



THE UNITED REPUBLIC OF TANZANIA
**MINISTRY OF HEALTH COMMUNITY DEVELOPMENT GENDER ELDERLY
AND CHILDREN**

Tanzania Mainland

**TANZANIA ELIMINATION OF MOTHER TO
CHILD TRANSMISSION OF HIV STRATEGIC
PLAN II
2018 – 2021**

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FOREWORD

Tanzania adapted the Global Plan for virtual elimination of Mother-to-Child Transmission of HIV launched in New York in June 2011 and translated it into local context by developing the 2012-2015 eMTCT Strategic Plan with a target of reducing new HIV infections among breastfeeding infants and children to 4%; and HIV attributed maternal deaths to zero by 2015. Today, five years since the implementation of the plan began, 69% fewer children are newly infected with HIV annually. This means that, every year about 15,000 children are saved from HIV infections. Maternal to Child Transmission rate at 6-weeks of age went as far down to 4% in 2015 while transmission after complete cessation of child exposure to breast milk was reduced from 26% in 2009 to 7.6% in 2015. HIV Infections among women aged 15-49 years decreased by 33% since 2009. During this period we realized a tremendous increase in Anti-Retroviral Treatment coverage among HIV infected pregnant and lactating women to above 90%. Antenatal Care Clinics HIV testing coverage was almost 92% in 2016 and HIV positivity among newly tested ANC attendees went down to almost 2.1% in 2016.

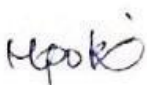
When the 2012-2015 Strategic Plan for Elimination of Mother –to-Child Transmission of HIV was launched, it was unimaginable that the successes we see today would have occurred. The progress achieved today is worthy celebration. It has been a great lesson to all of us that whenever there is commitment, accountability for everyone responsible, perseverance and partnership for all key stakeholders, results are always positive.

Despite the remarkable achievement obtained, still there is unfinished business. Service coverage for children and retention of mother-baby pairs are major challenges that need to be addressed without wasting time. Adolescent Girls and Young Women are less addressed even though studies show that the HIV epidemic is much more inclined towards this age group now. Contraceptive Prevalence Rate among HIV infected women is not promising at all.

The second Tanzania Strategic Plan for elimination of Mother-to-Child Transmission of HIV envisions to super-fast-track ending AIDS among Children, Adolescents and Young Women by 2021. It has been developed in-line with the Global Framework on **three** frees: Start Free (Zero New HIV infections among Children), Stay Free (Protection of Adolescents and Young Women from HIV infections) and AIDS Free (Provision of ART for all Children and Adolescents living with HIV).

It also builds upon the achievements of the earlier phase and concentrates in sustainable efforts to institutionalize the convergence of HIV/AIDS services in the health facilities.

The plan is expected to result in more children having a HIV-free start- a better chance to survive, thrive and fulfill their dreams. Furthermore, families and communities are expected to transcend through the powerful ripples of hope and healing.



Dr. Mpoki Ulisubisya
PERMANENT SECRETARY

ACKNOWLEDGEMENT

Development of the second Tanzania Strategic Plan for elimination of Mother-to-Child Transmission of HIV would not be possible without the devotion, tireless collaboration and participation of key stakeholders and consultants hired to review the 2012-2015 National eMTCT Strategic Plan and Develop this plan.

The Ministry of Health, Community Development, Gender, Elderly and Children would like to express sincere gratitude to all individuals, Ministerial Departments and Agencies, Development Partners, Implementing Partners and other stakeholders who worked with the Ministry to develop the second Tanzania Strategic Plan for elimination of Mother-to-Child Transmission of HIV. The completion of this document is a result of extensive consultations and collaboration with various stakeholders.

The Ministry acknowledges the financial and technical support from the Centers for Disease Control and Prevention of the United States of America (CDC) and United Nations Children Fund (UNICEF). Through this support consultants were hired and coordination of field works and stakeholders' meetings was possible. In particular the Ministry appreciates for the commendable job done by Winfred Mutsotso and Ms.Hafsa Khalfani from UNICEF in laying the foundation for the review of the previous plan and development of the New plan by engaging other partners in dialogue and resource mobilization.

The Ministry recognizes and acknowledges the hard work done by PriceWaterHouse Cooper's consultants (PwC). Sincere gratitudes should go to Dr. Ravish Behal (Lead Consultant), Dr.Francis Mhimbira (Epidemiologist), Dr. Sode Matiku (M&E Specialist), Ms. Happiness Saronga (Health economist), Dr. Rugola Mtandu (Bottleneck Analysis Specialist) and Mr. Evans Mwemezi (Pharmacist) for their tireless effort in collecting, analyzing and disseminating all the needed information for review of the previous and development of the new plan .

Sincere thanks should also go to Dr. Neema Rusibamayila, Director of Preventive Services at the Ministry of Health for her technical and moral support throughout the period of developing this plan.

Furthermore, the Ministry greatly appreciates the devotion of the PMTCT team; led by Dr. Deborah Mwikemo Kajoka for their endurance just to ensure that this plan comes out addressing important issues towards achieving the elimination goal. In particular, the Ministry acknowledges the commendable work done by Dr. Michael Msangi, Dr. Mukome Nyamhagatta, Dr Prosper Njau, Mrs. Elizabeth Sallu, Mrs. Levina Lema, Mrs. Grace Mtui, Ms. Pelagia Peshu Muchuruza, Mrs. Beatrice Sendegeya, Mrs. Mercy Kimaro and Mr. Jerome Ngowi and for their great contributions during the writing of the plan. The MoHCDGEC also appreciates the participation and contributions of Regional and District representatives through their inputs to the eMTCT Strategic Plan II.

It is not possible to mention each and every one who contributed to development of this noble strategic plan, however, the Ministry value the participation of all those who contributed in one way or the other.



Prof. Dr. Bakari Kambi
CHIEF MEDICAL OFFICER

ABBREVIATIONS

ANC	Antenatal Care
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral drugs
CHMT	Council Health Management Team
CHW	Community Health Worker
DHIS	District Health Information System
DQA	Data Quality Assessment
eMTCT	Elimination of Mother to Child Transmission
EUV	End User Verification
GFATM	The Global Fund to Fight against HIV/ AIDS, Tuberculosis and Malaria
HCW	Health Care Worker
HF	Health Facility
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
ILS	Integrated Logistics System
LLAPLa	Lifelong ART to Pregnant and Lactating women living with HIV
MoHCDGEC	Ministry of Health Community Development Gender Elderly & Children
MSD	Medical Stores Department
NACP	National Aids Control Programme
PEPFAR	President's Emergency Plan for AIDS Relief
PMTCT	Prevention of Mother to Child Transmission
PW	Pregnant Women
PWLHIV	Pregnant women living with HIV
RHMT	Regional Health Management Team
SCM	Supply Chain Management
STI	Sexually Transmitted Infection
TACAIDS	Tanzania Commission for AIDS
TB	Tuberculosis
TDHS	Tanzania Demographic and Health Survey
TFR	Total Fertility Rate
TSPA	Tanzania Service Provision Assessment survey
TZS	Tanzanian Shilling
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organisation

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The geographical territory of the United Republic of Tanzania is spread over an area of 945,087 sq. km making it the 31st largest in the world. Tanzania has an approximate population of 50,144,175 people of whom 24,412,889 are males and 25,731,286 are females. Forty six percent (46%) of the population is under 15 years of age. Twenty five percent (25%) of households are headed by women. On average a household has 4.9 members. About 77% of women and 83% of men in Tanzania are literate. Literacy is higher among women and men in urban Mainland areas than those in rural Mainland areas. The total annual health-related expenditure per household is Tanzanian shillings 48,332. Men are more likely to be exposed to all media than women. Among women and men, radio is the most widely accessed medium. 45% of women and 60% of men listen to the radio at least once a week. Newspapers are the least common medium among women (13%) and men (25%). A smaller percentage of women (8%) and men (16%) are exposed to all 3 forms of media. Almost half of women and 32% of men have no exposure to any of the mass media on a weekly basis. At current fertility levels woman in Tanzania will have an average of 5.2 children in her lifetime. The graph below shows fertility differentials for the past three years between Mainland Tanzania and Zanzibar and Urban and Rural

Figure 2: TFR Differentials between Tanzania Mainland and Zanzibar and Urban and Rural, 2015/2016, NBS 2016

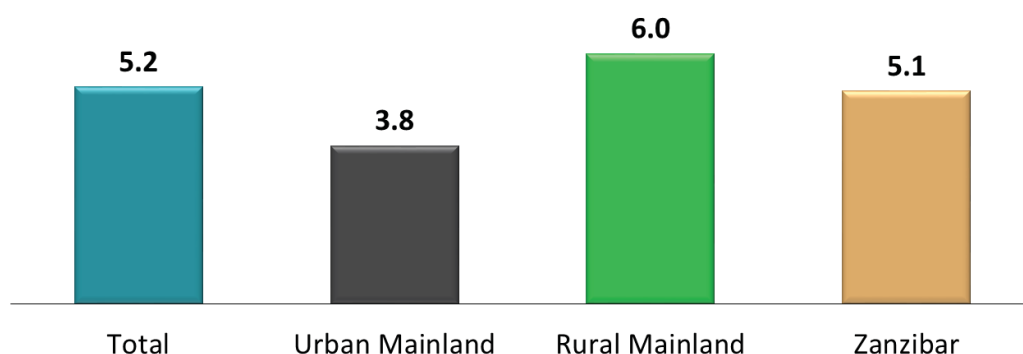


Figure 2: shows 3-year fertility differentials between Tanzania Mainland and Zanzibar and Urban and Rural. Zanzibar had a slightly lower fertility differential compared to Mainland Tanzania. Urban women had lower fertility differential as compared to rural women.

Fertility Trends

The six-year fertility trends show a decreasing lifetime number of children per woman. The graph below indicates how the fertility trend has been for the five-year Tanzania Demographic and Health surveys conducted between 1991 and 2016.

Figure 3: TFR trend among women aged 15-49 between 1991 and 2016, NBS 201

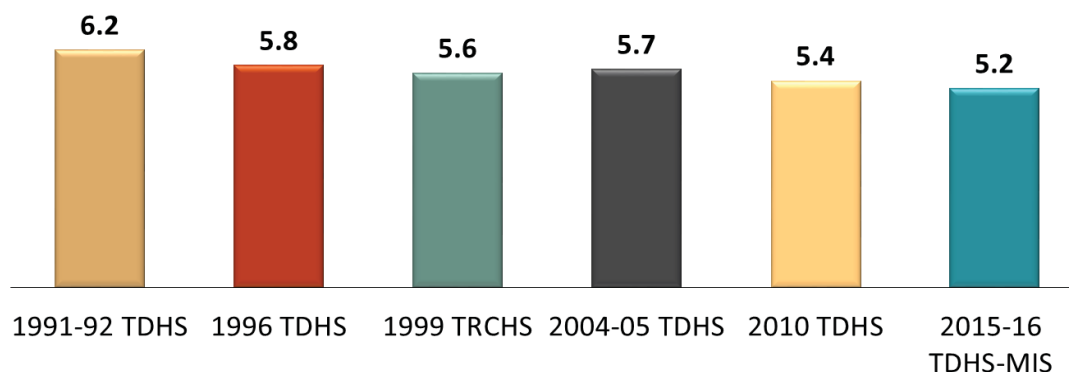


Figure 3: Shows a slightly decreasing TFR among women of reproductive age from 6.2 in 1991-92 to 5.2 in 2015-2016.

Birth Intervals and Teenage Pregnancies

Nineteen percent (19%) of Tanzanian children are born less than 24 months after a previous birth. The median birth interval in Tanzania is 35.0 months. Twenty one percent (21%) of young women between the ages of 15-19 are already mothers and 6% are pregnant with their first child. Tanzanian women begin sexual activity 1 year earlier than men; the median age at first sex for women age 25-49 is 17.2 years compared to 18.2 years for men. Women get married two years after sexual initiation at age 19.2. Men marry about 6 years after sexual initiation. The median age at first birth for women is 19.7 years, less than one year after marriage. 18% of currently married women and 9% of currently married men are in polygamous unions. For women, polygamy is defined as the percent of women who have one or more co-wife. For men, it is the percent with more than one wife. Twenty nine percent (29%) of currently married women want no more children or are sterilised. 22% of women want another child soon (within 2 years) while 42% of women want another child 2 or more years later. (NBS TDHS 2015-2016)

Family Planning

The contraceptive prevalence rate (CPR) is defined as the percentage of married women using a method of contraception. Currently, the CPR for Tanzania is 38% with 32% of married women using modern methods of contraception and 6% using any traditional method of contraception. Among married women, injectables, implants, and the pill are the most popular modern methods.

A greater percent (54%) of sexually active, unmarried women are using a method of contraception, and 46% are using a modern method. Injectables and male condoms are the most popular methods among sexually active, unmarried women. Use of modern methods is slightly higher in urban areas, where 47% of married women use modern methods, compared with 35% of women in rural areas. Regionally, modern contraceptive use ranges from a low of 7% in Kusini Pemba to a high of 52% in Lindi (NBS TDHS 2015-2016)

Figure 4: Contraceptive Prevalence rate among women aged 15-49 in Tanzania

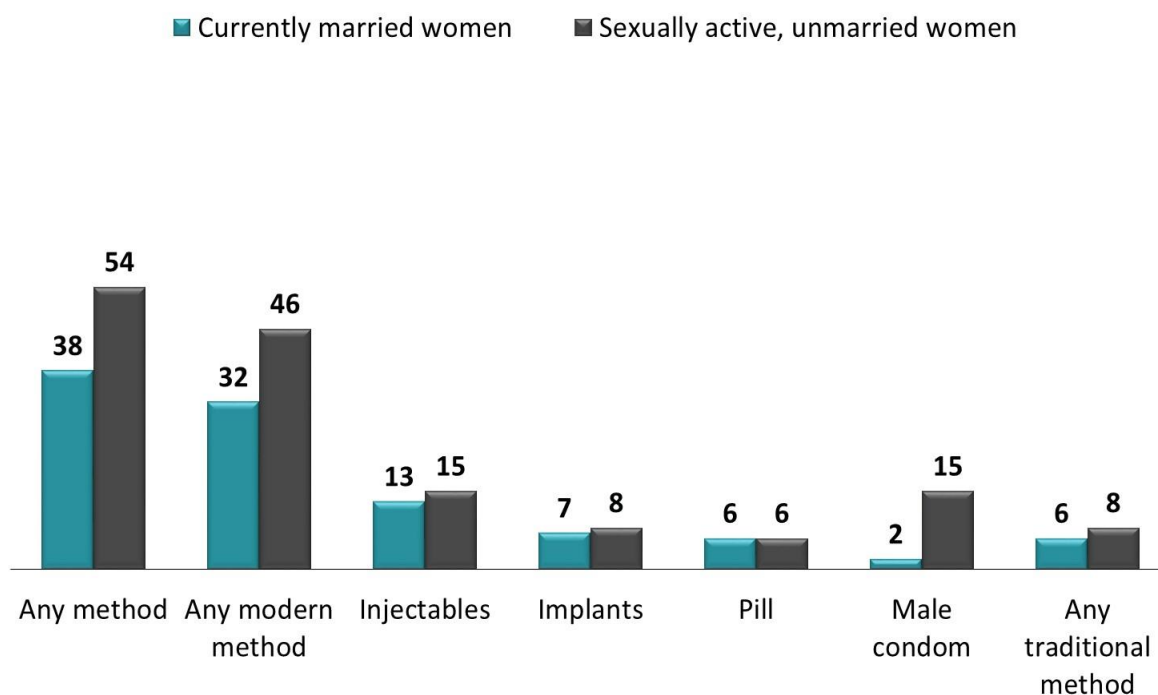


Figure 4: above shows injectable contraceptives were commonly used by both married and unmarried women compared to other methods. Male condom use for married women was very low at 2%.

Family Planning Trends

The use of family planning has been slightly increasing from 1991-2016. The graph below shows Family planning trends between the stated periods.

Figure 5: Trends in use of Family Planning Methods

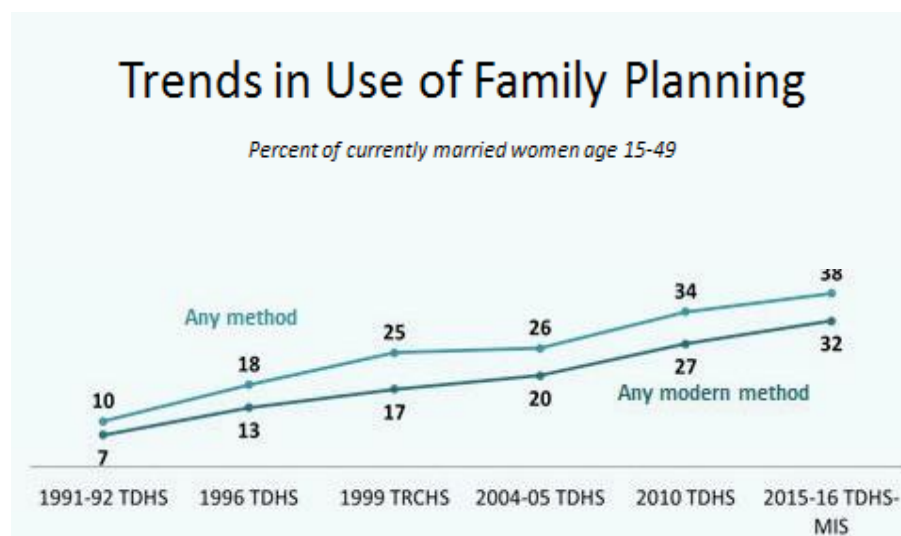


Figure 5: The graph above shows an increase of modern method use for contraception from 7% in 1991-92 to 32% in 2015-2016.

Unmet Need for Family Planning

Women are considered as having an unmet need for family planning if they are fecund and wish: to delay childbearing OR to limit childbearing altogether BUT are not using family planning 22% of currently married women have an unmet need for family planning.

Table 1: Tanzania demographic and epidemiological profile	
Indicators¹ <ul style="list-style-type: none"> • Total population (50.1 m) • Maternal mortality rate (556) • ANC coverage 1st visit (98%) • ANC coverage ≥ 4th visit (51%) • Skilled attendant deliveries (64%) • Population under 15 years (46%) • Population under 5 years (26%) • Under 5 mortality rate (67 per 1000 live births) • Infant mortality rate (43 per 1000 live births) • Pentavalent-1 coverage (97%) • Measles immunization coverage (86%) • Pentavalent-3 coverage (89%) • Rates of exclusive breastfeeding at 6m (60%) • Rates of stunting in children of age 0-59 months (27%) • Mean duration of breastfeeding (20 months) • Unmet need for FP in women of reproductive age living with HIV (22%) • Contraceptive prevalence rate for modern methods (32.4%) 	HIV/AIDS data <ul style="list-style-type: none"> • Number of people living with HIV/ AIDS (1.4m)² • Estimated number of mothers needing ART (86,000) • Mothers receiving PMTCT – effective regime (74,190) • Adult HIV prevalence (4.7%)³ • Pregnant women living with HIV accessing antiretroviral medicines (86%)³ • Mother to child transmission of HIV rates - 4% (six weeks) & 8% (final rate)³ • Rate of early infant diagnosis of HIV (42%)³ • Children living with HIV accessed antiretroviral therapy (56%) • Coverage of antiretroviral medicines (86%)

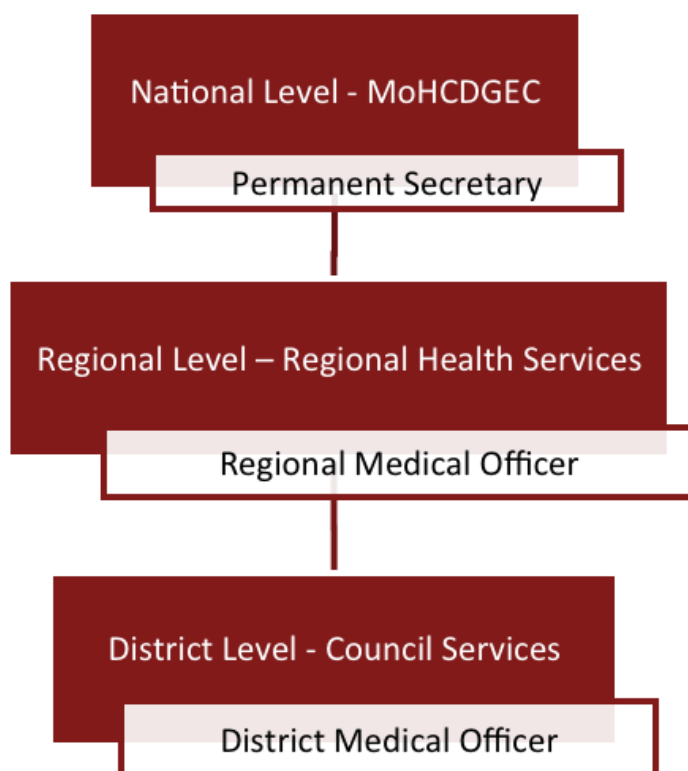
Table 1: Summary of the country demographic and epidemiological profile

Organization of the Health System

Governance and administrative structure of MoHCDGEC

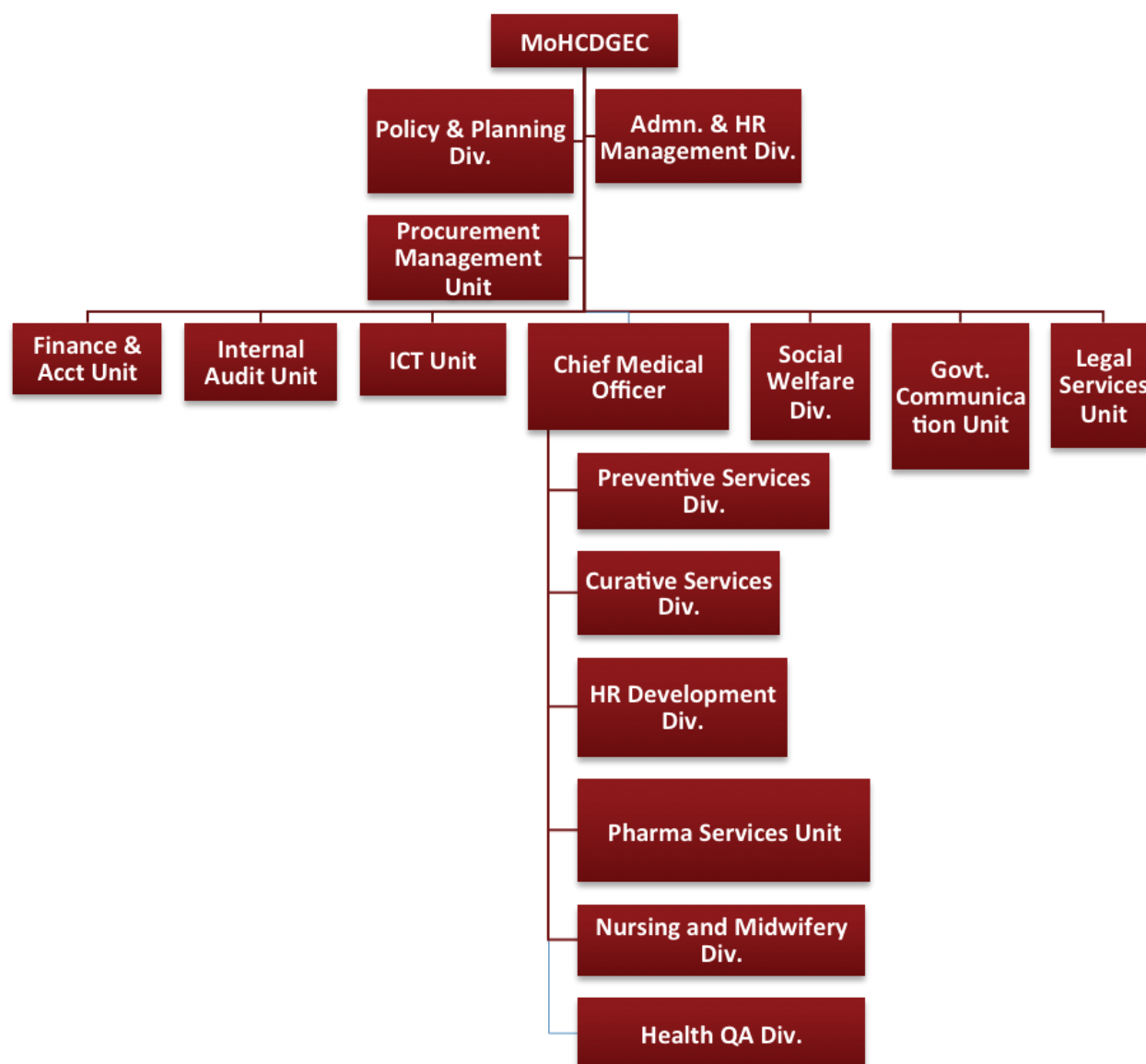
Ministry of Health Community Development Gender Elderly and Children (MoHCDGEC), Tanzania is mandated for the formulation of health and social welfare policies across the country. It monitors and evaluates the implementation of health and social policies and ensures that all Tanzanians have access to quality health and social welfare services. At the national level, Permanent Secretary governs all the activities related to Health systems across Tanzanian Mainland. At the regional level, the Regional Health Management Teams (RHMTs) translates Health policies and guidelines to Council Health Management Teams (CHMTs) who oversee the implementation of Health services at District level.

