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Global Health Initiatives in HIV/AIDS in Tanzania:

Situation analysis and review of key issues

A briefing paper established in the frame of the
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Abbreviations

3 by 5	WHO's "3 by 5" initiative: 3 million people on ART by end-2005
ART	Antiretroviral Therapy
ARV	Antiretroviral (drug)
AXIOS	Project of Abbott Laboratories
CCHP	Comprehensive Council Health Plan
CHMT	Council Health Management Team
DPG	Development Partner Group
EHP	Essential Health Package
GF	Global Fund
GFATM	Global Fund for HIV/AIDS, TB and Malaria
GHI	Global Health Initiative
GOT	Government of Tanzania
HAART	Highly-Active Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HR	human Resources
HSSP	Health Sector Strategic Paper
LGA	Local Government Authority
LGR	Local Government Reform
MDG	Millennium Development Goal
MOH	Ministry of Health
MSD	Medical Stores Department
MTEF	Medium Term Expenditure Framework
NACP	National AIDS Control Programme
NCTP	National Care and Treatment Plan
NTLP	National Tuberculosis and Leprosy Programme
N/A	Not available
OVC	Orphans and Vulnerable Children
PEPFAR	US President's Emergency Fund for AIDS Response
PER	Public Expenditure Review
PRS	Poverty Reduction Strategy
PRSP	Poverty Reduction Strategy Paper
PRSC	Poverty Reduction Support Credit (World Bank)
SWAp	Sector Wide Approach
TACAIDS	Tanzania Commission for HIV/AIDS
TAS	Tanzania Assistance Strategy
TMAP	World Bank's Tanzania Multi-Sectoral HIV/AIDS Project
US(A)	United States (of America)
VCT	Voluntary Counselling and Testing

1. Executive summary

Introduction

With the abundance of global health initiatives (GHI) operating these days, an obvious question to ask is “with what effect?” HIV/AIDS is one disease that is particularly loaded with global health initiatives, and Tanzania is no exception. Therefore, the specific question of this study is to examine to what extent the current global health initiatives in HIV/AIDS are integrated into the health sector in Tanzania, and harnessed to meet Poverty Reduction and Health Sector Strategic Plan targets. To answer these questions, the following global health initiatives in HIV/AIDS in Tanzania were assessed: the National Care and Treatment Plan (NCTP), the Global Fund for HIV/AIDS, TB and Malaria (GFATM), the World Bank’s Tanzania Multi-Sectoral HIV/AIDS Project (TMAP), WHO’s “3 by 5” initiative, and the US President’s Emergency Fund for AIDS Response (PEPFAR). These GHIs are assessed under different thematic areas, covering: coordination, priority setting and planning, resource allocation, funding channel, resource requirements for implementation, mode of programme delivery, monitoring and evaluation, and poverty alleviation.

Coordination of GHIs

In the HIV/AIDS sub-sector in Tanzania, the situation is moving very fast, and coordination mechanisms are quickly becoming outdated or superseded, thus making coordination difficult. Spending requirements for HIV/AIDS have been revised along with new targets for treatment and care, which now stands at US\$200 million per annum. Coordination mechanisms for HIV/AIDS include those at a level above the health sector (Tanzania Commission for AIDS; Tanzania Multi-Sectoral AIDS Project), those under the central Ministry of Health level (National AIDS Control Programme; National Care & Treatment Plan; the Global Fund and the Country Coordinating Mechanism; donor actions such as the Development Partner Group); and at sub-national level (Council Multisectoral AIDS Committees). While all these coordination efforts have taken some time to materialize, they are in principal up to the task of coordinating the national response to the HIV/AIDS epidemic, both within and outside the health sector. However, in the past the arrival of new GHIs and funding pledges has had destabilizing effects on the coordination efforts, as new GHIs are absorbed into the existing framework, or new frameworks are defined and established. A code-of-conduct for projects in HIV/AIDS should be outlined to strengthen the position of the Government of Tanzania.

Priority setting and planning of GHIs

In the areas of priority setting and planning, it is encouraging that in Tanzania the National Care and Treatment Plan developed collaboratively by the Ministry of Health and the Clinton Foundation is the national plan, and is set within the National HIV/AIDS strategy. However, two other GHIs have set their own global targets, and in 2003 the goalposts for the treatment plan changed several times. Reports have also note the existence of multiple strategies and plans for care and treatment which are neither harmonized nor having detailed operational modalities for effective implementation. Some donors are setting their own HIV/AIDS policies and strategies, based on which they define their own activity plans. However, in general, GHIs tend to support national plans (Clinton, Global Fund, TMAP) but at the same time heavily reinforcing top-down planning. This seriously threatens or reduces the powers of the newly formed Council Health Boards. WHO recommends a Quick Start Plan to develop a detailed synchronized operational plan, to clearly define the systems and processes for scaling up care and treatment. Also, perhaps it is concerning that the funds of some donors are becoming increasingly focused on HIV/AIDS, at the cost of other priority diseases and general health systems issues.

Resource allocation under GHIs

Resource allocation issues are divided into two separate areas, resource allocation of HIV/AIDS versus non-HIV/AIDS activities, and resource allocation within the overall HIV/AIDS budget. On the first issue, there is a concern that the annual budget for the NCTP now dwarfs the entire non-HIV/AIDS health sector budget including external support. This skewing of health sector resources is directly a result of GHIs. An indirect effect also is that, given the volume of external funds for HIV/AIDS, the Ministry of Finance is under less pressure to increase its allocations to HIV/AIDS, particularly to prevention activities. Furthermore, concerns have been raised about the low proportion of funds for HIV/AIDS that reach decentralized levels. The concern about the skew towards treatment is supported by cost-effectiveness studies that show how prevention activities are considerably more cost-effective than treating AIDS patients. It is recommended that power over priority setting should be given back to Tanzanians – national government, local government, and the community – at the same time allowing international agencies and initiatives, and the evidence-base, to be reflected in the priority setting process.

Funding channels for GHIs

The fund distribution system has received quite some attention in Tanzania in recent years, due to combined processes of decentralization and the sector-wide approach. Many gains have been made in terms of speed and efficiency of distribution as well as reporting for use of funds. Concerning the GHIs, this is one area where there is still some uncertainty, as for many of the initiatives the funds have not yet started flowing. HIV/AIDS activities are currently funded through a range of mechanisms. According to current plans, the NCTP funds are due to come via a basket, while TMAP proposes to utilize existing structures and procedures to the extent possible. On the other hand, PEPFAR and GFATM funds will flow mainly through NGOs, although for the latter the basket account remains a possibility for future activities. Based on existing funding mechanisms, a range of future options exist, which can be used together: the existing health basket; a separate basket for HIV/AIDS-specific funds; earmarked budget support; general budget support; on-budget projects; and off-budget projects. Each of these naturally has advantages and disadvantages in terms of efficiency, coordination, and monitoring and evaluation requirements.

Resource requirements for implementation of GHIs

The District Health Services Technical Review in March 2004 observed that the introduction of HAART would be an enormous additional burden on the health delivery system. This includes (a) human resources, requiring at least 25% increase in the workforce to deliver the NCTP, and a considerable amount of training of existing staff; (b) drugs and materials, which have been found to be in short supply for selected commodities, and where well-functioning procurement and distribution systems are needed to ensure implementation of the NCTP; (c) physical infrastructure, where clinics need to be established to prescribe ARVs, to monitor the patient condition and provide other care and treatment for HIV+ patients; (d) information resources, where the existing Health Management Information System is not adequate to support scaling up of care and treatment. Due to the resource needs of the planned activities in the health sector over the coming years, urgent action is needed to increase the supply of some key resources that face the most severe short term shortages. Furthermore, the health system should not miss this opportunity for a comprehensive and integrated health system development, using the increased funds provided by the global health initiatives in HIV/AIDS.

Mode of programme delivery under GHIs

The Ministry of Health has adopted an integrated programme delivery approach as the overall national strategy for the health sector, with a decentralized system of provision of health services, and considerable responsibility for management of health facilities at the regional and district level. However, despite this, a vertical approach is being adopted as one of the strategies for some GHIs. The NCTP and other GHIs make a variety of statements about programme delivery approach which give mixed signals about what is the central

approach. One area the NCTP clearly prefers a vertical approach is in the delivery of ARV drugs directly to facilities and not using the current drug distribution system via district offices. Other areas where the approach is likely to be vertically managed is the recruitment of staff, staff training, and supervision of programme activities to implement the NCTP, due to the huge challenges involved in achieving so much in such a short time period. Therefore, careful consideration must be given at this stage to the most appropriate ways of strengthening the capacities of the health system to deliver services, weighing sustainability and general health system issues with efficiency and timeliness criteria.

Monitoring and evaluation of GHIs

A strong and enforceable system of accountability is needed at all levels, but the details of this accountability are yet to be determined. The proposal to establish a care and treatment unit in NACP and a dedicated monitoring and evaluation system is sound and consistent with other successful models. The NCTP advocates for a pragmatic M&E system to ensure continuous upgrading of the programme. A detailed performance monitoring plan has been developed under the NCTP based on the logical framework and the selected indicators. The current health management information system, which is designed to monitor the essential health package, is unable to support the monitoring and reporting requirements in an expanded response to HIV/AIDS. It is therefore foreseen to develop new data collection systems. A common M&E system across all GHIs in HIV/AIDS could save considerable duplication, and provide the opportunity to unite stakeholders in their attempts to control HIV/AIDS. This would be facilitated by GHIs adopting a budget support approach, as opposed to a project approach, where in the latter case they are more likely to adopt separate M&E systems.

Poverty alleviation under GHIs

Policy statements of various key official documents are inconsistent on the issue of whether ARV treatment will be provided free of cost, or by a mechanism of cost sharing. While it is Tanzania's overall policy to provide certain services and medications free of charge in the public sector to patients with AIDS, this applies only to those meeting the clinical definition of AIDS and not those with asymptomatic HIV infection or "minor" HIV-related signs and symptoms. In addition, as the policy stands, this covers only treatment of opportunistic infections, and does not include antiretroviral drugs or laboratory tests such as CD4+ counts. ARVs are expected to be provided free of charge, but related services may be charged for. Therefore, GHIs, in order to reach poor and vulnerable groups, will need to revise the national policy. Discussion is ongoing about how ART will be rationed, and it seems likely that some social and economic criteria will be used. However, the application of this policy will be a considerable challenge, such as applying poverty 'criteria' to select patients for ART.

Conclusions and recommendations

1. It is crucial that GHIs are well adapted to the country situations and local stakeholder wishes. A code-of-conduct for new forms of support to HIV/AIDS should be elaborated without delay. New GHIs in HIV/AIDS should be discouraged, but instead funds should be provided on-budget to support the Government of Tanzania's plans.
2. The power of decisions about resource allocation should be shifted to Government of Tanzania and the local levels (community). Planning should be synchronized, and plans should be operationalised as soon as possible, through initiatives such as the Quick Start Plan and the Rapid Funding Envelope. Greater focus should be on general health systems development and absorptive capacity.
3. High-level discussions are needed with the Ministry of Finance about the health sector budget ceilings and the financing channels. Discussions need to be held on how to ensure other health sector priorities continue to be met, in the face of scarce resources (especially human resources) flowing to HIV/AIDS. Greater focus should be on poverty alleviation, equitable access and gender aspects.

4. Donors should continue to play the role of independent observer, ensuring issues are raised so that local stakeholders see clearly the evolution of the sector, allowing them to fine-tune as necessary. In particular, it is important to be aware of the future financial implications of decisions as reflected in the NCTP, such as the number of PLWHA who will need to be continued to be supported on ART after 2008.

2. Study background

With the abundance of global health initiatives (GHI) operating these days in many developing countries, an obvious question to ask is “with what effect?” While for some recent large scale GHIs it is too early to examine health impact, there are a lot of activities at central level and increasingly at local level that have been instigated following the arrival of these initiatives. HIV/AIDS is one disease that is particularly loaded with global health initiatives, especially when considering funds pledged or being raised to control HIV/AIDS. Tanzania is no exception.

Put within a broader historical context, one can see a progression over the last decade in international preferences for aid delivery mechanism, from projects to sector programmes to poverty reduction strategies, and now finally to global health initiatives. But is this last step really progress, or is it instead a regression?

Therefore, at the centre of this paper is the need to answer whether global health initiatives are an opportunity for world health, or instead a threat that must be contained, using HIV/AIDS initiatives in Tanzania as a case study. The most important argument favouring GHIs is that they focus attention and large amounts of finances on previously neglected diseases. However, for those concerned with the stability and long-term development path of the national health system, it could be argued that GHIs derail or threaten the effectiveness of mechanisms and processes which have received significant investments by the international community and recipient governments in recent years (e.g. SWAp or PRSP). In other words, GHIs distract governments from their core business and therefore test their commitment to the SWAp and PRS processes that have taken off in many countries. Added to this are the inefficiencies of financing parallel delivery systems, the risk of a narrow sectoral approach, and the uncertainty about future funding levels from GHIs.

3. Study aims and scope

The specific question of this study is the following:

To what extent are the current global health initiatives in HIV/AIDS integrated – or expected to be integrated – into the health sector in Tanzania, and harnessed to meet poverty reduction and Health Sector Strategic Plan targets?

To answer these questions, a selection of important global health initiatives in HIV/AIDS in Tanzania is assessed under different thematic areas, further elaborated in the findings:

1. How well the initiatives are coordinated by a government agency or a body set up to coordinate GHIs.
2. To what extent the priority setting and planning processes of GHIs follow national ones.
3. To what extent the resulting pattern of allocation of resources follows national priorities.
4. What channels the global initiatives use for their funds, and the implications for MOH.
5. What the resource requirements for implementation of global initiatives are, and the implications for the health system.
6. What the mode of programme delivery is, whether vertical, integrated, or mixed.
7. Whether government or parallel systems are used for monitoring and evaluation.
8. What implications initiatives have for poverty alleviation, including helping sufferers cope with economic impact of the disease, and the financing of health care.

Other relevant and related issues are discussed within this paper, although in such a brief paper not all issues can be covered thoroughly.

4. Methodology

Due to the short timeframe for this study, only a small number of GHIs could be examined in this current paper. The main criteria for selection of GHIs for inclusion were (a) supporting HIV/AIDS, (b) operating in Tanzania, (c) important level of activities and/or budget, (d) operating at national level and/or throughout the country; (e) involving more policy or implementation, and less product development. The application of these criteria lead to the following GHIs being included: the Ministry of Health and Clinton Foundation's National Care and Treatment Plan (NCTP); Global Fund for HIV/AIDS, TB and Malaria (GFATM) Round 3 and Round 4; the World Bank's Tanzania Multi-Sectoral HIV/AIDS Project (TMAP); WHO's "3 by 5" initiative; the US President's Emergency Fund for AIDS Response (PEPFAR). Also, possibly of importance, is the Axios Programme, which funds several sets of activity both at national and local level.

The main sources of information for this study were the following: (a) review of available documents on these GHIs, consisting mainly of proposals and activity plans (see reference list); and (b) a small number of discussions with selected development partners during March 2004. In terms of the report structure, each of the 8 thematic areas listed above form a sub-section in the findings Section 4, preceded by one overview sub-section. Section 5 provides some discussion, and Chapter 6 concludes and provides recommendations.

5. Findings

5.1 Overview

There are many international initiatives that have selected Tanzania as a country for intervention. Up to the time of writing (April 2004) only very few resources have actually been spent by the GHIs analysed in this study, of the following totals planned:

- The Clinton Foundation, together with the Ministry of Health, has developed a National Care and Treatment Plan that has undergone several redrafts during 2003. This has provided a solid basis for lobbying at international level for the funds to support this plan. The initial target was US\$539 million over 5 years. However, this has increased to **US\$964 million**, after taking on board the WHO's 3 by 5 targets. So far, funds have been raised from CIDA (US\$16M), SIDA (US\$22M), and Norway (US\$12M), adding to the funds available from GFATM and TMAP for the NCTP.
- Global Fund for AIDS, TB and Malaria, Round 3, approved **US\$86.9 million**.
- GFATM, Round 4, proposal under development **US\$207 million**
- Tanzania Multi-Sectoral HIV/AIDS Project (TMAP): **US\$70 million** over 5 years
- WHO 3 by 5, involving national targets set to meet international targets, and technical support from WHO. However, the initiative itself comes with no additional funding, but along with the NCTP provides the basis for lobbying for more funds.
- US President's Emergency Fund for AIDS Response (PEPFAR) is a major new initiative potentially bringing large sums of funds. The initiative apparently brings US\$9 billion of new money for 14 countries hardest hit by HIV/AIDS. Different financial volume figures have been quoted for Tanzania, between **US\$32** and **US\$60 million** over 5 years. PEPFAR has 2 'tracks', covering (1) centrally funded procurement for Blood Safety, Injection Safety, Abstinence and Being Faithful for Youth (ABY), OVC, and ARVs; (2) Country Operations Plan (COP), with a funding request of US\$49 m.
- The Axios Program is largely financed by Abbott Laboratories, financial volume N/A.

Added to these financial volumes are many smaller scale and local initiatives of many donor governments, NGOs and faith-based organizations, as well as the Government of Tanzania's contribution, with 3.1 bn TSh or around US\$3 m (MTEF 2003/4) and around 3.7 bn Tsh or around US\$3.4 planned for 2004/5. Table 1 provides an overview of six major GHIs.

Table 1. Characteristics of HIV/AIDS-specific International Health Initiatives

Theme	MOH / Clinton Foundation National Care and Treatment Plan	GFATM - AIDS/TB Component Round 3	GFATM - AIDS/TB Component Round 4	World Bank Tanzania Multi-sectoral HIV/AIDS Project	WHO's 3 by 5 Initiative	US President's Emergency Fund for AIDS Response
Year GHI started	2003	2003 (Round 3)	2005? (Round 4)	2003	2004	2004
Time frame of activities	2004-2008	2004-8	2005-2007?	2003-8	2004-2005	2004-8 initially
GHI Function	Advocacy, product access	Advocacy, product access, capacity building	Advocacy, product access, capacity building	Product access, capacity building	Advocacy, product access, capacity building	Product access, capacity building
Institutional location	NACP Care and Treatment Unit	Under Prime Minister's Office	Under PMOs office	TACAIDS	WHO	State Department, US Government
Funding volume	US\$964 m over 4 years	US\$86.9	US\$207	US\$70 m (US\$40 m to component 2)*	NCTP updated for 3 by 5 targets	US\$49 m proposed for 5 years
Main focus	Elaboration of NCTP	Package of care & support linked to VCT sites; integration HIV & TB (45 districts)	National scaling up of Round 3 activities and filling gaps	1. Civil society. 2. Public sector. 3. Institutions. 4. Zanzibar.	NCTP	Multiple interventions
1. Coordination	It is the national framework for C&T	Fits in NCTP	Fits in NCTP	Fits in NCTP. TAC-AIDS coordinates	Fits in revised NCTP	Scoping study by Synergy project
2. Planning	Other major funding sources & initiatives written into plan	Use of CCM and fits within NCTP	Proposal fills gaps in national response HIV/AIDS	Plans are those of the line ministry	WHO advises lower standards for scaling up ART	Gaps identified. Integrated country plans pending
3. Resource allocation	Largely focused on PLWHA	Largely focused on PLWHA	C&T; condoms; OVC; coordination	Large % US\$40 m to MOH	PLWHA eligible for ARV drugs	55% C&T; rest to prev, pall, OVC
4. Channel of funds	Via NACP to health facilities in plan	See NCTP	See NCTP	GOT disbursement channels	See NCTP	NGOs/private sector via US agencies
5. Resource needs	Massive HR and facility needs	See NCTP	For C&T component, see NCTP	For C&T component, see NCTP	See NCTP	Drain resources from public sector?
6. Programme delivery	Mix of integrated and vertical delivery	See NCTP	For C&T, see NCTP	Integrated	See NCTP	ART vertical; other treatm. integrated
7. M&E system	Own M&E framework & many data sources	See NCTP	For C&T, see NCTP	TACAIDS project M&E system	See NCTP	Probably own M&E systems
8. Poverty alleviation	Free ARVs targeted according to need, but not cost-beneficial	See NCTP	For C&T, see NCTP	TMAP aims to address poverty effects of HIV/AIDS	See NCTP	Criteria not known

* However, note that TMAP funding to the sector currently stands at US\$2 m annually (2004), and additional resources can be accessed

5.2 Coordination of Global Health Initiatives

Introduction

When global health initiatives come in any country, ideally there should be a process of discussion and negotiation for how it will fit in with current programmes and activities, and where responsibilities lie and how coordination will be managed. This starting point is absolutely crucial for what happens afterwards, such as the extent of coordination, the degree of integration of activities within the health sector, and the extent to which country health and management systems are respected and strengthened. Some questions which should be answered include the following:

- What, exactly, should be coordinated?
- Who is the first point of contact for a global health initiative in HIV/AIDS? What are the procedures for assignment of responsibility for coordination and planning?
- What leadership role have Tanzanian institutions played in terms of coordinating the various GHIs in HIV/AIDS?
- What coordination has been achieved in HIV/AIDS, and who has played a key role in this?

Some characteristics of best and worst case scenarios specifically relating to coordination are outlined in the box below:

Best case: coordination

1. All GHIs are coordinated by a national body mandated to coordinate activities within the sector or sub-sector.
2. GHIs respect national bodies and systems.
3. A regularly updated inventory of GHIs and their activities (planned or actual) is kept.
4. The number of GHIs is small enough to allow efficient and coordinated planning and implementation.

Worst case: coordination

There are a mass of GHIs that MOH (or the body responsible) cannot (or does not) have input to or play a coordination role in, and GHIs do not use national systems.

In the HIV/AIDS sub-sector in Tanzania, the situation is moving very fast, and coordination mechanisms are quickly becoming outdated or superseded, thus making coordination difficult. Spending requirements for HIV/AIDS have been revised along with new targets for treatment and care, from US\$60 million per annum (HIV/AIDS Strategy), to US\$108 million p.a. (first draft NCTP), to US\$200 million p.a. (NCTP latest version). Therefore, visions and perspectives as well as institutions and plans have all had to adapt as the funding envelope has grown. Furthermore, there are a lot of pledges but few funds arriving making it difficult to know how to start implementation.

Levels and types of coordination relevant in Tanzania

In Tanzania, several types of coordination are important, and the main coordination mechanisms are listed here and discussed in more detail below:

1. GHIs with MOH activities: *NCTP*
2. Donors and GHIs working in health sector coordinate with each other: *health partners meetings including the development partner group on HIV/AIDS; CCM.*
3. Different elements or programmes related to HIV (e.g. TB, ANC): *NCTP/GFATM.*
4. Central with decentralized levels of government: *Council Multisectoral AIDS Committees.*

5. Public with private sector activities: *PEPFAR (Synergy Project); NACP; TACAIDS.*
6. Health with non-health sector activities: *TACAIDS; TMAP.*
7. Treatment with prevention: *NCTP; Synergy Project (of USAID).*

Coordination mechanisms and their success

Each coordination mechanism or forum is described briefly and discussed in turn.

Tanzania Commission for AIDS (TACAIDS)

TACAIDS is the overall body responsible for control of HIV and AIDS in Tanzania, and is the first point of contact for all new projects in the area of HIV/AIDS. Established in 2001, it sits directly under the President's Office. The World Bank's TMAP now supports the work programme of TACAIDS directly. TACAIDS published in January 2003 the National Multi-Sector Strategic Framework on HIV/AIDS (2003–2007) [1]. The framework includes nine specific "frame strategies" designed to guide the various stakeholders in the national response against HIV/AIDS in their planning and implementation of programmes, projects and interventions. Recently created also is the Rapid Funding Envelope for AIDS by eight donor agencies and TACAIDS. However, an HIV/AIDS Sector assessment in 2003 found that TACAIDS and Zanzibar AIDS Commission both face tremendous challenges for leading and coordinating a multisector approach to fighting the serious HIV/AIDS epidemic [2].

National AIDS Control Programme (NACP)

The NACP is the body of the Ministry of Health responsible for health-related aspects of HIV and AIDS, and for coordinating health sector interventions to fight the epidemic. In February 2003 the NACP published the Health Sector HIV/AIDS Strategy for Tanzania [3], which has since been superseded for care and treatment by the NCTP due to the changing targets and funding envelope.

National Care & Treatment Plan (NCTP)

During 2003, the Government of Tanzania, in collaboration with the representatives of the William Jefferson Clinton Foundation, developed a National Care and Treatment Plan for people living with HIV/AIDS (PLWHA) to revise the care and treatment section of the Health Sector HIV/AIDS Strategy (dated March 2003) [4]. The National HIV/AIDS Care and Treatment plan was approved by Cabinet in October 2003. The NCTP is perceived by stakeholders as both a massive opportunity but also a potential threat (see later sections). There has been a certain amount of MOH leadership and ownership in this process, but this is still far from desirable levels. A positive sign for improved coordination is that the NCTP, which devotes a whole chapter to 'Linkages with other initiatives', states that the Programme can only be successful if it establishes successful linkages with a variety of partnering programmes and institutions.

One further positive development is that the GFATM Round 3 for HIV and TB fits within the NCTP, and the Round 4 proposal, if successful, is also planned to contribute further funds to realizing the NCTP. The Round 3 proposal includes as one of the components the provision of ART to 15,000 PLWHA by the end of 2005 in 45 out of 120 districts in the Tanzania Mainland. However, this is less than 10% of the target that has been imposed on Tanzania by the WHO's 3 by 5 initiative.

