Assessment of the
HIV/AIDS/STD Policy Environment in Tanzania

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### Abbreviations

<table>
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<th>Full Form</th>
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<tr>
<td>AIDS</td>
<td>Autoimmune Deficiency Syndrome</td>
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<td>APES</td>
<td>AIDS Policy Environment Score</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>MTP</td>
<td>Medium Term Plan</td>
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<td>NACP</td>
<td>National AIDS Control Programme</td>
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<td>NGO</td>
<td>Nongovernmental organization</td>
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<td>STD</td>
<td>Sexually Transmitted Disease</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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I. Introduction

National response to the HIV/AIDS epidemic in Tanzania

Tanzania is one of the countries in sub-Saharan Africa severely affected by the HIV epidemic. The first cases of AIDS in Tanzania were reported in 1983 in the Kagera region near Lake Victoria [1]. By 1986, all regions of Tanzania’s mainland had reported AIDS cases. The number of people infected with HIV increased to 800,000 by May 1992 and 1.5 million (approximately 5% of the total population) by December 1997 [2]. This number is projected to double by year 2000. These estimates are consistent with results from cohort studies which have shown that a large number of new HIV infections continue to occur in most parts of the country [3,4,5]. However, large geographical and gender differences in HIV prevalence exist within Tanzania. Some studies have shown HIV prevalence to be higher in urban areas than rural areas [6,7,8], while other studies have shown that HIV prevalence is higher among women than men [7,8].

As part of the national response to reduce further spread and impact of the epidemic, HIV/AIDS/STD prevention and control activities have been planned and implemented in phases by the Tanzanian government and nongovernmental organizations (NGOs). In the first phase, the Ministry of Health implemented a two-year Short Term Plan (STP) (1985-1986). The main aim of the STP was to mobilize and train health care workers about the disease and to develop blood transfusion safety standards. In June 1987, the National AIDS Control Programme (NACP) was established to coordinate the Tanzanian government’s national response against HIV/AIDS. During the subsequent phases, Medium Term Plans (MTPs) were developed and implemented. The first plan (MTP-I) was implemented during 1987-1991, followed by MTP-II in 1992-1996 [9]. In both MTP-I and MTP-II, a mass educational campaign to increase HIV/AIDS awareness and condom promotion was adopted as the principal strategy to reduce further spread of the HIV epidemic. In addition, MTP-II emphasized involvement of other sectors outside the Ministry of Health (MOH) and decentralization of AIDS control activities to the regions and districts.

During the second half of 1997, several workshops were held to assess the status of the HIV/AIDS epidemic in Tanzania and to review the implementation of MTP-II. By the end of 1997, a draft document for MTP-III, covering the period 1998-2002, was circulated to interested parties for comments. In June 1998, a national planning workshop was held to finalize the MTP-III and the program was officially launched by the Prime Minister in March 1999. Under MTP-III, a multisectoral, national, expanded response will be implemented to address both risk factors for, and vulnerability to, HIV/AIDS and other STDs.

Policy environment for HIV/AIDS/STDs

The MTP-III process identified the policy environment for HIV/AIDS/STD programs as an area that needs more attention. The policy environment is defined as the actions, customs, laws, or regulations by government or other social and civic groups that directly
or indirectly affect programs for AIDS prevention, people with AIDS, or families and communities affected by AIDS. It includes factors such as political support, national- and operational-level policies, and program elements that are beyond complete control of program managers. The MTP-III identifies lack of political commitment, in particular, as a serious constraint in the implementation of effective HIV/AIDS/STD activities and aims to build a supportive policy and legal environment by addressing the following:

- Policy development and analysis for a national AIDS policy, care for people living with HIV/AIDS, protection of vulnerable groups, and survivor support
- Policy advocacy and sensitization
- Integration of AIDS issues into macroeconomic and sectoral policies
- Government resource and budgetary allocations for AIDS activities
- Legal strategy for AIDS
- Advocacy program for ethics and legal support
- Legal literacy
- Ethical code of confidentiality
- Legal counseling services and network

Objectives of the assessment

This assessment of the policy environment for HIV/AIDS/STDs was undertaken in order to:

- Provide a baseline measure for future evaluation of changes in the policy environment over time, and,
- Identify specific strengths, weaknesses, and gaps in the policy environment to inform the design of policy interventions within the MTP-III.

