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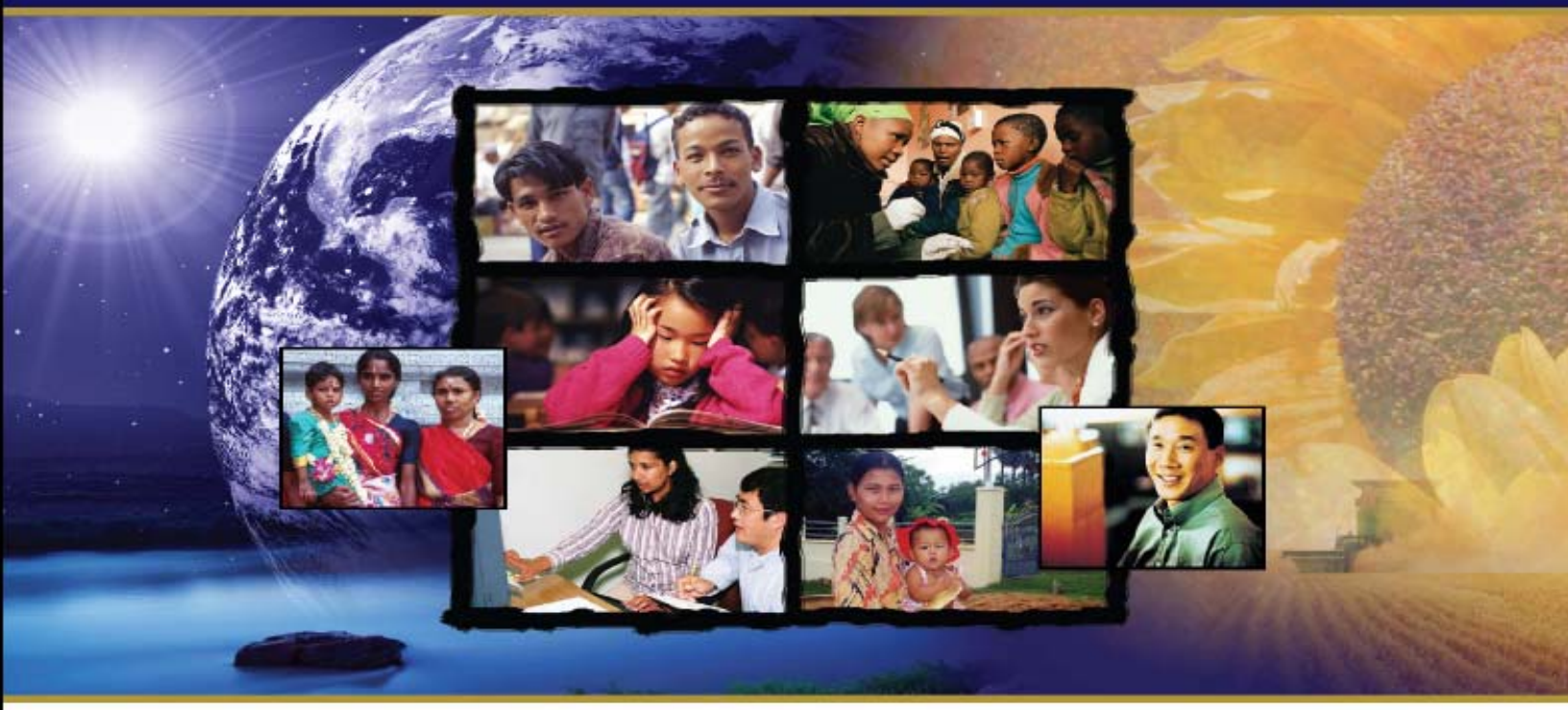
Preparing for Microbicide Access

TANZANIA COUNTRY PROFILE



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PREFACE

With funding from the European Community, the International Partnership for Microbicides (IPM) commissioned a series of country profiles that compiled information on demography, HIV and health systems in countries hosting or planning to host microbicide trials. They are intended to provide basic overviews that can inform the development of more detailed policy research agendas and support future planning for the introduction of microbicides. They do not set out detailed microbicide introduction strategies or address product-specific challenges.

Constella Futures was commissioned to prepare profiles for India, Nigeria, Rwanda and Tanzania. Studies were also conducted separately in South Africa and Zambia. The country profiles are available at www.ipm-microbicides.org

The recommendations made in the reports are those of the authors and do not necessarily reflect IPM's views, positions or plans.

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REPORTS IN THIS SERIES

Prepared by Constella Futures:

- India Country Profile
- Nigeria Country Profile
- Rwanda Country Profile
- Tanzania Country Profile

- Preparing for Microbicides Access: A Synthesis Report

Prepared by Jo Heslop (data are comparable to Constella Futures reports):

- South Africa Country Profile
- Zambia Country Profile

Prepared by Health and Development Africa:

- A Country Preparedness Assessment of Microbicide Access and Use in South Africa

Prepared by JHPIEGO/ Zambia:

- Microbicide Country Preparedness Assessment – Zambia: Prospective Introduction of a Microbicide to Prevent or Reduce HIV Transmission

CONTENTS

ACRONYMS

ADDO	Accredited day dispensing outlet
ANC	Antenatal care
API	AIDS Program Effort Index
ART	Antiretroviral therapy
ARV	Antiretroviral
CDC	Centers for Disease Control (US)
CPP	Certificate of Pharmaceutical Product
CRS	Catholic Relief Services
DFID	Department for International Development (UK)
DHS	Demographic and health survey
EC	European Commission
EDL	Essential Drug List
ELCT	Evangelical Lutheran Church of Tanzania
FHI	Family Health International
FP	Family planning
GDP	Gross domestic product
GFATM	The Global Fund to fight AIDS, Tuberculosis and Malaria
GOT	Government of Tanzania
GFCCM	The Global Fund Country Coordinating Mechanism
GMP	Good Manufacturing Practice
HIV/AIDS	Human Immunodeficiency Virus/ Acquired immunodeficiency syndrome
IPM	International Partnership for Microbicides
MAP	Multisectoral AIDS Programme
M&E	Monitoring and evaluation
MEMS	Mission for Essential Medical Supplies
MOHSW	Ministry of Health and Social Welfare
MOH	Ministry of Health
MOU	Memorandum of understanding
MSD	Medical Stores Department
MSH	Management Sciences for Health (US)
MWRA	Married women of reproductive Age
NACP	National AIDS Control Programme
NMSF	National Multisectoral Strategic Framework
NTC	National Therapeutics Committee
OTC	Over-the-counter

OVC	Orphans and vulnerable children
PAF	Programme acceleration funds
PEPFAR	The President's Emergency Plan for AIDS Relief
PLWHA	People living with HIV/AIDS
PMO	Prime Minister's Office
PMTCT	Prevention of mother-to-child transmission of HIV
PRB	Population Reference Bureau
PRSP	Poverty Reduction Strategy Programme
SEAM	Strategies for Enhancing Access to Medicines Programme
SPC	Summary of product's characteristics
SRH	Sexual and reproductive health
STI	Sexually transmitted infection(s)
SWAp	Sector-wide approach(es)
TACAIDS	Tanzania Commission for AIDS
TAMW	Tanzania Media Women's Association
TDHS	Tanzania Demographic and Health Survey
TFDA	Tanzania Food and Drug Administration
THIS	Tanzania HIV/AIDS Indicator Survey
TPI	Tanzania Pharmaceutical Industries Ltd.
UNAIDS	United Nations AIDS Organization
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Fund
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VCT	Voluntary counselling and testing of HIV
VHW	Village health worker
WFP	World Food Programme
WHO	World Health Organization

EXECUTIVE SUMMARY

This report for Tanzania is one of a series of country profiles commissioned by the International Partnership for Microbicides (IPM) to build a background on which to begin to examine microbicides access at the country level. The objectives of the project are to look at country settings and begin to identify mechanisms, critical pathways and key procedures to accelerate the availability of microbicides in developing countries. The team built the profiles as desk-based research using standard data sources; in-country consultants assisted the researchers by interviewing stakeholders and filling important gaps unavailable in the grey literature.

Demography. Tanzania is a vast East African country with a population of 38 million, the majority living in rural areas. Tanzania is a low-income country and over 90 percent of the people live on less than $2 a day. Both fertility and mortality are high in Tanzania and the average woman continues to have approximately six children (TFR 5.7, urban 3.6, rural 6.5). The population of Tanzania is expected to double by 2050. One in four married women uses a method of family planning. This is roughly the same rate found in the 1999 Demographic and Health Survey (DHS) as use of modern methods of family planning increased only slightly, from 17 to 20 percent. This is lower than the use of modern family planning found in Kenya and Malawi, but higher than that found in Uganda, Ethiopia and Rwanda (2004-2005 DHS).

HIV Trends. Tanzania is a high-burden, low-income country facing a mature, generalised HIV epidemic. Seven percent of Tanzanians ages 15 to 49 are infected with HIV and prevalence among women is higher (eight percent) than among men (six percent). There are important differences between regions and urban and rural areas (12 percent of urban women are HIV-positive). Young women who are widowed, divorced or separated ('formerly married') are much more likely to be HIV-positive (18 percent) than currently married women (four percent) or those who have never been married (two percent). Incidence data are unavailable. Comprehensive knowledge of HIV/AIDS among 15-to-24-years-olds is respectable (44 percent for women, and 49 percent for men) with an increasing age of first sexual encounter, and a decreasing proportion of the population reporting multiple partners (from eight to five percent in women, and 27 to 20 percent men). In Zanzibar, HIV prevalence is estimated at 0.6 percent for the general population, with evidence of a rise in infection rates. HIV prevalence in Zanzibar increased from 0.3 to 0.6 percent in pregnant women and from 0.5 to 1.5 percent in blood donors between 1987 and 1997.

Health system and expenditure. The Government of Tanzania (GoT) spends 13 percent of its budget on health, showing real commitment. Yet Tanzania has a vast health structure that

is severely challenged. Patients with HIV-related illnesses reportedly occupy 50 percent of hospital beds and HIV/AIDS is the leading cause of adult death. A recent health sector reform saw a major restructuring and decentralisation of the health system. In 2001, the GoT committed to increase expenditure in core areas including HIV/AIDS, yet three donors (Global Fund, PEPFAR and the World Bank) represent nearly 75 percent of HIV/AIDS expenditures. Currently, 71 percent of Tanzanian children have received all of the recommended vaccinations. However, delivery of services to the vast rural areas is challenging. Concurrently, the private sector was also encouraged to complement the public system.

Regulatory capacity. The Tanzania Food and Drug Administration (TFDA) was established in 2003 by the Tanzania Food Drug and Cosmetics Act. The TFDA is an executive agency under the Ministry of Health (MOH) and is the regulatory body responsible for the quality and safely of food, drugs, cosmetics and medical devices. It is responsible for drug registration and drug inspection, including Good Manufacturing Practice (GMP) and licensing of pharmaceutical manufacturers. It also manages the Quality Control Laboratories, which includes condoms. The current GMP is adapted from the WHO guidelines. Recent support from MSH (funded by the Gates Foundation) has improved the regulation process. Grey market and black market medications are relatively common.

Manufacturing. Tanzania's local manufacturing capabilities are limited and are more focused on re-packaging than actual manufacturing. Reportedly, if all pharmaceutical manufacturing companies in Tanzania worked to capacity, they could supply slightly more than one per cent of Tanzania's medication requirement, meaning that most drugs and medical supplies are imported. The Tanzania Pharmaceutical Industries Limited (TPI) was founded in 1980 as a government-owned company and was privatised in 1997. TPI formulates and manufactures pharmaceutical products, and with technical assistance from Thailand and raw materials from China, it manufactures antiretrovirals (ARVs). A number of companies in Tanzania package and distribute generic medicine.

Procurement. The Medical Stores Department (MSD) is an autonomous department of the Ministry of Health and operates on a commercial basis, responsible for its own financial sustainability. The MSD has successfully procured millions of dollars of pharmaceuticals and medical supplies from the international and domestic market at highly favourable prices (when compared to international standard pricing) and distributes to health facilities across the country. MSD focuses on a list of approved medicine and has an estimated capability of providing just 70 percent of public sector supply demands. There is a health sector-wide approach (SWAp) in Tanzania, which is funded by seven donors who work through the public procurement system. Likewise, the confessional missions operate a pharmaceutical supply

facility. Well-established social marketing efforts do their own procurement, clearing and local packaging, usually tax-free.

HIV programming. WHO describes Tanzania's political commitment to fight the HIV/AIDS epidemic as high.[1] In 2001, the government established the Tanzania Commission for AIDS (TACAIDS) by an act of Parliament under the Prime Minister's Office (PMO) to lead, facilitate, strengthen and coordinate the expanded national response to the epidemic. The commission, together with all stakeholders, developed the National Multisectoral Strategic Framework on HIV/AIDS (NMSF) as a tool to guide the national response based on the national policy. The MOH's long-standing National AIDS Control Programme (NACP) is charged with the technical response and outlining of a five-year plan of activities. Staffing, logistics and access to services, especially for the rural population, remain important obstacles to treatment and care. Treatment and care objectives are ambitious and a strong national policy framework guides the Tanzanian national response.[2]

IMPLICATIONS FOR A FUTURE MICROBICIDE

A range of key stakeholders were interviewed and asked what might have an impact or influence on a future microbicide. Below are some of the results of this informed speculation.

DELIVERY CONSIDERATIONS

Microbicides delivery would best be undertaken through **multiple channels**. If, in Tanzania, one of the main targets will be primary partnerships, ways to reach these women will have to be carefully considered. One such way is through existing reproductive health and family planning programmes. Not only are women already at these clinics receiving services, they are already thinking about prevention (albeit preventing births) and taking action to address a health issue. This might also make them more open to the concept of preventing disease, safe sex and using a condom or a microbicide. Family planning use may also mean that these women will have already communicated with their partners about seeking health information and services. Attention will also be needed to reach women who are not accessing services. Some of these women may not perceive themselves as having family planning or sexual health needs (which may or may not accord with actual risks). Others may face social, geographical or financial barriers to access.

