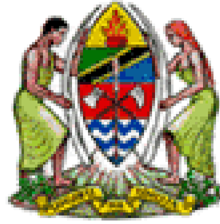

THE UNITED REPUBLIC OF TANZANIA

COUNTRY PROGRESS REPORTING

[PART A: Tanzania Mainland]

March 30, 2012

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Dr. Fatma Mrisho
Executive Chairperson
Tanzania Commission for HIV and AIDS

Acronyms

ABCT	AIDS Business Coalition Tanzania
AIDS	Acquired Immune Deficiency Syndrome
AMREF	African Medical Research Foundation
ANC	Antenatal Care
ARV	Anti-Retroviral Drugs
CARF	Community AIDS Response Fund
CBHC	Community Based health Care
CHACs	Council HIV and AIDS Coordinators
CIDA	Canadian International Development Agency
CSOs	Civil Society organizations
CSW	Commercial Sex Worker
DCR	District and community Response
DNA-PCR	Deoxyribonucleic Acid – Polymerase chain reaction
EID	Early Infant Diagnosis
FBOs	Faith Based Organizations
GFATM	Global Fund to fight AIDS, TBN and Malaria
HDT	Human Development Trust
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug Users
IEC	Information, Education and Communication
MDAs	Ministries, Departments and Agencies
MES	Monitoring and Evaluation System
M&E	Monitoring and Evaluation
MKUKUTA	*Mkakati wa Kukuza Uchumi na Kupunguza Umasikini Tanzania* (National Economic Growth and Poverty Reduction Strategy)
MoEVT	Ministry of Education and Vocational Training
MoHSW	Ministry of Health and Social Welfare
MSM	Men Having Sex with Men
MTCT	Mother to Child Transmission of HIV
MSD	Medical Stores Department
MVC	Most Vulnerable Children
NACP	National AIDS Control Programme
NACOPHA	National Council of People Living with HIV and AIDS
NMSF	National Multi Sectoral Strategic Framework on HIV & AIDS
OVC	Orphans and Vulnerable Children
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PER	Public Expenditure Review
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission of HIV
RFA	Regional Facilitating Agency
RFE	Rapid Funding Envelope
PWID	People Who Inject Drugs

STI	Sexually Transmitted Infections
TACAIDS	Tanzania Commission for AIDS
TB	Tuberculosis
TDHS	Tanzania Demographic and Health Survey
THIS	Tanzania HIV Indicator Survey
THIMS	Tanzania HIV and Malaria Indicator Survey
TMAP	Tanzania Multi-sectoral AIDS project
TANESA	Tanzania Essential Strategies Against AIDS
TOMSHA	Tanzania Output Monitoring System for HIV & AIDS
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
VCT	Voluntary Counseling and Testing
WB	World Bank
WHO	World Health Organization

1. Status at a Glance

1.1 The inclusiveness of the stakeholders in the report writing process

The process started with an initial meeting of all key stakeholders to discuss and agree on the process including responsibilities and work plan for development of the Global AIDS Response Progress Report for both `Tanzania Mainland and Zanzibar. Technical support was provided by UNAIDS, WHO and UNICEF. In close collaboration with the National AIDS Councils (NACs) of Tanzania Mainland and Zanzibar , the Coordination role of the M&E Advisor from UNAIDS Tanzania country office was initiated by making a presentation on the Guidelines for Construction of Core Indicators for monitoring the 2011 Political Declaration on HIV/AIDS which covered:

- Implementation at National level
- Core Indicators for Global AIDS response progress reporting

A technical team lead by TACAIDS for Mainland & ZAC for Zanzibar collected the data for the core indicators and undertook a documentary review of the relevant documents provided by the stakeholders. The analysis of the core indicators and the information obtained from the documentary review informed the narrative part during the drafting of the report. The draft report was presented to all stakeholders in a three-day workshop for further inputs, validation and consensus building.

The key stakeholders were collectively engaged in all the processes at every stage. Besides the government Ministries, Departments and Agencies (MDAs), other representatives included members from the multi-and bilateral donor support coordination group, the Development Partner Group (DPG)/ HIV/AIDS. In addition to Civil Society involvement, the process also involved active engagement and participation of the National Council of people living with HIV and AIDS (NACOPHA) in Tanzania Mainland and the Zanzibar Association of People Living with HIV/AIDS (ZAPHAR+).

1.2 The status of the epidemic

The 2010 country's projected total population was 43 million (NBS, 2010). The majority of the population is relatively young with 44% being under the age of 15 years. Fertility rates are high at 5.4% (THDS 2010). Mainland Tanzania faces a mature, generalized HIV and AIDS epidemic. HIV prevalence among adults 15-49 years of age was estimated at 5.7% (2007-08 Tanzanian HIV/AIDS and Malaria Indicator Survey (THMIS). Among the female and male population aged 15-24, the HIV prevalence is estimated at 3.39% and 1.39% respectively in 2012.[1]

The overall prevalence of HIV infection among voluntary blood donors decreased from 2.6% in 2009 to 1.6% in 2010. The HIV prevalence among males and female blood

[1] Estimates using Spectrum Version 4.47

donors was 2.6% and 2.4% in 2009 and 1.6% and 1.7% in 2010 respectively, showing a slight difference in HIV prevalence among males and female blood donors.[2]

Population based data for key populations are still lacking in Tanzania. The only data available is from sample based survey done in Dar es Salaam, City in Temeke District in 2011. Findings from this study show that among People Who Inject Drugs (PWIDs), overall 93 (34%) tested HIV positive. Among these 69 (29.9%) are males while 24 (66.7%) are females. Overall 74 (27.7%) tested HIV antibody positive, including 64 (27.7%) males and 10 (27.8%) females. Concurrent HIV and HCV seropositivity in 45 (16.9%) PWID overall, including 35 (15.2%) males and 10 (27.8%) females.

The number of people living with HIV is estimated at 1,434,003 (Year 2012), which is a small increase from the estimated 1,428,512 in 2010.[3] The HIV population among the under 5 (1-4) years population is estimated to be 66,233 i.e. 31,659 Males and 32,775 Females in 2012.[4] Furthermore, based on data from a surveillance study of Female Sex Workers (FSW) in Dar es Salaam, the HIV prevalence was 31.4% among Female Sex Workers (FSWs) compared to10.4% among the women in the general population of Dar es Salaam.[5]

1.3 Policy and programmatic response

The country has taken two important measures to strengthen policy implementation that have direct implications to the HIV/AIDS national response. One is the development of the "Global Health Initiative Strategy 2010-2015 and the PMTCT Strategic Plan. These two national responses are aligned to the Tanzania mainland policy and programmatic responses currently being implemented, which includes the third *Health Sector Strategic Plan* (HSSP III, 2009 – 2015), which was developed in line with the goals of the *National Strategy for Growth and Poverty Reduction* (MKUKUTA II), 2010/11 to 2014/15, the *National Health Policy* 2007, and the MDGs.

Building on over four decades of partnership and collaboration between the Governments of the United Republic of Tanzania (URT), civil society and the United States (USG), the five year Global Health Initiative (GHI) in Tanzania represents an opportunity to contribute further to Tanzania's development goals in health. The GHI vision is to improve the health of all Tanzanians, and especially the health of the most vulnerable groups of women, girls, newborns, and children under the age of five.

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[2] URT, 2011, HIV/AIDS/STIs Surveillance Report. Report Number 22 (Draft). National Aids Control Program (NACP), Ministry of Health and Social Welfare (MOHSW)
[3] Ibid.
[4] Spectrum Estimates, 2012
[5] Ministry of Health and Social Welfare,, 2011, HIV Behavioral and Biological Surveillance Survey among Female Sex Workers in Dar es Salaam, 2010. National Aids Control Program (NACP, Dar es Salaam)

Under URT guidance, partners will coordinate technical assistance across service delivery platforms and projects to strengthen health facilities' capacity to provide a full range of services at multiple contact points with clients. These include HIV care and treatment and maternal and child health clinics. Project elements include: the incorporation of FP/RH integration into existing provider training; updated quality assurance guidelines; consistent commodities and supplies; and inclusion into district-level URT planning and budgeting systems [*Ibid*].

The GHI supports implementation of the HSSP III. The HSSP III includes eleven strategies that cover specific health service delivery areas as well as four cross-cutting components of quality, equity, gender, and governance. Strategic objectives include increasing access to decentralized healthcare; reducing the healthcare financing gap; improving maternal, newborn, and child health; and strengthening social welfare, communicable and non- communicable disease services, including HIV/AIDS, TB, malaria, and substance abuse services.

Gender is a GHI priority in Tanzania. Interventions under GHI to address quality health services, health system strengthening, and healthy behaviors will benefit the lives and health of all Tanzanians, with a special focus given to the vulnerable populations of women and girls. Under GHI, the USG will address gender issues through programming focused on harmful gender norms, gender-based violence, and gender inequities. Solutions will include male involvement and equitable access to services and resources, with linkages to non-health activities such as education and economic strengthening. A core objective of GHI is to improve health outcomes among women and girls. Improved Adoption of Healthy Behaviors including Healthcare-Seeking Behavior with Focus on Girls and Women will:

- Facilitate sustainable outcomes in GHI target areas and diseases by addressing cultural norms to empower women and increase men's positive involvement in decision making
- Contribute to demand creation for quality preventive and curative health services and serve as a critical component of multiple service packages, including HIV prevention and treatment adherence, MNCH, and FP/RH
- Link with health, education, governance, and agriculture platforms with a strong focus on women, girls, and gender equity, including increasing men's individual knowledge and skills
- Build on synergies across development sectors, moving away from supporting vertical disease-specific programs to more integrated and comprehensive health programming within the USG
- Enhance partnerships and resource leveraging with other non-USG stakeholders

So far the following interventions are implemented by the Ministry of Health to address the impact of (GBV) in relation to HIV/AIDS:[6]

- Management of life-threatening injuries
- Pregnancy tests and prevention
- Post exposure Prophylaxis (PEP) to prevent HIV Prevention
- Counseling for HIV, FP, STIs
- STI Treatment
- Referral for other services

In addition, a handful of promising interventions have been or are being implemented by NGOs. Yet, they are limited in scope and number.[7]

The implementation of the Health Policy Initiative (HPI) in Tanzania is also aimed at building an enabling environment for the scale-up of family planning/reproductive health (FP/RH) and HIV prevention, care, and treatment.[8] The project aims at strengthen the capacity of important actors such as parliamentarians, faith-based organizations (FBOs), civil society organizations, NGOs, networks of people living with HIV (PLHIV),women's groups, media, and youth to enhance advocacy for increased policy dialogue, government ownership, political commitment, accountability, and resource allocation for FP/RH and HIV programs. Growing awareness of the importance of gender to the success—or lack of success—of these programs has led to an increased emphasis on gender-based violence (GBV) in HPI's activities in Tanzania[9]

One important collaborative effort with the MoHSW and multisectoral, multinational, and collaborating partners is the development of draft GBV management guidelines. The guidelines address not only healthcare providers and clinical services, but also the responsibilities of the community, the police, legal system, and even of survivors themselves, for ensuring that other needed services are available, that survivors are safe when they seek services, and that all know what to do when GBV takes place. Part of this work included the

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[6] Ministry of Health and Social Welfare (MoHSW, 2011, Gender and Gender Based Violence Interventions in Reproductive and Child Health Section. Welfare Paper presented by Reproductive and Child Health Section, (RCHS), During the Commemoration of Women's Day Karimjee Hall, Dar es Salaam, Tanzania March 07, 2011

[7] Myra Betron, 2008, Gender-Based Violence in Tanzania: An Assessment of Policies, Services, and Promising Interventions, USAID, Health Policy Initiative

[8] The Health Policy Initiative in Tanzania is implemented by the Futures Group. It is funded by USAID/Tanzania through the mission's Health and Population Office (for family planning/reproductive health activities) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR)

9 USAID Health Policy Initiative, 2011, Health Project Initiative, Project overview , June 2011.Addressing Genders –Based Violence in Tanzania

establishment of a GBV Technical Working Group and provision of technical assistance to this group.[10] HPI/Tanzania has similarly collaborated with partners to develop GBV policy guidelines that outline roles and responsibilities among various sectors and levels for expanding and improving the national GBV response[11]

Under TACAIDS leadership, costing of the NMSF (2008-2012) has been completed. Accordingly, an average cost of $852 million per year will be required to implement the NMSF, excluding prevention interventions. Costing of the National HIV Prevention Strategy is also close to conclusion. When initial findings from the two processes are combined, the total annual cost for the national response is approximately $1.14 billion per year. This translates into US$26.32 per capita or $920 per PLHIV.[12]

Table 1.1: Indicator data in an overview table

Indicator	**TARGET 1: Reduce sexual transmission of HIV by 50 per cent By2012**	**2008**	**2009/10**	**2012**
Indicator	**Indicator Description**	**Reporting Years**		
		2008	**2010**	**2012**
1.1	Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	No Data Available	No Data Available	40.2%
1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	10.49	No Data Available	10.5

10 Ibid.

11 Ibid.

[12] REPOA 2011, REPOA, Assessment of the Impact of HIV & AIDS on the economy in Tanzania, Cited in United Republic of Tanzania and The United States of America, 2010, Partnership Framework Implementation Plan: A Five-year Cooperative Plan in Support of the Tanzanian National Response to HIV and AIDS, 2009-2013 Between the Government of the United Republic of Tanzania and the Government of the United States of America December 8, 2010

1.3	Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	12.22	No Data Available	12.8
1.4	Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months and who report the use of a condom during their last intercourse	48.76	No Data Available	34.6%
1.5	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	18.9	No Data Available	35.4
1.6	Percentage of young people aged 15-24 who are living with HIV	No Data Available	6.77	2.44
1.7	Percentage of sex-workers reached with HIV prevention programmes	No Data Available	No Data Available	No Data Available
1.8	Percentage of sex workers reporting the use of a condom with their most recent client	No Data Available	No Data Available	No Data Available
1.9	Percentage of sex workers who have received an HIV test in the past 12 months and know their results	No Data Available	No Data Available	No Data Available
1.10	Percentage of sex workers who are living with HIV	No Data Available	No Data Available	No Data Available
1.11	Percentage of men who have sex with men reached with HIV prevention programmes	No Data Available	No Data Available	No Data Available
1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	No Data Available	No Data Available	No Data Available

1.13	Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	No Data Available	No Data Available	No Data Available
1.14	Percentage of men who have sex with men who are living with HIV	No Data Available	No Data Available	No Data Available
	TRAGET 2: Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015			
2.1	Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	No Data Available	No Data Available	No Data Available
2.2	Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	No Data Available	No Data Available	No Data Available
2.3	Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	No Data Available	No Data Available	No Data Available
2.4	Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	No Data Available	No Data Available	No Data Available
2.5	Percentage of people who inject drugs who are living with HIV	No Data Available	No Data Available	No Data Available
	Target 3. Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths			
3.1	Percentage of HIV-positive pregnant women who receive	55	68	71.12

	antiretrovirals to reduce the risk of mother-to-child transmission			
3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	18	26.5	29.06
3.3	Mother-to-child transmission of HIV (modeled)	No Data Available	No Data Available	18.31
	Target 4. Have 15 million people living with HIV on antiretroviral treatment by 2015			
4.1	Percentage of eligible adults and children currently receiving antiretroviral therapy	55	55.2	No Data Available
4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	No Data Available	64.54	70.74
	Target 5. Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015			
5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	No Data Available	29.68	25.97
	Target 6. Reach a significant level of annual global expenditure (US$22-24 billion) in low- and middle-income countries			
6.1	Domestic and international AIDS spending by categories and financing sources	No Data Available	No Data Available	No Data Available

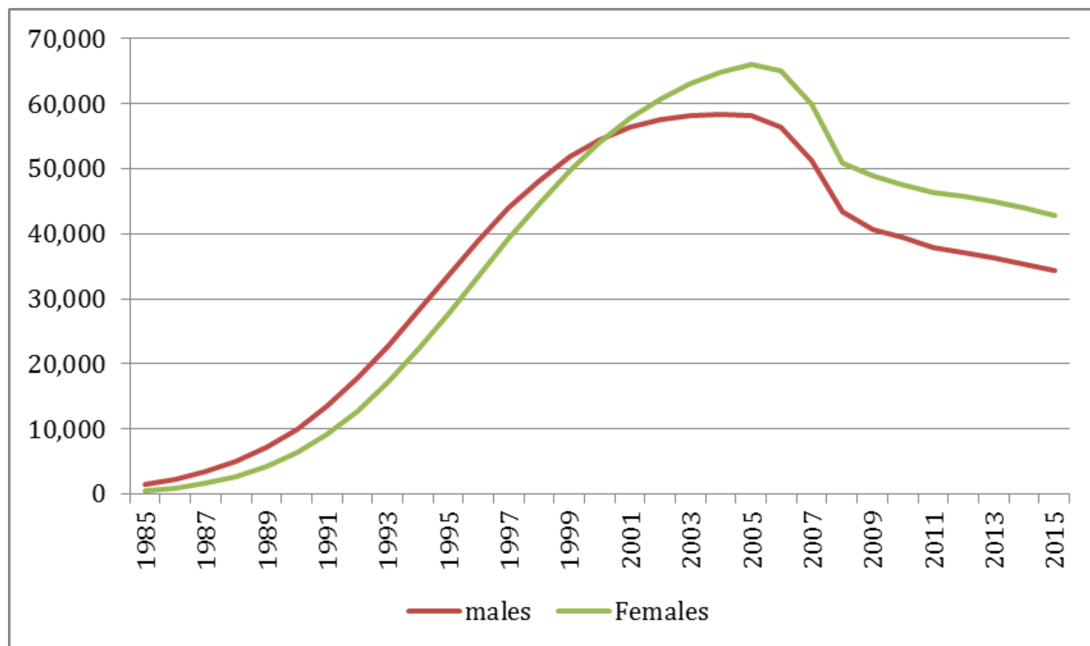
	Target 7. Critical enablers and synergies with development sectors			
7.1	National Commitments and Policy Instruments (NCPI) (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)			
7.2	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	No Data Available	No Data Available	No Data Available
7.3	Current school attendance among orphans and non-orphans aged 10–14	40.23	No Data Available	2.7% ie 225,264 out of 8,363,386 pupils in Primary level education in 2011 [Data is 7-13 yrs & Source: Basic Education Statistics in Tanzania. Ministry of Education and Vocational Training]
7.4	Proportion of the poorest households who received external economic support in the past 3 months	16	No Data Available	No Data Available

2 Overview of the AIDS epidemic

2.1 HIV/AIDS in the General Population

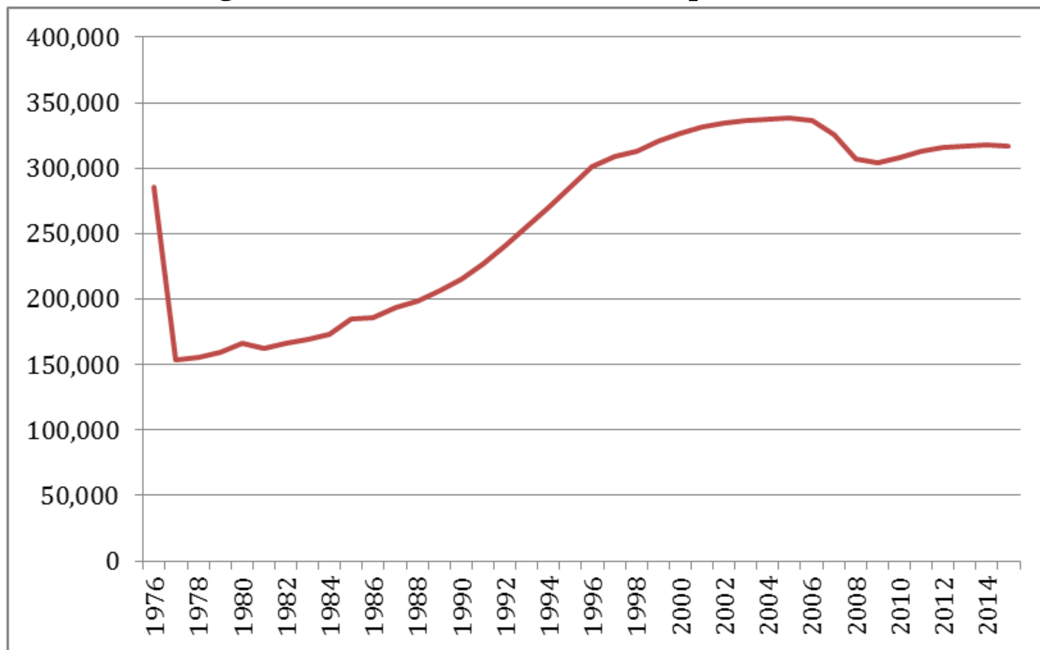
Estimated annual AIDS deaths are decreasing over time (Figure 2.1), which is an indication of significant effectiveness of the national response to HIV over the last years. Deaths due to AIDS are estimated to take a steep decline by 2015resulting into a significant decline of estimated number of orphans of below 350,000 annually.(Figure 2.2).

