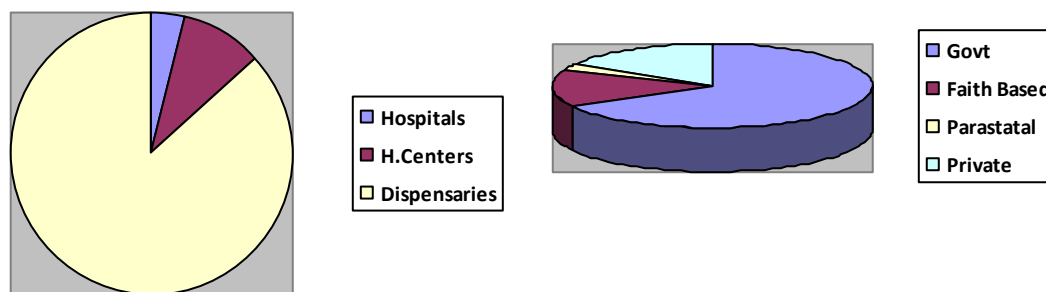
³ NACP 2011

⁴ PMTCT programme data 2010

1.2 Organization of the Health system

1.2.1 Health Services Delivery

Tanzania has a well-developed health care delivery system. Since independence there has been a remarkable expansion of health services to the rural areas to serve the majority of the population. According to Annual Health Statistical of 2009, there are total of 5,972 health facilities in the country of which 231 are Hospitals, 563 are Health centers and 5,178 are dispensaries. Among these 67% are government owned, while faith based organizations own 14%, parastatal owns 3% and 16% are private health facilities as represented below.



About 90% of population lives within five kilometers of a primary health facility. The Health Care Delivery system is organized into three levels namely the National, Regional and District/ council levels. The service delivery at the district level includes facility and community based approaches. The Ministry of Health and Social Welfare (MoHSW) and Prime Minister's Office-Regional Administration and Local Government (PMO-RALG) are jointly responsible for the delivery of health services. Zonal referral hospitals, Zonal Health Resource Centers and special programs are directly under the MoHSW while PMO-RALG manages regional and district health services. The MoHSW is further responsible for the provision of diagnostic services for both curative (hospital) and preventive services in collaboration with faith-based organizations, private-for-profit and NGOs. The District Health management team has the autonomy with respect to planning, coordination, supervision and implementation.

1.2.2 Human Resource

The total of staffing in the health sector stands at 35% of the actual need according to defined staffing norms. The available number of professional health workers in the public sector is 35,202 and deficit is 90,722. Shortages in the private sector, especially in Faith Based Organization institutions are also immense. The shortage is more severe in rural districts. The high attrition rate is a threat and is compounded by HIV/AIDS epidemic.

As regards to HIV and AIDS trainings, there has been specific capacity building in response to the epidemic. The Comprehensive PMTCT curriculum was first developed by the Ministry of Health in 2004. The training curriculum has been revised according to the 2010 WHO recommendations to support the implementation of the updated guidelines. The curriculum is being used to train trainers and health care workers on PMTCT and Early Infant Diagnosis. Training of health care workers using this curriculum takes two weeks. The capacity of health training institutions is limited for pre-service training. Consequently there is a low output of Pre-service trained health personnel. Training institutions have several setbacks (understaffing, inadequate infrastructure) to match the existing demand. Staff currently in the field requires reliable and accessible Continuing Professional Development to meet training needs, but capacity building of staff is often fragmented, linked to vertical programmes. There is high staff turnover such that the acquired skills is not maximized as intended.

1.2.3 Health Care Financing

Analysis on the proportion of the total government expenditure going to the health sector has almost remained the same from 13.45% in 2006/07 to 13.87% in 2008/09. In addition, the proportional budget spent on health is still below Abuja target of 15% by 2015.

1.2.4 Supply Chain Management System

The Medical Stores Department (MSD) is a government entity responsible for procurement, storage and distribution of pharmaceutical and medical supplies to government facilities and to approved non government hospitals. Further and alongside that role, MSD has the mandate for distributing ARVs, HIV test kits and other consumables to all accredited sites providing care and treatment services. Using funds from government and partners, MSD procures, stores and distributes medicines and supplies. Such procurement is governed by the government-enacted Public Procurement Act.

MSD plans to decentralize part of its functions to the zonal stores, which will be able to respond quicker to client needs. Hospitals and District Health Services will then be able to use generated funds more flexibly and procure approved medicines and supplies where available. MSD will also automate more of its stores management, making on-line information available for clients. Monitoring, evaluation and operational research in medicines supply and utilization will improve, using good management practices which, where practical, should include the use of Information Communication Technology (ICT) solutions.

1.2.5 Health Information Management System

The Monitoring and Evaluation (M&E) system for health in Tanzania consists of routine systems (HMIS, demographic and disease surveillance) and non-routine systems (household surveys and research). The MOHSW is in charge of Health management information system (HMIS) and disease surveillance, while non-routine information systems are often done by other government or research entities. FBOs in general comply with national information systems, but private-for-profit facilities often provide limited information. Disease surveillance is improving steadily, but still suffers from reporting delays.

The PMTCT M&E framework is organized around a data approach of collecting and reporting basic, reliable “core” summary data needed to monitor and evaluate the national PMTCT program. The recording and reporting tools and indicators have been reviewed in 2010, with the aim of capturing information that is required for programme planning at different levels and addressing national and international targets. The PMTCT M&E tools currently in use include: ANC PMTCT Register, Labour and Delivery PMTCT Register, PMTCT Care register and Mother/Infant Follow-up Register and their monthly summary forms. Others are PMTCT Medicine Register for ANC and Labour ward, PMTCT transfer/referral form. In addition, the supervision checklist has also been revised in line with the revised tools and guidelines.

Data is entered into these registers every day, as services are provided. At the end of each month, data are compiled in monthly summary forms corresponding to these registers. These reports are submitted to the DMO for verification and aggregation, then sent to the RMO. At the regional level, the data from the districts are compiled and sent to the Ministry of Health-PMTCT programme.

1.2.6 Community service delivery package

All the four prongs of the PMTCT require Community based interventions. Strategic objective 5 of the National Scale up Plan for PMTCT and Paediatric HIV/AIDS outlines strategies for developing a community service package, community mobilization and capacity building. However the actual implementation of community based interventions fell short of expectations due to lack of a clearly specified and implementable package.

1.3 The National response and achievements

1.3.1 Political leadership and commitment

Tanzania has demonstrated strong political commitment at the highest levels for achieving the health-related Millennium Development Goals (MDGs). This is best reflected in the national poverty reduction strategy MKUKUTA II, where maternal, newborn and child health and HIV feature as a critical agenda. In addition, His Excellency the President of the United Republic of Tanzania launched a campaign on reduction of maternal mortality rates in Tanzania in 2011 and the first lady of the country is the patron for the campaign. Tanzania is committed to eliminating new HIV pediatric infections by 2015. This was endorsed at the High Level Meeting held in Washington DC, June 2011 where the Vice President of the Tanzania was in attendance. This has led to formation of the national task team for virtual elimination of Mother to Child Transmission of HIV (eMTCT).

1.3.2 The strategic context

In line with the tenets of the New Delhi Declaration 2005, Tanzania developed the National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania (2008 – 2015) to improve maternal, newborn and child care. The Reproductive and Child Health Section (RCHS) of the Ministry of Health and Social Welfare (MoHSW), in collaboration with a number of different stakeholders, has developed this strategic plan to guide implementation of all maternal, newborn and child health interventions in Tanzania.

The National Road Map Strategic Plan stipulates various strategies to guide all stakeholders for Maternal, Newborn and Child Health (MNCH). The Primary Health Service Development Programme, (PHSDP/MMAM) 2007 - 2017, addresses the delivery of health services to ensure fair, equitable and quality services to the community and is envisioned to be the springboard for achieving good health for Tanzanians.

1.3.3 Sexual and Reproductive Health program

Maternal Mortality Ratio (MMR) remains persistently high at an estimated 454/100,000 live births⁵. 98% of the pregnant mothers attend ANC services at least once and the proportion goes down to 43% for the fourth visit and less than 50% of them deliver in a health facility. Insufficient numbers of health facilities are equipped and staffed according to standards to provide quality MNCH services. The total fertility rate remains high at 5.7 with an unmet need for family planning at 25%. The One Plan for Maternal Newborn and Child Health is the core strategy for improvement of MNCH and the plan has incorporated PMTCT interventions as part of the MNCH package.

PMTCT services have been integrated within the MNCH platform where HIV testing and syphilis testing are routinely offered to all pregnant women attending ANC and to those who do not know their status during labour and post natal period. Health care workers providing MNCH services are trained to provide a comprehensive package that includes PMTCT services. These integrated services are offered through static health facilities as well as during outreach and mobile ANC services. Mothers identified during the outreach ANC services are referred to next RCH clinics for follow up and delivery at health facility. ARV prophylaxis for mothers, is provided at the ANC as well as maternity. Baby prophylaxis is initiated at maternity continued through the postnatal period until one week after cessation of breastfeeding. However, based on 2012 WHO PMTCT update, from July 2013, all pregnant women diagnosed HIV positive during antenatal, labour and post delivery, will be initiated on fixed dose combination of TDF/3TC/EFV for life regardless of CD4 and the babies will receive ARV prophylaxis for a period of six weeks regardless of feeding option. Mothers who are diagnosed with syphilis are treated at the ANC using syndromic management.

⁵ TDHS 2010

For effective implementation of the new PMTCT guidance, Tanzania is in the process of integrating ART into RCH services to facilitate access to treatment by HIV infected women and their infants. Moreover, family planning is being integrated into ART programme as well as other HIV services including counseling and testing sites to reduce unmet need for family planning for HIV infected women. Guidelines and protocols for integration have been developed and are being operationalized. Furthermore, there is more effort being put on provision of family planning at community level which will accelerate utilization by the community.

1.3.4 Child Health and survival program

1.3.4.1 Immunization

The Expanded Programme on Immunization (EPI) has performed well over the past decade with DPT 3 coverage of 88%⁶. Children born to mothers in the lowest wealth quintile are less likely to be fully immunized than those born to mothers in the highest wealth quintile.

Tanzania has been implementing the Reaching Every District (RED) strategy to improve immunization coverage for all antigens including measles. Immunization services are offered through static and outreach services and this has contributed to the high immunization coverage.

Integration of PMTCT services within the child health/immunization clinics has so far been weak. This is evident by the low number of children accessing ARV prophylaxis and EID services at two months as compared to the relatively high BCG immunization coverage rate of about 95%⁷. High BCG coverage indicates that even those children that are born at home, are brought back to facility for BCG at early stage but the system does not identify those exposed to HIV for administration of prophylaxis and follow up. There are missed opportunities for following up HIV exposed children throughout the child health services due to weak integration of the PMTCT programme into the child health services. Tanzania will work towards integrating these linkages for effective implementation of the new guidelines and strengthened follow up of HIV expose children.

1.3.4.2 Integrated Management of Childhood Illness

Case management of common childhood illness is a key step to reducing child mortality. The IMCI strategy has been implemented at scale in Tanzania from 1996 with all districts implementing at different levels of coverage. IMCI has been found to be an effective delivery strategy for various child survival interventions and has contributed to a 13% mortality reduction over a two-year period in those districts in Tanzania where it has been implemented. This creates an opportunity for reaching HIV exposed and infected children with HIV services at every contact with the health service provider at health facility and in the community. However, the current IMCI practices has not integrated HIV Pediatric care and follow up strongly, Incorporation of pediatric HIV care, treatment and follow up in facility and community IMCI will increase access to HIV services.

⁶ TDHS 2010

⁷ TDHS 2010

1.3.4.3 Nutrition in the context of HIV

Breastfeeding is a norm in Tanzania and over 95% would breast-feed over 2 years. The mean duration of breastfeeding is 21 months while on the other hand only 50% of infants were reported to be exclusively breastfed by age of 6 months.

The national PMTCT guidelines on Infant feeding recommend that HIV exposed infants should be breastfed exclusively for the first six months of life and then introduce complementary foods while continuing to breastfeed up to 12 months of age. Baby continues to receive ARV prophylaxis as per PMTCT guidelines during the period of breast feeding. At 12 months if the child is either HIV-uninfected or of unknown HIV status, breastfeeding should stop gradually (over a period of one month) if a nutritionally adequate and safe diet without breast milk can be provided. If the child is known to be HIV-infected, mothers are strongly encouraged to continue breastfeeding as per the recommendations for the general population, that is, up to 24 months and beyond.

Women with unknown status: Should exclusively breastfeed for six months and continue with complementary feeding until 2 years and beyond. Should also be encouraged to test for HIV. Women who opt for replacement feeding should exclusively give replacement feed for six months and beyond, introduce complementary foods while giving other milk apart from breast feeding and baby should receive ARV prophylaxis as per PMTCT guidelines. Mixed feeding during the first 6 months of life is never recommended and should be avoided by all women, regardless of HIV status.

1.3.5 Status of Implementation of PMTCT and Pediatric HIV Care, treatment programme

The national PMTCT programme in Tanzania is based on the four-prong model recommended by the United Nations.

These include:

- i. Primary prevention of HIV for women of childbearing age
- ii. Prevention of unintended pregnancies among women living with HIV
- iii. Prevention of vertical transmission of HIV from mother to child:
 - HIV testing and counseling
 - Antiretrovirals for preventing mother-to-child transmission
 - Infant feeding counseling and support
- iv. HIV Treatment, care and support for women living with HIV, their children and other family members:
 - Increasing access to ART for pregnant women and children
 - Early diagnosis of HIV among infants
 - Co-trimoxazole prophylaxis for infants and children

In 2000, the Ministry of Health and Social Welfare in collaboration with UNICEF established the five initial PMTCT pilot sites in four referral and one regional hospitals located in five regions; Kilimanjaro, Mwanza, Kagera, Mbeya and Dar es Salaam. Since then, the Government of Tanzania has been scaling up the programme for Prevention of Mother to Child Transmission of HIV (PMTCT) mainly through integration of a package of PMTCT services in routine Maternal and Child Health services to ensure that there is reduce vertical transmission. By December 2011, 4603 (96%) of Reproductive and Child Health (RCH) facilities had integrated PMTCT in routine ANC, delivery and Post natal care services; about 64 % of estimated HIV infected pregnant women and 56 % of babies born to them received ARVs for PMTCT and 19 % of pregnant women with advanced HIV infection were started on lifelong antiretroviral treatment.

In terms of coverage of maternal ARVs for PMTCT excluding Single Dose NVP, Tanzania was placed as a Typology C country by UNICEF in 2011 as indicated in the table below:

Table 2: Unmet need for PMTCT: Maternal ARV coverage in 15 ESA countries 2011 report⁸	
TYPOLOGY A: >80% Coverage Botswana – >95% South Africa – >95% (85->95%) Namibia – >95% (79->95%) Swaziland – >95% (88->95%) Lesotho – 89% (77->95%)	TYPOLOGY B: 60-79% Coverage Zambia – 75% (67-85)
TYPOLOGY C: 30-59% Coverage Burundi – 36% (32-49%) Kenya – 43% (37-49%) Tanzania – 59% (52-68%) Mozambique – 52% (44-62%) Zimbabwe – 46% (40-52%) Uganda – 42% (36-51%)	TYPOLOGY D: <30% Coverage Angola – 20% (15-28) Ethiopia – [13-40%] Malawi – 23%-31%

The MOHSW in collaboration with development partners, as part of scaling up services, has developed guidelines on early infant diagnosis, including new guidelines for early initiation of ART and equipped the four referral hospitals (Muhimbili National Hospital-MNH, Mbeya, KCMC and Bugando Hospitals) to perform early infant diagnosis using DNA-PCR testing. By Dec 2010 there were 1,520 sites providing EID services through collection of DBS (Dried Blood Spots) and transporting to the reference laboratories for testing in the Tanzania mainland.

Since 2004, the Government, in collaboration with partners, initiated a Care and Treatment Programme under the National AIDS Control Programme (NACP). By September 2011, a total of 762,211 HIV-infected people had been enrolled at 1100 health facilities throughout the country. Scaling up ART remains a challenge. Out of the estimated 448,304 HIV-infected Tanzanians who are eligible, 398,677 were cumulatively on ART by September 2011 (NACP 2011).

Tanzania has adopted the WHO 2010 PMTCT recommendations and has opted for Option A. However, with the 2012 WHO guidance, Tanzania is moving towards option B+ where all the HIV infected pregnant women will be initiated on ART for life. To achieve this at facility level, PMTCT services are integrated into routine reproductive and child health services. The main areas of intervention include: Counselling and testing, provision of ARV (during antenatal visits, Intrapartum and Postpartum), modified obstetric care and counselling for safer infant feeding options. Other services include Paediatric care for exposed children, monitoring and evaluation and linkage of HIV positive mothers and their families to HIV care and treatment clinics for continuum of care.

⁸ WHO, UNAIDS and UNICEF, *Towards universal access: scaling up priority HIV/AIDS interventions in the health sector: progress report, 2011. Reanalyzed data for 22 priority countries*

1.4 Overview of The National Scale Up Plan for PMTCT

The goal of the National scale up plan (2009 – 2013) was to improve health of parents and their children by scaling up comprehensive PMTCT and paediatric HIV care and treatment and support services. The main objectives were:

- To increase the percentage of HIV positive pregnant women who receive ARVs from 34% in 2007 to 80% by 2012
- To improve child survival among HIV exposed and infected children by 50%.

This plan was envisioned to be implemented for five years from 2009-2013. However, during its course of implementation, there has been a shift from coverage scale up to elimination of new HIV infections among children by 2015, and keeping them and their mothers alive. This change of focus entail for improved reporting on access coverage results and impact, hence the need for the review of the plan. Bottleneck analysis of the PMTCT Programme was one of the pre-requisite for the review of the scale up plan and development of the eMTCT plan 2012 - 2015.

1.4.1 The PMTCT Bottleneck Analysis

A PMTCT bottleneck analysis was done in Tanzania for the following purposes:

- To inform revision of the PMTCT scale up plan,
- To identify populations and jurisdictions with highest unmet need,
- To prioritize key programme strategies and interventions that will accelerate progress towards MTCT elimination
- To better target and ensure more efficient allocation of available resources and
- For real-time performance monitoring of programmes focusing on bottlenecks and tracking of results

The BNA 2011 revealed revealed that, there are critical bottlenecks hindering effective implementation of PMTCT program with high unmet need in services access and thus limiting the possibility of achieving the elimination of MTCT. The bottlenecks are formed by both supply and demand determinants and affect achievement of the elimination targets. Some of the unmet needs for affecting each target include:

Target 1-50% Reduction of HIV incidence among women

- 15% of women attending RCH clinics are not counseled and tested for HIV
- 43% of pregnant made more than four ANC visits.
- 21% of male partners of pregnant women were tested for HIV

Target 2 – Reduce unmet need for FP among all women,

- 27% contraceptive prevalence rate
- 25% of unmet need of family planning
- 24% of reproductive age women married or in union used any modern method of contraception

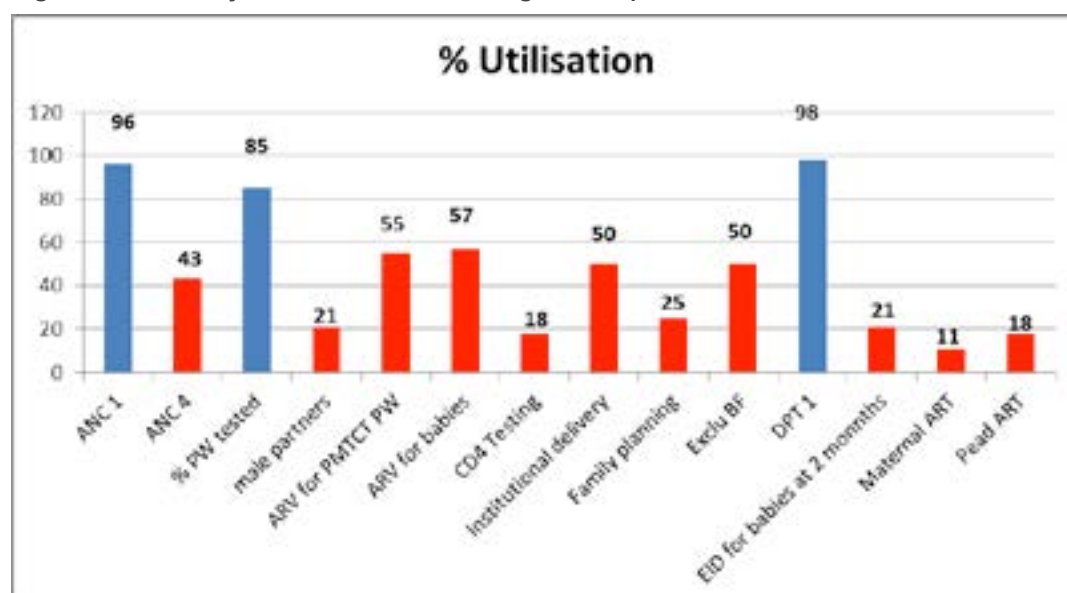
Target 3- Reduce vertical transmission rate to <5%,

- 76% of HIV + pregnant women were reached by PMTCT services that include health education, counselling, HIV testing
- 55% of HIV + pregnant women were reported to receive More Efficacious Combined Regimen (MECR) to prevent MTCT
- 57% of HIV exposed infants did receive ARVs to prevent MTCT .