Social marketing will be an important delivery channel. It will be difficult to base distribution of any new product singularly on the public health care system, which is already

[1] WHO, 2005.
[2] Ibid.

somewhat overloaded. Social marketing has been established and effective in Tanzania since 1993 and receives wide support from the government.

Over-the-counter products. As doctors and pharmacists are relatively few in Tanzania, achieving widespread access to a microbicide will require a product available without prescription. Deregulation of prescription drugs has been used in other areas, such as in the case of the malaria drug, Coartem. As with oral contraceptives or malaria drugs, women may visit a health facility for a first consultation and then use over-the-counter services for renewing their supplies.

Small drug shops. One option for microbicide distribution is through already established drug shops, particularly ones undergoing improvements. They are licensed to sell only non-prescription medicines but typically provide a much broader range of products and services. Some efforts have been made to improve training and quality of drug shops and expand the range of products that they can provide.

Do not assume that the mission sector will support delivery. While the mission sector is an important health service provider and could provide an important service network, few faith-based health providers in Tanzania distribute condoms.

Female condom experience. There has been a good experience in Tanzania with the female condom, with women reporting that they like to be able to initiate use. Scale-up is happening now, with pre-launch advertisements and media coverage. The female condom experience will provide important lessons for microbicide introduction. This includes branding, testing acceptability, distribution, pricing, and training on use. Both the female condom and a future microbicide will be female-initiated HIV prevention methods. Both require some training on utilisation and both will be seen as more expensive than the standard (a male condom).

Community mobilisers. Family planning programmes have successfully used community mobilisers to engage the community and effectively create demand. These mobilisers could receive microbicides training and play a role in building community awareness. They could also educate women in microbicide use. Community venues, such as hair dressers, have been useful service and education points for female condoms (e.g. in Zimbabwe)

Sexual reproductive health (SRH) and HIV communities not working together. There is little experience in Tanzania of HIV and SRH collaboration. Prevention of mother-to-child transmission of HIV (PMTCT) is not part of the SRH portfolio. There is no dual protection communication messaging used in Tanzania.

MANUFACTURING & REGISTRATION

Manufacturer and registration. Manufacturers will need to drive the registration process, but are likely to need a local agent to interact with the Tanzanian FDA. Registration can take time and there are examples of a number of current products being held up while awaiting registration clearance (e.g. PSI's new flavoured condom).

Fast-tracking. A number of products have been 'fast-tracked' through the regulatory process and made part of 'project' efforts. Fast-tracking is possible where a product has already been evaluated in the US or Europe, as in the case of ARVs and some TB drugs.

WHO prequalification. The FDA is also more likely approve a product quickly if it has been pre-qualified by WHO.

Local packaging in Tanzania. Local companies have capacity to package products in locally branded forms and with indigenous language instructions. Companies already provide such services for the packaging of insecticide-treated bed nets for malaria prevention.

Non-profit organisations. Linking a product with a non-profit organisation can be useful in avoiding tariffs and duties on products. In addition, NGOs have the capacity to reach remote and hard-to-reach communities.

PROCUREMENT

The Medical Stores Department (MSD) could procure a future microbicide product. Their effectiveness will depend on having official permission to procure and distribute, or to fast-track its distribution. All ARVs, for example, come in via the MSD.

Inclusion in the Essential Drug List. Priority is given to approving and procuring medical products included in the MOH's essential drug list. This also facilitates including the product for fast-track approval.

Social marketing organisations do their own procurement. Products are not procured through the MSD but often utilise similar warehousing facilities and networks.

SOCIAL ISSUES

Risk of gender violence. Intimate partner violence is already common. Microbicide use could potentially be a flashpoint for conflict. Women must be supported to communicate with

their partners about sexually related issues, including through education programmes aimed at men.

AIDS stigma still very strong. Marketing microbicides needs to take into consideration the negative impact of accessing and using microbicides if they were to be marketed only as HIV prevention products.

Dry sex practices. Dry sex is not uniformly practised in Tanzania and should not pose a significant problem to microbicide use. However, there are communities where dry sex is practised and awareness of activities should inform local microbicide programmes.

OTHER ISSUES

More human capacity needed. Integration of microbicides into the healthcare setting will require human capacity-building. Programmes will need to design clear and simple operation protocols and training materials in local languages. On-going monitoring and regular refresher courses will be needed to sustain engagement and quality.

MOH must gradually assume funding. Donors increasingly support health through SWAps and general budget support. Therefore, the MOH will need to eventually assume a substantial share of funding for microbicide programmes. Microbicide introduction programmes should plan ahead for a transition from project funding to MOH budget funding (or some combination of the two). This may be complex as not all donors participate in the SWAp.

Manage the introduction carefully. As with the female condom, building awareness of the concept of microbicides and then marketing a branded product will take time. Consider using the WHO strategic introduction, building on the lessons learned from reproductive health products.

Product replacement price. Some degree of sustainability may be possible through an element of cost-recovery in microbicide programmes. However, it is unlikely that consumers will be able to bear the full cost of commodities and programme delivery. Research is needed to decide what would be a reasonable product price, depending on the ability of consumers to pay and what financing mechanisms can be established to help those who cannot.

Media. Television has poor reach in Tanzania but radio at local and regional levels can provide a useful health promotion tool. Preparatory research will be required to understand the reach of different radio stations, to develop appropriate messages and to understand how the messages are received by sexual partners of prospective users.

ADDITIONAL RESEARCH OR FOCUSED ADVOCACY

Market research. Despite the availability of data from clinical trials and other sources that will be used to support product registration, it will also be necessary to undertake local studies in Tanzania to support country- and population-specific marketing strategies, including how to position and brand products.

Product variations. Market research should look at possible interest in product variations – such as smell or colour. Variations might also be aligned with different marketing strategies – e.g. as products that may enhance pleasure. PSI is just about to launch flavoured condoms in Tanzania and it will be interesting to see how this product variation is received.

Target market is probably in stable partnerships. Women in stable relationships who are often monogamous but whose partners may not be are a key target audience for microbicide use. Condom use in such relationships is usually very low, and abstinence is impractical. Reaching this population, however, will be difficult. This may be when SRH channels will prove the most helpful. Positioning microbicides appropriately in order to reach this group will be important. Experience from the female condom suggests that association of a product with HIV or with a group perceived as at high risk for HIV infection (e.g. sex workers) may inhibit more general adoption.

Campaigns. There will be the need for multiple campaigns within Tanzania. A pre-marketing awareness raising campaign will be needed to build in-country political support and interest in the concept of microbicides. Specific marketing campaigns will then be needed to generate demand for specific products.

RECOMMENDATIONS FOR KEY STAKEHOLDER OUTREACH

MOH support is crucial. MOH has control over product distribution within Tanzania. Working closely with the ministry as the product becomes reality will be important to generating support for introduction and integrating within broader health strategies, including mobilisation of domestic funding streams.

Tanzania Commission for AIDS (TACAIDS). Every intervention that is AIDS-related must be approved TACAIDS. The commission was established by law in 2001 and brings together key government ministries and agencies and provides political leadership to the HIV and AIDS response.

National AIDS Control Programme. The NACP, based at the Ministry of Health, remains the principal technical reference for any AIDS intervention. Integration of microbicides into the NACP will be essential for successful introduction.

Agency champion. Importation, distribution and communication about microbicide products will require an agency that champions the product. Social marketers have already been successful agents for a number of product-focused programmes and could be strong allies, programme drivers and implementers for microbicides.

HIV and SRH. Integrated SRH and HIV services would provide a good basis for microbicide introduction but these are currently limited in Tanzania. Improvements in integration should be monitored as opportunities for effective microbicide programming may arise in the future.

Build on good will of microbicides clinical trials. Two different microbicides organisations are carrying out clinical trials in Tanzania. These trials involve considerable community outreach and the building of trust within the country. If these trials are handled carefully and considerately, there will be a solid base of microbicides supporters in Tanzania.

Women's empowerment champion. Broad sectoral committees have had limited success in Tanzania. This product should seek to garner political support from a limited number of local organisations that champion women's empowerment issues. These might include a new foundation (TAMWA) established by the current first lady – Mrs. Jeannette Kagame - that is working on issues of education and inter-generational sex.

The Tanzania Media Women's Association (TAMWA). This group could be an effective ally in building demand for microbicide introduction and supporting fast-tracked government action.

1 INTRODUCTION

This report for Tanzania is one of a series of country profiles commissioned by the International Partnership for Microbicides (IPM) to build a background on which to begin to examine microbicides access at the country level. The primary aim of the project is 'to accelerate access of women in less-developed countries to microbicides as soon as possible after clinical trials have demonstrated their effectiveness in preventing HIV infection'. Broadly, the objectives of the project are to look at country settings and begin to identify some implications for microbicide introduction in developing countries.

This country profile for Tanzania is meant to be a resource for the microbicides community as access to microbicides becomes a reality over the next few years. The profile includes summary demographic and health information as well as an overview of the procurement, regulatory, and manufacturing situation. Finally, the profile includes institutional mapping, outlining the key players in HIV/AIDS and sexual and reproductive health (SRH). Some implications for a future microbicide in Tanzania conclude the report.

2 METHODOLOGY

The microbicides access country profiles are meant to be background documents for future microbicides research and modelling. IPM provided the outline for the country profile series. This outline is reflected in the table of contents for the report. The team built the profiles as desk-based research using standard data sources from the UN system, the Population Reference Bureau (PRB), the Demographic and Health Surveys, and the Global Fund. These data were chosen to allow comparability across countries. Additional studies and in-country data were included, if available. In-country consultants assisted the researchers by interviewing stakeholders and filling important gaps unavailable in the grey literature. Finally, each profile was reviewed by an in-country expert.

In addition, two meetings were held by the Constella Futures team: one in London including international experts, and one in Nairobi bringing together the country consultants. Both sets of experts provided additional information, giving their opinions on best ways to provide microbicides access as well as identifying obstacles.

3 DEMOGRAPHIC INFORMATION

3.1 BASIC DEMOGRAPHIC AND SOCIO-ECONOMIC CONTEXT

TABLE 3.1 DEMOGRAPHIC DATA

Total population *(PRB, 2006)*	37,858,000
Population density per square mile *(PRB, 2006)*	104
Percentage of population living in urban areas *(PRB, 2006)*	32%
GDP per capita *(WHO, 2005)*	US$267
Human Development Index *(WHO, 2005)*	0.418 (ranked 164/177)
Percentage of population on under $2 a day *(PRB, 2006)*	90%

The United Republic of Tanzania is a vast East African country, bordering on Kenya, Uganda, Rwanda, Burundi, the Democratic Republic of Congo, Zambia, Malawi and Mozambique. The Indian Ocean is to the east and the country shares three of the largest lakes in Africa: Victoria, Tanganyika and Nyasa. The population is largely rural, with a relatively low population density of 104 people per square mile. Almost a third of the people live in urban areas, most of these being concentrated around Dar es Salaam, the Mwanza lake zone and Zanzibar. Tanzania is a low-income country, with a GDP per capita of US$267 and a Human Development Index of 0.418 (the 14th lowest ranking in the world). Nine-tenths of the population lives on under $2 a day.

The United Republic of Tanzania was created by uniting Tanganyika, which became independent in 1961, with Zanzibar, which became independent in 1964. It is important to note that for many functions, Zanzibar has its own administration, including a MOH and a national AIDS control body. The mainland had its first multi-party democratic election in 1995 after 30 years of one-party 'socialist' rule. Dodoma is the new national capital, though Dar es Salaam is still the business and economic capital. The country is divided into 26 administrative regions (21 on the mainland and five in Zanzibar) with 130 administrative districts (120 on the mainland, 10 in Zanzibar). Official and widely spoken languages are Swahili and English, plus Arabic in Zanzibar. The population is one-third each Christian, Muslim and indigenous beliefs, though Zanzibar is over 99 percent Muslim. Main exports are gold, diamonds, coffee, cotton, sisal, tea, tobacco, cashew nuts and manufactured goods.[3]

Tanzania is seen as a stable country with relatively low crime and an established and representative government that is attracting greater investment.

[3] CIA, 2006.

3.2 HEALTH AND FERTILITY

TABLE 3.2 HEALTH AND FERTILITY DATA

Crude birth rate	42
Crude death rate	17
Projected population increase 2006-2050	92%
Life expectancy at birth	45 years
Life expectancy at birth (male)	44 years
Life expectancy at birth (female)	45 years
Total fertility rate	5.7
Ideal family size – women *(TDHS, 2005.)*	5.0
Ideal family size – men *(TDHS, 2005.)*	5.3
Percentage of married/in union women of reproductive age (MWRA) using contraception	26%
Percentage of MWRA using modern contraception	20%
Unmet need for family planning *(PSP-One, 2005.)*	22%
Age at first marriage (women) *(DHS, 2006).*	18.1 years
Age at first sex (women) *(DHS, 2006).*	16.8 years
Age at first birth *(TDHS, 2005.)*	19.4 years

Source: PRB, 2006, unless otherwise stated.

The birth and death rate are slightly higher than the average for sub-Saharan Africa. Between 1991 and 2001, life expectancy fell from 50 to 44 years, largely because of AIDS[4]. Since then, it has stabilised and has now increased again to 45 years. The total fertility rate has been declining but is still amongst the highest in sub-Saharan Africa at 5.7; this means the population is expected to almost double in size by 2050. Ideal family size is also high (but has reduced significantly in recent years), with men wanting slightly larger families than women. Actual and ideal family sizes vary enormously with socio-economic variables; people who are younger, urban and more educated want and have smaller families. One in four women uses contraception and one in five uses modern methods. There is a significant unmet need for family planning as one woman in five wishes to delay or terminate childbearing and is not using contraception.