II. Methodology

AIDS Policy Environment Score (APES)

The AIDS Policy Environment Score was developed by the POLICY Project\(^1\) in 1996 for the purpose of measuring the degree to which the policy environment in a particular country supports efforts to prevent the spread of HIV/STDs, provide quality care for people with AIDS, ensure the rights of people with AIDS, and ameliorate the negative impacts of AIDS on individuals, families, communities, and society. To date, the APES has been administered in three countries in sub-Saharan Africa (Malawi, Kenya, and Ghana) and in five countries in Central America (under the PASCA Project).

\(^1\) The POLICY Project is a 5-year project funded by USAID under Contract No. CCP-00-95-00023-04, beginning September 1, 1995. It is implemented by The Futures Group International in collaboration with Research Triangle Institute (RTI) and the Centre for Development and Population Activities (CEDPA).
The APES aims to measure seven separate components of the policy environment:

- Political support
- Policy formulation and planning
- Organizational structure
- Resources
- Evaluation and research
- Legal and regulatory environment
- Program components

The APES questionnaire comprises a list of statements about various aspects of each of these components. Respondents are asked to rate the degree to which they agree or disagree with the statements. In Tanzania, representatives from the NACP, NGOs, and donor community reviewed and modified the original APES to make it consistent with the local context of HIV/AIDS/STD programs and policies. The wording of some statements was modified and the scoring was changed from a five-point numeric system to a three-point categorical system. The Tanzania adaptation of the APES questionnaire is provided in Annex A.

**Data collection**

Study participants were selected from the list of 693 people who registered to attend the first National Multisectoral AIDS Conference, held 6-10 December, 1998, in Arusha, Tanzania. The conference, organized by the Ministry of Health in collaboration with Muhimbili University College of Health Sciences, attracted participants with various backgrounds from different parts of the country.

Eight categories of participants were identified from the list: NACP staff, donor community, MOH staff, other government staff, NGOs, research/academic community, religious organizations, and district AIDS workers. Five people were selected randomly from each of these groups to participate in the study, resulting in a total sample of 40 people. Written invitations to participate in the study were given to this sample of individuals at the time of conference registration. The invitations requested the selected individuals’ attendance at a meeting to complete the APES questionnaire. The meeting was held at the end of the first day of the conference. Several announcements also were made during the regular conference sessions to remind study participants to attend the meeting. These announcements extended invitations to all interested conference attendees.

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attendees, not just those who had been previously selected.

The NACP program manager chaired the meeting and, before data collection started, made a brief statement on the background and aims of the study. Then, questionnaires were distributed to participants and specific instructions on how to complete them were given. Each participant individually completed the questionnaire. No consultation between study participants was allowed during this period.

III. Results

Respondents

Forty-eight individuals attended the meeting and completed the APES questionnaire. Respondents included 36 of the 40 invited participants and 12 additional conference participants who responded to the open invitation at the conference. Sixty-one percent were males and 39% were females. They ranged in age from 29 to 72 years, with an average age of 45 years. Twenty percent considered themselves policymakers, 30% planners, and 40% policy implementers. Ten percent indicated they were in none of these categories. Respondents represented government departments, NGOs, and international donors.

Data analysis

Respondents were instructed to score the questionnaire items separately for 1997 and 1998, for purposes of comparing trends over time. However, each respondent’s scores for these two periods were virtually identical. Hence, only results based on 1998 scores are presented in this report.

Questionnaire data were numerically coded, entered into the computer, and analyzed using EPI INFO version 6. In addition to scoring the items, respondents were invited to provide written comments. These data were collated and analyzed separately. Results based on the coded data and written comments are summarized below by component.

Political support

Respondents were asked to rate (weak, moderate, strong) ten aspects of political support for HIV/AIDS/STD policies and programs: high-level government, senior civil servants, public opinion, media campaigns, political parties, national development plans, religious organizations, private sector leaders, NGOs, and international organizations. The results are presented in Figure 1.