Target 4 - 90% reduction in number of HIV associated maternal deaths during pregnancy, delivery and puerperium 90% reduction in HIV attributable deaths among infants and children <5years.

- 18% of PMTCT sites offer CD4 testing on site
- 21% of HIV + pregnant women were screened for ART eligibility
- 11% of HIV + pregnant women who are in need of ARVs for their own health did receive the medications.
- 30% of health facilities did provide EID services
- 21% HIV exposed infants accessed EID

Figure 2: Summary for un met needs along MNCH platform



1.4.2 National PMTCT and Pediatric HIV care bottle necks summary and proposed solutions.

The table 3 below summarizes the key findings from the bottle neck analysis in the broader health system context. The health system is provided through three service delivery modes: family-oriented community based services, population-oriented schedule services, and individual-oriented clinical services.

Table 3: Summary of bottle neck analysis				
Tracer intervention	Type of bottleneck	Indicators	Coverage	Causes
1- Provision of family planning services (population-oriented)	Supply-side	Commodities: % of health facilities with no stock out of contraceptives during the last three months	71%	<ul style="list-style-type: none"> • Lack of qualified HCWs • High turnover of staff , Low capacity of pre-service institutions • Shortage of staff due to high workload and no incentives for remote and hard to reach areas • Socio-cultural beliefs and practices: myths and misconceptions on the use of FP from men ; fear related to jeopardizing women fertility • Low public awareness of reproductive health matters • Inadequate male involvement
		Human resources: % of health facilities with sufficient HCWs	35%	
	Demand-side	Access: % pregnant women not reporting distance as a problem to access FP and PMTCT services	81%	
		Geographic coverage: % PMTCT services offering FP	99%	
		Utilisation: % women of reproductive age ever using any contraceptive method (prevalence)	28%	
		Continuity: % of women of reproductive age married or in an union not wanting any children to delay the birth of their next child who are currently using any method of contraception (unmet needs for FP)	25%	
2- Exclusive breastfeeding for the first six months of life (family-oriented)	Supply-side	Commodities: N/A		<ul style="list-style-type: none"> • Low quality of trainings provided to CHWs • Poor motivation due to no incentives • Insufficient knowledge and awareness on the benefits of breastfeeding • Inadequate community involvement and health promotion activities
		Human resources: % of CHWs trained in IYCF counseling and support	35%	
	Demand-side	Access: % pregnant women reached at ANC by PMTCT services	70%	
		Utilisation: % of children started breastfeeding within 1 h after birth	49%	
		Continuity: % children who are breastfed up to six months	98%	
		Effective coverage: % children on exclusively breastfed	50%	

Table 3: Summary of bottle neck analysis				
Tracer intervention	Type of bottleneck	Indicators	Coverage	Causes
3 Provision of quality antenatal care services (individual-oriented)	Supply-side	Commodities: % ANC services offering PMTCT with no stock out of HIV testing in the last 3 months	70%	<ul style="list-style-type: none"> • Lack of qualified staff in remote areas • Difficulties in leading qualified human resources to serve the poor , poor coordination • No attractive salary packages • Inadequate performance assessment of staff • Lack of training of HCWs in newborn care • Unfriendly services (client-provider relationship) • Financial constraints due to gender inequality in decision-making and access to resources at household level
		Human resources: % of health facilities with sufficient and trained HCWs	35%	
	Demand-side	Access: % of pregnant women not reporting distance as a problem to access ANC or PMTCT services	81%	
		Facility coverage: % ANC services providing PMTCT services	93%	
		Utilisation: % of pregnant women who attended at least 1 ANC visit	96%	
		Continuity: % of pregnant women who attended at least 4 ANC	43%	
		Effective coverage: proportion of pregnant women tested for HIV	85%	
4- Primary prevention of hiv in women of reproductive age in the context of pmtct (population-oriented)	Supply-side	Commodities: % ANC services offering PMTCT with no stock outs of HIV testing in the last 3 months	70%	<ul style="list-style-type: none"> • Shortage of skilled health providers • Weak management and supervision • High workload and lack of incentives • Low budget for salaries • Lack of male friendly RCH facilities • Social norms and gender roles: mindset (RHC only an issue of mother and child) • Inadequate community involvement
		Human resources: % of ANC facilities that offer HIV testing and counselling for PMTCT with sufficient and trained HCWs on PMTCT	35%	
	Demand-side	Access: % of pregnant women not reporting distance as a problem to access ANC or PMTCT services offering counselling for HIV test	81%	
		Facility coverage: % ANC services providing PMTCT services	93%	
		Utilisation: % pregnant women tested for HIV	85%	
		Continuity: % of male partners of estimated HIV- pregnant women tested for HIV	21%	
		Effective coverage: % HIV negative pregnant women reached at ANC among total estimated HIV negative pregnant women in the population	85%	

Table 3: Summary of bottle neck analysis				
Tracer intervention	Type of bottleneck	Indicators	Coverage	Causes
5- prevention of hiv infection from an hiv-positive woman to her infant (population-oriented)	Supply-side	Commodities: % of ANC services offering PMTCT with no stock outs of HIV testing for a period of over 5 days in the last three months	70%	<ul style="list-style-type: none"> • Shortage of skilled health providers • Turnover of staff due to high workload and no incentives • No rewarding systems
		Human resources: % of ANC facilities that offer HIV testing and counselling for PMTCT with sufficient and trained HCWs on PMTCT	35%	
		Access: % women of reproductive age not reporting distance as a problem to access ANC services and PMTCT services	81%	
	Demand-side	Geographic coverage: % ANC services offering PMTCT (HIV testing and ARVs)	93%	<ul style="list-style-type: none"> • Low awareness of clients' and service providers' rights and obligations • low public awareness of health matters • low women empowerment • Stigma / discrimination
		Utilisation: % pregnant women tested HIV+ among estimated HIV+ pregnant women in the population	76%	
		Continuity: % women who received ARV prophylaxis among estimated HIV+ pregnant women in the population	55%	
6- Care, treatment, and support for hiv positive mothers (individual-oriented)	Supply-side	Commodities: % care and treatment centers with no stock out of ARVs for a period of over 5 days in the last 3 months	100%	<ul style="list-style-type: none"> • Stigma and low women empowerment • Non- functional CD4 machines • Low knowledge on HIV • Inadequate male involvement
		Human Resources: % health facilities offering paediatric care and treatment with sufficient qualified personnel trained on ART in the context of PMTCT (as per national norms)	93%	
		Access: % of ART treatment services that offer CD4 testing on site or through system of collection and transportation of blood samples	100%	
	Demand-side	Utilisation: % pregnant women tested HIV + among estimated HIV+ pregnant women in the population.	76%	
		Continuity: % of HIV + pregnant women staged for ART eligibility	21%	
		Effective coverage: % HIV+ pregnant women started on ART for their own health	83%	

Table 3: Summary of bottle neck analysis				
Tracer intervention	Type of bottleneck	Indicators	Coverage	Causes
7- Early infant diagnosis of hiv among hiv exposed children (individual-oriented)	Supply-side	Commodities: % care and treatment centers offering EID with no stock out of ARVs for a period of over 5 days in the last 3 months	70%	<ul style="list-style-type: none"> • Weak political commitment and leadership and inadequate coordination between public and private facilities • Limited availability of EID services and PCR machines • Missing link between PMTCT and neonatal and child health services • Lack of transfer skills to practice and follow-up supervision • Low public awareness of EID
		Human Resources: % health facilities offering paediatric care and treatment with sufficient qualified personnel on EID (as per national norms)	60%	
		Access: % targeted health facilities offering EID	30%	
	Demand-side	Utilisation: % infants received ARV prophylaxis in the population	57%	
		Continuity: % infants born to HIV+ women receiving a biological HIV test by 2 months of age	21%	
		Effective coverage: %infants born to HIV+ women receiving a biological HIV test by 2 months of age who receive their results	21%	

*Coverage: green= good ($\geq 80\%$); yellow= medium (60%-79%); red= low ($\leq 59\%$)

Human Resource for Health was found to be a cross-cutting bottleneck with only 35% of health facilities meeting the staffing norm as per national guidelines. The overall national challenge in recruiting and retaining qualified and trained health workers within facilities hampers the effective implementation of PMTCT.

1.4.3 Strategies to overcome bottlenecks

The following strategies will be used to overcome the bottle necks

Table 4: Strategies to overcome the Key bottlenecks	
SUMMARY OF BOTTLENECKS	STRATEGIES TO OVERCOME THE BOTTLENECKS
Enabling environment: strong political commitment at national and local level but not in addressing resource mobilization and systems strengthening; adequately defined decentralized system but need strengthening, limited resources in providing access to quality care in an equitable manner	<ul style="list-style-type: none"> • Applying streamline procedures for the disbursement of funds from central to lower levels • Increasing political commitment and partnerships • Increasing commitment in addressing resource mobilization and providing resources • Strengthening Regional and District Health Management supervision mechanisms with focus on MNCH platform
Supply-side: <ul style="list-style-type: none"> • Inadequate human resources • Inadequate CD4 and EID testing sites, • Weak treatment system for children, • Poor linkages - PMTCT and immunization clinics • Weak PSM for PMTCT and EID, • Weak/No follow up system from health facilities to community, 	<ul style="list-style-type: none"> • Strengthen pre-service, apply task sharing and increase incentives and implement best practices, on-the-job coaching and mentoring • Expansion of PoC for CD4 testing and DBS for PCR • Expand provision of Paediatric HIV, Care and Treatment services especially in regions with high rate of unmet needs for PMTCT services • Strengthened Integration of PMTCT/EID within child health platform • Improve procurement and supply chain management system and maintain stock control system • Strengthen referral system between health facilities and communities
Demand-side: <ul style="list-style-type: none"> • Late ANC first visit and low fourth visit, • Low health facility delivery (50%), • Poor infant feeding practices (exclusive breastfeeding), • Low knowledge levels on MNCH, PMTCT, EID, ART • Low male involvement • Stigma and discrimination • lost to follow-up from ANC to CTC, 	<ul style="list-style-type: none"> • Increase national sensitization campaigns and Community mobilization and sensitization on MNCH and eMTCT including male championshp programmes • Develop a community service package for PMTCT utilizing home-based care providers, CHWs and outreach workers based on the EPI/IMCI model • Provide service delivery and follow up through innovation to increase demand for services (mHealth, use of mobile technology, sms printer etc) • Increase community follow up mechanisms including mother support groups, mother mentors etc.
Quality of health care: <ul style="list-style-type: none"> • High workload at facilities, • Lack of guidelines and standards for integration of services, • Lack of proper coordination and presence of multiple data sources, • Lack of qualified staffing, 	<ul style="list-style-type: none"> • Develop/update M&E data recording and quality assurance tools for PMTCT/ ANC services • Develop incentives for timely collection/compilation of data and make full use of the revised HMIS data collection tools (plus the DHIS reporting features) to ensure regular monitoring of finances and service delivery. • Capacity building with innovative training approaches of HCWs at all levels • Review and update national PMTCT and Paediatric care and treatment standards • Develop guidelines and tracking mechanisms for adequate integration of PMTCT into FP and ANC services: define new targets, disseminate guidelines and tools

1.4.4 Priority activities to address the bottlenecks and achieve MTCT elimination Targets

1.4.3.1 Achieving 50% reduction of HIV Incidence among women of reproductive age group (15-49)

- The reduction of HIV incidence among women of reproductive age group will be achieved through provision of quality early antenatal care services (ANC) and primary HIV prevention.
- Using antenatal care services as an entry point, scale up and outreach approach will be used to make the services availability in all regions. Using the community health workers(CHW) and Village health committees(VHC), pregnant women will be advised and encouraged to make at least 4 ANC visits during pregnancy. The ANC services will all provide quality PMTCT interventions.
- HIV counseling and testing will be made availability to all pregnant mothers reached. The quality of HIV counseling will be improved through use of peer support groups. Post test counseling will not only focus on HIV positive pregnant mothers but also HIV negative , so that they can remain negative and should also be retested within 3months.
- Male involvement will be prioritized through a multi-pronged approach in both facility and community. At the facility, couple HIV counseling and testing services will be offered and at the community there will be demand creation through village health committees and door to door HIV testing strategy will be used.
- Youth friendly services will also be offered in the context of ANC.
- The HR challenges will be addressed through various innovative approaches which include training, task sharing, re-hiring of retired HCWs, established financial scheme for community health workers, performance based motivation and implementation of retention packages. Training of 2 HCWs from the remaining 491 RCH facilities in the country on eMTCT and institutionalize PMTCT trainings. Further training of Health care workers on commodities management and in forecasting will improve the HIV test kits and commodities supply. Supportive supervision in all the regions will strengthen the quality of the services.
- Define a community interventions service package that includes roles of CHWs in eMTCT, selection criteria, training, deployment, supervision and compensation. Identify and train at least 2 CHWs per village (from existing community service providers, PLHIV and other community resource persons) to implement community based interventions starting with 6 high prevalence regions.

1.4.3.2 Reducing unmet need for family planning among all women of reproductive age group to 0

- Family planning (FP) services will be integrated into PMTCT and HIV care & treatment sites so as to reduce unmet need for family planning among HIV positive women.
- Service demand will be created through sustained community mobilization and access to FP services will be improved through integration of FP in PMTCT/CTC facilities and outreach programs.
- Family planning commodity security will be improved by ensuring commodities procurement of all modern methods of contraceptives and family planning health cards. Ensuring a more robust commodity management system at higher levels will be achieved through zonal RCH meetings to incorporate FP logistics management.

- The skills of health care workers will be improved by mentoring and training
- The Human Resource shortage will be addressed through task sharing for provision of short acting methods using community health representatives, PLHIV, Community Based Distributions (CBD) and other community representatives. These groups shall receive an orientation package. As part of the task sharing, one week orientation of at least two medical attendants per facility will be done to enable them provide short acting methods.
- The Human Resource shortage will be addressed through task sharing and community based interventions. As part of the task sharing at least two medical attendants per facility will be oriented (one week) to enable them provide short acting methods. The CHW will be orientated on the community service package which includes family planning. In addition to demand creation and addressing myths about FP, the CHWs will provide short acting FP methods in the community thus reducing workload for understaffed health facilities.
- Districts with the biggest input in FP services/district with a decrease of unmet needs will be rewarded during a "Family Planning Week" as a performance based motivation. Annual regional meeting on performance review will be done and rewards will be given for 21 regions.

1.4.3.3 Reducing MTCT during pregnancy, delivery and breastfeeding (MTCT rates <5%)

- Reduction of MTCT during pregnancy, delivery and breastfeeding will be achieved by; providing efficacious ARV prophylaxis to HIV positive pregnant women timely, identification and treatment of women eligible for ART, delivery by skilled attendant, ARV prophylaxis to HIV exposed infants during the period of breastfeeding and ensuring exclusive breastfeeding in the first six months.
- The revised PMTCT guidelines shall be finalized and disseminated to all the regions. Refresher training on the new guidelines shall be accelerated in all the districts. Job aids will be developed to assist health care workers implement the revised new guidelines and standards.
- Healthcare workers shall be motivated through retention packages incentives and pay for performance.
- ART/RCH integration will be adopted where feasible.
- The ARVs forecasting shall take into consideration the revised ARV prophylaxis regimens for mother and child. The supply chain management shall be improved through capacity building of health care workers on ARV forecasting and sensitization of the central and regional mechanisms on the new PMTCT ARV regimens.
- ARV adherence, facility delivery and exclusive breastfeeding for six months shall be improved through multipronged approach like use of peer support group (mothers2mothers, mentor mothers), use of SMS mobile phones and improved quality of counseling through mentorship program.
- Community mobilization to create awareness, reduce stigma and create demand will also be undertaken. CHW shall be oriented in PMTCT, Infant and Young Child Feeding in the context of HIV and will be used to increase service uptake and reduce lost to follow up.
- Quality of services shall be improved through routine supportive supervision of all facilities

1.4.3.4 Reduction(90%) in HIV – related maternal death up to 12 months post partum and reduction(90%) in HIV attributable deaths among infants and children <5years

- The reduction in HIV related maternal deaths and HIV attributable deaths among infants and children shall be achieved by providing care, treatment & support for HIV positive mothers , Early Infant Diagnosis (EID) and Cotrimoxazole(CPT) for HIV exposed infants (HEI) and Anti Retroviral therapy(ART) for HIV infected infants and children. Linkages, HIV/ MNCH integration, laboratory services, continuum of care and service delivery innovations will be improved to achieve this.
- HIV positive pregnant and postpartum women will all have CD4 tests availability either through improved laboratory network services (improved laboratory capacity-reagents, supplies, human resource, CD4 machines and specimen transport) and by making available Point-of-Care (PoC) CD4 machines With option B+, CD4 will be used for monitoring patients and not for eligibility criteria before initiating treatment. Access to ART will be improved by conducting ART outreach to PMTCT sites, and integration of ART in ANC settings. Provision of family centered care and treatment services models will also be scaled up .
- Adherence support will be improved through support groups, Community sensitization on ART and CHW orientation on treatment and adherence. Training on the new ART guidelines for early initiation of ARTs for HIV Positive pregnant women and dissemination of job aids will be done.
- Strengthening of EID will be done through many approaches. Integrating identification of exposed HIV children at all points of contact including immunization clinics, during outreach and under-five clinics will be undertaken. Provision of financial support for transportation of the DBS (e.g. EMS, bus, Fuel) using reliable system for transporting DBS samples between the zonal Laboratory and health facilities will be done. Innovations in improving the EID through SMS technology will be implemented. Procurement, distribution and maintenance of SMS Printers for selected health centers, at least 2 per district per year will be done. Provision of airtime to health facilities for follow up and feedback to mothers on test result will be initiated. Laboratory capacity building will be done through training laboratory personnel on PCR utilization and conducting onsite trainings in 2014. To improve supply chain management, establishment of a system for sharing quantified information for EID supplies between partners will be implemented. Improvement of commodities and supply chain management will also be done by monitoring of stock outs of EID supplies on monthly basis at all levels and by the use of mobile technology for feedback.
- Capacity building will be done through refresher training for existing PMTCT providers (Including under-five clinic staff) in sites where EID is not provided using new training guidelines targeting 3,642 (76%) of PMTCT sites, two people per facility. By 2013 100% PMTCT sites should be providing EID. Capacity building for EID will be achieved through different approaches like; training at least three HCWs from each of new PMTCT sites (491 sites) on PMTCT and EID, training/orientation of HCWs on forecasting for EID, ARV, Cotrimoxazole, data utilization and rational use of commodities . Other approaches will include; Orientation on Provider Initiated Testing and Counselling (PITC) including Couple HIV testing and counseling (CHTC) for service providers at various points of contacts for children – 3 per facility, Incorporation of PMTCT including EID into pre-service curriculum, onsite mentorship programmes for PMTCT/EID and comprehensive ART programmes in all PMTCT sites and follow up mentorship activities.

- Strengthening Logistics Management Unit at MoHSW will be done –improving Staff, supply of computers, furniture and stationery to address EID. Orientation and review of CHMT's/RHMT towards ownership and management of EID programme in all the districts and all RHMTs will be done through a one day meeting. Advocacy will be done for eMTCT at all levels.
- Continuum of care and longitudinal follow up will be improved through follow up systems at community level that includes establishment of HIV support groups (at least one group per facility) and follow up by CHWs, Support groups may include HIV positive mother/father support groups and other PLHIV initiated groups. Two days orientation of CORPS, and CHWs on follow up and referral for mothers and HIV exposed children targeting two CORPs per PMTCT site will be done. Provision of mobile phone and airtime to support groups for follow up and feedback to mothers on test result –1 Mobile phone per group and airtime. Electronic patient monitoring system will be introduced (for longitudinal follow up) for tracking and feedback on DBS results at district and regional level (at RCH) – Computerization and internet connection will be implemented. Quality improvement will be done through regular supportive supervision in all EID sites, updating reporting tools for longitudinal follow up, printing and distributing them. Review of PMTCT supervision checklist to incorporate supply and logistics issues will also be undertaken.
- Infant and Children HIV care and treatment will be strengthened through EID and follow up of HIV Exposed Infants (HEI) and initiating ART on all HIV infected children. Cotrimoxazole Preventive Therapy (CPT) will be initiated to all HEI at 6weeks and the guidelines on HEI follow up algorithm will be implemented in all PMTCT sites. Institutionalization of routine testing for children at all contacts of health system will be done to identify HIV infected children. Procurement and distribution of ARV drugs and Cotrimoxazole for children will be prioritized. Community support for Children HIV care and treatment will be undertaken. Community mobilization on availability and benefits of EID, ART and male involvement will be done through Media trainings, Community meetings and BCC materials. Capacity to provide the services will also be improved through training of HCWs providing PMTCT services on pediatric ART training. Quality of services will be improved through training of HCW and lay counselors on child counseling and disclosure on HIV status for children. Performance improvement will be done by conducting bi-annual review meeting at national, regional and district level. Infrastructure for service delivery will also be improved through renovations where feasible.
- The eMTCT plan will be monitored and evaluated using the existing data collection and reporting system through harmonization and linkage within health sectors (private and public). However much effort will be made to ensure that indicators for eMTCT are aligned and linked to existing M & E system within the sector (HIMS/and patient monitoring data and other sources)

1.5 Rationale for the eMTCT plan

The experience gained by the scale up of PMCT services to the current level of coverage shows that it is possible to achieve virtual elimination of new HIV infections in children and reduce HIV-related maternal and childhood mortality. This has led to the global initiative and plan to achieve virtual elimination (eMTCT) by 2015. In addition, the commitment demonstrated by the highest political leadership in the country and the policy frameworks provide a supportive platform for the development of this eMTCT plan.