Figure 2.1: Estimated Annual AIDS Deaths



Source: 2012 Spectrum Estimates

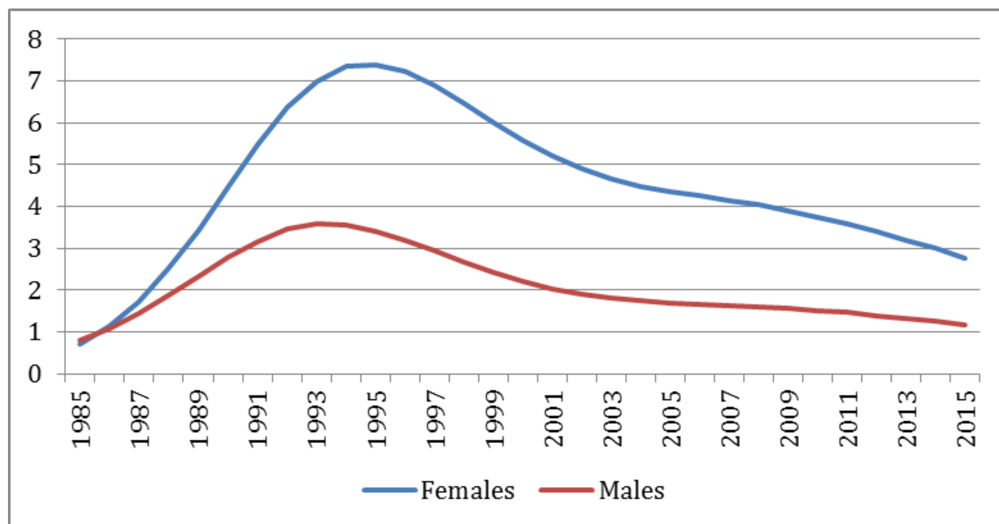
Figure 2.2: Estimated Number of Orphans



Source: 2012 Spectrum Estimates

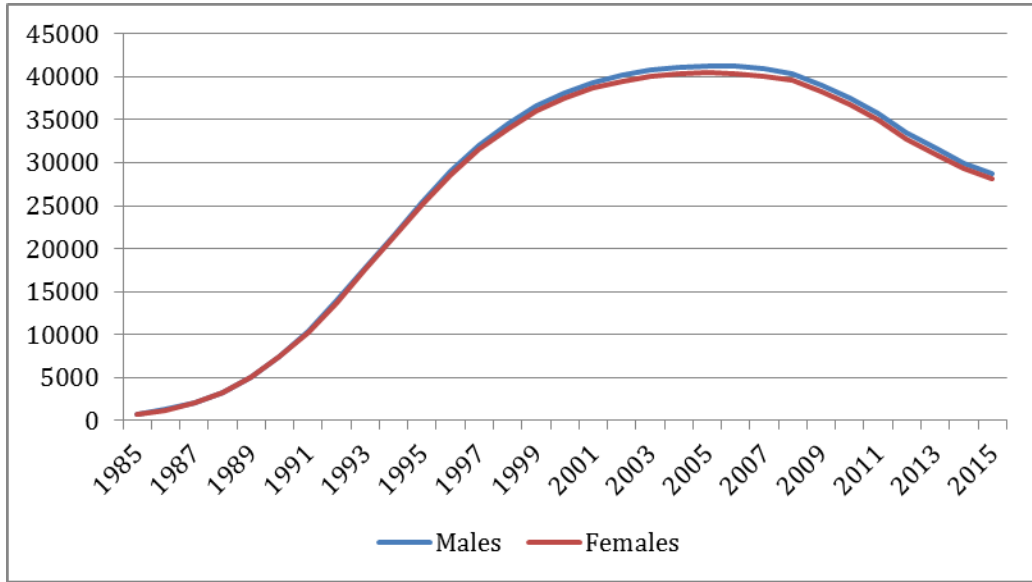
Prevalence of HIV is low among the male population as compared to the female population (Figure 2.5). HIV prevalence is also projected to continue taking a downward trend as we approach the year 2015. This projection again suggests positive effectiveness of the national HIV response. If the country will sustain the momentum, HIV prevalence will be brought down to below (3.5%) and (2%) among the female and male population respectively.

Figure 2.3: Estimated HIV Prevalence Rate among the (15-24) Age Group



Source: 2012 Spectrum Estimates

Figure 2.4: HIV Population (1-4) - (Total) (Males & Females)

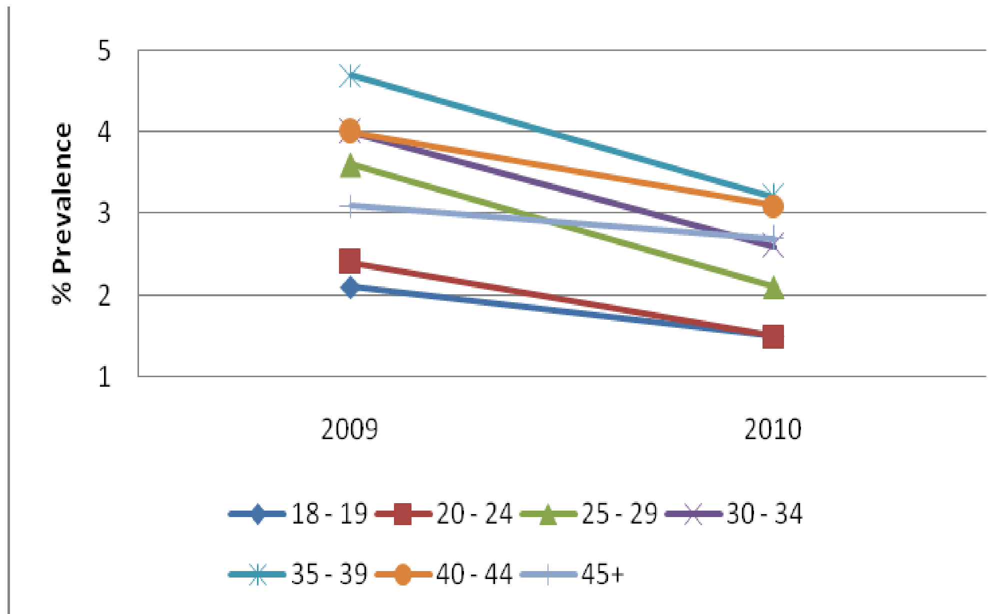


Source: 2012 Spectrum Estimates

The overall prevalence of HIV infection among voluntary blood donors decreased from 2.6% in 2009 to 1.6% in 2010[13] (See Trends in Figure 2.5). The HIV prevalence among males and females blood donors was 2.6% and 2.4% in 2009 and 1.6% and 1.7% in 2010 respectively, showing a slight difference in HIV prevalence among males and females blood donors.

[13] URT, 2011, HIV/AIDS/STIs Surveillance Report. Report Number 22 (Draft). National Aids Control Program (NACP), Ministry of Health and Social Welfare (MOHSW)

Figure 2.5: Comparison of age specific prevalence of HIV infection among voluntary blood donors for the period 2009 and 2010



Source: URT, 2011, HIV/AIDS/STIs Surveillance Report. Report Number 22 (Draft). National Aids Control Program (NACP), Ministry of Health and Social Welfare (MOoHSW)

2.2 HIV/AIDS among the Key Populations

2.2.1 Female Sex Workers (FSW)

Population based data on female sex workers (FSW) are still lacking in Tanzania. However, data is available from the HIV Behavioral and Biological Surveillance Survey among Female Sex Workers carried out in Dar es Salaam in year 2010[14]. Findings from this study revealed that HIV prevalence was high among FSWs.[15]

[14] Ministry of Health and Social Welfare,, 2011, HIV Behavioral and Biological Surveillance Survey Among Female Sex Workers in Dar es Salaam, 2010. National Aids Control Program (NACP, Dar es Salaam)

[15] The 2010 FSW surveillance survey used respondent-driven sampling to obtain samples of 537 FSWs aged 15 years and older in Dar es Salaam. RDS is a chain-referral sampling method designed to obtain probability-based samples of hard-to-reach populations. After obtaining an informed consent, respondents completed an interview, provided blood specimens to be tested for HIV, Hepatitis B (HBV), Hepatitis C (HCV), and Syphilis, and provided four vaginal swabs to be tested for Gonorrhea, Chlamydia, Bacterial Vaginosis and Candidiasis.

According to the HIV Behavioral and Biological Surveillance Survey among Female Sex Workers, HIV prevalence was 31.4%, much higher than that of women in the general population in Dar es Salaam (10.4%) [1]. Apart from the risk this poses to FSWs themselves, FSWs have multiple types of paying and nonpaying sexual partners who might provide a bridge for HIV transmission between FSWs, other high risk groups, and the general population. Reports of specific risk behaviors such as non-condom use depend considerably on sexual partner type i.e. a regular or a non-regular sex partner. In addition, the high prevalence of sexual and physical abuse by partners indicates that FSWs may not be able to make protective choices.

2.2.2 Injecting Drug Users

Findings from a quantitative sample survey study of 430 drug uses in Temeke District in Dar es Salaam Region (2011)suggests that injecting drug use is contributing to high rates of HIV transmission among drug using groups, with growing concerns of the potential for continued transmissions of HIV to non-drug using population. The study for instance, showed that among the twenty-five interviews conducted with 19 injectors, four smokers, and two key informants the most common routes of heroin administration in the district included intravenous injection and smoking. The study further established that the number of heroin users in Temeke by heroin users was 1,100; 650 PWID, 600 smokers as well as 313 sniffers. Borrowing a syringe previously used by another injector; sharing the same container; using a hidden or thrown away previously used syringe; frontloading (meaning using one syringe to transfer drug solution to another syringe); sharing one after another "half/half" with the same syringe; among others, are among potentially risky behaviors among this group.

The study shows a substantially higher HIV prevalence among both male and female PWID. Drug users aged 25 years and below reported a younger age of initiation (median age 17 years) and a shorter lag period between first use of heroin and first injection of heroin (median two years) compared to older participants (median age 20 years and median five year lag). These findings cement the targeting of drug education and prevention programs to younger populations, including programs designed to avoid transition from smoking to injecting heroin.

The study shows that there is no clear association between sexual risk behaviors and HIV among PWID. Transactional sex is a plausible explanation for the excess HIV observed in female drug users. Besides, inconsistent condom use was more prevalent among males than females with all partner types.

With regard to HIV and hepatitis seropositivity, Among People Who Inject Drugs (PWID), 93 (34.8) tested HIV, including 69 (29.9%) males and 24 (66.7%, 95%CI 22. 4-

33.5) females. Concurrent HIV and HCV seropositivity was detected in 45 (16.9%; 95%CI 12.6-21.9) PWID overall, including 35 (15.2%; 95%CI 10.8-20.4) males and 10 (27.8%; 95%CI 14.2-45.2) females. In that case, the study found that the potential co-infection among these drug using groups is of particular concern because of the known interactions between HIV and HCV and their disease progression and transmission dynamics.

2.3 Gender Based Violence

2.3.1 Gender Based Violence in the General Population

The TDHS 2010 shows that 20 percent of women have experienced sexual violence at least once within the last five years before the report. The likelihood of experiencing physical violence increases with the woman's age; from 13% for women age 15-19 to 25 percent for women age 25-29. Over one third of women who are divorced, separated, or widowed have experienced sexual violence, compared with 22 percent of women who are currently married and 11 percent of never-married women.

In the majority of cases, sexual violence is perpetrated by persons with whom the woman has a close personal relationship, either their current husband or partners (42 percent) or former husband or partners (18 percent) or current/former boyfriend (9 percent). It is worth noting that only 3 percent of sexual violence was committed by strangers. Women who have never been married reported that the main perpetrators of sexual violence are their fiends/acquaintances (32 percent) or current/former boyfriends (27 percent).

2.3.2 Gender Based Violence among Female Sex Workers (FSW)

According to the HIV Behavioral Female Sex workers study (2010), physical abuse by male clients and other sex partners; 51.7% of FSWs reported experiencing physical violence in the past 12 months. Among these, 33.3% reported being beaten by their clients. Almost one-third of FSWs (35.2%) having been forced to have sex and 66.0% of those who had been forced to have sex reporting being forced to have sex by their clients or.

Besides, abandonment by family or partner was common: 56.6% of women admitted they had been abandoned either before or after they became female sex workers (FSW) and over one-third (33.5%) were divorced, separated, or widowed. HIV prevalence was higher among FSWs who were widowed or divorced or separated.

3 National response to the AIDS epidemic

Achievements have been made in the national commitment and programme implementation as guided by the National Multisectoral Strategic frame work (NMSF2008-2012) in the four thematic areas; prevention, care, treatment and support, enabling environment and impact mitigation during the period January 2010–December 2011.

3.1 Prevention

3.1.1 Prevention of Mother to Child Transmission

Progress towards reduction of Mother to Child Transmission (MTCT) in Tanzania shows that 55% of women who were found to be HIV+ received any prophylaxis in 2010. This means that 45% of HIV+ pregnant women who have not accesed PMTCT servives had a potential transmission rate of about 35%. Tanzania is still using sub-optimal MTCT regimens; so the 55% who did receive treatment still have a transmission rate of around 20%. The current regimen (dual prophylaxis) only reduces the perinatal transmission rate partially and does not offer protection during breastfeeding. Since breastfeeding lasts on an average for about 22 months, it means that any regimen that does not provide prophylaxis during breastfeeding will have marginal success in preveting transmission to the baby and in reducing morbity for the mother.

Tanzania has developed and is currently implementing the Tanzania Elimination of Mother to Child Transmission of HIV plan, 2011-2015. The national PMTCT programme is based on the four-prong model recommended by the United Nations that includes;

1. Primary prevention of HIV for women of childbearing age
2. Prevention of unintended pregnancies among women living with HIV
3. Prevention of vertical transmission of HIV from mother to child:
    - HIV testing and counseling
    - Antiretroviral for preventing mother-to-child transmission
    - Infant feeding counseling and support
4. HIV Treatment, care and support for women living with HIV and their children:
    a. Increasing access to ART for pregnant women and children

b. Early diagnosis of HIV among infants

c. Co-trimoxazole prophylaxis for infants and children

Tanzania has adopted the WHO 2010 PMTCT recommendations and has opted for Option A. The policy directs that provider initiated testing and counseling of pregnant women should be promoted at all levels, and as far as possible this should include their spouses. In order to achieve this at facility level, PMTCT services are integrated into routine reproductive and child health services. The main areas of intervention include Counseling and testing, provision of ARV prophylaxis or treatment (during antenatal visits, Intrapartum and Postpartum), modified obstetric care and counseling for safer infant feeding options. Other services include Pediatric care for exposed children, monitoring and evaluation and linkage of HIV positive mothers and their families to HIV care and treatment clinics for continuum of care

By December 2010, 4,301 (93%) of Reproductive and Child Health RCH facilities had integrated PMTCT in routine ANC, delivery and Post natal care services; about 85% of estimated HIV infected among pregnant women and 57% of babies born to them received ARVs for PMTCT and 11% of pregnant women with advanced HIV infection were started on lifelong antiretroviral treatment.

Both HIV testing and syphilis testing are routinely offered to all pregnant women attending ANC and those that do not know their status during labor and post natal period. Health care workers providing MCH services are trained to provide a comprehensive package that includes PMTCT services. These integrated services are offered through static health facilities as well as during outreach and mobile ANC services. Mothers identified during the outreach ANC services are referred to next MCH facilities for follow up and delivery at health facility. ARV prophylaxis for mothers is provided at the ANC as well as maternity and baby prophylaxis is provided at maternity. Mothers who are diagnosed with syphilis are treated at the ANC using syndromic management.

New PMTCT guidelines have been developed. For effective implementation of the new PMTCT guidelines (2012), the country is moving towards provision of infant prophylaxis at RCH to increase access to that service among the infants. In addition, Tanzania is in the process of integrating ART into MCH services to facilitate access to treatment by HIV infected women. Moreover, family planning is being integrated into ART programme as well as other HIV services including counseling and testing to reduce unmet need for family planning for HIV infected women. Guidelines and protocols for integration have been developed and are being operationalized. Furthermore, there is more effort being put on provision of family planning at community level which will accelerate utilization by women at community level.

Evaluation indicates that the integration of PMTCT services within the child health/immunization clinics requires strengthening. This is evident by the low number of children accessing ARV prophylaxis and Early Infant Diagnosis (EID) services at two months as compared to the relatively high BCG immunization coverage rate of over 90%. High BCG coverage indicates that even those children that are born at home are brought back to facility for BCG at early stage but the system does not identify those exposed to HIV for administration of prophylaxis and follow up. There are missed opportunities for following up HIV exposed children through the child health services due to weak integration of the PMTCT programme into the child health services. Tanzania is working towards integrating these linkages for effective implementation of the new guidelines and strengthened follow up of HIV expose children.

Within this reporting period, Tanzania has also conducted a PMTCT bottleneck analysis The identified bottlenecks both from the supply side and demand side are:[16]

a. **Inadequate availability of human resources**
   Recruiting and retaining qualified and skilled health workers within facilities hampers the effective implementation of PMTCT. Only 35% of health facilities meet the staffing norm as per national guidelines. Most of the PMCT sites have only one staff trained in PMTCT and there are reports of high staff turnover. In most cases, the same health care worker is responsible for provision of other services within RCH and therefore faces increased workload

b. **Low access and availability of More Efficacious Regimen (MER) by all pregnant women and HIV exposed children due to high loss to follow up.**

So far PMTCT services are provided in 93% of the RCH facilities, but consistent utilization of these services is still low (Figure 3.1). The number of single ANC visits is high while the number of women who make at least four visits is low. According to the TDHS 2010, 98% of pregnant women attend ANC clinic at least once while the proportion of women of reproductive age who had at least 4 ANC visits during their current or last pregnancy is only 43%. Home delivery is common practice, with only fifty percent of births being delivered at a health facility, and 48 percent are delivered at home. Coupled with low frequency of ANC attendance, 15% of pregnant women are not accessing HIV testing services which contributes to higher risk of vertical transmission. The reasons for the low uptake of ANC services were on the supply side could be categorized either as supply side or demand side factor. On the supply side, attitude of

[16] United Republic of Tanzania, Ministry of Health and Social Welfare, 2010, Tanzania Elimination of Mother to Child Transmission of HIV plan, 2011-2015

healthcare workers being the major driver; and on the demand side the fallowing three factors are critical:

- Discouragement to attend RCH clinics by older women,
- Poor infrastructure for accessing health facilities and
- Stigma.

Though a significant proportion of pregnant women are reached by PMTCT services (76%) and counselled on infant feeding, only a half of infants (49%) are started on exclusive breast feeding within one hour after birth and significant proportion (98%) are breastfed up to six months with half of them on exclusive breast feeding (50%).