[4] World Bank, 2003.

3.3 GENDER

TABLE 3.3 GENDER DATA

Percentage of women aged 15-24 who are literate (can write a simple sentence)	89%
Literate women as a percentage of literate men	95%
Percentage of women aged 15+ who are economically active	87%
Percentage of men aged 15+ who are economically active	90%
Percentage of women with access to newspaper, TV and radio *(DHS, 2005)*	1% 55% of households own a radio. (THIS)

Source: PRB, 2005, unless otherwise stated.

Literacy levels for girls are relatively high in Tanzania – both the proportion of literate women and women's literacy as a percentage of men's literacy is much higher than the rest of East Africa and higher than the world average. Women are also almost as economically active as men. (This is not necessarily an indicator of women's empowerment, but often more a reflection of poverty levels, as a much lower proportion of women are economically active in Europe than Tanzania.) While just one per cent of women have full access to the media, 62 percent listen to the radio once a week and 33 percent have no media access at all (TDHS).

4 HIV LEVELS AND TRENDS

TABLE 4 HIV DATA

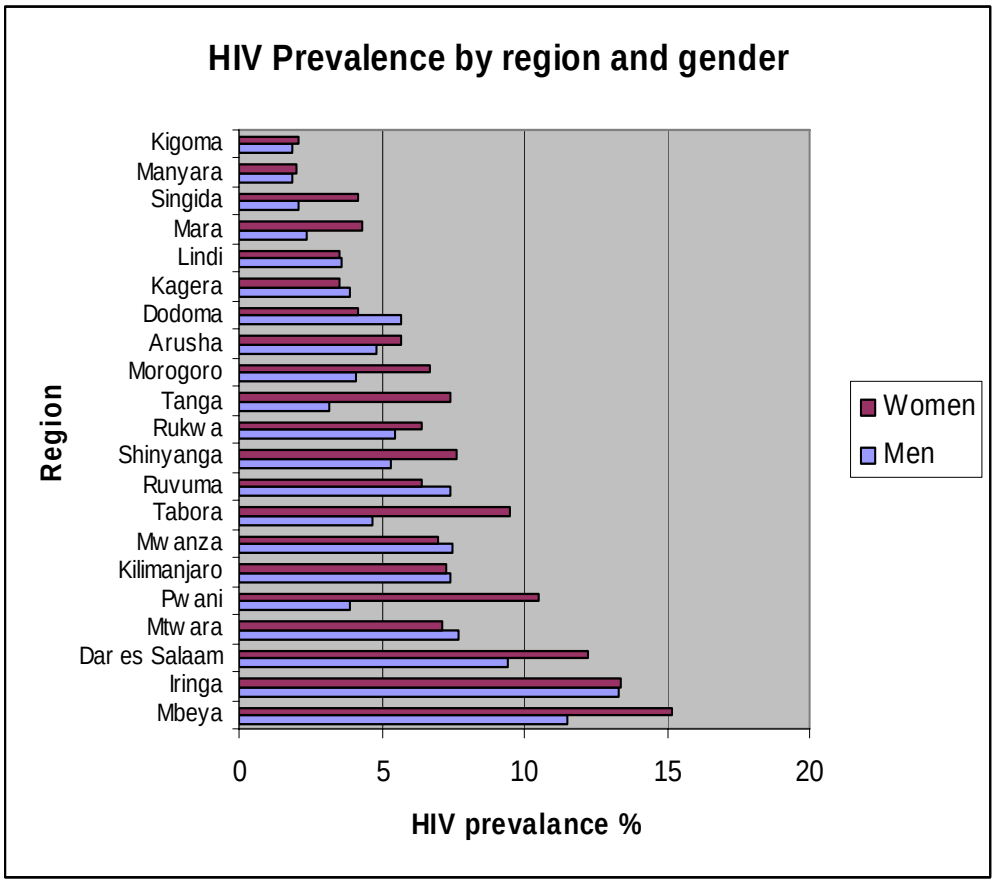
HIV prevalence	6.5%
# of people living with HIV (adults and children)	1,400,000
# of children (0-14) living with HIV	110,000
# of adults (15-49) living with HIV	1,300,000
# of adult women living with HIV	710,000 (55%)
# of children (aged 0-17) orphaned by AIDS	1,100,000

Source: UNAIDS, 2005.

Tanzania is a high-burden, low-income country facing a mature, generalised HIV epidemic. The Tanzania HIV Indicator Survey (THIS) carried out in 2003–2004 showed an overall prevalence rate of 6.5 percent among those 15–49 years old (mainland only), a lower rate than previous estimates by UNAIDS (8.8 percent) based on antenatal care (ANC) sentinel surveillance. Tanzania remains in the top 15 HIV/AIDS prevalence countries (PRB, 2006). There are very important differences between regions and between urban and rural areas

(see Figure 4.1). Mbeya, Iringa and Dar es Salaam are the hardest-hit, each having an HIV prevalence of over 10 percent, and the relative prevalence between men and women varies widely between region. HIV prevalence trends among pregnant women suggest a relatively stable epidemic overall. However, the recent survey found that more people are practising safe sex compared with five years ago, which may suggest some decline in sexual activity with multiple partners.[5] There is no reliable standardised or national-level information available on HIV incidence, nor prevalence data for high-risk sub-populations.

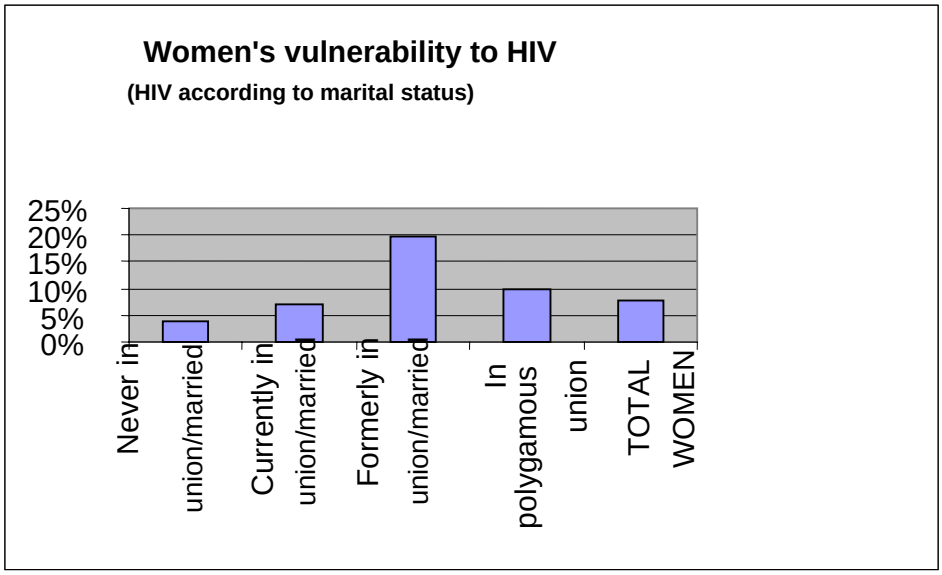
FIGURE 4.1



Source: THIS, 2005.

[5] UNAIDS, 2005.

FIGURE 4.2 (Source: TDHS, 2005.)



It is estimated that 1.4 million Tanzanians are infected with HIV, with women accounting for 55 percent of estimated infections. Divorce can be a risk factor for women in Tanzania. Never-married women have an HIV prevalence of 3.8 percent (low) compared to 6.9 percent for married women (intermediate), 9.9 percent for those in polygamous unions and 19.8 percent for those formerly married (see Figure 4). Tanzanian women marry young (18.1 years) and have their first sexual encounter even younger (16.8 years), contributing to the increased risk that women face (see Table 4.2). HIV prevalence in Tanzania increases (for men and women) with level of education, employment and wealth, as well as being higher in urban settings, reflecting increased life "opportunities."[6]

A macroeconomic simulation model estimated that the impact of AIDS on the growth path of the Tanzanian economy would be to reduce GDP by between 15-25 percent by the year 2010, and to reduce per capita income by between 0-10 percent. HIV/AIDS is also expected to reduce the size of the labour force by 10 percent and there will be a decrease in production as younger, less-experienced people will replace those who have died.[7] Children orphaned by AIDS are now reckoned to number 1.1 million, one of the highest numbers in the world.

[6] THIS, 2004.
[7] World Bank, 2005.

5 HEALTH SYSTEM PROFILE

5.1 DESCRIPTION

In 1994, the Government of Tanzania first proposed a health sector reform. Proposed action includes managerial restructuring or decentralising health services; financial reforms, such as enhancing user charges in government hospitals and introducing health insurance, and introducing community health funds and public-private mix reforms, such as encouraging the private sector to complement public health services. Organisational reforms, such as integrating vertical health programmes into general health services, and funding and instituting health research, are also included.[8]

In 2000-2001, the Government of Tanzania committed to increased expenditure in core areas. For health, this included providing drugs, essential medical supplies, equipment and vaccinations; rehabilitating the health infrastructure; strengthening primary health care and maternal and child health programmes; and building capacity for HIV/AIDS and sexually transmitted infection activities.[9]

The current system is deeply challenged. At the best of times, delivery of services to remote rural areas would be difficult. With the increased burden of HIV/AIDS and its associated issues (such as TB), this is now a major undertaking. While the efforts are valiant, it is not clear that those efforts are succeeding.

GOVERNMENT HEALTH MANAGEMENT STRUCTURES

Decentralisation has now been extended to all 113 districts as part of the health sector reform programme. Responsibilities are as follows:

District level. The district level focuses on quality service delivery within the context of comprehensive district health planning and equitable resource allocation. The secondary and tertiary hospitals will assure efficient quality referral services and technical support to district hospitals.

Regional level. The regional level provides supervisory and technical support to councils, and ensures adherence to policies and guidelines.

Central ministry. The central ministry develops the policies and regulatory framework, tracking policy information, reform management, monitoring and quality control.
Source: URT, 2003.

[8] SEAM, 2003.
[9] Ibid

GOVERNMENT HEALTH SERVICE DELIVERY STRUCTURES

Village health services are the lowest level of health care delivery in the country and essentially provide preventive services which can be offered in homes. Usually, each village health post has two village health workers (VHWs).

Dispensary services are the second level of health services. The dispensary provides for between 6,000 and 10,000 people and supervises all the village health posts in its ward.

Health centres serve 50,000 people, which is the approximate population of one administrative division.

District hospitals serve an important role in the country's provision of health care services. The national government runs most of the district hospitals, but some rural districts have hospitals run by non-profit religious organisations.

Regional hospitals offer similar services to those at district level; however, regional hospitals have specialists in various fields and offer additional services.

Referral/consultant hospitals comprise the highest level of hospital services in the country. Currently, the four government-run referral hospitals are the Muhimbili National Hospital which serves the eastern zone, the Kilimanjaro Christian Medical Centre which serves the northern zone, Bugando Hospital which serves the western zone and Mbeya Hospital which serves the southern highlands.
Source: URT, 2006.

5.2 ANNUAL EXPENDITURE

TABLE 5.2 HEALTH EXPENDITURE DATA

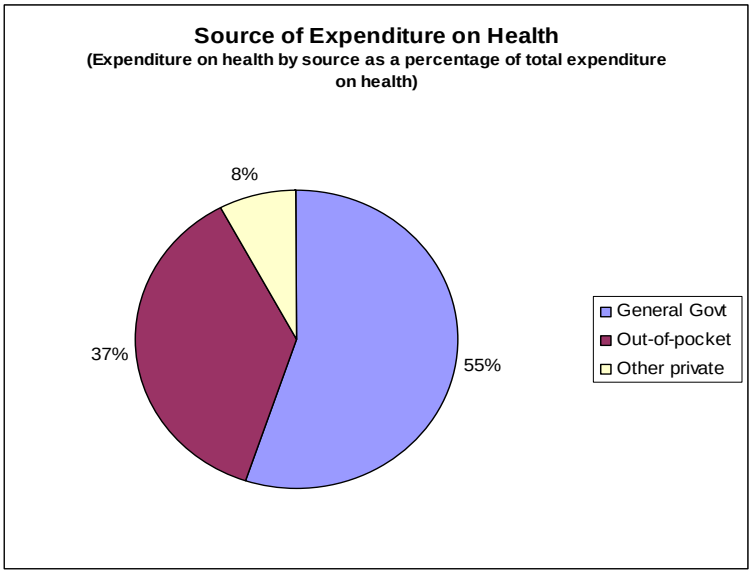
Total annual expenditure on health (all sources)	US$454 million
Per capita expenditure on health	US$12
Percentage of government budget spent on healthcare	13%
Total expenditure on health as a percentage of GDP *(PSP-One).*	5%

Source: WHO, 2005, unless otherwise stated.

The government spends 13 percent of its budget on health, showing a strong commitment; moreover, "the overall health sector response capacity in the United Republic of Tanzania is rated as high compared with other countries in Africa with a similar level of development."[10]

While the state covers over half of health spending, a good proportion is paid for by the general public out-of-pocket (see Figure 5.2).

FIGURE 5.2 (Source: PSP-One, 2005)



5.3 PROPORTION OF DONOR FUNDING

TABLE 5.3 ESTIMATED HEALTH FUNDING SOURCES IN FINANCIAL YEAR 2002/03

Funding source	Amount in USD	Percentage
Government of Tanzania	145.1 m	59.5 %
User Fees	6.2 m	2.5 %
Donors	92.6 m	38.0 %
TOTAL	**243.8 m**	**100.0 %**

Source: SEAM, 2003.