Tanzania Multi-Sectoral AIDS Project

TMAP is a five year project starting in 2003, essentially making the National HIV/AIDS Programme truly multi-sectoral by mainstreaming HIV/AIDS control into the action plan of every Government Ministry and Local Government Authority and by strengthening capacity of TACAIDS for overall national coordination [5]. A large share of component 2, which has been allocated US\$40 million, is destined for the health sector, to support the health sector plans for prevention, care and treatment. Therefore the arrival of TMAP

should be seen as boding well for coordination in HIV/AIDS generally, as well as within the health sector specifically.

The Global Fund (GF) and the Country Coordinating Mechanism (CCM)

Considerable coordination has also been achieved by the CCM of the Global Fund, the existence of which over recent years has gradually strengthened the partnership between the GOT (Ministry of Health), development partners, civil society organizations and the private and voluntary sectors. The Global Fund CCM is also considering extending its scope and mandate to include other global and international sources of funding for HIV/AIDS, such as TMAP and the Clinton Foundation HIV/AIDS initiative [6]. Objective 5 of the GFATM Round 3 proposal states that an “annual review to harmonise the Global Fund programme with the national strategy on HIV/AIDS will be conducted...the GF programme will be consistent with the development framework of the PRS and the TAS.” Furthermore, reference is made to the strengthening of referral hospitals by the Clinton Foundation plans, which the GF project proposes to coordinate with in order to scale up the interventions proposed. Actual state?

A second type of coordination achieved by the proposed Global Fund activities is that between the HIV/AIDS problem and other programs currently providing care for HIV-infected persons or with potential for diagnosing HIV infections. Examples of parts of the health system or programmes achieving such coordination include voluntary testing and counseling centres, antenatal clinics, prevention of mother-to-child transmission, tuberculosis clinics, and clinics that offer treatment for sexually transmitted diseases.

Donor actions

The joint technical support provided by donors for the development of a Global Fund proposal and the TACAIDS multisector plan has contributed significantly to coordination of HIV/AIDS activities. This has been achieved through close informal collaboration between donors, as well as through official fora such as the Development Partner Group on HIV/AIDS. Another recent example of a donor action to improve coordination is the Synergy Project Assessment, conducted in October 2003 [2]. The study aim was to assess what actions would be most appropriate under a coordinated US response to the HIV/AIDS epidemic. The study made conclusions and recommendations in four strategic areas to help give the PEPFAR direction for its own activity planning, covering removing constraints to knowledge, products and services, institutional capacity building, and supporting policy making. It is not clear, however, whether the items within the NCTP, which also aims to fill gaps and address constraints, were fully taken into account in recommending activities for the PEPFAR.

Council Multisectoral AIDS Committees

As is often the case in large scale development projects, the initial focus of new global health initiatives has been at the central level, thus taking a long time to reach the periphery. The Synergy Project report argues that “the current approach to leadership development follows a central and hierarchical conceptual model that does not empower communities and decentralized partners who are responsible for implementation”. However, it should be added that the recently created Council Multisectoral AIDS Committee have begun to assume a leadership role in coordinating the multi-sectoral and intra-sectoral efforts at the district, ward and community level. It may take some time before the effect of these committees is seen, depending on how much responsibility is handed to them.

The way forward

While coordination efforts have been quite impressive in the area of HIV/AIDS, at the various levels listed above, these efforts have been frustrated by the rapidly and continually changing situation with regard to targets, funding envelopes, and the scale of activities planned. This

has often led to some key players being left behind, especially at the strategy formulation and planning stages. Coordination has proven to be a time-consuming activity, as suggested by the remark of the MOH in the March 2004 Health Sector Review report on milestones, that “the multiple HIV/AIDS projects in the health sector place a high administrative and coordination burden on NACP Secretariat”. Also noteworthy was the call during the meeting for a code-of-conduct for projects in HIV/AIDS. Therefore, it is advisable that the next phase focuses on coordination, consolidation and implementation of existing plans, and that new GHIs in HIV/AIDS (especially large ones) are encouraged to contribute to existing GHIs or provide budget support for implementing preventive activities or the NCTP.

5.3 Priority setting and planning

Introduction

Once a global health initiative has been authorized to work in a country, following the coordination activities necessary, the next important activity is that of deciding what the GHI will actually do. As most GHIs already have a disease focus, it is then a matter of deciding which activities are most important to target. Some questions which should be answered include the following:

- Do GHIs address diseases and populations that accord with national priorities?
- Are national procedures of priority setting and planning in the health sector used?
- Do the activities planned take into account ongoing and planned activities in the health sector? Do these activities overlap or duplicate each other?
- Do GHIs specify the route to achieving the target, and give a sense of value-added? Are cost-effectiveness criteria explicitly used in setting priorities?

Some characteristics of best and worst case scenarios specifically relating to priority setting and planning are outlined in the box below:

Best case: priority setting and planning

1. Plans are made and priorities are set in the framework of a national strategy and plan of work.
2. The newly decentralized system of planning is not recentralized.
3. Activities within the plan of the GHI complement and do not duplicate each other.
4. High priority needs and items are addressed before secondary ones.
5. National partners have an (at least) equal say in priority setting, so that plans reflect national more than international priorities.
6. All partners recognize the need to balance humanitarian considerations (e.g. extending life expectancy of those infected with HIV) with economic considerations (cost per unit of benefit obtained).

Worst case: priority setting and planning

GHIs come in with their plans and targets with no reference to national plans and priorities, or activities being implemented. A high proportion of funds are planned for minority groups at the expense of other groups who have high potential to benefit.

GHI priority setting and planning in Tanzania

In the areas of priority setting and planning, it is encouraging that in Tanzania the Care and Treatment Plan developed collaboratively by the MOH and the Clinton Foundation, is the national plan, and is set within the National HIV/AIDS strategy. However, two GHIs

(WHO/UNAIDS's "3 by 5" initiative and PEPFAR) have set their own global targets and the first of these has led to the revision of the national targets for coverage of ART. The last year has seen some changing goalposts for the treatment plans.

- In February 2003 the MOH Health Sector HIV/AIDS Strategy planned for 13,000 PLWHA to be on HAART by end-2006.
- In September 2003, the NCTP increased the numbers to 65,000 (end-2005), 151,000 (end-2006) and 400,000 (end-2008).
- The WHO's "3 by 5" initiative has changed the end-2005 target to 220,000 PLWHA.

The WHO's "3 by 5" Mission noted the existence of multiple strategies and plans for care and treatment which are neither harmonized nor having detailed operational modalities for effective implementation [7]. As the NCTP was designed before WHO developed and published its simplified processes and guidelines for ARV treatment, the Mission report states that the implementation of NCTP is now more complex and costly than what can be envisaged. The Mission recommends that the NCTP revises the plans and budgets according to WHO recommended standards and guidelines for ART delivery, revision of existing guidelines according to simplified WHO guidelines, and integration of care and treatment planning into national planning processes at all levels of the health system. This is being duly done.

One thing that GHIs tend to do is to support national plans (Clinton, Global Fund, TMAP) but at the same time heavily reinforcing top-down planning. This seriously threatens or reduces the powers of the newly formed Council Health Boards, who should be responsible for many of the plans¹. However, the public sector fund component of TMAP will not involve a separate work plan process for the project, and HIV/AIDS work plans to be financed by the project will be incorporated into the existing annual planning and budgeting process for both line ministries and LGAs. For the overall TMAP project, the Secretariat of TACAIDS will prepare and present annual work plans and regular progress reports, including findings from monitoring and evaluation, to the Commission. The Executive Chairman in TACAIDS is responsible for the submission of annual work plans and regular financial and implementation progress reports.

Some donors are setting their own HIV/AIDS policies and strategies, based on which they define their own activity plans. These are not always entirely consistent with the national framework, as defined by the TACAIDS National Multisector Strategic Framework on HIV/AIDS (2003-2007). For example, USAIDS's Tanzania AIDS Strategy 2003-2005 does not include STI control and case management, but although otherwise it reflects the TACAIDS framework [8].

Given these events, it is clear that large-scale external initiatives are distorting the plans NACP has for the sub-sector. GHIs have very clearly shifted the spending focus for HIV/AIDS from prevention to treatment activities. It is true that NACP's original targets were based on the resource envelope envisaged at that time, and therefore as the financial envelope predicted for the sub-sector grew during 2003/4 this meant new targets could be set. However, it does raise the question "what would Tanzania's target for ART coverage be if all the resources in the sub-sector were Tanzanian resources?" In other words, would Tanzania choose to spend so many resources on AIDS cases, given other health priorities in the country?

The way forward

Importantly, the WHO report recommends as one of the key actions of a Quick Start Plan (QSP) to develop a detailed synchronized operational plan, which will clearly define the systems and processes necessary to make the scaling up of care and treatment for the

¹ Note that Council Health Boards are not yet fully operational throughout the country

whole country a reality. In order to help fulfill its leadership role in health, and specifically HIV/AIDS, WHO is currently going through a process of strengthening its country office in Tanzania.

One further issue that is worth discussion is the greatly increased focus of some key donor agencies on HIV/AIDS control. Is this focus necessarily a good thing, given that these agencies have broader mandates than just HIV/AIDS? For example, in a recent report for Tanzania, WHO's stated their 3 by 5 initiative to be a top priority WHO-wide initiative, and consequently all expertise in the country office should be mobilized to adequately support the national care and treatment activities which would facilitate the achievement of the national 3 by 5 targets. Moreover, the report states that all sections of the WHO Country Office Team should make 3 by 5 a core business, and ensure that all available expertise is mobilised to contribute to the national initiative. Is this going too far? Certainly it deserves debate.

5.4 Resource allocation

Introduction

Resource allocation is a closely linked and direct result of the priority setting and planning processes discussed in the last section. Resource allocation is assessed separately because it is a tangible and quantitative result of the processes of priority setting and planning. Also, the realities of the implementation process may mean that the resources allocated do not reflect closely the plans. Some questions which should be answered include the following:

- What criteria are used for resource allocation of funds from GHIs? (e.g. poverty) Are these criteria explicit or implicit?
- Do resource allocations to priority diseases now reflect better the burden of disease in Tanzania? Or are resource allocations now skewed towards certain diseases or populations?
- Are there important priority areas that remain under-funded?

Some characteristics of best and worst case scenarios specifically relating to resource allocation are outlined in the box below:

Best case: resource allocation

1. Additional resources are allocated according to priorities (i.e. in proportion to) the Health Sector Strategic Plan.
2. MOH and local council wishes for spending are respected.

Worst case: resource allocation

Resources allocated completely skew MOH priorities towards low priority and cost-ineffective services, and further inequalities in health and health expenditure develop.

Resource allocation: HIV/AIDS versus non-HIV/AIDS

Overall resources for some of the main GHIs are provided in Table 1 and section 4.1. It is clear that, when compared with the current health sector spending of around US\$200 million on budget, the allocations pledged for the HIV/AIDS sub-sector will change considerably the balance of the current spending. As stated by one development partner, the "annual budget for the AIDS Care & Treatment Plan dwarfs the entire Health Sector budget including external support (Health Sector Budget FY04 TSh, 201 bn (US\$100 m) (on budget))". At the same time, though, there is a risk that with greater reliance on external funds, the MOF is under less pressure to increase its allocations to HIV/AIDS, particularly to prevention.

Furthermore, it is becoming clear that funds for HIV/AIDS will not contribute significantly to general capacity development, and therefore will not benefit control of other diseases. It is likely that other major killer diseases will not be addressed sufficiently, leading to gross inefficiencies in resource allocation. The HIV/AIDS Public Expenditure Review (November 2003) already showed that donor projects do not all address government priorities.

The HIV/AIDS PER 2003 warns that while the intention is to finance the NCTP from 'additional' money, "existing donors are being approached, and the experience of HIPC is that donor assurances of the additionality of funding cannot be verified and should probably not be believed." The PER goes on to state: "although it has been stressed by DPG Health partners of the need to have the total budget for NCTP fully integrated into the Ministry of Health's MTEF, however, given that the ceilings for the Health Sector are stagnant and the costs for HIV/AIDS are now skewing funding within the Sector for other identified priority areas (preventive services instructed to reduce their budget by 20%), it is now not clear how this can be addressed."

Resource allocation: Allocation within HIV/AIDS

In the last 2 years, there has been a dramatic reversal of funding balance from prevention to treatment. This is supported by USAID's assessment, which found that the overall HIV/AIDS prevention effort in Tanzania is weak and fragmented, despite millions of dollars poured into prevention since the 1980s. Constraints include knowledge gaps, human resource and commodity shortages, financing shortages, and lack of management capacity. A clear skewing of resources is noticeable, as contraceptives and condoms financing are not assured, suggested by the fact that the MOH has been approaching different donors independently to seek funds.

The HIV/AIDS PER draws attention to the importance that the NCTP does not divert attention away from the National Multi-Sectoral Framework, citing evidence that it is considerably more cost-effective to prevent HIV cases than treat AIDS patients. Various studies have been conducted internationally on the cost-effectiveness of different AIDS control strategies. For example, the cost of saving one year of life by different interventions, adjusted for the extent of disability, has been estimated as: PMTCT US\$19, STD control US\$13, VCT US\$18, Blood safety US\$8, while HAART is US\$350². These large differences between the cost-effectiveness of prevention and treatment are further heightened by the different population sizes that can be affected by prevention and treatment activities, at 88% and 1% of the population, respectively. Furthermore, increased spending on prevention now reduces future costs as incidence and prevalence are reduced, whereas a strategy focusing on treatment will face growing numbers of patients who are costly to treat, raising questions over the sustainability of such a strategy.

The PER also makes a strong case for the need for more resources at district and community level, recommending that funding for LGAs should be earmarked for HIV/AIDS spending. Also, there has been an inequitable distribution of the support to LGAs, which will be further strengthened by the Global Fund which focuses on 45 districts.

The way forward

Given the large skewing of resources towards HIV/AIDS (compared to health), and towards HIV/AIDS care and treatment (compared to HIV prevention), it is urgent to convene meetings at the highest political levels to address this imbalance. The irony is that only a few years ago there was almost universal international support for increasing HIV/AIDS budgets due to the lack of resources being spent in this priority area, as well as integrating care and treatment options within the national responses. While their intention is good, global health initiatives

² Source: Marseille et al, Lancet, 2002:359:1851-56.

are largely responsible for this current situation In Tanzania. Given the extremely high unit cost of ART (per person per year), and the corresponding limited benefit, it is doubtful that national government would allocate resources in this way. Therefore, the responsibility for priority setting should be given back to Tanzanians – national government, local government, and the community – at the same time allowing international agencies and initiatives, and the evidence-base, to be heard in a balanced way in the priority setting process. In particular, this requires the further involvement of the Ministry of Finance in discussions on priority setting related to the care and treatment plan, who have until now not been engaged.

5.5 Channel of funds

Introduction

How the GHIs plan for funds to be distributed, along with the linked processes of planning (4.3) and monitoring (4.7), are very important aspects of GHIs. Some questions which should be answered include the following:

- Are funds currently included in the MOH Medium Term Expenditure Framework?
- Are funds channeled through a 'basket' or pooled fund, managed by the MOH or managed by the donor/GHI?
- Are funds challenged via the basket earmarked? How strictly are funds earmarked?
- What are the potential implications on the current ceilings of the Health Sector?
- Are the promises of funding credible? What is the planned timing of funds and how credible is this timescale?

Some characteristics of best and worst case scenarios specifically relating to the channel of funds are outlined in the box below:

Best case: channel of funds

1. GHI funds flow through government systems, thus improving them, or via other agents who are coordinated with MOH and the national plan.
2. Funds are earmarked to the least extent possible to allow decentralized priority setting and planning.
3. Funds channeled through the government systems do not displace other sector funding (due to strict budget ceilings set by the Ministry of Finance).
4. Pledges made by GHIs are received in full and at the time stated.

Worst case: channel of funds

Funds are kept within and spent by unsustainable project structures, with very strict, parallel mechanisms for spending and accounting.

Financing channels in Tanzania

The fund distribution system has received quite some attention in Tanzania in recent years, due to combined processes of decentralization and the sector-wide approach. Many gains have been made in terms of speed and efficiency of distribution as well as reporting for use of funds. However, the situation is still quite fragile, and further improvements are still to be made.

Concerning the GHIs, this is one area where there is still some uncertainty, as for many of the initiatives the funds have not yet started flowing. As GTZ has noted, the response to HIV/AIDS involves multiple stakeholders including diverse organisations from large central Government departments to small grass roots NGOs and businesses in the private sector.

HIV/AIDS activities are therefore funded through a range of mechanisms and different procedures for financial management which reflect this diversity amongst stakeholders”³.

According to current plans, the NCTP funds are due to come via a basket, but it is not clear yet if they are to be earmarked for specific activities. The NCTP states “several models are possible for controlling the flow of funds into the programme. It is expected that some variant of the existing ‘basket funding’ or ‘rapid funding envelope’ processes will be used to manage the flow of funds into the country and the financing of the programme...the plan foresees formation of a board to oversee financing matters and monitor implementation of the plan”.

A guiding principle in the design of the financial arrangements for TMAP is to utilize existing structures and procedures to the extent possible, and except for Community AIDS Response Fund (CARF), all funds will flow through existing government systems according to channels established for GOT’s own funds. World Bank standard procedures for accounting and auditing will apply to funds disbursed to both public and private institutions.

Other GHIs intend not to use pooled or GOT mechanisms:

- GFATM funds will flow mainly through NGOs. The GFATM Round 3 proposal for HIV/AIDS states “for the current proposal, the SWAp will not be used to administer the Global Fund grant; however, it remains a possible existing mechanism for future efforts.”
- PEPFAR funds will be disbursed in project mode, via US agencies and NGOs.

A project (or vertical delivery) mode may be more effective at spending money, hence the hesitancy of some donors or GHIs to commit via the budget. As the HIV/AIDS PER notes, there is a general lack of capacity to plan, budget, and account for funds allocated for HIV/AIDS activities. For example, in fiscal year 2001/2, 65% of the money channeled through TACAIDS was unspent. No doubt this situation has improved considerably since then.

What is encouraging, however, is that year on year the MTEF is capturing higher proportions of the total HIV/AIDS allocations, and a higher proportion of funds are coming via the budget. The PER projections for 2005/6 suggest a reversal in the proportion of funds to come on budget: in 2003 only Tsh 4.5 bn out of Tsh 40 bn was channeled via the budget, and the rest was via other channels.

The way forward

As stated above, the fact that few funds from major GHIs in HIV/AIDS have been disbursed yet means there is some uncertainty about financing channels, and conditionalities associated with funding. No decision has been made yet concerning how funds will flow to support the NCTP. The range of choices includes the following:

1. Using the existing Health Basket. However, given the ceilings for the health sector have not been adapted yet to the new situation, this channel could not accommodate massively increased levels of funds for HIV/AIDS without displacing GOT allocations destined for non-HIV/AIDS activities.
2. Developing a separate Basket for HIV/AIDS-specific funds.
3. Earmarked Budget Support. One possibility that has been presented to development partners has been a mechanism whereby the GOT creates an “HIV Fund” which receives competitive bids for the use of funds from ministries and departments of the GOT, giving them funds *additional* to their normal budget. An alternative could be an annual allocation (non-competitive), as was recommended in the HIV/AIDS 2003 PER. This latter approach, it argues, would have several benefits, but would not lend to integrated planning, spending, reporting and health system development more generally.
4. General Budget Support, through the PRBS/PRSC mechanism.

³ Financial Management and Funding Mechanisms for HIV/AIDS, Beng’M. Issa, TACAIDS, 1st Annual Review on NMSF AIDS

5. On budget projects, such as PEPFAR, and EU “budget line support” to NGOs.
6. Off budget projects. These will, however, need to be captured by TACAIDS to maintain their overview and support co-ordination. This mechanism seriously jeopardizes harmonization and leadership of GOT.

5.6 Resource requirements for implementation

Introduction

With the massive funding pledges of many GHIs throughout the developing world, a naïve interpretation could be that resource shortages are no longer an issue for diseases targeted by these same GHIs. However, it could be argued that the opposite is, in fact, true: that GHIs pose a grave threat to the health sector. First, their demands for scarce resources are considerable, ‘scarce’ meaning that in the short- to medium-term there are serious constraints on increasing the availability of some health sector inputs. This scarcity in particular relates to human resources, but also there are serious constraints in terms of physical carrying capacity of the health system (number of health centres and hospitals). Second, the relative wealth of GHIs compared to the government health budget is such that some resources may be attracted to GHIs, thus denuding non-GHI activities of essential resources. Again, this in particular relates to personnel who may be attracted by higher salaries or per diems. This is true for senior management, middle management, and front line workers alike. Some questions which should be answered include the following:

- What are the potential resource implications (human, physical, logistical, infrastructural) of GHIs? At central level? At local level?
- How much do GHIs attract resources (especially human resources) from the government system, or divert them from their ordinary activities?
- To what extent is the resource requirement determined by whether GHIs use an integrated, parallel or mixed approach

Some characteristics of best and worst case scenarios specifically relating to the resource requirements for implementation are outlined in the box below:

Best case: resources for implementation

1. GHIs do not put government systems and resources under undue stress and do not divert them from routine duties.
2. Where more resources are needed to undertake GHI activities, these are employable.

Worst case: resources for implementation

Government resources are diverted towards GHIs, and other resources are not employable/ obtainable.

Resource issues in the health sector in Tanzania

Presented at the March 2004 Health Sector Review, the District Health Services Technical Review observed that “it became clear that the introduction of HAART will be an enormous additional burden on the health delivery system”. The types of burden or constraint differ by type of resource, presented individually below.

Human resources

Various estimates exist for human resource needs for scaling up ART and other HIV/AIDS interventions in Tanzania. NCTP estimated 10,000 additional workers, while the HR needs of the health sector to reach the MDGs are 68,000 (without ART) compared to the current

workforce of 43,000 [9]. Under the unrevised NCTP (without 3 by 5), up to 10,000 additional health care workers need to be recruited and trained in prescribing ARVs and related care. While there are disagreements about the exact numbers of unemployed and underemployed health workers in Tanzania, whatever these are there is no doubt that there is a human resource 'crisis', which is irresolvable even in medium term. Human resource constraints are particularly acute in counseling for VCT. Also, scaling up prevention activities in Tanzania will struggle to succeed [2].

The NCTP states that new staff number required may be less than those planned, because each individual facility strengthening plan will determine how to integrate the HIV/AIDS Care and Treatment Programme with their existing staff and programmes. In the likely event of shortage of new personnel for hiring, this will seem inevitable, and seriously threatens the provision of other services. Furthermore, it is certain that the NCTP in its entirety will divert scarce government resources. Due to the lack of capacity, NGOs are being used and also the private for-profit sector, where it exists, is planned to be mobilized. With these plans, there is a real risk that government staff leave public sector.

In the longer term, the Clinton Foundation-supported health care worker positions are planned to be phased into government-funded positions during the lifetime of the NCTP. This will require forward financial planning on the part of the Ministry of Health, and correspondingly higher budgets set aside for salaries.

The training required is also highly ambitious. For example, the NCTP aims to train virtually the entire health care workforce in HIV/AIDS care and treatment fundamentals, with an emphasis on the uses of antiretroviral therapy.

Drugs and materials

USAID's assessment found that "commodities used in HIV/AIDS prevention, including condoms and drugs to treat sexually transmitted infections for use by the public, as well as latex gloves and disposable needles for use in the health sector, are often not available in sufficient quantities when and where they are needed. Product availability varies by product type; for example, condoms are generally less available in rural areas, whereas examination gloves are in short supply in public health care facilities in urban and rural areas. Given the critical role that these commodities play in preventing the spread of HIV, reducing or eliminating shortages—as well as expanding the availability of these products in more remote areas—should be a much higher priority than it appears to be." Pages 21-22 [2]

Logistical support was on of the areas marked for rapid scale-up by the WHO's "3 by 5" Within the context of the existing INDENT system and the vertical procurement and distribution systems, it is necessary to set up a system that ensures implementation of the NCTP.

Physical infrastructure

The NCTP strengthening plan is entirely focused on establishing clinics able to prescribe ARVs, to monitor the patient condition and provide other care and treatment for HIV+ patients. This focuses on institutional structures (e.g. local advisory committee), training and orientation, establishment of clinic space and laboratory plan, equipment plan (inventory, maintenance), new secure pharmacy, links with other programmes, facility operations and community resources (see page 55 for 'Certification Requirements').

Laboratory was on of the areas marked for rapid scale-up by the WHO's "3 by 5" Mission. The reports states that the current state of the laboratory infrastructure is inadequate and

cannot support the planned care and treatment emergency scale up, and recommends an updating of laboratory guidelines and protocols and an assessment of laboratory capacity.

Information system

- Health Management Information System. The existing Health Management Information System (HMIS) is not adequate to support scaling up of care and treatment. This issue is already being addressed by the MOH. The Mission therefore recommends that the reviewed HMIS should incorporate a national patient tracking system, as well as a system to track the process, outputs and impact of the ART intervention program at the national level in line with the WHO monitoring and evaluation guidelines for ART.

The way forward

The health system in Tanzania faces a very real threat that could potentially change the focus of health care. Due to the resource needs of the planned activities in the health sector over the coming years, urgent action is needed to increase the supply of some key resources that face the most severe short term shortages. Due to the financial and political support in the area of HIV and AIDS, especially for the care and treatment plan, these are likely to divert resources and attention away from other health services, and reduce the quantity and quality of these other types of health care available. The health system should not miss this opportunity for a comprehensive and integrated health system development, using the increased funds provided by the global health initiatives.