Strongest political support was attributed to NGOs, media campaigns, and international organizations. Approximately 90% of respondents rated support from these factions as strong or moderate; over 50% felt support from these groups was strong. Support among religious organizations also was highly rated; about 80% of respondents rated this support as strong or moderate. Public opinion was viewed as moderate for the most part,
22% indicating strong support, 53% indicating moderate support, and 18% weak support. High-level government officials and senior civil servants were seen as somewhat less supportive; fewer than 30% of respondents indicated strong support, while about 30-40% rated support from these groups as weak. Development plans, private sector leaders, and political parties were seen as least supportive; 36% to 46% of respondents rated them as weak.

**Policy formulation and planning**

Respondents were presented with eight statements regarding HIV/AIDS/STD policy formulation and program planning. For each statement, respondents indicated the extent to which they agreed with the statement, i.e., strongly agree, agree, disagree, and do not know. Results are presented in Figure 2.

Most respondents (66% - 80%) strongly agreed or agreed that program goals existed, strategies met those goals, a national coordinating body was in place, international organizations facilitated the process, and NGOs were involved in policy formulation and planning. Perceptions about the involvement of ministries other than the Ministry of Health were more divergent; half of respondents strongly agreed or agreed, 31% disagreed, and 19% were unsure. Similarly, about half of respondents agreed that a national policy existed and that the national coordinating body functioned effectively, while the other half disagreed or didn’t know.
Organizational structure

Six statements were presented to respondents to assess the organizational structure of HIV/AIDS/STD programs in Tanzania. Respondents were asked to rate the extent to which they agreed with each statement, i.e., strongly agree, agree, disagree, or don’t know. Figure 3 summarizes the results.
A majority of respondents strongly agreed or agreed that the NACP effectively partnered with NGOs (72%), NACP provided effective leadership for HIV policymaking and program implementation (61%), NACP was appropriately placed to effectively coordinate a national AIDS response across sectors (60%), and NGOs had clearly defined roles and responsibilities in the National AIDS Control Programme (58%). About half of respondents strongly agreed or agreed that ministries besides health were involved in HIV/AIDS/STD program implementation. Roles of the private sector were seen as more ambiguous; only 30% of respondents agreed that their roles and responsibilities were clearly defined.

**Program resources**

Study participants were presented with eight statements about mobilization and allocation of human, technical, and financial resources for the HIV/AIDS/STD program. Respondents were asked to indicate the extent to which they agreed or disagreed with statements about the process and the quality of the resources. Results are shown in Figure 4.
Most respondents (about 80%) strongly agreed or agreed that national priorities for HIV/AIDS/STD programming existed. However, only 35% believed that resources were allocated according to those priorities. Perceptions of the NACP’s effectiveness in mobilizing resources varied; 48% of participants believed that the NACP was effective, 31% disagreed, and 21% indicated lack of knowledge of their effectiveness. Support from international organizations was widely acknowledged; nearly 90% of respondents strongly agreed or agreed that these organizations provided a significant portion of funding for HIV/AIDS/STD interventions.

About half of respondents strongly agreed or agreed that staff at headquarters (MOH), ministries other than health, and NGOs were competent in coordinating and implementing HIV/AIDS/STD activities. District-level staff were seen as somewhat less competent; 36% of respondents agreed or strongly agreed that they were competent, 38% disagreed, and 25% expressed lack of knowledge about their competence.

Additionally, respondents were asked to rate the level (high, medium, low, or don’t know) of financial support for HIV/AIDS/STD programs provided by the government and other organizations. Results are given in Figure 5.
Most respondents (58%) agreed that financial support from the international donor community was high. NGOs were viewed as providing high (23% of respondents) to medium support (42% of respondents). Perceptions about financial support from religious organizations varied: 12% rated it as high, 35% as medium, and 25% as low. On the other hand, the majority of respondents (53%) rated support from the Ministry of Health as low. Many respondents (about 35%) indicated lack of knowledge of the levels of support from non-health public sectors and the private sector. Another 35% to 40% rated support from these sectors as low.