This plan builds on and improves the current PMTCT scale up plan (2009-2013) by focusing on addressing the identified bottlenecks as listed in the table 3 above.

To summarize, in order to achieve virtual elimination, the analysis and plan suggest that a number of things need to be done differently from the current PMTCT implementation. The key issue in the eMTCT plan is to put focus and resources on areas where key bottlenecks that will affect achievement of the targets.

These include:

- a. Political commitment to be translated into more resources for eMTCT.
- b. Advocacy for political accountability at all levels to be strengthened
- c. Greater involvement of other sectors in funding of the eMTCT plan through public private partnership (PPP)
- d. Monitoring the proportion of HIV-infected pregnant women reached with PMTCT services should be used as a measure of how effectively PMTCT services are reaching the population in need, as opposed to monitoring the proportion of facilities providing PMTCT services
- e. Greater focus and strengthening of Prong 1 and Prong 2 of the PMTCT strategy and indicators developed for measuring the effort around these two prongs, as opposed to the previous approach of reporting Prong 3 and 4 indicators only. Focus on counseling for discordant couples
- f. Strategies for the following areas will be clearly spelt out in the eMTCT plan and implemented:
 - o Ensure early ANC attendance for earlier ARV initiation when found to be HIV positive,
 - o Reaching more women in need of ART for their own health, specifically reach women at the primary level PMTCT sites, task sharing should be allowed to address staffing challenges and increase access to ART for those women in need
 - o Increase the number of infants provided with ARV prophylaxis
 - o Ensure effective post natal follow up of mother-baby pairs (for ARV prophylaxis for the infants in the first 6 weeks of life, for infant feeding support, for ART for the mother, and for care of the exposed children including EID).
- g. Monitoring and evaluation should be strengthened to effectively measure impact of the program both at 6 weeks and 18 months postnatal.
- h. Finally the persistent shortages of laboratory supplies (rapid antibody test kits, DBS kits) and other supplies need to be addressed.

2.0 Goal and objectives of the elimination of MTCT plan

2.1 Goal

To eliminate new HIV pediatric infections and keep mothers alive through improved maternal, newborn and child health and survival programmes by 2015 in Tanzania

2.2 Impact Results

- Reduction of mother to child transmission of HIV from an estimated 26% in 2011 to 4% by 2015
- Reduction of new HIV infections among child-bearing women by 50% by 2015
- Reduction of unmet need for family planning among women of child bearing age living with HIV by 100% by 2015
- Increase the percentage of HIV positive pregnant women who receive ARVs treatment for PMTCT and for their health from 55% in 2010 to 98% by 2015
- Increase the proportion of HIV exposed children tested for HIV by age of two months from 21% to 90% by 2015
- Increase the proportion of HIV-infected infants and children initiated on ART before the age of 2 years to 90% by 2015

2.3 Strategic Objectives

- 2.3.1 To strengthen national, regional and district capacity to effectively plan, manage, implement and coordinate eMTCT programme in Tanzania
- 2.3.2 To develop institutional and human resource capacity in comprehensive eMTCT and pediatric HIV care and Treatment
- 2.3.3 To provide Quality integrated comprehensive eMTCT services that will reduce new infection among children and keep mothers alive at all levels
- 2.3.4 To ensure nationwide active community involvement and participation in elimination of MTCT, pediatric AIDS and keeping their mothers alive.
- 2.3.5 To strengthen systems for monitoring and evaluation of eMTCT and pediatric HIV care and treatment services at all levels
- 2.3.6 To Strengthen health logistics to include comprehensive management of PMTCT commodities

2.4 The Guiding Principles

The e-MTCT plan implementation will be in line with the Health Sector Strategic Plan III 2009-2015 and the Health Sector HIV and AIDS Strategic Plan II 2008-2012. The key principals include:

Equity of access

Equity considerations constitute the basis for the interventions identified in this strategy and how they have to be scaled up. This is particularly the case with ART, which need to be a component of a continuum of care.

Ethical conduct and human rights

People should be allowed to make informed decisions. There are major ethical and human rights issues involved not only in medical interventions, but also in other health interventions such as Communication and Education.

Quality

Although the ultimate goal will be to scale-up HIV services and interventions, due recognition will be given to quality. Thus quality training of health care workers will precede interventions, materials have to be in place before services or interventions are promoted.

Accountability

Accountability for the resources utilised, services provided and to the communities served at all levels of health service delivery.

Partnerships

Partnership with all the stakeholders, taking full advantages of the synergies provided by each stakeholder group and aligned and harmonised with the health sector strategic priorities and the National e MTCT (2011-15)

Decentralisation

Decentralization of key responsibilities like planning, organization, coordination, control of healthcare service delivery and resources; from central level to regions, districts and health facilities. Community participation will be a clear link between health facilities and the community they serve.

Leadership

Appropriate, efficient and effective leadership in the implementation of the elimination plan, at all stages of the healthcare delivery system

Gender

Gender imbalances underlie the pattern of response to illness and health care seeking behaviour. They also affect how care and other forms of support are provided.

PLWHAs

The active participation and engagement of PLWHAs is pivotal in the successful implementation, monitoring and evaluation of the plan.

3.0 Population based national targets

Indicator	Baseline (2010)	2011	2012	2013	2014	2015	Data/ Source	Frequency
HIV incidence among women of reproductive age 15-49 yrs	6.8	6.0	5.5	4.0	3.8	3.4	UN spectrum	Annually/ EVERY 4 YEARS
Proportion of pregnant women attended at least one ANC visit	96%	97%	98%	98%	98%	98%	Routine RCH reports	Annually
Proportion of pregnant women attended at least four ANC visits	43%	50%	50%	60%	70%	80%	Routine RCH reports	Annually
Percentage of pregnant women tested for HIV	86%	90%	94%	95%	98%	99%	Routine PMTCT reports	Annually
Percentage of pregnant women whose male partners were tested for HIV	21%	30%	35%	40%	45%	50%	Routine PMTCT reports	Annually
Proportion of HIV negative pregnant women reached at ANC	85%	90%	90%	90%	90%	90%	Routine PMTCT reports	Annually
Proportion of RCH facilities providing PMTCT services	93%	100%	100%	22%	100%	100%	Routine PMTCT reports	Annually
Proportion of RCH facilities providing ART	30%	50%	80%	100%	100%	100%	Routine PMTCT reports	Annually
Proportion of RCH facilities offering PMTCT services with at least 2 HCWs trained on PMTCT	TBD	TBD	TBD	TBD	TBD	TBD	Survey/ Routine PMTCT reports	Annually

Indicator	Baseline (2010)	2011	2012	2013	2014	2015	Data/ Source	Frequency
Proportion of RCH facilities offering PMTCT reported stock out of HIV TEST KITS in the last 3 months	TBD	TBD	TBD	TBD	TBD	TBD	Survey/ Routine PMTCT reports	Quarterly
Percentage of females aged 15-49 years who had more than one sexual partners in the past twelve months reporting the use of condoms in the last sexual intercourse	42%	50%	60%	70%	70%	80%	DHS	Annually
Number of condoms distributed	TBD	TBD	TBD	TBD	TBD	TBD	Survey	Two yearly
Contraceptive prevalence rate (CPR)	28%	40%	50%	60%	70%	70%	DHS	Two yearly
Unmet need for FP among all women	25%	10%	10%	5%	3%	0%	DHS	Two yearly
Percentage of reproductive age women attending CTC services with unmet need for FP	50%	35%	20%	10%	5%	0%	Survey	Annually
Proportion of health facilities which reported at least one stock out of condoms/modern contraceptives in the last three months	TBD	TBD	TBD	TBD	TBD	TBD	Quarterly reports	Quarterly
Proportion of health facilities offering C&T services with at least 1 HCW trained on FP methods	TBD	TBD	TBD	TBD	TBD	TBD	NACP	Annually
MTCT rate at 4-6 weeks	12%	8%	4%	3%	3%	2%	PMTCT/EID MONITORING SYSEM	Annually

Indicator	Baseline (2010)	2011	2012	2013	2014	2015	Data/ Source	Frequency
MTCT rate at 18 months	26%	22%	12%	6%	6%	4%	SURVEY / MODELING	Two yearly
Proportion of HIV positive pregnant women receiving efficacious regimen (based on WHO 2010 guidelines)	N/A%	N/A%	40%	25%	0%	0%	Routine PMTCT reports	Annually
Proportion of HIV positive pregnant women receiving ART	11%	15%	20%	55%	90%	98%	Routine PMTCT/ART reports	Annually
Percentage of HIV exposed infants receiving ARV for PMTCT for the first 6 weeks	57%	70%	80%	80%	90%	90%	Routine PMTCT reports	Annually
Percentage of HIV exposed infants receiving ARV for PMTCT during breast feeding	N/A%	N/A%	65%	45%	0%	0%	Routine PMTCT reports	Annually
Proportion of exposed infants who are exclusively breast fed for six months	NO DATA%	TBD	TBD	TBD	TBD	TBD	Routine PMTCT reports	Annually
Percentage HIV Positive pregnant women assessed for ART eligibility	21%	30%	40%	45%	0%	0%	Routine PMTCT reports	Annually
Percentage of HIV-infected pregnant women who were assessed for CD4 cell count	NA	NA	20%	50%	70%	90%	Routine PMTCT reports	Annually
Proportion of RCH facilities offering PMTCT reported stock out of ARVs in the last 3 months	TBD	TBD	TBD	TBD	TBD	TBD	Routine PMTCT reports	Quarterly
Proportion of HCWs trained in IYCF counselling and support	TBD	TBD	TBD	TBD	TBD	TBD	Routine PMTCT reports	Annually

Indicator	Baseline (2010)	2011	2012	2013	2014	2015	Data/ Source	Frequency
Percentage of infants born to HIV-infected Pregnant women who receiving virological test within 2 months of birth	25%	40%	50%	60%	70%	80%	Routine PMTCT reports	Annually
Percentage of infants born to HIV-infected Pregnant women who receiving antibody test at 18 months of birth	7%	20%	30%	40%	50%	60%	Routine PMTCT reports	Annually
Proportion of CTC facilities reported stock out of ARVs in the last 3 months	30%	30%	20%	15%	10%	5%	survey	Quarterly
Percentage of HIV-exposed infants who received CPT within 2 months	17%	40%	65%	80%	90%	100%	Routine PMTCT reports	Annually
Proportion of PMTCT facilities reported stock out of DBS in the last 3 months	40%	40%	30%	20%	10%	5%	survey	Quarterly
Proportion of PMTCT facilities with at least 2 HCWs trained on ART	TBD	TBD	TBD	TBD	TBD	TBD	survey	Annually

4.0 Evidence based strategies to achieve the eMTCT plan

As a Typology C country, Tanzania will need to focus on increasing coverage and utilization of services in order to achieve its elimination agenda. Core priority actions will include to integrate PMTCT services into MNCH platform, increase access and its utilization and improve the quality of ANC services. In addition, there will be actions towards identifying and focusing on providing PMTCT services in areas and populations with the highest HIV prevalence and highest numbers of women with unmet need for PMTCT interventions. Moreover, Implementing strategic service delivery using community-based approaches, by addressing bottlenecks to access and utilization of ANC/MNCH and PMTCT services. Cross cutting actions will include strengthening the quality of MNCH services to deliver effective PMTCT interventions; strengthening human resources capacity, supply chain management and information systems; developing and engaging community systems; and improving measurement of performance and impact.

Key strategies are outlined below:

Strategic Objective 1: To strengthen national, regional and district capacity to effectively plan, manage, implement and coordinate eMTCT programme in Tanzania

Strategy 1.1: To strengthen political leadership, policies and resource mobilization for comprehensive eMTCT and paediatric and adolescent care, treatment at all levels

- Advocate for an establishment of an eMTCT accountability structure for engagement by government and political leaders at all levels – ward, district, regional and national – through which awareness and commitment to addressing eMTCT and paediatric HIV care, treatment is increased
- Launch the eMTCT campaign at all levels for increased awareness and support towards achievement of eMTCT targets
- Develop and disseminate eMTCT advocacy package and materials for political leaders at all levels
- Conduct sensitization of political leaders, policy makers, partners, communities and all other stakeholders, including those in the private sector, at national, regional and district levels, collaboratively with other RCH and HIV/AIDS programs, and TB programs, ensuring gender issues are adequately addressed, using existing and new opportunities
- Liaise with TACAIDS on resource mobilization for implementation of the eMTCT plan
- Government to commit at least 30% of any resources put aside for ART, to Pediatric HIV care and treatment activities, including ARVs and OI drugs, from the HIV funding pool
- In collaboration with SRH conduct stakeholders analysis and map key partners in advocating for adolescent SRH at all level
- In collaboration with SRH, advocate for resource mobilization and allocation for adolescent SRH intervention at all right

Strategy 1.2: To develop National, Regional and District Capacity for integrated planning, management, coordination and supervision of PMTCT and pediatric AIDS programmes by 2015

- Conduct advocacy meetings for incorporation of eMTCT and Pediatric HIV Care issues and allocation of resources in National development frameworks (MTEFs, NDPs, Health Sector Strategies etc), Regional and Comprehensive Council Health Plans , etc)
- Together with other stakeholders advocate for increase enrolment of students in the Health institutions.
- Together with other stakeholders advocate for increase funding for training and recruitment of health professionals in the health sector.
- Together with other stakeholders advocate for development of an incentive package for retaining HCWs in remote rural areas.
- Advocate for task sharing for evidence based non medical eMTCT interventions including provision of health education, post test counseling, psychosocial support and follow up for HIV infected pregnant women and exposed infants.
- Disseminate the national eMTCT plan and targets at all levels
- Develop regional and district specific eMTCT plans with clear targets in line with the national targets.
- Orient all 21 regional and 133 council managers on eMTCT and Pediatric HIV Care and treatment plan and their roles and responsibilities towards achievement of eMTCT targets
- Train RHMT and CHMT on equity focused eMTCT bottleneck analysis and eMTCT planning and review
- Conduct coordination meetings for eMTCT and Pediatric HIV care and treatment with other RCH, TB and HIV/AIDS programs using existing and new opportunities including RCH/HIV and AIDS Joint Partnership fora, RCH and HIV working groups.
- Include eMTCT and Pediatric HIV care and treatment aspects (integrated with FP, Newborn and Child health and other HIV/AIDS programs) as a permanent agenda item on National, Regional and Council Health Management Team meetings
- Finalize and integrate eMTCT and paediatric HIV care and treatment supportive supervision tools with those of FP, Newborn and Child health and HIV/AIDS program tools
- Carry out supportive supervision of eMTCT and paediatric HIV care and treatment activities at all levels, integrated into other supervision activities

Strategic Objective 2: To develop institutional and Human resource capacity in comprehensive eMTCT and pediatric HIV care and Treatment

Strategy 2.1: Review and update National PMTCT and Pediatric care and treatment guidelines and protocols

- Regularly review, update and disseminate National Pediatric care and treatment guidelines and protocols with up to date evidence based approaches on service provision
- Regularly review, update and disseminate National PMTCT guideline
- Develop/revise, print and disseminate job aids for eMTCT and Pediatric HIV care and treatment, and the follow-up/referral of HIV-positive mothers and their children
- Develop, print and disseminate standardized eMTCT and Pediatric HIV psychosocial support (PSS) guidelines that will feed into broader HIV& AIDS PSS guidelines.

Strategy 2.2: Capacity building for health service providers to provide comprehensive eMTCT, EID and pediatric care services at all levels of health facilities.

- Conduct rapid assessment of human resource capacity in RCHs to support the delivery of eMTCT and Pediatric HIV care and treatment services.
- Develop national, regional and district eMTCT - Pediatric HIV care and treatment training plans, which will feed into the broader RCH and HIV/AIDS human resource development plan.
- In collaboration with Human Resource Development(HRD)programme, review and Update pre-service training materials for all health cadres to always be in line with the most up to date knowledge and relevant best practices in eMTCT and Pediatric HIV care and treatment
- Collaborate with HRD to Train pre-service curriculum for TOTs in PMTCT and Pediatric HIV care and treatment in Colleges and Training Schools (nurses, doctors, pharmacists, laboratory technologists, etc).
- To support integration and scale up of eMTCT and Pediatric HIV care and treatment services into MNCH (complement input of other programs)
- Build capacity to the national, regional and district RCH/HIV & AIDS, TOT teams, with public and private sector representatives, in eMTCT, EID and Pediatric HIV care and treatment through training, refresher courses, orientation meetings and support supervisory visits
- Provide training materials to the regional and district eMTCT TOT teams (with public and private sector representatives)
- Conduct modular training/refreshers of health providers (with practical component) in eMTCT , EID and Pediatric HIV care and treatment as defined in the National, Regional and District training plans
- Train health workers on infant and young child feeding counseling using National infant feeding package(5 days training)
- Establish systematic follow up and post-training support for all trainees
- Conduct mentoring of health workers already trained and providing services in general PMTCT, infant feeding, EID and adult ART to also deliver Pediatric HIV care and treatment, using modules of the updated training materials
- Scale up zonal Pediatric HIV care and treatment centers of excellence / regional learning hub that provide practical training for health workers.
- In collaboration with Sexual Reproduction Health (SRH), review /develop/ print and distribute curricula for different levels of health cadres to integrate adolescent SRH
- In collaboration HRD and SRH , Support training institutions in the health sector to roll out trainings on adolescent friendly SRH services

Strategy 2.3: Improve infrastructure and equipment of quality Reproductive, maternal, new born and child health services for delivery of quality antenatal and delivery services at all levels

- Upgrade/renovation of existing Reproductive ,Maternal ,New born and Child Health Service and maternity premises to allow provision of quality eMTCT/ART services
- Establish care and treatment within RCH

Strategic Objective 3: To provide Quality integrated comprehensive eMTCT services that will reduce new infection among children and keep mothers alive at all levels

Strategy 3.1: Expand provision of HIV services for Primary prevention among young women and their partners

- Provide HIV and syphilis prevention information and promote HIV testing as a routine service in all RCH services, STI clinics and outpatient clinics.
- Promote early initiation of ANC (at least by 12 – 14 weeks) by pregnant women through community mobilization.
- Provide re-testing for HIV negative pregnant women during antenatal, labour and post natal in line with National guidelines
- Promote couple/partner HIV/STI testing and counseling for all young women
- Promote safer sex for discordant couples, dual protection; evaluate and prioritize for treatment
- Promote condom use/dual protection among young women and men
- Provide STI treatment to young women and their partners tablishment Adolescent, friendly Sexual Reproductive trategmissed words

Strategy 3.2: Expand provision of services that prevent unintended pregnancies among HIV infected women

- Finalize and disseminate guidelines for integration of FP into other MNCH and HIV services
- To scale up Integration of family planning counseling and services including condoms provision into all RCH and HIV services
- Provide family planning services (including dual protection) through community based structures that provide support to HIV infected women and partners.
- Develop ,Print and disseminate tools to facilitate integrated of FP RCH and HIV services

Strategy 3.3: Increase access to more efficacious ARV regime for HIV infected pregnant women and HIV exposed infants within the RCH platform.

- Strengthen routine offer of HIV testing to all pregnant women with unknown HIV status in ANC, maternity and post natal
- Ensure provision of eMTCT prevention to HIV infected pregnant women and their children as per National guideline at all levels
- Finalize and disseminate guideline for integration of ART/HIV into MNCH services
- Ensure access to CD4 testing for pregnant women with HIV by building laboratory network and provide facilities with CD4 POC devices.
- Scale up Provision of integrated Care and Treatment with RCH services Promote access to safe delivery by skilled attendant in health facilities by HIV pregnant women
- Provide quality infant feeding counseling and support during ANC, delivery, post natal and immunization clinics including during outreach service provision.