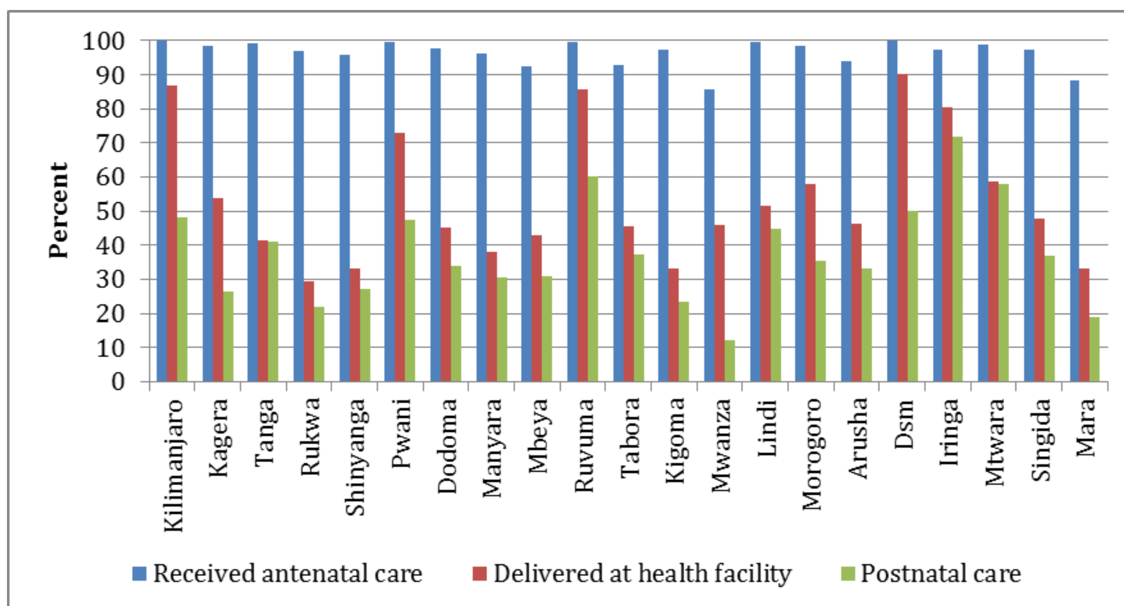
c. Non-functional CD4 machines and weak referral systems

A considerable proportion (24%) of HIV positive pregnant women miss the PMTCT opportunity and yet among those who attend RCH clinics only 21% are screened for ART eligibility and 24.6% of HIV positive pregnant women who are in need of ARVs for their own health do not receive the medications.

d. Insufficient Supply of ANC commodities at the public health care facilities

Adequate and timely supply of commodities remains a challenge. It is estimated that, there is a continuous interruption of supply of essential ANC commodities including HIV test kits in 30% of HFs. Besides insufficient PMTCT personnel, early infant diagnosis of HIV is also challenged by both frequent supply interruptions of DBS Kits, and PCR machines or lab-network and EID services in PMTCT facilities. As a result, 70% of health facilities do not provide EID services and 43% of HIV exposed infants do not receive any prophylaxis to prevent MTCT. On the other hand only 21% of HIV exposed infants access EID (PMTCT reports 2010). On the contrary, the immunization rates in Tanzania are high including BCG and yet the number of children accessing prophylaxis and EID is low. This shows a missing link between PMTCT and child services which lead to missed opportunities to identify HIV exposed children and follow them up. Limited facilities that offer EID also contributes significantly to lack of access to the services by children.

Figure 3.2: Antenatal care, deliverances at health facilities and postnatal care

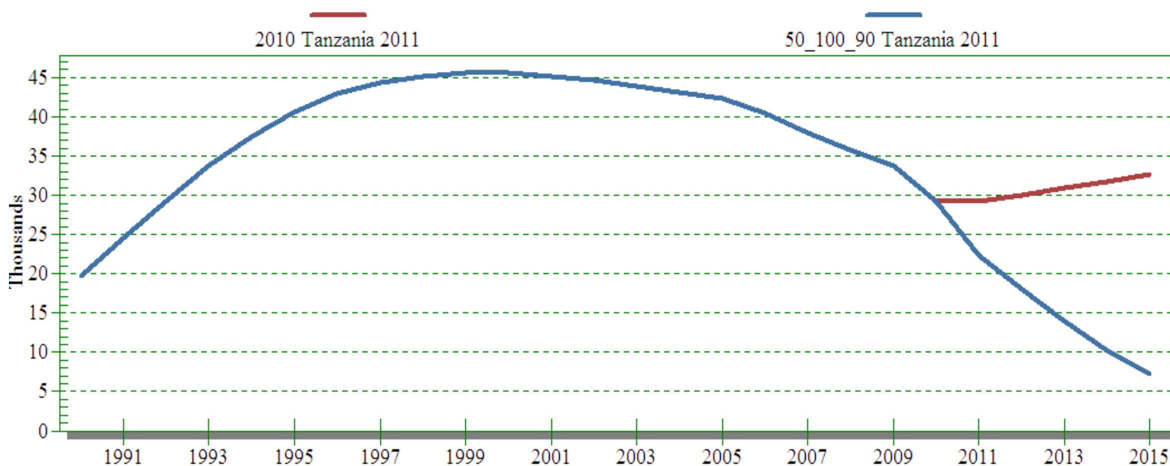


Source: Data from TDHS (2010)

3.1.2 What could be achieved with these Interventions: PMTCT Scenario Planning

Scenario planning using the Spectrum has been performed to estimate what could be achieved by 2015. The number of new child infections resulting from the base scenario is compared to estimates of new child infections in a scenario where the interventions are accelerated. An estimated 33,800 children were infected with HIV in 2009. If the interventions are scaled up between 2010 and 2015 there would be 7,200 new child infections in 2015, a 79% decline in the number of new child infections between the years 2009 and 2015 (see Figure 3.6).

Figure 3.3: Number of new child HIV infections due to mother to child transmission, by scenario, Tanzania



2010 –base scenario: 2009 programme coverage maintained through 2015

50_100_90 – intervention scenario: 50% reduction in HIV incidence, eliminates unmet need for family planning; provide ARVs or ART to 90% of women in need.

Interventions

The impact of staying at the current programme efforts compared to implementing the interventions simultaneously is described below for Tanzania.

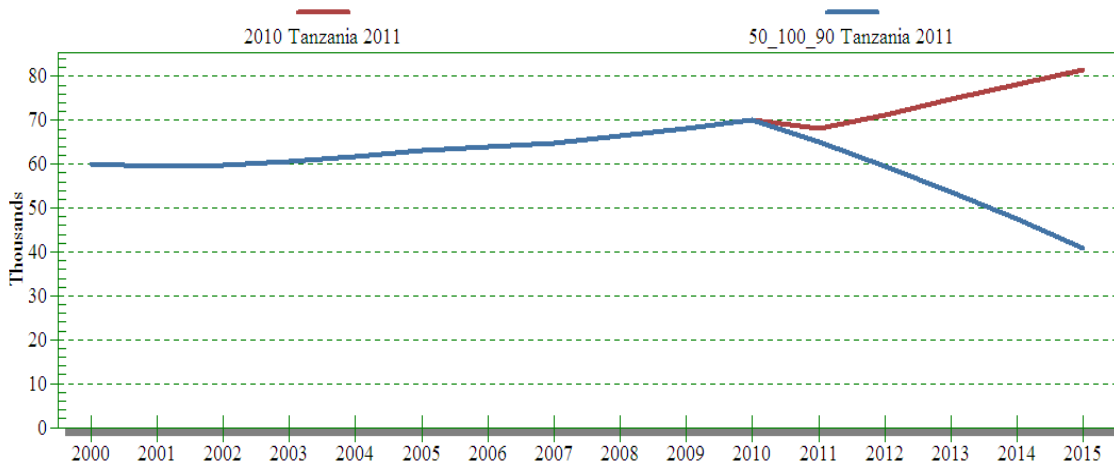
HIV[17] Incidence – prong

Based on surveillance data from Tanzania, including antenatal care sentinel surveillance and population based surveys, the country team created an incidence curve in Spectrum. That curve was used to define the HIV incidence and prevalence from the start of the epidemic until 2009.

In the intervention scenario the 2010 estimated HIV incidence is reduced by 50% between 2010 and 2015. The number of new infections among reproductive age women will be reduced from a projected 81,500 to 41,000 (see Figure 3.6).

[17] United Republic of Tanzania, Ministry of Health and Social Welfare, 2010, Tanzania Elimination of Mother to Child Transmission of HIV plan, 2011-2015

Figure 3.4: Number of new HIV infections among reproductive age women, by scenario, Tanzania



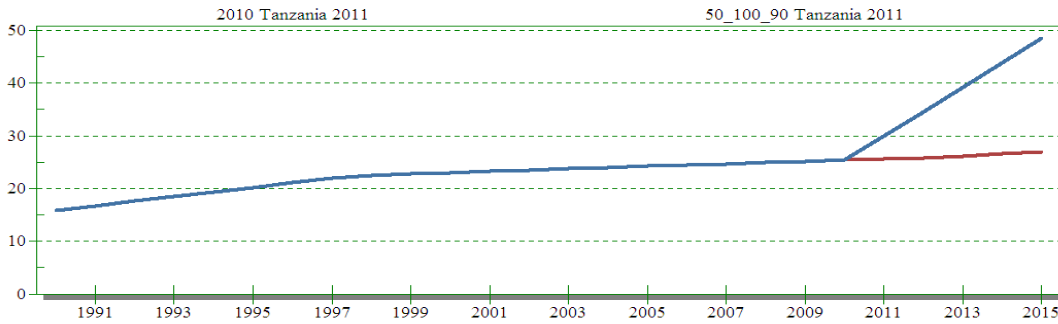
2010 – Base scenario: 2009 programme coverage maintained through 2015

50_100_90 –Intervention scenario: 50% reduction in HIV incidence, eliminate unmet need for family planning, provide ARVs or ART to 90% of women in need.

Family Planning – Prong

The family planning module in Spectrum is informed by recent national population based surveys. Based on survey data, approximately 22% of reproductive age women currently in a union, who are not using contraceptive methods, would like to delay or limit the number of births they have. By meeting 100% of unmet need, contraceptive prevalence will increase to 50% in 2015 (see Figure 3.7).

Figure 3.5: Contraceptive prevalence rate, by scenario, Tanzania



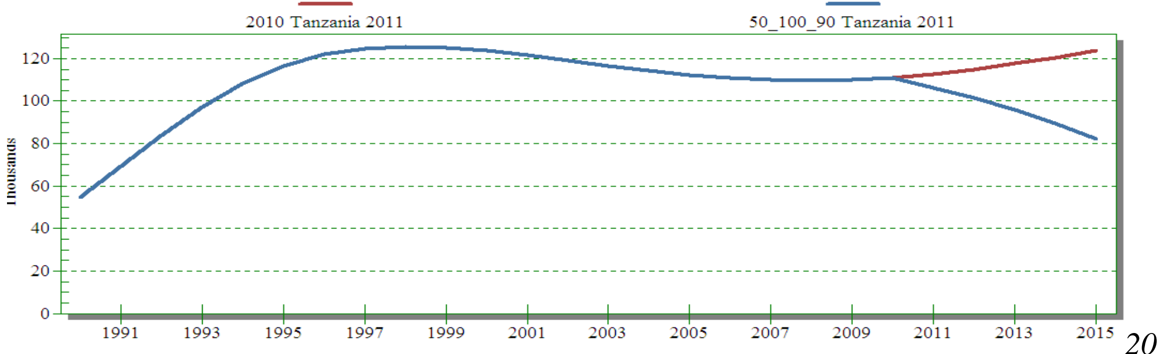
2010 –Base scenario: 2009 programme coverage maintained through 2015

50_100_90 – intervention scenario: 50% reduction in HIV incidence, eliminates unmet need for family planning; provide ARVs or ART to 90% of women in need.

Eliminating unmet need for family planning will reduce the number of births among all women (regardless of HIV status) from a projected 2,100,000 in 2015 to 1,600,000 in 2015

The 50% reduction in HIV incidence and meeting unmet need for contraception will reduce the number of births to HIV-positive women from a projected 123,800 to 82,100 (see Figure3.6)

Figure 3.6: Number of women living with HIV giving birth (women in need of PMTCT services), by scenario, Tanzania



2010 –Base scenario: 2009 programme coverage maintained through 201550_100_90 – Intervention scenario: 50% reduction in HIV incidence, eliminate unmet need for family planning, provide ARVs or ART to 90% of women in need.

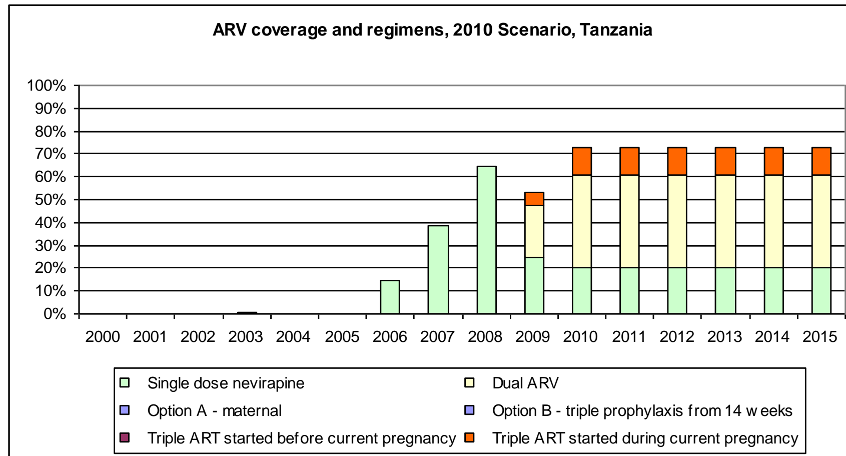
ART or ARV prophylaxis coverage and regimen – Prong 3

Based on data provided in the 2010 Tanzania Spectrum model and Universal Access Reporting, 73% of HIV-positive pregnant women received ARV prophylaxis in 2010. Over half of those women received single or dual prophylaxis with no post natal

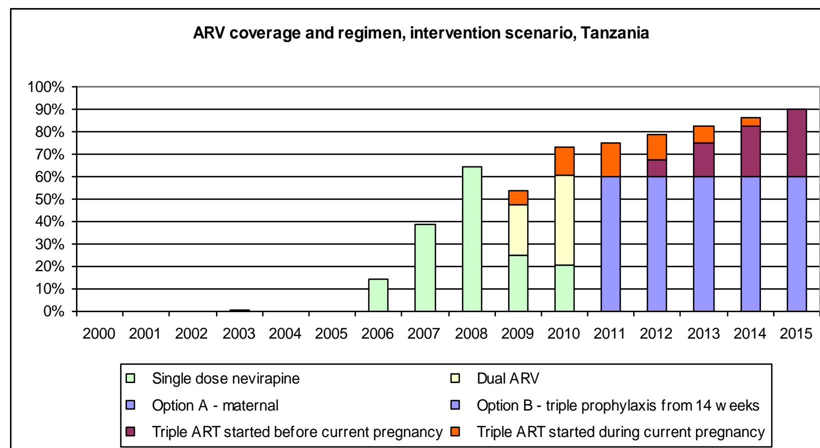
prophylaxis. In the base scenario (2010) it is assumed that the proportion and regimens of women receiving ARVs in 2010 is maintained through 2015 (see Figure 3.7a and 3.7b).

In the intervention scenario the ARV regimens are switched to follow the 2010 WHO recommended regimens (providing lifelong ART for women with CD4 levels below 350mm^3 or highly effective ARV prophylaxis from 14 weeks through the end of breastfeeding) and coverage is increased to 90% by 2015.

Figure 3.7a and 3.7b: Percent of women receiving ARV or ART by regimen, by scenario, Tanzania



In this scenario the 2015 regimen and coverage will result in 26% transmission rate.

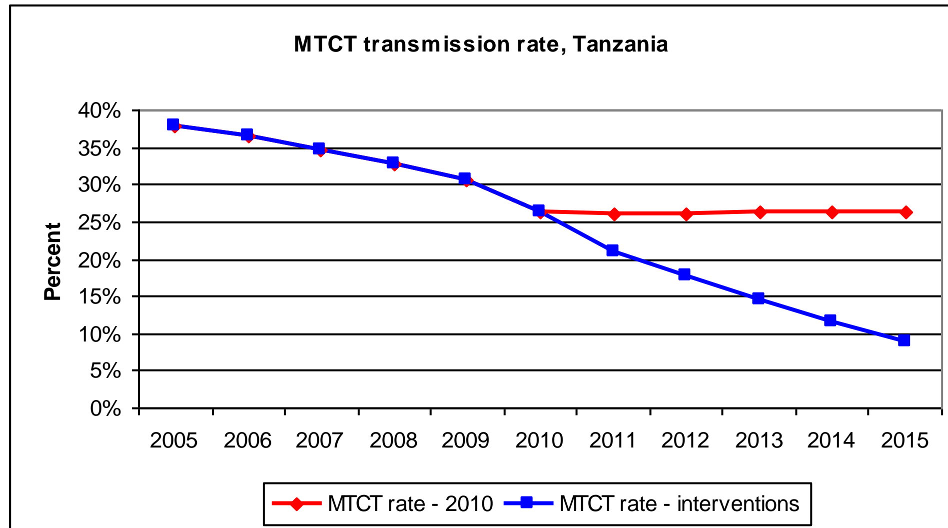


In this scenario the 2015 regimen and coverage will result in 9% transmission rate

The 2010 estimated mother to child transmission rate for Tanzania, including transmission during pregnancy, delivery and breastfeeding, is estimated to be 26%. This is primarily due to the low effectiveness of the regimens used, and the long duration of

breastfeeding. If the proposed interventions are implemented and taken to scale the transmission rate could go as low as 9% in 2015

Figure 3.8: Estimated mother to child transmission rate (including transmission during pregnancy, delivery and breastfeeding), by scenario, Tanzania



2010 –Base scenario: 2009 programme coverage maintained through 2015

50_100_90 –Intervention scenario: 50% reduction in HIV incidence, eliminate unmet need for family planning, provide ARVs or ART to 90% of women in need.

Safe infant feeding

There would be additional benefits if women in the PMTCT programme were encouraged to end breastfeeding and take up safe feeding alternatives at 6 months: New child infections would be reduced to 5,200 and the overall transmission rate would be reduced to around 6%.

Tanzania

	2009	2010	2011	2012	2013	2014	2015
Number of women in need							
Base scenario (2010 coverage)	110,100	111,000	112,500	114,800	117,600	120,600	123,800
Intervention scenario	110,100	111,000	106,100	101,300	95,800	89,300	82,100
Number of new HIV infections, reproductive age women							
Base scenario (2010 coverage)	68,100	70,200	68,100	71,100	74,900	78,300	81,500
Intervention scenario	68,100	70,200	65,000	59,600	53,800	47,600	41,000
Contraceptive prevalence rate (%)							
Base scenario (2010 coverage)	26	26	26	26	27	27	28
Intervention scenario	26	26	31	35	40	45	50
Number of women on ARV or ART							
Base scenario (2010 coverage)							
Single or dual	52,327	67,504	68,400	69,803	71,494	73,304	75,274
Highly effective prophylaxis	0	0	0	0	0	0	0
ART for their own need	6,506	13,554	13,725	14,007	14,346	14,709	15,104
Intervention scenario							
Highly effective prophylaxis	0	0	63,631	68,403	71,865	73,712	73,865
ART for their own need	6,506	13,554	15,908	19,001	21,560	23,454	24,622
Number of new child infections due to MTCT							
Base scenario (2010 coverage)	33,800	29,200	29,200	30,000	30,900	31,700	32,600
Intervention scenario	33,800	29,200	22,300	18,000	13,900	10,200	7,200
MTCT transmission rate (%)							
Base scenario (2010 coverage)	31%	26%	26%	26%	26%	26%	26%
Intervention scenario	31%	26%	21%	18%	15%	11%	9%

Table 3.1: Summary table of….

3.1.3 HIV Testing and Counseling

HIV Counseling and Testing (HCT) services have been provided by the public sector, NGOs and FBOs through health care facilities, stand-alone sites as well as mobile and outreach services.[18] This service includes three approaches, Voluntary Counseling and Testing (VCT), Provider Initiated Testing and Counseling (PITC), and Home Based Care Counseling and Testing (HBCT). The services are currently available in all Regions in Tanzania mainland. By December 2010, there were 2,137 established HIV Counseling and Testing (HCT) sites served by 5,002 trained counselors countrywide.

According to the DHS 2010, In Tanzania mainland, 59 percent of women age 15-49 and 43 percent of men age 15-49 have ever been tested for HIV, and 55 percent of women and 40 percent of men have been tested at some time and have received the results of their HIV test. Three in ten women and 25 percent of men were tested for HIV in the year preceding the survey and received the results of their test. These figures are much higher

[18] Prime Minister's Office, 2011, National HIV/AIDS Response Report 2010m for Mainland. TACAIDS, Dar es Salaam, Tanzania

than those recorded in the 2004-05 TDHS (6 percent of women and 7 percent of men) and in the 2007-08 THMIS (19 percent of women and 19 percent of men), suggesting that Tanzanians are increasingly aware of opportunities for testing and learning their HIV status. Overall, 64 percent of women who gave birth in the two years preceding the survey received HIV counseling during antenatal care, and almost all of these women also received post-test counseling (63 percent). Over half of the women (55 percent) had pretest counseling and then an HIV test, after which they received the test results.