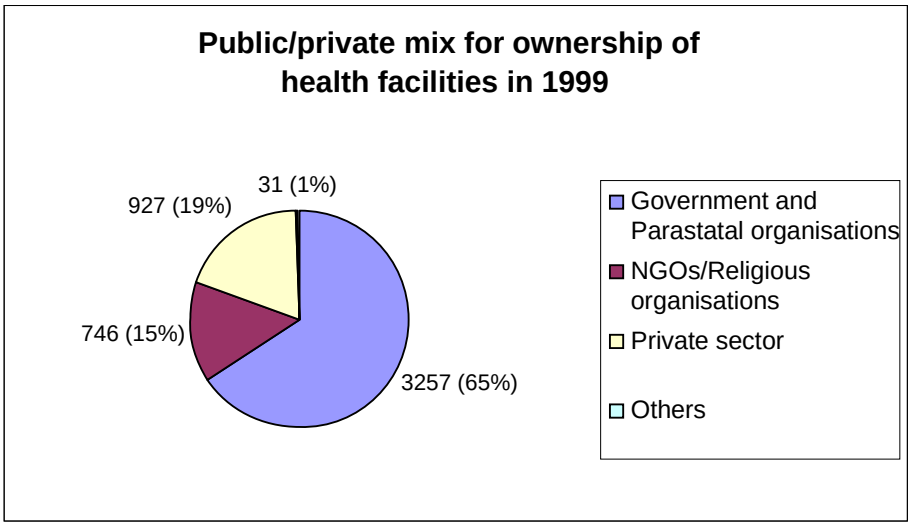
A good proportion of public health expenditure (38 percent) is funded by donors (see Table 5.3). However, external support to the Tanzania health sector is generally lower than that of neighbouring countries in per-capita terms.

[10] WHO, 2005.

5.4 PUBLIC/NOT-FOR-PROFIT/PRIVATE MIX

Historically, health service delivery has largely been the prerogative of the state. While some private, for-profit health services are available in major towns, missionary health services have provided much-needed services across the country – nearly half the hospitals and 20 percent of dispensaries. More recently, the role of private, for-profit providers has been growing rapidly as private practice was made legal again in 1991. However, it is still a small proportion (see Figure 5.4.1 and Table 5.4).

FIGURE 5.4.1



Source: GOT, 2006.

TABLE 5.4 DISTRIBUTION OF HEALTH FACILITIES IN TANZANIA IN 2000

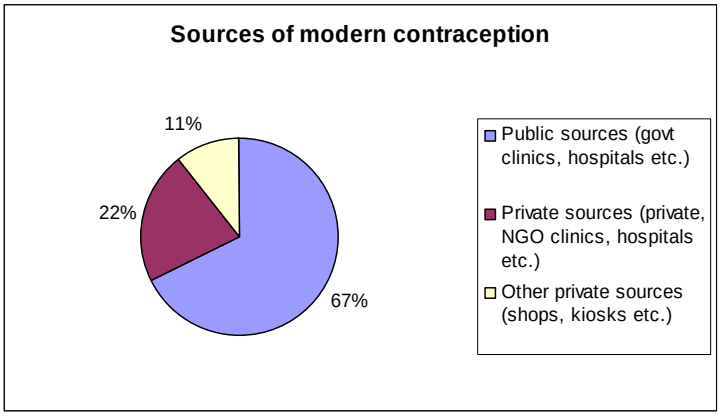
Facility	Agency					
	Govt.	Parastatal	NGO/ religious	Private	Others	TOTAL
Consultancy/ specialised hospitals	4	2	2	0	-	**8**
Regional hospitals	17	0	0	0	-	**17**
District hospital	55	0	13	0	-	**68**
Other hospital	2	6	56	20	2	**86**
Health centres	409	6	48	16	-	**479**
Dispensaries	2450	202	612	663	28	**3,955**
Specialised clinics	75	0	4	22	-	**101**
Nursing homes	0	0	0	6	-	**6**
Laboratories	18	3	9	184	-	**214**
Private X-ray units	5	3	2	16	1	**27**
TOTAL	**3,035**	**222**	**746**	**927**	**31**	**4,961**

Source: GOT, .2006

Public/private mix for family planning

The public/private mix for family planning services does not differ significantly from the health sector in general (see Figure 5.4.2)

FIGURE 5.4.2 (Source: PRB, 2002)



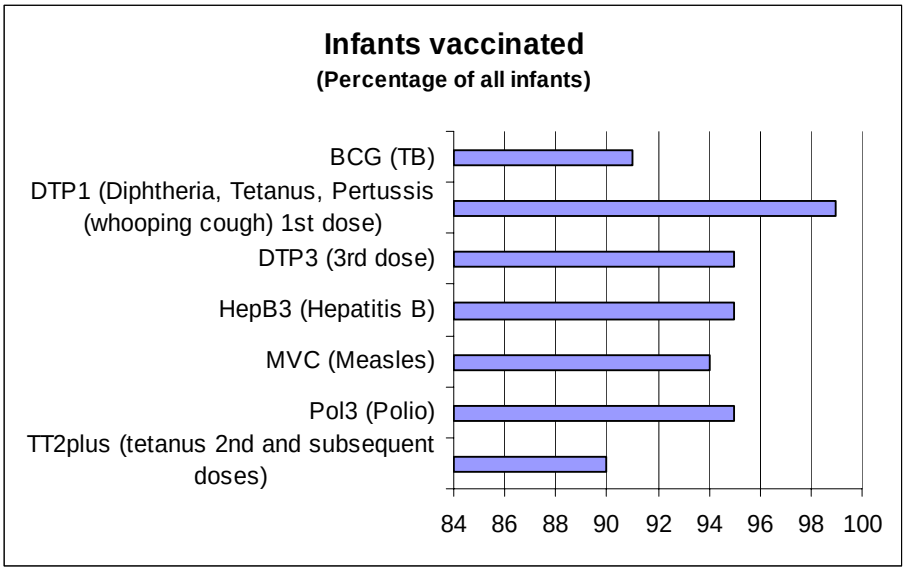
5.5 KEY HEALTH INTERVENTIONS

5.5.1 KEY VACCINES

The Government of Tanzania has adopted the WHO guidelines for vaccinating children. The programme is implemented by the Ministry of Health's expanded rogramme on Iimmunisation, which was rolled out nationally in 1996 and coverage has generally increased since then.[11] Coverage rates are now all over 90 percent, which is high in relation to neighbouring countries (see Figure 5.5.1) and only Rwanda has higher rates.

[11] TDHS, 2005.

FIGURE 5.5.1



Source: UNICEF, 2006.

TT is administered to pregnant women.

5.5.2 CONTRACEPTIVE COVERAGE

The fertility rate in Tanzania has not significantly changed in 10 years. Tanzanian women continue to have an average of 5.7 children. This is one of the higher fertility rates in East Africa. Fertility is lower in urban areas (3.6) than rural areas (6.5) and highest in the poorest households (7.3) and among women with no education (6.9).

More than one-quarter of young women ages 15 to 19, have already begun childbearing; 20 percent of women ages 15-19 are already mothers and seven percent are pregnant with their first child.

One in four married women uses a method of family planning according to the 2004/5 Tanzanian Demographic and Health Survey (TDHS). This is the same rate found in the 1999 DHS survey, but use of modern methods of family planning increased slightly from 17 to 20 percent. This is lower than the use of modern family planning found in Kenya and Malawi, but higher than that found in Uganda, Ethiopia and Rwanda.

Unmarried, sexually active women were most likely to use family planning; more than a third said they used a modern method and 15 percent used condoms.

The 2004 DHS showed that knowledge of contraception is high among men and women; married men and women who had ever had sex knew on average seven family planning methods, while unmarried women who had never had sex knew four methods. Nine out of 10 women had heard about the pill, injectables, and the male condom.

TABLE 5.5.2.1 CONTRACEPTIVE METHOD MIX

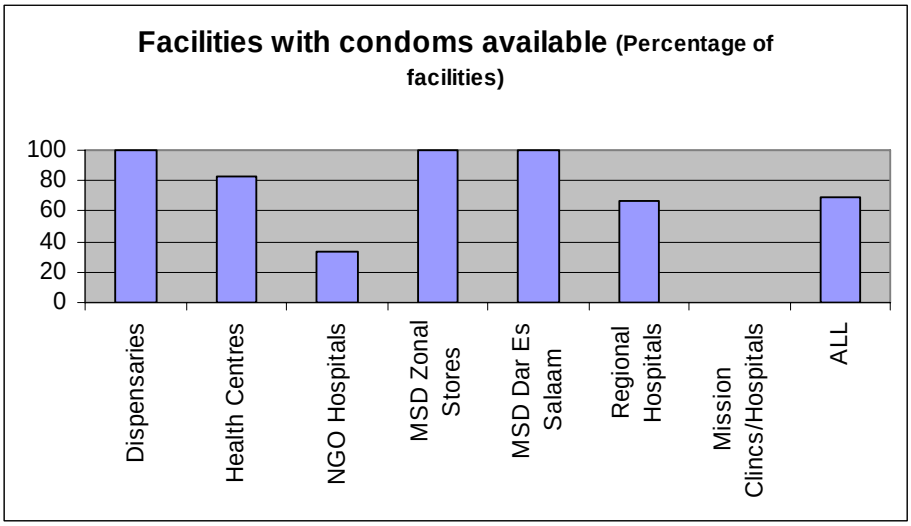
Married Women Who Are Currently Using Family Planning (percent)

Modern methods	Oral contraceptives	6%
	Injectables	8%
	Male condoms	2%
	Female sterilisation	3%
	Total	**20%**
Traditional methods	Total	6%
All Methods	**Total**	**26%**

SOURCE: (TDHS, 2004/5)

Condom distribution in Tanzania is widespread, with three social marketing agencies as well as government undertaking distribution. Over half of young women and almost three-quarters of young men know a place where a person can get condoms (THIS). Condoms are available in two-thirds of health facilities, although not in every religious hospital or clinic (see Figure 5.5.2). Shops and pharmacies dominate the market (see Table 5.5.2.2). The table shows that condom use for family planning purposes in Tanzania is relatively low. Most condom use is for HIV and STI prevention.

FIGURE 5.5.2



Source: SEAM, 2003.

TABLE 5.5.2.2 SOURCE OF CONDOMS

(Married women of reproductive age using condoms for family planning)

Government/parastatal	Health centre	4.7%
	Dispensary	12.2%
	Others	3.4%
	Total	**20.3%**
Religious/voluntary	**Total**	**1.7%**
Private medical	**Total**	**0.9%**
Other private	Pharmacy	35.9%
	Shop/kiosk	36.8%
	Others	4.4%
	Total	**77.1%**

Source: TDHS, 2005

5.5.3 ESSENTIAL MEDICINES

A recent assessment on accessibility of essential medicines found that:

- Geographical access to drugs does not appear to be a problem and is not perceived as a problem by the public;
- Availability of drugs is a problem at the Medical Stores Department (MSD), especially, but not exclusively, at zonal stores outside the Dar Es Salaam zone;

- Availability issues exist in public sector primary health care facilities and also many hospitals;
- Availability does not seem to be a significant problem at mission health facilities;
- In respect to quality of drugs and services, SEAM data from districts surveyed revealed that the public sector cannot be assured of the quality for a significant proportion of drugs in the Tanzania market.

(The assessment used 27 tracer items and assessed availability at service delivery and stores points. Mean availability ranged from 25.9 percent for Hydroclorothiazide 25mg/50mg tablets to 97.9 percent for Paracetamol 50mg tablets.)
Source: SEAM, 2003.

Tanzania has a well-developed system of official and less-than-official drug shops where the population can access most essential supplies and medication. There are issues with quality and trained personnel, but the service tends to be affordable and credit is available.

6 REGULATORY CAPACITY

The Tanzania Food and Drug Administration (TFDA) was established in 2003 by the Tanzania Food Drug and Cosmetics Act and inherited the functions of the defunct Pharmacy Board. The TFDA is an executive agency under the MOH and is the regulatory body responsible for the quality and safely of food, drugs (including herbal drugs), cosmetics and medical devices. It is responsible for drug registration and drug inspection including Good Manufacturing Practice (GMP) and licensing of pharmaceutical manufacturers. It also manages the Quality Control Laboratories.

All drugs manufactured or imported must be registered, and the availability of the drugs must be in the public interest, safe, efficacious, and of acceptable quality. The current GMP is adapted from the WHO guidelines. Recent support from MSH (funded by the Gates Foundation) has improved the regulation process.

Generics require:

- a Certificate of Pharmaceutical Product (CPP) as per the WHO format;
- a draft summary of the product's characteristics (SPCs);
- quality of APIs;
- quality of finished dosage (manufacturing, quality control, stability data, labelling); and
- therapeutic equivalence data (which can be a problem area).

For new drugs, further requirements include:

- SPCs quality data on APIs and FP (as for generics);
- Safety or preclinical data; and
- Clinical data including clinical trials data.

Speed of registration. Time for registration is usually 12 months and it is a bureaucratic process, with strict compliance required. Three months are required for fast-track priority products such as ARVs, anti-malarials and TB drugs, as TFDA has an exception mechanism for inspection requirement, this shortens the timeline. This is essentially a fast-track approach to facilitate access that could be used for microbicides. There is a procedure for temporary or 'experimental' registration via the MOH in case of need.

Pre-registration GMP inspection is applicable before products are registered but there is an exception for countries within the International Conference on Harmonisation of Technical Requirements for Registration of Pharmaceuticals for Human Use.

A number of products have been fast-tracked through this process and made part of 'project' efforts. This is not an impossible task, and it is felt that this can be done for a microbicide that has been through the registration process in Europe or the US.

Prescription versus over-the-counter. Prescription medications cannot be distributed at the dispensary level. However, as doctors are relatively few in Tanzania, if universal access is desirable, deregulation is possible as in the case of the malaria drug Coartem. To move this drug from prescription to over-the-counter (called the general sales list), permission would be sought from the National Therapeutics Committee (NTC). An agency (in the case of microbicides, this would be NACP) must make a recommendation to the Chief Pharmacist, who would present to the NTC. If approved, the NTC would signal the TFDA for an adjustment of the National Formulary and the Essential Drug List (EDL) for the various levels of public facility. This must go through the legal committee of the TDFA, which takes a few months as the NTC does not meet often.

What a microbicide would need. Any new drugs would need to be put on the essential drug list (EDL). If microbicides have a WHO prequalification, particularly for a second-generation product, registration will be faster. There is a problem in general with the ability of the authorities to carry out testing because of a lack of correct equipment, trained personnel, and data against which to test.

Any new product needs a 'champion' to see it through the regulatory process. It would help if it were classified as an over-the-counter product (OTC), and if it were seen as an essential

product to Tanzania's struggle against AIDS. Even then, it will need a person or agency to see it through to certification.

US or European approval. The US Food and Drug Administration (FDA) approval is best in facilitating local approval, but European registration should be acceptable. An Indian Pharmacopoeia (IP) approval is also possible (and there are many strong links between Tanzania and India), but would be more problematic since the public perception is that Indian goods do not carry the same guarantee of quality, and can easily be counterfeit.

It is not clear what role the Tanzania Bureau of Standards would play in approving the importation and distribution of each lot (as they do with condoms).

7 Local Manufacturing Capacity

Tanzania local manufacturing capabilities are limited. If country pharmaceutical manufacturing companies worked to capacity, they could supply slightly more than one per cent of Tanzania's medication requirement. Most drugs and medical supplies are imported.

'Real' manufacturing is limited. A good number of companies import the raw materials that are then packaged (bottles, pills, blister packs, or sachets) in Tanzania with labelling in KiSwahili. Much of the raw material comes from Asia, and regional brands, usually manufactured in Kenya, that are distributed across the East African community are common.

The Tanzania Pharmaceutical Industries Limited (TPI) is one of the largest pharmaceutical industries in East Africa. It was founded in 1980 as a government-owned company and privatised in 1997. (The shareholders are now a firm of Tanzania entrepreneurs.) The manufacturing facility is located in Arusha, in northern Tanzania. TPI is a complete healthcare concern, formulating and manufacturing pharmaceutical products for human use. It derives its strength from its integrated manufacturing, warehousing, quality control/assurance and engineering facilities, which are backed up by competent management capabilities. The company's fully equipped tablets and capsules division is capable of formulating and manufacturing a whole range of products in both tablet and capsule dosage formulas, which are then bulk- and blister-packed. TPI also has a state-of-the-art facility which manufactures a whole range of syrups and suspensions. Production conforms to established international standards and Good Manufacturing Practice (GMP). TPI's products are evident in most pharmacies and appear to be well ensconced in the market. TPI is receiving technical assistance from Thailand to develop an ARV with Chinese raw materials. TB and malaria medications are under consideration.

Other small manufacturers include: A.A. Pharmaceuticals, Keko Pharmaceuticals, Shelys (part of the Sumaria Group), TanzanSino United Pharmaceuticals (joint venture with China), and Interchem Pharmaceuticals (part of the Mac Group who also manage Nufica, the only national distribution agency).

If a new product microbicide has a 'gel' formulation to be packaged in a branded sachet (as is the case with the current brand of insecticide for mosquito net treatment), this can be easily packaged with instructions and branding. Should there be a need to bring in the primary product in bulk (20 litres to 200 litres) and package this in sachets in Tanzania, the sealing equipment and foil would need to be imported. Some consideration should be given to associating the product to a non-profit NGO, thus resolving any duty issues.

8 PROCUREMENT SYSTEMS

The Medical Stores Department (MSD) has primary responsibility for the procurement process in the Tanzania MOH. Anecdotally, there seems to room for improvement. That said, they are working in difficult conditions as they are set up to be financially self-sustaining and many hospitals are not able to carry out proper demand forecasting. The current MSD is seen as a vast improvement to the former Central Medical Store (prior to 1994). MSD has successfully procured millions of dollars of pharmaceuticals and medical supplies from the international and domestic market at favourable prices (when compared to international standard pricing). In 1999, the MSD prices were about 65 percent of an MSH international standard pricing guide, but this situation has since stabilized. Due to continued high demand, the MSD is estimated to be able to meet only about 65 to 70 percent of supply requests.

While the GoT is generally pursuing a decentralisation strategy and is increasingly decentralising ministry budgets and functions, this is not happening for the drugs budget. Resources to be used for drugs by local health care facilities are part of the MOH budget and the MOH uses an internal allocation formula for drugs to allocate the available resources to internal accounts, from which local government can purchase drugs for the MSD.

NOTE: All Tanzania's ARVs come in through the MSD.

8.1 PUBLIC SECTOR

The Medical Stores Department is responsible for procurement, storage and distribution of medicines to all public sector facilities nationwide. Some mission facilities also get their medicinal supplies from MSD. MSD is responsible for forecasting, procurement, clearance, storage and distribution (and repackaging, if needed) of all health products for the MOH. Hospitals order drugs against the national essential drugs list and have the right to procure

from other suppliers if the MSD fails to deliver within a specified time (maximum of two months). Hospitals must adhere to price settings as developed by the MOH. In case of dire need (and when they have stock), the MSD has a moral obligation to supply private health care providers also.

Government procurement regulations require:

- All purchases over $5,000 be made via open tender;
- Tenders to be internationally advertised and most are run by MSD;
- Central tendering board administers procurement of $3 million or more;
- Central tendering board reviews between $1 to $3 million;
- Regional tendering boards administer tenders less than $1 million.

Distribution. Two systems of distribution exist in Tanzania. The 'push' system uses a standard-content essential drug kit and delivers a certain number to all health facilities (whether or not they are needed). Under the 'pull' system, each health facility decides on the number of products required and orders them accordingly. At the moment, all health centres receive the same blue kit once a month and dispensaries receive the same yellow kit. All districts are to be converted to the 'pull' system by 2007. MSD distributes commodities to all the MSD zonal stores which, in turn, supply the districts (where the responsibility of the MSD ends). No commodity is issued with an expiry date of less than three months. Beyond the distribution of the basic kit, the second priority is to ensure a steady supply of vaccines. This system works well, as evidenced in the good vaccination coverage in Tanzania.

Storage. The MSD has national and zonal warehouses and has little storage capacity to accommodate large numbers of stocks. They have, however, recently acquired an additional warehouse that will be used for malaria and other selected drug products.

Taxes. Import duties and VAT are levied on all Tanzanian imports unless otherwise exempt. Drugs to combat HIV/AIDS, malaria and TB however, are fully exempt from all duties and taxes. Medical supplies are not usually exempt, but HIV test kits have a special exemption to be obtained through the MOH. (If donor-funded then normal donor exemptions may apply, given the request).

Quality. There are ongoing issues of questionable drug quality in both the public and private health sectors. Poor quality drugs, including counterfeits, are widely found in Tanzania, especially in the private sector. The Tanzania Food and Drug Administration (TFDA) was established in 2003 by the Tanzania Food Drug and Cosmetics Act and is the regulatory body responsible for the quality and safely of food, drugs (including herbal drugs), cosmetics and medical devices. It is responsible for drug registration and drug inspection including Good

Manufacturing Practice (GMP) and licensing of pharmaceutical manufacturers. It also manages the Quality Control Laboratories. (See regulatory section for more on drug registration.) The QC Laboratories were assessed by WHO in 2005 and various gaps were identified that still need to be addressed.

Problems. The most common problems encountered in the Tanzanian procurement system are:

- Non-availability or insufficient quantities of essential drugs;
- Unreliable services;
- Over-invoicing;
- Delays due to unnecessarily long procedures or long waiting chains;
- High prices compared to other sources of supplies; and
- Delivery delays (so that, in some cases, facility staff must pick up items personally).

8.2 DONOR

Tanzania has had a health 'sector-wide approach', or SWAp since 1998 funded by seven donors: Denmark, Germany, Ireland, Netherlands, Norway (until 2002), Switzerland, the UK, and the World Bank. So called 'basket funds' are channelled directly to the MOH and to the local councils. Initially, the donors micro-managed the funds, but over the years, donor processes have become more open and more linked to Government processes. The GoT would like external resources of the priority sectors of the Poverty Reduction Strategic Programme (PRSP) to be channelled as budget support. DFID is the only donor ready to do this so far. Drug supplies are treated as public sector (see above).

8.3 NOT-FOR-PROFIT/MISSION

A very considerable amount of healthcare in Tanzania is delivered through faith-based organisations. The Evangelical Lutheran Church in Tanzania (ELCT) is responsible for over 20 hospitals and 160 health centres and a wide range of community-based health services, including HIV/AIDS control programmes, which account for approximately 15 percent of the national health services. This group also plays a role in pharmaceutical supply services, although their specific role in drug supply and procurement activities is not very well documented.

Recently, a number of hospitals have investigated the potential for establishing an alternative source of drug supply, calling the initiative the Mission for Essential Medical Supplies (MEMS). During the development of this system, it became obvious that even a parallel system was going to have many of the same problems operating in Tanzania as the MSD. This system is still in existence but has not improved drug shortages in any major way. The

system is new, however, and may make a difference given more time. MEMS is faith-based (Lutheran) but is funded by the Danish and the Dutch and supplies some contraceptives. This may mean that supplying microbicides would not present a problem.

The three social marketing projects handle all of their own procurement individually (including male and female condoms).

8.4 PRIVATE

Patients in Tanzania are often forced to turn to the private sector, often small drug shops or '*Duka la Dawa*' for medicines, where prices are commonly twice those found in public facilities. Often, the patient can then only afford a portion of the prescribed dosage, resulting in ineffective therapy and the increased risk of resistance. Many drugs are of questionable quality and regulation is difficult.

Procurement is managed directly by private sector organisations in accordance with their needs.

These private drug shops are of potential interest to the microbicides community. They are licensed to sell only non-prescription medicines but typically provide a much broader range of products and services. There are estimated to be approximately 4,600 shops and they are the most convenient retail outlets in which to buy drugs. Their weaknesses include no assurance of quality, high prices, insufficiently qualified staff and illegal stocking (unauthorised by the Pharmacy Board). The Gates Foundation had been funding a project through MSH to help the TFDA establish a network of 'branded' accredited drug dispensing outlets (ADDOs). ADDOs can only sell products for which they have market authorisation from the TFDA and their employees have completed courses covering both the management and medical aspects of the products they dispense. These ADDOs are designed to address some of the weakness of the private drug shops. Close regulation of the ADDOs will be required. Currently the programme is still small, only working in two regions, but there may be scope here for an initial delivery of microbicides.

As with using social marketing to deliver a future microbicide, there are issues with educating women on how to use a microbicide properly. A woman is likely to first need microbicide information and education from a health clinic or a community-based mobilisation worker. She could then subsequently obtain her microbicide re-supply from a private drug shop or a social marketing programme.

9 HIV PROGRAMMING

9.1 Level of Political Commitment

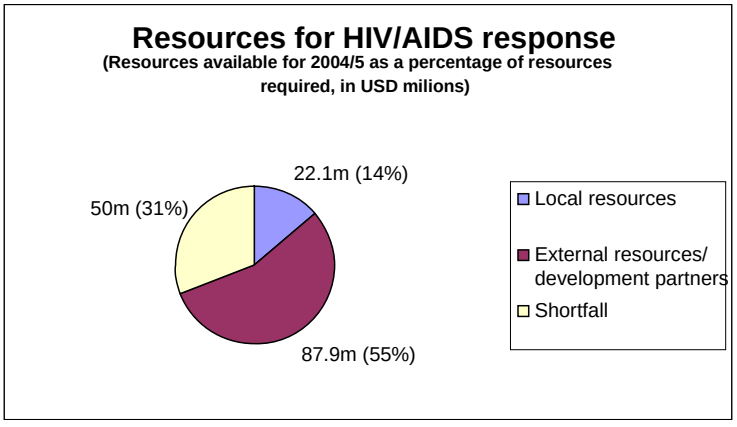
The level of effort in the national response to HIV/AIDS is strong and WHO describes political commitment to fight the HIV/AIDS epidemic as "high."[12] Robust frameworks are in place, including the following:

- The Tanzania Commission for HIV/AIDS (TACAIDS), created in 2001, leads the national response to HIV/AIDS from the Prime Minister's Office;
- The National Multisectoral Strategic Framework for HIV/AIDS for 2003–2007 was officially launched in May 2003 and provides strategic orientation for implementation of the response;
- An MOU between the Government of Tanzania and its partners was signed in 2003, laying the foundation for a joint implementation strategy for planning, monitoring and evaluation, and resource mobilisation for the National Multisectoral Strategic Framework for HIV/AIDS for 2003–2007; and
- In February 2003, the National AIDS Control Programme (NACP) of the Ministry of Health also elaborated the Health Sector Strategy on HIV/AIDS for 2003–2008, outlining a five-year plan of activities. A strong national policy framework guides the national response.[13]

9.2 Funding for HIV/AIDS

A public expenditure review in May 2005 suggested the fight against HIV/AIDS would require US$160 million per annum in Tanzania. While the government has increased its local resources to $22.1 million, and receives four times this funding from external sources, there is still a substantial shortfall (see Figure 9.2).

Figure 9.2 (Source: TACAIDS, 2006)



[12] WHO, 2005.
[13] Ibid.

Table 9.2 shows major donor funding for HIV/AIDS from 2003 to 2005. The Global Fund, PEPFAR and the World Bank provide three-quarters of donor funding.

TABLE 9.2 MAJOR EXTERNAL FUNDING SOURCES, 2003-2005

Donor	Funding (USD)
Global Fund	92,400,000
USAID - PEPFAR	89,560,000
World Bank (T-MAP)	70,000,000
SIDA	23,900,000
CIDA	16,350,000
NORAD	15,390,000
DFID	7,140,000
UNFPA	5,090,000
GTZ	3,700,000
EU	3,340,000
WHO	2,280,000
UNDP	1,760,000
UNDAF Theme Group	1,550,000
UNAIDS (PAF funds)	820,000

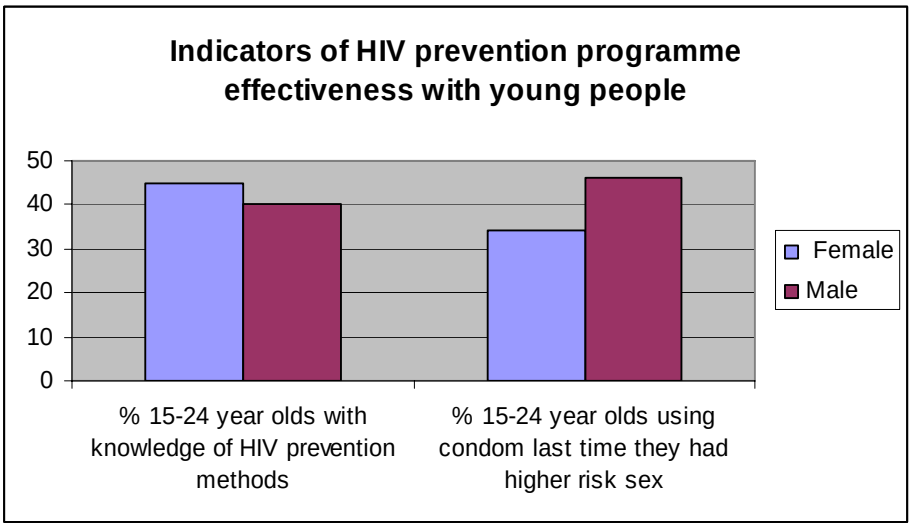
Source: UNAIDS, 2004.

9.3 COVERAGE OF HIV/AIDS INTERVENTIONS

Prevention coverage

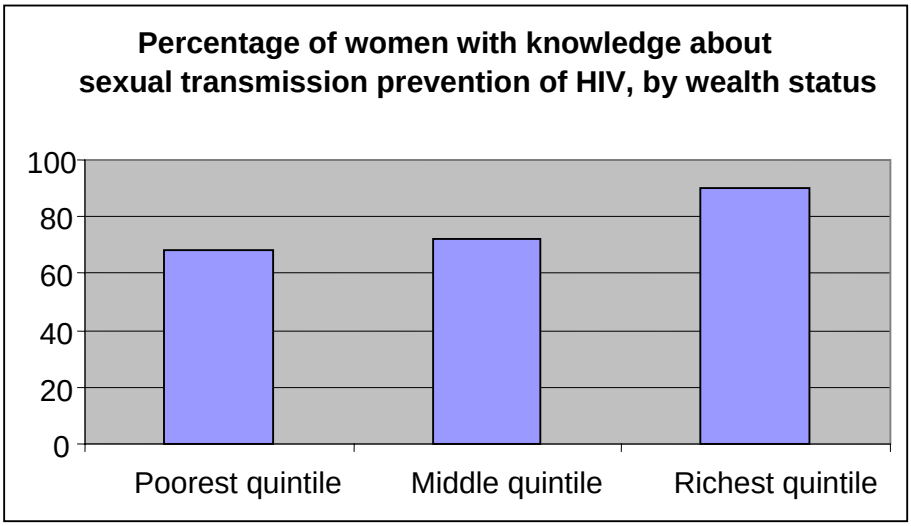
Knowledge of HIV prevention (ability to correctly identify condom use and limiting sex to one uninfected partner as major ways of preventing the sexual transmission of HIV, ability to correct two of the most common misconceptions about HIV, and knowing that a healthy-looking person can transmit HIV) is 45 percent for young women and 40 percent for men (see Figure 9.3.1). This is high in relation to other countries in the region and is an indication of effective HIV prevention and education programming. Still, UNAIDS recommends more education to secondary schools as well as finding ways to reach out-of-school youth with AIDS information to improve prevention behaviour in Tanzania (UNAIDS, 2006). Meanwhile, Figure 9.3.2 illustrates how socioeconomic status effects HIV prevention knowledge.

FIGURE 9.3.1



Source: WHO, 2005.

FIGURE 9.3.2



Source: PRB, 2004.

Care coverage

Care is difficult to measure, since in Africa most care takes place in the home. Community- and home-based care initiatives are being introduced and, as of December 2005, 814 home-based care providers from 70 districts have been trained. The Ministry of Health has reviewed

and adapted the existing national home-based care curriculum according to the WHO generic module for training community-based treatment supporters.[14]

Treatment coverage

The GoT calculates that nearly two million Tanzanians are HIV-positive (GoT, 2003). From that population, 1.2 million need medication for opportunistic infections, and 400,000 to 500,000 need ARVs. While only 2,000 people were receiving ARVs in 2003, that number has grown to more than 22,000 at the end of 2005 (WHO, 2006).

The numbers indicate that most people who carry the virus have no idea of their status, and never find out. The very real issue of stigma and discrimination means that others who do discover their status work to keep the issue a secret.

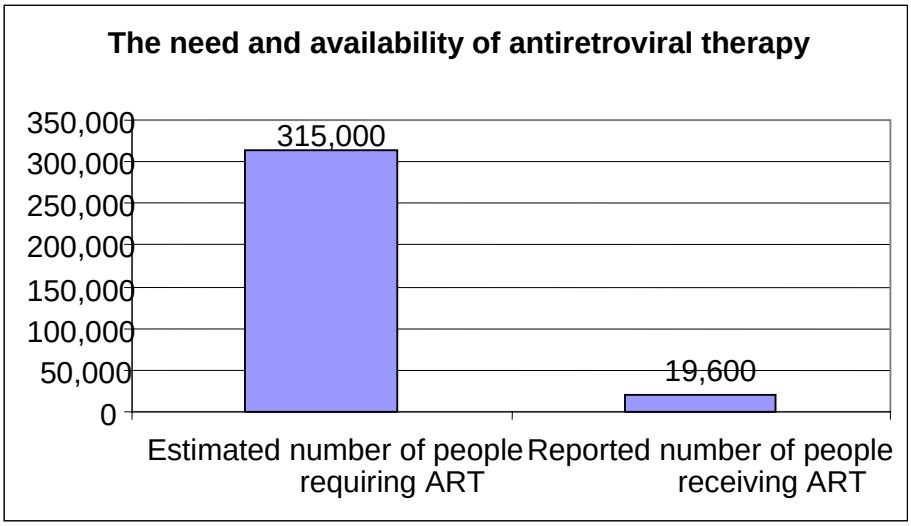
The number of centres providing antiretroviral therapy (ART) increased from 32 at the end of 2004 to 96 as of September 2005, covering 64 of 121 districts in the country. Of these, 61 were in the public sector. With the intensive efforts of a range of donors, this number is growing quickly.

WHO describes the recent and current ART situation: "Tanzanian experts and an international team sponsored by the William J. Clinton Foundation jointly developed a national care and treatment plan. Adopted in October 2003, the National Care and Treatment Plan expands the objective of the Health Sector Strategy on HIV/AIDS of providing antiretroviral therapy to all eligible people living with HIV/AIDS by the end of 2008. A quick-start plan was initiated in November 2003 to prepare 19 selected health facilities to begin providing antiretroviral therapy within a three-month period. Subsequently, in an attempt to integrate the various plans and frameworks, an Operational Plan for Care and Treatment for HIV/AIDS was developed by a broad team including the Ministry of Health, the National AIDS Control Programme, the William J. Clinton Foundation, WHO, non-governmental organisations, and the private sector. It covered a one-year period beginning in July 2004 and projected the involvement of 96 health facilities. In 2004, the government announced a commitment to provide antiretroviral drugs free of charge in the public sector, faith-based organisations and some private facilities. Guidelines for antiretroviral therapy and voluntary counselling and testing have been developed. As of September 2005, the average cost of the first-line drug regimen for adults was US$180 per person per year."[15]

In a bid to rationalise the training and support effort, the US government has established a list of regions where six US organisations has operational responsibility.

[14] WHO, 2005.
[15] Ibid

FIGURE 9.3.3



Source: WHO, 2005 (for comparability with other reports)

Voluntary counselling and testing services have also been expanding rapidly in recent years, both in health facilities and as stand-alone sites. The number of sites increased from 480 at the end of 2004 to 527 by September 2005, covering all 121 districts in the country. However, the number of people accessing voluntary counselling and testing services remains low, largely due to stigma and discrimination and cost of services.[16]

The number of centres providing services for preventing mother-to-child transmission has also increased gradually, from 199 at the end of 2004 to 334 in September 2005.[17]

TABLE 9.3.2 USE OF HEALTH SERVICES FOR HIV PREVENTION

# of VCT sites	527
# of VCT sites per 1,000,000 population	14.4
# of people tested at VCT sites (cumulative)	227,973
# of sites providing PMTCT services	334

Source: WHO, 2005.

[16] WHO, 2005.
[17] Ibid.

Microbicides clinical trials

Two different microbicides organisations are carrying out clinical trials in Tanzania: the UK Medical Research Council Microbicides Development Programme (MDP) and the International Partnership for Microbicides (IPM).

TABLE 9.3.3 MICROBICIDES CLINICAL TRIALS IN TANZANIA, 2007

Candidate	Developer	Partner	Location	Phase
PRO 2000	UK Medical Research Council MDP	Mwanza HIV Research Collaboration (NIMR/AMREF/LSHTM)	Mwanza	Phase 3
Dapivirine gel	IPM	Kiimanjaro Christian Medical Centre	Moshi	Phase 1

Care and treatment

Although there has been substantial improvement in care and treatment efforts since 2001, the overall scores are very low in relation to other countries in East Africa or Africa as a whole (see Table 9.3.3). However, large-scale expansion is beginning to take place under new initiatives (see section 9.5).

The NACP has established an incredibly ambitious objective of expanding treatment from the current 40,000 patients to 400,000 by 2008. This will require a Herculean effort, dynamic organisation and coordination of efforts, and continued funding.

Recent discussions with treatment and care implementers indicate that the current system, predominantly public-sector driven, is facing three important issues, including human resources, the logistical system, and the large distances that separate rural populations from the nearest healthcare facility.

9.4 SCALE-UP PLANS

3–BY-5 INITIATIVE

In early 2003, the Health Sector Strategy on HIV/AIDS proposed a cautious, integrated scale-up of ART at tertiary centres. The National Care and Treatment Plan was introduced in October 2003, involving a huge scale-up of treatment and care interventions. The 3-by-5 Initiative was launched soon after, and the MOH has been attempting to harmonise the two. The treatment target of 220,000 was downsized to 44,000, based on available funding. Main constraints to the scale-up are:

- Insufficient access to entry points (including VCT, PMTCT, TB and STIs)
- Low treatment literacy (among health professionals and the general public)

- Stigma and discrimination.[18]

GLOBAL FUND

The focus of funding for the fourth round of the Global Fund is:

- OVC impact mitigation
- Condom procurement
- Support for the National Care and Treatment Plan, incorporating the 3-by-5 Initiative
- Development of ART monitoring system
- National coordination of multisectoral partners, including GFCCM and TACAIDS.

The condom procurement focus aims to increase male condom distribution by 10 percent in the public sector and 30 percent in the social marketing sector, and female condom distribution by 30 percent annually, increasing condom usage by 2 percent. This will be achieved through:

- Ensuring condom security in the public sector
- Expanding private sector access to condoms through social marketing
- Developing capacity of the Medical Stores Department to manage condom procurement.[19]

UNITED STATES GOVERNMENT

PEPFAR is a major force in scaling up the treatment and care effort in Tanzania. The US embassy coordinates its efforts through USAID and CDC, with additional support from the Department of Defence. The US CDC supports a range of 'treatment partners' that are responsible for specific regions of Tanzania, including Columbia University, FHI/Deloitte & Touche, Harvard University, William J. Clinton Foundation, AIDS Relief/CRS with Constella Futures, and others. USAID supports a care and support programme that has recently passed from CARE Tanzania to Deloitte & Touche/FHI, a treatment and care project implemented by FHI, and a rapid funding envelope managed by Deloitte & Touche.

The US CDC is planning to develop and distribute a 'HIV+ Support Kit' containing a small number of essential items for someone who is HIV positive. This will include a mosquito net, water treatment and condoms (for discordant couples). Some coordination with the treatment and care community on initiatives such as this can provide important channels for distribution.

[18] WHO, 2005.
[19] GFATM, 2004.

9.5 SOCIAL MARKETING

Tanzanian social marketing efforts, including condoms comprises:

Organisation	Product	Details
Population Services International	"Salama" – male condom, "Care" – female condom, net treatment, water treatment	Salama Condom introduced 1993, annual sales of 50M, Care introduced 1998. PSI collaborates with TACAIDS, MOH and over 30 NGOs/CBOs. Funding from DFID, Global Fund, Royal Netherlands Embassy, KfW.
Marie Stopes International	"Raha" and "LifeGuard" male condom	Raha (meaning "pleasure") was launched in 2003 as a young sexy alternative brand. Introducing Lifeguard from Uganda in 2006.
T-MARC (Tanzania Marketing and Communications project) AED	"Dume" – male condom, "Lady Pepeta" – Female condom	Lady Pepeta launched 2005, Dume (meaning "strength and responsibility") launched 2006. USAID-funded social marketing effort.
Constella Futures	Technical support to private sector, and communications	Regional support office based in Tanzania.

Sources: PSI, 2006; MSI, 2006; USAID, 2006.

Tanzania is an important social marketing laboratory. With strong government support, many of the social marketing ideas that we now take for granted were developed in Tanzania.

10 IMPLICATIONS FOR A FUTURE MICROBICIDE

A range of key stakeholders were interviewed, each being asked what might have an impact or influence on a future microbicide. Here are some of the results of this informed speculation.

DELIVERY

Microbicides delivery will be through **multiple channels**. If, in Tanzania, one of the main targets will be primary partnerships, ways to reach these women will have to be carefully considered. One way is through existing reproductive health and family planning

programmes. Not only are women already at these clinics receiving services, they are already used to thinking about health prevention (albeit preventing births) and are empowered to the extent they would seek family planning. This might also make them more open to the concept of preventing disease, safe sex and using a condom or a microbicide. Family planning use may also mean that these women will have already communicated with their partners about health-seeking behaviour.

Social marketing. It will be difficult to base distribution of any new product on the public health care system alone, which is somewhat overloaded already. Social marketing has been established and effective in Tanzania since 1993 and receives wide support from the government. There is an important body of government, NGO and private-sector experience that could be brought to bear with the introduction of a new product. It will be difficult to base distribution of any new product solely on the existing public health care system as it is already overloaded. Social marketing has been established and effective in Tanzania since 1993 and receives the wide support of the Tanzanian government.

Over-the-counter. As doctors are relatively few in Tanzania, if universal access is desirable, deregulation is possible, as seen with the malaria drug Coartem. As with the oral contraceptive or a malaria drug, women may visit a health facility in the first instance and then use social marketing or over-the-counter purchasing for restocking their supplies. To move a drug from prescription to over-the-counter (called the general sales list), permission must be sought from the National Therapeutics Committee (NTC). The National AIDS Control Programme must make a recommendation to the Chief Pharmacist, who would present to the NTC. If accepted, the NTC would signal the TFDA for an adjustment of the National Formulary and the EDL for the various levels of public facility.

Small drug shops. One option for microbicide distribution is the drug shops where they exist and particularly where they are being improved. These are licensed to sell only non-prescription medicines but typically provide a much broader range of products and services. There are estimated to be approximately 4,600 shops and they are the most convenient retail outlets to buy drugs. The Gates Foundation is funding a project through MSH to improve the network of accredited drug dispensing outlets (ADDOs). The MSD and the public sector do not provide supplies to drug shops but the social marketing programmes do.

Do not assume that the mission sector will support delivery. While the mission sector is an important health services provider and important service network, few faith=based health providers in Tanzania currently distribute condoms.

Female condom experience. There has been a good experience in Tanzania with the female condom as the women say they are glad for the control. Scale-up is happening now, with pre-launch advertisements and media coverage. The introduction of a branded female condom may provide important lessons for microbicide introduction. Both the female condom and a future microbicide will be female-initiated HIV prevention methods. Both require some training on how to use and both will be seen as more expensive than the standard (a male condom).

Community mobilisers. Use community mobilisers, as some family planning programmes have done to engage the community effectively. These mobilisers will receive microbicides training and will inform the community about the product. They may also educate women in microbicide use. For example, female condom introduction has been achieved successfully through hairdressers in Zimbabwe. This could be a range of people in Tanzania, from NGO community agents to village health workers (VHWs).

Sexual and reproductive health (SRH) and HIV communities not working together. There is little experience in Tanzania of HIV and SRH collaboration. Prevention of mother–to-child transmission of HIV (PMTCT) is not part of the SRH portfolio. There is no dual protection communication messaging used in Tanzania.

MANUFACTURING & REGISTRATION

Manufacturer and registration. Any product will require significant support from the manufacturer. Likewise, as the manufacturers will need to drive the registration process, they are likely to need a local 'agent' to interact with the Tanzanian FDA. Registration can be a time-consuming process and there are a number of examples of current products that are being delayed due to the registration clearance process (e.g. PSI's new flavoured condom).

Fast-tracking. A number of products have been fast-tracked through the regulatory process and made part of 'project' efforts. This is not an impossible task, and it is felt that this can be done for a microbicide that has been through the registration process in Europe or the US. This has happened in the case of ARVs and some TB drugs.

WHO pre-qualification. The FDA will more likely approve a product quickly if it has been pre-qualified by WHO.

Local packaging in Tanzania. Local companies have the capacity to package products, such as gels, in locally branded forms and with indigenous language instructions. Such packaging and branding are already provided for insecticide-treated bed nets for malaria prevention.

Non-profit organisations. Some consideration should be given to associating the product with a non-profit NGO, thus resolving any duty and tariff issues. NGOs also have the capacity to reach remote and hard-to-reach communities.

PROCUREMENT

Social marketing organisations do their own procurement. Though products are not procured through the MSD, they often utilise similar warehousing facilities and networks. For the most part, this system seems to be effective. For instance, when the government supply of condoms was questioned, social marketing agencies were able to step in and their market share has not decreased. And, though social marketing has placed products in public sector health facilities, cost recovery continues to be a challenge. Many public sector health facilities simply cannot handle a cash transaction.

The Medical Stores Department (MSD) could procure a future microbicide product. The effectiveness of MSD will depend on having official permission to procure and distribute, or to fast-track its distribution. All ARVs, for example, come in via the MSD.

Inclusion in the Essential Drug List. Priority is given to approving and procuring medical products included in the MOH's essential drug list. This also facilitates including the product for fast-track approval.

SOCIAL ISSUES

Increased risk of gender violence. Microbicides might increase gender violence for those already at risk. Women must be supported in talking with their partners about sexually related issues, including through education programmes aimed at men.

AIDS stigma still very strong. Marketing microbicides needs to take into consideration the negative impact of accessing and using microbicides if they were to be marketed only as HIV prevention products.

Dry sex practices. Dry sex is regional in Tanzania and should not pose a significant issue for microbicide use. However, in those communities where such sexual practices are prevalent, the information should be utilised to inform local microbicide programmes.

OTHER ISSUES

More human capacity needed. Integration of microbicides into the healthcare setting will require human capacity-building. This includes ensuring clear, simple operating protocols and

training materials are printed in local languages. Monitoring quality and providing on-going refresher courses will also be needed to ensure the quality and sustained engagement.

MOH must gradually assume funding. Donors increasingly support health trough SWAps and general budget support. Therefore, the MOH will need to eventually assume a substantial share of funding for microbicide programmes. Microbicide introduction programmes should plan ahead for a transition from project funding to MOH budget funding (or some combination thereof). This may be complex as not all donors participate in the SWAp.

Manage the introduction carefully. As with the female condom, communication on the class of products and their development can and should start as soon as possible. Consider using the WHO strategic introduction, building on the lessons learned from reproductive health products.

Product replacement price. Some degree of sustainability may be possible through an element of cost-recovery in microbicide programmes. However, it is unlikely that consumers will be able to bear the full costs of commodities and programme delivery. Research is needed to decide what would be a reasonable product price depending on the ability of consumers to pay and what financing mechanism can be established to help those who cannot.

Media. As television has a poor reach in Tanzania, radio at local and regional levels can provide a more useful promotion tool. Preparatory research will be required to understand the reach of different radio stations, to develop appropriate messages and to understand how the messages are received by sexual partners of prospective users.

ADDITIONAL RESEARCH OR FOCUSED ADVOCACY

Market research. Despite the availability of clinical trial and other data that will be used to support product registration, it will also be necessary to undertake local studies in Tanzania to support country and population specific marketing strategies, including how to position and brand products.

Target market is probably in stable partnerships. It is the women in stable relationships whose partners are not monogamous who are an obvious target population. Reaching this population, however, will be difficult. This may be when SRH channels may be the most helpful. Positioning microbicides appropriately in order to reach this group will be important. Experience from the female condom suggests that association of a product with HIV or with a group perceived as at high risk for HIV infection (e.g. sex workers) may inhibit more general adoption.

Campaigns. There will be the need for multiple campaigns within Tanzania. A pre-marketing awareness raising campaign will be needed to build in-country political support and interest in the concept of microbicide products. Specific marketing campaigns will then be needed to generate demand for specific products. None of these campaigns need be mass media, though it may be effective to fold them into existing efforts, as in a radio soap opera (e.g. the STRADCOM Project).

Product variations. Market research should look at possible interest in product variations – such as smell or colour. Variations might also be aligned with different marketing strategies – e.g. as products that may enhance pleasure. PSI is just about to launch flavoured condoms in Tanzania and it will be interesting to see how this product variation is received.

RECOMMENDATIONS FOR KEY STAKEHOLDER OUTREACH

MOH support is crucial. MOH has control over product distribution within Tanzania. Working closely with the ministry as a product becomes reality will be important to generating support for introduction and integrating within broader health strategies, including mobilisation of domestic funding streams.

Tanzania Commission for AIDS (TACAIDS). Every intervention that is AIDS-related must be approved through TACAIDS. The commission was established by law in 2001 and brings together key government ministries and agencies and provides political leadership to the HIV and AIDS response.

National AIDS Control Programme. The NACP remains the principal technical reference for any AIDS intervention and is based at the Ministry of Health. Integration of microbicides into the NACP will be essential for successful introduction.

Agency champion. Importation, distribution and communication about microbicide products will require an agency that champions the product. Social marketers have been successful agents for a number of product focused programmes and could be strong allies, programme drivers and implementers for microbicides.

HIV and SRH. Integrated SRH and HIV services would provide a good basis for microbicide introduction but these are currently limited in Tanzania. Improvements in integration should be monitored as opportunities for effective microbicide programming may arise in the future.

Build on good will of microbicides clinical trials. Two different microbicides organisations are carrying out clinical trials in Tanzania. These trials involve considerable community

outreach and the building of trust within the country. If these trials are handled carefully and considerately, there will be a solid base of microbicides supporters in Tanzania.

Women's empowerment champion. Broad sectoral committees have had limited success in Tanzania. This product should seek to garner political support from a limited number of local organisations that champion women's empowerment issues. This might include a new foundation (TAMWA) established by the current first lady – Mrs. Jeannette Kagame - that is working on issues of education and inter-generational sex.

The Tanzania Media Women's Association (TAMWA). This group could be an effective ally in building demand for microbicide introduction and supporting fast-tracked government action on microbicides.

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ANNEX - SUMMARY INSTITUTIONAL MAPPING

HIV/AIDS AND SEXUAL & REPRODUCTIVE HEALTH

This section includes summary information on key responsibilities, main programmes and key contacts.

KEY AGENCIES WORKING IN HIV/AIDS AND SEXUAL AND REPRODUCTIVE HEALTH

	Organisation	Responsibilities/Activities	Names and Contacts
Government agencies	Ministry of Health and Social Welfare	Coordinates National AIDS Control Programme. Leads and manages surveillance, monitoring and evaluation, information management and operational research activities.	Dr. Gabriel Upunda – CMO, glupunda@moh.go.tz
	Ministry of Health and Social Welfare – Reproductive and Child Health Unit	Coordinates the National Family Planning Programme.	Dr. Catherine Sanga
	TACAIDS (Tanzania Commission for AIDS)	National coordination of the HIV response (under the Prime Minister's Office).	http://www.tacaids.go.tz/ Major General Herman Lupogo – Executive Chairman, tacaids@raha.com Dr. Temba, Temba@TACAIDS.go.tz
	President's Office of Regional Administration and Local Government	Coordination of district response.	Mr.Andrew Sayille – HIV/AIDS Focal Person, ps@poralg.go.tz
	Ministry of Education and Culture	Prevention in schools.	Dr. Laetitia Sayi – HIV/AIDS Focal Person, ps@moec.go.tz
	Ministry of Community	District response.	Mr. Christopher Lushiku – Assistant Director,

	Organisation	Responsibilities/Activities	Names and Contacts
	Development, Gender and Children		comdev@intafrica.com
	Medical Stores Department	Drug and commodities procurement and supply chain management.	http://www.msd.or.tz/ Joseph D. Mgaya, Gen Manager Mariam Malima, Chair
Donors	DFID	Public Expenditure Review.	
	USAID	Cross-cutting support, surveillance.	Charles Llewellyn Health and Population Office US Agency for International Development 686 Old Bagamoyo Rd., Msasani Dar es Salaam/Tanzania Tel.: 255 22 266-8490 ext. 8267 Cell.: 255 0754-333315 Fax: 255 22 266-8421 e-mail: cllewellyn@usaid.gov URL http://tanzania.usaid.gov
	CDC	PMTCT, blood safety, palliative care, laboratory infrastructure, strategy and policy strengthening.	Dr. Stefan Wiktor
	JICA	Prevention, treatment, procurement.	
	GTZ	Cross-cutting support.	Dr. Shmidt Ehry
	Royal Netherlands Embassy	Cross-cutting support.	Dr Timmermans – Senior Advisor health and HIV/AIDS, dia.timmermans@minbuza.nl
	Swiss Development Agency	Cross-cutting support.	
	CIDA	Care and treatment.	