Strategy 3.4: Expand provision of appropriate treatment; care and support to HIV infected mothers and their infants and family

- Procure and provide Cotrimoxazole prophylaxis to all HIV infected mothers and exposed children
- Scale up HIV testing to HIV exposed children according to guidelines (Virological and antibody testing)
- Scale up EID services in all PMTCT sites with operational sample transportation system to reference laboratory, timely results and feedback systems to health facility and the mother
- Introduce use of mobile technology to follow up HIV infected women and exposed children. Other innovative approaches include; integrated HIV/EPI identification of HIV exposed infant, follow up and referral system within the Immunization and growth monitoring services in health facility and outreach.
- Provide ART to infants and children diagnosed with HIV within RCH services
- Establish and operationalize HIV infected mother support groups at least a minimum of one at each PMTCT site to conduct follow up and peer support
- Establish Breast feeding support groups at health facilities and communities for continued breastfeeding counseling and support to HIV infected mothers

Strategy 3.5: Increase adolescents' access to, and utilization of integrated quality reproductive health services.

- Strengthened human resource development on adolescent friendly SRH service provision for in and pre service training institutions.
- In collaboration with SRH, assess existing national curricula for training various cadres on health to identify gaps and incorporate adolescent friendly SRH issues

Strategic Objective 4: To ensure nationwide active community involvement and participation in elimination of MTCT, pediatric AIDS and keeping their mothers alive.**Strategy 4.1: Develop a community interventions service package for eMTCT and Pediatric HIV care and treatment utilizing community health workers based on models that have proved to be effective (best practices)**

- Review the existing community based models and identify best practices
- Compile best practices and harmonize approaches into a comprehensive community service package that can be owned and sustainably implemented at all levels in Tanzania.
- Pre test and finalize community interventions service package for eMTCT and Pediatric HIV care and treatment in at least one region.
- Print and disseminate the community interventions service package to all community structures, including men and influential key gatekeepers

Strategy 4.2: Strengthen community systems and structures to deliver the community interventions service package of eMTCT and Pediatric HIV care and treatment

- Identify existing community structures that can be used to deliver the national plan for eMTCT
- Identify existing community organizations, civil society activities, local culture group activities and professional organizations that can be used to support and build capacity of community structures in delivering the national plan for eMTCT

- Identify existing and diverse types of community based health workers and incorporate relevant eMTCT functions as defined in the community interventions service package in their roles
- Standardize the selection criteria, training, supervision and compensation of CHWs who will implement community based interventions for eMTCT,
- identify and train at least 2 CHWs per village (from existing community service providers, PLHIV and other resource people) to implement community based interventions in a phased manner starting with 6 high prevalence regions in the first year, 12 in second year and 8 in the third year.
- Train community organizations, PLHIV and civil society organizations, using gender sensitive and rights based approaches, on how to sensitize and capacitate local communities to support and deliver PMTCT and Pediatric HIV care.
- Accelerate and standardize setting up Pediatric HIV care and treatment support groups, building on existing PMTCT and other HIV&AIDS support groups.

Strategy 4.3: Engage community systems and structures to deliver the community service package of eMTCT and Pediatric HIV care and treatment

- Launch the eMTCT campaign at District and community level (ward/village) for increased awareness and support towards achieving eMTCT targets.
- Utilization of Village/ward council meetings to create community awareness on eMTCT community service package for support and demand creation.
- The use of mobile phones (mHealth) for the follow up of PLHIV women and their exposed infants/children to ensure continuum of care and accuracy of data
- Engagement of the facility HCWs to monitor and supervise the CHWs and PLHIV groups in the community for effective implementation of the eMTCT plan
- Engagement of CHWs to provide HIV prevention information and promote HIV testing as a routine service in all RCH sites (ANC, Maternity, Postpartum clinics, Child health/immunization clinics, Family planning clinics, STI clinics, outpatient clinics, outreach clinics etc) as well as advocating for couple HIV testing and counseling for all young women.
- Support CHWs to create demand for safe delivery services by skilled attendant in health facilities as well as utilization of postpartum care by actively tracking both mothers and infants.
- Engagement of HIV positive women with personal experience in PMTCT and CTC as expert patients and mentor mothers to provide education and peer psychosocial support to other women working in support of HCWs at facilities and at community level.

Strategic Objective 5: To strengthen systems for Monitoring and evaluation of eMTCT and paediatric HIV care and treatment services at all levels

Strategy 5.1: Strengthen and Operationalize the eMTCT M & E System

- Establish M & E technical working group to support PMTCT M & E from different stakeholders
- Conduct regular reviews of the eMTCT planned targets and achievement at all levels - quarterly M & E technical working group and annually by different stakeholders
- Disseminate M & E Framework for eMTCT
- Capacity building for M&E at Central and Regional Level through training and recruitment.

Strategy 5.2: Improve the routine monitoring and evaluation of eMTCT and Pediatric HIV care and treatment

- Disseminate indicators for integrated eMTCT and Pediatric HIV care and treatment to regional and District Health Management Teams
- Develop, regularly update, print and distribute M&E data recording and reporting tools for eMTCT and Pediatric HIV care and treatment to all regions, districts and health facilities in the context of the existing M & E system.
- Develop mechanism to ensure availability of quality eMTCT data through Data Quality Assessment
- Review and scale up the existing DHIS database to capture eMTCT and Pediatric HIV care and treatment information at district, regional and national levels
- Develop and scale up Facility based PMTCT database
- Train or refresh regional and district ToTs and HCWs on M&E for eMTCT and Pediatric HIV care and treatment
- Conduct joint supportive supervision visits to the regions, districts and health facilities on a regular basis

Strategy 5.3: Carry out operational research (OR) surveillance and Surveys to guide program implementation

- Review national Operational Research priorities agendas for eMTCT and Pediatric HIV care and treatment, including relevant gender and human issues
- Conduct Operational Research in line with identified eMTCT and Pediatric HIV care and treatment priorities
- Establish eMTCT surveillance system to monitor transmission at 6 weeks, 6, 12 and 18 months for impact assessment
- Conduct Midterm and End term Evaluation of the implementation of eMTCT

Strategy 5.4: Improve PMTCT Services provision through promoting data use

- Identify, document and share the innovations and best practices in the implementation of activities geared towards eMTCT
- Disseminate eMTCT M&E reports and other eMTCT research findings through various fora (eg Annual and Zonal RCH meetings, Regional and District health fora and joint implementing Partner's meetings)
- Introduce performance based appraisal system for regions and district
- Develop data analysis and utilization training package for regional, district and HCWs.

Strategic objective 6: Strengthen health logistics to include comprehensive management of PMTCT commodities**Strategy 6.1: Mobilize resources for eMTCT related commodities (ARVS, Ols, FP, Rapid HIV test kits, DBS kits) to ensure continuous commodity availability**

- Identify resource needs and gaps related to eMTCT commodities
- Mobilize resource to filling the gaps
- Liaise with TACAIDS to advocate for innovative strategies to expand the AIDS fund basket to ensure continuous commodities availability (Tourism sectors, Airline contribution, Country entry fee, soft drinks)

Strategy 6.2: Increase the capacity of RHMT, CHMT and health care workers at all levels in managing PMTCT commodities in collaboration with supply chain management system programme

- Train personnel dealing with commodities at national level on forecasting & quantification, procurement and supply chain management
- Develop SoP manuals for Commodity management and rational use
- Print and distribute logistic management tools in collaboration with SCMS
- Conduct sensitization meeting with the Local Government Authorities on logistic management
- Train Regional (RHMT) and District (CHMT) on commodity management mentorship skills

Strategy 6.3: Intergrate the management of PMTCT commodities with other health commodity logistics systems to increase data visibility and product availability

- Review the current PMTCT commodity management systems and management tools
- Conduct workshop to discuss the Integration of PMTCT commodities management tools with other commodities managed at service delivery points
- Conduct workshop to review the PMTCT and other commodities managed under Integrated Logistic System (ILS)

Strategy 6.4: Integrate the basic logistics monitoring indicators with other PMTCT monitoring and evaluation systems

- Review the M&E tools and include indicators for commodity management
- Incorporate commodity management indicators into the existing PMTCT database
- and conduct biannual assessment of logistic system performance indicators
- Explore various existing innovative commodity stock tracking system such as SMS based tracking systems and apply in the management of PMTCT commodities (SMS for life under malaria program)
- Conduct biannual joint supportive supervision and mentorship with NACP
- Establish a mechanism for analysis and utilization of essential data items for decision making at national level

Strategy 6.5: Increase the capacity of health care facilities to store PMTCT commodities to comply with storage guidelines

- Conduct the assessment on storage capability and status of the health facilities
- Review or design the standard structure for medicine storage and advise for modification
- Support CHMTs to include storage improvement infrastructure and equipment budget in their CCHPs

Strategy 6.6: Strengthen Logistics, supply chain management including drugs, diagnostics and other medical supplies

- Establish coordinating mechanisms at central level to manage logistics data
- Establish Logistic Management Unit (LMU) at central level (link with PSU in the MOHSW) in collaboration with other stakeholders
- Develop a national plan for maintaining the continuous availability of eMTCT and Pediatric HIV care and treatment medicines, diagnostics and other medical supplies

- Develop and implement a system for regular quantification of eMTCT and Pediatric HIV medicines, diagnostics and medical supplies, at national, regional and district levels
- Procure and distribute eMTCT , Pediatric HIV medicines, diagnostics and other medical supplies through MSD
- Maintain a stock-control system for eMTCT and Pediatric HIV medicines, diagnostics and other medical supplies in all health facilities
- Conduct bi-annual review partners meetings to monitor the progress
- Conduct annual Focused Training of the CHMTs on leadership, coordination and follow up skills of the logistics and supply chain management
- Procurement and distribution of the HIV test kits, at least 1 POC - CD4 machines per facility, ARVs for mothers and children based on the eMTCT targets.
- Training/orientation of HCWs on forecasting for EID, ARV, Cotrimoxazole and Data utilization and rational use of commodities.



5.0 Logical framework for the virtual MTCT elimination plan

Strategies	Detailed activities	2012				2013				2014	2015	Responsible authority	Implementers & Supporting partners	Method of verification
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategic Objective 1: To strengthen national, regional and district capacity to effectively plan, manage, implement and coordinate eMTCT programme in Tanzania														
1.1: To strengthen political leadership, policies and resource mobilization for comprehensive eMTCT and pediatric care, treatment at all levels	1.1.1: Advocate for establishment of eMTCT accountability structures for government/political leaders at all levels											MoHSW (RCHS PMTCT), TACAIDS,	MoHSW (RCHS PMTCT, regional & district authorities	Annual reports
	1.1.2: Launch the eMTCT campaign at all levels for increased awareness and support towards achievement of eMTCT targets											MoHSW (RCHS PMTCT), TACAIDS	MoHSW (RCHS PMTCT, IPs, Supporting partners	Annual reports
	1.1.3: Conduct sensitization of political leaders, policy makers, partners, communities and all other stakeholders, including those in the private sector,											MoHSW (RCHS PMTCT), TACAIDS, RHMT, CHMT	RCHS PMTCT, Regional and district authorities, IPs	Annual reports
	1.1.4: Develop resource mobilization strategy											MoHSW (RCHS PMTCT),	MoHSW (RCHS PMTCT), IPs, Supporting partners	Resource mobilization strategy document
	1.1.5: From the HIV funding pool, commit at least 30% of any resources put aside for ART to Ped. HIV care and treatment											MoHSW (RCHS PMTCT), RHMT, CHMT	MoHSW (RCHS PMTCT), Regional & district authorities	ART budgets
	1.1.6: In collaboration with SRH conduct stakeholders analysis and map key partners in advocating for ASRH at all level											MoHSW (RCHS PMTCT), Supporting partners	MoHSW (RCHS PMTCT), IPs, Supporting partners	ASRH partner data base
	1.1.7: In collaboration with SRH, advocate for resource mobilization for adolescent SRH											MoHSW (RCHS PMTCT), Supporting partners	MoHSW (RCHS PMTCT), IPs, Supporting partners	Budgets with ASRH components

Strategies	Detailed activities	2012				2013				2014	2015	Responsible authority	Implementers & Supporting partners	Method of verification
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategic Objective 1: To strengthen national, regional and district capacity to effectively plan, manage, implement and coordinate eMTCT programme in Tanzania														
Strat-egy 1.2: To develop National, Regional and District Capacity for integrated planning, management, coordination and supervision of PMTCT and pediatric AIDS programmes by 2015	1.2.1: Conduct advocacy meetings for incorporation of eMTCT and Pead. HIV Care issues and allocation of resources in National development frameworks											MoHSW (RCHS PMTCT), TACAIDS,	MoHSW (RCHS PMTCT, supporting partners	Meeting reports
	1.2.2: With other stakeholders advocate for in-crease enrolment of students in the Health institutions.											MoHSW, PMORALG, MOeVT, MoSTC	Training institutions & zonal referral hospitals	Training institution reports
	1.2..3: With other stakeholders advocate for in-crease funding for training and recruitment of health professionals											MoHSW, PMORALG, MOeVT, MoSTC	Training institutions & zonal referral hospitals	Training institu-tion reports
	1.2.4: Advocate for development of an incentive package for retaining HCW in remote rural areas.											MoHSW, PMORALG,	MoHSW, PMORALG, RHMT, CHMT, develop-ment partners	Incentive pack-age
	1.2.5: Advocate for task sharing for evidence based non-medical eMTCT intervention											MoHSW (RCHS PMTCT), supporting partners	MoHSW (RCHS PMTCT), regional & district au-thorities	Task sharing policy/guideline
	1.2.6: Disseminate the national eMTCT plan and targets at all levels											RCHS PMTCT, support-ing partners	MoHSW (RCHS PMTCT), RHMT, CHMT, IPs	eMTCT plan in all regions/ districts
	1.2.7: Develop regional and district specific eMTCT plans											PMTCT, RHMT, CHMT	MoHSW (RCHS PMTCT), RHMT, CHMT, IPs	eMTCT plan in all regions/ districts
	1.2.8: Orient all 26 regional and 133 council managers on eMTCT and Paed.											PMTCT, RHMT, CHMT Supporting partners	MoHSW (RCHS PMTCT), regional & district au-thorities, IPs	Training reports
	1.2.9: Train RHMT and CHMT on equity focused eMTCT bottleneck analysis and eMTCT planning and review											PMTCT, RHMT, CHMT Supporting partners	MoHSW (RCHS PMTCT), RHMT, CHMT, IPs	Training reports

Strategies	Detailed activities	2012				2013				2014	2015	Responsible authority	Implementers & Supporting partners	Method of verification
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategic Objective 1: To strengthen national, regional and district capacity to effectively plan, manage, implement and coordinate eMTCT programme in Tanzania														
	1.2.10: Conduct coordination meetings for eMTCT and Pediatric HIV care and treatment with other RCH, TB and HIV/AIDS programs											MoHSW (RCHS PMTCT), Supporting partners	MoHSW (RCHS PMTCT), RHMT, CHMT, IPs	Meeting reports
	1.2.11: Include eMTCT and Paed. HIV care and treatment aspects as a permanent agenda item on National, RHMT & CHMT meetings											MoHSW (RCHS PMTCT, NACP), Supporting partners	MoHSW (RCHS PMTCT), regional & district au- thorities	Meeting reports
	1.2.12: Finalize and integrate eMTCT and paediatric HIV care and treatment supportive supervi- sion tools											MoHSW (RCHS PMTCT, NACP),	MoHSW (RCHS PMTCT), IPs	Supervision tools
	1.2.13: Carry out national, regional and district sup- portive supervision of eMTCT and Paediatric HIV care and treatment											MoHSW (RCHS PMTCT), RHMT, CHMT's	MoHSW (RCHS PMTCT), regional & district au- thorities, IPs	Supervision reports

Strategies	Detailed activities	2012				2013				2014	2015	Responsible authority	Implementers & Supporting partners	Method of verification
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategic Objective 2: To develop institutional and Human resource capacity in comprehensive eMTCT and paediatric HIV care and Treatment														
Strategy 2.1: Review and update National PMTCT and Pediatric care and treatment guidelines and protocols	2.1.1: Regularly review, Update and disseminate National Paediatric care and treatment guidelines and protocols											MoHSW (RCHS PMTCT, NACP), Supporting partners	MoHSW (RCHS PMTCT), IPs	Final guidelines & protocol
	2.1.2: Regularly review, update and disseminate National PMTCT guideline											MoHSW (RCHS PMTCT, NACP), Supporting partners	MoHSW (RCHS PMTCT), IPs	Reviewed guide- lines & protocol
	2.1.3: Develop/revise, print and disseminate job aids for eMTCT and Paediatric HIV care and treatment,											MoHSW (RCHS PMTCT, NACP), Supporting partners	MoHSW (RCHS PMTCT), IPs	Job aids in facilities
	2.1.4: Develop, print and disseminate standardized eMTCT and Paediatric HIV PSS guidelines											MoHSW (RCHS PMTCT, NACP), Supporting partners	MoHSW (RCHS PMTCT), IPs	PSS guidelines

Strategies	Detailed activities	2012				2013				2014	2015	Responsible authority	Implementers & Supporting partners	Method of verification
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategic Objective 2: To develop institutional and Human resource capacity in comprehensive eMTCT and paediatric HIV care and Treatment														
Strategy 2.2: Capacity building for health service providers to provide comprehensive eMTCT, EID and paediatric care services at all levels of health facilities.	2.2.1: Conduct rapid assessment of human resource capacity in RCHS											MoHSW (RCHS PMTCT, HRD), Supporting partners	MoHSW (RCHS PMTCT), IPs, Regional & district authorities	Assessment report
	2.2.2: Develop National, regional and district eMTCT - Paediatric HIV care and treatment training plans,											MoHSW (RCHS PMTCT, HRD), Supporting partners	MoHSW (RCHS PMTCT, HRD), IPs, Regional & district authorities	Training plans
	2.2.3: Review and update pre-service training materials											MoHSW (RCHS PMTCT, HRD), Training institutions	MoHSW (RCHS PMTCT, HRD), IPs, training institutions, supporting partners	Reviewed training materials
	2.2.4: Collaborate with HRD to train pre-service curriculum for TOTs in PMTCT and Pediatric HIV care and treatment											MoHSW (RCHS PMTCT, HRD),	MoHSW (RCHS PMTCT, HRD), IPs, training institutions	Training reports
	2.2.5: Build capacity to the national, regional and district RCH/HIV & AIDS TOT teams in PMTCT, EID and Paediatric HIV care and treatment											MoHSW (RCHS PMTCT),	MoHSW (RCHS PMTCT) IPs, Regional & district authorities	Training reports
	2.2.6: Provide training equipment and materials to the regional and district PMTCT TOT teams											MoHSW (RCHS PMTCT) Supporting partners	MoHSW (RCHS PMTCT,) IPs, Regional/ & district authorities	Annual reports
	2.2.7: Conduct modular training/refreshers of health providers (in PMTCT, EID and Paediatric HIV care and treatment											MoHSW (RCHS PMTCT) Supporting partners	MoHSW (RCHS PMTCT) IPs, Regional/ & district authorities	Training reports

Strategies	Detailed activities	2012				2013				2014	2015	Responsible authority	Implementers & Supporting partners	Method of verification
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategic Objective 2: To develop institutional and Human resource capacity in comprehensive eMTCT and paediatric HIV care and Treatment														
	2.2.8: Train health workers on infant and young child feeding counseling											MoHSW (RCHS PMTCT, TFNC) Supporting partners	MoHSW (RCHS PMTCT) IPs, Regional/ & district authorities	Training reports
	2.2.9: Establish systematic follow up and post-training support for all trainees											MoHSW (RCHS PMTCT) Supporting partners	MoHSW (RCHS PMTCT) IPs, Regional/ & district authorities	Supervision reports
	2.2.10: Conduct mentoring of health workers											MoHSW (RCHS PMTCT) Supporting partners	MoHSW (RCHS PMTCT) IPs, Regional/ & district authorities	Monthly/ annual reports
	2.2.11: Scale up zonal Pediatric HIV care and treatment centers of excellence											MoHSW (RCHS PMTCT) Supporting partners	MoHSW (RCHS PMTCT) IPs, Regional/ & district authorities	Annual reports