There are a number of challenges experienced by health care providers of HIV testing and counseling services in the country. The major ones are listed below: [19]

- Irregular supply of HIV test kits
- Limited recognition of the benefits of HTC among the general population
- HTC services not considered as a priority intervention to be included for resource allocation in the Comprehensive Council Health Plans (CCHP).
- Lack of skills to provide services to special groups such as the deaf, blind, disabled and children
- Limited infrastructure and weak referral systems after post counseling services
- Lack of effective support mechanisms, e.g. a functional post-test support system
- Ineffective recording and reporting system and
- Stigma

3.1.4 Condom Delivery

A national survey on the availability of male and female condoms at retail outlets and service delivery points has not been conducted. Population Services International (PSI) has conducted a survey to establish product availability through measuring access and performance project in 2010 to measure market penetration in rural, urban and high risk places. The survey revealed that the availability of socially marketed condoms at high risk outlets increased from 81% to 86% between 2009 and 2010.

In the year 2010, by December 2010, the number of condoms distributed by implementers i.e. PSI, Medical Stores Department (MSD) and Tanzania Marketing and Communication Company Limited (TMARC) were 76.2 Million Male condoms and 572,490 Female condoms to end users.

[19] URT, 2011, HIV/AIDS/STIs Surveillance Report. Report Number 22 (Draft). National Aids Control Program (NACP), Ministry of Health and Social Welfare (MOHSW)

Table 3.2: Condom Distribution by Implementers (2010)

Implementing Organization	Number of Condoms Distributed	
	Female	Male
PSI	572,490	73,291,248
MSD	9,274,320	23,941,100
TMAC	540,360	13.630.320
Total	**10,387,170**	**110,862,668**

3.1.5 Workplace HIV Prevention and Care Policies and Program

Currently, a policy does exist, developed by POPSM in 2006, and would soon be reviewed. TACAIDS in collaboration with POPSM is developing a checklist for monitoring MDA performance. Some public and private institutions have already developed HIV/AIDS programs and policies and some are in the process of implementation

3.1.6 Donated Blood Safety

In order to ensure blood safety, Tanzania established zonal blood transfusion centers in 2004. Between 2009 and 2010, only 33.7% of blood units collected in the ZBTC was screened for HIV as per WHO quality assurance procedures.

3.1.7 Development of Strategies/Action Plans for HIV Prevention

Administratively Tanzania mainland consists of 25 Regions. The Tanzania HIV and Malaria Indicator Survey (THMIS) 2007/08 showed high HIV prevalence above national average in some of the regions. In May 2010, TACAIDS, in collaboration with United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA), organized a prevention prioritization meeting with 10 regions that were considered to be high prevalence regions. Participants discussed and defined the potential drivers of the epidemic in regions with high HIV prevalence and developed regional strategies/action plans that were to be in line with the National Multisectoral HIV Prevention Plan[20]. The regional strategies/action plans were aimed at addressing the major drivers of the epidemic.

As reported in the previous UNGASS Country progress reports, Tanzania Mainland faces a generalized HIV epidemic. The main drivers of the epidemic in the high prevalence regions were identified and classified as follows:[21]

a. **Behavioral drivers**: Among others include the following:

[20] TACAIDS, GIZ, and Tanzania and American Partnership to Fights HIV/AIDS (2010). Tanzania Regional Triangulation, Mbeya and Iringa RegionHIV/AIDS Data Synthesis Project. Final Report
[21] Ibid.

- unsafe sexual behaviors,
- increased alcoholic consumption,
- stigma,
- discrimination and denial,
- low and inconsistent condom use,
- polygamy, multiple concurrent partners, and
- Widow inheritance. Low rate of male circumcision.

b. **Structural drivers, or biomedical drivers**: Among others includes the following:

- low coverage of youth and workplace interventions,
- unsafe practices of traditional healers,
- Low participation of people living with HIV/AIDS (PLHIVA).

3.2 Care, Treatment and Support

In the area of care and support, the country's national response over the reporting period has been guided by the Health Sector HIV/AIDS Strategic Plan (HSHSP-2) which runs from 2008 to 2012 and includes thematic areas covering care and treatment and health systems strengthening. Interventions in the thematic areas include provision of services in health facilities and the community, laboratory strengthening, surveillance, operational research, and public health evaluations. In order to facilitate entry to care and treatment services, new HIV testing approaches such as provider-initiated testing and counseling (PITC) and home-based counseling and testing (HBCT), have been introduced in several regions.

Up to December 2010, the number of health facilities providing and reporting HIV care and treatment services were 825 (Table 3.3). The cumulative number of clients enrolled in HIV care was 740,040. This number of clients accounted for 31% of the 2,344,969 country's estimated PLHIV in Table 3.3 below.

So far available data shows that the percentage of adults and children who remain on treatment twelve months after the initiation of ARV show no substantial difference (between 74% and 78% for adults and between 79% and 83% for children.[22] It has been note that the number of patients who remain on treatment in the subsequent years tend to drop between 65% to 70% for adults and 72% to 77% for children.[23]

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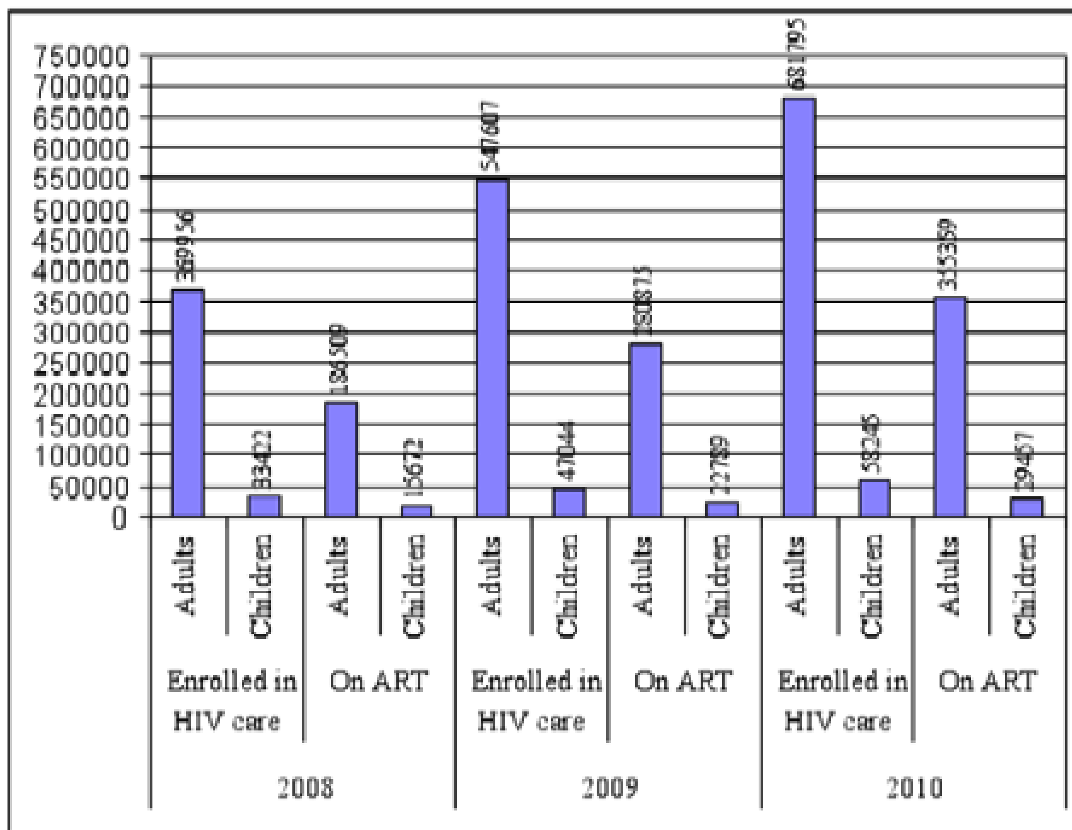
[22] Prime Minister's Office, 2010, National HIV/AIDS Response Report: Tanzania Mainland.TACIDS, Dar es Salaam, Tanzania
[23] Ibid.

By the end of 2010, the number of adults and children with advanced HIV infection receiving antiretroviral therapy was 53% [355,359 Adults and 29,457 Children}. Furthermore, the total number on care was 740,040, and among those enrolled on care i.e. 681,795 were adults and 58,245 children.

Figure 3.9: Cumulative Number of Clients Enrolled in HIV Care and on ART (Dec.



2008-Dec. 2010

The diagram above indicates that the modest increase in adults accessing ART is not matched by children accesing ART between the 3 years of reporting – state reasons and strategy for addressing this challenge

Table: 3.3: Population statistics, number of care and treatment facilities, HIV prevalence, and number of clients enrolled in HIV care and those on ART by regions up to December 2010

1	2	3	4	5	6	7
REGION	**Regional Population 2009**	**HIV Prevalence (THMIS-2007/08)**	**Estimated PLHIV (Based on HIV prevalence rates)**	**Reporting C&T facilities**	**Clients enrolled in HIV Care by Dec 2010**	**Clients on ART by Dec 2010**
Arusha	1,701,464	1.4	23,820	51	28,275	16,268
Dar es salaam	3,354,070	8.9	298,512	65	123,345	72,513
Dodoma	1,992,149	3.3	65,741	34	21,072	13,120
Iringa	1,659,588	14.7	243,959	45	82,039	44,595
Kagera	2,518,475	3.4	85,628	47	28,948	13,880
Kigoma	2,331,352	0.9	20,982	29	12,791	5,433
Kilimanjaro	1,543,464	1.9	29,326	41	31,364	15,559
Lindi	872,188	3.9	34,015	53	15,221	6,640
Manyara	1,350,850	1.7	22,964	27	8,794	4,862
Mara	1,626,838	5.3	86,222	36	24,178	13,001
Mbeya	2,443,879	7.9	193,066	51	73,580	36,137
Morogoro	2,106,188	4.2	88,460	33	28,386	16,327
Mtwara	1,269,864	3	38,096	60	19,091	9,668
Mwanza	3,667,941	5	183,397	34	55,546	25,286
Pwani	1,049,728	5.3	55,636	28	23,212	9,985
Rukwa	1,462,469	4.5	65,811	20	15,784	7,803

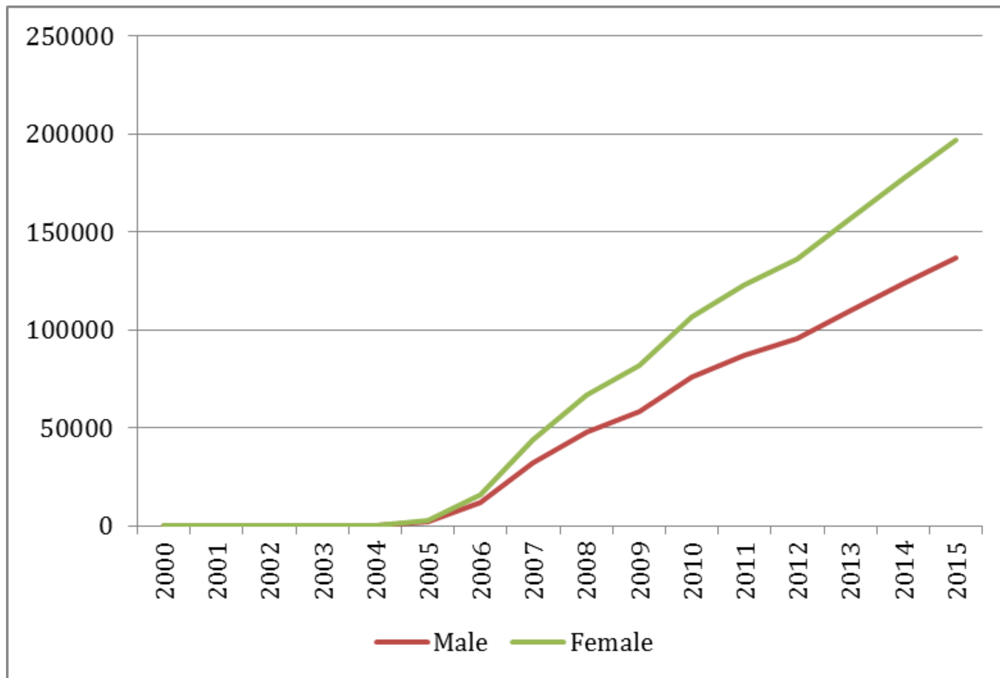
1	2	3	4	5	6	7
REGION	**Regional Population 2009**	**HIV Prevalence (THMIS-2007/08)**	**Estimated PLHIV (Based on HIV prevalence rates)**	**Reporting C&T facilities**	**Clients enrolled in HIV Care by Dec 2010**	**Clients on ART by Dec 2010**
Ruvuma	1,327,959	5.4	71,710	28	25,755	13,337
Shinyanga	3,521,477	7.6	267,632	46	44,831	21,644
Singida	1,278,963	2.6	33,253	28	9,860	5,788
Tabora	2,200,484	6.1	134,230	33	37,702	15,842
Tanga	1,860,422	3.8	70,696	36	30,266	17,128
TOTAL	**41,139,812**	**5.7**	**2,344,969**	**825**	**740,040**	**384,816**

Source: URT 2011,

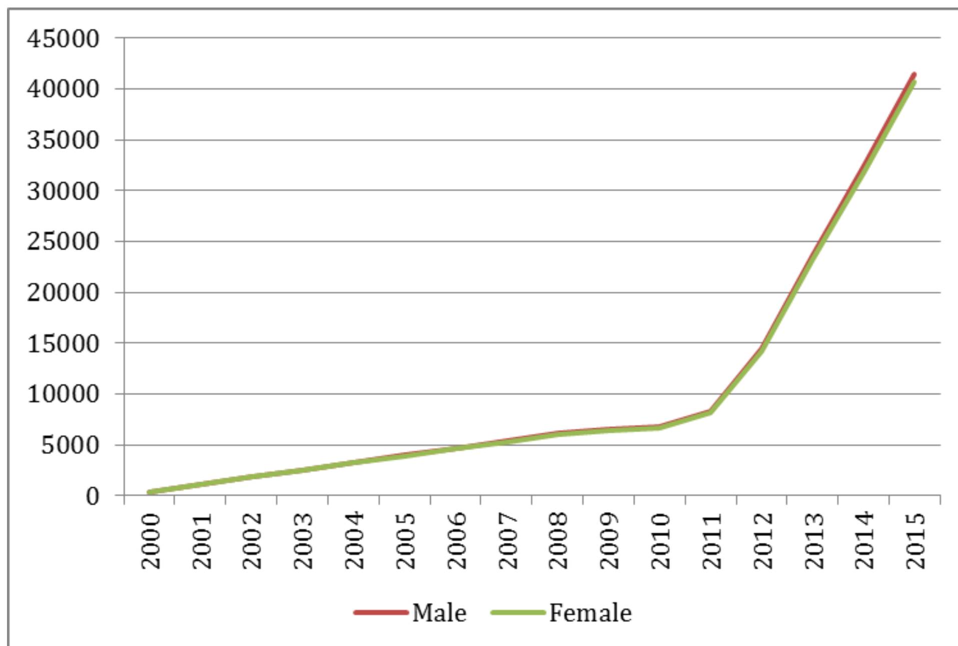
Available data shows regional variation in the number of clients enrolled in HIV care. The lowest number was 8,794 in Manyara region and the highest was 123, 345 in Dar-es-Salaam region. By December 2010, a total of 384,816 patients had ever started on ART, representing 51.9% of all clients enrolled in HIV care and treatment in this period.

Furthermore, in Arusha region, the number of patients ever on ART (28,275) is higher than the estimated 23, 820 HIV infected persons. Similarly, in Kilimanjaro region, the number of clients enrolled in HIV care (31,316) is higher than the estimated 29, 326 persons. The observed pattern is probably related to under-estimation of HIV prevalence in these regions. In contrast, estimated number of PLHIV in Iringa is remarkably high compared to actual clients enrolled in care during this reporting period. In overall, the projected number of people receiving ART is expected to increase as one moves towards the year 2015 as indicated on the tow graphs below (Figure10 and 11). Among the age group >15, more women are expected to receive ARTs as compared to men, while among the children below 15 years, the rate of increase in the number of those receiving ART is projected to be almost similar for both the female and male population.

Figure 3.10: Number receiving ART (Aged >15 yrs.)



3.11: Number receiving ART (Aged <15 yrs.)

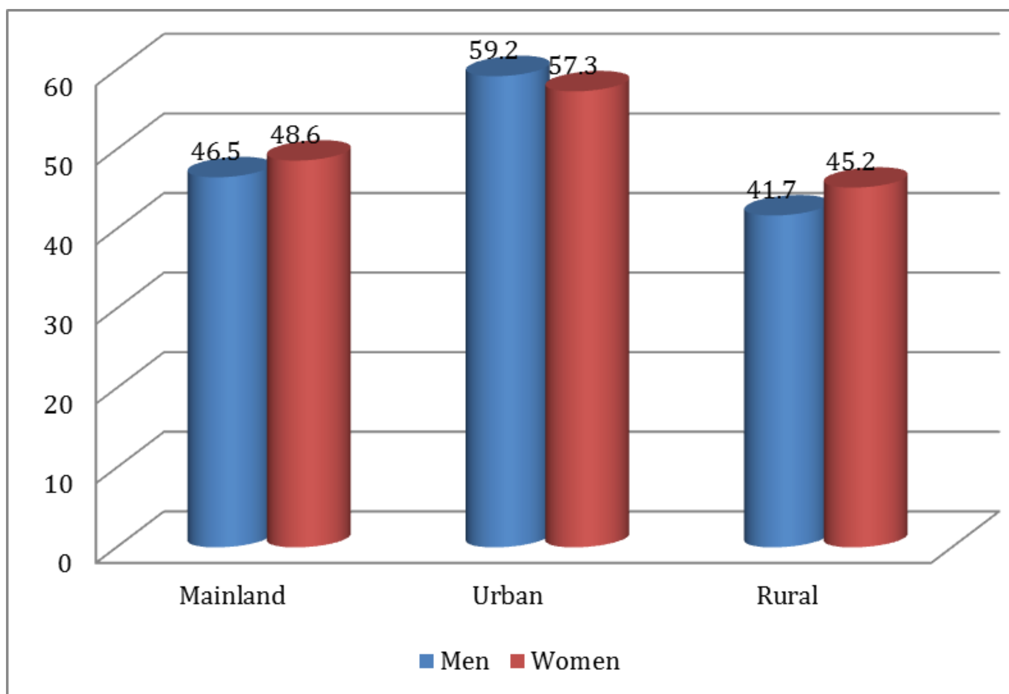


3.3 Knowledge and Behavior Change

The TDHS 2010 provides the most recent population based data with regard to knowledge and behavioral change. Accordingly, knowledge of AIDS is currently widespread in Tanzania, with 99 percent of respondents having heard of AIDS. At least 95 percent of all respondents, regardless of background characteristics, have heard of the epidemic.

Less than half of the respondents have comprehensive knowledge of HIV transmission and prevention methods: 48 percent of women and 46 percent of men. Comprehensive knowledge is lowest among young people age 15-24 (43 percent). Figure 3.2 provides a general picture of comprehensive knowledge of HIV.

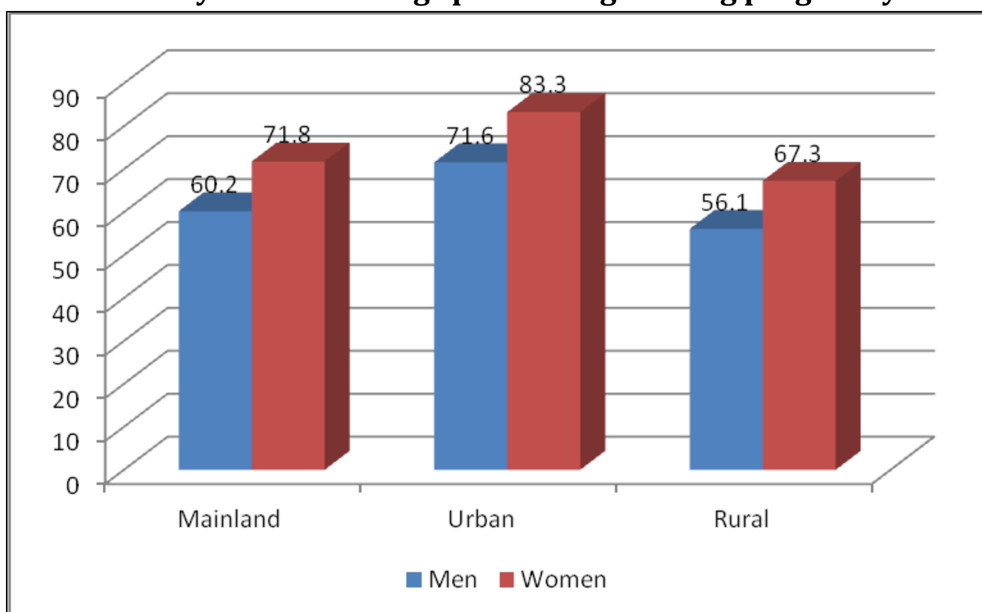
Figure 3.12: Percentage with a comprehensive Knowledge of HIV and AIDS:



Source: Data from the TDHS 2010

Increasing the level of general knowledge of HIV transmission from mother to child and reducing the risk of transmission using antiretroviral drugs (ARTs) is critical to reducing mother-to-child transmission (MTCT) of HIV during pregnancy, delivery, and breast feeding. The TDHS 2010 data shows that MTCT knowledge is 71.8 percent among women and 60.2 among men in the mainland.