Figure 6: - Governance structure of MoHCDGEC¹



¹ Source- MoHCDGEC website

Figure 7: Management structure of MoHCDGEC²



Prevention of Mother to Child Transmission of HIV (PMTCT) Unit

PMTCT services are implemented under the platform of Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH). The Unit is responsible for coordinating activities under the eMTCT Plan, and for managing and monitoring the program performance.

The PMTCT Unit has thematic technical working groups with participation from UN agencies, US government and local implementing partners who support the MoHCDGEC/ PMTCT in the different technical areas and help in mobilising resources. These Technical Working groups are Policy & Guidance, Mode of Care and Social mobilization, Monitoring & Evaluation, and Logistics & Supply Chain Management.

Health Services Delivery

Tanzania has a well-developed health care delivery system. Since independence in 1961 there has been a remarkable expansion of health services to the rural areas to serve the majority of the population. According to Health Facility Register³, there are a total of 7,072 health facilities in the country of which

² Source- <http://www.moh.go.tz/index.php/about-us/organizational-structure>

³ <http://hfrportal.ehealth.go.tz/index.php?r=site/index>

87.5 % are dispensaries, 10.5% are Health Centers, 1.7% are Hospitals and 0.5% are specialized clinics and maternity homes. Among these 73.7% are government owned, while the remaining 26.3% are private health facilities as represented below.

Figure 8: Distribution of Health facilities by category of Ownership

Number of Operating Facilities by Ownership

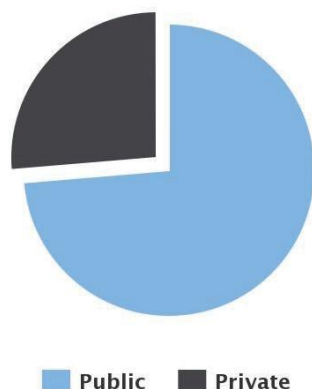
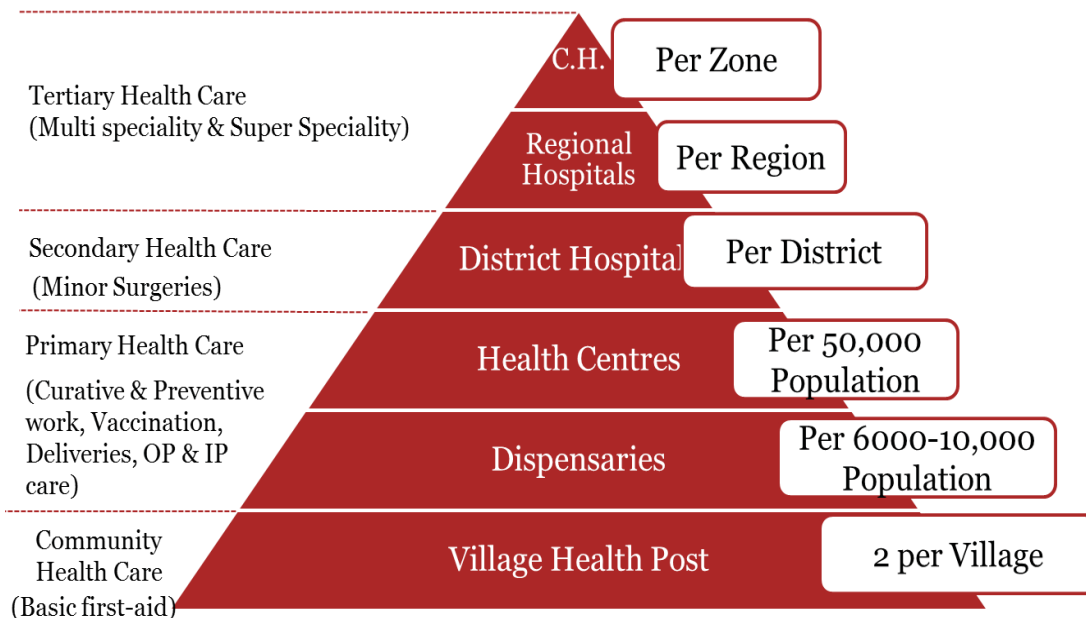


Figure 8: Number of operating health facilities by ownership, Tanzania 2016

The level of health care delivery system is organized as depicted below:

Figure 9: Organizational Pyramid of Health Service Structure- Mainland⁴



4 Source- <http://www.moh.go.tz/index.php/health-services-in-tanzania>

Table below describes the services available at each level of health care system in Tanzania- Mainland.

Table 2: Service available at health care facilities in Tanzania- Mainland⁵

Health Infrastructure	No. of Beds	Service Availability
Village Health Post	-	Provide promotive and preventive services offered in homes and communities through health education & enforcement of by-laws.
Dispensary	Day care	Provide outpatient and reproductive and child health services including, family planning, HIV Counseling and Testing, provision of ARVs to HIV infected women and HIV Exposed infants, diagnostic services, immunization services to children and mothers, treatment for TB, Leprosy, Mental & other diseases
Health Centre	20	Offers all services offered at dispensary level and In-patient services including, maternity care, laboratory, dispensing and mortuary services, provide promotive, preventive, curative and rehabilitative services
District Hospitals	100	Provides out-patient and In-patient care, perform general surgical and obstetric operations
Regional Hospitals	More than 200	Provide all services offered at district level but at a higher level of expertise, Offer specialized treatment in Medicine, Surgery, Obstetrics and Gynaecology and Pediatric, and shall include Eye, Dental, Mental illnesses, Orthopaedics and Trauma.
Referral/ Consultant Hospitals	-	The Hospitals offer all medical services offered by level two hospitals but at a higher specialist level.

Human Resource and capacity building

There has been a substantial improvement in the human resource availability for service delivery. Nearly 51% for the health care workers (HCWs) required for service delivery at various levels are available (35% available in 2012). PMTCT services are provided by both clinicians and nurses trained on provision of comprehensive PMTCT services.. Task sharing policy was adapted in 2013 in line with implementation of PMTCT option B+ to overcome some of the service delivery challenges. The government has on-going efforts to recruit more Health care workers to cover the human resource gap. Availability of staff is of particular concern in remote and rural areas, and large variations are present across regions. The government is addressing these inequities through redeployment of existing personnel.

Since 2000, the PMTCT programme evolved through various phases. Single dose Nevirapine was provided during early pilot and scale up phase. Thereafter more efficacious regimens were introduced to prevent MTCT. Elimination phase went together with introduction of PMTCT option B+ (treatment for prevention). Every time when changes emerged there was review of guidelines and refresher training packages. Health Care Workers have been trained to capacitate them with service provision in line with new guidelines. Consolidated guidelines have been developed in line with 2016 WHO recommendations which also include PMTCT guidelines. Key training related activities coordinated at National level include, development of protocols, development and sharing of training and supervisory packages, periodic reviews of clinical guidelines in line with national and international standards, coordination of training activities using multidisciplinary teams of master trainers, in collaboration with stakeholders (health management teams, hospitals and partners), supportive supervision to trained HCWs in regions and districts and maintaining a training database. A massive training effort was undertaken by the PMTCT unit for 2 years since November 2013 after introduction of PMTCT option

B+ with support from the regional and district / council health management teams (RHMTs and CHMTs) together with the IPs. About 11,000 Health Care Workers were trained to provide Life Long ART to Pregnant and Lactating women living with HIV by December 2016. Countrywide rollout was quickly achieved within one year. PMTCT guidelines were revised to offer Option B+. Guidelines and training package incorporated recommendations on the use of ARVs for PMTCT, Early Infant Diagnosis (EID) and infant and child feeding practices. Additionally, pre-service training curricula for nurses, clinical assistants and clinical officers were developed in 2014 and 120 nurse tutors from various government and FBOs nursing colleges were trained on facilitating comprehensive PMTCT services.

Health Care Financing

The 2016 Government expenditure on health was around 7.7% of the total government budget. The sources of funds for PMTCT include government funds, donor funding from international organizations, user fees and pre-paid mechanisms (NHIF, CHF and TIKa). Initiatives such as Health Basket Fund support health service provision at the Local Government Authorities where primary health care level is strengthened.

PMTCT is mainly funded by Global Fund, PEPFAR (CDC/USAID/DOD) and UN agencies, with PEPFAR being the largest funder. Endorsement for the establishment of AIDS Trust Fund (ATF) for HIV services was done in 2015 to mobilize resources to support domestic funds. The ATF will complement existing HIV financing mechanisms by mobilizing, managing, and disbursing domestic funds to support a comprehensive national response to HIV and AIDS in Tanzania. In doing so, the ATF has been envisaged to help Tanzania build a sufficient and sustainable resource base, reduce new HIV infections, and help ensure that those living with or affected by HIV receive high-quality services. The Government and other stakeholders provided seed money to ATF in 2016 and institutional structures are being set up.

Supply Chain Management System

The Medical Stores Department (MSD) as well as Tanzania Food and Drugs Authority (TFDA) are government entities responsible for procurement, storage and distribution of pharmaceutical and medical supplies to government facilities and to approved non-government hospitals. While TFDA deals with the regulation of medicines and medical related products, MSD has been entrusted with the Procurement, Storage and Distribution of medicines.

The PMTCT commodities (as part of general HIV commodities) distribution starts from the central MSD to Zonal MSD stores. From there, commodities are distributed to CTC sites directly and ordering is done using ARV Reporting and Requesting forms, but for the standalone PMTCT sites, antiretroviral Treatment (ART) commodities, particularly the eMTCT commodities are on the Integrated Logistics System (ILS). Under the ILS, the commodities go directly to the health facility level from the Zonal MSD ("last mile delivery"). Despite a few challenges encountered, this initiative has proven to be a great addition to the PMTCT programme.

Health Management Information System

In 2013, Tanzania introduced and rolled out the District Health Information System (DHIS 2) which integrated all health programme indicators including the ones for PMTCT. PMTCT data are collected at health facility level using paper and electronic based tools and monthly reports are sent to the district level. At the district level PMTCT data is verified and entered into the DHIS 2.

Figure 10: Flow of Health Information and Feedback

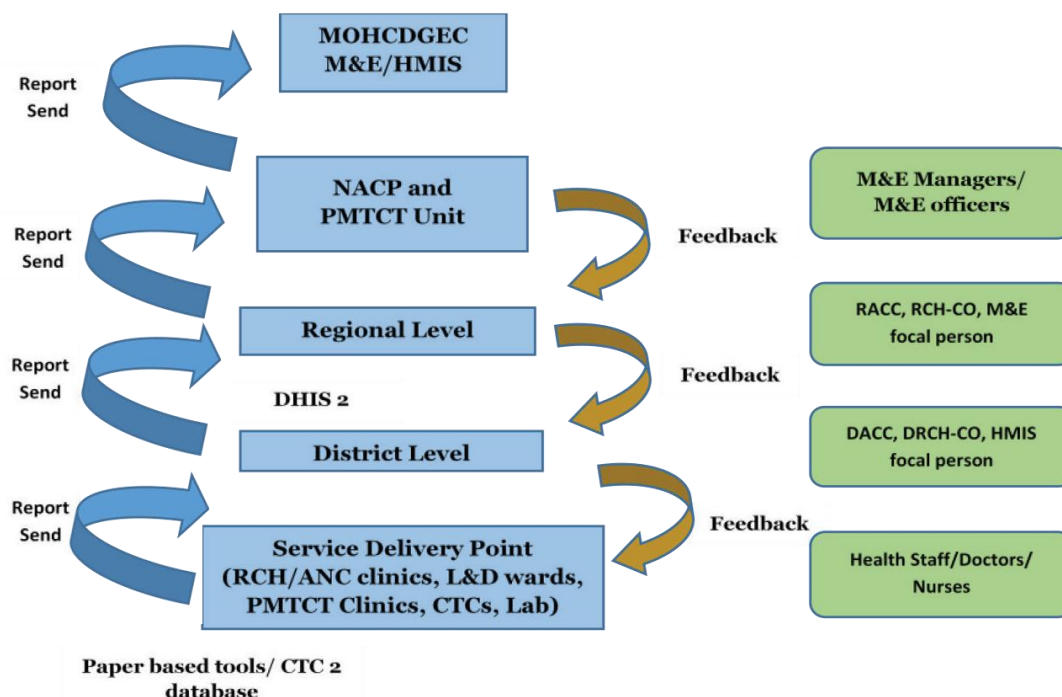


Figure 10: Show the flow of health information, including PMTCT at different levels and personnel responsible for its management

To achieve planned performance based appraisal system for regions and district, the Ministry introduced PMTCT colour-coded score card in 2014, which is completed on quarterly basis by CHMTs, and RHMTs, and annually by MoHCDGEC. It utilises 11 indicators along the PMTCT services cascade, including testing or PW and male partners, HEID and prophylaxis for exposed infants, initiation of PLHIV and infected children on ART, etc. The objectives of the score card was; systematic use of data to assess performance at different levels and identify areas needing attention; assess data challenges such as timeliness, completeness, and accuracy; and develop actionable plans and such to create competition among districts and regions PMTCT score card is monitored in quarterly basis at all levels, facility to national. Also the Programme developed an enhanced Monitoring System for periodic assessment of health facility performance after introducing Life-long ART for Pregnant and lactating women (LLAPLa) in 2013. The system is called LARS (LLAPLa Assessment and Response System). The system has 3-modules. The first module systematically identifies health facilities eligible for being visited based on three criteria; HIV testing uptake of less than 90% among pregnant women, HIV positive yield of more than 3 and ART initiation of less than 90%. The second module is the assessment questionnaires with M&E, commodities and Laboratory sections. The third module is the action plan from which identified gaps are systematically instituted with corrective actions at both facility and district levels.

Mother-Child cohort Monitoring System was developed in 2015 as a way of Monitoring outcomes and retention of mother- baby pairs in PMTCT care. PMTCT Cascade indicators have been developed in line with Mother-Child Cohort indicators and integrated into the DHIS2. Assessment of performance using cascade indicators is done quarterly.

Community mobilization

Community engagement is critical for achieving eMTCT goals, and is a key factor for ensuring progress on each of the PMTCT prongs. A variety of community based interventions have been piloted and implemented between 2012 and 2015 including engaging with community based organisations and structures, using satisfied clients as peer motivators, involving community leaders as “champions”, mentor mothers, psychosocial support groups, etc. Community health workers are increasingly playing

an important role in bridging the gap between the community and the health system, and are involved in various activities under the PMTCT programme. Government commitment on increasing production and deployment of Community Health Workers is expected to increase demand creation of services at community level and integrate community based health services in promoting healthy behaviours and preventing diseases.

The National response and achievements

Health policies

The current health, HIV/AIDS and development policies, plans, and frameworks have a bearing on the PMTCT programme in the country. These include the following:

Tanzania Development Vision 2025

The Tanzania Development Vision 2025 guides the direction for long-term economic and social development. The main objective of this vision is to achieve a high quality of life for all Tanzanians, and it identifies health as a priority sector contributing to achieving this goal. This high quality of life is to be attained through strategies that will ensure the realization of the following health service goals:

- Access to quality primary health care for all;
- Access to quality reproductive health services for all individuals of appropriate ages;
- Seventy-five percent reduction in infant and maternal mortality rates, as compared with 1998 levels;
- Universal access to clean, safe water;
- Life expectancy comparable to the level attained by typical middle-income countries;
- Food self-sufficiency and food security; and
- Gender equality and empowerment of women in all health parameters.

MKUKUTA and Five-Year Development Plans 2011/12–2015/16 and 2016/17–2020/21

The National Strategy for Growth and Reduction of Poverty (known in Kiswahili as MKUKUTA), represents Tanzania's commitment to achieving the MDGs. It focuses on growth, social wellbeing, and governance, and is a framework for all government development efforts and for mobilising resources. MKUKUTA aims to foster greater collaboration between all sectors and stakeholders, and has mainstreamed cross-cutting issues (e.g., gender, environment, HIV/AIDS, disability, children, youth, elderly, employment, and settlements).

The Five Year Development Plans 2011/12–2015/16 and 2016/17–2020/21 aim to mobilise Tanzania's resource potential to fast track the provision of basic conditions for broad-based and pro-poor growth.

Third National Multi-Sectoral Framework (NMSF III) (2013-18)

The Third National Multi-Sectoral Strategic Framework (NMSF III), provides a common understanding for all HIV and AIDS stakeholders and reflects current normative guidance in the national response effort. The NMSF III recognizes that while the national average adult HIV prevalence rate has declined over the last ten years, HIV transmission rates among key populations, women, and in certain regions are not being adequately controlled; the comprehensive needs of People Living with HIV (PLHIV) are often not being met; stigma and discrimination still prevail; and the coordination of the national response is not resulting in all necessary services being available to those who need them.

The NMSF III aims towards the long-term goals of elimination of new HIV infections, deaths from HIV, and HIV-associated stigma and discrimination. Specifically, the policy aims to achieve a HIV incidence rate of no more than 0.16% (from a baseline of 0.32% in 2012), a significant reduction in AIDS-related deaths, and a reduced HIV related stigma and discrimination among People Living with HIV and AIDS in the society.

Third Health Sector HIV and AIDS Strategic Plan (HSHSP III) (2013-17)

The Third Health Sector HIV and AIDS Strategic Plan 2013-2017 (HSHSP III) is guided by the third National Multi-Sectoral Strategic Framework for HIV and AIDS 2013-2017 (NMSF III) and the Third Health Sector Strategic Plan July 2008-June 2015 (HSSP III). The HSHSP III guides the health sector contribution towards achieving the aims of Vision 2025, the National Strategy for Growth and Reduction of Poverty (NSGRP III or MKUKUTA III) and the Five year Development Plan (FYDP) 2011/12-2015/16. Specifically, the HSHSP III provides the context for the development of HIV and AIDS annual operational plans and budgets that are reflected in the Medium Term Expenditure Framework (MTEF) of the Ministry of Health and Social Welfare (now MoHCDGEC) and the Prime Minister's Office Regional Administration and Local Government / PMO-RALG (now under the President's Office / PO-RALG), Regional Health Plans (RHP) of all regions and Comprehensive Council Health Plans (CCHP) of all Local Government Authorities (LGAs) in Tanzania. It therefore guides the actions of all public, faith-based and private organisations in the health sector as they respond to the HIV and AIDS pandemic.

The vision of the HSHSP III is to have an HIV free society where new infections are halted and those infected and affected by HIV and AIDS receive quality services.

The mission of the plan is to lead and guide the health sector in the intensification, optimisation and scaling up of quality HIV and AIDS prevention, care and treatment services to facilitate the attainment of the three Zeros.

The Goals of the plan are:

- (i) To achieve universal access to comprehensive HIV prevention, treatment, care and support services in order to significantly minimise the transmission of new HIV infections and reduce HIV-related mortality, stigma and discrimination
- (ii) To strengthen the capacity of the health system to support quality HIV and AIDS interventions and foster integration within the health sector

Health Sector Strategic Plan-HSSP IV (2015-2020)

The HSSP IV guides the health sector transformation, address the unfinished MDG agenda, and the increasing demand for decentralized, affordable, equitable and quality health services in a performance-oriented mode. The country has made significant steps in early diagnosis and treatment of HIV, but more efforts are needed to prevent HIV in all age groups. The Plan aims at reaching the all households with essential health care and social welfare services with quality standards and applying evidence-based interventions. The key components of the HSSP IV are⁶:

- Quality improvement of primary health care services
- Equitable access to health focusing on hard to reach geographic areas and vulnerable groups
- Strengthen community partnerships to improve health and social wellbeing
- Innovative partnerships to get value for money
- Address the social determinants of health in multi-sectoral approach

eMTCT Plan 2012-2015

In 2012, Tanzania adopted and adapted the Global Plan toward elimination of new HIV infections among children and keeping their mothers alive. A national eMTCT Plan 2012-2015 was formulated, addressing the four prongs of the PMTCT model recommended by the United Nations:

- 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; and
- IV. HIV Treatment, care and support for WLHIV, their children and other family members.

6 Ministry of Health and Social Welfare 2015. Health Sector Strategic Plan July 2015 – June 2020 (HSSP IV)

The Plan was informed by a bottleneck analysis carried out in 2012 and strategies and activities were formulated to address the bottlenecks towards virtual elimination of MTCT in Tanzania. During implementation of this plan, Tanzania experience shows the importance of political leadership at the highest level, government commitment, strong partnership with development partners, implementing partners and civil society, quality improvement initiatives, continuous capacity-building and mentoring, programme monitoring and evaluation and community involvement.

Review of the 2012- 2015 eMTCT Plan

The PMTCT Unit within the Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC), sought to review the achievements of the eMTCT 2012-2015 Plan, including documentation of key lessons as well as barriers faced in implementation, both demand side and supply side. The aim was to provide recommendations to support continued improvement of Tanzania's PMTCT services, and inform the development of the new eMTCT strategy for the next five years (2016-2020).

The objectives of the review were to:

1. Review the progress against the targets set out in the 2012-2015 eMTCT Plan
2. Identify key elements of success and barriers faced in the implementation of the plan
3. Review the management, coordination and integration for implementation of the eMTCT plan across different levels
4. Assess community knowledge, and facilitating factors as well as barriers for uptake of eMTCT services
5. Identify and document good practices and innovations for possible replication
6. Review procurement and supply chain management for PMTCT commodities
7. Undertake revision of eMTCT targets at National and regional levels and in regions with high prevalence, establish district targets
8. Facilitate development of the 2016-2020 eMTCT plan, within the context of the Sustainable Development Goals.