Strategies	Detailed activities	2012				2013				2014	2015	Responsible authority	Implementers & Supporting partners	Method of verification
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategic Objective 3: To provide Quality integrated comprehensive eMTCT services that will reduce new infection among children and keep mothers alive at all levels														
Strategy 3.1: Expand provision of HIV services for Primary prevention among young women and their partners	3.1.1: Provide HIV and syphilis prevention information and promote HIV testing											MoHSW (RCHS PMTCT, NACP)	MoHSW (RCHS PMTCT) IPs, Regional/ & district authorities	Monthly/annual reports
	3.1.2: Promote early initiation of ANC (at least by 12 – 14 weeks) under community mobilization											MoHSW (RCHS PMTCT)	MoHSW (RCHS PMTCT) IPs, Regional/ & district authorities	Monthly/annual reports
	3.1.3: Provide re-testing for HIV negative pregnant women											MoHSW (RCHS PMTCT, NACP)	MoHSW (RCHS PMTCT) IPs, Regional/ & district authorities	Monthly/annual reports
	3.1.4: Promote couple/partner testing and counseling for all young women											MoHSW (RCHS PMTCT, NACP)	MoHSW (RCHS PMTCT) IPs, Regional/ & district authorities	Monthly/annual reports
	3.1.5: Promote condom use/dual protection among young women											MoHSW (RCHS PMTCT, NACP)	MoHSW (RCHS PMTCT) IPs, Regional/ & district authorities	Monthly/annual reports
	3.1.6: Promote safer sex for discordant couples,											MoHSW (RCHS PMTCT, NACP)	MoHSW (RCHS PMTCT) IPs, Regional/ & district authorities	Monthly/annual reports
	3.1.7: Provide STI treatment to young women and their partners											MoHSW (RCHS PMTCT, NACP)	MoHSW (RCHS PMTCT) IPs, Regional/ & district authorities	Monthly/annual reports

Strategies	Detailed activities	2012				2013				2014	2015	Responsible authority	Implementers & Supporting partners	Method of verification
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategic Objective 3: To provide Quality integrated comprehensive eMTCT services that will reduce new infection among children and keep mothers alive at all levels														
Strategy 3.2: Expand provision of services that prevent unintended pregnancies among HIV infected women	3.2.1: Finalise and disseminate protocols for integration of FP into other MNCH and HIV services											RCHS, PMTCT, NACP	RCHS PMTCT IPs, RHMT, CHMT	Protocol on integration
	3.2.2: Integrate family planning counseling and services including condoms provision into RCH and HIV sites											RCHS, PMTCT, NACP	RCHS PMTCT IPs, RHMT, CHMT	Protocol on integration
	3.2.3: Provide family planning services through community based structures											MoHSW (RCHS PMTCT) Supporting partners	MoHSW (RCHS PMTCT) IPs, Regional/ & district authorities	Monthly/annual reports
	3.2.4: Print and disseminate FP tools											MoHSW (RCHS PMTCT) Supporting partners	MoHSW (RCHS PMTCT) IPs, RHMTs, CHMTs	FP tools

Strategies	Detailed activities	2012				2013				2014	2015	Responsible authority	Implementers & Supporting partners	Method of verification
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategic Objective 3: To provide Quality integrated comprehensive eMTCT services that will reduce new infection among children and keep mothers alive at all levels														
Strategy 3.3: Increase access to more efficacious ARV regime for HIV infected pregnant women and HIV exposed infants within the RCH platform.	3.3.1: Institutionalize routine offer for HIV testing to all pregnant women											MoHSW (RCHS PMTCT)	MoHSW (RCHS PMTCT) IPs, RHMTs, CHMTs	Monthly/annual reports
	3.3.2: Ensure provision of eMTCT prevention to HIV infected pregnant women and their children as per National guideline at all levels											PMTCT, NACP	RCHS PMTCT IPs, RHMTs, CHMTs	Monthly/annual reports
	3.3.4: Finalize and disseminate guideline for integration of ART/HIV into MNCH services											RCHS PMTCT Supporting partners	RCHS PMTCT IPs, RHMTs, CHMTs	ART integration guideline
	3.3.5: Ensure access to CD4 testing											MoHSW (RCHS PMTCT, Dignostics) Supporting partners	RCHS PMTCT IPs, RHMTs, CHMTs	Monthly/annual reports
	3.3.6: Scale up Provision of integrated Care and Treatment with RCH services											RCHS, PMTCT, NACP Supporting partners	MoHSW (RCHS PMTCT) IPs, RHMTs, CHMTs	Monthly/annual reports
	3.3.7: Promote access to safe delivery by skilled attendant											MoHSW (RCHS PMTCT)	MoHSW (RCHS PMTCT) IPs, RHMTs, CHMTs	Monthly/annual reports
	3.3.8: Provide quality infant feeding counseling and support											MoHSW (RCHS PMTCT, TFNC) Supporting partners	RCHS, PMTCT IPs, RHMTs, CHMTs	Monthly/annual reports

Strategies	Detailed activities	2012				2013				2014	2015	Responsible authority	Implementers & Supporting partners	Method of verification
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategic Objective 3: To provide Quality integrated comprehensive eMTCT services that will reduce new infection among children and keep mothers alive at all levels														
Strategy 3.4: Expand provision of appropriate treatment; care and support to HIV infected mothers and their infants and family	3.4.1: Procure and provide Cotrimoxazole prophylaxis											PMTCT, NACP, Supporting partners	PMTCT, IPs, RHMTs, CHMTs	Stock status reports
	3.4.2: Scale up HIV testing to HIV exposed children according to guidelines											MoHSW (RCHS PMTCT) Supporting partners	MoHSW (RCHS PMTCT) IPs, RHMTs, CHMTs	Monthly/annual reports
	3.4.3: Scale up EID services in all PMTCT sites with operational sample transportation system to reference laboratory,											MoHSW (RCHS PMTCT) Supporting partners	MoHSW (RCHS PMTCT) IPs, RHMTs, CHMTs	Monthly/annual reports
	3.4.4: Introduce use of mobile technology to follow up HIV infected women and children											MoHSW (RCHS PMTCT, Dignostics) Supporting partners	RCHS, PMTCT, IPs, Regional/ & district authorities	Monthly/annual reports
	3.4.5: Provide ART to infants and children											PMTCT, NACP) Supporting partners	PMTCT, IPs, RHMTs, CHMTs	Monthly/annual reports
	3.4.6: Establish and operationalize HIV infected mother support groups											MoHSW (RCHS PMTCT) Supporting partners	PMTCT, IPs, RHMTs, CHMTs	Monthly/annual reports
	3.4.6: Establish Breast feeding support groups											MoHSW (RCHS PMTCT, TFNC) Supporting partners	MoHSW (RCHS PMTCT) IPs, RHMTs, CHMTs	Monthly/annual reports
Strategy 3.5: Increase adolescents' access to, and utilization of integrated quality reproductive health services	3.5.1: Strengthened human resource development on AFSRH											MoHSW (RCHS PMTCT, HRD) Supporting partners	RCHS PMTCT, IPs, RHMTs, CHMTs	Training reports
	3.5.2: In collaboration with SRH , assess existing national curricula for ASRH											MoHSW (RCHS PMTCT)	MoHSW (RCHS PMTCT) IPs, Training institutions	Review report

Strategies	Detailed activities	2012				2013				2014	2015	Responsible authority	Implementers & Supporting partners	Method of verification
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategic Objective 4: To strengthen Community awareness and involvement in the delivery of community eMTCT and Paediatric HIV care and Treatment services														
Strategy 4.1: Develop a community service package for eMTCT and Pediatric HIV care and treatment utilizing community health workers based on models that have proved to be effective (best practices)	4.1.1: Review the existing community based models and identify best practices											PMTCT, IMCI, RCH BCC UNIT, NACP IEC UNIT	PMTCT, IMCI, RCH BCC UNIT, NACP IEC UNIT in collaboration with partners	Draft community PMTCT peadiatric HIV package
	4.1.2: Compile best practices and harmonise approaches into a comprehensive community service package											PMTCT, IMCI, RCH BCC UNIT, NACP IEC UNIT	PMTCT, IMCI, RCH BCC UNIT, NACP IEC UNIT in collaboration with partners	Report on best practices
	4.1.3: Pre- test and finalize the community package for eMTCT											PMTCT, IMCI, RCH BCC UNIT, NACP IEC UNIT	PMTCT, IMCI, RCH BCC UNIT, NACP IEC UNIT in collaboration with partners	Final community PMTCT peadiatric HIV package
	4.1.4: Print and disseminate the community package											PMTCT, IMCI, RCH BCC UNIT, NACP IEC UNIT	PMTCT, IMCI, RCH BCC UNIT, NACP IEC UNIT in collaboration with partners	Communities with PMTCT 7 Pead AIDS package
Strategy 4.2: Strengthen community systems and structures to deliver the community service package of eMTCT and Pediatric HIV care and treatment	4.2.1: Identify existing community structures to deliver the national plan for eMTCT											PMTCT, RCH BCC UNIT, NACP IEC UNIT, RHMT, CHMT	PMTCT, IMCI, RCH BCC UNIT, NACP IEC UNIT in collaboration with partners	Annual Reports
	4.2.1: Identify existing community organizations, civil society activities, and professional organizations to support of community structures											PMTCT, RCH BCC UNIT, NACP IEC UNIT, RHMT, CHMT	PMTCT, IMCI, RCH BCC UNIT, NACP IEC UNIT in collaboration with partners	Data base of community organisations
	4.2.3: Identify existing and diverse types of community based health workers											PMTCT, RCH BCC UNIT, NACP IEC UNIT, RHMT, CHMT	PMTCT, IMCI, RCH BCC UNIT, NACP IEC UNIT in collaboration with partners	Data base of community health workers
	4.2.4: Standardize the selection criteria, training, supervision and compensation of CHWs											PMTCT, RCH BCC UNIT, NACP IEC UNIT, RHMT, CHMT	PMTCT, IMCI, RCH BCC UNIT, NACP IEC UNIT in collaboration with partners	Criteria and protocol for CHW

Strategies	Detailed activities	2012				2013				2014	2015	Responsible authority	Implementers & Supporting partners	Method of verification
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategic Objective 4: To strengthen Community awareness and involvement in the delivery of community eMTCT and Paediatric HIV care and Treatment services														
	4.2.5: Identify and train at least 2 CHWs per village to implement community based interventions.											PMTCT, RCH BCC UNIT, NACP IEC UNIT, RHMT, CHMT	PMTCT, IMCI, RCH BCC UNIT, NACP IEC UNIT in collaboration with partners	Monthly/annual Reports
	4.2.6: Train community organizations, PLHIV and civil society organizations											PMTCT, RCH BCC UNIT, NACP IEC UNIT, RHMT, CHMT	PMTCT, IMCI, RCH BCC UNIT, NACP IEC UNIT in collaboration with partners	Training reports
	4.2.7: Accelerate and standardize setting up Pediatric HIV care and treatment support groups,											PMTCT, RCH BCC UNIT, NACP IEC UNIT, RHMT, CHMT	PMTCT, IMCI, RCH BCC UNIT, NACP IEC UNIT in collaboration with partners	Data base on community support groups
Strategy 4.3: Engage community systems and structures to deliver the community service package of eMTCT and Pediatric HIV care and treatment	4.3.1: Launch the eMTCT campaign at District and community level											PMTCT. RHMT, CHMT	RHMT, CHMT, IPs	Monthly/Annual reports
	4.3.2: Utilization of Village/ward council meetings to create community awareness on eMTCT.											PMTCT. RHMT, CHMT	RHMT, CHMT, IPs	Meeting minutes
	4.3.3: The use of mobile phones (mHealth) for the follow up of PLHIV women and their exposed infants/children											PMTCT. RHMT, CHMT	RHMT, CHMT, IPs	Annual Reports
	4.3.4: Engagement of the facility HCWs to monitor and supervise the CHWs and PLHIV groups											PMTCT. RHMT, CHMT	RHMT, CHMT, IPs	Monitoring reports
	4.3.5: Engagement of CHWs to provide HIV prevention information and promote HIV testing as a routine service in all RCH sites											RHMT, CHMT, IPs	RHMT, CHMT, IPs, CHWs	Annual reports
	4.3.6: Conduct outreaches by CHWs											RHMT, CHMT, IPs	RHMT, CHMT, IPs, CHWs	Monthly/Annual reports
	4.3.7: Engagement of HIV positive women											RHMT, CHMT, IPs	PLHIV, CHMTs, IPs	ACTIVITY REPORTS

Strategies	Detailed activities	2012				2013				2014	2015	Responsible authority	Implementers & Supporting partners	Method of verification
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategic Objective 5: To strengthen systems for monitoring and evaluation of eMTCT and pediatric HIV care and treatment services at all levels														
Strategy 5.1: Strengthen and Operationalize the eMTCT M & E System	5.1.1: Establish M & E technical working group											PMTCT, NACP, HMIS	PMTCT, NACP, HMIS and partners	TWG minutes
	5.1.2: Conduct regular reviews of the eMTCT planned targets and achievement at all levels -											PMTCT, NACP, HMIS	PMTCT, NACP, HMIS and partners	Review reports
	5.1.3: Finalize M & E Framework/Plan											PMTCT, NACP, HMIS	PMTCT, NACP, HMIS and partners	Final M & E Framework
	5.1.4: Capacity building at Central and National Level.											PMTCT, NACP, HMIS	PMTCT, NACP, HMIS and partners	Training reports
	5.1.5: integration of eMTCT M & E in HIV communication strategy											PMTCT, NACP, HMIS	PMTCT, NACP, HMIS and partners	Reports
Strategy 5.2: Improve the routine monitoring and evaluation of eMTCT and Pediatric HIV care and treatment	5.2.1: Disseminate indicators for integrated eMTCT and Paediatric HIV care and treatment to Regional and district teams											PMTCT, NACP, HMIS	PMTCT, NACP, HMIS and partners	Indicators incorporated in regular reports
	5.2.2: Develop/update and distribute M&E data recording, reporting and quality assurance tools											PMTCT, NACP, HMIS	PMTCT, NACP, HMIS and partners	Tools available at all levels
	5.2.3: Develop mechanism to ensure availability of quality eMTCT data											PMTCT, NACP, HMIS	PMTCT, NACP, HMIS and partners	Data availability
	5.2.4: Review/Scale up the existing DHIS database to capture eMTCT and Ped. HIV information											PMTCT, NACP, HMIS	PMTCT, NACP, HMIS and partners	Data base with PMTCT
	5.2.5: Develop and scale up Facility based PMTCT database											PMTCT, NACP, HMIS	PMTCT, NACP, HMIS, RHMTs, CHMTs, and partners	Data base available
	5.2.6: Train/refresh regional and district ToTs/HCWs on M&E for eMTCT											PMTCT, NACP, HMIS	PMTCT, NACP, HMIS, RHMTs, CHMTs, and partners	Training reports

Strategies	Detailed activities	2012				2013				2014	2015	Responsible authority	Implementers & Supporting partners	Method of verification
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategic Objective 5: To strengthen systems for monitoring and evaluation of eMTCT and pediatric HIV care and treatment services at all levels														
Strategy 5.3: Carry out operational research (OR) surveillance and Surveys to guide program implementation	5.3.1: Refine/review national Operational Research priorities issues for eMTCT and Paediatric HIV care and treatment											PMTCT, NACP, research institutes, training institutions, COSTECH	PMTCT, NACP, research institutes, training institutions, COSTECH, partners	Set of PMTCT & Pead AIDS priorities
	5.3.2: Conduct operational research											PMTCT, NACP, research institutes, training institutions, COSTECH	PMTCT, NACP, research institutes, training institutions, COSTECH, partners	Research findings and publications
	5.3.3: Establish eMTCT surveillance system to monitor transmission											PMTCT, NACP, research institutes, training institutions, COSTECH	PMTCT, NACP, research institutes, training institutions, COSTECH, partners	Surveillance reports
	5.3.4: Conduct Mid-term and End term Evaluation of the implementation of eMTCT											PMTCT, NACP, research institutes, training institutions, COSTECH	PMTCT, NACP, research institutes, training institutions, COSTECH, partners	Evaluation reports
	5.3.5: Identify, document and share the innovations and best practices											PMTCT, NACP, research institutes, training institutions, COSTECH	PMTCT, NACP, research institutes, training institutions, COSTECH, partners	Annual reports
Strategy 5.4: Improve PMTCT Services provision through promoting data use	5.4.2: Dissemination plan for various levels											PMTCT, NACP, HMIS	PMTCT, NACP, HMIS, RHMTs, CHMTs, and partners	Reports
	5.4.3: Introduce performance based system for regions/district											PMTCT, NACP, HMIS	PMTCT, NACP, HMIS, RHMTs, CHMTs, and partners	Reports

Strategies	Detailed activities	2012				2013				2014	2015	Responsible authority	Implementers & Supporting partners	Method of verification
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategic objective 6: Strengthen health logistics to include comprehensive management of PMTCT commodities														
Strategy 6.1: Review/commit/mobilize resources for eMTCT related commodities (ARVS,OIs, FP, Rapid HIV test kits,DBS kits) to ensure continuous commodity availability	6.1.1: Conduct donor resource mapping in relation to eMTCT commodities											RCHS, PMTCT, NACP, MSD, Diagnostics	RCHS, PMTCT, NACP, MSD, Diagnostics, supporting partners, IPs	Report on resources availability
	6.1.2: Mobilize resource to filling the gap											RCHS, PMTCT, NACP, MSD, Diagnostics	RCHS, PMTCT, NACP, MSD, Diagnostics, supporting partners, IPs	Stock status report
	6.1.3: Advocate for innovative strategies to expand the AIDS fund basket											RCHS, PMTCT, NACP, MSD, Diagnostics	RCHS, PMTCT, NACP, MSD, Diagnostics, supporting partners, IPs	Stock status report
Strategy 6.2. Increase the capacity of RHMT, CHMT and health care workers at all levels in managing PMTCT commodities	6.2.1:Train commodities managers on forecasting procurement and supply chain management											RCHS, PMTCT, NACP, MSD, SCMS, Diagnostics	RCHS, PMTCT, NACP, MSD, SCMS, Diagnostics, partners	Training reports
	6.2.2: Develop SoP manuals for Commodity management and rational use											RCHS, PMTCT, NACP, MSD, SCMS, Diagnostics	RCHS, PMTCT, NACP, MSD, SCMS, Diagnostics, partners	SoP s available
	6.2.3: Print of logistic management tools											RCHS, PMTCT, NACP, MSD, SCMS, Diagnostics	RCHS, PMTCT, NACP, MSD, SCMS, Diagnostics, partners	Logistics management tools
	6.2.4: Conduct meeting with DED & DMO on logistic management											RCHS, PMTCT, NACP, MSD, SCMS, Diagnostics	RCHS, PMTCT, NACP, MSD, SCMS, Diagnostics, partners	Minutes of meeting
	6.2.5: Train RHMT & CHMT on commodity management											RCHS, PMTCT, NACP, MSD, SCMS, Diagnostics,	RCHS, PMTCT, NACP, MSD, SCMS, Diagnostics, RHMT, CHMT, Partners	Training reports

Strategies	Detailed activities	2012				2013				2014	2015	Responsible authority	Implementers & Supporting partners	Method of verification
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategic objective 6: Strengthen health logistics to include comprehensive management of PMTCT commodities														
Strategy 6.3: Integrate the management of PMTCT commodities with other health commodity logistics systems to increase data visibility and product availability	6.3.1: Review the current PMTCT commodity management systems/ management tools											RCHS, PMTCT, NACP, MSD, SCMS, Diagnostics,	RCHS, PMTCT, NACP, MSD, SCMS, Diagnostics, RHMT, CHMT, Partners	Review report
	6.3.2: Conduct workshop to discuss the Integration of PMTCT management commodities tools with other commodities managed at SDP											RCHS, PMTCT, NACP, MSD, SCMS, Diagnostics,	RCHS, PMTCT, NACP, MSD, SCMS, Diagnostics, RHMT, CHMT, Partners	Workshop report
	6.3.3: Conduct workshop to review the PMTCT and other commodities managed under ILS											RCHS, PMTCT, NACP, MSD, SCMS, Diagnostics,	RCHS, PMTCT, NACP, MSD, SCMS, Diagnostics, RHMT, CHMT, Partners	ILS with PMTCT information
Strategy 6.4: Integrate the basic logistics monitoring indicators with other PMTCT monitoring and evaluation systems	6.4.1: Review the M&E tools and include indicators for commodity management											RCHS, PMTCT, NACP, MSD, SCMS, Diagnostics, HMIS	RCHS, PMTCT, NACP, MSD, SCMS, Diagnostics, RHMT, CHMT, Partners	M & E tools with PMTCT supplies
	6.4.2: Incorporate into the existing PMTCT database the commodity management indicators											RCHS, PMTCT, NACP, MSD, SCMS, Diagnostics, HMIS	RCHS, PMTCT, NACP, MSD, SCMS, Diagnostics, RHMT, CHMT, Partners	PMTCT data based with commodity information
	6.4.3: Conduct biannual assessment of logistic system performance of the indicators											RCHS, PMTCT, NACP, MSD, SCMS, Diagnostics, HMIS	RCHS, PMTCT, NACP, MSD, SCMS, Diagnostics, RHMT, CHMT, Partners	Assessment reports
	6.4.4: Explore and employ existing different SMS based tracking systems in the management of PMTCT commodities											RCHS, PMTCT, NACP, MSD, SCMS, Diagnostics, HMIS	RCHS, PMTCT, NACP, MSD, SCMS, Diagnostics, RHMT, CHMT, Partners	Annual reports
	6.4.5: Conduct Supportive supervision and mentoring on biannual basis Link with supervisions undertaken by NACP and RCHs											RCHS, PMTCT, NACP, MSD, SCMS, Diagnostics, HMIS	RCHS, PMTCT, NACP, MSD, SCMS, Diagnostics, RHMT, CHMT, Partners	Supervision reports
	6.4.6: Establish a mechanism of aggregating and use of essential data items											RCHS, PMTCT, NACP, MSD, SCMS, Diagnostics, HMIS	RCHS, PMTCT, NACP, MSD, SCMS, Diagnostics, RHMT, CHMT, Partners	Annual reports