Figure 3.13: Comprehensive MTCT knowledge: Percentage of Women and Men who know that HIV can be transmitted by breastfeeding and risk of MTCT can be reduced by mother taking special drugs during pregnancy



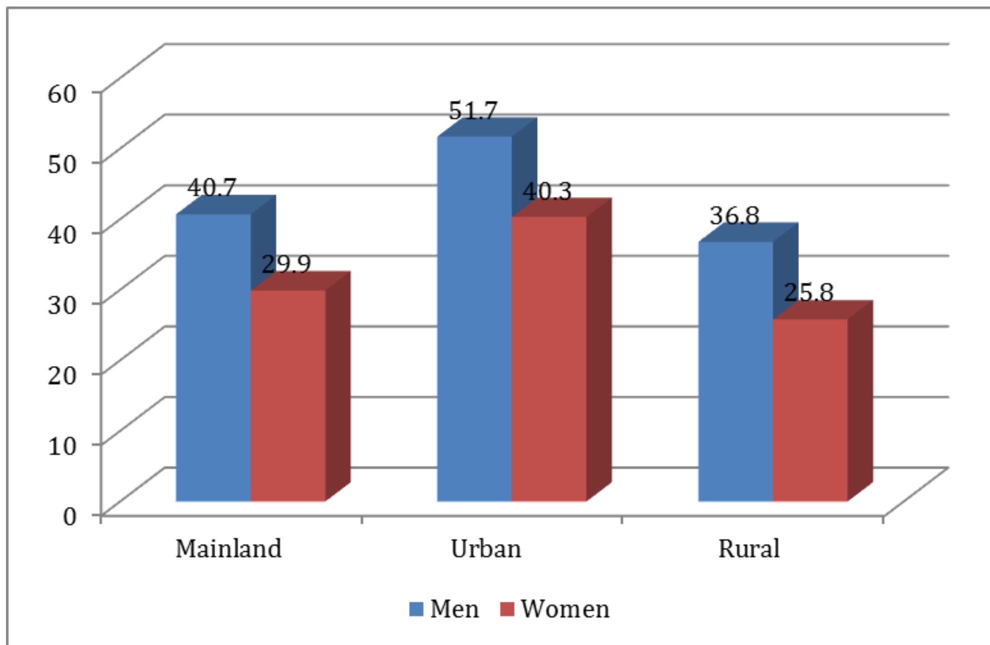
Widespread stigma and discrimination towards people infected with HIV or living with AIDS, are among factors that negatively influence both people's willingness to be tested for HIV and also their adherence to antiretroviral therapy. The TDHS 2010 includes reduction of stigma and discrimination as one of the important indicator for measuring success of programs targeting HIV/AIDS prevention and control. To assess survey respondents' attitudes towards people living with HIV/AIDS, respondents who had heard of AIDS were asked the following questions:

a. If they would be willing to care for a relative sick with AIDS in their own households,
b. If they would be willing to buy fresh vegetables from a market vendor who had the AIDS virus,
c. If they thought a female teacher who has the AIDS virus but is not sick should be allowed to continue teaching, and
d. If they would want to keep a family member's HIV positive status secret.

In Tanzania Mainland, 30 percent of women and 41 percent of men show acceptance in all four indicators. Among women, the highest rate of acceptance is in the Eastern zone (39 percent), and the lowest is in the Lake and Southern zones (22 percent). Among men, the highest rate of acceptance is in the Central zone (54 percent), and the lowest is in the Lake zone (30 percent), Respondents in urban areas are one and a half times as likely as

those in rural areas to show acceptance on all four indicators. Education and wealth are correlated with positive attitudes towards those who are HIV positive. Women and men with higher educational attainment and in wealthier households are more likely than other respondents to accept all four indicators.

Table 3.14: Accepting attitude towards those living with HIV/AIDS: Percentage expressing acceptance attitudes on all four indicators



The HIV Behavioral and Biological Surveillance Survey among Female Sex Workers provide the following findings regarding knowledge and behavioral change among the FSW:[24]

- FSWs reported several different partner types. Almost three-quarters of FSWs (72.6%) reported having a steady nonpaying partner, while 20.4% reported having casual nonpaying partners. FSWs reported a median of three clients on their last day of work.
- Rates of condom use varied markedly by partner type with relatively high condom use with clients: 83.3% of FSWs reported using condoms the last time they had sex. Consistent condom use ("always used a condom") was highest with regular clients (68.1%) and lowest with steady partners (29.9%). The most common reason reported by FSWs for not using a condom was partners' objection to using one or being paid more for unprotected sex.

[24] Findings based on a Sample Study of FGSW in Dar es Salaam City where the HIV Behavioral and Biological Surveillance Survey Among Female Sex Workers was done

- Drug Use by FSW and clients: Non-injection drug use was common, though injection drug use was rarely reported; 61.1% of FSWs had ever used drugs, and 1.3% had ever injected drugs. Having a partner who injected drugs or whose injection drug use was unknown was associated with HIV infection. Most of FSW (67.7%) had used alcohol in the past 30 days prior to the survey day. Of these, 43.6% were using alcohol once or more than once a day.

3.4 Impact alleviation during the period January 2010–December 2011

According to the Basic Education Statistics (2010), total enrollment of students in secondary schools was 1,638,699, of which 910,171 are males and 728,528 are females. Out of the total number of students enrolled in secondary schools, 5.8% were orphans, of which 3,827 (40%) are female and 43,904 (52%) are male. In primary schools total enrollment in 2010, was 8,419,305 out of these 2.95?% are orphans of which 125, 290 (52%) are female and 115,172 (48%) are males.

The government of Tanzania in collaboration with implementing partners has undertaken a national community based identification process for the most vulnerable children (MVC). As of end December 2010, identification of the MVC was carried out in 91 councils out of 133 Councils.[25] A total of 813,270 (431,033 Male 382,237 Female MVC were identified. Seventy two percent (72%) of all the identified MVC had received at least one core service including health care, psychosocial support, food and nutrition, and educational support.

3.5 Financing the HIV/AIDS National Response

3.5.1 Introduction:

HIV/AIDS consumes a substantial amount of government budget. The amount contributed by the government is only 5% of the total expenditures of HIV/AIDS. The rest of it is contributed by Developing Partner[26]. In view of the declining world economy whereby support from Developing Partners is likely to decrease which has recently demonstrated by the Global Health Initiatives, the government needs to take necessary actions to prepare itself for any eventuality.

3.5.2 Expenditures:

Expenditures on HIV/AIDS have been rising rapidly by almost 60% between 06/07 and 08/09. The rise can be attributed to increasing activities that were meant to bring

[25] Prime Minister's Office, 2010, National HIV/AIDS Response, 2010. TACAIDS, Dar es Salaam, Tanzania

[26] Public Expenditure Review 2007-2009 HIV/AIDS Tanzania Mainland

awareness of the diseases to different sectors of the economy and increased health sector response attributed to increase in number of Voluntary Counselling and Testing centres and the introduction of the Anti-Retroviral Virus treatment.

The increasing expenditures are faced with the declining resources especially external resources. Examining the composition of the expenditures one finds that it is predominantly madeup of off budget expenditures of which the government may have limited discretion to plan and budget. The report on the HIV/AIDS Public Expenditure Review for June 2010 estimates that of the total resources for HIV/AIDS between 78% and 86% are off budget expenditures. The government may need to take decisive measure to address this matter, especially now when it is faced with decreasing resources to finance national HIV/AIDS activities.

3.5.3 Opportunities:

There are existing opportunities the government can utilise to mitigate the current financing shortfall that may likely be facing HIV/AIDS. First and foremost is the creation of HIV/AIDS Trust Fund which will have a great potential to generate resources that will enable to maintain the current activities at the same level even contributing in meeting the challenges of increasing demand for services.

Furthermore, the health basket fund with government discretion to allocate according to their priority is another widow of accessing resources for HIV/AIDS health sector response especially for activities planned by the Local government Authorities.

The off budget expenditures can contribute more efficiently and limit expenditures inefficiencies if it planned together with government resources. Reduction in these inefficiencies may contribute in adding resources for HIV/AIDS activities.

Last but not least the planned financial modelling that will examine the economic growth of Tanzania and its ability to finance HIV/AIDS activities using its budgetary provision is another opportunity that needs to be used effectively. This endeavour is undertaken by TACAIDS with the help of DANIDA.

4. Best practice

A number of important best practices in this reporting period could be acknowledged from Tanzania Mainland as follows:

i) Data from the key population have been lacking in the previous progress reporting. Tanzania has carried out a surveillance study for Female Sex Workers (FSW) in Dar es Salaam, the major city and main commercial center of Tanzania. The study provided critical information for informing programming and national response to this group of key population. A sample survey study has also been done in one District (Temeke District) in Dar es Salaam to obtain data from Injecting Drug Users (IDUs). At the same time, we are now having more interactions and information sharing among the key population groups through meetings and trainings that are on-going on sensitization of government officials on the understanding and planning for needs and concern for these populations, besides a major step has been the involvement of the members of the legal enforcers (police) who were very negative towards some of the key populations especially the MSM. Of course this would take time to reach a level that is required

ii) The year 2015 is only three years ahead. Without making concrete plan for guided action and interventions, meeting both national and global targets would be impossible. In order to meet the country's commitment and global targets on women and children with regard to HIV/AIDS, Tanzania mainland has developed a *Tanzania Elimination of Mother to Child Transmission of HIV plan, 2011-2015.* The main goal of this plan is to eliminate new HIV pediatric infections and keep mothers alive through improved maternal, newborn and child health and survival programmes by 2015 in Tanzania,

iii) The Development of an AIDS Trust Fund and

iv) Development of an HIV and AIDS National Gender Plan

v) There are two ongoing studies on MSM/Anal Sex and Know your epidemic/Know your response

5. Major challenges and remedial actions

The major challenges confronting the national response can be placed into two categories as follows:[27]

1. The national Multisectoral HIV/AIDS response demands involvement and commitment from all sectors – including partners and stakeholders who are not aware of the important role they play in realizing a holistic national response to the epidemic. Despite a coherent and comprehensive policy framework in place, it known by only few and has limited support. The HIV/AIDS response in the critical sectors such as trade, infrastructure, minerals and natural resources, fisheries and culture is still weak. Given the fact that the nature of activities carried out in these sectors contributes to the spread of HIV, these sectors are also highly affected by the epidemic.

2. Secondly; most of the funds for HIV and AIDS activities are off-budget and not captured by the Exchequer system of budget and reporting. Government's influence is limited on how the off-budget funds are spent; budget allocation is thereby not a steering tool for the Government. Expenditures are not publicly transparent and thereby not easily assessed as to how they align with the NMSF and the MKUKUTA targets. Though, the PER observed that the main off-budget funders are closely linked to the strategic framework and the spending could be assessed in accordance to the thematic areas of the NMSF

[27] Tanzania Commission for AIDS (TACAIDS), 2010, Public Expenditure Review 2007-2009 (HIV/AIDS), Tanzania Mainland

6 Support from the country's Development Partners

The Development Partners Group (DPG) in Tanzania comprises of 16 bilateral and 5 multilateral agencies (UN counted as one) working with the government and the people of Tanzania in their pursuit of a better future. [28]The group was established to promote principles of Aid Effectiveness in development assistance to Tanzania. This involves structured dialogue and engagement between Development Partners (DPs) and the government in high-level forums, through different sector and thematic groups and core reform with a view of achieving harmonization, promoting coordinated policy dialogue and reducing transaction costs in the management and administration of aid to Tanzania.

By and large, over 80% of HIV/AIDS funding in Tanzania over the 2012 reporting period remained largely dependent on Donor funding namely the PEPFAR and the Global Fund for AIDS, Tuberculosis and Malaria.[29] Other donors include the Governments of Japan, Sweden, Canada, Belgium, the Netherlands, Norway, the Clinton Foundation, and the United Nations Joint Program. PEPFAR supports a wide range of activities across care and treatment, prevention, impact mitigation, and cross cutting activities. Global Fund resources have been used for treatment, prevention, impact mitigation, and cross-cutting support as well, although like PEPFAR the largest portion of funding has supported care and treatment. For the Global Fund a larger percentage of treatment resources have supported drug and commodity purchases, while PEPFAR resources have supported service delivery. Round 8 and Round 9 Global Fund resources are intended for treatment (with a focus on drugs and commodities procurement) and health systems strengthening.[30]

The bilateral development partners are to a larger extent pooling their support to civil society through the Foundation for Civil Society or through the Rapid Funding Envelop – which both provide grant for a wide range of HIV projects carried out by local CBOs or CSOs[31]

The government of the United Republic of Tanzania (URT) and the Government of the United States of America (U.S. Government) signed a "Five-Year Partnership Framework in Support of the Tanzanian National Response to HIV and AIDS, 2009 – 2013". The Partnership Framework establishes six goals, and a subset of expected

[28] http://www.tzdpg.or.tz/external/dpg-tanzania/about-dpg-in-tanzania.html: Accessed on Wednesday, March 28, 2012
[29] (HIV/AIDS PER 2010
[30] Government of the United Republic of Tanzania (URT) and the Government of the United States of America (U.S. Government) signed a "Five-Year Partnership Framework in Support of the Tanzanian National Response to HIV and AIDS, 2009 – 2013".
[31] Public Expenditure Review for HIV/AIDS June 2010

contributions associated with each goal, that provide a fixed reference point for more detailed, iterative planning between the URT and U.S. Government through 2013. The six goals are:

1. Service Maintenance and Scale up
2. Prevention
3. Leadership, Management, Accountability, and Governance
4. Sustainable and Secure Drug and Commodity Supply
5. Human Resources
6. Evidence-based and Strategic Decision Making

In support of sustainable country leadership, the PFIP integrates five strategies across the six goals:

1. **Align planning and share information**. The need for aligned and coordinated planning applies to all partners contributing to the national response, including donors, civil society organizations, and the private sector, as well as to *multi-sectoral and intra-governmental efforts. Both Governments have endorsed the following broad-based efforts: formulation of national plans and service standards where* lacking, as a platform for harmonized planning, reduction of duplication, and quality assurance; movement toward centralized data systems and a unified national approach to M&E; and sharing timely and accurate financial information, to increase predictability of resource flows and enable appropriate planning. Development of the Partnership Framework and PFIP has already contributed to improved alignment and information sharing between the U.S. Government and URT. Future monitoring and adjustment of the PFIP under the aegis of established URT bodies (Tanzania National Coordination Mechanism (TNCM), Joint Thematic Working Group on AIDS (JTWG), and Zanzibar Chief Minister's Office (CMO)), should further contribute to these objectives.

2. **Transition select responsibilities to URT**. The two Governments recognize the need to gradually and responsibly move the URT toward increased programmatic and financial responsibility for the national HIV and AIDS response. The PFIP highlights several areas where the URT is expected to increase its management burden during the life of the Partnership. Most notably, transition of responsibility from the U.S. Government to URT is expected in the areas of procurement, blood and injection safety, and management of centralized data (reducing to the greatest extent possible the need for parallel reporting systems). The U.S. Government also plans to phase out investments in infrastructure concomitant with increased URT responsibility for this area. To facilitate transfer of responsibility without a reduction in quality, the U.S. Government plans to provide significant technical

assistance for implicated Tanzanian institutions. For example, the U.S. Government is putting in place mechanisms to strengthen the planning, oversight, and/or technical capacities of the Ministry of Health and Social Welfare (MOHSW), the Medical Stores Department, Regional Medical Offices, and Local Government Authorities (LGAs), among others. For its part, the URT intends to ensure that appropriate budgetary and management plans are in place and fully executed to facilitate transition. Furthermore, to assist the URT in encouraging the private sector to assume increased responsibility in responding to the HIV and AIDS epidemic, the U.S. Government plans to collaborate with the URT in developing public-private partnerships (PPPs) and testing and modeling ways of mobilizing private sector resources for the national response

3. **Support local/decentralized leadership and management capacity.** The need for effective national leadership to address the AIDS epidemic applies equally to regional and local levels. The two Governments propose several strategies to specifically increase the efficacy of decentralized actors in the response to HIV. These include support to integrate financial planning for HIV services into LGAs and Medium Term Expenditure Framework (MTEF) budgets; formalizing a coordination structure for civil society input to LGA planning and budgeting; strengthening district ownership and leadership on HIV and AIDS consistent with the Government policy of "Decentralization by Devolution"; piloting of U.S. Government direct contracting with LGAs; and building the capacity of Public Expenditure Tracking committees at the local level in order to increase sustainability and accountability.

4. **Increase the capacity of indigenous organizations**. While the URT may be expected to coordinate the national response to HIV and AIDS, non-governmental actors have vital roles to play to support services and hold government accountable, and similarly require concerted and sustained technical assistance, mentoring, and training support to realize their full potential. The U.S. Government intends to continue working with international partners to help ensure skills transfer to indigenous sub-partners in the areas of financial management, accounting, planning, monitoring and reporting; to build the capacity of PLHIV groups around internal organization and governance, coordination, and advocacy; and to enhance the technical capacity of civil society organizations (CSOs) to provide high-quality interventions. References to specific mechanisms for such capacity building activities can be found throughout Annex 1, especially under Goal 3 (Leadership, Management, Accountability, and Governance).

5. **Human resources issues prioritized for sustainability**. Of all the systems constraints hindering expanded country leadership on HIV and AIDS,

human resources issues are arguably paramount. Without adequate staffing for clinical and community-based services and programs, delivery systems and channels, and research and management functions, Tanzania cannot hope to reduce its dependence on external technical and financial assistance. Under the PFIP, the URT and U.S. Government intend to address the human resources crisis in Tanzanian by improving the URT's ability to produce qualified health and social welfare workers; supporting local government to improve recruitment, retention, and productivity of human resources for health; and emphasizing scale up of pre-service training.

CHAI supports care and treatment operations in two southern regions; PEPFAR covers the remaining regions. Funding from the Japanese International Cooperative Agency (JICA), and UNITAID is scheduled to end in the near term, although World Bank HIV and AIDS funding may continue in different form. CIDA and DANIDA support a pooled NMSF Fund which supports all Local Governments Authorities for non-medical, Multisectoral HIV and AIDS activities, while DANIDA supports capacity-building of TACAIDS and MSD. CIDA is also supporting a multi-donor health workforce initiative. The UN Joint Program provides capacity-building programming to national level institutions as well as targeted technical support, and is a major partner in the HIV and AIDS response in Zanzibar. The German Development Cooperation supports the HIV and AIDS response with a focus on the enabling environment and HIV prevention, contributing to condom social marketing and technical support at both regional and district levels in four regions. JICA supports STI control and VCT services including the provision of test kits.

Challenges experienced with regard to development partners' support include the following:

- Some development partners (DPs) do not channel funds through the Tanzania Government preferred mechanism
- Different budget cycles
- Uncertainty about future funding and
- Different reporting formats

7. Monitoring and evaluation environment

7.1 An overview of the Current Monitoring and evaluation (M&E) System

Mainland Tanzania is currently implementing a three year period "Tanzania National Multisectoral HIV/AIDS Monitoring and Evaluation Plan (2011-2013).[32] On a day-to-day routine basis, activities are monitored and data collected, then strategic information is compiled on a monthly basis. The routine monitoring information systems mainly focus on needs, service coverage and some limited amounts of behavioral trends. Within the health care delivery facilities, clinical data is collected and reported through the MoHSW, managed and coordinated by Health Management Information System (HMIS) and NACP through routine monitoring system. Within the community based interventions, non-medical HIV and AIDS data is collected by outreach workers and subsequently channeled to the national levels through TOMSHA. TOMSHA is coordinated by TACAIDS, EMIS monitoring system managed by Ministry of Education and Vocational Training (MoEVT) and NACOPHA MIS while at the same time the LGA Monitoring system is being strengthened to which TOMSHA will soon be fully integrated with.
On a periodic basis, surveys and surveillance are undertaken to generate information related to the NMSF implementation. These include ANC surveillance, THMIS, TDHS, workplace survey, and behavioral surveillance among selected key population groups. This strategic information concerns HIV related behavior, risk, vulnerability and impact. More detailed information generated periodically includes prevalence, vulnerability, risks, behavioral trends, demographic factors like size estimation, geographical locations, sexual networks, needs, service coverage and access factors. Research is also undertaken on priority basis as per the National HIV and AIDS Research and Evaluation agenda of 2010.

7.2 Challenges faced in the implementation of a Comprehensive M&E System;

In the development of the Multisectoral M&E Plan 2011-2013, the following challenges and gaps were identified by the stakeholders: [33]

a. Some indicators for key data sources like Ministry of Health and Social Welfare (MoHSW) and Ministry of Education and Vocational Training (MoEVT) had been

[32] TACAIDS, 2011, Tanzania National Multisectoral HIVAIDS Monitoring and Evaluation Plan (2011-2013)
[33] Ibid.

recently revised and therefore needed to be harmonized with the Multisectoral HIV M&E system

b. The UNAIDS UNGASS guidelines of 2010 revised some indicators and their protocols necessitating revision of the existing HIV M&E indicators and their protocols in Tanzania mainland as well.

c. Stakeholders are encountering gaps in information related to key populations, gender, human rights, male circumcision and networks of PLHIV

d. It was not feasible to generate data for other indicators due to constraints related to technical capacity or funds shortage and

e. UNAIDS published new guidelines for developing a comprehensive and Multisectoral M&E Plans in alignment to the 12 components of a functional M&E system in the year 2010.

Without reviewing and updating the M&E plan, the following threats were foreseen: (i) there would still be challenges concerning strategic information not always being available when needed; (ii) stakeholders would not be in a position to better understand the HIV epidemic with its driving factors as well as track the trends in areas related to gender, human rights and key populations; (iii) stakeholders would be unable to determine if their activities are on track to realize the set targets and desired results of the NMSF. These foreseen threats would therefore make it difficult to enhance accountability, learning and programming functions of the M&E system.

7.3 Remedial Actions Planned to Overcome the Challenges

Remedial actions planned to overcome the challenges include development of the HIV M&E Plan that would enhance harmonization and linkages with other HIV M&E information systems in Tanzania and the UNGASS indicators. Already the National Multisectoral HIVAIDS Monitoring and Evaluation Plan has been revised and updated to address and accommodate the key issues or challenges which were identified by stakeholders. Besides reinforcing the UNAIDS "*Three Ones Principle*" the Tanzania Multisectoral NIV/AIDS M&E Plan, the main purpose of 2011-2013 HIV/AIDS M&E Plan is to assess extent to which the goals contained in the strategic framework are achieved between the years 2011 to 2013. It avails critical data and strategic information used for expanding and scaling up provision of high quality HIV and AIDS services in the country. The strategic information is generated in a systematic and organized manner through the implementation of the M&E Plan.

COUNTRY ROGRESS REPORTING

[PART B: ZANZIBAR]

March 29, 2012

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Dr. Omar Shauri
Executive Director
Zanzibar AIDS Commission

Acronyms

ABCT AIDS	Business Coalition Tanzania
AIDS	Acquired Immune Deficiency Syndrome
AMREF	African Medical Research Foundation
ANC	Antenatal Care
ARV	Anti Retroviral Drugs
CARF	Community AIDS Response Fund
CBHC	Community Based health Care
CHACs	Council HIV and AIDS Coordinators
CIDA	Canadian International Development Agency
CSOs	Civil Society organizations
CSW	Commercial Sex Worker
DCR	District and community Response
DNA-PCR	Deoxyribonucleic Acid – Polymerase chain reaction
EID	Early Infant Diagnosis
FBOs	Faith Based Organizations
FSW	Female Sex Workers
GFATM	Global Fund to fight AIDS, TBN and Malaria
HDT	Human Development Trust
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug Users
IEC	Information, Education and Communication
MDAs	Ministries, Departments and Agencies
MES	Monitoring and Evaluation System
M&E	Monitoring and Evaluation
MKUKUTA	Mkakati wa Kukuza Uchumi na Kupunguza Umasikini Tanzania (National Economic Growth and Poverty Reduction Strategy)
MoEVT	Ministry of Education and Vocational Training
MoHSW	Ministry of Health and Social Welfare
MSM	Men Having Sex with Men
MTCT	Mother to Child Transmission of HIV
MSD	Medical Stores Department
MVC	Most Vulnerable Children
NACP	National AIDS Control Programme
NACOPHA	National Council of People Living with HIV and AIDS
NMSF	National Multi Sectoral Strategic Framework on HIV & AIDS
OVC	Orphans and Vulnerable Children
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PER	Public Expenditure Review

PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission of HIV
RFA	Regional Facilitating Agency
RFE	Rapid Funding Envelope
PWID	People Who Inject Drugs
STI	Sexually Transmitted Infections
TACAIDS	Tanzania Commission for AIDS
TB	Tuberculosis
TDHS	Tanzania Demographic and Health Survey
THIS	Tanzania HIV Indicator Survey
THIMS	Tanzania HIV and Malaria Indicator Survey
TMAP	Tanzania Multi-sectoral AIDS project
TANESA	Tanzania Essential Strategies Against AIDS
TOMSHA	Tanzania Output Monitoring System for HIV & AIDS
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
VCT	Voluntary Counseling and Testing
WB	World Bank
WHO	World `Health Organization
ZAC	Zanzibar AIDS Commision
ZACP	Zanzibar AIDS Control Program
ZAPHA+	Zanzibar Association of People Living with HIV/AIDS

1. Status at a Glance

1.1 The inclusiveness of the stakeholders in the report writing process;

1.2 The status of the epidemic;

In Zanzibar, the epidemic is concentrated, with HIV prevalence estimated at 0.6 percent in the sexually active population in 2011.[34] These estimates are similar to the data reported in the Tanzania HIV and Malaria Indicator Survey (THMIS, 2008). The findings suggests prevalence of HIV in Zanzibar has stabilized below (1%) over the last three years. Recent studies of most at risk populations (Key Populations) have estimated HIV prevalence for injecting drug users (IDUs), female sex workers (FSWs), and men who have sex with men (MSM) at 16.0%, 10.8%, and 12.3%, respectively.

1.3 The policy and programmatic response

Zanzibar's *Health Sector Reform Strategic Plan* (ZHSRSP II), which is based on the Zanzibar Strategy for Growth and the Reduction of Poverty, goes through 2011. The strategy is now being updated. This is a guiding document for the health sector. Through this document the Revolutionary government of Zanzibar recognizes, that the improvement of people's quality of life is essential to their ability to participate fully in their country's productive processes, thus placing the health sector as a government priority.

The Revolutionary Government of Zanzibar commits approximately 8% of its annual budget to the health sector. The majority of these funds are for government salaries and infrastructure. The health sector is expected to receive an increasing share of the government budget as indicated in the Zanzibar Strategy for Growth and Reduction of Poverty (ZSGRP). All ministries have a budget line for mainstreaming HIV and AIDS incorporated into their MTEF. The current estimated cost of the national response in Zanzibar to HIV and AIDS for FY2005/06 to FY2010/2011 is $52.8 Million. Annual national program estimates indicate overall program costs to be between $8 and $9 million per year. Combining domestic and development partner funding, an annual gap of $4 million is estimated for Zanzibar.

Though health issues are not union matters, however the United Republic of Tanzania in collaboration with the US Government is implementing a Global Health Initiative that covers both the Mainland and Zanzibar. Building on over four decades of partnership and collaboration between the Governments of the United Republic of Tanzania (URT), civil society and the United States (USG), the five year Global Health Initiative (GHI) in Tanzania represents an opportunity to contribute further to Tanzania's development goals in health. The GHI vision is to improve the health of all Tanzanians, and especially the health of the most vulnerable groups of women, girls, newborns, and children under the age of five. [Foot note]

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[34] Sentinel Surveillance Report (Draft 2011)

Under URT guidance, partners will coordinate technical assistance across service delivery platforms and projects to strengthen health facilities' capacity to provide a full range of services at multiple contact points with clients. These include HIV care and treatment and maternal and child health clinics. Project elements include: the incorporation of FP/RH integration into existing provider training; updated quality assurance guidelines; consistent commodities and supplies; and inclusion into district-level URT planning and budgeting systems. [Ibid]

The GHI supports implementation of the HSSP III. The HSSP III includes eleven strategies that cover specific health service delivery areas as well as four cross-cutting components of quality, equity, gender, and governance. Strategic objectives include increasing access to decentralized healthcare; reducing the healthcare financing gap; improving maternal, newborn, and child health; and strengthening social welfare, communicable and non- communicable disease services, including HIV/AIDS, B, malaria, and substance abuse services, prevention.

Gender is a GHI priority in Tanzania. Interventions under GHI to address quality health services, health system strengthening, and healthy behaviors will benefit the lives and health of all Tanzanians, with a special focus given to the vulnerable populations of women and girls. Under GHI, the USG will address gender issues through programming focused on harmful gender norms, gender-based violence, and gender inequities. Solutions will include male involvement and equitable access to services and resources, with linkages to non-health activities such as education and economic strengthening. A core objective of GHI is to improve health outcomes among women and girls. Improved Adoption of Healthy Behaviors including Healthcare-Seeking Behavior with Focus on Girls and Women will:

- Facilitate sustainable outcomes in GHI target areas and diseases by addressing cultural norms to empower women and increase men's positive involvement in decision making
- Contribute to demand creation for quality preventive and curative health services and serve as a critical component of multiple service packages, including HIV prevention and treatment adherence, MNCH, and FP/RH
- Link with health, education, governance, and agriculture platforms with a strong focus on women, girls, and gender equity, including increasing men's individual knowledge and skills
- Build on synergies across development sectors, moving away from supporting vertical disease-specific programs to more integrated and comprehensive health programming within the USG
- Enhance partnerships and resource leveraging with other non-USG stakeholders

Implementation of the ZHSRSP throughout the period, focused on strategic priorities with implications to the HIV/AIDS response. Since HIV/AIDS in Zanzibar is a concentrated epidemic

mostly among the Key Populations, implementation of the ZHRSP II paid particular attention to the Key Populations as follows:[35]

- Key Populations have been acknowledged and their needs incorporated and initiated in key national documents and some resources mobilized.
- In realizing the challenges facing Key Populations groups, peer educators have been identified, trained and supported in operationalization of various strategies. In addition to specific studies, special community based programmes such as access to HIV counseling and testing services have been made available to Key Populations.
- Increased access has also been provided/ ensured to potential sites and clients of some Key Populations through the Moonlight Outreach Educational Campaign and HCT in night clubs and bars. The health sector in collaboration with development partners develop and launched the Integrated HIV and Substance Abuse Strategic Plan[36].
- The substance abuse recovery programme has been initiated on a small scale. The programme includes a twelve step recovery method as well as a Sober House.
- Key Populations related IEC materials and education has been done using electronic and paper based media.
- Zanzibar is now undertaking the construction of the detoxification and rehabilitation centre.
- Special low fledged STD services for Key Populations have been initiated
- A national anti-stigma campaign and promotion of universal non-paying access to all HIV services, particularly in the public domain, is another commendable milestone in Zanzibar efforts in addressing Key Populations and Key Populations needs.
- Political level commitment on Key Populations is also noted at the national and union levels whereby various laws have been enacted and/or international laws ratified. To give but two examples, there are laws on Human Rights and the enactment of the substance abuse act that support access to detoxification and rehabilitation by substance users in Zanzibar.

However, besides all these initiatives at the policy and programmatic level, the ZAPHAR+ 2010 study that involved 417 respondents,[37] shows that majority of PLWHA had not heard, read or discussed the content of declarations and laws/policies protecting the rights of people living with HIV. 61% and 64% of the respondents had not heard of declaration of commitment on HIV/AIDS and national policy protecting the rights of PLWHA respectively. Of those who had heard about the two, 80% and 79% had never read or discussed declaration of commitment on HIV/AIDS and National policy protecting the rights of people living with HIV respectively.

[35] ZAC 2011, Monitoring and Evaluation Indicators for MARPS and Vulnerable Groups
[36] Zanzibar Substance Abuse-HIV & AIDS Strategic Plan (207-2011) – SUHISP.
[37] Zanzibar Association of People Living with HIV/AIDS (ZAPHAR+), 2010, People Living with HIV Stigma Index Assessment in Zanzibar.

Table 1.1: Indicator data in an overview table

Indicator	TARGET 1: Reduce sexual transmission of HIV by 50 per cent By2012	2008	2009/10	2012
1.1	Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	62.25	No Data Available	57.9
1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	2.5	No Data Available	2.2
1.3	Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	10.2	No Data Available	2.2
1.4	Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months and who report the use of a condom during their last intercourse	25.65	No Data Available	25
1.5	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	11.55	No Data Available	22.9
1.6	Percentage of young people aged 15-24 who are living with HIV*	0.2	No Data Available	0.2 295/1707130
1.7	Percentage of sex-workers reached with HIV prevention programmes	No Data Available	No Data Available	592 number
1.8	Percentage of sex workers reporting the use of a condom with their most recent client	76.8	No Data Available	No Data Available
1.9	Percentage of sex workers who have received an HIV test in the past 12 months and know their results	No Data Available	No Data Available	55.2(327/592)
1.10	Percentage of sex workers who are living with HIV	10.8	No Data Available	4.0
1.11	Percentage of men who have sex with men reached with HIV prevention programmes	No Data Available	No Data Available	707Number
1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	28.9	No Data Available	No Data Available
1.13	Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	No Data Available	No Data Available	80.0
1.14	Percentage of men who have sex with men who are living with HIV	No Data Available	No Data Available	2.3
	TRAGET 2: Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015			
2.1	Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	No Data Available	No Data Available	No data
2.2	Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	31.1(62/199)	No Data Available	No Data Available
2.3	Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	43.8	No Data Available	No Data Available

2.4	Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	191 number	No Data Available	346 number
2.5	Percentage of people who inject drugs who are living with HIV	26.2(50/191)	No Data Available	8.7(30/346) VCT data
Indicator	**Target 3. Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths**	**2008**	**2009/10**	**2011**
3.1	Percentage of HIV-positive pregnant women who receive antiretroviral to reduce the risk of mother-to-child transmission	84	No Data Available	82.4 [234/284]
3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	10	No Data Available	58.5% [185/316]
3.3	Mother-to-child transmission of HIV (modeled)	No Data Available	No Data Available	
	Target 4. Have 15 million people living with HIV on antiretroviral treatment by 2015			
4.1	Percentage of eligible adults and children currently receiving antiretroviral therapy	No Data Available	No Data Available	96.9 [2772/2861]
4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	85.4	No Data Available	66.8% [374/560]
	Target 5. Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015			
5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	100	No Data Available	42.5% [17/49]
	Target 6. Reach a significant level of annual global expenditure (US$22-24 billion) in low- and middle-income countries			
6.1	Domestic and international AIDS spending by categories and financing sources			
	Target 7. Critical enablers and synergies with development sectors			
7.1	National Commitments and Policy Instruments (NCPI) (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)	No Data Available	No Data Available	
7.2	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	No Data Available	No Data Available	7.7
7.3	Current school attendance among orphans and non orphans aged 10–14	No Data Available	1.03% THMIS	1.03% THMIS
7.4	Proportion of the poorest households who received external economic support in the past 3 months	12	No Data Available	No Data Available

2 Overview of the AIDS Epidemic

2.1 HIV/AIDS in the General Public

Currently, the HIV prevalence in the general population is 0.6% (THMIS, 2008). Although HIV prevalence remains low in the general population, disparities in HIV prevalence are observed among sub-population. HIV prevalence estimates among key population from the 2007 behavioral surveillance have shown that IDU, MSM and FSW have higher HIV prevalence than the general population (16%, 12.3% and 10.8%, respectively (Figure 2.1))) (ZACP, 2007). Sentinel Surveillance data for 2011 further shows that:

- HIV incidence in women 15-49 years old (%) is 0.6% (Figure 2.2)
- Percentage of infants born to HIV-infected women provided with antiretrovirals (either mother or infant) to reduce the risk of HIV transmission during the breastfeeding period = is 20 out of 185, which is 10.8%
- the number of women in need of PMTCT is 0.6% i.e. 316 out of 5262
- the number of children under 15 who are on ART between July 2010 - June 2011 is 57.3%
- HIV infection increased with age from 0.3% in age group 15 – 24 years and plateau at age groups 25-44 years (0.8%). There was no observed HIV infection in lower and upper age groups (10-14 and 45-54 years).
- Analysis of HIV infection by level of education showed that HIV infection was low among those with no formal education (0.4%). It was highest among those who had gone to primary school only (1.2%) and it declined again among those who had gone to secondary school (0.4%). The differences in HIV infection between no formal education and primary education (p=0.03) and that between primary and secondary education (p=0.004) are statistically significant (Figure 2.3)
- Comparison of HIV infection by marital status showed HIV infection to be lowest among those married (0.5%) and it was significantly higher among the divorced (6.5%) (p =0.0005). (Figure 2.4)
- HIV infection was found to be 10 times higher in Unguja (1%) than in Pemba (0.1%). It was highest in Urban (2.1%), followed by Central (1.7%) and South (1%) districts while nobody was found to be HIV infected in Micheweni, Wete and Mkoani districts. (ANC sentinel surveillance, 2010)

Figure 2.1: HIV, Viral Hepatitis and Syphillis among Key Populations (RDS, 2007

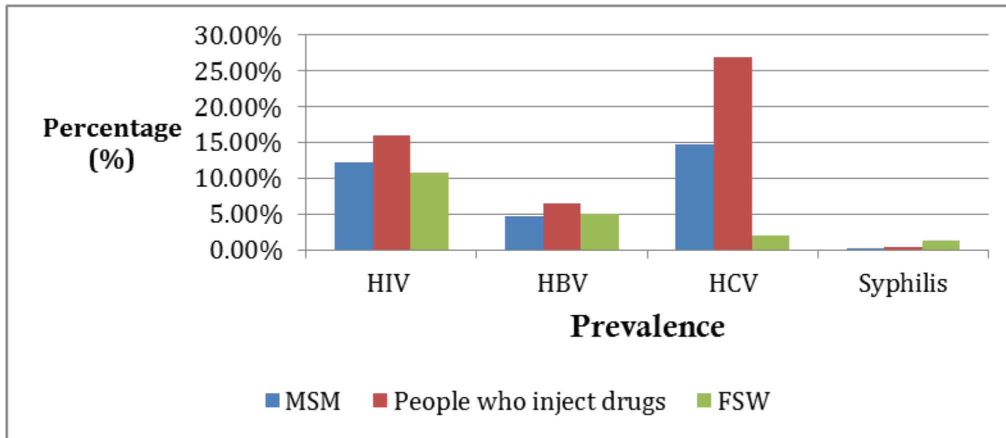


Figure 2.2: Blood borne infections among ANC surveillance participants, Zanzibar, 2010

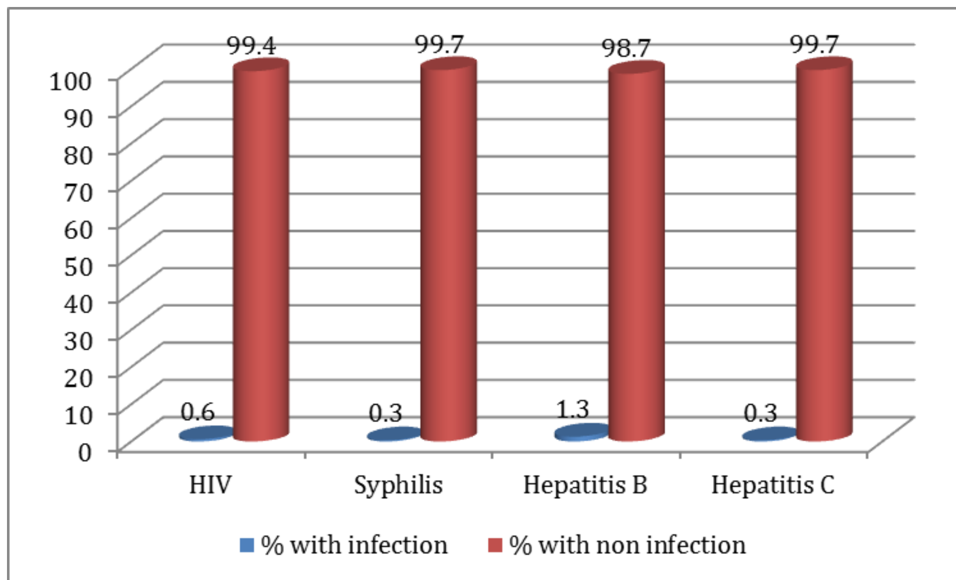


Figure 2.3: Distribution of ANC surveillance participants with HIV infection by demographic characteristics, Zanzibar, 2010: Level of Education