5.7 Type of programme delivery

Introduction

There is a long debate over what is the most efficient type of programme delivery, and strong arguments are advanced by advocates of both vertical and integrated programmes [10]. Both vertical and integrated programme delivery structures can work well under certain circumstances, but basic preconditions for both are good quality programme management, motivated health care providers, and robust and efficient systems and processes supporting the programmes (planning, information, finances, supervision, training). Some characteristics of best and worst case scenarios specifically relating to the type of programme delivery for implementation are outlined in the box below:

Best case: type of programme delivery

1. Where possible, programmes are delivered in an integrated fashion, taking into account other programmes that relate to each other.
2. Where parallel structures are necessary, these are planned with intention of long-term integration.
3. HIV/AIDS services should be implemented to have positive effects on the entire health system.

Worst case: type of programme delivery

There is no relation or integration with other linked programmes, and the HIV/AIDS activities are given priority at the expense of other activities.

GHI approaches to programme delivery in Tanzania

The Ministry of Health has adopted an integrated programme delivery approach as the overall national strategy for the health sector, with a decentralized system of provision of health services, and considerable responsibility for management of health facilities at the regional and district level. However, despite this, a vertical approach is being adopted as one

of the strategies for some GHIs. The NCTP and other GHIs give a variety of statements about programme delivery approach which give mixed signals about what is the central approach. On the one hand, the NCTP states that integration within the existing health care structure should be emphasized in expanding care and treatment. However, the plan rather confusingly adds that the “advantages of a team approach to HIV/AIDS care and treatment should be recognized, and that a rapid scale-up of this dimension requires some specialisation”. One area the NCTP clearly prefers a vertical approach is in the delivery of ARV drugs by MSD directly to facilities and not through zonal warehouses to District Medical Officers, which is the current system for MSD. Other areas where the approach is likely to be vertically managed is the recruitment of staff, staff training, and supervision of programme activities to implement the NCTP, due to the huge challenges involved in achieving so much in such short time period.

Another issue of service delivery is the integration of national TB and HIV/AIDS programmes, which have remained unintegrated due to government structure as separate vertical programmes. Objective 3 of the GFATM proposal aims to increase the number of VCT clients and TB patients who are screened for both conditions and treated, with a focus on getting TB patients tested for HIV (Round 3: for 45 districts only). This will contribute to the NCTP aim of promoting routine counseling and testing of all ‘at risk’ patients entering a hospital or attending medical and specialized clinics (NTLP, ANC, STI).

Likewise, the Global Fund proposal (Objective 5) will rely on existing structures within the MOH and the local government for implementation, and will build capacity in these structures (except for where it works through NGOs and FBOs).

In scoping for future interventions of the US government, the Synergy Project assessment recommends that antiretroviral therapy should be administered as a vertical program, with an integrated, decentralized strategy for treatment of opportunistic infections and routine follow-up of patients with HIV infection. The vertical approach is justified on the grounds that delivery of ART requires a high degree of specialized knowledge about the pathophysiology of HIV infection, current treatment guidelines, adverse drug events, drug interactions, and patient follow-up⁴. The assessment concluded that “a vertical program ensures the greatest chance of success”. A vertical system would also be preferable given concerns about possible pilferage and the importance of a tight accountability system for tracking drugs.

At the same time, the Synergy Project assessment recommends an integrated approach for diagnosis and treatment of common opportunistic infections and other complications (such as skin rash), as well as recognition of common or severe side effects in patients who take antiretroviral drugs. The “routine” treatment of HIV-infected patients should be managed in an integrated fashion at the local level without the need to refer to an HIV specialist. In addition, the large and rural-based nature of Tanzania and its health care system argue for the capacity to treat common complications at the local levels and in a decentralized fashion, based on national guidelines and training. This minimizes the burden on a limited number of specialists, and allows patients to have accessible and timely care. (page 46) [2]

The way forward

Similar to the financing channel(s) to be used, there is still some uncertainty concerning the extent and type of integration of HIV/AIDS activities within the existing health system. If HIV/AIDS activities could be planned and implemented in an integrated way, there is potential for considerable benefit to the general health system. However, as suggested

⁴ “Given current human resource constraints (in terms of both number of personnel and training), the potentially high cost of failure (in terms of widespread HIV drug resistance), the need to be up-to-date on the most current information, and certain similarities between an antiretroviral and tuberculosis treatment program.”

above there is a risk that vertical channels will be used for implementation, to safeguard the HIV/AIDS activities. Therefore, careful consideration must be given at this stage to the most appropriate ways of strengthening the capacities of the health system to deliver services, weighing sustainability and general health system issues with efficiency and timeliness criteria.

5.8 Monitoring and evaluation

Introduction

Monitoring and evaluation is a key activity of government ministries. These days, one of the major responsibilities of M&E is towards making available data on indicators for the PRS. However, GHIs may require other indicators for measuring performance. Some questions which should be answered include the following:

- Choice of indicators?
- What system do GHIs use for their M&E needs?
- Do they strengthen the government system?
- What information cannot be provided by government systems?

Some characteristics of best and worst case scenarios specifically relating to the M&E system are outlined in the box below:

Best case: resources for implementation

1. Government systems used and as a result are strengthened.
2. Additional information needs are met with minimum disruption.

Worst case: resources for implementation

Government systems bypassed and as a result are weakened. Additional information requirements take up a considerable amount of staff time, thus diverting them from their day to day activities.

Monitoring and evaluation for GHIs in Tanzania

In light of the urgency of the HIV/AIDS epidemic, a dedicated monitoring and evaluation system must be established to guide the Ministry of Health's HIV/AIDS Care and Treatment Plan. The proposal to establish a care and treatment unit in the National AIDS Control Program and a dedicated monitoring and evaluation system, which is being developed by the Clinton Foundation in consultation with the Ministry of Health and the Tanzania Commission for AIDS, is sound and consistent with the NTLP system, which has been identified as a model for HIV/AIDS to emulate [2].

The National Multisectoral Strategic Framework on HIV/AIDS reports that although guidelines have been developed in many areas, an overall monitoring and evaluation plan has not been developed, and the existing Monitoring and Evaluation Unit does not have a sufficiently strong mandate to put the plan into effect. The NCTP advocates for a pragmatic M&E system to ensure continuous upgrading of the HIV/AIDS Care and treatment Programme. A detailed performance monitoring plan has been developed under the NCTP based on the logical framework and the selected indicators. M&E consists of routine evaluations (process aspects, programme outcome measurement, and impact evaluation), and long-term programme assessment including research to answer policy questions. The current health management information system (HMIS), which is designed to monitor the essential health package, is unable to support the monitoring and reporting requirements in an expanded response to HIV/AIDS. Therefore, while it is proposed that existing data sources will be integrated in the M&E system, it is foreseen to also develop new data

collection systems. The project will support the establishment of an M&E system within TACAIDS to perform the task of M&E during project implementation. Programme evaluation will evolve around the annual reviews when data is collated and analysed specifically against the goals set. Reviews will be carried out on technical and operational aspects of implementation.

The Global Fund proposal states that M&E will be linked to the HIV/AIDS National Multisector Strategic Framework on HIV/AIDS 2003-2007 developed by TACAIDS, as well as to the Health Sector HIV/AIDS Strategy (2003-2006). As the HMIS is weak concerning epidemiological data, the current proposal will use the existing separate systems established under NACP and NTLP for HIV/AIDS and TB surveillance. In addition, there is parallel M&E of the Local Fund Agent consisting of collection of information from routine data systems, collection of documents, and submitting reports to the GFATM Board.

The M&E plans for the PEPFAR are not clear at present. The Synergy Project assessment found that the biggest barriers to control of HIV/AIDS were the lack of data. When data were collected, there was no formal system for analysis, dissemination, and feedback so that the information could be used for public health or treatment planning and evaluation. The report also notes that systems are too fragmented and that surveys are planned and implemented in isolation from each other. Furthermore, AIDS case data are characterized by underreporting. The report also notes the benefits and success of the NTLP model of collecting relatively simple, standardized, and uniform data on a national basis, and that this model may be a useful in designing the specific characteristics for HIV/AIDS M&E [2].

The way forward

The Synergy Project assessment concluded that a strong and enforceable system of accountability is needed at all levels, but that the details of this accountability will need to be determined [2]. A common M&E system across all GHIs in HIV/AIDS could save considerable duplication, and provide the opportunity to unite stakeholders in their attempts to control HIV/AIDS. This would be facilitated by GHIs adopting a budget support approach, as opposed to a project approach, where in the latter case they are more likely to adopt separate M&E systems. The health sector is in the process of defining an Information Strategy, which should be taken on board in developing M&E systems for HIV/AIDS.

5.9 Poverty alleviation

Introduction

With the increased emphasis on the link between health status and economic indicators, health donors and GHIs are heavily concerned with health improvement with the aim of reducing poverty. The Some questions which should be answered include the following:

- How aligned are GHIs with the current PRS?
- What is the potential to support Tanzania in achieving the identified goals and targets of the PRS?
- What financing provisions are made for services provided by GHIs? Are these different from the national policy?

Some characteristics of best and worst case scenarios specifically relating to health care financing and poverty alleviation are outlined in the box below:

Best case: poverty alleviation

1. Poverty is a central concern in planning interventions, and PRS and poverty indicators used as a basis.
2. Government policy of charging respected, and ability to pay the highest consideration.

Worst case: poverty alleviation

Poverty considerations are completely ignored in spending additional resources. Services are provided indiscriminately. GHIs have different a different financing approach to the national policy. Services are unaffordable for the poorest.

HIV/AIDS and poverty alleviation in Tanzania

It is Tanzania's overall policy to provide certain services and medications free of charge in the public sector to patients with AIDS. This applies only to those meeting the clinical definition of AIDS and not those with asymptomatic HIV infection or "minor" HIV-related signs and symptoms. In addition, as the policy stands, this covers only treatment of opportunistic infections, and does not include antiretroviral drugs or laboratory tests such CD4+ counts. ARVs are expected to be provided free of charge, but related services may be charged for. Therefore, GHIs, in order to reach poor and vulnerable groups, will need to revise the national policy. Discussion is ongoing about how ART will be rationed, and it seems likely that some social and economic criteria will be used, such as providing ART to adults responsible for families or productive adults. However, the application of this policy will be a considerable challenge, such as applying poverty 'criteria' in selecting patients for ART.

Even with these limitations, the reality in Tanzania is that severe resource constraints limit what care and drugs can be provided to patients with AIDS from the national budget. For example, drugs to treat tuberculosis seem available and accessible to most patients, even at the local level. On the other hand, the team of the Synergy Project visited district hospitals where drugs (such as fluconazole) to treat fungal infections were not available, and patients had to purchase the drug at local pharmacies. The cost of a full course of these drugs could be significant, especially for poor patients [2].

The way forward

On comparing policy statements of various key official documents, the WHO's "3 by 5" Mission noted certain inconsistencies on the issue of whether ARV treatment will be provided free of cost, or by a mechanism of cost sharing. The Government of Tanzania needs to harmonize the existing policies on ART to clarify its position on this issue. In the light of current gaps in access to ART, a clear definition of the social criteria taking into account gender aspects for rationing of ART in the early phases of national implementation is needed in order to ensure the protection of the poor and vulnerable groups, particularly women.

The implementation of the policy is being considered through the application process for health facilities to be certified to provide ART. In the process, the CTU will consider whether treatment will be made available on an equitable basis to all eligible patients regardless of ability to pay. Therefore, this will require presentation of a plan of action for how the facility intends to achieve this. While this is a good idea, and could work, the monitoring and evaluation of this policy will be important.

6. Conclusions and recommendations

This paper has covered many important issues that need to be addressed with the recent advent of global health initiatives in the area of HIV/AIDS in Tanzania. Clearly not all issues related to global health initiatives could be addressed separately in this paper, especially for a disease as complex as HIV/AIDS. Conclusions and recommendations are made below, covering each theme evaluated in this paper, followed by a statement of optimistic and pessimistic viewpoints.

Conclusions

- Global health initiatives will probably continue to exist for the foreseeable future, although the focus may change over time from one disease to another.
- Donors have played an important role in ensuring a coordinated response to HIV/AIDS, through supporting the setting up and financing of TACAIDS, by leading the national care and treatment plan, and various other inputs.
- TACAIDS has the mandate for coordination of GHIs and donors in HIV/AIDS. However, it has been severely tested in its' ability to fulfill the mandate due to the large number of GHIs.
- GHIs in HIV/AIDS are generally designed to strengthen national systems of planning and financing, although some inconsistencies exist between donor and government plans and priorities. However, at the same time GHIs tend to be vertical in approach.
- Planning and budget setting have been focused on central levels, and to a lesser degree decentralized levels.
- There has been a shift in the balance of planned expenditure from prevention to care and treatment, due to the focus of the GHIs.
- The planned expenditure for the coming years on HIV/AIDS (through the health sector) is almost as great as for the rest of the health sector.
- The shift in planned expenditure has been partially donor-driven, and has not followed closely national processes of priority setting. It is unlikely that the GOT would spend such huge amounts on care and treatment of HIV/AIDS, if it was totally responsible for the budget. It is recognized, however, that there is some political pressure within Tanzania to support Care and Treatment of HIV/AIDS patients.
- Due to fungibility in financing, increased financing available from GHIs for HIV/AIDS may (a) reduce GOT own allocations to HIV/AIDS, and (b) reduce donor spending on non-HIV/AIDS health activities.
- With current spending at the level of the health sector ceiling, the funding of non-HIV/AIDS health sector activities is threatened.
- There will remain a diversity of funding channels, but the shift is towards national systems of financing (baskets) and more is being captured by the MTEF.
- Due to short- and medium-term shortages of resources in the health sector, there is a serious threat that resources and systems will be drawn towards serving the HIV/AIDS sub-sector.
- While at the macro-level, there is expected to be a joint monitoring and evaluation system, in terms of M&E of activities, there is expected to be a number of systems for different GHIs. Uniting behind a single monitoring and evaluation system could improve considerably coordination, and the effectiveness of different initiatives.
- One major concern should be the sustainability of activities at the currently planned level, and crucially whether or not there will be continued financing for HIV/AIDS activities beyond 2008. There are currently many uncertain elements that make it difficult to plan 5 years ahead, such as the future direction of the epidemic, the extent on continued commitment to HIV/AIDS, and the performance of GHIs in meeting their targets.

Recommendations

- As new global health initiatives arrive, and existing initiatives are extended or change their focus, it is crucial that these are well adapted to the country situations and local stakeholder wishes. Ownership continues to be an important element that should not be ignored. Also, local stakeholders need to realize what decisions, choices and trade-offs that to be made in moving forward with initiatives such as AIDS Care & Treatment.
- New GHIs in HIV/AIDS should be discouraged, but instead funds should be provided on-budget to support the Government of Tanzania's plans.
- A code-of-conduct for new forms of support to HIV/AIDS should be elaborated without delay.
- As currently the major resource allocation decisions are made by GHIs themselves (possibly with some national participation), the power of decisions about resource allocation should be shifted to Government of Tanzania and the local levels (community).
- Planning should be synchronized, and plans should be operationalised as soon as possible, through initiatives such as the Quick Start Plan and the Rapid Funding Envelope.
- Greater focus should be on general health systems development and absorptive capacity.
- High-level discussions are needed with the Ministry of Finance about the health sector budget ceilings and the financing channels.
- Discussions need to be held on how to ensure other health sector priorities continue to be met, in the face of scarce resources (especially human resources) flowing to HIV/AIDS.
- Greater focus should be on poverty alleviation, equitable access and gender aspects.
- Donors should continue to play the role of independent observer, ensuring issues are raised so that local stakeholders see clearly the evolution of the sector, allowing them to fine-tune as necessary.
- It is important to be aware of the future financial implications of decisions as reflected in the NCTP, such as the number of PLWHA who will need to be continued to be supported on ART after 2008. Therefore, the government should explicitly consider the sustainability of activities started now. One way it could address this is to require new projects and GHIs to include a paragraph on plans for after project funding.

An optimistic view

The Synergy Project assessment optimistically states that "As a change agent, the Clinton Foundation may provide opportunities to reengineer and strengthen the entire health delivery system in Tanzania while focusing on the most pressing challenge facing the health sector today" [2]. Similarly, one development partner states 'Scale up of ART provision has the potential to strengthen systems, if the investment is used to address infrastructure, human resources and logistical weaknesses.'

A pessimistic view

However, these gains will only be seen if certain conditions are met and approaches adopted. The same development partner (above) goes on to add: "Reviewing the question of whether health systems like the Tanzanian are ready to incorporate ARVs identify issues like equity, maintaining clinical standards, affordability of monitoring, emergence of resistance, and to address ill-equipped and under-resourced health systems and underpaid health workers....there is need to carefully and realistically analyze the possibilities for expansion of care and treatment without jeopardizing an already weak health system".

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