Strategies	Detailed activities	2012				2013				2014	2015	Responsible authority	Implementers & Supporting partners	Method of verification
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategic objective 6: Strengthen health logistics to include comprehensive management of PMTCT commodities														
Strategy 6. 5: Increase the capacity of health care facilities to store PMTCT commodities to comply with storage guidelines	6.5.1: Conduct the assessment on storage capability											NACP, MSD, SCMS, Diagnostics,	NACP, MSD, SCMS, Diagnostics, RHMT, CHMT, partners	Assessment report
	6.5.2: Review/Design the standard structure for medicine storage											NACP, MSD, SCMS, Diagnostics,	NACP, MSD, SCMS, Diagnostics, RHMT, CHMT, partners	Reports
	6.5.3: Conduct meeting to sensitize CHMTs and RHMT											RCHS, PMTCT, NACP, MSD, SCMS, Diagnostics,	NACP, MSD, SCMS, Diagnostics, RHMT, CHMT, partners	Meeting reports
Strategy 6.6: To strengthen Logistics, supply chain management including drugs, diagnostics and other medical supplies	6.6.1: Establish coordinating mechanisms at central level to aggregate and manage logistics data											MoHSW (RCHS-PMTCT, NACP, MSD, Diagnostics)	MoHSW (RCHS-PMTCT, NACP, MSD, Diagnostics) & partners	
	6.6.2: Develop a national plan for maintaining the continuous availability of eMTCT & Pediatric HIV care and treatment supplies											MoHSW (RCHS-PMTCT, NACP, MSD, Diagnostics)	MoHSW (RCHS-PMTCT, NACP, MSD, Diagnostics), partners	Plan document
	6.6.3: Develop and implement a system for regular quantification of eMTCT and Paediatric HIV medicines, diagnostics and medical supplies, taking into account targets and capacity at national, regional and district levels											MoHSW (RCHS-PMTCT, NACP, MSD, Diagnostics)	MoHSW (RCHS-PMTCT, NACP, MSD, Diagnostics) , RHMT, CHMT & partners	Forecasting reports
	6.6.4: Procure eMTCT and other Pediatric HIV medicines, diagnostics and supplies											MoHSW (RCHS-PMTCT, NACP, MSD, Diagnostics)	MoHSW (RCHS-PMTCT, NACP, MSD, Diagnostics) , RHMT, CHMT & partners	Supply stock out status

Strategies	Detailed activities	2012				2013				2014	2015	Responsible authority	Implementers & Supporting partners	Method of verification
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategic objective 6: Strengthen health logistics to include comprehensive management of PMTCT commodities														
	6.6.5: Maintain a stock-control system for eMTCT and Pediatric HIV medicines & diagnostics											MoHSW (RCHS-PMTCT, NACP, MSD, Diagnostics)	MoHSW (RCHS-PMTCT, NACP, MSD, Diagnostics) , RHMT, CHMT & partners	Supply stock out status
	6.6.6: Conduct bi-annual partners meetings allocation.											MoHSW (RCHS-PMTCT, NACP, MSD, Diagnostics)	MoHSW (RCHS-PMTCT, NACP, MSD, Diagnostics) & partners	Meeting reports
	6.6.7:Conduct annual Forecasting Training of the CHMTs											MoHSW (RCHS-PMTCT, NACP, MSD, Diagnostics)	MoHSW (RCHS-PMTCT, NACP, MSD, Diagnostics) , RHMT, CHMT & partners	Training reports
	6.6.8: Procurement and distribution of the HIV test kits, at least 1 POC - CD4 machines per facility & ARVs.											MoHSW (RCHS-PMTCT, NACP, MSD, Diagnostics)	MoHSW (RCHS-PMTCT, NACP, MSD, Diagnostics) , RHMT, CHMT & partners	Supply stock out status

6.0 eMTCT resource requirements

6.1 Model and Data Sources

This cost analysis provides estimates of the resource requirements for the implementation of the eMTCT Plan by all the stakeholders. The estimates provide indications of resource needs that will guide mobilization of resources from government, its development partners and other stakeholders in implementing the eMTCT Plan.

The costing analysis of the strategic plan utilized the ASAP costing model. The model uses an activity based approach to cost HIV services and interventions. The costing approach involved three steps. Step one consisted of obtaining and inputting demographic and HIV prevalence data into the ASAP. The data included projected annual number of pregnant women during the period 2012-2015, the HIV prevalence among pregnant women, percentage of women with some antenatal care attendance, percentage of pregnant women attending ANC to be tested for HIV, percentage of pregnant women attending ANC testing HIV positive, and percentage of HIV positive pregnant women on ARV (prophylaxis and treatment). The population of pregnant women used varies from year to year, and was generated using the ASAP model. The numbers used are 1.78 million in 2011 (base), 1.83 million in 2012, 1.87 million in 2013, 1.92 million in 2014, and 1.97 million in 2015. These numbers were estimated using projected population of Tanzania Mainland from Tanzania National Bureau of Statistics (TNBS) given as 44.48 million in 2011, 45.83 million in 2012, 47.21 million in 2013, 48.64 million in 2014 and 50.10 million in 2015. Additionally crude birth rates from Spectrum that was used were 40.1, 39.9, 39.7, 39.5, and 39.3 in the years 2011, 2012, 2013, 2014, and 2015, respectively. The second step involved obtaining the targets for the eMTCT plan and inputting them in the model. The third step consisted of collecting and estimating unit costs of different activities for input into the model.

The sources of data included Tanzania Bureau of Statistics, Reproductive and Child Health Section of the MOHSW, EMTCT working group on targets, EMCT working groups on the four prongs, WHO choice model, and costing studies from the regions.

6.2 Costing Approach

The costing analysis concentrated on the activities in each of the four prongs, using the provider (supply side) perspective. Broadly, the activities included in the cost analysis are:

- Counselling and testing in the context of eMTCT
- Provision of ARV prophylaxis for mother and baby
- Provision of ART treatment in the context of PMTCT.
- Monitoring tests provision (CD4, ALT, Creatinine, FBC)
- Conducting various trainings
- Procurement of POC CD4 machines
- Programme support activities (operationsmanagement, advocacy, M&E, research)

In the costing analysis, three data inputs were used, consisting of population in need of the different services, coverage targets, and unit costs. The estimated cost per activity was computed by the following formula:

-Cost per activity or service (Tsh) = population x coverage target x unit cost.

In the case of activities, which did not relate to the population, the cost was calculated by multiplying quantity by the unit costs.

Population in need is the number of persons who require the service. For instance this can be number HIV positive pregnant women who need ARV prophylaxis, the number of HIV positive pregnant women who need ART treatment, etc. The coverage target is the percentage of the population in need that will be reached by the service, e.g., 90% of HIV positive pregnant women will be provided with efficacious ARV by 2015. Unit cost is the estimated amount of resources to provide a service to one person.

6.3 Summary Estimates of Funding Requirements

The total funding requirements for the eMTCT Plan in the four year period are presented in Figure 6.1

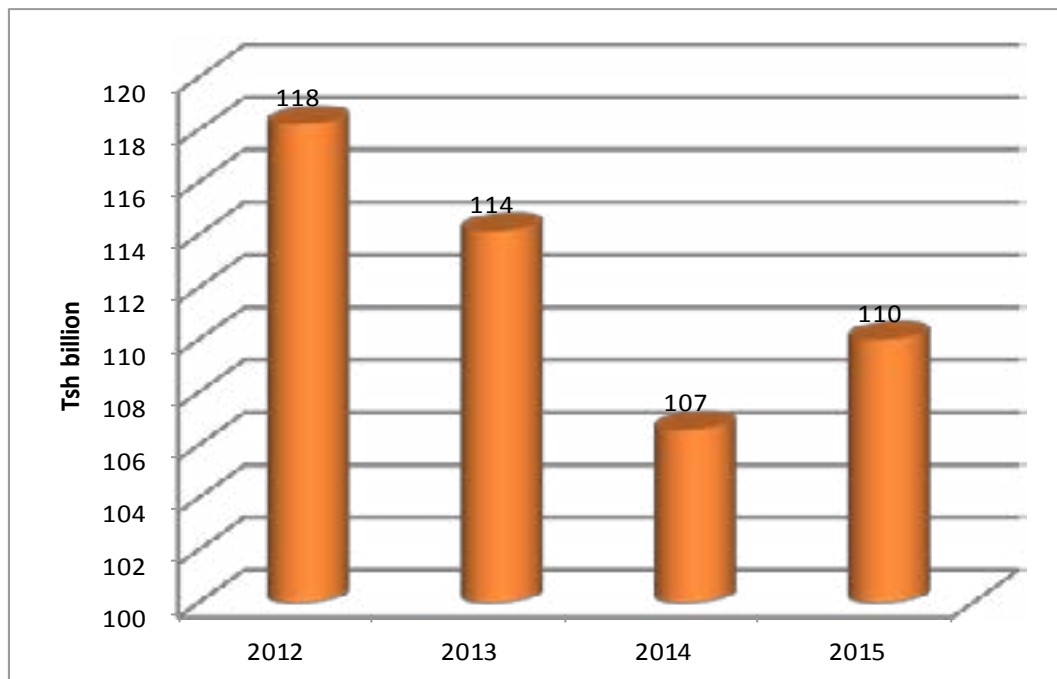


Figure 6.1: Total resource requirements 2012-15

The estimate resources are about Tsh 118.22 billion (US\$ 71.65 million⁹) in 2012, Tsh 114.15 billion (US\$ 69.18 million) in 2013, Tsh 106.60 billion (US\$ 64.61million) in 2014, and Tsh 110.00 billion (US\$ 66.67 million) in 2015. Overall, it will cost Tsh 448.97 billion (US\$ 272.10 million) to implement the eMTCT plan during the plan period. The highest cost is recorded during the year 2012, attributed mainly to extensive capacity building of the human resources and start-up costs in the health sector to provide comprehensive PMTCT services.

Table 6.1 presents the estimated costs by the six strategic objectives. The table shows that strategic objective accounts for the largest amount of the total resource requirement. By inspection it will take more 50% of all the resources, It followed by strategic objective 2 and 1.

⁹ Exchange rate: 1US\$ =Tsh 1,650

Table 6.1: Cost estimates by strategic objective

	Tsh million					US\$ million				
	2012	2013	2014	2015	Total	2012	2013	2014	2015	Total
Strategic Objective 1	11,179	6,933	2,705	2,976	23,793	6,775	4,202	1,639	1,803	14,420
Strategic Objective 2	21,590	13,107	9,078	6,560	50,334	13,085	7,944	5,502	3,976	30,506
Strategic Objective 3	80,097	88,199	89,997	95,148	353,441	48,544	53,454	54,544	57,665	214,206
Strategic Objective 4	21	535	-	-	556	13	324	-	-	337
Strategic Objective 5	2,561	2,885	2,243	2,266	9,954	1,552	1,748	1,359	1,373	6,033
Strategic Objective 6	2,774	2,488	2,574	3,057	10,894	1,681	1,508	1,560	1,853	6,602
Total	118,222	114,147	106,597	110,005	448,972	71,650	69,180	64,605	66,670	272,104

The estimated costs by type of major cost category are presented in Table 6.2. In the table treatment and care (ART) will take lion share of resources. This is followed by costs of various capacity building activities to support implementation of eMTCT. ARV prophylaxis service for pregnant women and infants, and HIV counseling and testing associated with PMTCT will also consume significant share of the resources. It should be pointed that treatment and care is already factored in the national ART programme, and can be excluded from eMTCT programme. The cost estimates without treatment and care for HIV women whose CD4 is less 350 are shown in Table 6.3. Therefore the results in Table 6.3 will inform efforts to mobilize resources for eMTCT Strategic Plan.

Table 6.2: Cost estimates by expenditure type

	Tsh million					US\$ million				
	2012	2013	2014	2015	Total	2012	2013	2014	2015	Total
*ARV Prophylaxis Service	9,914	11,083	11,913	12,967	45,878	6,009	6,717	7,220	7,859	27,805
ART Treatment service	58,364	61,728	64,627	67,609	252,328	35,372	37,411	39,168	40,975	152,926
HTC	6,843	7,216	7,872	8,452	30,384	4,147	4,374	4,771	5,123	18,414
IED	4,954	8,171	5,585	6,119	24,829	3,002	4,952	3,385	3,708	15,048
M&E	2,338	2,601	1,999	1,949	8,888	1,417	1,576	1,212	1,181	5,386
Operations ¹⁰	11,025	8,275	5,010	4,248	28,559	6,682	5,015	3,037	2,575	17,309
Training	23,958	13,884	8,403	7,472	53,717	14,520	8,414	5,093	4,529	32,556
POC machines	825	1,188	1,188	1,188	4,389	500	720	720	720	2,660
Total	118,222	114,147	106,597	110,005	448,972	71,650	69,180	64,605	66,670	272,104

* Cost for ARV prophylaxis and ART treatment to be realigned with option B+

¹⁰ Cost of programme support such advocacy, management, supervision, and advocacy

Table 6.3: Cost estimates by expenditure type without ART

	Tsh million					US\$ million				
	2012	2013	2014	2015	Total	2012	2013	2014	2015	Total
*ARV Prophylaxis Service	9,914	11,083	11,913	12,967	45,878	6,009	6,717	7,220	7,859	27,805
HTC	6,843	7,216	7,872	8,452	30,384	4,147	4,374	4,771	5,123	18,414
IED	4,954	8,171	5,585	6,119	24,829	3,002	4,952	3,385	3,708	15,048
M&E	2,338	2,601	1,999	1,949	8,888	1,417	1,576	1,212	1,181	5,386
Operations	11,025	8,275	5,010	4,248	28,559	6,682	5,015	3,037	2,575	17,309
Training	23,958	13,884	8,403	7,472	53,717	14,520	8,414	5,093	4,529	32,556
POC machines	825	1,188	1,188	1,188	4,389	500	720	720	720	2,660
Total	59,858	52,419	41,971	42,396	196,644	36,277	31,769	25,437	25,695	119,178

* Cost for ARV prophylaxis to be realigned with option B+

6.4 Detailed Budget Estimates of Funding Requirements

Table 6.4: Detailed cost of eMTCT (Tsh 000's)

Strategic Objective 1: To strengthen national, regional and district capacity to effectively plan, manage, implement and coordinate eMTCT programme in Tanzania													Total
			2012				2013				2014	2015	
Strategies	Detailed activities	Costing assumptions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
1.1: To strengthen political leadership, policies and resource mobilization for comprehensive eMTCT and pediatric care, treatment at all levels	1.1.1: Advocate for establishment of eMTCT accountability structures for government/ political leaders at all levels –	Cost covered below											
	1.1.2: Launch the eMTCT campaign at all levels for increased awareness and support towards achievement of eMTCT targets	2 national meetings of 30 people each at cost of Tsh 2,070,000 per meeting, 1 meeting of 30 people per region at cost of Tsh 2,070,000 per meeting, 1 meetings of 30 people per district at cost of Tsh 2,070,000 per meeting, meetings of 30 people per district at cost of Tsh 2,070,000 per meeting		1,503,290	1,502,040	1,498,720	1,498,720						6,002,770
	1.1.3: Conduct sensitization of political leaders, policy makers, partners, communities and all other stakeholders, including those in the private sector,	5 national meetings of 30 people each at cost of Tsh 2,070,000 per meeting, 2 meetings of 30 people per region at cost of Tsh2,070,000 per meeting, 2 meetings of 30 people per district at cost of Tsh 2,070,000 per meeting		12,420	20,700	10,350	117,990	117,990	115,920	115,920			511,290
	1.1.4: Develop resource mobilization strategy	Retreat of 30 people @ Tsh 165,000 per person x 2 days + consultancy at Tsh 660,000 /day for 14 days			19,140								19,140

Strategic Objective 1: To strengthen national, regional and district capacity to effectively plan, manage, implement and coordinate eMTCT programme in Tanzania													Total
			2012				2013				2014	2015	
Strategies	Detailed activities	Costing assumptions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
	1.1.5: From the HIV funding pool, commit at least 30% of any resources put aside for ART to Ped. HIV care and treatment	Under 1.1.2											0
	1.1.6: In collaboration with SRH conduct stakeholders analysis and map key partners in advocating for ASRH at all level	Under 1.1.3											0
	1.1.7: In collaboration with SRH, advocate for resource mobilization for adolescent SRH	Cost covered in 1.1.2 and 1.1.3											0

Strategic Objective 1: To strengthen national, regional and district capacity to effectively plan, manage, implement and coordinate eMTCT programme in Tanzania													Total
			2012				2013				2014	2015	
Strategies	Detailed activities	Costing assumptions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
Strategy 1.2: To develop National, Regional and District Capacity for integrated planning, management, coordination and supervision of PMTCT and pediatric AIDS programmes by 2015	1.2.1: Conduct advocacy meetings for incorporation of eMTCT and Pead. HIV Care issues and allocation of resources in National development frameworks	Cost covered in 1.1.2 and 1.1.3											
	1.2.2: With other stakeholders advocate for increase enrolment of students in the Health institutions.	Cost covered in 1.1.2 and 1.1.3											
	1.2.3: With other stakeholders advocate for increase funding for training and recruitment of health professionals	Cost covered in 1.1.2 and 1.1.3											
	1.2.4: Advocate for development of an incentive package for retaining HCW in remote rural areas.	Cost covered in 1.1.2 and 1.1.3											

Strategic Objective 1: To strengthen national, regional and district capacity to effectively plan, manage, implement and coordinate eMTCT programme in Tanzania													Total
			2012				2013				2014	2015	
Strategies	Detailed activities	Costing assumptions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
	1.2.5: Advocate for task sharing for evidence based non medical eMTCT intervention	Cost covered in 1.1.2 and 1.1.3											
	1.2.6: Disseminate the national eMTCT plan and targets at all levels	Production and distribution of 1,000 copies to all levels at cost of Tsh 300,000 per copy		300,000									300,000
	1.2.7: Develop regional and district specific eMTCT plans	Retreat of 30 people @ Tsh 165,000 per person x 5 days per district or region				1,905,750	1,905,750						3,811,500
	1.2.8: Orient all 26 regional and 133 council managers on eMTCT and Paed.	3 day meeting of 25 participants per region and district at Tsh 4,194,500 per meeting		-	322,977	322,977							645,954
	1.2.9: Train RHMT and CHMT on equity focused eMTCT bottleneck analysis and eMTCT planning and review	5 day meeting of 25 participants per region or district at Tsh 9,865,000 per meeting		621,495	611,630	601,765	601,765						2,436,655

Strategic Objective 1: To strengthen national, regional and district capacity to effectively plan, manage, implement and coordinate eMTCT programme in Tanzania													Total
			2012				2013				2014	2015	
Strategies	Detailed activities	Costing assumptions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
	1.2.10: Conduct coordination meetings for eMTCT and Pediatric HIV care and treatment with other RCH, TB and HIV/AIDS programs	Quarterly meeting of 60 people @ Tsh 165,000/person x 1 day		9,900	9,900	9,900	10,890	10,890	10,890	10,890	47,916	52,708	173,884
	1.2.11: Include eMTCT and Paed. HIV care and treatment aspects as a permanent agenda item on National, RHMT & CHMT meetings	Cost covered under other routine meetings											0
	1.2.12: Finalize and integrate eMTCT and paediatric HIV care and treatment supportive supervision tools	Consultancy at Tsh240,000 /day for 14 days			3360								3,360
	1.2.13: Carry out national, regional and district supportive supervision of eMTCT and Paediatric HIV care and treatment	Quarterly supportive supervision to HFs with RCH services	473,165	473,165	473,165	473,165	520,482	572,530	629,783	692,761	2,657,110	2,922,821	9,888,147
	Sub-total		473,165	2,920,270	2,962,912	4,822,627	4,655,597	701,410	756,593	819,571	2,705,026	2,975,529	23,792,700



Table 6.4: Detailed cost of eMTCT (Tsh 000's)