**Evaluation, monitoring, and research**

Respondents were asked to indicate the extent to which they agreed or disagreed with three statements about evaluation, monitoring, and research in HIV/AIDS/STD policy and programming. These results are presented in Figure 6.
The majority of respondents expressed agreement with all three statements: 66% strongly agreed or agreed that evaluation and research findings were actively used in HIV/AIDS/STD policy formulation and planning; 63% agreed or strongly agreed that special studies were undertaken as needed to improve HIV/AIDS/STD programming; and, 52% strongly agreed or agreed that a formal evaluation component existed within the NACP. However, a significant proportion of respondents (37%) indicated lack of knowledge about the NACP evaluation component.

**Legal and regulatory environment**

Respondents were presented with twelve statements on various aspects of the legal and regulatory environment and asked to indicate the extent to which they agree or disagree with each statement. Results are presented in Figure 7.

Although the majority of respondents viewed the environment for condom advertising (87%) and condom distribution (76%) as favorable (i.e., they strongly agreed or agreed with the statements), many (44%) expressed lack of knowledge about the extent to which import regulations facilitated condom procurement. STD services and procurement regulations were rated similarly: 80% agreed or strongly agreed that there were no restrictions on who may receive STD services, but 37% indicated lack of knowledge about import regulations on STD drug procurement.
Most (61%) strongly agreed or agreed that a policy to ensure confidentiality of HIV testing existed. Whereas many (52%) also strongly agreed or agreed that HIV testing was not a mandatory requirement for such licenses as housing, marriage, insurance, and visas, a significant proportion of respondents (32%) disagreed with this statement.

A majority of respondents (57%) strongly agreed that unethical laws of incarceration, quarantine, and discrimination against people living with AIDS have not been enacted; an additional 18% agreed with this statement. However, there was less agreement on the existence of laws to protect people living with HIV/AIDS, i.e., fewer than half of respondents agreed that such laws existed. Many respondents (47%) also disagreed with the statement that laws prohibited harassment of high-risk groups, such as commercial sex workers, men having sex with other men, and intravenous drug users.

About half of respondents strongly agreed or agreed that AIDS was a mandatory reportable disease, although 36% disagreed with this statement. There also was less consensus among respondents on the fairness and clarity of procedures for NGO registration; about half agreed procedures were fair, 23% disagreed with the statement, and 26% indicated lack of knowledge.

**NACP leadership of program components**

NACP leadership was assessed for ten HIV/AIDS/STD program components. For each component, respondents were asked to rate NACP leadership as strong, weak, no
leadership role, or don’t know. Results are shown in Figure 8.

**Figure 8. NACP Leadership of Programme Components**

The majority of respondents (58%) indicated the NACP strongly led the provision of national guidelines for treatment of STDs. Also, nearly half of respondents gave the NACP a high leadership rating on guidelines for universal blood screening. Other program components received more mixed ratings. For example, about 40% of respondents gave the NACP high leadership scores on a surveillance system, the availability of counseling and testing, the logistics system for HIV/AIDS/STD commodities, and targeting of vulnerable groups. However, another 35%-45% of respondents rated NACP leadership of these components as weak. NACP leadership in the area of guidelines for the social marketing of both condoms and STD drugs also received mixed ratings; many respondents lacked knowledge of the NACP’s leadership role in social marketing, especially in the marketing of STD drugs (i.e., 40% responded “don’t know”). Promotion and reporting of accurate media coverage was viewed as the NACP’s weakest role, with 59% of respondents rating their leadership in this component as weak.
IV. Discussion and Conclusions

This study is the first attempt to assess empirically the HIV/AIDS/STD policy environment in Tanzania and provides a baseline for measuring future changes in the policy environment. Since the APES measures peoples’ perceptions of the environment rather than tangible elements, such as the existence of policy documents, the results should be interpreted accordingly. On the other hand, many aspects of the policy environment are subjective and can only be measured in terms of peoples’ perceptions.