To address the review objectives, a mixed approach of primary and secondary methods was used. Desk reviews, interviews including consultations at various levels and field visits for quantitative and qualitative data collection were conducted

Table 3: Progress on eMTCT Plan 2012-2015 Impact Indicators

Indicators	Baseline	Target (2015)	Achieved	Source	Progress
Mother to child transmission of HIV	26% (2011)	4%	4% (six weeks) 8% (final rate)	UNAIDS	
New HIV infections among WRA	NA	50% reduction	33% reduction since 2009		
Unmet need for FP in WRA living with HIV	25% (2010)	0%	22%	TDHS	
PWLHIV receiving ARV treatment for PMTCT and own health	55% (2010)	98%	86%	UNAIDS	
Exposed children tested for HIV by age 2 months	21%	90%	64%	PMTCT	
Infants and children with HIV initiated on ART before 2 years age	NA	90%	56%	UNAIDS	

PMTCT Bottleneck Analysis

Additionally, as a part of the review of the eMTCT Plan 2012-2015; a bottleneck analysis was done to assess:

- i) Positive or negative changes in previous bottlenecks
- ii) Emergence of any new bottlenecks
- iii) Significant changes in other determinant coverage

The BNA 2016 revealed variable results. While there is some improvement in some of the indicators (as shown in the table below), significant other bottlenecks persist hindering effective implementation of PMTCT program and the ultimate goal of eliminating mother to child transmission of HIV. The bottlenecks are still formed by both supply and demand components. Table 4 below, summarizes the key findings from the bottleneck analysis in the broader health system context:

Table 4: Summary of bottleneck analysis

TRACER INTERVENTION	TYPE OF BOTTLENECK	INDICATORS	COVERAGE	COLOUR CODE	CAUSES
1 - Provision of quality antenatal care services	Supply-side	<i>Commodities</i> : % ANC services offering PMTCT with no stock out of HIV testing in the last 3 months	89%		<ul style="list-style-type: none"> Inadequate supply of qualified HR from training institutions, and poor resources for recruitment Lack of incentive mechanisms for staff retention and motivation Late antenatal booking Irregular availability of testing kits
		<i>Human resources</i> : % of health facilities with sufficient and trained HCWs	51%		
		Access: % of pregnant women not reporting distance as a problem to access ANC or PMTCT services	74%		
		Facility coverage: % ANC services providing PMTCT services	98%		
	Demand-side	Utilisation: % of pregnant women who attended at least 1 ANC visit	98%		
		<i>Continuity</i> : % of pregnant women who attended at least 4 ANC visits	51%		
		Effective coverage: % of pregnant women tested for HIV	86%		

TRACER INTERVENTION	TYPE OF BOTTLENECK	INDICATORS	COVERAGE	COLOUR CODE	CAUSES
2 - Primary prevention of HIV in WRA	Supply-side	Commodities: % ANC services offering PMTCT with no stock outs of HIV testing in the last 3 months	89%		<ul style="list-style-type: none"> Lack of innovative male friendly strategies to attract males to RCH facilities
		Human resources: % of ANC facilities that offer HIV testing and counselling for PMTCT with sufficient and trained HCWs on PMTCT	51%		
		Access: % of pregnant women not reporting distance as a problem to access ANC or PMTCT services offering counselling for HIV test	74%		
		Facility coverage: % ANC services providing PMTCT services	98%		
	Demand-side	Utilisation: % pregnant women tested for HIV	86%		
		Continuity: % of male partners of estimated HIV- pregnant women tested for HIV	54%		
		Effective coverage: % HIV negative pregnant women reached at ANC among total estimated HIV negative pregnant women in the population	96%		

TRACER INTERVENTION	TYPE OF BOTTLENECK	INDICATORS	COVERAGE	COLOUR CODE	CAUSES
3 - Prevention of unintended pregnancies among WRA	Supply-side	Commodities: % of health facilities with no stock out of contraceptives during the last three months	76%		<ul style="list-style-type: none"> Socio-cultural beliefs and practices: myths and misconceptions on the use of FP methods Issues with last mile delivery of FP commodities
		Human resources: % of health facilities with sufficient HCWs	51%		
		Access: % pregnant women not reporting distance as a problem to access FP and PMTCT services	74%		
		Geographic coverage: % PMTCT services offering FP	100%		
	Demand-side	Utilisation: % women of reproductive age ever using any contraceptive method (prevalence)	39%		
		Continuity: % of women of reproductive age married or in an union who are currently using any method of contraception (unmet needs for FP)	22%		
		Effective coverage: proportion of women of reproductive age married or in a union not wanting any more children or wanting to delay the birth of their next child currently using a modern method of contraception	33%		
4 - PMTCT (Option b+)	Supply-side	Commodities: % of PMTCT sites with no stock outs of ARVs for option B+ lasting more than a week in the last year	95%		<ul style="list-style-type: none"> Low public awareness of health matters Low women empowerment
		Human resources: % of PMTCT sites (as per national set up) with sufficient trained staff on option B+	98%		
		Access: % ANC services offering Option B+ services	80%		
	Demand-side	Utilisation: % pregnant women tested HIV+ among estimated HIV+ pregnant women in the population	87%		
		Continuity: % of HIV + pregnant women receiving option B +	79%		
		Effective coverage: % of HIV + pregnant women known to be alive and on treatment (option B+) 12 months after initiation	63%		

TRACER INTERVENTION	TYPE OF BOTTLENECK	INDICATORS	COVERAGE	COLOUR CODE	CAUSES
5 - Exclusive breastfeeding	Supply-side	Commodities	N/A		<ul style="list-style-type: none"> • Insufficient knowledge and awareness on the benefits of breastfeeding • Inadequate community involvement and health promotion activities
		<i>Human resources:</i> % of health facilities with sufficient HCWs	51%		
		<i>Access:</i> % pregnant women reached at ANC by PMTCT services	86%		
	Demand-side	<i>Utilisation:</i> % of children started breastfeeding within 1 h after birth	51%		
		<i>Continuity:</i> % children who are breastfed up to six months	98%		
		<i>Effective coverage:</i> % children on exclusive breastfeeding	59%		
6 - Early infant diagnosis of HIV among exposed children	Supply-side	<i>Commodities:</i> % care and treatment centers (CTC) with no stock out of tests for early infant diagnosis in the last 3 months	88%		<ul style="list-style-type: none"> • Home delivery: HIV exposed infants born at home miss the NVP prophylaxis opportunity offered at health facilities • Poor knowledge on the risk of HIV transmission during breastfeeding
		<i>Human Resources:</i> % health facilities offering paediatric care and treatment with sufficient qualified personnel on EID (as per national norms)	76%		
		<i>Access:</i> % targeted health facilities offering EID	76%		
	Demand-side	<i>Utilisation:</i> % infants received ARV prophylaxis in the population	53%		
		<i>Continuity:</i> % infants born to WLHIV receiving a biological HIV test by 2 months of age	64%		
		<i>Effective coverage:</i> %infants born to WLHIV who received antibody test at 18 months of age	32%		

TRACER INTERVENTION	TYPE OF BOTTLENECK	INDICATORS	COVERAGE	COLOUR CODE	CAUSES
7 - Primary prevention of HIV among adolescent girls	Supply-side	Commodities: % of health facilities that had no stock out of condoms lasting more than one week in the last year	76%		<ul style="list-style-type: none"> Inadequate provision and poor coordination of sexuality, gender, HIV, health education and BCC among in and out of school children
		Human resources: % of health facilities with sufficient (as per national guidelines) health care providers	51%		
		Access: % of adolescent girls not reporting distance as a problem to access FP (fixed or outreach)	74%		
	Demand-side	Utilisation: % of adolescent girls who report knowledge on condom use as a way of HIV prevention	59%		
		Continuity: % of adolescent girls who report comprehensive knowledge about HIV prevention	37%		
		Effective coverage: % of adolescent girls who are sexually active and reporting the use of a condom at last sexual intercourse	60%		
8 - Paediatric ART	Supply-side	<i>Commodities:</i> % of health facilities offering HIV Paediatric care and treatment with no stock out of first line Paediatric ARVs lasting more than one week in the last year	88%		<ul style="list-style-type: none"> Inadequate coordination between PMTCT and Paediatric ART services Paediatric ART is not given equal importance as Adult ART
		<i>Human Resources:</i> % of health care workers currently trained on Paediatric ART	N/A		
		<i>Coverage:</i> % of health facilities that are currently offering Paediatric ART	61%		
	Demand - side	<i>Utilisation:</i> % of children who were identified as HIV + among estimate HIV positive children in the population	78%		
		<i>Continuity:</i> % of HIV + infants who are initiated on ART	73%		
		Effective coverage: % of HIV+ infants known to be alive and on treatment 12 months after initiation of ART	66%		

Next phase of eMTCT plan: The Tanzania eMTCT of HIV Strategic Plan II (2018-2021)

With the focused efforts under eMTCT plan 2012-2015, Tanzania has achieved a 72% reduction in new paediatric HIV infections since 2009, the second highest among the priority countries. It has also achieved the Global Plan goal of 90% of pregnant women living with HIV receiving antiretroviral medicines. Even though virtual elimination of mother to child transmission could not be achieved, building blocks have been put in place which will help in accelerating progress in the coming years for achieving the goal:

1. Updated guidelines and policies have been developed in key programme areas, incorporating current technical knowledge.
2. Even though Option B+ was adopted one year after the Plan began, its roll out was quickly achieved with active support of all stakeholders.
3. Training packages have been developed for important interventions, and pre-service training is being strengthened.
4. Community level initiatives through CHWs and peer mechanisms are being strengthened.
5. Monitoring formats and systems have been developed and implemented.
6. The programme responded to an important emerging challenge, of retention of PWLHIV on ART, by introducing a mother-baby cohort monitoring system and initiating training for the same (it is planned for scale up).
7. A data driven model for supportive supervision, coupled with on-job training and mentoring (LLAPLa Assessment and Response System/ LARS) was introduced and is being scaled up. This is an efficient use of resources targeting facilities with most need for improvement.
8. Logistics systems have been integrated and online mechanisms developed.
9. AIDS Trust Fund has been set up to help mobilise domestic resources and reduce dependence on donor funding.
10. There is active engagement of and commitment from all stakeholders in the programme.

The next phase of the eMTCT plan for 2018-2021 extends commitment towards achieving elimination of transmission and saving mother's and new born lives. It builds upon the achievements of the earlier phase and concentrates in sustainable efforts to institutionalize the convergence of HIV/AIDS services in the health facilities. The bottlenecks identified during the review of 2012–2015 eMTCT plan will be key focus areas of improvement and effective implementation of the programme. The success of the next phase of plan necessitates political commitment, extensive resource mobilization and convergence at all levels.

CHAPTER 2: GOAL AND OBJECTIVES OF eMTCT PLAN II

Goal

To achieve a nation with children born free of HIV infection, helping them navigate adolescence and youth stay free of HIV, and attain healthier life trajectories.

Impact results

1. Eliminate new HIV infection at end of exposure, among HIV exposed infants from 7.6 % in 2016 to below 2% in 2021
2. Reduce proportion of adolescents and young women among PLHIVs from 14% in 2016 to 4% by 2021
3. Increase access to ART among HIV infected children from 60% in 2016 to 95% by 2021

Strategic objectives

- I. To foster evidence based planning, results based management and coordination of the PMTCT program in Tanzania
- II. To improve quality of PMTCT care through mentoring, accreditation/star rating of health facilities providing PMTCT and RMNCH services.
- III. To increase community dialogue, participation and accountability for quality and equitable PMTCT care
- IV. To develop accountability and resilience mechanisms, through monitoring, evaluation, and learning
- V. To improve responsiveness of health logistic systems towards PMTCT care demands

The Guiding principles

The implementation this plan will be in line with the Tanzania Development Vision 2025, Health Sector Strategic Plan-HSSP IV (2015-20) and Fourth Health Sector HIV and AIDS Strategic Plan (HSHSP IV) (2017-2022). The key principals include:

Commitment

Political leadership, accountability and resource mobilization commitment will be required towards achieving quality PMTCT services.

Multi-sectoral approach

Decentralisation of service delivery and full integration into HIV prevention, care and treatment services; and the maternal, nutrition, newborn, child, adolescent health and other reproductive health programmes.

Improvement and innovation

Improvement of HIV programmes, taking into account lessons learned at national, regional and global level should be a continuous process. The framework recognizes the dynamism and fast pace of the disease and the global response to it and endeavours to adopt a flexibility and adaption to change.

Human rights

The national response upholds individual and human rights by promoting the dignity, non-discrimination and welfare of all people, whether infected or affected by HIV and AIDS and ensuring equitable access to health and social support services regardless of race, creed, religious or political affiliation or socio-economic status.

Community involvement

Mobilization and awareness at community level to increase the accountability and utilization of services.

Partnerships

Strengthening partnerships with implementing partners, donors and civil society organizations at all levels, including involvement of the people living with HIV and advocating for increased resources.

Monitoring

Tracking programme performance and impact on MTCT rates and on maternal and child health outcomes.

CHAPTER 3: POPULATION BASED NATIONAL TARGETS

Progress on the eMTCT Plan II will be measured against the following key indicators and targets:

Table 5: National targets and key indicators for PMCTC Programme

S.No.	INDICATOR	BASELINE		TARGET 2021	DATA SOURCE	FREQUENCY
		Value	Year			
OUTPUTS						
1	Proportion of PMTCT sites ⁴ providing ART	80%	2015	100%	PMTCT Reports ²	Annual
2	Proportion of ART sites providing pediatric ART	61%	2015	90%	NACP reports	Annual
3	Proportion of PMTCT sites reporting stock out of HIV test kits lasting a week or longer, in the last 3 months	11.5%	2015	1%	eLMIS / End User Verification (EUV) activity	Annual
4	Proportion of PMTCT sites reporting stock out of ARVs for Option B+ lasting a week or longer, in the last 3 months	5.5%	2015	1%	eLMIS / End User Verification (EUV) activity	Annual
5	Proportion of PMTCT sites offering EID, reporting stock out of DBS kits lasting a week or longer in the last 3 months	11.7%	2015	1%	eLMIS / End User Verification (EUV) activity	Annual
6	Proportion of PMTCT sites offering Pediatric HIV care and treatment, reporting stock out of 1 st line pediatric ARVs lasting one week or longer in the last 3 months	12.3%	2015	1%	eLMIS / End User Verification (EUV) activity	Annual
7	Proportion of PMTCT sites with at least 1 HCW trained on the new HIV and Infant Feeding guidelines	NA	2016	TBD	PMTCT Training reports	Annual
OUTCOMES						
8	Proportion of pregnant women (PW) attended ANC visit within the first 3 months of pregnancy	24.6%	2015-16	TBD	TDHS	Periodic
9	Proportion of PW attended at least four ANC visits	51%	2015-16	TBD	TDHS	Periodic
10	Proportion of PW tested for HIV and know their HIV status	86%	2015	98%	PMTCT Reports / DHIS-2	Annual
11	Proportion of Couples tested for HIV	54%	2015	70%	PMTCT Reports / DHIS-2	Annual
12	Proportion of PW tested for syphilis during pregnancy	45%	2015	>95%	DHIS-2	Annual
13	Proportion of PW living with HIV (PWLHIV) receiving ART to prevent vertical HIV transmission	86%	2015	≥98%	PMTCT Reports; Spectrum estimates	Annual
14	% of HIV exposed infants received ARV prophylaxis to reduce risk of vertical HIV transmission	94%	2016	95%	PMTCT Reports / DHIS-2	Annual
15	% of HIV exposed infants initiated on Cotrimoxazole within 2 months after birth	50%	2016	95%	PMTCT Reports	Annual

S.No.	INDICATOR	BASELINE		TARGET 2021	DATA SOURCE	FREQUENCY
16	% of HIV exposed infants receiving 1st HIV test within 2 months after birth (PCR test)	64%	2015	≥90%	PMTCT Reports	Annual
17	% of HIV exposed children received HIV confirmatory HIV test at ≥18 months of age	32%	2015	≥80%	PMTCT Reports	Annual
18	Proportion of HIV exposed infants exclusively breastfed for 6 months	NA		TBD	PMTCT Reports	Annual
19	Contraceptive prevalence rate (CPR) for modern methods	32.4%	2015-16	TBD	TDHS	Periodic
20	Unmet need for FP	22%	2015	TBD	TDHS	Periodic
IMPACT						
21	HIV incidence among women of reproductive age 15-49 yrs.	NA		TBD	UN spectrum	Annual/4 years
22	Incidence of congenital syphilis			<50 per 100,000 live births	PMTCT Reports / DHIS-2	Annual
23	Proportion of WLHIV alive and on ART for PMTCT 12 months after initiation	70%	2015	>90%	PMTCT Reports / Mother-child cohort system	Annual
24	% of HIV exposed children alive and HIV free at >18 months of age	NA		TBD	PMTCT Reports / Mother-child cohort system	Annual
25	% of HIV exposed infants tested HIV positive within 2 months of age	4%	2015	<2%	Mother-child cohort system / Spectrum	Annual
26	% of HIV exposed children tested HIV positive within 24 months of age	8%	2015	<4%	Mother-child cohort system / Spectrum	Annual

CHAPTER 4: EVIDENCE BASED STRATEGIES TO ACHIEVE THE eMTCT PLAN II

Key strategies are outlined below:

Strategic Objective 1: To foster evidence based planning, results based management and coordination of the PMTCT program in Tanzania

Strategy 1.1: Strengthen Coordination and accountability for comprehensive PMTCT at all levels

1. Advocate for resource mobilization for eMTCT activities at all levels (continue engagement with DPs and AIDS Trust Fund for resource mobilisation for PMTCT)
2. Engage political leaders, policy makers, partners, communities and all other stakeholders for increased accountability and demand creation

Strategy 1.2: Ensure integrated planning, management and supervision of PMTCT and Paediatric AIDS programmes.

1. Conduct data driven joint planning meetings between IPs and Councils
2. Orient Health facility Management Teams on results based Management Skills.
3. Disseminate the national eMTCT plan II and targets at all levels, and orient RHMTs and CHMTs
4. Conduct quarterly Data Review meetings at district and regional levels, to highlight issues on EID, Paediatric ARV and retention in care.
5. Conduct bi-annual Comprehensive supportive supervision of PMTCT and Paediatric HIV care and treatment

Strategy 1.3: Streamline PMTCT management and coordination at the national level

1. Conduct joint coordination meetings for PMTCT and Paediatric HIV care and treatment with other RCH, TB, HIV/AIDS, and STI programmes, and DPs and IPs.
2. Conduct annual meetings of the Policy & Guidance TWG of PMTCT, to discuss any review and updating of policies related to PMTCT programme.
3. Conduct regular meetings of the Training, Mode of Care, and Community Engagement TWG of PMTCT, to review progress on programme implementation, and identify and address any issues.
4. Conduct quarterly meetings of the M&E TWG of PMTCT, as part of coordination and implementation of PMTCT M&E activities.
5. Conduct regular reviews of the eMTCT planned targets and achievement from National to facility levels.
6. Conduct regular meetings of the Logistics and Supply Chain TWG of PMTCT, to assess performance on logistics indicators, progress on planned activities and issues.

Strategic Objective 2: To improve quality of PMTCT care through mentoring, accreditation/star rating of health facilities providing PMTCT and RMNCH services.

Strategy 2.1: Review and update National guidelines, protocols, and job aids

1. Regularly review, update and disseminate National PMTCT guidelines.
2. Review and update, job aids for PMTCT and Paediatric HIV care and treatment, and the follow-up/referral of HIV-positive mothers and their children

Strategy 2.2: Build capacity of health care workers to provide comprehensive PMTCT, HEID and paediatric care services at all levels of health facilities

1. Train National, Regional and District RCH/HIV & AIDS ToT teams, with public and private sector representatives, in eMTCT, HEID and Paediatric HIV care and treatment.
2. Conduct focused modular training on HEID and Paediatric HIV care and treatment, utilising training packages already developed, in line with comprehensive Regional and District plans.
3. Scale up Mother-Child cohort monitoring system to all Regions and PMTCT facilities.
4. EID apprenticeship training scale up.
5. Conduct mentoring of health workers already trained and providing services in general PMTCT, infant feeding, HEID and adult ART.
6. Strengthen data driven supportive supervision and mentorship through LARS-based follow up visits to under-performing health facilities on a quarterly basis.
7. Establish distance learning programme for PMTCT.
8. Finalise pre-service training package on PMTCT for doctors.
9. Review and update pre-service training materials for all health cadres to incorporate evolving technical guidelines/ protocols and relevant best practices in eMTCT and Paediatric HIV care.
10. Train pre-service curriculum for TOTs in PMTCT and Paediatric HIV care and treatment in Colleges and Training Schools (nurses, doctors, pharmacists, laboratory technologists, etc.)
11. Scale up Paediatric HIV care and treatment centres to Centres of Excellence.

Strategy 2.3: Expand provision of HIV services for Primary prevention among WRA and their partners, with a focus on adolescents and young women

1. Provide HIV and STI prevention information.
2. Promote early initiation of ANC within 12 weeks of pregnancy.
3. Promote safer sex for discordant couples
4. Promote couple/partner testing and counselling on HIV and Syphilis for all pregnant women and their partners, with a focus on adolescent and young pregnant women.
5. Promote male friendly RMNCH services
6. Provide re-testing for HIV negative pregnant women, according to National Guidelines
7. Promote condom use/dual protection among young women
8. Provide STI treatment to infected pregnant women and their partners.

Strategy 2.4: Expand provision of services that prevent unintended pregnancies among women living with HIV

1. Promote increased access to reproductive health information and FP services, with a focus on adolescents and youth persons.
2. Scale up integration of FP counselling and services, including condom provision, into all RMNCH and PMTCT/HIV services.
3. Increase outreach for integrated RMNCH (FP, Immunization, HIV counselling and testing) services (including dual protection) in the community.
4. Sustain and scale up Community sensitization to promote condom use focusing on adolescent girls and young women
5. Enhance existing mentorship package for health care workers on family planning, with male involvement.
6. Conduct mentorship to health care workers to accelerate Male involvement in HIV prevention and family planning for ANC clients

Strategy 2.5: Expand provision of appropriate treatment; care and support to women living with HIV, and their infants and family

1. Provide re-testing for HIV negative pregnant women during antenatal, peripartum and postnatal periods, in line with National guidelines.

2. Provide ART to pregnant women and mothers living with HIV.
3. Provide Nevirapine and Cotrimoxazole prophylaxis to all HIV exposed children
4. High and low risk HIV exposed infants given NVP and NVP/AZT prophylaxis
5. Promote and enforce testing to HIV exposed children according to guidelines (Virological and antibody testing)
6. Scale up and maintain 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
7. Scale up Point of Care (POC) diagnostics to strengthen HEID, and monitor maternal viral load and adherence to treatment.

Strategy 2.6: Strengthen follow up of HIV infected mothers and infants at facility and community

1. Enforce use of in-facility procedures for identification of patients with missed appointments and lost to follow-up
2. Establish and operationalize HIV infected mother support groups at least one group at each PMTCT site to conduct follow up and peer support infected mothers.

Strategy 2.7: Increase adolescent's access to and utilization of integrated quality reproductive health services

1. Strengthen provision of adolescent friendly SRH (AFSRH) services.

Strategic Objective 3: To increase community dialogue, participation and accountability for quality and equitable PMTCT care

Strategy 3.1: Implement the community interventions service package for eMTCT and Paediatric HIV care and treatment, and the community MNCH package for CHWs

1. Pre-test the draft community interventions service package for eMTCT and Paediatric HIV care and treatment and finalize.
2. Disseminate final community interventions service package for eMTCT and Paediatric HIV care and treatment.
3. Disseminate the integrated community MNCH package for CHWs.
4. Train CHWs on MNCH including eMTCT in all the regions in a phased manner to achieve at least two trained CHWs per village.

Strategy 3.2: Strengthen community systems and structures to deliver the community interventions service package of eMTCT and Paediatric HIV care and treatment

1. Sensitize Village/ward council leaders to create community awareness on eMTCT community interventions service package for support and demand generation.
2. Establish/ strengthen existing community support groups for effective implementation of eMTCT community interventions service package and encourage active male participation.
3. Update supportive supervision tools to capture use of National eMTCT Communications Strategy
4. Regular supportive supervision visits to be conducted by the Regional/Council Community Health Worker Coordinator and health supervisors at facility level for the CHWs and PLHIV groups to check on the effective implementation of the National eMTCT Communications Strategy.