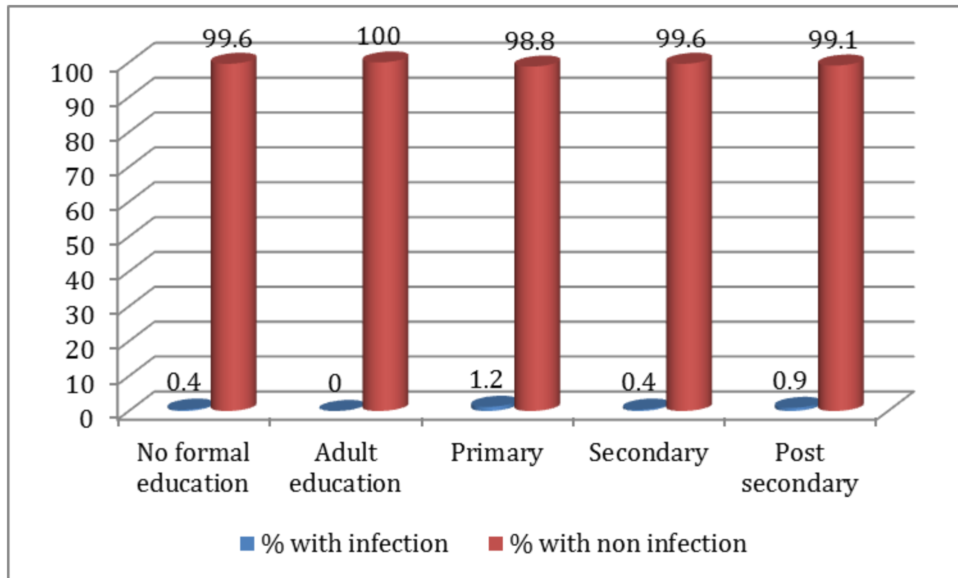
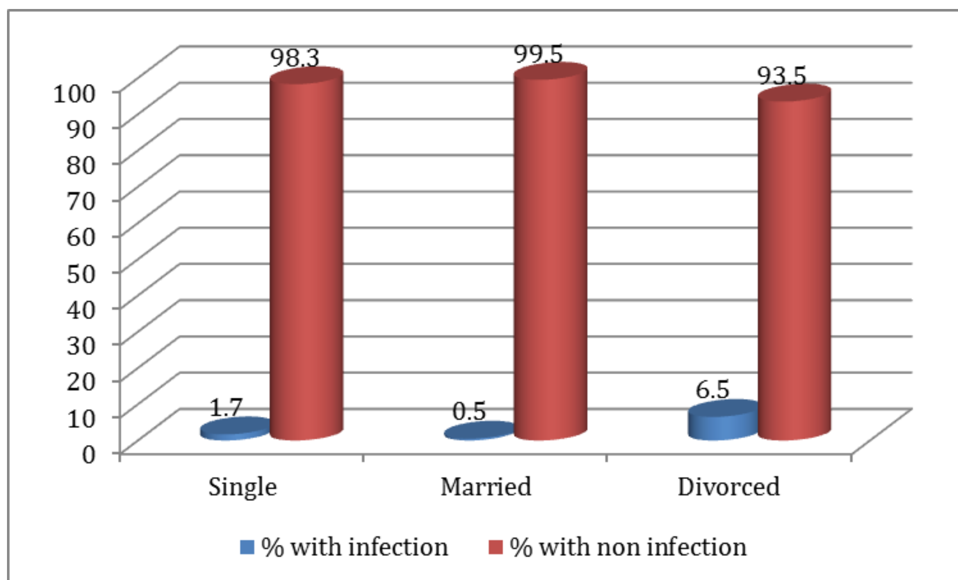


Figure 2.4: Distribution of ANC surveillance participants with HIV infection by demographic characteristics, Zanzibar, 2010: Marital status



With regards to Key Populations, more recent data on Key Populations is currently not available. The only data available is based on previous studies and most of which have been reported in the previous UNGASS progress reports for Zanzibar. Accordingly, evidence on Key Populations in Zanzibar shows high levels of HIV among all three risk sub-groups in comparison to the general population of Zanzibar. HIV prevalence was 16.0 percent among IDUs, 12.3 percent among

MSM and 10.8 percent among FSWs. While Key Populations are characterized by unique risk behaviors, these groups are not mutually exclusive and there is considerable overlap in transmission risks. Among MSM, 13.9 percent reported injecting drugs in the previous three months and 77.5 percent reported being paid for sex in the last year. Although only 2.8 percent of FSWs reported injection drug use, a larger proportion (10.9-17.6%) suspected their sex partners of using injection drugs[38].

The cross-over (bridging) potential to the general population has been documented in key population through the Integrated Behavioural and Biological Surveillance Survey (IBBSS) (2007). Among the documented issues include: nearly three-quarters of MSM (71.2%) reported having female sex partners in the previous year; half of FSWs (48.9%) reported having a steady non-paying partner; and more than half of IDUs (52.8%) reported being sexually active in the previous month. HIV infection levels among correctional facilities students (CFS) who were IDUs were recorded at 4 percent.

The key population, women and youth remain the most vulnerable to HIV/AIDS risks. The driving forces for vulnerability to HIV risks are identified and cited in the Zanzibar Monitoring and Evaluation Indicators for key population and Vulnerable Groups as follows:[39]

i. ***High levels of HIV and other STI*** among Key Populations (MSM, FSW and IDUs) who have riskier sexual relations with other segments of the population. Various studies among key populations in Zanzibar have documented high sexual and drug related riskier behaviors. These include[40]:
    - IDUs: 53.8 percent of IDUs reported injecting with a previously used needle in the past month; 63.0 percent reported having two or more partners while 66.7 percent to 73.4% reported "never" using condoms.
    - MSM: Transactional sex: Multiple partners: MSM had a median of three male partners and one female partner in the past month; 63.3 percent to 77.2 percent of MSM reported never using a condom with different partner types while 13.9 percent reported injection drug use.
    - FSW: only 55.7 percent of FSWs reported using condoms the last time they had sex. The most common reason reported by FSWs for not using a condom was partners' objection to using one (42.5%). Condom use is still a taboo in Zanzibar and strategies have effected in to the Zanzibar national HIV&AIDS strategic plan that, include involvement

[38] MARPs study : RDS methodology- Zanzibar AIDS Control Programnme (2007-08)
[39] Zanzibar AIDS Commission (ZAC) 2011, Monitoring and Evaluation Indicators for MARPS and Vulnerable Population
[40] Integrated behavioural and Biological Surveillance surveys for MARPs-2008 (ZACP)

5. ZNSP II

of faith-based organization in condom programming and religious counseling to discordant couples

ii. ***High Risk behaviors (sexual and Drug related Behaviours) among Most at Risk Populations and people in Correctional Facilities***: High sexual and drug risk behaviors inclusive of unprotected sex, rape, group sex, sharing of injecting paraphernalia and flash blood practices aggravate the situation.

iii. ***Stigma and Discrimination towards Key Populations and PLHIV***: based on the stigma index survey done in 2010 in Zanzibar, PLHIV and key population are still facing stigma and discrimination within their community, at workplaces and schools. There are high levels of stigma directed towards some sub-populations (MSM -50.2 percent reported being beaten by family members, FSW-37.2 percent, IDUs->70 percent inclusive of losing respect; name calling and abandonment-60.3 percent). Stigma and discrimination for PLHIV and the key population hampers their accessibility to most of the HIV related services (prevention, care, treatment and support). Similarly, based on stigma and negative unfriendly attitudes, marginalized populations' needs are not being adequately addressed. The right to health to any human being is an important aspect of the normative content of Article 12 of the International Covenant on Economic, Social and Cultural Rights in which, Zanzibar through the United Republic of Tanzania has signed and ratified its implementation.

iv. ***Poverty and transactional sex***: Transactional sex (paying or being paid) is high among all the three sub-population of Key Populations in Zanzibar. In addition, the THMIS has documented the existence of multiple sexual relationships in the general population that might, if unabated, fuel up the epidemic. These include 0.7 percent of male in general public have paid for sex, while 16.5 percent among IDUs (received money for sex). Evidence on sex for payment were high among MSM where 68.4 percent bought sex in the past one year while 77.5 percent have reported to have been paid for sex in the past one year and the two observations are mutually exclusive. Trans-generation sex, which was earlier reported (verbally), has now been reported in THMIS to be 9.7 percent of among women (number not weighted/adjusted).

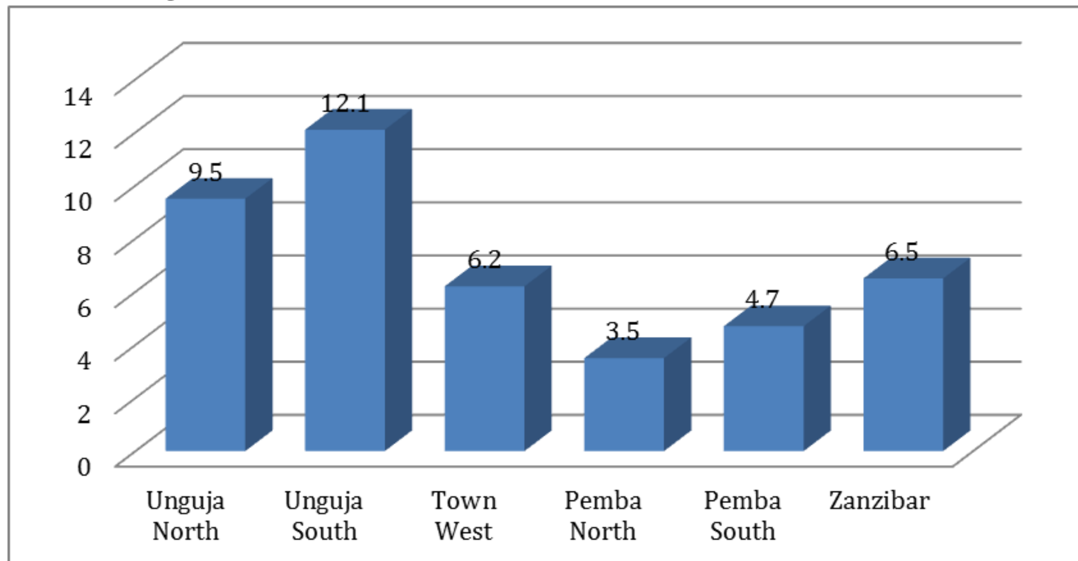
Sentinel Surveillance Report (2011) shows that HIV testing level is highest in lower age groups (80% in age groups 10-24 years) and decreases with age to 71% in the age group 45-54 years. HIV testing level is also higher in those who have ever married (78% in married and 79% in divorced) compared to those who are single (54%). Levels of study participants who have ever tested increase with level of education; it is lowest in those with no formal education (64%) and highest in those who have attained post secondary education (88%).

Comparison of HIV testing by island revealed no considerable differences on HIV testing levels between Unguja (78%) and Pemba (77%). However, comparison by district showed that HIV testing was highest in Urban district (88%), followed by Chake Chake district (85%) and lowest in North B and Micheweni districts (66% and 61% respectively).

2.2 Sex Based Violence

Sexual violence is generally acknowledged to be one of the factors that could risk HIV transmission to the raped person. The TDHS 2010 data shows that sexual violence is not a major problem in Zanzibar with overall prevalence of 6.5%. Among the sample population of women interviewed during the survey. Prevalence of sexual violence varies by geographical location with Unguja South indicating a high rate (12.1%) that was around twice above the general average in Zanzibar, followed by Unguja North 9.5%.

Figure 2.5: Prevalence of Sexual Violence in Zanzibar (2010)



Source: Tanzania Demographic and Health Survey (TDHS) 2010

3 National response to the AIDS epidemic

3.1 Prevention

3.1.1 Prevention of Mother to Child Transmission (PMTCT)

PMTCT services were established in 2005, to date the services exists in 111 sites out of 154 that provide RCH services. The main goal of PMTCT is to reduce HIV transmission from pregnant mother to her child. It is also aimed at improving care for infected partners and their children. PMTCT scale up plan has the following targets:

- Increased utilization by 95% of pregnant women and 30% of male partners, and
- Increased health facility deliveries of all HIV positive pregnant women to 95%

In 2011, the guideline used was updated according to the WHO recommendations. Refresher trainings for RCH care providers were conducted to implement this revised guideline. Key components in the refresher trainings were:

- When to start ART in pregnant woman and the required regimen
- When to start ARV prophylaxis for PMTCT in pregnant woman and the required regimen
- What ARV prophylaxis regimen to give to the exposed newborn in immediate postpartum period, and
- Regimen to use for preventing breastfeeding transmission of HIV beyond postpartum period

During the year 2011, a total of 34717 were tested for HIV at ANC, labor and delivery sites, 195 women were found positive. Mothers delivered in health facilities were 173 (88.7%).

Preparation to MTCT is underway. Formation of multi sectoral task force to guide its implementation is already formed with its TOR.

The main challenges that face the program are:

- Inadequate space and HCW capacity within facilities hinders the expansion and at times integration of PMTCT services with other related services.
- Inadequate functioning of the referral system to respond the HIV epidemic.
- Low male involvement partly aggravated by socio-cultural forces and the nature and type of Health facility infrastructure.
- Inadequate linkages with HMIS and other M&E system apart from those existing within the ZACP
- Failure of mother to disclose the status to her spouse
- Home deliveries, and
- Losing of mother infant pair.

Efforts are being taken to sensitize communities through religious leaders, public relay systems and health talks at various opportunities, to overcome these challenges.

3.1.2 Voluntary Counseling and Testing (VCT)

The Counseling Unit of the ZCAP coordinates the national CT services in the country. This had been made possible by developing counseling policies and guidelines, training protocols and manuals, standard operating procedures job aids as well as training of service providers (health care workers) for HCT. Quality promotion had been the driving motto and this has been done through supportive participatory approach, on job training and technical guidance, as well as through Quality assurance schemes...

The Ministry of Health (MOH)/Zanzibar AIDS Control Program (ZACP) has the responsibility of coordinating the national health sector response to HIV/AIDS. An important aspect of this response is the national Voluntary Counseling and Testing (VCT) program, which was initiated in 1988. To date, there are over 56 VCT sites in Zanzibar. ZACP, through its Counseling Unit, coordinates the national CT program through development of policies and guidelines, national training protocols and manuals, and standard operating procedures and job aides. ZACP also provides supervision and technical guidance to implementing partners, strengthens the training of counselors to secure the required quantity and quality of services, and monitors the progress of implementation of CT activities through reports from districts, NGOs, and other stakeholders. Collaboration with other partners for smooth referral of HIV positive clients to comprehensive HIV care and treatment was also ensured. The main emphasis had been to reach as many clients as possible through PITC, VCT and community VCT outreach efforts

CT is identified as a key entry point in the continuum of care for HIV/AIDS. To date, Zanzibar's CT strategy has been a VCT model, which is more suitable for HIV prevention but may not be the most effective approach for Care and Treatment. The introduction of provider-initiated HIV testing and counseling will respond to the need to increase access to the national care and treatment program. It is envisaged that by increasing the coverage of CT services in clinics providing TB and STI services, people living with HIV/AIDS (PLHA) requiring care and treatment will be identified and be referred to ART services.

Currently, ZACP is reviewing the counseling and testing guidelines to put greater emphasis on provider initiated testing and counseling including DCT. The development and finalization of the CT policies, technical guidelines, protocols stakeholders. The ZACP is rolling out CT in public health facilities in the country and introduce provider-initiated testing and counseling starting with DCT in IPD, OPD, TB, and STI clinics. This will be coupled with training programs for counselors. In an effort to operationalize CT, 2 sites will be selected to assist the Counseling Unit at ZACP to assess and review its structure and functions in order to provide adequate capacity for managing and coordination of the CT activities in the country.

Scaling up of:

- PITC sites from existing 13 to 25
- VCTsites from 23 to 56
- HIV testing done by non laboratory CT service provider

The challenges that are seen in CT include:

- In proper archiving of records and reports of CT activities
- High HCW burn out rate as well as the turnover rate within the health system slows the provision of counseling and testing service in peripheral areas in Zanzibar.
- Inadequate infrastructure to allow comprehensive and confidential counseling services in most facilities hampers the quality and magnitude of service utilisation.
- The cost sharing of VCT services within the CSO challenges the concept of universal access to HCT services.

3.2 Care, Treatment and Support

Prior to March 2005, access to HIV/AIDS care and treatment services in Zanzibar has been limited to palliative care and management of opportunistic infections. In recognition these limitation the MOH in collaboration with partners including USG, Clinton Foundation and Columbia University set an entry stage by introducing comprehensive continuum care in Zanzibar. This support facilitated the strengthening of the existing services including scaling up of Home Based Care and the expansion of HIV /AIDS clinic to provide HAART. The initiation of ART services in Zanzibar started on March 2005 since then around 5923 HIV clients have been enrolled in care and 3172 are on ARVs in 10 care and treatment sites. The target is to cover the estimated 9,000 people currently living with HIV in Zanzibar.

Special efforts were made to build capacity of health care providers, develop treatment guidelines and standard operating procedures, renovate and equip health facilities and to improve collaboration with other health services such as PMTCT, VCT, HBC and MCH.

In order to ensure quality services are provided, todate 95 health care workers have been trained on Care and Treatment for HIV, 25 have been trained on adherence counselling services and 26 have been trained on Paediatric HIV/AIDS management. ZACP has also developed and disseminated Information Education and Communication materials in order to increase demand for the services in the Islands.

Among the identified challenges that face this services includes, staff shortage, effective patient tracking system, inadequate monitoring and evaluation system, lack of necessary equipments, regular supplies and commodities, low enrolment of children in CTC, scaling up the Key Populations enrollment to CTC services (particularly MSM).

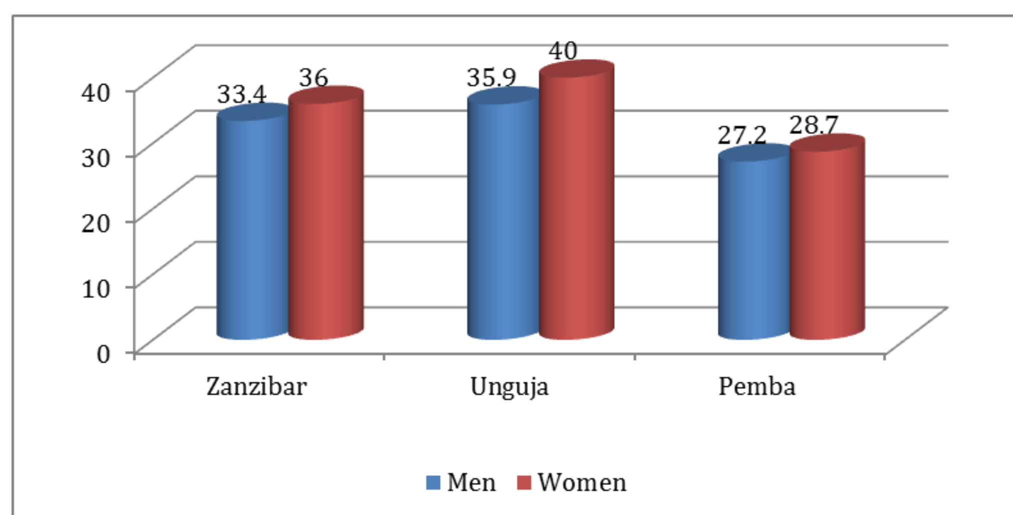
To overcome these challenges, ZACP is organizing and conduct coordination meetings with stakeholders in order to strengthen collaboration and coordination between NGOs and other MOH departments/units. Increase of home based care practices for ART clients. Enhance synergism between alternative medicine and HBC services on patient outcome. Co-opting new WHO recommendations on ARVs initiation (criteria)

3.3 Knowledge and Behaviour Change

3.3.1 Knowledge of HIV Prevention and Transmission

A number of studies have come up with evidence of drastic increase in knowledge and awareness of HIV and AIDS almost universally over the last 25 years since the disease was identified in Zanzibar. Despite this awareness, there is still a marked gap on the knowledge of HIV prevention and transmission that is currently posing a major challenge in translating knowledge into behavior change that can support mitigation of spreading new infections.[41] The TDHS 2010 shows that less than a half of the people aged between 15 and 49 have comprehensive knowledge about HOV/AIDS.[42] Women and men in Zanzibar are less knowledgeable about AIDS than those in Mainland Tanzania (36 and 49 percent, respectively, for women; 33 and 47 percent, respectively, for men).