Obviously, the process and criteria for selecting individuals to complete the APES influences the results. As noted, participants in this study were selected from attendees at a national multisectoral AIDS conference and represented government institutions, international organizations, and NGOs working on HIV/AIDS/STD issues and programs in various parts of the country. Hence, the study results provide a reasonably representative cross-section of informed perceptions and opinions about the policy environment in Tanzania. It should be noted, however, that this sample does not represent a group of “HIV/AIDS policy experts.” The study results, therefore, should not be used as an indicator of policy components that can be better assessed by such experts or observed directly. For example, more precise levels of financial support could be obtained (albeit with some difficulty) directly from the various organizations.

Two objectives guided this study. The first objective addresses the need by the NACP, USAID, and others to measure changes in the policy environment over time. MTP-III recognizes the need to work toward a more supportive policy environment; policymakers and program managers need to be able to ascertain whether progress toward this goal is being made. Also, relationships among the policy environment, program efforts, and the eventual course of the epidemic are not well understood. Reliable and valid measures of the policy environment would enable some of these relationships to be examined more systematically. In order to obtain reliable and valid data that can be examined over time, careful attention must be paid to sample selection in future administration of the APES. The process and criteria used in this baseline assessment should be replicated in future assessments.

The second objective of the study was to collect information that would inform the design of policy interventions within the MTP-III. Overall, the APES findings are consistent with findings from the review of MTP-II, conducted in 1997, which subsequently shaped the policy priorities under MTP-III. In particular, several key APES findings deserve attention and suggest immediate action. These include:

- Consensus exists that political support is weakest among high-level public sector leaders, private sector leaders, and political parties. Efforts to engage these groups in dialogue and strengthen their support should be a high priority.

- Only 36% of the study participants correctly knew that a national HIV/AIDS/STD policy did not exist. This suggests limited awareness of the status of official policy documents on HIV/AIDS. This ambivalent response is reasonable given the current
status of the policy. A national HIV/AIDS policy was first drafted in 1995, but it was never approved. This document was revised in 1998 and currently is under review. Approval of the national policy will require support from all sectors. About half of APES respondents either viewed other ministries as not involved in HIV/AIDS policy and planning, or were uncertain of their roles. If these perceptions are accurate, then efforts to bring sectors other than health into the policy process should be intensified. Once the national policy is approved, efforts should be made to vet it with a broad range of stakeholder groups in order to communicate the government’s position and build consensus for the national response.

- Most respondents agreed that the NACP provided effective leadership for HIV/AIDS program implementation and effectively partnered with NGOs. However, a substantial proportion thought that the roles of the private sector, and to some extent the non-health public sectors, were not clearly defined. Respondents noted the need for many types of additional resources and also demonstrated limited knowledge of current levels of financial support. The multisectoral approach advocated under MTP-III will require a significant shift in NACP management and coordination strategies in order to nurture full participation of all sectors. It also will require more intensive human, technical, and financial resources.

- While the legal and regulatory environment for HIV/AIDS/STD issues generally was viewed in a positive light, responses point to a need to strengthen laws that protect high-risk groups and people living with AIDS. These findings recommend closer examination of relevant laws and their enforcement concerning human rights and the stigma of AIDS, and more sensitization and dialogue on these issues. Knowledge about certain regulations, such as commodity procurement, was limited but perhaps expected based on respondents’ backgrounds.

- Although most respondents agreed that media campaigns were permitted and encouraged, they criticized the NACP’s leadership in promoting and monitoring media reporting. No APES questions addressed specifically the quality of reporting or the role of media organizations, but this critical assessment implies that media coverage and quality need improvement. Again, in line with a multisectoral approach, the relationship between the NACP and media organizations should be viewed as a collaborative partnership. Media organizations must be educated and empowered to provide accurate and relevant coverage of HIV/AIDS/STD issues and events because the media play a pivotal role not only in reflecting the policy environment, but also in defining and influencing it.
References


Annex A

POLICY ENVIRONMENT SCORE
(APES)

This instrument was designed to measure the policy environment that surrounds Tanzania’s HIV/AIDS/STD control programme. The APES is comprised of seven categories to assess the policy environment: political support, policy formulation, organizational structure, legal and regulatory environment, program resources, program components, and evaluation and research. In responding to the questions, follow the instructions provided at the beginning of each section.