Strategy 3.3: Improve community knowledge, awareness, attitudes, perceptions, behaviours and practice in eMTCT and Paediatric HIV care and treatment through communication interventions

1. Develop, pre-test, produce and disseminate communication material (including print, audio, and visual) on eMTCT.
2. Orient cultural/ folk theatre groups on eMTCT and paediatric HIV prevention, stigma reduction, promotion of male involvement, and gender issues.

3. Disseminate IEC messages and materials through social media and digital media (website, blogs, SMS, calls etc.) on Paediatric HIV prevention and treatment
4. Continued media orientation on eMTCT and Paediatric HIV treatment and prevention
5. Conduct live phone in sessions on radio & TV during shows/ talks on PMTCT and Paediatric HIV care and treatment.
6. Conduct monitoring of IEC/BCC related activities to establish reach, coverage, understanding etc.

Strategy 3.4: Increase male involvement in eMTCT services through improved awareness, reduction in stigma, and community engagement

1. Undertake awareness creation, sensitization, and community mobilization activities.
2. Identify and mobilize male champions/ peer educators.
3. Constitute/ leverage existing male clubs, etc. and disseminate IEC messages through male champions.
4. Reach out to men with appropriate messages, through use of innovative media forms such as m-Health (SMS), promotional materials (T shirts, caps, diary etc.), wheel covers with IEC messages.

Strategy 3.5: Increased focus towards adolescent friendly services for HIV prevention and transmission

1. Research for media forms which are more appealing for adolescents (e.g. mobile apps, internet, social media), and use these for providing adolescents-specific HIV messages related to prevention, transmission, treatment and care.
2. Identify and use eMTCT advocates/ champions/ ambassadors to increase awareness and knowledge on adolescent PMTCT/ HIV issues.
3. Advocate parent/ guardian – adolescent relationships to open up/ disclose concerns on PMTCT/ HIV issues.
4. Provide adolescent friendly HIV/SRH services on special days, for adolescent girls and young women.
5. Targeted SRH/HIV/STI outreach services for adolescent girls and young women (AGYW).
6. Establish peer support groups in the community and HFs for adolescent girls and young women.

Strategy 3.6: Develop m-Health services for increased follow up and retention

1. Develop integrated mobile application providing all relevant services i.e. IEC, care / treatment follow up, e-modules with focused HIV prevention practices etc.
2. Update and link mobile numbers of pregnant women/ male partner and CHWs at central database for active follow up through use of software (online and offline modes)
3. Leverage existing m-Health platforms to expand coverage for the follow up of PLHIV women and their exposed infants/children to ensure continuum of care and accuracy of data.

Strategy 3.7: Strengthen community involvement and enhanced participation of community structures in comprehensive eMTCT and Paediatric care and support

1. Engage community health workers in close coordination with community groups for enhanced support for implementation of eMTCT and Paediatric community intervention package.
2. Strengthen **Adolescent** friendly and school based HIV prevention practices with active involvement of community.

Strategic Objective 4: To develop accountability and resilience mechanisms, through monitoring, evaluation, and learning

Strategy 4.1: Strengthen implementation of the eMTCT Monitoring & Evaluation System

1. Develop, print and disseminate M&E Framework for eMTCT Plan 2017 – 2020 to Regional and District Health Management Teams.
2. Orient M&E focal persons and RCH coordinators at Regional and District level on the use of Mother-Child cohort monitoring data.

Strategy 4.2: Improve routine monitoring and evaluation of eMTCT and Paediatric HIV care and treatment, with a focus on adolescent girls and young pregnant women.

1. Review and update the existing DHIS database to include evolving priorities of the PMTCT programme.
2. Update M&E data recording and reporting tools for eMTCT and Paediatric HIV care and treatment, based on M&E Framework 2017-2020, including age-disaggregated data and indicators.
3. Support quarterly data review meetings at district level for verification and harmonisation of PMTCT and HIV data.
4. Advocate at district level for budget allocation from Comprehensive Council Health Plans (CCHPs) on modems and internet bundles to ensure connectivity/ access for improving data entry and reporting at district and health facilities level.
5. Conduct quarterly PMTCT and Paediatric HIV care and treatment Data Quality Assessment in sample districts

Strategy 4.3: Carry out Operational Research (OR), surveillance and Surveys to review guide program implementation

1. Review and update national Operational Research priorities for eMTCT and Paediatric HIV care and treatment, including relevant gender and human issues
2. Conduct Operational Research in line with identified eMTCT and Paediatric HIV care and treatment priorities
3. Establish eMTCT surveillance system to monitor transmission at 6 weeks, 6, 12 and 18 months for impact assessment
4. Conduct Mid-term and End-term Evaluation of the implementation of 2017-2020 eMTCT Plan

Strategy 4.4: Improve PMTCT and Paediatric HIV care and treatment services provision through promoting data use

1. Identify, document and share the innovations and best practices in the implementation of activities geared towards eMTCT
2. Develop, print and disseminate PMTCT Annual Reports on progress of implementation of eMTCT Plan 2017-2020.
3. Disseminate eMTCT M&E reports and other eMTCT research findings through various fora (e.g. Annual and Zonal RCH meetings, Regional and District health fora and joint Implementing Partners' meetings).
4. Develop PMTCT data analysis and utilization training package for regional, district and facility level.

Strategic Objective 5: To improve responsiveness of health logistic systems towards PMTCT care demands

Strategy 5.1: Strengthen the capacity of RHMT, CHMT and health care workers at all levels in managing PMTCT commodities

1. Develop/adopt and pre-test training modules for commodity management (data quality and use of data for decision making, targeting Pharmacist, Laboratory Technologist, and RCH Coordinators across regions and districts).
2. Build capacity of Regional and district Pharmacists, Laboratory Technologists, and RCH Coordinators across regions and districts, on commodity management, data quality and use of data for decision making earmarking the cascade to the lower level facilities. (Sustainability of program).
3. Print and distribute logistic management tools.
4. Strengthen mentorship, supportive supervision and OJT for HCWs on commodity management, on data quality and use of data for decision making.
5. Provide refresher training on updated treatment guidelines and supply chain tools, as required.
6. Conduct coordination meetings with Regions, Districts, Supply Chain Implementing Partners, Medical Stores Department and other stakeholders on sharing commodity updates, supply chain challenges and possible solutions.

Strategy 5.2: Integrate the basic logistics monitoring indicators with other PMTCT monitoring and evaluation systems

1. Develop M&E and update logistic tools (where applicable) with indicators for effective commodity management.
2. Develop the mechanisms for extracting regular reports, as per data requirements, from eLMIS system.
3. Conduct quarterly assessment of logistic system performance of the indicators. Review the performance indicators of PMTCT and linkages with e-LMIS and other systems.
4. Review the different SMS based tracking systems in practice and adopt the relevant ones for management of PMTCT commodities.

Strategy 5.3: Strengthen logistics SCM including medicines diagnostics and other medical supplies

1. Maintain continuous availability of eMTCT & Paediatric HIV care and treatment supplies through the existing logistics system.
2. Participate in regular quantification exercises to ensure eMTCT and Paediatric HIV medicines, diagnostics and medical supplies taking into account targets of the program.
3. Maintain a stock control system for eMTCT Paediatric HIV medicines and diagnostics.
4. Institutionalize data use for decision making at all levels in supply chain platforms, TWGs, QIT meetings, etc.
5. Assess lower health facilities' capacity to implement pharmacy module and rollout of pharmacy module at lower level HFs.

CHAPTER 5: LOGICAL FRAMEWORK FOR THE VIRTUAL eMTCT PLAN

Strategies	Activities	Details	Level	2018			2019				2020	2021	Responsible authority	Supporting/ implementing partners	Methods for verification
				Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategic objective 1: To foster evidence based planning, results based management and coordination of the PMTCT program in Tanzania															
Strategy 1.1: Strengthen Co-ordination and accountability for comprehensive eMTCT at all levels	1.1.1. Advocate for resource mobilization for eMTCT activities at all levels (continue engagement with DPs and AIDS Trust Fund for resource mobilisa-tion for PMTCT)	National annual meeting involving 30-people for 1-day and Regional (26) annual meetings for 2-days	National										MoHCDGEC (PMTCT), TACAIDS	MoHCDGEC (RCHS, NACP), DPs and IPs	• Annual reports
		Regional													
	1.1.2. Engage political leaders, policy makers, partners, com-munities and all other stakehold-ers for increased accountability and demand creation	National, Regional (26), District (167) levels - 30 par-ticipants for 1 day - annually	National										MoHCDGEC (PMTCT), TACAIDS	MoHCDGEC (RCHS, NACP), DPs and IPs, RHMT and CHMT	• Meeting minutes (showing participation of regional commissioners, political leaders, etc.) • Feedback sent to regions on quarterly scorecards
			Re-gional/ District												

Strategies	Activities	Details	Level	2018			2019				2020	2021	Responsible authority	Supporting/ implementing partners	Methods for verification
				Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategy 1.2: Ensure integrated planning, management and supervision of PMTCT and Paediatric AIDS programmes.	1.2.1. Conduct joint planning meetings between IPs and Councils	One planning meeting conducted annually for each council (167) for 3-days (15-people per meeting)	District										PORALG, MoHC-DGEC, IPs	MoHCDGEC (RCHS, PMTCT, NACP), DPs	• Annual reports
	1.2.2. Orient Health facility Management Teams on Management Skills.	Two people for each health facility (an In-charge and Matron) for 2-days. Nearly 12,000 persons to be trained, in 2 sessions per district (batch size of 36, with 5 resource persons/ session, of which 1 national).	District										PORALG, MoHC-DGEC, IPs	MoHCDGEC (RCHS, PMTCT, NACP), DPs	• Training Institution reports/ Annual reports
	1.2.3. Disseminate the national eMTCT plan and targets at all levels, and orient RHMTs and CHMTs	Printing and distribution of the Plan (7000 copies)	National										MoHCDGEC (PMTCT)	MoHCDGEC (RCHS, NACP), DPs and IPs, RHMT and CHMT	• Document printed and distributed • Minutes of dissemination meetings/ Annual reports
		Dissemination meetings and orientation at regional (26) levels (One day meeting excluding travel days, 60 participants per region, 2 National level resource persons per meeting, covering 3 regions in a 7 days trip - total 9 visits).	Regional												
	1.2.4. Conduct bi-annual Data Review meetings at district level, to highlight issues on EID, Paediatric ARV and retention.	One day meeting involving 15-people for each council (167), bi-annually	District										CHMTs and IPs	MoHCDGEC (PMTCT, NACP), DPs, RHMT	• Meeting minutes/ Annual reports
	1.2.5. Conduct bi-annual Comprehensive supportive supervision to selected Health Facilities with RCH services (approx. 200 x 2 times a year) (2-National, 3-Regional, and 3-district supervisors for 1-week) total of 50 visits per year (8 HFs / visit / week)	Bi-annual supportive supervision to selected Health Facilities with RCH services (approx. 200 x 2 times a year) (2-National, 3-Regional, and 3-district supervisors for 1-week) total of 50 visits per year (8 HFs / visit / week)	Zonal/ Regional/ District										MoHCDGEC (PMTCT) PORALG	MoHCDGEC (RCHS), DPs and IPs, RHMT and CHMT	• Supportive Supervision reports • Annual reports

Strategies	Activities	Details	Level	2018			2019				2020	2021	Responsible authority	Supporting/ implementing partners	Methods for verification
				Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategy 1.3: Streamline PMTCT management and coordination at the national level	1.3.1. Conduct joint coordination meetings for PMTCT and Paediatric HIV care and treatment with other RCH, TB, HIV/AIDS, and STI programmes, and DPs and IPs.	Quarterly coordination meetings at National level of 30-people for 1-day	National										MoHCDGEC (PMTCT)	MoHCDGEC (RCHS, NACP), DPs and IPs	• Meeting minutes/ Annual reports
	1.3.2. Conduct annual meetings of the Policy & Guidance TWG of PMTCT, to discuss any review and updating of policies related to PMTCT programme.	Annual meeting with 30 participants for one day	National										MoHCDGEC (PMTCT,	MoHCDGEC (NACP, RCHS), DPs and IPs	• Meeting minutes
	1.3.3. Conduct regular meetings of the Training, Mode of Care, and Community Engagement TWG of PMTCT, to review progress on programme implementation, and identify and address any issues.	Quarterly one-day meeting with 40 participants, at national level	National										MoHCDGEC (PMTCT)	MoHCDGEC (NACP, RCHS, Health Promotion Section), DPs and IPs	• Meeting minutes
	1.3.4. Conduct quarterly meetings of the M&E TWG of PMTCT, as part of coordination and implementation of PMTCT M&E activities.	1 meeting/ quarter (25 participants – 3 outstation)	National										MoHCDGEC (PMTCT, NACP)	MoHCDGEC (RCH HMIS), DPs and IPs	• TWG Meeting minutes

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Strategies	Activities	Details	Level	2018			2019				2020	2021	Responsible authority	Supporting/ implementing partners	Methods for verification
				Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategic objective 2: To improve quality of PMTCT care through mentoring, accreditation/star rating of health facilities providing PMTCT and RMNCH services.															
Strategy 2.1: Review and update National guidelines, protocols, and job aids	2.1.1. Regularly review, update and disseminate National PMTCT guidelines.	a. Meeting with technical experts (2 -meetings, 20-people for 5-days)	National										MoHCDGEC (PMTCT)	MoHCDGEC (RCHS, NACP), DPs and IPs	• Revised guidelines
		b. Printing of 10,000 copies (twice)	National												
		c. Dissemination meetings and orientation at Regional (26) level - 1 meeting for 1 day involving 40 participants – 2 National participants covering 3 regions in 1 week visit – total 9 visits of one week each (twice).	Regional												
	2.1.2. Review and update, job aids for PMTCT and Paediatric HIV care and treatment, and the follow-up/ referral of HIV-positive mothers and their children	a. Meeting with technical experts (2-meetings, 5-days involving 30 participants each, national level)	National										MoHCDGEC (PMTCT)	MoHCDGEC (RCHS, NACP), DPs and IPs	• Revised job aids
		Printing of 10,000 copies (twice)	National												

Strategies	Activities	Details	Level	2018			2019				2020	2021	Responsible authority	Supporting/ implementing partners	Methods for verification
				Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategic objective 2: To improve quality of PMTCT care through mentoring, accreditation/star rating of health facilities providing PMTCT and RMNCH services.															
Strategy 2.1: Review and update National guidelines, protocols, and job aids	2.1.1. Regularly review, update and disseminate National PMTCT guidelines.	a. Meeting with technical experts (2 -meetings, 20-people for 5-days)	National										MoHCDGEC (PMTCT)	MoHCDGEC (RCHS, NACP), DPs and IPs	• Revised guidelines
Strategy 2.2: Build capacity of health care workers to provide comprehensive PMTCT, HEID and paediatric care services at all levels of health facilities	2.2.1. Train National, Regional and District RCH/ HIV & AIDS ToT teams, with public and private sector representatives, in eMTCT, HEID and Paediatric HIV care and treatment.	TOTs training/ refresher training and orientation meetings (60 TOTs for 5-days excluding travel days) – batch of 30 TOTs x 2 batches; 5 resource persons	Regional										MoHCDGEC (PMTCT)	PORALG, IPs, RHMT and CHMT	• Training reports/ Annual reports
	2.2.2. Conduct focused modular training on HEID and Paediatric HIV care and treatment, utilising training packages already developed, in line with comprehensive Regional and District plans.	Training of HCWs (3000 HCWs, to be trained, for 5-days excluding travel days; 100 batches of 30 participants each; 5 trainers per batch; 100 batches of 30 participants each; 5 trainers per batch – 1 national level)	Regional										MoHCDGEC (RCHS, PMTCT)	MoHCDGEC (NACP), IPs, RHMT and CHMT,	• Training reports/ Annual reports
	2.2.3. Scale up Mother-Child cohort monitoring system to all Regions and PMTCT facilities.	Training of staff (8000 HCWs trained for 5-days, at Regional headquarters – batch size of 40 participants with 5 trainers – 1 trainer from National level - total 200 batches)	Regional											Training Institutions	• Training reports

Strategies	Activities	Details	Level	2018			2019				2020	2021	Responsible authority	Supporting/ implementing partners	Methods for verification
				Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategic objective 2: To improve quality of PMTCT care through mentoring, accreditation/star rating of health facilities providing PMTCT and RMNCH services.															
Strategy 2.1: Review and update National guidelines, protocols, and job aids	2.1.1. Regularly review, update and disseminate National PMTCT guidelines.	a. Meeting with technical experts (2 -meetings, 20-people for 5-days)	National										MoHCDGEC (PMTCT)	MoHCDGEC (RCHS, NACP), DPs and IPs	• Revised guidelines
	2.2.4. EID apprenticeship training scale up.	400 health facilities covered biannually; 300 HFs by 2 Regional and 2 District mentors; 100 HFs by 2 National, 1 Regional and 1 District mentors; week long visits with 2 facilities covered per visit - Total 400 visits per year.	Regional/ District												
	2.2.5. Conduct mentoring of health workers already trained and providing services in general PMTCT, infant feeding, HEID and adult ART.	2-National Mentors, 2-Regional Mentors, 1-Council mentor in 200 Health facilities (2 health facilities per week – 100 visits per year)	District										MoHCDGEC (PMTCT, NACP)	MoHCDGEC (RCHS), IPs, RHMT and CHMT, and Training Institutions	• Mentoring/ Training reports
	2.2.6. Strengthen data driven supportive supervision and mentorship through LARS-based follow up visits to under-performing health facilities on a quarterly basis.	400 HFs followed up annually, team comprising of 2-National supervisors, 2-Regional supervisors and 3-district supervisors (8 facilities / visit / week – 50 visits per year)	District										MoHCDGEC (PMTCT)	MoHCDGEC (RCHS, NACP), IPs, RHMT and CHMT	• Supervision/ Training reports
	2.2.7. Establish distance learning programme for PMTCT.	Engage consultancy firm to develop distance learning modules and training modalities.											MoHCDGEC (RCHS, PMTCT,)	MoHCDGEC (RCHS, PMTCT,), IPs, Regional and district authorities	• Distance learning modules • Training reports/ Annual reports

Strategies	Activities	Details	Level	2018			2019				2020	2021	Responsible authority	Supporting/ implementing partners	Methods for verification
				Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategic objective 2: To improve quality of PMTCT care through mentoring, accreditation/star rating of health facilities providing PMTCT and RMNCH services.															
Strategy 2.1: Review and update National guidelines, protocols, and job aids	2.1.1. Regularly review, update and disseminate National PMTCT guidelines.	a. Meeting with technical experts (2 -meetings, 20-people for 5-days)	National										MoHCDGEC (PMTCT)	MoHCDGEC (RCHS, NACP), DPs and IPs	• Revised guidelines
	2.2.8. Finalise pre-service training package on PMTCT for doctors.												MoHCDGEC (PMTCT)	I-TECH, NACTE	• Pre-service training pack- age for doctors
	2.2.9. Review and update pre-service training materials for all health cadres to incorporate evolving technical guidelines/ protocols and relevant best practices in eMTCT and Paedi- atric HIV care.	a. Technical review meet- ings (2-Meetings, involving 30-people for 5-days).	National										MoHCDGEC (PMTCT, HRD)	MoHCDGEC (RCHS, NACP), DPs and IPs, NACTE, Train- ing institutions	• Meeting min- utes/ Annual reports • Updated pre-service training pack- ages
		Printing of updated pre-ser- vice training packages (1000 copies twice).													
	2.2.10. Train pre-service cur- riculum for TOTs in PMTCT and Paediatric HIV care and treatment in Colleges and Training Schools (nurses, doctors, pharmacists, lab- oratory technolo- gists, etc.)	60 TOTs trained for 2-weeks - batch of 30 TOTs x 2 batch- es; 5 resource persons	Regional										MoHCDGEC (PMTCT, NACP, HRD), NACTE	Training institu- tions	• Training reports/ Annual reports
2.2.11. Scale up Paediatric HIV care and treatment centres to Centres of Excellence.												MoHCDGEC (NACP)	MoHCDGEC (RCHS, PMTCT), DPs and IPs	• Annual re- ports	

Strategies	Activities	Details	Level	2018			2019				2020	2021	Responsible authority	Supporting/ implementing partners	Methods for verification
				Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategic objective 2: To improve quality of PMTCT care through mentoring, accreditation/star rating of health facilities providing PMTCT and RMNCH services.															
Strategy 2.1: Review and update National guidelines, protocols, and job aids	2.1.1. Regularly review, update and disseminate National PMTCT guidelines.	a. Meeting with technical experts (2 -meetings, 20-people for 5-days)	National										MoHCDGEC (PMTCT)	MoHCDGEC (RCHS, NACP), DPs and IPs	• Revised guidelines
Strategy 2.3: Expand provision of HIV services for Primary prevention among WRA and their partners, with a focus on adolescents and young women	2.3.1. Provide HIV and STI prevention information.	Covered in SO 4	Regional/ District												
	2.3.2. Promote early initiation of ANC within 12 weeks of pregnancy.														
	2.3.3. Promote safer sex for discordant couples														
	2.3.4. Promote couple/partner testing and counselling on HIV and Syphilis for all pregnant women and their partners, with a focus on adolescent and young pregnant women.	- Procurement and supply of HIV and Syphilis testing kits (HIV test kits covered in Strategy 3.3 below; Syphilis test kits through RCHS). - Community mobilization (covered in SO 4).	National/ Regional/ District									MoHCDGEC (PMTCT, MSD)	MoHCDGEC (RCHS, NACP), IPs RHMT and CHMT, Community organisations	• Training reports • DHIS-2 • Annual re-ports	
	2.3.5. Promote male friendly RM-NCH services	Provide ancillary services for NCD to male partners, including Hypertension, Diabetes Screening, and BMI Counseling on nutrition.	Regional/ District										MoHCDGEC (RCHS)	MoHCDGEC (PMTCT), IPs, RHMT and CHMT	• Annual re-ports
	2.3.6. Provide re-testing for HIV negative pregnant women, according to National Guide-lines	Test at first ANC visit, re-test at third trimester or labour and delivery and 6 weeks postnatally-Covered in Strategy 3.3 below	Regional/ District												

Strategies	Activities	Details	Level	2018			2019				2020	2021	Responsible authority	Supporting/ implementing partners	Methods for verification
				Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategic objective 2: To improve quality of PMTCT care through mentoring, accreditation/star rating of health facilities providing PMTCT and RMNCH services.															
Strategy 2.1: Review and update National guidelines, protocols, and job aids	2.1.1. Regularly review, update and disseminate National PMTCT guidelines.	a. Meeting with technical experts (2 -meetings, 20-people for 5-days)	National									MoHCDGEC (PMTCT)	MoHCDGEC (RCHS, NACP), DPs and IPs	• Revised guidelines	
	2.3.7. Promote condom use/dual protection among young women	- Provide condoms to pregnant and breastfeeding women and their partners (through FP programme). - Community mobilization and IEC (covered in SO 4).	Regional/ District									MoHCDGEC (PMTCT, MSD)	MoHCDGEC (NACP, RCHS), IPs, RHMT and CHMT, Community organisations	• Annual re-ports	
	2.3.8. Provide STI treatment to infected pregnant women and their partners.	- Procurement and supply of testing kits and medicines (covered under NACP and RCHS). - Screen and refer identi-fied pregnant women for treatment of STIs (routine services).	National									MoHCDGEC (RCHS, NACP)	MoHCDGEC (PMTCT, MSD, HRD), IPs, RHMT and CHMT	• Annual re-ports	

Strategies	Activities	Details	Level	2018			2019				2020	2021	Responsible authority	Supporting/ implementing partners	Methods for verification
				Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategic objective 2: To improve quality of PMTCT care through mentoring, accreditation/star rating of health facilities providing PMTCT and RMNCH services.															
Strategy 2.1: Review and update National guidelines, protocols, and job aids	2.1.1. Regularly review, update and disseminate National PMTCT guidelines.	a. Meeting with technical experts (2 -meetings, 20-people for 5-days)	National										MoHCDGEC (PMTCT)	MoHCDGEC (RCHS, NACP), DPs and IPs	• Revised guidelines
Strategy 2.4: Expand provision of services that prevent unintended pregnancies among women living with HIV	2.4.1. Promote increased access to reproductive health information and FP services, with a focus on adolescents and youth persons.	Develop and print IEC materials with specific messages for FP and HIV.	National										MoHCDGEC (RCHS, NACP)	PO-RALG, MoHCDGEC (PMTCT, MSD), IPs, RHMT and CHMT, Community organisations	• DHIS-2 • Annual re-ports
	2.4.2. Scale up integration of FP counselling and services, including condom provision, into all RMNCH and PMTCT/HIV services.	Increase outreach of integrated RMNCH care (FP, Im-munization, HIV counselling and testing) by using various methods including mobile and home-based outreach services, setting up family planning event days / weeks in villages, outreach centers, workplaces, etc. (through RCHS/ FP programme).	Regional/ District												
	Increase outreach for integrated RMNCH (FP, Immunization, HIV counselling and testing) services (including dual protection) in the community.														

Strategies	Activities	Details	Level	2018			2019				2020	2021	Responsible authority	Supporting/ implementing partners	Methods for verification
				Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategic objective 2: To improve quality of PMTCT care through mentoring, accreditation/star rating of health facilities providing PMTCT and RMNCH services.															
Strategy 2.1: Review and update National guidelines, protocols, and job aids	2.1.1. Regularly review, update and disseminate National PMTCT guidelines.	a. Meeting with technical experts (2 -meetings, 20-people for 5-days)	National										MoHCDGEC (PMTCT)	MoHCDGEC (RCHS, NACP), DPs and IPs	• Revised guidelines
	2.4.3. Sustain and scale up Community sensitization to promote condom use focusing on adolescent girls and young women	Designate existing structures such as public offices, shops, sports centres, youth clubs, accredited drug dispenser outlets, etc. into community condoms outlets where adolescent girls and young women can readily access condoms. Condom dispensers to be procured and installed in such places (through FP programme).	Regional/ District										PORALG, MoHCDGEC (RCHS)	MoHCDGEC (PMTCT), DPs and IPs, RHMT and CHMT, Community organisations	• Community condom outlets will be available to the community
	2.4.4. Enhance existing mentorship package for health care workers on family planning, with male involvement.	2 workshops of 3 days each, with 30 participants, at National level (for reviewing draft and for finalisation).	National										PORALG, MoHCDGEC (RCHS)	MoHCDGEC (PMTCT, NACP), DPs and IPs	• Formulated mentorship package available
	2.4.5. Conduct mentorship to health care workers to accelerate Male involvement in HIV prevention and family planning for ANC clients	- Advocacy towards mentorship to health care workers to accelerate Male involvement in HIV prevention and family planning for ANC clients. - Train mentors on integrated HIV prevention and family planning. Biannual mentorship visit to health facilities will be conducted (covered under existing visits in strategy 1.2 and strategy 2.2).	Regional/ District										MoHCDGEC (RCHS, NACP)	MoHCDGEC (PMTCT), DPs and IPs, RHMT and CHMT, Training institutions	• Mentorship reports

Strategies	Activities	Details	Level	2018			2019				2020	2021	Responsible authority	Supporting/ implementing partners	Methods for verification
				Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategic objective 2: To improve quality of PMTCT care through mentoring, accreditation/star rating of health facilities providing PMTCT and RMNCH services.															
Strategy 2.1: Review and update National guidelines, protocols, and job aids	2.1.1. Regularly review, update and disseminate National PMTCT guidelines.	a. Meeting with technical experts (2 -meetings, 20-people for 5-days)	National										MoHCDGEC (PMTCT)	MoHCDGEC (RCHS, NACP), DPs and IPs	• Revised guidelines
Strategy 2.5: Expand provision of appropriate treatment; care and support to women living with HIV, and their infants and family	2.5.1. Provide re-testing for HIV negative pregnant women during antenatal, peripartum and postnatal periods, in line with National guidelines.	a. Disseminate and promote HIV testing guidelines, including enforcing retesting in the third trimester and intrapartum testing in all PMTCT sites (under NACP).	National										MoHCDGEC (PMTCT, MSD),	MoHCDGEC (RCHS, NACP), IPs RHMT and CHMT	• Monthly/ Annual reports
		b. Procurement and supply of testing kits for 98% PW and 75% male partners.	National												
		c. Community mobilisation and IEC (covered in SO 4).	Regional/ District												
	2.5.2. Provide ART to pregnant women and mothers living with HIV.	ART for 98% PWLHIV – covered in ART programme.	National										MoHCDGEC (PMTCT)	MoHCDGEC (MSD, NACP, RCHS), IPs, RHMT and CHMT	• Monthly/ Annual reports
	2.5.3. Provide Nevirapine and Cotrimoxazole prophylaxis to all HIV exposed children	ARV prophylaxis (for exposed infants - 75% in 2017; 80% in 2018; 90% in 2019 and 2020).	National										MoHCDGEC (PMTCT)	MoHCDGEC (MSD, NACP, RCHS), IPs, RHMT and CHMT	• Monthly/ Annual reports
	2.5.4. High and low risk HIV exposed infants given NVP and NVP/AZT prophylaxis	Identification of high-risk infants through viral load of mother.	Regional/ District												

Strategies	Activities	Details	Level	2018			2019				2020	2021	Responsible authority	Supporting/ implementing partners	Methods for verification
				Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategic objective 2: To improve quality of PMTCT care through mentoring, accreditation/star rating of health facilities providing PMTCT and RMNCH services.															
Strategy 2.1: Review and update National guidelines, protocols, and job aids	2.1.1. Regularly review, update and disseminate National PMTCT guidelines.	a. Meeting with technical experts (2 -meetings, 20-people for 5-days)	National										MoHCDGEC (PMTCT)	MoHCDGEC (RCHS, NACP), DPs and IPs	• Revised guidelines
	2.5.5. Promote and enforce testing to HIV exposed children according to guidelines (Virological and antibody testing)	a. Promote and conduct on job training and mentoring to increase skills for DBS collection for younger infants.	Regional/ District										MoHCDGEC (PMTCT)	MoHCDGEC (MSD, NACP, RCHS), IPs, RHMT and CHMT	• Monthly/ Annual reports
		b. Enforce confirmatory Antibody testing at 18 months of age, by conducting on job training, mentoring and dissemination of SoPs and Job aids.	Regional/ District												
		c. Community based tracking (under SO 4).	Regional/ District												
		d. Use of mHealth and SMS tracking.	Regional/ District												
		e. Testing at 6 weeks (target 95%).	Regional/ District												
		f. Testing at 18 months (target 90%).	Regional/ District												
	2.5.6. Scale up and maintain 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	a. Sample transportation from lower level facilities	Regional/ District										MoHCDGEC (PMTCT)	MoHCDGEC (MSD, NACP, RCHS), IPs, RHMT and CHMT	• Monthly/ Annual reports
		b. Harmonize and scale-up technology for results feedback to health facilities from testing labs	Regional/ District												
		c. Using technology for sharing results with facility and the mother (covered in SO 5).	Regional/ District												

Strategies	Activities	Details	Level	2018			2019				2020	2021	Responsible authority	Supporting/ implementing partners	Methods for verification
				Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategic objective 2: To improve quality of PMTCT care through mentoring, accreditation/star rating of health facilities providing PMTCT and RMNCH services.															
Strategy 2.1: Review and update National guidelines, protocols, and job aids	2.1.1. Regularly review, update and disseminate National PMTCT guidelines.	a. Meeting with technical experts (2 -meetings, 20-people for 5-days)	National										MoHCDGEC (PMTCT)	MoHCDGEC (RCHS, NACP), DPs and IPs	• Revised guidelines
	2.5.7. Scale up Point of Care (POC) diagnostics to strengthen HEID, and monitor maternal viral load and adherence to treatment.	a. Procurement of POC diagnosis machines (through NACP).	National												
		b. Training of HCWs on POC diagnosis (through NACP).	National												
Strategy 2.6: Strengthen follow up of HIV infected mothers and infants at facility and community	2.6.1. Enforce use of in-facility procedures for identification of patients with missed appointments and lost to follow-up	a. Distribute appointment and tracking registers (2 each per health facility)	National										MoHCDGEC (PMTCT)	IPs, RHMT and CHMT	
		b. Include lost to follow-up and missed appointment indicators as permanent agenda of health facility quality improvement activities.	Regional/ District												
	2.6.2. Establish and operationalize HIV infected mother support groups at least one group at each PMTCT site to conduct follow up and peer support infected mothers.	a. Develop /harmonize guidance tools and SoPs for support groups (2 meetings of 5 days each with 20 participants).	National										MoHCDGEC (PMTCT)	MoHCDGEC (RCHS, NACP), IPs, RHMT and CHMT	Guideline available and in use Monthly/ Annual reports
		b. Operationalize support groups with long term economic empowerment schemes (e.g. Vicoba, live-stock rearing activities)	Regional/ District										PO-RALG, (Councils, Ward, Village Committees)	MoHCDGEC (RCHS, NACP), IPs, RHMT and CHMT	

Strategies	Activities	Details	Level	2018			2019				2020	2021	Responsible authority	Supporting/ implementing partners	Methods for verification
				Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategic objective 2: To improve quality of PMTCT care through mentoring, accreditation/star rating of health facilities providing PMTCT and RMNCH services.															
Strategy 2.1: Review and update National guidelines, protocols, and job aids	2.1.1. Regularly review, update and disseminate National PMTCT guidelines.	a. Meeting with technical experts (2 -meetings, 20-people for 5-days)	National										MoHCDGEC (PMTCT)	MoHCDGEC (RCHS, NACP), DPs and IPs	• Revised guidelines
Strategy 2.7: Increase adolescent's access to and utilization of integrated quality reproductive health services	2.7.1. Strengthen provision of adolescent friendly SRH (AFSRH) services.	a. Track adolescent mothers and provide information on primary prevention of HIV and unintended pregnancies (regular services).	Regional/ District										MoHCDGEC (PMTCT, Adolescent Health)	MoHCDGEC (NACP), Donors and IPs, RHMT and CHMT	• Revised AFSRH guidelines • Training reports
		b. Review and update the guidelines for AFSRH services (2 meetings of 5 days each with 30 participants – to review the guidelines and finalise the draft)	National												
		c. TOT on AFSRH services based on revised national guidelines (60 TOTs for 2 days in batch of 30, with 5 trainers).	National												
		d. Capacity building of various cadres on AFSRH services based on the revised national guidelines (1 HCW per HF, 2-day orientation – nearly 35 per district with 5 trainers, including 1 national; 3 districts covered in one visit – total 56 visits).	Regional/ District												

Strategies	Activities	Details	Level	2018			2019				2020	2021	Responsible authority	Supporting/ implementing partners	Methods for verification
				Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategic objective 3: To increase community dialogue, participation and accountability for quality and equitable PMTCT care															
Strategy 3.1: Implement the community interventions service package for eMTCT and Paediatric HIV care and treatment, and the community MNCH package for CHWs	3.1.1. Pre-test the draft community interventions service package for eMTCT and Paediatric HIV care and treatment and finalize.	a. Pre-test in 2 regions, across 2 districts each. Involving 6 National staff, 12 participants at the region and 30 at the district-pre test will be a one day activity (two regions and 4 districts) - one region and two districts covered in 1 week visit by 3 national staff (total 2 visits)	Regional/ District										MoHC-DGEC (PMTCT)	MoHCDGEC (RCHS BCC Unit, NACP IEC Unit), DPs and IPs	• Community interventions service package
		b. Technical meeting to finalise based on pre-test results - One day activity, 50 participants	National												
	3.1.2. Disseminate final community interventions service package for eMTCT and Paediatric HIV care and treatment.	a. Printing of package (500,000 copies)	National										MoHC-DGEC (PMTCT)	MoHCDGEC (RCHS BCC Unit, NACP IEC Unit), DPs and IPs, RHMT and CHMT	• Annual report
		b. Dissemination to regional and district managers (1 day event - 1 at National level with 30 participants; 3 per zone with 60 participants and 2 National level resource persons each – covered in one visit per zone for 5 days including travel - total 6 visits)	National												
			Re-regional/ District												
	3.1.3. Disseminate the integrated community MNCH package for CHWs.	a. Print copies for programme managers at all levels, HFs, and @ 2 CHWs per village (1500 villages) – total 10,000 copies.	National										MoHC-DGEC (PMTCT, RCHS, NACP, Health Promotion Section)	DPs and IPs, RHMT and CHMT	• Annual report
		b. Dissemination.													
	3.1.4. Train CHWs on MNCH including eMTCT in all the regions in a phased manner to achieve at least two trained CHWs per village.	1 training per facility for new CHWs (no. to be trained, duration). 3000 CHWs to be trained, duration of training 21 days (40 per batch – 75 batches; 4 local resource persons and 1 National level trainer per batch)	Regional / District										RHMT and CHMT, Training institutions, IPs	MoHCDGEC(P-MTCT, RCHS, NACP, Health Promotion Section)	• Training reports/ Annual reports

Strategies	Activities	Details	Level	2018			2019				2020	2021	Responsible authority	Supporting/ implementing partners	Methods for verification
				Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategy 3.2: Strengthen community systems and structures to deliver the community interventions service package of eMTCT and Paediatric HIV care and treatment	3.2.1. Sensitize Village/ward council leaders to create community awareness on eMTCT community interventions service package for support and demand generation.	Sensitisation meetings – one day each (1500 villages, 10-15 community leaders/ influencers, CBOs, etc. each) (5 meetings per district with 40 participants and 2 resource persons each – total 167*5= 835 meetings).	District										MoHC-DGEC (PMTCT)	IPs, RHMT and CHMT	• Annual reports
	3.2.2. Establish/ strengthen existing community support groups for effective implementation of eMTCT community interventions service package and encourage active male participation.	Advocate for establishment of new support groups to address eMTCT, gender, male participation, adolescent, health provider attitude, ECD – mama salama – peer mentors, etc.	District										MoHC-DGEC (PMTCT, RCHS, NACP)	IPs, RHMT and CHMT	• Activity reports/ Annual reports
	3.2.3. Update supportive supervision tools to capture use of National eMTCT Communications Strategy	a. Technical meeting to update SS tools (20-30 participants, 3 days, national level) b. Dissemination of revised SS tools / formats (electronically)	National										MoHC-DGEC (PMTCT)	MoHCDGEC (RCH BCC Unit, NACP IEC Unit), IPs, RHMT and CHMT	• Revised SS tools

Strategies	Activities	Details	Level	2018			2019				2020	2021	Responsible authority	Supporting/ implementing partners	Methods for verification
				Q2	Q3	Q4	Q1	Q2	Q3	Q4					
	3.2.4. Regular supportive supervision visits to be conducted by the Regional/Council Community Health Worker Coordinator and health supervisors at facility level for the CHWs and PLHIV groups to check on the effective implementation of the National eMTCT Communications Strategy.												RHMT and CHMT	MoHCDGEC (PMTCT, RCH BCC unit, NACP IEC unit), IPs	• SS reports/ field visit reports
Strategy 3.3: Improve community knowledge, awareness, attitudes, perceptions, behaviours and practice in eMTCT and Paediatric HIV care and treatment through communication interventions	3.3.1. Develop, pre-test, produce and disseminate communication material (including print, audio, and visual) on eMTCT.	Hiring of communication agency											MoHC-DGEC (PMTCT)	MoHCDGEC (RCH BCC Unit, NACP IEC Unit), DPs and IPs	• Material developed • Dissemination plan
	3.3.1. Orient cultural/ folk theatre groups on eMTCT and paediatric HIV prevention, stigma reduction, promotion of male involvement, and gender issues.	Orientation workshops (to be combined with above dissemination activities)											RHMT, CHMT	MoHCDGEC (PMTCT, RCH BCC Unit, NACP IEC Unit), IPs	• Workshop reports/ Annual reports
	3.3.1. Disseminate IEC messages and materials through social media and digital media (website, blogs, SMS, calls etc.) on Paediatric HIV prevention and treatment												MoHC-DGEC (PMTCT, RCH BCC Unit, NACP IEC Unit)	DPs and IPs	• Annual reports

Strategies	Activities	Details	Level	2018			2019				2020	2021	Responsible authority	Supporting/ implementing partners	Methods for verification
				Q2	Q3	Q4	Q1	Q2	Q3	Q4					
	3.3.1. Continued media orientation on eMTCT and Paediatric HIV treatment and prevention	Orientation workshops across regions											MoHC-DGEC (PMTCT, RCH BCC Unit, NACP IEC Unit)	IPs, RHMT and CHMT	• Annual reports
	3.3.1. Conduct live phone in sessions on radio & TV during shows/ talks on PMTCT and Paediatric HIV care and treatment.												MoHC-DGEC (PMTCT)	MoHCDGEC (RCH BCC unit, NACP IEC unit), IPs	• Annual reports
	3.3.1. Conduct monitoring of IEC/ BCC related activities to establish reach, coverage, 3.3.1. understanding etc.	Periodic impact assessment through communication/ media agencies											MoHC-DGEC (PMTCT)	MoHCDGEC (RCH BCC unit, NACP IEC unit), IPs, RHMT and CHMT	• Monitoring/ assessment reports • Annual reports

Strategies	Activities	Details	Level	2018			2019				2020	2021	Responsible authority	Supporting/ implementing partners	Methods for verification
				Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategy 3.4: Increase male involvement in eMTCT services through improved awareness, reduction in stigma, and community engagement	3.4.1. Undertake awareness creation, sensitization, and community mobilization activities.												MoHC-DGEC (PMTCT), RHMT, CHMT	MoHCDGEC (RCH BCC Unit, NACP IEC Unit), IPs	• Annual reports
	3.4.2. Identify and mobilize male champions/ peer educators.												RHMT, CHMT, IPs	MoHCDGEC (PMTCT, RCH BCC Unit, NACP IEC Unit)	• Annual reports
	3.4.3. Constitute/ leverage existing male clubs, etc. and disseminate IEC messages through male champions.												RHMT, CHMT, IPs	MoHCDGEC (PMTCT, RCH BCC Unit, NACP IEC Unit)	• Annual reports
	3.4.4. Reach out to men with appropriate messages, through use of innovative media forms such as mHealth (SMS), promotional materials (T shirts, caps, diary etc.), wheel covers with IEC messages.												MoHC-DGEC (PMTCT), RHMT, CHMT	MoHCDGEC (RCH BCC Unit, NACP IEC Unit), DPs and IPs	• Annual reports
Strategy 3.5: Increased focus towards adolescent friendly services for HIV prevention and transmission	3.5.1. Research for media forms which are more appealing for adolescents (e.g. mobile apps, internet, social media), and use these for providing adolescents-specific HIV messages related to prevention, transmission, treatment and care.												MoHC-DGEC (PMTCT)	MoHCDGEC (RCH BCC Unit, NACP IEC Unit, Adolescent Health), DPs	• Research report

Strategies	Activities	Details	Level	2018			2019				2020	2021	Responsible authority	Supporting/ implementing partners	Methods for verification
				Q2	Q3	Q4	Q1	Q2	Q3	Q4					
	3.5.2. Identify and use eMTCT advocates/ champions/ ambassadors to increase awareness and knowledge on adolescent PMTCT/ HIV issues.												RHMT, CHMT, IPs	MoHCDGEC (PMTCT, RCH BCC Unit, NACP IEC Unit, Adolescent Health)	• Activity reports
	3.5.3. Advocate parent/guardian – adolescent relationships to open up/ disclose concerns on PMTCT/ HIV issues.	a. Develop advocacy package (2-day technical meeting with 30 participants)	National										MoHC-DGEC (PMTCT, Adolescent Health)	MoHCDGEC (RCH BCC Unit, NACP IEC Unit), DPs and IPs, RHMT and CHMT	• Advocacy package developed • Activity reports
		b. Orient HCWs (Nearly 6,000 @ 1 per HF – 1 session per district with 35 participants and 5 resource persons, 1 day)	District												
Strategy 3.6: Develop mHealth services for increased follow up and retention	3.5.4. Provide adolescent friendly HIV/SRH services on special days, for adolescent girls and young women.	Orientation of HCWs on Adolescent friendly SRH services guidelines (orientation to be clubbed with other activities).											RHMT and CHMT, IPs	MoHCDGEC (PMTCT, Adolescent Health, RCHS, NACP)	• Activity reports
	3.5.5. Targeted SRH/HIV/STI outreach services for adolescent girls and young women (AGYW).	Leverage existing outreach platforms.											RHMT and CHMT, IPs	MoHCDGEC (PMTCT, Adolescent Health, RCHS, NACP)	• Activity reports
	3.5.6. Establish peer support groups in the community and HFs for adolescent girls and young women.	a. Develop guidelines for the AGYW peer support groups – 2 day consultation meeting with 30 participants.	National										MoHC-DGEC (PMTCT, Adolescent Health), DPs	MoHCDGEC (NACP, RCHS), IPs, RHMT and CHMT	• Guidelines • Annual reports
		b. Establish support groups involving parents, peers, religious leaders, and community influencers.													

Strategies	Activities	Details	Level	2018			2019				2020	2021	Responsible authority	Supporting/ implementing partners	Methods for verification
				Q2	Q3	Q4	Q1	Q2	Q3	Q4					
	3.6.1. Develop integrated mobile application providing all relevant services i.e. IEC, care / treatment follow up, e-modules with focused HIV prevention practices etc.	a. Leverage existing application / develop new application through a technical agency.											MoHC-DGEC (PMTCT)	MoHCDGEC (RCHS, NACP), DPs and IPs	• Activity report/ Annual report
		b. Orientation of programme managers across regions and districts.													
	3.6.2. Update and link mobile numbers of pregnant women/ male partner and CHWs at central database for active follow up through use of software (online and offline modes)	Orientation of programme managers across regions and districts.											MoHC-DGEC (PMTCT)	MoHCDGEC (RCHS, NACP), IPs	• Activity report/ Annual report
	3.6.3. Leverage existing mHealth platforms to expand coverage for the follow up of PLHIV women and their exposed infants/children to ensure continuum of care and accuracy of data.	a. Technical consultation meeting (30 participants for 2 days).	National										MoHC-DGEC (PMTCT)	MoHCDGEC (RCHS, NACP), DPs and IPs	• Activity report/ Annual report
		b. Orientation of programme managers across regions and districts.													