Figure 3.1: Percentage with a comprehensive Knowledge of HIV and AIDS



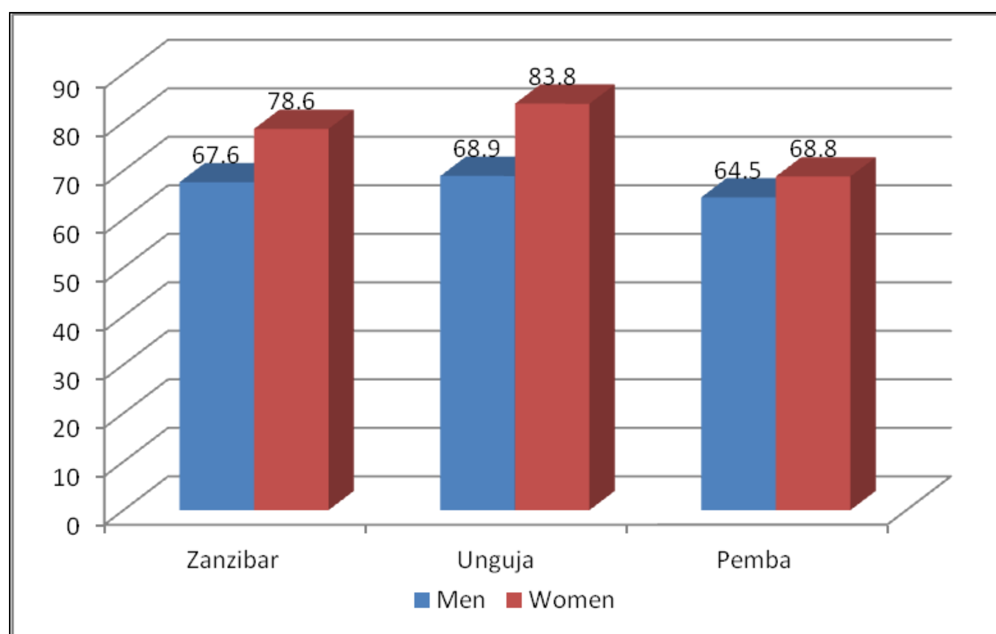
Source: Tanzania Demographic and Health Survey (TDHS) 2010

[41] Zanzibar AIDS Commission, 2011, Monitoring and Evaluation Indicators for MARPs and Vulnerable Groups
[42] Comprehensive knowledge of HIV/AIDS is defined as (1) knowing that both consistent condom use and limiting sex to one uninfected partner are HIV prevention methods, (2) being aware that a healthy-looking person can have HIV, and (3) rejecting the two most common local misconceptions—that HIV/AIDS can be transmitted through mosquito bites and by sharing food with someone who has AIDS

3.3.2 Comprehensive MTCT Knowledge

Increasing the level of general knowledge of HIV transmission from mother to child and reducing the risk of transmission using antiretroviral drugs (ARTs) is critical to reducing mother-to-child transmission (MTCT) of HIV during pregnancy, delivery, and breast feeding. The TDHS data shows that 83.8 percent of women in Unguja and 68.8 percent in Pemba have comprehensive knowledge about MTCT, while 68.9 and 64.5 percent of men in Unguja and Pemba respectively have comprehensive knowledge about Mother to Child Transmission of HIV.

Figure 3.2 Comprehensive MTCT knowledge: Percentage of Women and Men who know that HIV can be transmitted by breastfeeding and risk of MTCT can be reduced by mother taking special drugs during pregnancy in Zanzibar (2010)



Source: Tanzania Demographic and Health Survey (TDHS) 2010

3.3.3 Risk Behavior

Risk sexual behavior is one of the major contributing factors for HIV transmission. The ANC surveillance 2011, shows that girls aged 10-14 have relatively higher tendency of having sex with a non-regular partners compared older women (Figure 3.3). The tendency decreases with age. Furthermore, single and divorced women in Zanzibar are more likely (30.9% and 29%) respectively to have sexual intercourse with non-regular partner as compared to married women (1.2%), (Figure 3.4).

Figure 3.3: Distribution of ANC surveillance participants by sexual intercourse with non-regular partner in the past 12 months and demographic characteristics, Zanzibar, 2010: Sex with non-regular partner

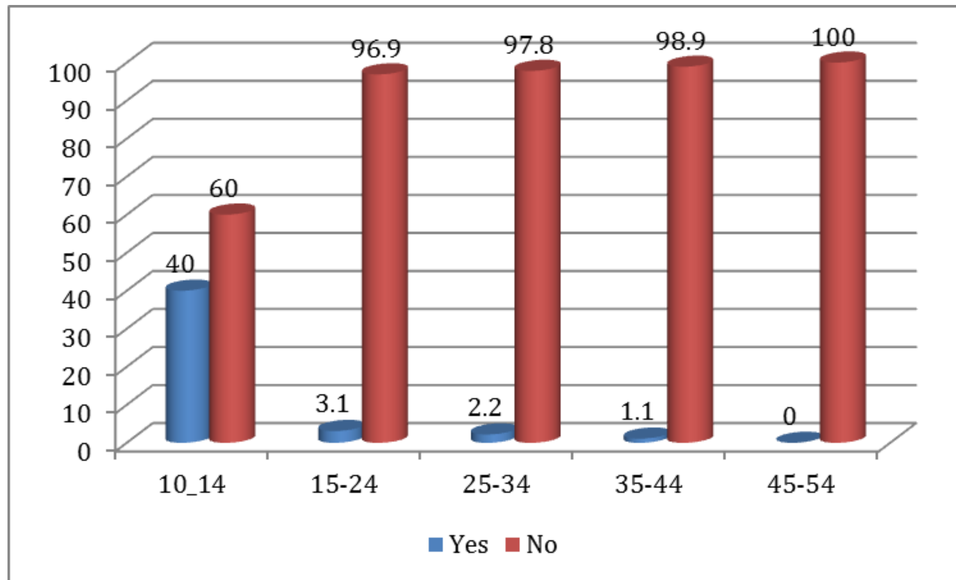
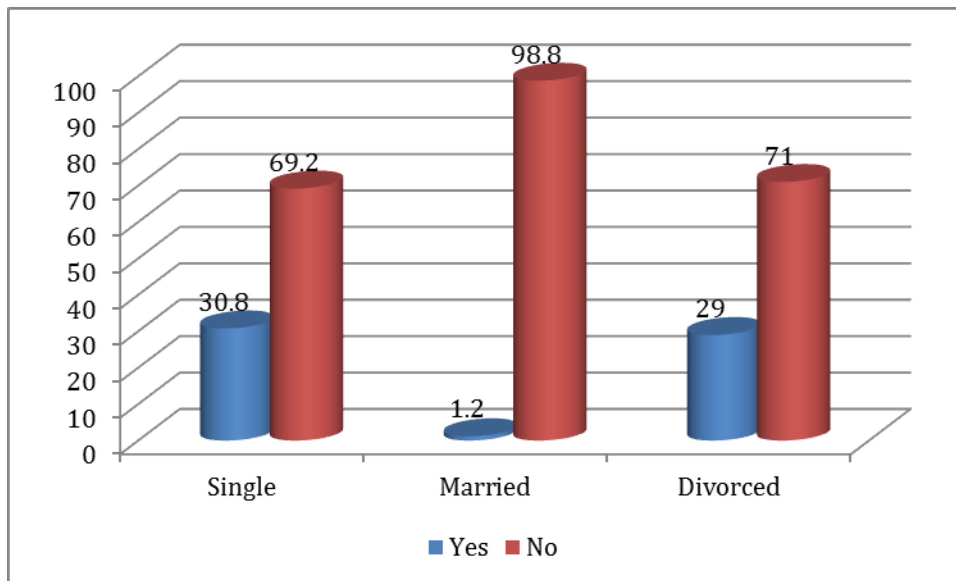


Figure 3.4: Distribution of ANC surveillance participants by sexual intercourse with non-regular partner in the past 12 months and demographic characteristics, Zanzibar, 2010: Marital status



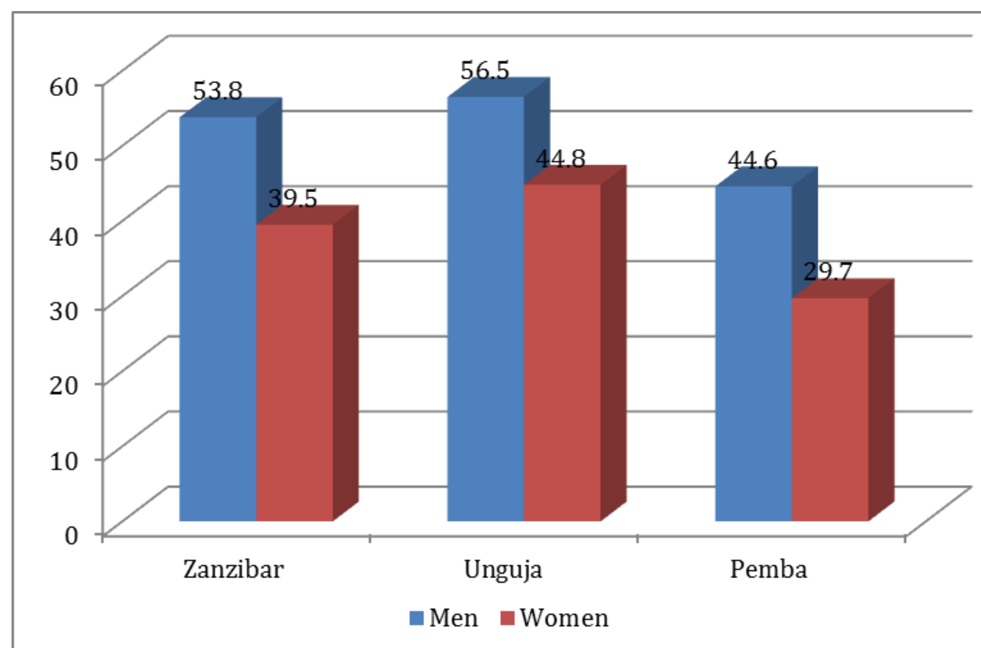
3.3.4 Stigma and Discrimination

Widespread stigma and discrimination towards people infected with HIV or living with AIDS, are among factors that negatively influence both people's willingness to be tested for HIV and also their adherence to antiretroviral therapy. The TDHS 2010 includes reduction of stigma and discrimination as one of the important indicator for measuring success of programs targeting HIV/AIDS prevention and control. To assess survey respondents' attitudes towards people living with HIV/AIDS, respondents who had heard of AIDS were asked the following questions:

e. If they would be willing to care for a relative sick with AIDS in their own households,
f. If they would be willing to buy fresh vegetables from a market vendor who had the AIDS virus,
g. If they thought a female teacher who has the AIDS virus but is not sick should be allowed to continue teaching, and
h. If they would want to keep a family member's HIV positive status secret.

Women and men in Zanzibar still show a low level of acceptance in all four indicators of tolerance, (40 percent of women and 53 percent of men (Figure 3.5)

Figure 3.5: Accepting attitude towards those living with HIV/AIDS: Percentage expressing acceptance attitudes on all four indicators in Zanzibar (2010)



Source: Tanzania Demographic and Health Survey (TDHS) 2010

Findings from the People Living with HIV Stigma Index Assessment in Zanzibar in 2010,[43] shows that: ever being gossiped is the most common form of discrimination that was reported by 58.1% of the respondents (Table 3.1). The other forms included being verbally insulted reported by 30.3% of the respondents, being excluded from social gathering reported by 29.8% of the respondents and being subjected to psychological pressure/manipulation by husband/wife reported by 21% of the respondents. Being gossiped and sexual rejection were experienced more often as reported by 38.9% and 14.1% of the respondents respectively. A small proportion (5.3%) of the respondents reported having been discriminated by other people living with HIV.

Table 3.1: Stigma from other people

Experience	**Often**	**A few times**	**Once**	**Never**	**Total**
Excluded from social gathering	52 (13.1%)	40 (10.1%)	26 (6.6%)	278 (70.2%)	396 (100%)
Excluded from religious activities	8 (2.0%)	9 (2.3%)	4 (1.0%)	375 (94.7%)	396 (100.0%)
Excluded from family activities	24 (6.1%)	8 (2.0%)	8 (2.0%)	356 (89.9%)	396 (100.0%)
Being Gossiped	154 (38.9%)	47 (11.9%)	29 (7.3%)	166 (41.9%)	396 (100.0%)
Verbally insulted	52 (13.1%)	32 (8.1%)	36 (9.1%)	276 (69.7%)	396 (100.0%)
Physically harassed	22 (5.6%)	10 (2.5%)	14 (3.5%)	350 (88.4%)	396 (100.0%)
Physically assaulted	9 (2.3%)	12 (3.0%)	14 (3.5%)	361 (91.2%)	396 (100.0%)
Subjected to psychological pressure/manipulation by husband/wife because f HIV status	30 (7.6%)	39 (9.8%)	14 (3.5%)	313 (79.0%)	396 (100.0%)
Sexual rejection	56 (14.1%)	18 (4.5%)	4 (1.0%)	318 (80.3%)	396 (100.0%)
Discriminated by other PLWHA	6 (1.5%)	11 (2.8%)	4 (1.0%)	375 (94.7%)	396 (100.0%)

[43] Zanzibar Association of People Living with HIV/AIDS (ZAPHAR+), 2010, People Living with HIV Stigma Index Assessment in Zanzibar.

Experience	Often	A few times	Once	Never	Total
Wife/husband/ partner or member of household discriminated because of your HIV status	27 (7.2%)	26 (6.9%)	7 (1.9%)	316 (84.0%)	376 (100.0%)

Source: ZAPHAR+ 2010, People Living with HIV Stigma Index Assessment in Zanzibar

3.4 Impact Alleviation

The Revolutionary government of Zanzibar emphasizes poverty alleviation and addressing the problem of vulnerability. Key approaches to help ensure the improved wellbeing of MVC include sustainable, innovative, and gender-sensitive interventions to strengthen the capacity of households, families, communities, MVC safety nets, and local governments to care for and protect MVC over the long. The national Action Plan for the Most Vulnerable Children was launched in 2011, and is currently being implemented. Besides systems strengthening the plan pays specific attention to increased resource mobilization and allocation to support the Most Vulnerable Children that includes Orphans due to HIV/AIDS and strengthening resilience at the community level and household level through economic capacity strengthening interventions.

3.5 Best Practices

One of the best practices in Zanzibar is the focus on Key Populations studies including the IBBSS, size estimation and utilization of the findings to inform policy and programmatic interventions to control the spread of HIV in the Zanzibar Islands. It has also managed to stabilize the HIV prevalence among the general population at 0.6% (2007 -2011). The involvement of faith-based organizations in the national response to HIV and participation of PLHIV as expert patients have also been practiced in Zanzibar. Marriage among people who tested positive for HIV and that tested negative (discordant) is also in place in Zanzibar. The integration of HIV and other public health services have led to the improved utilization of HIV services among the key population, as for instance about 1,200 MSM out of 2,164 are now accessing HIV and other health services in our CTC centres in Zanzibar

3.6 Major challenges and remedial actions

Like in the mainland Tanzania, financing the national response is one of the major challenges. Key strategic issues on health financing for HIV and AIDS include the challenges of funding a rapidly expanding national HIV and AIDS response in the absence of the large annual funding increases that characterized the first five years of PEPFAR, as well as the unpredictability of future Global Fund support.

Furthermore, important challenges include inadequate availability of human resources for health (HRH). This situation is a major challenge for the health sector in general, and for the HIV and AIDS response in particular. The major reason is local movement of skilled health human

resources from public to private sectors

- Another challenge faces HIV related program is stigma and discrimination. Other supply site, the situation limits the clients to access to heath rights (care and treatment services). On the demand side, self stigma is also still high to some extent driven by stigma and discrimination drawn by society. Both supply and demand side stigma are forcing people in Zanzibar to seek HIV prevention , care, treatment and supports from places far from their residence and some time as far as Main land (Tanzania) for those who can afford.
- Inadequate CD4 machine
  In availability of viral load counts machine in the Zanzibar health facilities (this service does not offered in Zanzibar
- Public health infrastructure in Zanzibar was not designed for handling HIV/AIDs related services which needs privacy and confidentiality, which is difficult, ensure in the current setting. Besides, the health system in Zanzibar in general is still challenged with a weak referral system.
- HIV prevention, care, treatment and support and impact mitigation services for the key populations are still poor

4 Support from the country's development partners (if applicable)

In Zanzibar, the United Nations Joint Programme and several development partners are actively involved in the health sector, particularly HIV and AIDS. For example, UNDP and the World Bank T-MAP project (closing out in 2010) are primary supporters for mainstreaming HIV and AIDS into sector and district health plans. In addition, UNDP and the World Bank (WB) provide support for policy and strategy development. The U.S. Government supports a number of prevention, treatment, and care activities as well as the effective management of the health sector's strategic information system. DANIDA is also providing support to strengthen the MOHSW HMIS system. Apart from providing financial assistance, UNFPA, ILO, PEPFAR, UNAIDS, GF, WHO, UNICEF, the U.S. Government, CU, CHAI and WB have provided ongoing technical assistance to the health sector, on various HIV-related issues, including the formulation of policy guidelines, protocols, and standard operating procedures.

Zanzibar has received two HIV and AIDS Global Fund grants, along with one TB grant. For HIV and AIDS, $11.1 million in Global Fund funding has been approved, and $2.7 million has been disbursed to date. The bulk of Zanzibar's HIV and AIDS Global Fund support ($8.8 out of $11.1 million) comes from the Round 6 grant, which supports scale up for prevention, care, and treatment with a focus on most at-risk populations, in accordance with the concentrated, rather than generalized, nature of the epidemic in Zanzibar

5. Monitoring and Evaluation Environment

5.1 An overview of the current monitoring and evaluation (M&E) system

Zanzibar is using the Zanzibar National HIV&AIDS Programme Monitoring System (ZHAPMoS) for collecting non-health facility data and the health clinic data collection systems. Over 300 agencies are currently using the Zanzibar National HIV&AIDS Programme Monitoring System (ZHAPMoS). Data collection is done by focal persons responsible for M&E. in the public sector ministries, departments and agencies (MDAs) and in the non-public sector i.e. the civil society organizations (CSOs and the Faith Based Organization (FBOs).

HIV prevalence estimates in Zanzibar are derived from the data collected from three sources: 1) HIV sero-surveys among antenatal clinic (ANC) attendees and most at risk population (Key Populations) 2) general population based surveys with HIV testing, where population based estimates of HIV prevalence are reported 3) passive surveillance through programs offering HIV testing, such as HIV counseling and testing (HCT) services, prevention of mother to child transmission (PMTCT) services. Using the data submitted by implementers, ZAC generates quarterly service coverage reports, the annual HIV reports.

Data obtained from the M&E system in Zanzibar is currently been used in ***information products*** which cover:

- Key highlights and trends in the national AIDS response
- Main achievements and quantity of HIV services provided
- Challenges and shortcomings in implementing HIV work in Zanzibar
- Recommended actions to strengthen the HIV response in Zanzibar.

5.2 Challenges faced in the implementation of a comprehensive M&E system

Zanzibar faces similar M&E challenges like mainland Tanzania. These challenges are also highlighted in the mainland report and they include among others reporting delays. Generally, monitoring and evaluation has been an area of challenge for the national HIV and AIDS response, given the weakness in the routine health management information system. The following weaknesses are observed:

- Data from health facilities are not always complete.
- Delays in the submission of data collected
- Feedback to the collecting facilities, especially from the district level, is practically nonexistent. This has in part led HIV and AIDS partners such as PEPFAR and the Global Fund to create parallel reporting systems.

5.3 Remedial actions planned to overcome the challenges

- Conducting training of health care providers on data collection and reporting system,
- Establishing a data framework for data flow with a log book system at each level to record the time when report are received from the various data collection points.
- Institutionalizing a follow up system to ensure action is taken to address problem of delayed submission of reports and any other emanating issues in the M&E process

5.4 Highlight, where relevant, the need for M&E technical assistance and Capacity-building

Further technical assistance is still needed in strengthening understanding workplace surveys, and to harmonize the data collection tools used for poverty monitoring the Zanzibar AIDS Control Program (ZACP) and the Zanzibar Aids Commission (ZAC).