Strategic Objective 2: To develop institutional and Human resource capacity in comprehensive eMTCT and paediatric HIV care and Treatment													Total
			2012				2013				2014	2015	
Strategies	Detailed activities	Costing assumptions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
Strategy 2.1: Review and update National PMTCT and Pediatric care and treatment guidelines and protocols	2.1.1: Regularly review, Update and disseminate National Paediatric care and treatment guidelines and protocols	Consultancy @Tsh 660,000/day x 30 days + meeting of 50 pax @Tsh 24,500 /pp x 2 days every 2 years				21,285					25,755		47040
	2.1.2: Regularly review, update and disseminate National PMTCT guideline	Covered in 2.1.1											0
	2.1.3: Develop/revise, print and disseminate job aids for eMTCT and Paediatric HIV care and treatment,	Produce, printing, and disseminate @ Tsh33,000/copy x 18,000 copies				594,000					718,740		1312740
	1.1.4: Develop, print and disseminate standardized eMTCT and Paediatric HIV PSS guidelines	Produce, printing, and disseminate @ Tsh 49,500/copy x 12,000 copies					594,000				718,740		1312740

Strategic Objective 2: To develop institutional and Human resource capacity in comprehensive eMTCT and paediatric HIV care and Treatment													Total
			2012				2013				2014	2015	
Strategies	Detailed activities	Costing assumptions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
Strategy 2.2: Capacity building for health service providers to provide comprehensive eMTCT, EID and pediatric care services at all levels of health facilities	2.2.1: Conduct rapid assessment of human resource capacity in RCHS	Consultancy @Tsh 660,000/day x 30 days + meeting of 50 pax @Tsh 24,500 /pp x 2 days			29,700								29700
	2.2.2: Develop National, regional and district eMTCT - Paediatric HIV care and treatment training plans,	Consultancy @ Tsh 660,000/day x 45days + 2 day meeting of 15 pax @Tsh 24,500/pp & 25pax @Tsh 165,000 out of town		34,193							41,373		75566
	2.2.3: Review and update pre-service training materials	Consultancy @Tsh 660,000/day x 30 days + meeting of 50 pax @Tsh 24,500 /pp x 2 days every 2 years					21,285				25,755		47040
	2.2.4: Collaborate with HRD to train pre-service curriculum for TOTs in PMTCT and Pediatric HIV care and treatment	Costs covered under human resource development (HRD)											0
	2.2.5: Build capacity to the national, regional and district RCH/ HIV & AIDS TOT teams in PMTCT, EID and Paediatric HIV care and treatment	25 TOTs per district @ Tsh 4,194,500 per district every year	139,467	139,467	139,467	139,467	153,414	153,414	153,414	153,414	675,021	742,523	2589068

Strategic Objective 2: To develop institutional and Human resource capacity in comprehensive eMTCT and paediatric HIV care and Treatment													Total
			2012				2013				2014	2015	
Strategies	Detailed activities	Costing assumptions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
	Assist the training of CHWs to support eMTCT and Paediatric HIV care)	Costs covered elsewhere											0
	2.2.6: Provide training equipment and materials to the regional and district PMTCT TOT teams	Covered under various trainings											0
	2.2.7: Conduct modular training/refreshers of health providers (in PMTCT , EID and Paediatric HIV care and treatment	Various trainings for 86,389 person training days in 2012, 55,918 persons days 2013, 27,160 person days in 2014, and 22,367 person days in 2015 @ 214,600 per person day	5,088,192	5,088,192	5,088,192	5,088,192	2,969,554	2,969,554	2,969,554	2,969,554	6,872,376	5,817,193	44920553
	2.2.8: Train health workers on infant and young child feeding counseling	Under 2.2.7											0
	2.2.9: Establish systematic follow up and post-training support for all trainees	Under 2.2.7											0

Strategic Objective 2: To develop institutional and Human resource capacity in comprehensive eMTCT and paediatric HIV care and Treatment													Total
			2012				2013				2014	2015	
Strategies	Detailed activities	Costing assumptions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
	2.2.10: Conduct mentoring of health workers	Under 2.2.7											0
	2.2.11: Scale up zonal Pediatric HIV care and treatment centers of excellence	Cost covered ART programme											0
	2.2.12: In collaboration with SRH, review /develop/ print and distribute AFSRH curricula	Covered in HRD											0
	2.2.13: Support training institutions to roll out trainings on AFSRH	Covered in HRD											0

Strategic Objective 2: To develop institutional and Human resource capacity in comprehensive eMTCT and paediatric HIV care and Treatment													Total
			2012				2013				2014	2015	
Strategies	Detailed activities	Costing assumptions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
Strategy 2.2: Improve infrastructure and equipment of quality Reproductive, maternal, new born and child health services for delivery of quality antenatal and delivery services at all levels	2.3.1: Upgrade /renovation of existing ANC and maternity for provision of PMTCT/ART	Cost under health systems strengthening - not eMTCT specific											0
	2.3.2: Establish care and treatment within RCH	Covered elsewhere											0
	Sub-total		5,227,659	5,261,851	5,257,359	5,842,944	3,738,252	3,122,967	3,122,967	3,122,967	9,077,760	6,559,716	50334442



Strategic Objective 3: To provide Quality integrated comprehensive eMTCT services that will reduce new infection among children and keep mothers alive at all levels													Total
			2012				2013				2014	2015	
Strategies	Detailed activities	Costing assumptions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
Strategy 3.1: Expand provision of HIV services for Primary prevention among young women and their partners	3.1.1: Provide HIV and syphilis prevention information and promote HIV testing	Counselling and testing at cost of Tsh 1,824 per person	1,352,319	1,352,319	1,352,319.03	1,352,319.03	1,447,857	1,447,857	1,447,857	1,220,156	5,999,883	6,344,638	23,317,524
	3.1.2: Promote early initiation of ANC (at least by 12-14 weeks)	under community mobilization											0
	3.1.3: Provide re-testing for HIV negative pregnant women	Counselling and testing at cost of Tsh 1,824 per person	67,646	67,646	67,646	67,646	72,425	72,425	72,425	72,425	300,126	317,372	1,177,782
	3.1.4: Promote couple/partner testing and counseling for all young women	Counselling and testing at cost of Tsh 1,824 per person	290,847	290,847	290,847	290,847	340,735	340,735	340,735	340,735	1,571,779	1,790,239	5,888,346
	3.1.5: Promote condom use/ dual protection among young women	Cost under other HIV prevention interventions apart from eMTCT											0

Strategic Objective 3: To provide Quality integrated comprehensive eMTCT services that will reduce new infection among children and keep mothers alive at all levels													Total
			2012				2013				2014	2015	
Strategies	Detailed activities	Costing assumptions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
	3.1.6: Promote safer sex for discordant couples,	Cost under other HIV prevention interventions apart from eMTCT											0
	3.1.7: Provide STI treatment to young women and their partners	Costs under general curative health services											0

Strategic Objective 3: To provide Quality integrated comprehensive eMTCT services that will reduce new infection among children and keep mothers alive at all levels													Total
			2012				2013				2014	2015	
Strategies	Detailed activities	Costing assumptions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
Strategy 3.2: Expand provision of services that prevent unintended pregnancies among HIV infected women	3.2.1: Finalise and disseminate protocols for integration of FP into other MNCH and HIV services	Consultancy @Tsh 660,000/day x 30 days + meeting of 50 pax @ Tsh 24,500 / pp x 2 days every 2 years			21,285								21285
	3.2.2: Integrate family planning counseling and services including condoms provision into RCH and HIV sites	Covered under training of health workers in 2.2.7											0
	3.2.3: Provide family planning services through community based structures.	Covered in Family Planning Strategy											0
	Print and disseminate FP tools	Covered in Family Planning Strategy											0

Strategic Objective 3: To provide Quality integrated comprehensive eMTCT services that will reduce new infection among children and keep mothers alive at all levels													Total
			2012				2013				2014	2015	
Strategies	Detailed activities	Costing assumptions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
Strategy 3.3: Increase access to more efficacious ARV regime for HIV infected pregnant women and HIV exposed infants within the RCH platform.	3.3.1: Institutionalize routine offer for HIV testing to all pregnant women	Costs covered under HIV testing above			21,285								21285
	3.3.2: Ensure provision of eMTCT prevention to HIV infected pregnant women and their children as per National guideline at all levels	ARV prophylaxis - 60% of HIV positive women (coverage of 74% of eligible HIV positive women in 2012, and 90% in 2015) at cost of Tsh 92,578 per pregnant woman											0
		ARV treatment (40% of HIV positive pregnant women). (Coverage of 74% of eligible HIV positive women in 2012, and 90% in 2015). Tsh 652,175 per woman per year. However, this cost is borne by ART programme											

Strategic Objective 3: To provide Quality integrated comprehensive eMTCT services that will reduce new infection among children and keep mothers alive at all levels													Total
			2012				2013				2014	2015	
Strategies	Detailed activities	Costing assumptions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
	3.3.4: Finalize and disseminate guideline for integration of ART/HIV into MNCH services	Cost under ART programme											0
	3.3.5: Ensure access to CD4 testing	Cost of CD4 testing in 3.3.2 and POC CD machines											0
	3.3.6: Scale up Provision of integrated Care and Treatment with RCH services	Cost under ART programme											
	3.3.7: Promote access to safe delivery by skilled attendant	Costs under general health services											
	3.3.8: Provide quality infant feeding counseling and support	Costs under general health services											

Strategic Objective 3: To provide Quality integrated comprehensive eMTCT services that will reduce new infection among children and keep mothers alive at all levels													Total
			2012				2013				2014	2015	
Strategies	Detailed activities	Costing assumptions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
Strategy 3.4: Expand provision of appropriate treatment; care and support to HIV infected mothers and their infants and families	3.4.1: Procure and provide Cotrimoxazole prophylaxis	Costs under 3.3.2 and 3.4.2			21,285								21285
	3.4.2: Scale up HIV testing to HIV exposed children according to guidelines	PCR testing at 6 weeks, 9 months and rapid tests at 12 months. PCR test at Tsh 23,100 and rapid test at Tsh 1,650	754,307	754,307	754,307	754,307	889,621	889,621	889,621	889,621	3,990,595	4,493,259	15,059,566
	3.4.3: Scale up EID services in all PMTCT sites with operational sample transportation system to reference laboratory,	Deliver samples @ 8 days a month per lower level facility @ Tsh 99,000 per month. The need for this service will reduce with continued purchase of POC CD4 machines, and this is captured in the costing	128,304	128,304	128,304	128,304	85,536	85,536	85,536	85,536	171,072	59,400	1,085,832

Strategic Objective 3: To provide Quality integrated comprehensive eMTCT services that will reduce new infection among children and keep mothers alive at all levels													Total
			2012				2013				2014	2015	
Strategies	Detailed activities	Costing assumptions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
	3.4.4: Introduce use of mobile technology to follow up HIV infected women and children	Sms cost Tsh 99,000 per facility per month - 25% of facilities covered in 2012, 75% by end of 2013, and 100% in 2014 & 2015			711,761	711,761	1,067,641	1,067,641	1,067,641	1,067,641	1,423,521	1,565,873	8,683,480
	3.4.5: Provide ART to infants and children	Cost under normal HAART and not eMTCT											0
	3.4.6: Establish and operationalize HIV infected mother support groups	Cost under training of support groups											0
	3.4.6: Establish Breast feeding support groups	Cost under training of support groups											0

Strategic Objective 3: To provide Quality integrated comprehensive eMTCT services that will reduce new infection among children and keep mothers alive at all levels													Total
			2012				2013				2014	2015	
Strategies	Detailed activities	Costing assumptions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
Strategy 3.5: Increase adolescents' access to, and utilization of integrated quality reproductive health services	3.5.1: Strengthened human resource development on AFSRH	costs under HRD											0
	3.5.2: In collaboration with SRH , assess existing national curricula	costs under HRD											0
	Sub-total		19,663,145	19,663,145	20,396,190	20,374,905	22,106,562	22,106,562	22,106,562	21,878,861	89,997,151	95,147,519	353,440,602

Strategic Objective 4; To strengthen Community awareness and involvement in the delivery of community eMTCT and Paediatric HIV care and Treatment services													Total
			2012				2013				2014	2015	
Strategies	Detailed activities	Costing assumptions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
Strategy 4.1: Develop a community service package for eMTCT and Paediatric HIV care and treatment utilizing community health workers based on models that have proved to be effective (best practices)	4.1.1: Review the existing community based models and identify best practices	Consultancy @Tsh 660,000/day x 30 days + meeting of 50 pax @ Tsh 24,500 / pp x 2 days				21,285							21285
	4.1.2: Compile best practices and harmonise approaches into a comprehensive community service package	Cost under 4.1.1											0
	4.1.3: Pre and finalize the community package for eMTCT	Consultancy @Tsh 660,000/day x 30 days					19,800						19800
	4.1.4: Print and disseminate the community package	Produce, printing, and disseminate @Tsh 49,500/copy x 10,000 copies						495,000					495000

Strategic Objective 4: To strengthen Community awareness and involvement in the delivery of community eMTCT and Paediatric HIV care and Treatment services													Total
			2012				2013				2014	2015	
Strategies	Detailed activities	Costing assumptions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
Strategy 4.2: Strengthen community systems and structures to deliver the community service package of eMTCT and Paediatric HIV care and treatment	4.2.1: Identify existing community structures to deliver the national plan for eMTCT	Costs covered in 4.1.1 and 4.1.2											0
	4.2.2: Identify existing community organizations, civil society activities, and professional organizations to support of community structures	Consultancy @ Tsh 660,000/day x 30days + 1 day meeting of 20 pax @ Tsh 24,750/pp					20,295						20295
	4.2.3: Identify existing and diverse types of community based health workers	Cost under 4.2.1											0
	4.2.4: Standardize the selection criteria, training, supervision and compensation of CHWs	Cost under HRD											0

Strategic Objective 4; To strengthen Community awareness and involvement in the delivery of community eMTCT and Paediatric HIV care and Treatment services													Total
			2012				2013				2014	2015	
Strategies	Detailed activities	Costing assumptions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
	4.2.5: Identify and train at least 2 CHWs per village to implement community based interventions.	Covered under trainings											0
	4.2.6: Train community organizations, PLHIV and civil society organizations	Covered under trainings											0
	4.2.7: Accelerate and standardize setting up Pediatric HIV care and xtreatment support groups,	Cost covered elsewhere such HIV support groups											0

Strategic Objective 4; To strengthen Community awareness and involvement in the delivery of community eMTCT and Paediatric HIV care and Treatment services													Total
			2012				2013				2014	2015	
Strategies	Detailed activities	Costing assumptions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
Strategy 4.3: Engage community systems and structures to deliver the community service package of eMTCT and Paediatric HIV care and treatment	4.3.1: Launch the eMTCT campaign at District and community level	Cost covered under advocacy											0
	4.3.2: Utilization of Village/ward council meetings to create community awareness on eMTCT.	Cost covered under advocacy											0
	4.3.3: The use of mobile phones (mHealth) for the follow up of PLHIV women and their exposed infants/children	Cost covered under 3.3.4											0
	4.3.4: Engagement of the facility HCWs to monitor and supervise the CHWs and PLHIV groups	Costs covered elsewhere											0
	4.3.5: Engagement of CHWs to provide HIV prevention information and promote HIV testing as a routine service in all RCH sites	Cost under general health services											0
	4.3.6: Conduct outreaches by CHWs	Cost covered under 3.3.4											0
	4.3.7: Engagement of HIV positive women	Costs under support groups training in training cost in 2.2.7											0
	Sub-total		-	-	-	21,285	40,095	495,000	-	-	-	-	556380

Strategic Objective 5: To strengthen systems for monitoring and evaluation of eMTCT and paediatric HIV care and treatment services at all levels													Total
			2012				2013				2014	2015	
Strategies	Detailed activities	Costing assumptions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
Strategy 5.1: Strengthen and Operationalize the eMTCT M & E System	5.1.1: Establish M & E technical working group	Retreat of 30 people @ Tsh 165,000person x 2 days			9,900								9900
	5.1.2: Conduct regular reviews of the eMTCT planned targets and achievement at all levels -	One regional or district meeting @ Tsh ,2760,000, and national @ Tsh 1.287,500			425,040	-	467,544	-	514,298	-	1,080,027	1,188,029	3674938
	5.1.3: Finalize M & E Framework/Plan	Meeting of 30 people @ Tsh 165,000 per person x 2 days + consultancy at Tsh 660,000 /day for 14 days		19,140									19140
	5.1.4: Capacity building at Central and National Level.	Costs under HRD											0
	5.1.5: integration of eMTCT M & E in HIV communication strategy	Costs covered elsewhere											0

Strategic Objective 5: To strengthen systems for monitoring and evaluation of eMTCT and paediatric HIV care and treatment services at all levels													Total
			2012				2013				2014	2015	
Strategies	Detailed activities	Costing assumptions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
Strategy 5.2: Improve the routine monitoring and evaluation of eMTCT and Pediatric HIV care and treatment	5.2.1: Disseminate indicators for integrated eMTCT and Paediatric HIV care and treatment to Regional and district teams	1 meeting of 30 people per region at cost of Tsh 1,250,000 per meeting, 1 meetings of 30 people per district at cost of Tsh 2,070,000 per meeting			150,780	150,780							301560
	5.2.2: Develop/update and distribute M&E data recording, reporting and quality assurance tools	Printing @ Tsh 33,000/ copy x 10,000 copies				82,500							82500
	5.2.3: Develop mechanism to ensure availability of quality eMTCT data	Costs covered elsewhere											0
	5.2.4: Review/Scale up the existing DHIS database to capture eMTCT and Ped. HIV information	Costs covered under overall health sector M&E											0
	5.2.5: Develop and scale up Facility based PMTCT database	500 computer/printer/UPS sets/modem sets @ Tsh 41,250,000		309,375	309,375	309,375	309,375	226,875	226,875	226,875	226,875		2145000
	5.2.6: Train/refresh regional and district ToTs/HCWs on M&E for eMTCT	25 TOTs per district @ Tsh 4,194,500 per district every year and 4 per region at Tshn 671,120	142,991	142,991	142,991	142,991	157,290	157,290	157,290	157,290	692,074	761,281	2654479
	5.2.7: Conduct joint supportive supervision visits	Cost covered overall supervision											

Strategic Objective 5: To strengthen systems for monitoring and evaluation of eMTCT and paediatric HIV care and treatment services at all levels													Total
			2012				2013				2014	2015	
Strategies	Detailed activities	Costing assumptions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
Strategy 5.3: Carry out operational research (OR) surveillance and Surveys to guide program implementation	5.3.1: Refine/review national Operational Research priorities issues for eMTCT and Paediatric HIV care and treatment	Meeting of 50 people @ Tsh 165,000pp x 5 days	41,250										41250
	5.3.2: Conduct operational research	3 OR projects / year @ Tsh 33,000,000 each				99,000				108,900	119,790	131,769	459459
		1 survey / year @ Tsh 82,500,000				82,500				90,750	99,825	109,808	382883
	5.3.3: Establish eMTCT surveillance system to monitor transmission	Cost covered under strategy 5.2											0
	5.3.4: Conduct Mid term and End term Evaluation of the implementation of eMTCT	Consultancy @ Tsh 660,000 /day x 60 days + 4 review teams of 5 each @ 165,000pp/day x 5 days								61,710		74,669	136379

Strategic Objective 5: To strengthen systems for monitoring and evaluation of eMTCT and paediatric HIV care and treatment services at all levels													Total
			2012				2013				2014	2015	
Strategies	Detailed activities	Costing assumptions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
Strategy 5.4: Improve PMTCT Services provision through promoting data use	5.4.1: Identify, document and share the innovations and best practices	Consultancy @ Tsh 660,000/day x 30days + 1 day meeting of 20 pax @ Tsh 24,750/pp							22,325		24,557		46882
	5.4.2: Dissemination plan for various levels	Costs covered elsewhere											0
	5.4.3: Introduce performance based system for regions/district	No direct eMTCT cost attached											0
	5.4.4: Develop data analysis and utilization package.	Costs under overall health sector M&E											0
	Sub-total		184,241	471,506	1,038,086	867,146	934,209	384,165	920,787	645,525	2,243,148	2,265,556	9,954,369

Strategic objective 6: Strengthen health logistics to include comprehensive management of PMTCT commodities													Total
			2012				2013				2014	2015	
Strategies	Detailed activities	Costing assumptions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
Strategy 6.1: Review/commit/mobilize resources for eMTCT related commodities (ARVS, OIs, FP, Rapid HIV test kits, DBS kits) to ensure continuous commodity availability	6.1.1: Conduct donors mapping in relation to eMTCT commodities	Consultancy @ Tsh 660,000/day x 30days + 1 day meeting of 20 pax @ Tsh 24,750/pp			20,295								20295
	6.1.2: Mobilize resource to filling the gap	Task force to be formed for resource mobilization. Annual cost of the task force will be established											0
	6.1.3: Advocate for innovative strategies to expand the AIDS fund basket	Task force to be formed for resource mobilization.											0

Strategic objective 6: Strengthen health logistics to include comprehensive management of PMTCT commodities													Total
			2012				2013				2014	2015	
Strategies	Detailed activities	Costing assumptions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
Strategy 6.2: Increase the capacity of RHMT, CHMT and health care workers at all levels in managing PMTCT commodities	6.2.1: Train commodities managers on forecasting procurement and supply chain management	10 day training workshop of 10 persons at Tsh 147,000 per person per day (JSI estimate of the unit cost)					14,700						14700
	6.2.2: Develop SoP manuals for Commodity management and rational use	Consultancy @ 240,000 per day per day per for seven days one time effort (JSI estimate)						1,680					1680
	6.2.3: Print of logistic management tools	Registers for PMTCT commodities =14000x 8000 (point of usage section) = TZS 112,000,000 annually starting 2013 year2; Report forms 14000x 4000 (facilities) 56,000,000 annually stating year 2013 (JSI estimates)					168,000				184,800	203,280	556080
	6.2.4: Conduct meeting with DED & DMO on logistic management	Costs under advocacy above											0
	6.2.5: Train RHMT & CHMT on commodity management	Cost covered under training in 2.2.7											0

Strategic objective 6: Strengthen health logistics to include comprehensive management of PMTCT commodities												Total	
			2012				2013				2014	2015	
Strategies	Detailed activities	Costing assumptions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
Strategy 6.3: Integrate the management of PMTCT commodities with other health commodity logistics systems to increase data visibility and product availability	6.3.1: Review the current PMTCT commodity management systems/ management tools	3 day workshop of 10 people. Per diem Tsh 80,000 pp/d, meal Tsh 10,000 pp/d, materials @ Tsh 5,000 pp, transport Tsh 15,000 per person (pp), conference hall Tsh 100,000 per day,			4,660								4660
	6.3.2: Conduct workshop to discuss the Integration of PMTCT management commodities tools with other commodities managed at SDP	2 day workshop of 10 people. Per diem Tsh 80,000 pp/d, meal f Tsh 10,000 pp/d, materials @ Tsh 5,000 pp, transport Tsh 15,000 per person (pp), conference hall Tsh 100,000 per day,				3,680							3680
	6.3.3: Conduct workshop to review the PMTCT and other commodities managed under ILS	1 day workshop of 10 people. Per diem Tsh 80,000 pp/d, meal Tsh 10,000 pp/d, materials @ Tsh 5,000 pp, transport Tsh 15,000 per person (pp), conference hall Tsh 100,000 per day,					1,420						1420

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Strategic objective 6: Strengthen health logistics to include comprehensive management of PMTCT commodities													Total
			2012				2013				2014	2015	
Strategies	Detailed activities	Costing assumptions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
Strategy 6.5: Increase the capacity of health care facilities to store PMTCT commodities to comply with storage guidelines	6.5.1: Conduct the assessment on storage capability	Not eMTCT specific hence not costed											0
	6.5.2: Review/Design the standard structure for medicine storage	Not eMTCT specific hence not costed											0
	6.5.3: Conduct meeting to sensitize CHMTs and RHMT	Not eMTCT specific hence not costed											0

Strategic objective 6: Strengthen health logistics to include comprehensive management of PMTCT commodities													Total
			2012				2013				2014	2015	
Strategies	Detailed activities	Costing assumptions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
Strategy 6.5: To strengthen Logistics, supply chain management including drugs, diagnostics and other medical supplies	6.6.1: Establish coordinating mechanisms at central level to aggregate and manage logistics data	Costs covered under national logistic system											0
	6.6.2: Develop a national plan for maintaining the continuous availability of eMTCT & Pediatric HIV care and treatment supplies	Retreat of 30 people @ Tsh 165,000 per person x 2 days + consultancy at Tsh 660,000 /day for 14 days			19,140								19140
	6.6.3: Develop and implement a system for regular quantification of eMTCT and Paediatric HIV medicines, diagnostics and medical supplies, taking into account targets and capacity at national, regional and district levels	Training of the CHMTs (1995 persons) on leadership, coordination and follow up skills of the logistics and supply chain management @Tsh 264,000 per person	131,670	131,670	131,670	131,670							526680
		Training/orient of HCWs on forecasting for EID, ARV, Cotrimoxazole and data utilization and rational use of commodities. 2 people per facility, 3 days training, for all PMTCT sites spread through four years (@ Tsh 214,600 per person	171,430	171,430	171,430	171,430	188,573	188,573	188,573	188,573	829,719	912,691	3182422
	6.6.4: Procure eMTCT and other Pediatric HIV medicines, diagnostics and supplies	Costs covered under various testing, ARV prophylaxis and ART treatment											

Strategic objective 6: Strengthen health logistics to include comprehensive management of PMTCT commodities													Total
			2012				2013				2014	2015	
Strategies	Detailed activities	Costing assumptions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
Strategy 6.5: To strengthen Logistics, supply chain management including drugs, diagnostics and other medical supplies	6.6.5: Maintain a stock-control system for eMTCT and Pediatric HIV medicines & diagnostics	Cost covered elsewhere											0
	6.6.6: Conduct bi-annual partners meetings allocation.	Meeting of 30 persons semi-annually at Tsh 49,500 per person			19,140								19140
	6.6.7: Conduct annual Focused Training of the CHMTs	Cost covered in 2.2.7	131,670	131,670	131,670	131,670							526680
	6.6.8: Procurement and distribution of the HIV test kits, at least 1 POC - CD4 machines per facility & ARVs.	Tests kits cost covered tests,											
		Procurement of 100 CD4 machines every year @ 8,250,000 per machine, POC reagents cost covered under CD4 testing		275,000	275,000	275,000	297,000	297,000	297,000	297,000	1,188,000	1,188,000	4389000
	6.6.9: Training/orientation of HCWs on forecasting	Cost in 6.6.3											
	Sub-total		304,585	681,400	860,933	926,993	688,317	640,454	509,298	650,144	2,574,399	3,057,057	10,893,580
	Grand total		25,852,795	28,998,172	30,515,480	32,855,900	32,163,032	27,450,558	27,416,207	27,117,068	106,597,484	110,005,377	448,972,073



7.0 Roles and responsibilities towards achieving elimination

7.1 Ministry of Health and Social Welfare (Central, MSD and Zonal level)

- Coordinate and supervise different partners implementing eMTCT and Pediatric HIV care and treatment activities in the country.
- Mobilize resources and advocate for eMTCT and Pediatric HIV care and Treatment.
- Overall technical leadership guidance, advice, Monitoring and Evaluation on the implementation of eMTCT and Pediatric HIV care and treatment, ensuring availability of essential drugs and supplies by facilitating efficient procurement and distribution to all levels of service delivery.
- Facilitate effective development, recruitment and deployment of skilled health workers at health facilities in collaboration with PMO-RALG and the President's office-Public services management (PO-PSM).
- Review and harmonize the existing Health Management Information system (HMIS) and Community base management information system (CBMIS) in collaboration with the district councils.
- Facilitate the integration of eMTCT and Pediatric HIV care and treatment with other RCH community based interventions and programmes.
- Design, develop and disseminate eMTCT and Pediatric HIV care and treatment guidelines, Training material Monitoring and Evaluation tools, Develop IEC/BCC materials with the involvement of other stakeholders
- Identify and propose eMTCT and Pediatric HIV care and treatment monitoring indicator, update monitoring/data recording and reporting tools.
- Organize and Coordinate eMTCT and Pediatric HIV care and treatment research in collaboration with research institutions.

7.2 PMTCT Unit/Reproductive and Child health section, Directorate of preventive services

- The Role of PMTCT programme management Unit at the National level is to plan, design, coordinate and monitor the national programme. Specifically, it will undertake the following activities:
- Advocate for the implementation of eMTCT and Pediatric HIV /AIDS care and treatment strategies and scale up plan.
- Coordinate the implementation, monitoring and evaluation of eMTCT and Pediatric HIV care and treatment interventions.
- Involve and collaborate with various stakeholders at all levels for planning and implementation of the eMTCT and Pediatric HIV care and treatment Facilitate capacity development at national, zonal, regional and district levels by developing guidelines, protocols and training packages for eMTCT and Pediatric HIV care and treatment Design and develop IEC/BCC materials with stakeholders and disseminate them to the intended users.
- In collaboration with the procurement unit, facilitate procurement of ARV, HIV test kits and other laboratory supplies and their distribution to all health facilities
- Design and develop a monitoring and evaluation framework and ensure availability of recording and reporting tools for PMTCT and Pediatric HIV care and treatment that includes nutrition, postnatal care, child care including user friendly data base.

- Promote research on PMTCT and Pediatric HIV care and treatment Capacity development for the implementation of PMTCT and Pediatric HIV care and treatment
- Lead and coordinate the promotion of eMTCT, pediatric HIV care and treatment best practices that will be identified through routine M&E and periodic evaluation and operational research.

7.3 PMO-RALG (Central Level)

- Facilitate effective recruitment and deployment of skilled health workers at health facilities in collaboration with MOHSW and Presidents Office-Public Services Management
- Collaborate with various stakeholders at all levels for planning and implementation of Health Programmes.
- Design and develop planning guidelines (MTEF, Opportunities and Obstacles to Development)

7.4 RMO/Regional Health Management Teams

- Provide technical support during planning and implementation of eMTCT and Pediatric HIV care and treatment at the district/council level by assisting CHMTs to include eMTCT and Pediatric HIV care and treatment activities in the CCHP
- Ensure quality training of health care providers on eMTCT and Pediatric HIV care and treatment at the district level
- Analyze, compile, disseminate and use received eMTCT and Pediatric HIV care and treatment reports and data from the districts/councils and send to the National Level
- Coordinate, supervise and monitor eMTCT and Pediatric HIV care and treatment activities and partners in the region

7.5 Local Government Authorities (City, Municipal, and District Councils)

- Planning, implementation, Monitoring and Evaluation of eMTCT and Pediatric HIV care and treatment activities at the Council level
- Coordinate different stakeholders implementing eMTCT and Pediatric HIV care and treatment activities in the district/Council level - Council Management Teams, District/Council Health boards and council standing committees to ensure adequate resource allocation for eMTCT and Pediatric HIV care and treatment activities
- Advocate for the implementation of eMTCT and Pediatric HIV care and treatment activities

7.6 DMO/Council Health Management Teams

- Planning and incorporating eMTCT and Pediatric HIV care and treatment activities into the Comprehensive Council Health Plan (CCHP) then into the council plan
- Implementation, Monitoring/Supervision and Evaluation of eMTCT and Pediatric HIV care and treatment activities at the District/Council level
- Provide technical support for quality eMTCT and Pediatric HIV care and treatment services at the health facility level/ (district hospital, health centers, dispensaries) including voluntary agencies and private health facilities
- Ensure quality eMTCT and Pediatric HIV care and treatment training of service providers is conducted

- Mobilize and Coordinate partners and resources for implementation of eMTCT and Pediatric HIV care and treatment activities in the District
- Ensure follow up mechanism up to the community level for eMTCT and Pediatric HIV care and treatment is in place through involvement of community owned resource persons (CORP)
- Involve and collaborate with stakeholders for planning and implementation of PMTCT and Pediatric HIV care and treatment activities in the District/Council
- Capacity building/training of the existing CORPS on eMTCT and Pediatric HIV care and treatment
- Facilitate the incorporation of eMTCT and Pediatric HIV care and treatment activities into the village plans through O and OD planning process
- Establish and/or strengthen the community based management information system.
- Strengthen HMIS by Compiling, disseminating and use eMTCT and Pediatric HIV care and treatment data for service improvement
- Compile, disseminate and use eMTCT and Pediatric HIV care and treatment data for program improvement

7.7 Health facilities (Hospitals, Health centers, and Dispensaries)

Health facility-based interventions:

- Information and education on preventing HIV transmission
- HIV testing and counseling, including: Provider-initiated testing and counseling, Couple counseling and testing, Infant testing and diagnosis, and Family testing and counseling
- Prevention of mother-to-child transmission of HIV, including: Information and counseling on preventing HIV transmission, Family planning for pregnant women living with HIV, Use of antiretroviral drugs to prevent HIV transmission from mother to child, Infant feeding counseling, and HIV treatment and care for infected mothers, infants and other family members
- Prevention of sexual transmission, including: STI detection and management, Safer sex and risk reduction counseling, Condom promotion and provision, Special interventions for adolescents
- Prevention of transmission in health-care settings, including: Safe blood, Universal precautions and safe medical waste management, Safe injections, and Post-exposure prophylaxis
- Prevention services for people living with HIV
- Clinical management of people living with HIV, including Co-trimoxazole prophylaxis and Management of opportunistic infections
- Community-based interventions: HIV testing and counseling, including voluntary HIV counseling and testing, home-based testing and counseling for partners, and community mobilization

7.8 Civil Society Organizations

Civil society is defined as groups both informal and formal that are non-government, yet offer services and support that enhances the public sector PMTCT and Pediatric AIDS programs. These groups include registered Non Governmental organizations (NGOs), Community Based Organizations (CBOs), PLHIV, , Community Owned Resource Persons and others. For the purposes of this document, private/NGO/FBO health facilities are described in 8.11 (public-private-partnership). ing on preventing HIV transmission, Family planning for pregnant women

- Role of CSO: It is expected that civil society groups play a role in implementing the National eMTCT and the Scale up Plan according to their capacities. CBOs, NGOs and CORPs can actively engage in supporting mobilization, community follow up and delivery of care as lay counselors.
- Male often influence women's access to and utilization of sexual Reproductive health and HIV services. Male involvement can result in reduced gender based violence ,increased contraception use, increased communication with spouse use of couple HIV counseling and testing that foster mutual disclosure and enhance uptake of services Districts and facilities should establish male support groups to jointly identify their roles and offer opportunities for them to be utilized
- Special role of women infected with HIV: women infected with HIV mobilized through support groups and mentoring programs have been found to improve the continuum of care for women and infants and play a role in Task sharing. Their role can be to work hand in hand with health facilities to educate other mothers, both pre and post natal, and provide intensive support and counseling during the pre and post natal periods and in the community. Establishment of "Family Support Groups" should be encouraged at facilities to educate women, provide mentoring and support and ensure women receive the highest possible quality of care.

7.9 Development Partners

USG and PEPFAR, UN Family (e.g. WHO, UNICEF, UNAIDS, UNDP, UNFPA, WFP), USG (US-AID, CDC, DOD, and Peace Corps), Global Fund for AIDS, Tuberculosis and Malaria, GTZ, and other development partners.

Roles of Development Partners (DPs):

- Coordination within themselves: DPs should coordinate themselves through their defined body (e.g. Donor Partner Group for HIV and for Health) and should ensure representation at the national Coordination Group for the National Scale Up Plan set up by the Ministry of Health and Social Welfare.
- Predictable Funding: The partners are requested to provide financial support to the National eMTCT Plan. Funding will be provided both through a variety of modalities, including direct budget or basket support and through support to projects that focus on eMTCT and Pediatric HIV care and treatment as part of comprehensive HIV and RCH services. In line with Paris Declaration, development partners are also requested to coordinate funding approaches and timing as much as possible for both funding to both the Government of Tanzania and to Civil Society.
- Strategy input: Development partners are requested to participate in development of national strategies to ensure wide acceptance and buy in. The role of development partners in stimulating Technical approaches and innovations is also valued and welcomed. The National eMTCT Plan and Pediatric HIV care and, Treatment will embrace the different approaches, but requests coordination at the national level through the DPG.
- Coordination of Implementing Partners: Development partners providing direct budget support should prioritize the national Scale up Plan within their programs and ensure funding and accountability for results. Development partners supporting projects should be aware of the technical approaches and progress of their funded partners and how they feed into the overall Plan.

7.10 Implementing Partners

The Overall role is to actively support the use and implementation of the national scale up plan and engage as active partners, working vertically, horizontally and synergistically to improve expansion, quality and access to services. The NACP and MOHSW have defined key partners to work in regions (regionalization of eMTCT and HIV care and treatment). These partners have special roles to support the broad scale up of eMTCT and Pediatric AIDS programs.

Specific roles include:

- Coordination and Partnership: Implementing Partners should coordinate amongst themselves at national level to share experiences, innovations and challenges in eMTCT and Pediatrics HIV care and treatment continuum of care. Implementing partners should be coordinated under the National Coordinating Body as well as their key donors.
- Supporting Program Implementation:
 - Assist Regions and Districts to identify needs/gaps for strengthening expansion and improving quality of eMTCT and Pediatric HIV care and treatment services.
 - Assist districts and regions to translate the National eMTCT plan into regional specific, actionable /effective comprehensive plans. Supporting innovative task sharing approaches such as use of lay counselors and non medical personnel, retired medical personnel and PLHIV including HIV+ women in supporting elements of care delivery and follow up.
 - Work with districts to ensure that eMTCT and Pediatric HIV care and treatment activities are prioritized and their respective funding allocations are reflected in the Comprehensive Council Health Plans
 - Develop innovations that can be tested and shared with regional and council health management teams, partners and MOHSW to improve implementation of the plan, uptake and outcomes of services.
- Capacity Building:
 - Assist the MoHSW in building capacity of CHMT and RHMT and NGO/FBOs to effectively plan, manage, implement and monitor the program.
 - In collaboration with RHMTs, CHMTs provide technical support, mentoring, training and supervision. Training will be both the standard packages and on-the-job Continuing Medical/Nursing Education.
 - In partnership with CHMTs build capacity to ensure councils have planned and ordered for key supplies and commodities and ensure no stock outs of co-trimoxazole, ARV prophylaxis, test kits and other laboratory supplies for PMTCT and Pediatric HIV care and treatment services.
 - In collaboration with MoHSW, RHMTs and CHMTs build/develop a solid sample transportation system for blood samples (DBS and CD4)
 - In collaboration with the MoHSW strengthen M&E systems at site and council level; ensure timely and accurate reporting through the district, regional and national structures.
 - In collaboration with CHMTs facilitate development or strengthening a Multidisciplinary team at facility level to include RCH, maternity, pediatric, pharmacy, and laboratory for improving quality and continuity of comprehensive care

7.11 Public and Private Partnerships

Private sector groups are defined here as groups with cost recovery and income schemes and have potential to greatly expand access of services for eMTCT and Pediatric HIV care and treatment, as well as to improve sustainability of the national program through less reliance on public sector or donor funding. The role of these groups is to implement the National Scale up Plan particularly as regards to implementing the technical approaches in accordance with the national guidelines.

The private sector offers a unique alternative to defray costs, by offering preventive and HIV services for free. These groups include Faith Based Health Facilities and Private for Profit and Not for Profit Health facilities (e.g. MST, UMATI, Private hospitals, clinics and dispensaries and maternity homes, private nurse midwives). Currently private sector clinics offer HIV services including eMTCT for free, although they may charge a fee for other related costs. Some clients may desire to see private providers and have resources to pay for services. We should encourage Private Hospitals to make eMTCT and Pediatric HIV care and treatment services available.

Private groups should have access to state of the art training and technical assistance to enable them to carry out quality services for clients. Private facilities should be encouraged to report their data through the district as per other partners.

8.0 Monitoring and evaluation of the plan

Successful implementation of the EMTCT framework will require continuously monitoring and adjustment of the implementation process. National indicators and targets have been developed and will be used for on-going performance tracking of the implementation of this framework. These indicators feed into global EMTCT monitoring indicators (Annex 1).

Regions, districts and facilities will be expected to set own targets in line with national targets. Decentralised level monitoring capacity will be key in improving data quality and routine systems. Data collection and reporting on the EMTCT indicators will in part be through routine monitoring, sentinel cohort monitoring, operations research, programme reviews and population level surveys

The routine monitoring systems and tools to be used include the **HMIS, LMIS, THMIS, and DHS**.

9.0 REFERENCES

1. The National Road Map strategic plan to accelerate reduction of maternal, newborn and child deaths in Tanzania 2008-2015
2. MoHSW, NACP 2011. HIV/AIDS/STI Surveillance Report, Report Number 22
3. MoHSW (Mainland), MoHSW (Zanzibar), WHO 2006. Tanzania Service Availability Mapping 2005–2006
4. MoHSW, Reproductive Health Section, 2009. National Scale up Plan for The Prevention of Mother-to-Child Transmission of HIV and Pediatric HIV Care and Treatment 2009 – 2013.
5. MoHSW, 2008. The National Road Map Strategic Plan To Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008 – 2015
6. National Bureau of Statistics (NBS) [Tanzania] and ICF Macro. 2011. Tanzania Demographic and Health Survey 2010. Dar es Salaam, Tanzania: NBS and ICF Macro
7. PEPFAR Tanzania, PMTCT Acceleration Plan 2012
8. Tanzania Commission for AIDS (TACAIDS), Zanzibar AIDS Commission (ZAC), National Bureau of Statistics (NBS), Office of the Chief Government Statistician (OCGS), and Macro International Inc. 2008. Tanzania HIV/AIDS and Malaria Indicator Survey 2007-08. Dar es Salaam, Tanzania: TACAIDS, ZAC, NBS, OCGS, and Macro International Inc.

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