The APES is meant to assess the current environment as well as changes over a period of years. Many of the items will change little over a two- or three-year period; nevertheless, this allows the same features of the policy environment to be systematically assessed at regular intervals. The respondent should fill in responses for 1998 and 1997 years.

We value and appreciate your input in this exercise.
The POLICY Project

ASSESSMENT OF TANZANIA HIV/AIDS/STD POLICY ENVIRONMENT

1. MINISTRY/ORGANISATION/ COMPANY

_____________________________________________________

2. POSITION:________________________________________

3. JOB TITLE:_________________________________________

4. WOULD YOU CONSIDER YOURSELF

   A Policymaker

   A Planner

   An Implementer of Policy

   None of the above

5. SEX: Male

   Female

6. AGE: _______________ Years
TANZANIA AIDS POLICY ENVIRONMENT SCORE (APES)

I. POLITICAL SUPPORT

Please indicate the level of support, which is provided by the following groups for an effective HIV/AIDS/STD policy and programme in Tanzania.

(Scoring: 1=Weak; 2=Moderate; 3=Strong; 4=Don’t Know)

1. Highest level of government support exists for HIV/AIDS/STD policies and programmes.
   Comments:

2. Senior civil servants (Principal Secretaries, Heads of Policy and Planning Sections) support HIV/AIDS/STD policies and programmes.
   Comments:

   Comments:

4. Media campaigns are permitted and encouraged.
   Comments:

5. The main political parties support HIV/AIDS/STD policies and programmes.
   Comments:

   Comments:

7. Major religious organizations support HIV/AIDS/STD policies and programmes.
   Comments:

8. Private sector leaders support HIV/AIDS/STD policies and programmes.
   Comments:

9. NGOs support HIV/AIDS/STD policies and programmes.
   Comments:

10. International Organizations have made a significant contribution to strengthening the political commitment of government leadership.
   Comments:
II. POLICY FORMULATION AND PLANNING

Please read the following statements regarding HIV/AIDS/STD programmes and policies in Tanzania. Indicate the degree to which you agree or disagree with each statement.

(Scoring: 1 = Strongly agree; 2 = Agree; 3 = Disagree; 4 = Don’t Know)

   Comments:

2. Explicit HIV/AIDS/STD programme goals exist.
   Comments:

3. Specific strategies to meet HIV/AIDS/STD programme goals exist.
   Comments:

   Comments:

   Comments:

6. Ministries other than Health are involved in HIV/AIDS/STD policy formulation and planning.
   Comments:

7. HIV/AIDS policy formulation and planning involves NGOs, community leaders, and representatives of the private sector and special interest groups.
   Comments:

8. International organisations have facilitated policy formulation and planning through the provision of technical assistance and guidelines.
   Comments:

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III. ORGANIZATIONAL STRUCTURE

Please read the following statements regarding HIV/AIDS/STD programs and policies in Tanzania. Indicate the degree to which you agree or disagree with each statement.

(Scoring: 1 = Strongly agree; 2 = Agree; 3 = Disagree; 4 = Don’t Know)

1. The National AIDS Control Programme (NACP) is appropriately placed to effectively coordinate a national AIDS response across sectors.
   Comments:

2. The NACP provides effective leadership for HIV/AIDS policy making and programme implementation.
   Comments:

3. The NACP effectively partners with local NGOs and the private sector in HIV/STD prevention.
   Comments:

4. Ministries other than Health are involved in HIV/AIDS/STD programme implementation.
   Comments:

5. NGOs have clearly defined roles and responsibilities in the AIDS control program.
   Comments:

6. The private sector has clearly defined roles and responsibilities in the AIDS control programme.
   Comments:
IV. PROGRAMME RESOURCES

Please read the following statements regarding HIV/AIDS/STD programmes and policies in Tanzania. Indicate the degree to which you agree or disagree with each statement.