Strategies	Activities	Details	Level	2018			2019				2020	2021	Responsible authority	Supporting/ implementing partners	Methods for verification
				Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategy 3.7: Strengthen community involvement and enhanced participation of community structures in comprehensive eMTCT and Paediatric care and support	3.7.1. Engage community health workers in close coordination with community groups for enhanced support for implementation of eMTCT and Paediatric community intervention package.	Orientation of community groups and CHWs.											MoHC-DGEC (PMTCT)	MoHCDGEC (RCHS, NACP), IPs	• Activity report
	3.7.2. Strengthen Adolescent friendly and school based HIV prevention practices with active involvement of community.	Leverage the School Health Programme platform.											MoHC-DGEC (PMTCT, Adolescent Health, School Health Programme)	MoHCDGEC (RCHS, NACP), DPs and IPs, RHMT and CHMT	• Strategy document • Annual report
Strategic objective 4: To develop accountability and resilience mechanisms, through monitoring, evaluation, and learning															
Strategy 4.1: Strengthen implementation of the eMTCT Monitoring & Evaluation System	4.1.1. Develop, print and disseminate M&E Framework for eMTCT Plan 2017 – 2020 to Regional and District Health Management Teams.	a. Technical meeting to develop M&E Framework (approx. 25 participants, National level).	National										MoHC-DGEC (PMTCT, NACP)	MoHCDGEC (RCH HMIS), DPs and IPs	• M&E Framework
		b. Print copies of M&E Framework (1000 copies).	National												
		c. Disseminate framework to RHMT and CHMT (6- zonal Dissemination meetings of 2 days each with 80 participants and 2 National resource persons)	Regional/ District												
	4.1.2. Orient M&E focal persons and RCH coordinators at Regional and District level on the use of Mother-Child cohort monitoring data.	6-Orientation meetings at zonal level, 80 participants and 2 National level persons, each lasting for 5-days	Regional/ District												

Strategies	Activities	Details	Level	2018			2019				2020	2021	Responsible authority	Supporting/ implementing partners	Methods for verification
				Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategy 4.2: Improve routine monitoring and evaluation of eMTCT and Paediatric HIV care and treatment, with a focus on adolescent girls and young pregnant women.	4.2.1. Review and update the existing DHIS database to include evolving priorities of the PMTCT programme.	Technical meeting to review and update DHIS data elements for PMTCT, (one day meeting annually – club with a TWG meeting, budgeted under SO 7).											MoHC-DGEC (PMTCT)	MoHCDGEC (RCHS, NACP), DPs and IPs	• Review reports
	4.2.2. Update M&E data recording and reporting tools for eMTCT and Paediatric HIV care and treatment, based on M&E Framework 2017-2020, including age-disaggregated data and indicators.	a. Technical meeting to update tools (one-time, nationally, estimated 25 participants, for 5 days)	National										MoHC-DGEC (PMTCT, NACP)	MoHCDGEC (RCH HMIS), DPs and IPs	• Updated M&E tools
		b. Print recording and reporting formats (6000 copies to cover all facilities).	National												
	4.2.3. Support quarterly data review meetings at district level for verification and harmonisation of PMTCT and HIV data.	1 review meeting/ quarter/ District for one day (25 local participants)	District										RHMT and CHMT, IPs	MoHCDGEC (PMTCT, NACP, RCH HMIS)	• Review reports
	4.2.4. Advocate at district level for budget allocation from Comprehensive Council Health Plans (CCHPs) on modems and internet bundles to ensure connectivity/ access for improving data entry and reporting at district and health facilities level.												MoHC-DGEC (PMTCT, RCH HMIS)	MoHCDGEC (NACP), DPs and IPs	• Activity reports

Strategies	Activities	Details	Level	2018			2019				2020	2021	Responsible authority	Supporting/ implementing partners	Methods for verification
				Q2	Q3	Q4	Q1	Q2	Q3	Q4					
	4.2.5. Conduct quarterly PMTCT and Paediatric HIV care and treatment Data Quality Assessment in sample districts	DQA Health Facility Visits and Assessment using LARS (400 Health facilities visited annually, National team-3, Regional team-3, and District team- 2 participants) (2-week visit, covering 16 HFs per visit – total 25 visits).	District										RHMT and CHMT	MoHCDGEC (PMTCT, NACP), IPs	• Assessment reports
Strategy 4.3: Carry out Operational Research (OR), surveillance and Surveys to review guide program implementation	4.3.1. Review and update national Operational Research priorities for eMTCT and Paediatric HIV care and treatment, including relevant gender and human issues	Technical meeting to review and update Operational Research priorities (1 day meeting with 30 participants, national level, one-time)	National										MoHC-DGEC (PMTCT, NACP)	Research & training institutions, COSTECH, DPs and IPs	• Priorities Document
	4.3.2. Conduct Operational Research in line with identified eMTCT and Paediatric HIV care and treatment priorities	# no. of research studies done											MoHC-DGEC (PMTCT, NACP)	Research & training institutions, COSTECH, DPs and IPs	• Research findings and publications
	4.3.3. Establish eMTCT surveillance system to monitor transmission at 6 weeks, 6, 12 and 18 months for impact assessment		National										MoHC-DGEC (PMTCT)	MoHCDGEC (RCHS, NACP), DPs and IPs	• Surveillance reports
	4.3.4. Conduct Mid-term and End-term Evaluation of the implementation of 2017-2020 eMTCT Plan	Mid-term evaluation in late 2018 and End-term evaluation in late 2020 along with development of next phase eMTCT Plan	National										MoHC-DGEC (PMTCT)	MoHCDGEC (RCH, NACP), DPs and IPs, RHMT and CHMT	• Evaluation reports

Strategies	Activities	Details	Level	2018			2019				2020	2021	Responsible authority	Supporting/ implementing partners	Methods for verification
				Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategy 4.4: Improve PMTCT and Paediatric HIV care and treatment services provision through promoting data use	4.4.1. Identify, document and share the innovations and best practices in the implementation of activities geared towards eMTCT	a. Documentation of best practices (twice).	National										MoHC-DGEC (PMTCT, NACP)	MoHCDGEC (RCHS), DPs and IPs, RHMT and CHMT	• Best practices documents/ Annual reports
		b. Review meetings to discuss documentation (two annual reviews).	National												
	4.4.2. Develop, print and disseminate PMTCT Annual Reports on progress of implementation of eMTCT Plan 2017-2020.	1,000 copies of annual reports x 4 reports	National										MoHC-DGEC (PMTCT)	MoHCDGEC (RCH HMIS, NACP), DPs and IPs	• Annual reports
	4.4.3. Disseminate eMTCT M&E reports and other eMTCT research findings through various fora (e.g. Annual and Zonal RCH meetings, Regional and District health fora and joint Implementing Partners' meetings).	# no. of disseminations (6-zonal meetings annually, each 80 participants for 3-days, 2 National persons to attend)	Zonal										MoHC-DGEC (PMTCT, NACP)	MoHCDGEC (RCHS), DPs and IPs, RHMT and CHMT	• Activity reports
	4.4.4. Develop PMTCT data analysis and utilization training package for regional, district and facility level.	a. Technical meeting to develop training package (2-weeks for 25 participants at national level, 1 week to develop and 1 week to review draft and finalise).	National										MoHC-DGEC (PMTCT)	MoHCDGEC (RCH HMIS, NACP), DPs and IPs	• Training modules developed and printed
		b. Printing of training modules (1,000 copies).	National												
		c. Training covered under M&E Framework dissemination.													

Strategies	Activities	Details	Level	2018			2019				2020	2021	Responsible authority	Supporting/ implementing partners	Methods for verification
				Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategy 5.1: Strengthen the capacity of RHMT, CHMT and health care workers at all levels in managing PMTCT commodities	5.1.1. Develop/ adopt and pre-test training modules for commodity management (data quality and use of data for decision making, targeting Pharmacist, Laboratory Technologist, and RCH Coordinators across regions and districts.	a. Technical consultations for development of training modules (2 consultants for 20 days each LOE, 3 day meeting at National level with 25 participants to finalise the modules).	National										MoHC-DGEC (NA-CP,PMTCT MSD)	MoHCDGEC (RCHS), DPs and IPs	• Training module
		b. Pre-test the training modules in 3 regions (1 district each), involving 6 national level resource persons) – 15 participants at region level and 30 at district level – 1 day activity at each level (excluding travel) - one region and one district covered in a 4 day visit by 2 national persons (total 3 visits).	Regional / District												
		c. Printing of training modules (2,900 copies).	National												
	5.1.2.Build capacity of Regional and district Pharmacists, Laboratory Technologists, and RCH Coordinators across regions and districts, on commodity management, data quality and use of data for decision making earmarking the cascade to the lower level facilities. (Sustainability of program).	a. 3-day training to 60 TOTs who will be conducting OJT to HCWs at PMTCT facilities (2 batches of 30 participants each for 3 days at national level, 5 trainers per batch – all national).	National										MoHC-DGEC (NACP, PMTCT, PSU, GHSC, MSD)	MoHCDGEC (RCHS), DPs and IPs, RHMT and CHMT	• Training reports
		b. On Job trainings conducted across regions (26) annually - 2 sessions, 3 days each, 65 participants, team of 6 trainers (2 each National, regional and district) - both sessions covered in one visits - 26 visits.	Regional / District												
		c. Training of identified HCWs (285 sessions over 3 years for a total of 10,000 participants – batch of 35 with 5 trainers over 3 days training).	Regional / District												

Strategies	Activities	Details	Level	2018			2019				2020	2021	Responsible authority	Supporting/ implementing partners	Methods for verification
				Q2	Q3	Q4	Q1	Q2	Q3	Q4					
	5.1.3. Print and distribute logistic management tools.		National										MoHC-DGEC (NACP, MSD)	MoHCDGEC (PMTCT, RCHS), DPs and IPs	• Logistics management tools printed
	5.1.4. Strengthen mentorship, supportive supervision and OJT for HCWs on commodity management, on data quality and use of data for decision making.		Regional /District										MoHC-DGEC (NACP, PMTCT)	MoHCDGEC (RCHS), IPs, RHMT and CHMT	• SS reports
	5.1.5. Provide refresher training on updated treatment guidelines and supply chain tools, as required.	1 refresher session per region/ per year to RHMT & CHMT who will cascade the mentorship to lower level facilities - 4 members of each RHMT and CHMT, 2 days training to batch of 30 per region, 2 regions covered in a 1-week trip by 5 national level resource persons (13 visits per year).	Regional / District										MoHC-DGEC (NACP, PMTCT, MSD)	MoHCDGEC (RCHS), IPs, RHMT and CHMT	• Training reports
	5.1.6. Conduct coordination meetings with Regions, Districts, Supply Chain Implementing Partners, Medical Stores Department and other stakeholders on sharing commodity updates, supply chain challenges and possible solutions.	a. Quarterly meetings in each region (26) – 1 day meeting with 30 participants.	Regional / District										MoHC-DGEC (PMTCT; NACP, MSD)	MoHCDGEC (, RCHS), DPs and IPs, RHMT and CHMT	• Meeting minutes/ Annual reports
		b. Annual meetings at national level involving 80 participants for 2 days each.	National												

Strategies	Activities	Details	Level	2018			2019				2020	2021	Responsible authority	Supporting/ implementing partners	Methods for verification
				Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategy 5.2: Integrate the basic logistics monitoring indicators with other PMTCT monitoring and evaluation systems	5.2.1. Develop M&E and update logistic tools (where applicable) with indicators for effective commodity management.	Technical meeting (annually for 5 days, 40 participants, at national level)	National										MoHC-DGEC (PMTCT, NACP)	MoHCDGEC (RCHS, MSD), DPs and IPs	• Updated M&E tools
	5.2.2. Develop the mechanisms for extracting regular reports, as per data requirements, from eLMIS system.	a. Development of dashboard for PMTCT on eLMIS system.	National										MoHC-DGEC) PMTCT	MoHCDGEC , MSD), IPs	• Dashboard • Quarterly and Annual reports
		b. Auto generation of customised reports on periodic basis (quarterly, annual) for PMTCT from eLMIS system.	National												
	5.2.3. Conduct quarterly assessment of logistic system performance of the indicators. Review the performance indicators of PMTCT and linkages with e-LMIS and other systems.	Quarterly review meetings by TWG (20 participants per session, at national level).	National										MoHC-DGEC (PMTCT, NACP)	MoHCDGEC (RCHS, MSD), DPs and IPs	• Meeting minutes • Assessment reports
	5.2.4. Review the different SMS based tracking systems in practice and adopt the relevant ones for management of PMTCT commodities.	Technical meeting (25 participants – 2 days, national level, annually).	National										MoHC-DGEC (PMTCT, MSD)	MoHCDGEC (PMTCT, RCHS, NACP), DPs and IPs	• Annual report

Strategies	Activities	Details	Level	2018			2019				2020	2021	Responsible authority	Supporting/ implementing partners	Methods for verification
				Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Strategy 5.3: Strengthen logistics SCM including medicines diagnostics and other medical supplies	5.3.1. Maintain continuous availability of eMTCT & Paediatric HIV care and treatment supplies through the existing logistics system.	Work and collaborate with MSD, PORALG and IPs to ensure quality data is collected and recorded correctly in the tools; and monitor and track commodities at facility monthly to ensure availability of PMTCT commodities at MSD and health facility levels.	National										MoHC-DGEC (MSD, PMTCT)	PORALG, MoHCDGEC (NACP), IPs, RHMT and CHMT	• Logistic reports
	5.3.2. Participate in regular quantification exercises to ensure eMTCT and Paediatric HIV medicines, diagnostics and medical supplies taking into account targets of the program.	Participate in the Quantification of ARVs and Lab supplies at NACP.	National										MoHC-DGEC (NACP, PMTCT MSD)	MoHCDGEC , IPs, RHMT and CHMT	• Quantification reports
	5.3.3. Maintain a stock control system for eMTCT Paediatric HIV medicines and diagnostics.	Work closely with MSD to get monthly stock status of ARVs and lab supplies.	National										MoHC-DGEC (PMTCT, NACP, MSD)	MoHCDGEC (MSD), IPs, RHMT and CHMT	• Stock reports
	5.3.4. Institutionalize data use for decision making at all levels in supply chain platforms, TWGs, QIT meetings, etc.	Ensuring discussion on issues at all fora, using analysis of data on performance indicators, dashboards, etc..	National										MoHC-DGEC (PMTCT,	MoHCDGEC (RCHS, MSD), DPs and IPs, RHMT and CHMT	• Meeting minutes
	5.3.5. Assess lower health facilities' capacity to implement pharmacy module and rollout of pharmacy module at lower level HFs.	Development and rollout of Facility pharmacy module.	National, Regional, District										MoHC-DGEC , NACP)	MoHCDGEC. IPs	• Field Reports

CHAPTER 6: eMTCT PLAN II RESOURCE REQUIREMENTS

Costing Approach and Data Sources

This section estimates financial cost for implementing the plan in the next four years (2018-21). These estimates will guide resource mobilization by the PMTCT unit from various sources including the government and partners.

Costing of the plan involved identification of unit costs and coverage levels for the various activities from which detailed work plan and budget were developed. Costs consisted of time compensation to personnel, procurement (ARVs, test kits), sample transportation, printing and distribution, consultancy fees, venue, meals, travel, vehicle operation and maintenance. Unit costs were sourced from the PMTCT Unit and PEPFAR PMTCT costing study conducted in 2015⁷.

PMTCT coverage levels considered estimated pregnant women needing HIV counselling and testing, estimated couples needing counselling and testing, estimated number of women needing ART, estimated number of HIV exposed infants receiving ARV prophylaxis, estimated number of infants needing testing at 2 months and 18 months. These estimates were retrieved from Spectrum with assistance from the PMTCT Unit.

Costs were computed using the following formula;

Cost per activity or service = population in need target coverage*unit cost*

Population in need is the number of clients requiring a service for example, estimated number of pregnant women needing HIV counselling and testing or estimated number of infants needing virological test. Target coverage is the planned coverage level (in percentage) for the various services for a certain time period. For example in the current plan, HTC provision to pregnant women is planned to reach and be sustained at 98%. Unit cost is the cost per input into PMTCT activity, for example cost of ART provision per woman. Note that some activities do not involve direct services to PMTCT clients, for example training and supportive supervision, in such cases activity cost is estimated by multiplying input quantities by their unit prices.

*Cost per activity = quantity*unit price*

Cost estimates for future years (2018-2021) were adjusted for inflation, assumed to be constant at 5%, to take care of possible price hikes for PMTCT inputs in future. Cost estimates were made in Tanzanian Shillings (TZS) and converted to United States Dollars (USD) using prevailing exchange rate, 1 USD = 2,200 TZS.

Estimated Cost of Implementing Plan

Implementation of the plan will require approximately TZS 571.6 billion equivalent to USD 259.8 million for the whole four-year period (2018-2021) (see figure 1). Specifically, approximately TZS 298 billion (USD 135.5 million) is required for the first year (2018), TZS 98.8 billion (USD 44.9 million) for the second year (2019), TZS 85 billion (USD 38.7 million) for the third year (2020) and TZS 89.4 billion (USD 40.6 million) for the last year of the plan (2021).

⁷ Tanzania Ministry of Health, Community Development, Gender, Elderly and Children, U.S. Centers for Disease Control and Prevention, and ICF International. (2016). Cost of Prevention of Mother-to-Child Transmission (PMTCT) Services Using Option B+ in Tanzania. Dar es Salaam, Tanzania and Atlanta, GA (USA): U.S. Centers for Disease Control and Prevention.

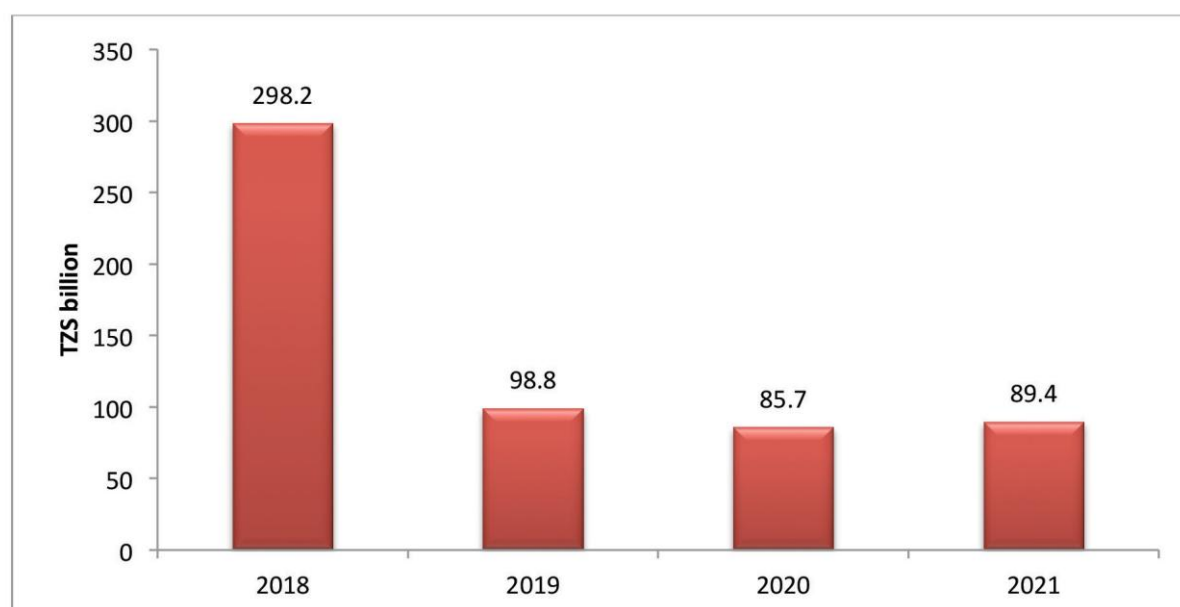


Figure 11: Estimated financial cost of plan implementation, 2018-21

Forty eight percent (48%) of the estimated resources are required for implementing strategic objective two on improving quality of PMTCT care through mentoring, accreditation/star rating of health facilities providing PMTCT and RMNCH services (table 1). Strategic objective two is focused on service provision ranging from prevention and treatment to care, support and follow-up. Moreover, this plan has given special focus on community initiatives under strategic objective three with about TZS 225 billion required to actively engage the community.

Summary estimates of funding requirements

Table 7: Cost Estimates By Strategic Objective

STRATEGIC OBJECTIVE	TZS (million)					USD (million)				
	2018	2019	2020	2021	TOTAL	2018	2019	2020	2021	TOTAL
Strategic Objective 1	10,688	9,144	6,782	7,121	33,736	4.86	4.16	3.08	3.24	15.33
Strategic Objective 2	63,527	71,087	67,217	69,844	271,676	28.88	32.31	30.55	31.75	123.49
Strategic Objective 3	217,033	7,404	409	430	225,276	98.65	3.37	0.19	0.20	102.40
Strategic Objective 4	3,963	4,687	4,099	4,988	17,737	1.80	2.13	1.86	2.27	8.06
Strategic Objective 5	3,000	6,508	6,709	7,045	23,261	1.36	2.96	3.05	3.20	10.57
TOTAL	298,211	98,830	85,217	89,429	571,686	135.55	44.92	38.74	40.65	259.86

In terms of expenditure types, Community initiatives requires thirty six percent of the estimated resources (table 8). This is followed by ART costs, training, HIV testing and counselling, operations, HEID, M&E and printing and IEC respectively.

Table 8: Cost Estimates By Expenditure Type

STRATEGIC OBJECTIVE	TZS (million)					USD (million)				
	2018	2019	2020	2021	TOTAL	2018	2019	2020	2021	TOTAL
ART costs	29,783	32,876	33,920	34,798	131,376	13.54	14.94	15.42	15.82	59.72
HTC	13,246	14,027	15,022	16,081	58,376	6.02	6.38	6.83	7.31	26.53
HEID	8,336	9,943	11,248	12,086	41,613	3.79	4.52	5.11	5.49	18.92
M&E	4,003	5,365	4,739	5,607	19,714	1.82	2.44	2.15	2.55	8.96
Operations	10,522	11,569	12,163	12,754	47,009	4.78	5.26	5.53	5.80	21.37
Printing and IEC	6,897	123	407	188	7,616	3.13	0.06	0.19	0.09	3.46
Training	20,991	24,613	7,389	7,567	60,560	9.54	11.19	3.36	3.44	27.53
Community Initiatives	204,433	314	330	346	205,423	92.92	0.14	0.15	0.16	93.37
TOTAL	298,211	98,830	85,217	89,429	571,686	135.55	44.92	38.74	40.65	259.86

Detailed budget estimates of funding requirements

Strategies	Activities	Details	Level	Assumptions	No. of Units	Fre- quency	Final Unit Cost ('000 TZS)	2018			2019				2020	2021	TOTAL BUDGET ('000 TZS)
								Q2	Q3	Q4	Q1	Q2	Q3	Q4			
																	571,686,442
Strategic objective 1: To foster evidence based planning, results based management and coordination of the PMTCT program in Tanzania																	33,735,796
Strategy 1.1: Strengthen Co- ordination and accountability for comprehensive eMTCT at all levels	Advocate for resource mobilization for eMTCT activities at all levels (continue engagement with DPs and AIDS Trust Fund for resource mobilisation for PMTCT)	National annual meeting involving 30-people for 1-day and Regional (26) annual meetings for 2-days	National	80% participants will be govt. / entitled to per diem (70% will be eligible for half per diem with no transport allowance, and 10% from outside Dar will be eligible for full per diem, including travel days, with transport allowance); Remaining 20% - no transport allowance or per diem.	1	4.0	3,730	-	3,730	-	-	-	3,917	-	4,112	4,318	16,077
			Regional	75% participants will be eligible for full per diem and transport allowance; 25% will be eligible for half per diem and no transport allowance	26	4.0	19,632	-	255,216	255,216	123,682	144,295	123,682	144,295	562,751	590,889	2,200,026
	Engage political leaders, policy makers, partners, communities and all other stakeholders for increased accountability and demand creation	National, Regional (26), District (167) levels - 30 participants for 1 day - annually	National	80% participants will be govt. / entitled to per diem (70% will be eligible for half per diem with no transport allowance, and 10% from outside Dar will be eligible for full per diem, including travel days, with transport allowance); Remaining 20% - no transport allowance or per diem.	1	4.0	17,770	-	17,770	-	-	18,659	-	-	19,591	20,571	76,591
			Regional/ District	75% participants will be eligible for full per diem and transport allowance; 25% will be eligible for half per diem and no transport allowance	193	4.0	16,832	-	1,615,872	1,632,704	848,333	866,006	848,333	848,333	3,581,555	3,760,633	14,001,769
Strategy 1.2: Ensure integrated planning, management and supervision of PMTCT and Paediatric AIDS programmes.	Conduct joint planning meetings between IPs and Councils	One planning meeting conducted annually for each council (167) for 3-days (15-people per meeting)	District	75% participants will be eligible for full per diem and transport allowance; 25% will be eligible for half per diem and no transport allowance	167	4.0	6,295	-	528,780	522,485	555,219	-	548,609	-	1,159,020	1,216,971	4,531,084
	Orient Health facility Management Teams on Management Skills.	Two people for each health facility (an In-charge and Matron) for 2-days. Nearly 12,000 persons to be trained, in 2 sessions per district (batch size of 36, with 5 resource persons/ session, of which 1 national).	District	All participants will be eligible for full per diem and transport allowance; 4 local resource persons and 1 national (get 1 day before and 2 days after training, for prep and report writing; assuming both sessions done in one trip for national person)	167	1.0	41,236	1,443,260	1,443,260	1,443,260	1,515,423	1,169,041	-	-	-	-	7,014,244

		Printing and distribution of the Plan (7000 copies)	National		1	1.0	84,000	84,000	-	-	-	-	-	-	-	-	84,000
	Disseminate the national eMTCT plan and targets at all levels, and orient RHMTs and CHMTs	Dissemination meetings and orientation at regional (26) levels (One day meeting excluding travel days, 60 participants per region, 2 National level resource persons per meeting, covering 3 regions in a 7 days trip - total 9 visits).	Regional	75% participants will be eligible for full per diem and transport allowance; 25% will be eligible for half per diem and no transport allowance	9	1.0	62,386	561,474	-	-	-	-	-	-	-	-	561,474
	Conduct bi-annual Data Review meetings at district level, to highlight issues on EID, Paediatric ARV and retention.	One day meeting involving 15-people for each council (167), bi-annually	District	75% participants will be eligible for full per diem and transport allowance; 25% will be eligible for half per diem and no transport allowance	167	7.0	2,545	-	213,780	211,235	224,469	221,797	224,469	221,797	937,158	984,016	3,238,721
	Conduct bi-annual Comprehensive supportive supervision of PMTCT and Paediatric HIV care and treatment	Bi-annual supportive supervision to selected Health Facilities with RCH services (approx. 200 x 2 times a year) (2-National, 3-Regional, and 3-district supervisors for 1-week) total of 50 visits per year (8 HF / visit / week)	Zonal/ Regional/ District		50	4.0	8,114	129,824	137,938	137,938	110,756	102,236	110,756	102,236	447,284	469,648	1,748,618
Strategy 1.3: Streamline PMTCT management and coordination at the national level	Conduct joint coordination meetings for PMTCT and Paediatric HIV care and treatment with other RCH, TB, HIV/AIDS, and STI programmes, and DPs and IPs.	Quarterly coordination meetings at National level of 30-people for 1-day	National	80% participants will be govt. / entitled to per diem (70% will be eligible for half per diem with no transport allowance, and 10% from outside Dar will be eligible for full per diem, including travel days, with transport allowance); Remaining 20% - no transport allowance or per diem.	1	15.0	3,670	3,670	3,670	3,670	3,854	3,854	3,854	3,854	16,185	16,994	59,603
	Conduct annual meetings of the Policy & Guidance TWG of PMTCT, to discuss any review and update of policies related to PMTCT programme.	Annual meeting with 30 participants for one day	National	80% participants will be govt. / entitled to per diem (70% will be eligible for half per diem with no transport allowance, and 10% from outside Dar will be eligible for full per diem, including travel days, with transport allowance); Remaining 20% - no transport allowance or per diem.	1	4.0	2,350	2,350	-	-	-	2,468	-	-	2,591	2,720	10,129
	Conduct regular meetings of the Training, Mode of Care, and Community Engagement TWG of PMTCT, to review progress on programme implementation, and identify and address any issues.	Quarterly one-day meeting with 40 participants, at national level	National	80% participants will be govt. / entitled to per diem (70% will be eligible for half per diem with no transport allowance, and 10% from outside Dar will be eligible for full per diem, including travel days, with transport allowance); Remaining 20% - no transport allowance or per diem.	1	15.0	4,730	4,730	4,730	4,730	4,967	4,967	4,967	4,967	20,859	21,902	76,818

	Conduct quarterly meetings of the M&E TWG of PMTCT, as part of coordination and implementation of PMTCT M&E activities.	1 meeting/ quarter (25 participants – 3 outstation)	National	80% participants will be govt. / entitled to per diem (70% will be eligible for half per diem with no transport allowance, and 10% from outside Dar will be eligible for full per diem, including travel days, with transport allowance); Remaining 20% - no transport allowance or per diem.	1	15.0	2,420	2,420	2,420	2,420	2,541	2,541	2,541	2,541	10,672	11,206	39,302
		Quarterly by M&E technical working group (meeting costs covered above)			-	-	-	-	-	-	-	-	-	-	-	-	-
	Conduct regular reviews of the eMTCT planned targets and achievement from National to facility levels.	Annual National review meeting (50 participants – national level)	National	80% participants will be govt. / entitled to per diem (70% will be eligible for half per diem with no transport allowance, and 10% from outside Dar will be eligible for full per diem, including travel days, with transport allowance); Remaining 20% - no transport allowance or per diem.	1	4.0	6,000	-	-	6,000	-	-	-	6,300	6,615	6,946	25,861
	Conduct regular meetings of the Logistics and Supply Chain TWG of PMTCT, to assess performance on logistics indicators, progress on planned activities and issues.	Quarterly review meetings by Logistics and Supply Chain TWG (25 participants each, including 3 outstation)	National	80% participants will be govt. / entitled to per diem (70% will be eligible for half per diem with no transport allowance, and 10% from outside Dar will be eligible for full per diem, including travel days, with transport allowance); Remaining 20% - no transport allowance or per diem.	1	15.0	3,170	3,170	3,170	3,170	3,329	3,329	3,329	3,329	13,980	14,679	51,482
Strategic objective 2: To improve quality of PMTCT care through mentoring, accreditation/star rating of health facilities providing PMTCT and RMNCH services.																	271,676,119
Strategy 2.1: Review and update National guidelines, protocols, and job aids	Regularly review, update and disseminate National PMTCT guidelines.	Meeting with technical experts (2 -meetings, 20-people for 5-days)	National	80% participants will be govt. / entitled to per diem (70% will be eligible for half per diem with no transport allowance, and 10% from outside Dar will be eligible for full per diem, including travel days, with transport allowance); Remaining 20% - no transport allowance or per diem. Assuming 2 of the participants will be involved in report writing.	1	2.0	14,810	-	14,810	-	-	-	-	-	16,328	-	31,138
		Printing of 10,000 copies (twice)	National		1	2.0	120,000	-	120,000	-	-	-	-	-	132,300	-	252,300

		Dissemination meetings and orientation at Regional (26) level - 1 meeting for 1 day involving 40 participants – 2 National participants covering 3 regions in 1 week visit – total 9 visits of one week each (twice).	Regional	75% participants will be eligible for full per diem and transport allowance; 25% will be eligible for half per diem and no transport allowance; air transport unit cost divided by 3 to cover 3 meetings in one trip.	9	2.0	13,730	-	-	123,570	-	-	-	-	136,236	-	259,806
	Review and update, job aids for PMTCT and Paediatric HIV care and treatment, and the follow-up/referral of HIV-positive mothers and their children	Meeting with technical experts (2-meetings, 5-days involving 30 participants each, national level)	National	80% participants will be govt. / entitled to per diem (70% will be eligible for half per diem with no transport allowance, and 10% from outside Dar will be eligible for full per diem, including travel days, with transport allowance); Remaining 20% - no transport allowance or per diem. Assuming 2 of the participants will be involved in report writing.	1	2.0	20,790	-	20,790	-	-	-	-	-	22,921	-	43,711
		Printing of 10,000 copies (twice)	National		1	2.0	120,000	-	120,000	-	-	-	-	-	132,300	-	252,300
Strategy 2.2: Build capacity of health care workers to provide comprehensive PMTCT, HEID and paediatric care services at all levels of health facilities	Train National, Regional and District RCH/HIV & AIDS ToT teams, with public and private sector representatives, in eMTCT, HEID and Paediatric HIV care and treatment.	TOTs training/ refresher training and orientation meetings (60 TOTs for 5-days excluding travel days) – batch of 30 TOTs x 2 batches; 5 resource persons	Regional	All participants will be eligible for full per diem and transport allowance; 4 local resource persons and 1 national (get 1 day before and 2 days after training, for prep and report writing)	2	1.0	39,777	39,777	39,777	-	-	-	-	-	-	-	79,554
	Conduct focused modular training on HEID and Paediatric HIV care and treatment, utilising training packages already developed, in line with comprehensive Regional and District plans.	Training of HCWs (3000 HCWs, to be trained, for 5-days excluding travel days; 100 batches of 30 participants each; 5 trainers per batch; 100 batches of 30 participants each; 5 trainers per batch – 1 national level)	Regional	All participants will be eligible for full per diem and transport allowance; 4 local resource persons and 1 national (get 1 day before and 2 days after training, for prep and report writing)	100	1.0	35,177	703,540	703,540	703,540	738,717	738,717	-	-	-	-	3,588,054
	Scale up Mother-Child cohort monitoring system to all Regions and PMTCT facilities.	Training of staff (8000 HCWs trained for 5-days, at Regional headquarters – batch size of 40 participants with 5 trainers – 1 trainer from National level - total 200 batches)	Regional	All participants will be eligible for full per diem and transport allowance; 4 local resource persons and 1 national (get 1 day before and 2 days after training, for prep and report writing)	200	1.0	34,495	689,900	1,034,850	1,034,850	1,086,593	1,086,593	1,086,593	1,086,593	-	-	7,105,970
	EID apprenticeship training scale up.	400 health facilities covered biannually; 300 HFs by 2 Regional and 2 District mentors; 100 HFs by 2 National, 1 Regional and 1 District mentors; week long visits with 2 facilities covered per visit - Total 400 visits per year.	Regional/ District	Regional and district team does 300 visits annually	300	4.0	3,432	343,200	343,200	343,200	270,270	270,270	270,270	270,270	1,135,134	1,191,891	4,437,705
				Full team does 100 visits annually	100	4.0	5,162	154,860	206,480	154,860	135,503	135,503	135,503	135,503	569,111	597,566	2,224,887

Conduct mentoring of health workers already trained and providing services in general PMTCT, infant feeding, HEID and adult ART.	2-National Mentors, 2-Regional Mentors, 1-Council mentor in 200 Health facilities (2 health facilities per week – 100 visits per year)	District		100	4.0	5,870	176,100	234,800	176,100	154,088	154,088	154,088	154,088	647,168	679,526	2,530,043
Strengthen data driven supportive supervision and mentorship through LARS-based follow up visits to under-performing health facilities on a quarterly basis.	400 HF's followed up annually, team comprising of 2-National supervisors, 2-Regional supervisors and 3-district supervisors (8 facilities / visit / week – 50 visits per year)	District		50	4.0	6,586	98,790	131,720	98,790	89,899	82,984	89,899	82,984	363,053	381,206	1,419,324
Establish distance learning programme for PMTCT.	Engage consultancy firm to develop distance learning modules and training modalities.		Lump sum cost USD 30,000 (assuming 100 person days of effort)	1	1.0	66,000	-	66,000	-	-	-	-	-	-	-	66,000
Finalise pre-service training package on PMTCT for doctors.	On-going – funds already provided.			-	-	-	-	-	-	-	-	-	-	-	-	-
Review and update pre-service training materials for all health cadres to incorporate evolving technical guidelines/ protocols and relevant best practices in eMTCT and Paediatric HIV care.	Technical review meetings (2-Meetings, involving 30-people for 5-days).	National	80% participants will be govt. / entitled to per diem (70% will be eligible for half per diem with no transport allowance, and 10% from outside Dar will be eligible for full per diem, including travel days, with transport allowance); Remaining 20% - no transport allowance or per diem. Assuming 2 of the participants will be involved in report writing.	1	2.0	21,170	21,170	-	-	-	-	-	-	23,340	-	44,510
	Printing of updated pre-service training packages (1000 copies twice).			1	2.0	12,000	12,000	-	-	-	-	-	-	13,230	-	25,230
Train pre-service curriculum for TOTs in PMTCT and Paediatric HIV care and treatment in Colleges and Training Schools (nurses, doctors, pharmacists, laboratory technologists, etc.)	60 TOTs trained for 2-weeks - batch of 30 TOTs x 2 batches; 5 resource persons	Regional	All participants will be eligible for full per diem and transport allowance; 4 local resource persons and 1 national (get 1 day before and 2 days after training, for prep and report writing)	2	1.0	71,580	-	143,160	-	-	-	-	-	-	-	143,160
Scale up Paediatric HIV care and treatment centres to Centres of Excellence.	Cost covered under NACP		No costs	-	-	-	-	-	-	-	-	-	-	-	-	-

[illegible]

	Sustain and scale up Community sensitization to promote condom use focusing on adolescent girls and young women	Designate existing structures such as public offices, shops, sports centres, youth clubs, accredited drug dispenser outlets, etc. into community condoms outlets where adolescent girls and young women can readily access condoms. Condom dispensers to be procured and installed in such places (through FP programme).	Regional/ District	No costs	-	-	-	-	-	-	-	-	-	-	-	-	-
	Enhance existing mentorship package for health care workers on family planning, with male involvement.	2 workshops of 3 days each, with 30 participants, at National level (for reviewing draft and for finalisation).	National	80% participants will be govt. / entitled to per diem (70% will be eligible for half per diem with no transport allowance, and 10% from outside Dar will be eligible for full per diem, including travel days, with transport allowance); Remaining 20% - no transport allowance or per diem. Assuming 2 of the participants will be involved in report writing.	2	1.0	10,230	20,460	-	-	-	-	-	-	-	-	20,460
	Conduct mentorship to health care workers to accelerate Male involvement in HIV prevention and family planning for ANC clients	- Advocacy towards mentorship to health care workers to accelerate Male involvement in HIV prevention and family planning for ANC clients. - Train mentors on integrated HIV prevention and family planning. Biannual mentorship visit to health facilities will be conducted (covered under existing visits in strategy 1.2 and strategy 2.2).	Regional/ District	No costs	-	-	-	-	-	-	-	-	-	-	-	-	-
Strategy 2.5: Expand provision of appropriate treatment; care and support to women living with HIV, and their infants and family	Provide re-testing for HIV negative pregnant women during antenatal, peripartum and postnatal periods, in line with National guidelines.	Disseminate and promote HIV testing guidelines, including enforcing retesting in the third trimester and intrapartum testing in all PMTCT sites (under NACP).	National	No costs	-	-	-	-	-	-	-	-	-	-	-	-	-
		Procurement and supply of testing kits for 98% PW and 75% male partners.	National	Adult test kits (factoring in 75% re-testing for PW who are HIV -ve on first test, already excludes positive PW; Target for male testing @ 75%) - unit cost assumed from Costing Study 2015.	18,088,719	1.0	2,992	4,415,369	4,415,369	4,415,369	3,506,687	3,506,687	3,506,687	3,506,687	15,021,711	16,081,026	58,375,594
		Community mobilisation and IEC (covered in SO 4).	Regional/ District	No costs	-	-	-	-	-	-	-	-	-	-	-	-	-
	Provide ART to pregnant women and mothers living with HIV.	Cost of ART for 98% PWLHIV – covered in ART programme.	National	Unit cost assumed for one year of t/t per PW, from Costing Study 2015.	326,996	1.0	368.50	9,825,169	9,825,169	9,825,169	8,129,875	8,129,875	8,129,875	8,129,875	33,500,315	34,341,784	129,837,105

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Strategy 2.6: Strengthen follow up of HIV infected mothers and infants at facility and community	Enforce use of in-facility procedures for identification of patients with missed appointments and lost to follow-up	Distribute appointment and tracking registers (2 each per health facility – 12,000 each)	National	Printing and distribution costs.	1	1.0	144,000	-	144,000	-	-	-	-	-	-	-	144,000
		Include lost to follow-up and missed appointment indicators as permanent agenda of health facility quality improvement activities.	Regional/ District	No costs	-	-	-	-	-	-	-	-	-	-	-	-	-
	Establish and operationalize HIV infected mother support groups at least one group at each PMTCT site to conduct follow up and peer support infected mothers.	Develop/harmonize guidance tools and SoPs for support groups (2 meetings of 5 days each with 20 participants).	National	80% participants will be govt. / entitled to per diem (70% will be eligible for half per diem with no transport allowance, and 10% from outside Dar will be eligible for full per diem, including travel days, with transport allowance); Remaining 20% - no transport allowance or per diem. Assuming 2 of the participants will be involved in report writing.	2	1.0	11,410	22,820	-	-	-	-	-	-	-	-	22,820
		Operationalize support groups with long term economic empowerment schemes (e.g. Vicoba, live-stock rearing activities)	Regional/ District	No costs	-	-	-	-	-	-	-	-	-	-	-	-	-
Strategy 2.7: Increase adolescent's access to and utilization of integrated quality reproductive health services	Strengthen provision of adolescent friendly SRH (AFSRH) services.	Track adolescent mothers and provide information on primary prevention of HIV and unintended pregnancies (regular services – no additional costs).	Regional/ District	No costs	-	-	-	-	-	-	-	-	-	-	-	-	-
		Review and update the guidelines for AFSRH services (2 meetings of 5 days each with 30 participants – to review the guidelines and finalise the draft)	National	80% participants will be govt. / entitled to per diem (70% will be eligible for half per diem with no transport allowance, and 10% from outside Dar will be eligible for full per diem, including travel days, with transport allowance); Remaining 20% - no transport allowance or per diem. Assuming 2 of the participants will be involved in report writing.	2	1.0	16,950	33,900	-	-	-	-	-	-	-	-	33,900
		TOT on AFSRH services based on revised national guidelines (60 TOTs for 2 days in batch of 30, with 5 trainers).	National	Assuming 33% participants and 40% trainers come from far off regions by air; remaining participants and trainers coming from regions closer to Dar will be eligible for half per diem and transport	2	1.0	16,510	-	33,020	-	-	-	-	-	-	-	33,020
		Capacity building of various cadres on AFSRH services based on the revised national guidelines (1 HCW per HF, 2-day orientation – nearly 35 per district with 5 trainers, including 1 national; 3 districts covered in one visit – total 56 visits).	Regional/ District	All participants will be eligible for full per diem and transport allowance; 4 local resource persons and 1 national (get 1 day before and 2 days after training, for prep and report writing)	56	1.0	59,290	-	355,740	889,350	1,245,090	933,818	-	-	-	-	3,423,998

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	Train CHWs on MNCH including eMTCT in all the regions in a phased manner to achieve at least two trained CHWs per village.	1 training per facility for new CHWs (no. to be trained, duration). 3000 CHWs to be trained, duration of training 21 days (40 per batch – 75 batches; 4 local resource persons and 1 National level trainer per batch)	Regional/ District	All participants will be eligible for TZS 60,000 per diem and TZS 30,000 transport allowance; 4 local resource persons and 1 national (get 1 day before and 2 days after training, of which 4 local and 1 national).	75	1.0	150,095	-	3,001,900	2,251,425	3,151,995	3,151,995	-	-	-	-	11,557,315
	Sensitize Village/ward council leaders to create community awareness on eMTCT community interventions service package for support and demand generation.	Sensitisation meetings – one day each (1500 villages, 10-15 community leaders/ influencers, CBOs, etc. each) (5 meetings per district with 40 participants and 2 resource persons each – total 167*5= 835 meetings).	District	All participants will be eligible for 20,000 per diem and 10,000 transport allowance; 2 local resource persons (get 1 day before and 2 days after training)	835	1.0	244,750	-	122,619,750	81,746,500	-	-	-	-	-	-	204,366,250
	Establish/ strengthen existing community support groups for effective implementation of eMTCT community interventions service package and encourage active male participation.	Advocate for establishment of new support groups to address eMTCT, gender, male participation, adolescent, health provider attitude, ECD – mama salama – peer mentors, etc. Costs covered in sensitisation / training.	District	No costs	167	1.0	211,725	-	-	-	-	-	-	-	-	-	-
Strategy 3.2: Strengthen community systems and structures to deliver the community interventions service package of eMTCT and Paediatric HIV care and treatment	Update supportive supervision tools to capture use of National eMTCT Communications Strategy	Technical meeting to update SS tools (20-30 participants, 3 days, national level)	National	80% participants will be govt. / entitled to per diem (70% will be eligible for half per diem with no transport allowance, and 10% from outside Dar will be eligible for full per diem, including travel days, with transport allowance); Remaining 20% - no transport allowance or per diem. Assuming 2 of the participants will be involved in report writing.	1	1.0	9,150	9,150	-	-	-	-	-	-	-	-	9,150
		Dissemination of revised SS tools / formats (electronically)(any orientation required on revised tools -covered through other dissemination meetings)		No costs	-	-	-	-	-	-	-	-	-	-	-	-	-
	Regular supportive supervision visits to be conducted by the Regional/Council Community Health Worker Coordinator and health supervisors at facility level for the CHWs and PLHIV groups to check on the effective implementation of the National eMTCT Communications Strategy.	SS visits – costs covered elsewhere.		No costs	50	4.0	5,774	-	-	-	-	-	-	-	-	-	-

Strategy 3.5: Increased focus towards ado- lescent friendly services for HIV prevention and transmission	Research for media forms which are more appealing for adolescents (e.g. mobile apps, internet, social media), and use these for providing adolescents-specific HIV messages related to prevention, transmission, treatment and care.	Media research through consultancy firm (lump sum costs – check with UNICEF/USAID/NACP for reference)		Costs awaited	1	1.0	220,000	-	-	-	-	-	-	-	-	-	-
	Identify and use eMTCT advocates/ champions/ ambassadors to increase awareness and knowledge on adolescent PMTCT/HIV issues.			No costs	-	-	-	-	-	-	-	-	-	-	-	-	-
	Advocate parent/ guardian – adolescent relationships to open up/ disclose concerns on PMTCT/HIV issues.	Develop advocacy package (2-day technical meeting with 30 participants)	National	80% participants will be govt. / entitled to per diem (70% will be eligible for half per diem with no transport allowance, and 10% from outside Dar will be eligible for full per diem, including travel days, with transport allowance); Remaining 20% - no transport allowance or per diem. Assuming 2 of the participants will be involved in report writing.	1	1.0	6,630	6,630	-	-	-	-	-	-	-	-	6,630
		Orient HCWs (Nearly 6,000 @ 1 per HF – 1 session per district with 35 participants and 5 resource persons, 1 day)	District	75% participants will be eligible for full per diem and transport allowance; 25% will be eligible for half per diem and no transport allowance	167	1.0	9,110	-	455,500	455,500	640,889	-	-	-	-	-	1,551,889
	Provide adolescent friendly HIV/SRH services on special days, for adolescent girls and young women.	Orientation of HCWs on Adolescent friendly SRH services guidelines (orientation to be clubbed with other activities).		No costs	-	-	-	-	-	-	-	-	-	-	-	-	-
	Targeted SRH/HIV/STI outreach services for adolescent girls and young women (AGYW).	Leverage existing outreach platforms – no additional costs.		No costs	-	-	-	-	-	-	-	-	-	-	-	-	-
	Establish peer support groups in the community and HFs for adolescent girls and young women.	Develop guidelines for the AGYW peer support groups – 2 day consultation meeting with 30 participants.	National	80% participants will be govt. / entitled to per diem (70% will be eligible for half per diem with no transport allowance, and 10% from outside Dar will be eligible for full per diem, including travel days, with transport allowance); Remaining 20% - no transport allowance or per diem. Assuming 2 of the participants will be involved in report writing.	1	1.0	7,140	-	7,140	-	-	-	-	-	-	-	7,140
		Establish support groups involving parents, peers, religious leaders, and community influencers.		No costs	-	-	-	-	-	-	-	-	-	-	-	-	-

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Strategy 4.1: Strengthen implementation of the eMTCT Monitoring & Evaluation System	Develop, print and disseminate M&E Framework for eMTCT Plan 2017 – 2020 to Regional and District Health Management Teams.	Technical meeting to develop M&E Framework (approx. 25 participants, National level).	National	80% participants will be govt. / entitled to per diem (70% will be eligible for half per diem with no transport allowance, and 10% from outside Dar will be eligible for full per diem, including travel days, with transport allowance); Remaining 20% - no transport allowance or per diem. Assuming 2 of the participants will be involved in report writing.	1	1.0	15,930	15,930	-	-	-	-	-	-	-	-	15,930
		Print copies of M&E Framework (1000 copies).	National		1	1.0	12,000	12,000	-	-	-	-	-	-	-	-	12,000
	Orient M&E focal persons and RCH coordinators at Regional and District level on the use of Mother-Child cohort monitoring data.	Disseminate framework to RHMT and CHMT (6- zonal Dissemination meetings of 2 days each with 80 participants and 2 National resource persons)	Regional/ District	75% participants will be eligible for full per diem and transport allowance; 25% will be eligible for half per diem and no transport allowance.	6	1.0	52,320	-	313,920	-	-	-	-	-	-	-	313,920
		6-Orientation meetings at zonal level, 80 participants and 2 National level persons, each lasting for 5-days	Regional/ District	75% participants will be eligible for full per diem and transport allowance; 25% will be eligible for half per diem and no transport allowance.	6	1.0	83,146	-	498,876	-	-	-	-	-	-	-	498,876
Strategy 4.2: Improve routine monitoring and evaluation of eMTCT and Paediatric HIV care and treatment, with a focus on adolescent girls and young pregnant women.	Review and update the existing DHIS database to include evolving priorities of the PMTCT programme.	Technical meeting to review and update DHIS data elements for PMTCT, (one day meeting annually – club with a TWG meeting, budgeted under SO 7).		No costs	1	4.0	9,000	-	-	-	-	-	-	-	-	-	-
	Update M&E data recording and reporting tools for eMTCT and Paediatric HIV care and treatment, based on M&E Framework 2017-2020, including age-disaggregated data and indicators.	Technical meeting to update tools (one-time, nationally, estimated 25 participants, for 5 days)	National	80% participants will be govt. / entitled to per diem (70% will be eligible for half per diem with no transport allowance, and 10% from outside Dar will be eligible for full per diem, including travel days, with transport allowance); Remaining 20% - no transport allowance or per diem. Assuming 2 of the participants will be involved in report writing.	1	2.0	16,450	16,450	-	-	-	-	-	-	-	-	16,450
		Print recording and reporting formats (6000 copies to cover all facilities).	National	6,000 per copy for printing and distribution	1	4.0	144,000	-	144,000	-	-	-	-	-	-	-	144,000
	Support quarterly data review meetings at district level for verification and harmonisation of PMTCT and HIV data.	1 review meeting/ quarter/ District for one day (25 local participants)	District	75% participants will be eligible for full per diem and transport allowance; 25% will be eligible for half per diem and no transport allowance	26	15.0	3,920	654,640	654,640	654,640	687,372	687,372	687,372	687,372	2,886,962	3,031,311	10,631,681

Strategy 4.3: Carry out Operational Research (OR), surveillance and Surveys to review guide program imple- mentation	Advocate at district level for budget allocation from Comprehensive Council Health Plans (CCHPs) on modems and internet bundles to ensure connectivity/ access for improving data entry and reporting at district and health facilities level.	NA (Costed in CCHPs)			-	-	-	-	-	-	-	-	-	-	-	-	-
	Conduct quarterly PMTCT and Paediatric HIV care and treatment Data Quality Assessment in sample districts	DQA Health Facility Visits and Assessment using LARS (400 Health facilities visited annually, National team-3, Regional team-3, and District team- 2 participants) (2-week visit, covering 16 HFs per visit – total 25 visits).	District		26	4.0	15,824	110,768	110,768	110,768	116,306	132,922	116,306	116,306	436,149	457,956	1,708,250
	Review and update national Operational Research priorities for eMTCT and Paediatric HIV care and treatment, including relevant gender and human issues	Technical meeting to review and update Operational Research priorities (1 day meeting with 30 participants, national level, one-time)	National	80% participants will be govt. / entitled to per diem (70% will be eligible for half per diem with no transport allowance, and 10% from outside Dar will be eligible for full per diem, including travel days, with transport allowance); Remaining 20% - no transport allowance or per diem. Assuming 2 of the participants will be involved in report writing.	1	1.0	9,320	-	9,320	-	-	-	-	-	-	-	9,320
	Conduct Operational Research in line with identified eMTCT and Paediatric HIV care and treatment priorities	# no. of research studies done (lumpsum costing – USD 120,000)			1	1.0	880,000	-	-	-	277,200	-	-	-	388,080	305,613	970,893
	Establish eMTCT surveillance system to monitor transmission at 6 weeks, 6, 12 and 18 months for impact assessment	(Lumpsum costing – USD 60,000)	National		1	1.0	660,000	-	165,000	165,000	173,250	173,250	-	-	-	-	676,500
	Conduct Mid-term and End-term Evaluation of the implementation of 2017-2020 eMTCT Plan	Mid-term evaluation in late 2018 and End-term evaluation in late 2020 along with development of next phase eMTCT Plan	National	Engagement of a consulting agency – lumpsum USD 200,000 for MT and USD 300,000 for ET evaluation and next phase Plan development	1	1.0	1,100,000	-	-	-	-	-	-	462,000	-	764,033	1,226,033
Strategy 4.4: Improve PMTCT and Paediatric HIV care and treatment services provision through promoting data use	Identify, document and share the innovations and best practices in the implementation of activities geared toward eMTCT	Documentation of best practices (twice).	National	Engagement of consultant for 20 days of effort each time, no travel only National level discussions	1	2.0	26,400	-	-	-	-	27,720	-	29,106	-	56,826	
		Review meetings to discuss documentation (two annual reviews – costs covered above).	National	No costs	-	-	-	-	-	-	-	-	-	-	-	-	-
	Develop, print and disseminate PMTCT Annual Reports on progress of implementation of eMTCT Plan 2017-2020.	1,000 copies of annual reports x 4 reports	National	6,000 per report for printing and distribution	1	4.0	45,340	-	-	-	47,607	-	-	-	49,987	104,973	202,568

	Disseminate eMTCT M&E reports and other eMTCT research findings through various fora (e.g. Annual and Zonal RCH meetings, Regional and District health fora and joint Implementing Partners' meetings).	# no. of disseminations (6-zonal meetings annual- ly, each 80 participants for 3-days, 2 National persons to attend)	Zonal	75% participants will be eligible for full per diem and transport allowance; 25% will be eligible for half per diem and no transport allowance	4	4.0	46,726	-	-	280,356	-	-	-	294,374	309,092	324,547	1,208,369
	Develop PMTCT data analysis and utilization training package for regional, district and facility level.	Technical meeting to develop training package (2-weeks for 25 participants at national level, 1 week to develop and 1 week to review draft and finalise).	National	80% participants will be govt. / entitled to per diem (70% will be eligible for half per diem with no transport allowance, and 10% from outside Dar will be eligible for full per diem, including travel days, with transport allowance); Remaining 20% - no transport allowance or per diem. Assuming 2 of the participants will be involved in report writing.	1	1.0	33,590	33,590	-	-	-	-	-	-	-	-	33,590
		Printing of training modules (1,000 copies).	National	6,000 per copy for printing and distribution	1	1.0	12,000	-	12,000	-	-	-	-	-	-	-	12,000
		Training covered under M&E Framework dissemination.		No costs	-	-	-	-	-	-	-	-	-	-	-	-	-
Strategic objective 5: To improve responsiveness of health logistic systems towards PMTCT care demands																	23,261,424
Strategy 5.1: Strengthen the capacity of RHMT, CHMT and health care workers at all levels in managing PMTCT commodities	Develop/adopt and pre-test training modules for commodity management (data quality and use of data for decision making, targeting Pharmacist, Laboratory Technologist, and RCH Coordinators across regions and districts.	Technical consultations for development of training modules (2 consultants for 20 days each LOE, 3 day meeting at National level with 25 participants to finalise the modules).	National	80% participants will be govt. / entitled to per diem (70% will be eligible for half per diem with no transport allowance, and 10% from outside Dar will be eligible for full per diem, including travel days, with transport allowance); Remaining 20% - no transport allowance or per diem.	1	1.0	34,150	34,150	-	-	-	-	-	-	-	-	34,150
		Pre-test the training modules in 3 regions (1 district each), involving 6 national level resource persons) – 15 participants at region level and 30 at district level – 1 day activity at each level (excluding travel) - one region and one district covered in a 4 day visit by 2 national persons (total 3 visits).	Regional/ District	75% participants will be eligible for full per diem and transport allowance; 25% will be eligible for half per diem and no transport allowance	2	1.0	8,595	17,190	-	-	-	-	-	-	-	-	17,190
		Printing of training modules (2,900 copies).	National		1	1.0	34,800	-	34,800	-	-	-	-	-	-	-	34,800

Build capacity of Regional and district Pharmacists, Laboratory Technologists, and RCH Coordinators across regions and districts, on commodity management, data quality and use of data for decision making earmarking the cascade to the lower level facilities. (Sustainability of program).	3-day training to 60 TOTs who will be conducting OJT to HCWs at PMTCT facilities (2 batches of 30 participants each for 3 days at national level, 5 trainers per batch – all national).	National	Assuming 33% participants and 40% trainers come from far off regions by air; remaining participants and trainers coming from regions closer to Dar will be eligible for half per diem and transport.	2	1.0	23,950	-	47,900	-	-	-	-	-	-	-	47,900
	On Job trainings conducted across regions (26) annually - 2 sessions, 3 days each, 65 participants, team of 6 trainers (2 each National, regional and district) - both sessions covered in one visits - 26 visits.	Regional/ District	75% participants will be eligible for full per diem and transport allowance; 25% will be eligible for half per diem and no transport allowance.	26	3.5	79,990	-	239,970	799,900	587,927	503,937	587,927	503,937	2,292,913	2,407,559	7,924,069
	Training of identified HCWs (285 sessions over 3 years for a total of 10,000 participants – batch of 35 with 5 trainers over 3 days training).	Regional/ District	All participants will be eligible for full per diem and transport allowance; 4 local resource persons and 1 national (get 1 day before and 2 days after training, for prep and report writing; 1 national and regional resource person will need air travel - 2 batches covered in one visit - 143 visits).	143	1.0	55,060	-	275,300	330,360	635,943	635,943	635,943	635,943	2,670,961	2,804,509	8,624,901
Print and distribute logistic management tools.	Printing of tools – costing underNACP	National		-	-	-	-	-	-	-	-	-	-	-	-	-
Strengthen mentorship, supportive supervision and OJT for HCWs on commodity management, on data quality and use of data for decision making.	SS visits to HFs each quarter (costed under SS elsewhere).	Regional/ District		-	-	-	-	-	-	-	-	-	-	-	-	-
Provide refresher training on updated treatment guidelines and supply chain tools, as required.	1 refresher session per region/ per year to RHMT & CHMT who will cascade the mentorship to lower level facilities - 4 members of each RHMT and CHMT, 2 days training to batch of 30 per region, 2 regions covered in a 1-week trip by 5 national level resource persons (13 visits per year).	Regional/ District	75% participants will be eligible for full per diem and transport allowance; 25% will be eligible for half per diem and no transport allowance	13	4.0	37,550	112,650	112,650	150,200	157,710	157,710	157,710	157,710	538,185	565,095	2,109,620

	Conduct coordination meetings with Regions, Districts, Supply Chain Implementing Partners, Medical Stores Department and other stakeholders on sharing commodity updates, supply chain challenges and possible solutions.	Quarterly meetings in each region (26) – 1 day meeting with 30 participants.	Regional/ District	75% participants will be eligible for full per diem and transport allowance; 25% will be eligible for half per diem and no transport allowance	26	15.0	9,290	241,540	241,540	241,540	253,617	253,617	253,617	253,617	1,065,191	1,118,451	3,922,730
		Annual meetings at national level involving 80 participants for 2 days each.	National	80% participants will be govt. / entitled to per diem (70% will be eligible for half per diem with no transport allowance, and 10% from outside Dar will be eligible for full per diem, including travel days, with transport allowance); Remaining 20% - no transport allowance or per diem.	1	4.0	44,460	-	44,460	-	-	-	46,683	-	49,017	51,468	191,628
Strategy 5.2: Integrate the basic logistics monitoring indicators with other PMTCT monitoring and evaluation systems	Develop M&E and update logistic tools (where applicable) with indicators for effective commodity management.	Technical meeting (annually for 5 days, 40 participants, at national level)	National	80% participants will be govt. / entitled to per diem (70% will be eligible for half per diem with no transport allowance, and 10% from outside Dar will be eligible for full per diem, including travel days, with transport allowance); Remaining 20% - no transport allowance or per diem. Assuming 2 of the participants will be involved in report writing.	1	4.0	35,890	35,890	-	-	37,685	-	-	-	39,569	41,547	154,690
	Develop the mechanisms for extracting regular reports, as per data requirements, from eLMIS system.	Development of dashboard for PMTCT on eLMIS system.	National	No costs	-	-	-	-	-	-	-	-	-	-	-	-	-
		Auto generation of customised reports on periodic basis (quarterly, annual) for PMTCT from eLMIS system.	National	No costs	-	-	-	-	-	-	-	-	-	-	-	-	-
	Conduct quarterly assessment of logistic system performance of the indicators. Review the performance indicators of PMTCT and linkages with eLMIS and other systems.	Quarterly review meetings by TWG (20 participants per session, at national level).	National	80% participants will be govt. / entitled to per diem (70% will be eligible for half per diem with no transport allowance, and 10% from outside Dar will be eligible for full per diem, including travel days, with transport allowance); Remaining 20% - no transport allowance or per diem.	1	15.0	8,650	8,650	8,650	8,650	9,083	9,083	9,083	9,083	38,147	40,054	140,480
	Review the different SMS based tracking systems in practice and adopt the relevant ones for management of PMTCT commodities.	Technical meeting (25 participants – 2 days, national level, annually).	National		1	4.0	13,750	13,750	-	-	14,438	-	-	-	15,159	15,917	59,264

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CHAPTER 7: MONITORING, EVALUATION, LEARNING AND ACCOUNTABILITY OF THE eMTCT PLAN II

Successful implementation of the eMTCT Plan II framework will require continuously monitoring and adjustment of the implementation process. The program implementation logic follows the theory of change as stipulated in the logical diagram bellow. This logical flow provides a framework through which the plan will be monitored and evaluated

MONITORING AND EVALUATION PLAN

Input monitoring

Inputs will be monitored regularly, at least once a year. Input monitoring will be done through review of annual implementation plans of all PMTCT stakeholders. This is the responsibility of the Ministry of health Community Development, Gender, Elderly and Children through the PMTCT national Coordination Unit. This will occur around planning periods between stakeholders, implementers and Funders, usually around September and October, for USG funded partners, and other appropriate times for non-USG funded partners. Implementing partners will be required to submit a summary of their planned PMTCT annual activities, in a tabular form (Annex)

Inputs monitored will include but not limited to the following list

1. Financial investment in country's PMTCT portfolio tracked from all sources
2. HRH;
 - a. Number of planned trainings disaggregated by training content/curricula
 - b. Number of planned capacity building field visits, this will include, mentoring visits, supportive supervision and data verification visits
 - c. Number of community activities planned, disaggregated by agenda
 - d. Number of planned HIV programs performance review workshops
 - e. Number of planned hiring and deployment of RMNCH – PMTCT workforce, disaggregated by specialties, eg Clinicians, M&E, CHWs, supply chain staff etc.
3. Planned investment in other health systems blocks, eg technologies, medicines and medical equipments, and medical devices, infrastructure and information systems

Inputs will be verified by review of annual reports, against the proposed inputs/activities and how it aligns or depart from the eMTCT plan II.

Output Monitoring

Output monitoring will focus on Key PMTCT indicators, across the cascade. Data on output indicators will be obtained from established monitoring and reporting systems, (DHIS – HMIS) and in some cases, complemented by planned special field surveys. Outputs will be monitored in quarterly basis, and summary briefs will be prepared in semi-annual basis.

1. HIV and syphilis screening
 - a. Number and proportion of pregnant women who know their HIV status
 - b. Number and proportion of pregnant women counselled and tested for Syphilis
 - c. Number and proportion of couples who know their HIV status
2. Quality of PMTCT care
 - a. Number and proportion of HIV positive pregnant women already on ART during this pregnancy
 - b. Number and proportion of HIV positive pregnant women initiated on ART for the first time during this pregnancy
 - c. Proportion of HIV positive women receiving ARV to reduce the risk of MTCT

- d. Number and proportion of HIV exposed infants receiving virological test within 2 months of age.
- e. Number and proportion of pregnant women received viral-load testing

Outcomes monitoring

Outcomes monitoring will focus on intermediate to long term events. Outcome monitoring will draw data from PMTCT cohort monitoring system, and where necessary, will be complemented by planned special surveys. Outcome monitoring will be done annually, with culmination of annual program reports.

- 3. Known HIV status at community level (Community surveys, eg AIDS impact survey, and Demographic and Health surveys)
 - a. Number and proportion of adolescent and youths who know their HIV status in the community
 - b. Number and proportion of adolescent and youths with risky sexual and reproductive behaviors in the community
 - c. Number and proportion of men and women who know their HIV status in the community
 - d. Number and proportion of men and women with risky sexual and reproductive behaviors in the community
- 4. PMTCT adherence and retention
 - e. Proportion of women alive and on ART 12 months from PMTCT enrollment
 - f. Proportion of women alive and on ART 24 months from PMTCT enrollment
 - g. Proportion of HIV exposed infants receiving rapid HIV test, at 18 months of age

Impact monitoring

Impact monitoring involves monitoring of distal outcomes within the PMTCT program and impact at population level. Impact monitoring will draw data from PMTCT cohort monitoring system for distal outcomes, and where necessary, will be complemented by planned special surveys for population level. Mathematical modelling using spectrum software, will be used to model population level outcomes for a period between serial population based surveys.

Distal outcomes monitoring metrics will be used to improve reliability of inputs into models that estimates population level impact.

Impact monitoring will be done annually using PMTCT cohort data and mathematical modeling, while population level impact monitoring will be done in the interval between three to five years.

- 5. Elimination of vertical HIV transmission
 - a. Number and proportion of HIV exposed infants tested HIV positive within 2 months of age
 - b. Number and proportion of HIV exposed infants tested HIV negative within 2 months of age
 - c. Cumulative Number and proportion of HIV exposed infants tested HIV positive within 18 months of age
 - d. Number and proportion of HIV exposed infants tested HIV negative at 18 months of age
- 6. Reduction of HIV incidence among adolescent and young people in the population
- 7. Proportion of adolescents and young people with risk sexual reproductive health behaviours

EVALUATION

The evaluation of this plan will consist of two phases, the midterm evaluation and end term evaluation. The universal coverage and national wide approach of PMTCT interventions, precludes any robust evaluation methods, and thus the program evaluation will mainly be formative, with pre-post estimations.

However, should there be special planned interventions, the program strongly suggests use of robust designs, that can measure effect and impact. This is essential to enable the results to inform policies.

All evaluation work will be commissioned by the Ministry of Health, Community Development, Gender, Elderly and Children. All evaluation work will be assessed by the country's PMTCT National Sub-committee before commissioning.

RESEARCH

All PMTCT research will be governed by the National HIV research agenda, however indicative topics for future research in PMTCT are indicated here. These proposed topics are resultant of analysis of country performance

1. ARV resistance in pregnancy
2. Adherence and viral suppression in PMTCT
3. Perinatal HIV transmission rates
4. Breast feeding practices among mothers living with HIV
5. Fertility desires and family planning among couples receiving PMTCT services
6. Delivery and maternity care among PMTCT clients
7. Impact of PMTCT on general HIV epidemic, quality of life, disabilities and economy

eMTCT PLAN II LOGICAL FRAMEWORK OF MONITORING EVALUATION

SN	Description	Indicator	Method of verification	Assumption
1	Goal; To achieve a nation with children born free of HIV infection, helping them navigate adolescence and youth stage free of HIV, and attain healthier life trajectories	<ol style="list-style-type: none"> 1. Prevalence of HIV among children below 14 years 2. Prevalence of HIV among adolescent and young people 	Population based survey; Tanzania HIV Indicator survey	Continued political stability and positive partnership with main donors
2	Eliminate new HIV infection at end of exposure, among HIV exposed infants from 7.6 % in 2016 to below 2% in 2021	<ol style="list-style-type: none"> 1. Proportion of pregnant women who know their HIV status 2. Proportion of HIV positive women receiving ARV to reduce the risk of MTCT 3. Proportion of women alive and on ART 24 months from PMTCT enrollment 	Program report	There will be consistent supply of PMTCT commodities, and sustained high acceptability of services
3	Increase access to ART among HIV infected children from 60% in 2016 to 95% by 2021	<ol style="list-style-type: none"> 1. Number and Proportion of HIV exposed infants testing HIV positive by the end of Mother-Baby pair cohort follow-up 2. Number and Proportion of HIV infected infants initiated on ART 	Program reports; PMTCT program and ART program	Improved and sustained quality of PMTCT care High acceptability of pediatric ART
4	SO1: To foster evidence based planning, results based management and coordination of the PMTCT program in Tanzania	<ol style="list-style-type: none"> 1. Proportion funding against the total cost of the plan in a year 2. Number and proportion of activities implemented according to agreed plans 	Cooperative agreement implementation reports (National, Implementing partners, etc)	Cooperative agreements align with the eMTCT Plan II Funds are released timely and adequately

5	SO2: To improve quality of PMTCT care through mentoring, accreditation/ star rating of health facilities providing PMTCT and RMNCH services.	<ol style="list-style-type: none"> 1. Proportion of HIV exposed infants receiving virological test results within 2 months of age. 2. Proportion of women alive and on ART 12 months from PMTCT enrollment 3. Proportion of women alive and on ART 24 months from PMTCT enrollment 4. Proportion of HIV exposed infants receiving rapid HIV test results, at 18 months of age 	Program reports; PMTCT program	<p>There will be consistent supply of PMTCT commodities, and sustained high acceptability of services</p> <p>Activities planned for quality improvement will be implemented as planned and meet the targeted audience</p>
6	SO3: To increase community dialogue, participation and accountability for quality and equitable PMTCT care	<ol style="list-style-type: none"> 1. Number and proportion of couples who know their HIV status 	Program reports; PMTCT program	Activities planned for quality improvement will be implemented as planned and meet the targeted audience
7	SO4: To develop accountability and resilience mechanisms, through monitoring, evaluation, and learning	<ol style="list-style-type: none"> 1. Semi-annual program Performance briefs 2. Annual program performance reports 3. Midterm plan evaluation report 4. End term plan evaluation report 	Program reports Mid and end term evaluation reports of the eMTCT Plan II	
8	SO5: To improve responsiveness of health logistic systems towards PMTCT care demands	<ol style="list-style-type: none"> 1. % PMTCT clinics with no stock out of rapid tests for early infant diagnosis in the last 3 months 2. % PMTCT clinics with no stock out of first line ARVs the last 3 months 3. % PMTCT clinics with no stock out of tests for early infant diagnosis in the last 3 months 	LMIS reports	

(Footnotes)

1. TDHIS 2015-16
2. UNAIDS estimates 2015-16
3. UNAIDS Global Plan Factsheet 2016
4. Includes both standalone and CTC