	Organisation	Responsibilities/Activities	Names and Contacts
	NORAD	Care and treatment.	
	Finnish AID	Care and treatment.	
	DANIDA	Cross-cutting support.	
	Clinton Foundation	Development of training curricula, laboratory systems and pharmacies.	Dr. Yahya Ipuge yipuge@clintonfoundation.org 3rf Floor, Skyways Building Ohio Street & Sokoine Drive P.O. Box 77277 Dar es Salaam Tanzania
	UN Theme Group on HIV/AIDS	Supports an expanded response and policy advice on preventing transmission of HIV, providing care and support, reducing the vulnerability of individuals and communities to HIV/AIDS	Dr. Edward T Maganu (WHO) P.O. Box 9292, Dar es Salaam, Tanzania Fax: +255 22 211 3180 Tel: +255 22 211 3005 / +255 22 211 6412 / +255 22 211 1718 Mobile: +255 0744 009920 Email: maganue@tz.afro.who.int Website: www.who.int
Multilateral agencies	UNAIDS	UNAIDS leads, strengthens and supports an expanded response aimed at preventing transmission of HIV, providing care and support, reducing the vulnerability of individuals and communities to HIV/AIDS.	Country Coordinator Bernadette Olowo-Freers P.O. Box 9182, Dar es Salaam, Tanzania Tel.: +255 22 213 0350 / 211 8081/8, Ext. 3232 Fax: +255 22 213 9654 Mobile: +255 744 30 8797 E-mail: olowofreersb@undp.org Website: www.unaids.org
	UNDP	Finance, strategy and mainstreaming of HIV/AIDS in government.	Mr. John Hendra – Regional Representative, johnhendra@undp.org
	UNICEF	OVCs, prevention among	

	Organisation	Responsibilities/Activities	Names and Contacts
		youth.	
	WFP	Impact mitigation.	
	WHO	Technical guidance, development of tools and guidelines.	
	UNFPA	Cross-cutting support.	Dorothy Sipora Temu-Usiri, Asst. Rep. usiri@unfpa.org 10 Ocean Road, Sea View P.O. Box 9182, DSM +255 22 2132002/3/5
NGOs	MSH	Policy, resource mobilisation, coordination.	Ken Heise kheise@msh.org
	World Vision	District response – impact mitigation.	Umati Building P.O. Box 6399 Dar es Salaam, Tanzania Richard_rugemalira@wvi.org
	JSI-Deliver	Drug procurement.	Barry Chovitz Resident Logistics Advisor Land Line: 2123970 Mobile: 0741 486691 E-mail: barry_chovitz@jsi.com
	PSI	Social marketing to deliver health products; male and female condoms, water treatment, mosquito net treatment, etc.	Nils Gade P.O. Box 33500, Dar es Salaam, Tanzania Tel: +255 22 215 1581/3 Fax: +255 22 215 1530 E-mail: ngade@psi.or.tz Website: www.psi.org.
	CARE International	Cross-cutting support.	Nick Southern P.O. Box 10242 Dar es Salaam, Tanzania nsouthern@care.or.tz
	Christian Social Services	Cross-cutting support.	Dr. Frederick Kigadye – Director,

	Organisation	Responsibilities/Activities	Names and Contacts
	Commission		fkigadye@cssctz.co.tz
	Christian Council of Tanzania	Cross-cutting support.	
	PLHA Council	Network and support organisation for PLWHA.	
	SHDEPHA+	Network and support organisation for PLWHA.	Mr. Joseph Kato – Chairperson, shepha3@yahoo.com
	Marie Stopes Tanzania	FP services, Technical support to private service providers of FP, VCT, condom distribution and other services.	+255 (22) 2152000 Plot No 372 Kalenga st. Upanga Area P.O BOX 7072 Dar es Salaam Tanzania
	Constella Futures	Policy, Stigma & Discrimination, M&E, social marketing and communication.	Tim Manchester Director of Program Development/East Africa Tmanchester@ConstellaGroup.com +255.753.251.849
	UMATI (IPPF affiliate)	FP services, capacity building of government health facilities.	
	Human Development Trust	HIV/AIDS programming.	Yovita Mrima Programme officer P.O. Box 65137 DSM Tel.: 2772264 E-mail: info@hdt.or.tz Web: www.hdt.or.tz
	Response Foundation	HIV/AIDS programming	Paul j. Mzuka Chairperson P.O. Box 8401 DSM Tel./Fax: 2182433 E-mail: response@realtimeconsult.com or response@africamail.com SUWATA complex – Kariakoo

	Organisation	Responsibilities/Activities	Names and Contacts
	VUKA	HIV/AIDS programming.	J. Kayombo Coordinator P.O. Box 15241 Tel.: 2856345 E-mail: vukat@kicheko.com
	YOPAC	HIV/AIDS programming.	Paschal Maziku Executive Director P.O. Box 3799 DSM E-mail: yopack@africaonline.co.tz
	About Health Foundation	HIV/AIDS programming	Dr. Rose Lily Maeda Executive Director P.O. Box 11173 Tel: 2773022
	TAYOA	HIV/AIDS programming Including hotline, music and video studio, and community organisation	Peter Masika Executive Director P.O. Box 77874 DSM Tel: +255 22 2667492 pmasika@toyoafund.org, tayoafund@yahoo.com Togo Tower Kinondoni Dar es Salaam
	FHI International	HIV/AIDS programming	Dr. Eric van Praag Country Director P.O. Box 78082, DSM Tel: +255 22 21248885/6 E-mail:evanparaag@fhi.org, evanpraag@fhitan.org
	Tanzania Network of Women Living with HIV	HIV/AIDS programming	Joan Chamungu P.O. Box 77704 DSM Tel: 2128458 E-mail: tzpositivewomen@yahoo.com
	TANEPA (Tanzania Network of	HIV/AIDS programming	Alex Margery Chairperson P.O. Box 71489, Dar es

	Organisation	Responsibilities/Activities	Names and Contacts
	People Living with HIV/AIDS		salaam
	International Committee of Red Cross society		Otmar Hofman Head of Mission P.O. Box 23431 Dar es Salaam
	COUNSENUTH		Mary Materu Executive Director P.O. Box 8218 DSM Tel.: 2152705 E-mail:counsenuth@cats-net.com
	African Medical &Research Foundation-Tanzania (AMREF)	HIV intervention and research projects in high incidence areas; prevention; promotion of sexual health for women; control of STDs; sexual and reproductive health programmes for adolescents; counselling and testing.	Dr. Paul Waibale P.O. Box 2773, Dar es Salaam, Tanzania Tel: +255 22 211 6610 +255 22 213 6731 +255 22 213 0860 Fax: +255 22 211 5823 Email: info@amreftz.org, paulw@amreftz.org Website: www.amref.org / www.angaza-vct.org
	African Regional Youth Initiative	Over 100 youth- and community-based organisations combating HIV/AIDS and malaria in Africa. The organisation provides a number of programmes to youth and community organisations, including a volunteer programme for youth all over the world interested in development work to work alongside youth in Africa.	Neema Mgana P.O. Box 11704, Dar es Salaam, Tanzania Tel./Fax: +1 831 303 5285 Email: aryi_2002@yahoo.com Website: www.aryi.interconnection.org

	Organisation	Responsibilities/Activities	Names and Contacts
	Catholic Women Of Tanzania Association (WAWATA)	HIV/AIDS programming.	P.O. Box 31147, Dar es Salaam, Tanzania Tel.: +255 513 5216 Fax: +255 513 5216 E-mail: nunzio@cats-net.com
	Comprehensive Community-Based Rehabilitation in Tanzania (CCBRT)	HIV/AIDS programming.	Geert Vanneste, Executive Director P.O. Box 23310, Dar es Salaam, Tanzania Tel.: +255 22 260 1543 / 74 460 4301 Fax: +255 22 260 1544 E-mail: vanneste@intafrica.com / info@ccbrt.or.tz Website: www.ccbrt.or.tz
	Eastern Africa National Networks Of AIDS Service Organisations (EANNASO)	Network of the 12 HIV/AIDS national networks in East African countries. Its mission is to enhance the community response to HIV/AIDS in eastern Africa by promoting the development and existence of sustainable and effective country networks that provide leadership and capacity-building in advocacy, programme development, and enhanced greater involvement of people living with HIV and AIDS.	Lucy Ng'ang'a Box 6187 Arusha, Tanzania Tel.: +255 27 254 8224 Fax: +255 27 254 8224 E-mail: annea@habari.co.tz Website: www.annea.or.tz
	Kwetu Counselling Centre - Association of PLWHA		David Burrows P.O. Box 1273, Dar es Salaam, Tanzania Tel.: +255 51 85 0543 E-mail:

	Organisation	Responsibilities/Activities	Names and Contacts
			David.Burrows@TZN.salvationarmy.org Website: www1.salvationarmy.org
	Medical Women Association of Tanzania (MEWATA)		Dr. Marina Njelekela P.O. Box 2nd Floor, Tulyer House, Sea View (adjacent to Court Yard Hotel) P.O. Box 65443 Dar Es Salaam, Tanzania Tel.: 255-0746-44 89 11 Fax: 255-22-215 04 65 E-mail:mewata@yahoo.com
	National Institute For Medical Research (NIMR)		Dr. Andrew Kitua Headquarters, Ocean Road, P.O. Box 9653, Dar es Salaam, Tanzania, East Africa. Tel.: +255 22 212 1400 Fax: +255 22 212 1360 / 212 1380 Telex: 41919 NIMR TZ Telegrams: MEDSEARCH E-mail: headquarters@nimr.or.tz Website: www.nimr.or.tz
	T Marc AED Implemented	Social marketing to deliver health products, services and information that enable low-income and other vulnerable people to lead healthier lives.	P.O. Box 63266, DSM Plot 331, Garden Road, Mikocheni B, DSM Tel: +255 22 270 0772/4 JBosco@tmarc.or.tz (troubled implementation. Avoid)
	Southern	Supports community	Adolf Mrema / Adelardus

	Organisation	Responsibilities/Activities	Names and Contacts
	African AIDS Trust (SAT)	responses to HIV and AIDS through in-depth partnership, networking, skills exchange and lesson sharing in HIV prevention, HIV and AIDS care and support throughout the region.	Kilangi - Programme Manager P.O. Box 34198, Dar es Salaam, Tanzania Tel.: +255 22 277 3684/87 Fax: +255 22 277 3677 E-mail: sat.tanzania@satregional.org Website: www.satregional.org
	Tanzania Gender Networking Programme (TGNP)	Gender-related issues and advocates.	P.O. Box 8921, Dar es Salaam, Tanzania Tel.: +255 22 244 3205 Fax: +255 22 244 3244 E-mail: tgnp@muchs.ac.tz / tgnp@tgnp.co.tz Website: www.tgnp.co.tz
	Tanzania Network of People with HIV/AIDS (TANOPHA)	Regional coordinating network for people with HIV/AIDS: information exchange; capacity-building; health promotion.	Julius Kaaya P.O. Box 76724, Dar es Salaam, Tanzania Tel.: +255 74 444 7354 Fax: +255 22 213 6639 E-mail: tanopha@yahoo.co.uk
	Upendo AIDS Information + Counselling Centre	AIDS service organisation dealing with orphans and grandparents.	Wandoa Mwambu, Director P.O. Box 77014, Dar es Salaam, Tanzania Tel.: +255 51 76 1043 / 081 162 2785
	WAMATA - Dar es Salaam	Prevention, advice, support, information.	Georgia Baguma P.O. Box 32960, Dar es Salaam, Tanzania Tel: +255 270 0282 E-mail: wmata.dar@twiga.com
	Women's Research and Documentation	Prevention, advice, support, information	The Convenor P.O. Box 35108, Dar es

	Organisation	Responsibilities/Activities	Names and Contacts
	Project Association (WRDP)		Salaam, Tanzania Tel.: +255 514 3500 Ext. 2460, or (255 51) 43 5009/ 48 23 54 9192 Fax: +255 514 3395 / +255 514 3016 E-mail: wrdp@udsm.ac.tz / wrdp@udsmucc.gn.apc.org
	Tanzania Network of Women Living with HIV	Self-help, prevention; advice; counselling care and support; information for people living with HIV and AIDS HIV/AIDS.	JOAN CHAMUNGU P.O. BOX 77704 DSM TEL.: 2128458 E-MAIL: TZPOSITIVEWOMEN@YAHOO.COM
	PASADA	HIV and AIDS programming.	YOVITA MRIMA PROGRAMME OFFICER P.O. BOX 65137 DSM TEL: 2772264 E-MAIL: INFO@HDT.OR.TZ WEB: WWW.HDT.OR.TZ
	Shree Hindu Mandal Hospital	HIV AND AIDS programming	D K Asher, *Financial Controller* P. O. Box 581 DSM Fax 2113459 *Land Line:* 2114991/4 *Mobile:* 0741 301625 *Fax:* *E-mail:* d.asher_hindu@cats-net.com
	Christian Social Services Commission (CSSC)	HIV AND AIDS programming	Josephine Balati, *HIV/AIDS Coordinator* P.O. BOX 9433 Dsm *Land Line:* 255 22 2112918 & 2123730 *Mobile:* 0744 290699 *Fax:* 255 22 2118552

	Organisation	Responsibilities/Activities	Names and Contacts
			Email: jbalati@cssc.or.tz
	TPDF	HIV AND AIDS programming.	Dr. J. W. Bigambo *AIDS Focal Person* P.O. BOX 60541 Dsm *Land Line:* *Mobile:* 0741 237538 *Fax:* *E-mail:* jbigambo@yahoo.com
	CUAMM	HIV AND AIDS programming.	Flavio Bobbio, *Medical Doctor* P.O. BOX 23447 *Land Line:* 022/2775227 *Mobile:* 0744 673797 *E-mail:* cuamm-dsm@cats-net.com, Bobbio_f@starnova.IT
	Anglican Church of Tanzania, Health Dept.	HIV AND AIDS programming.	Chilongani, Baraka E. P.O. BOX Dodoma *Land Line:* 026 2321242 *Mobile:* 0744 489140 *Fax:* 026 2324565*:* *E-mail* bchilongani@yahoo.com
	Action AID Tanzania	HIV AND AIDS programming	Dr. Peter Bujari *HIV/AIDS Advisor* P.O. BOX 21496 Dsm *Land Line:* 2150711 *Mobile:* 0748/41 217127 *Fax:* 2151003 *E-mail:* admin@actionaidtz.org, PeerB@actionaidtz.org
Research organisations	Muhimbili University College of Health Sciences	Adolescent Reproductive Health Network (ARHNe) Research network involved in research and/or	M.T. Leshabari P.O. Box 65015, Dar es Salaam, Tanzania Tel.: +255 22 15 1596

	Organisation	Responsibilities/Activities	Names and Contacts
		implementation of programmes targeting adolescent sexual and reproductive health and risk behaviours. PMTCT research; depression and progression to HIV; vaccine initiative; TB vaccine initiative; HIV counselling and testing; reducing violence against women.	E-mail: info@muchs.ac.tz (some attention needs to be given as to who is assigned the actual research. Organisations in Tanzania have very different experiences with Muhimbili and the factors seem to come down to the PI and who actually supervises the study).
	National Institute of Medical Research	As above	

Source: GFATM, 2004; WHO, 2005.