(Scoring: 1 = Strongly agree; 2 = Agree; 3 = Disagree; 4 = Don’t Know)

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<tr>
<td>Comments:</td>
<td></td>
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<tr>
<td>2.</td>
<td>HIV/AIDS/STD programme resources are allocated according to priority guidelines.</td>
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<tr>
<td>Comments:</td>
<td></td>
<td></td>
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<tr>
<td>3.</td>
<td>The NACP effectively mobilises resources.</td>
<td></td>
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<tr>
<td>Comments:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Technically competent staff lead and manage government HIV/AIDS/STD programme at the headquarters.</td>
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<tr>
<td>Comments:</td>
<td></td>
<td></td>
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<tr>
<td>5.</td>
<td>The districts have technically competent staff to co-ordinate district HIV/AIDS/STD response.</td>
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<tr>
<td>Comments:</td>
<td></td>
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<tr>
<td>6.</td>
<td>There are technically competent professional staff in other non-health Public sector to implement HIV/AIDS programme.</td>
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<tr>
<td>Comments:</td>
<td></td>
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<tr>
<td>7.</td>
<td>Technically competent staff leads and manages NGOs HIV/AIDS/STD programmes.</td>
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</tr>
<tr>
<td>Comments:</td>
<td></td>
<td></td>
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<tr>
<td>8.</td>
<td>International organisations have provided a significant portion of funding for HIV/AIDS/STD prevention.</td>
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Please rate the level of financial support for HIV/AIDS/STD programmes provided by the following groups.

(Scoring: 1 = Low; 2 = Medium; 3 = High; 4 = Don’t know)

   Comments:

   Comments:

    Comments:

    Comments:

12. Non-Governmental Organisations.
    Comments:

13. International donor community.
    Comments:

V. EVALUATION, MONITORING AND RESEARCH

Please read the following statements regarding HIV/AIDS/STD programmes and policies in Tanzania. Indicate the degree to which you agree or disagree with each statement.

(Scoring: 1 = Strongly agree; 2 = Agree; 3 = Disagree; 4 = Don’t Know)

1. Evaluation and research findings are actively used in HIV/AIDS/STD policy formulation and planning.
   Comments:

2. A formal evaluation component currently exists within the National AIDS/STD Control Programme.
   Comments:

3. Special studies are undertaken as needed to improve the HIV/AIDS/STD programming.
   Comments:
VI. LEGAL AND REGULATORY ENVIRONMENT

Please read the following statements regarding the HIV/AIDS/STD legal and regulatory environment. Indicate the degree to which you agree or disagree with each statement.

(Scoring: 1 = Strongly agree; 2 = Agree; 3 = Disagree; 4 = Don’t Know)

1. Condom advertising is allowed. Comments:

2. Laws to protect people living with HIV/AIDS exist. Comments:

3. Mandatory HIV testing (e.g. for housing, visa, marriage, insurance) is not required. Comments:

4. Policy exists to ensure confidentiality for HIV testing. Comments:

5. Current import regulations facilitate condom procurement. Comments:

6. Current import regulations facilitate procurement of STD drugs. Comments:

7. There are no legal restrictions on condom distribution. Comments:

8. Unethical AIDS laws (quarantine, incarceration, discrimination) have not been enacted. Comments:

9. Law prohibits harassment of high-risk groups (such as commercial sex workers, men having sex with other men, intravenous drug users). Comments:

10. HIV/AIDS is a mandatory reportable disease. Comments:

11. NGO registration procedures are clear, straightforward and fair. Comments:

12. There are no restrictions on who may receive STD services. Comments:

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VII. PROGRAM COMPONENTS

Please read the following list of program components and indicate the degree to which NACP provides leadership?
(Scoring: 1 = Strong leadership; 2 = Weak leadership; 3 = Plays no role; 4 = Don’t Know)

1. Guidelines for universal blood screening.
   Comments:

2. Guidelines to reduce the risk of transmission of HIV to health workers.
   Comments:

3. Promotion and monitoring of accurate reporting by the media.
   Comments:

4. A functioning logistics system for reproductive health commodities for STD/HIV/AIDS related (such as STD drugs, HIV test kits and condoms).
   Comments:

5. Guidelines for social marketing of condoms.
   Comments:

6. Guidelines for social marketing of STD drugs.
   Comments:

   Comments:

8. Targeting of vulnerable groups.
   Comments:

9. Confidential testing and counseling available on demand.
   Comments:

10. A functioning surveillance system.
    Comments: