UNITED REPUBLIC OF TANZANIA

UNGASS REPORTING FOR 2010

(TANZANIA MAINLAND AND ZANZIBAR)

The United Republic of Tanzania

UNGASS 2010 PROGRESS REPORING

TANZANIA MAINLAND

Table of Contents

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

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
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 Counselling and Testing
WB	World Bank
WHO	World Health Organisation

1 Status at a Glance

1.1 Inclusiveness of Stakeholders in the Report Writing Process

Stakeholders were involved in the report writing process from the initial stages of awareness creation for the assignment and the data collection process to the finalization and validating of the final report. The stakeholder consultation provided the opportunity for stakeholders to participate and provide the initial input for the draft report. Stakeholders were purposefully samples to represent the central and local governments, development partners, the private sector and the Civil Society Organizations.[1] Representation from the civil societies included organizations for people living with HIV/AIDS.

Two joint National Workshops that includes Tanzania mainland and Zanzibar were organized to provide platform for further stakeholder consultation and engagement with the technical people in the writing process. The first workshop was aimed at confirming the data and indicators provided in the draft report as well as to examine and analyze the validity of the narrative content. The second workshop provided an opportunity for stakeholders to review the second draft report in the perspective of the deliberation of the first workshop and to finalize and validate the indicators, qualitative data and consistency of reporting.

A technical meeting was also held with the UN experts from within the country, East and Central Africa and UN headquarters with local experts from the Tanzania Commission for AIDS (TACAIDS) and Zanzibar AIDS Commission to provide technical input into the report. The UN experts also participated in the second workshop with other stakeholders to provide further technical support in the report finalization process.

1.2 The Status of the Epidemic

The HIV epidemic in the mainland has stabilized around 6% since 1997 as also reflected in reported AIDS cases, surveillance among pregnant women and blood donors.[2] The current national HIV prevalence of 5.7%[3] shows a 1.3% decline from the 2003-2004 survey.[4] However, a small secondary increase has been projected due to the increase in rural incidence of HIV infections and uptake of ART services over the last five years. The number of people living with HIV (PLHIV) is also expected to increase more in rural areas due to the spread of the epidemic to these areas,[5] most of which are characterized by poverty.

1 See Annex for the list

2 The HIV epidemic in Tanzania mainland: Where have we come from, where is it going? And how are we responding? UNAIDS 2008.

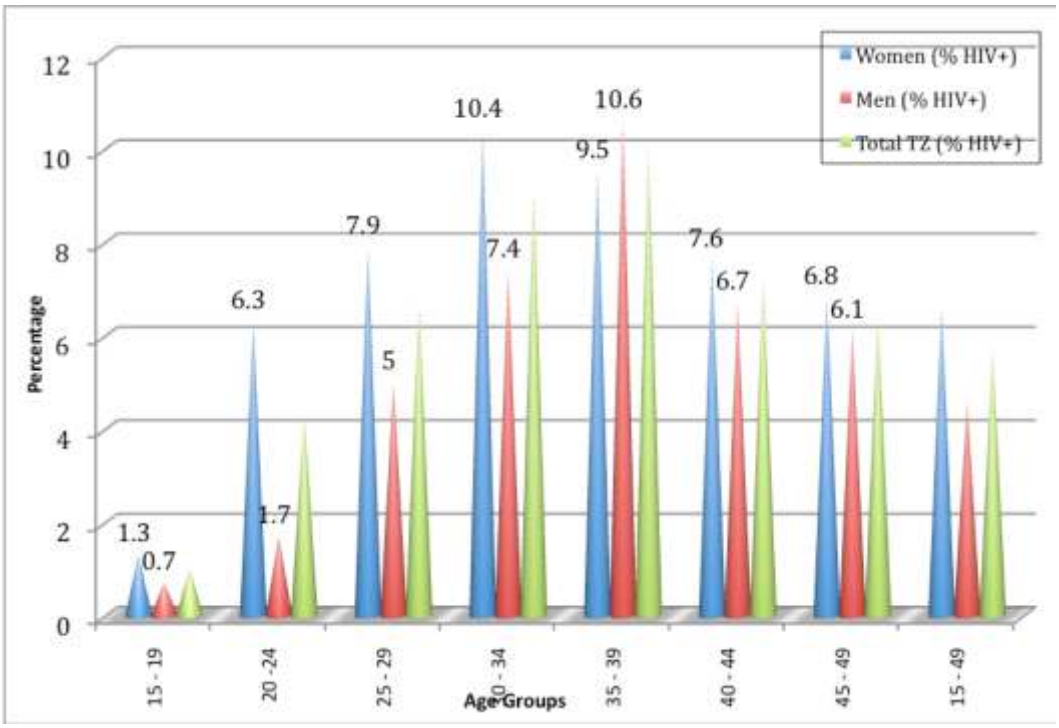
3 THMIS 2007-2008

4 THIS 2003-2004

5 The HIV epidemic in Tanzania mainland: Where have we come from, where is it going? And how are we responding? UNAIDS 2008.

HIV and AIDS in Tanzania is a generalized epidemic. By early 2008 it was estimated that 1.3 million people including adult and children in Tanzania mainland were living with HIV and 10% are children (below18 yrs). Adults in the age group of (35 – 39) are more likely to be infected than the other age groups (Figure1). Knowledge changes are noted in the THIMS but risky sexual acts still prevail among men and women of various age and socio-economic groups. Some of the driving factors includes poverty, (34% of households live below poverty line); pervasive **socio-**cultural norms and practices – which includes early marriages, gender inequities, gender-based violence, and cross-generational.[6] Prevalence is also determined by promiscuity. The THIMS 2007-98 population based survey shows that the number of sexual partners one has determines the likelihood of being HIV positive. HIV prevalence is highest among women (21.5%) and men (11.4%) with more than 10 sexual partners (Figure 1). It is also estimated that 70,000 to 80,000 newborn infants are at risk of acquiring HIV every year either during pregnancy, labour and delivery, or through breastfeeding.[7]

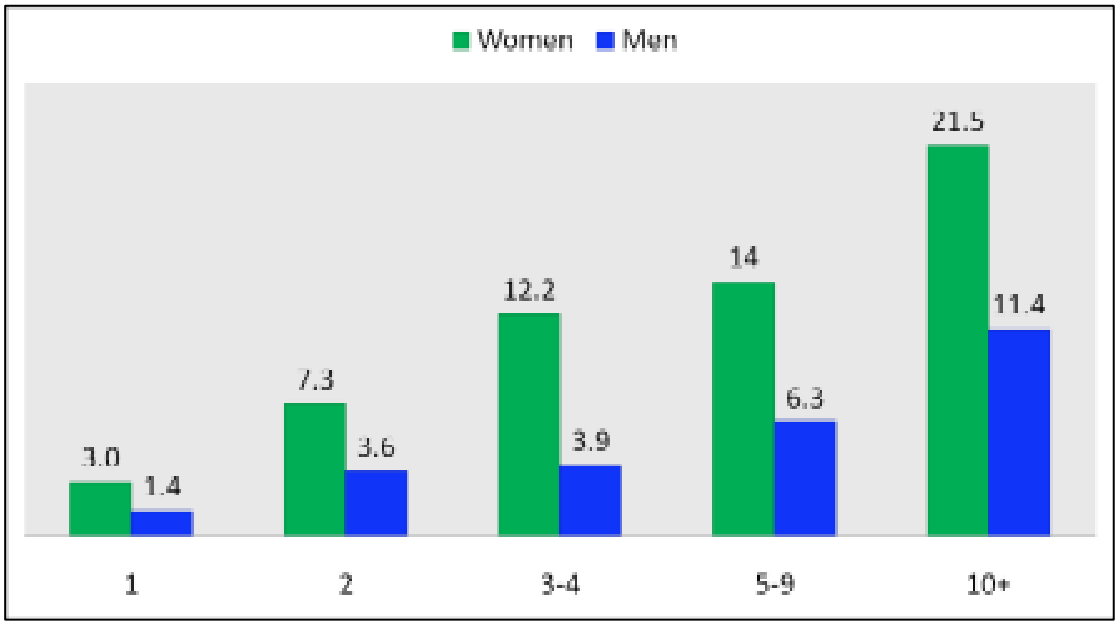
Figure 1: HIV Prevalence by Age Groups



Source: THMIS

[6] UNICEF, 2009, Child Protection Situation Analysis (SiTAN)
[7] THMIS, 2007-2008

Figure 2: HIV Prevalence and Number of Sexual Partners in Life Time



Source: THIMS 2007-08

1.3 The Policy and Programmatic Response

The Government's goal (MKUKUTA and NMSF):
Reduced HIV prevalence among 15 -24 year pregnant women from 11 percent in 2004 to 5 percent in 2010;
Reduced HIV prevalence from 11 percent in 2004 to 5 percent in 2010 between the ages of 15 and 24 years;
Reduce HIV and AIDS prevalence among women and men with disabilities
Increased the knowledge of HIV and AIDS transmission in the general population
Reduce HIV and AIDS stigmatization

Tanzania mainland began care and treatment services late 2004 where there were 96 Care and Treatment Centers (CTC) targeted to enroll 44,000 patients. By December 2006, CTC sites increased to 200 with total enrolment of 125,139 of whom 12,563 were children under 15 years, and 73,087 were women.[8] Recent data (March 2009) show that the cumulative number of clients enrolled in HIV CTCs totaled 454,681 representing 21.5 % of the 2,113, 158 estimated PLHIV.[9] While there has been a positive trend among women accessing services at CTC, the number of children accessing these services represented only 9% of the total CTC clients by December 2008, way below the 20% target set by the Ministry of Health and Social Welfare (MOHSW). There are major challenges exist in the area of early identification and enrollment of infected children into care. So far there are 509 (15%) out of 3420 PMTCT centers in the country conducting HIV Early Infant Diagnosis (HEID).

The national guidelines for PMTCT, VCT, and CTC, access to CTC, follow-up and continued care and support are available in all CTCs and ART including pediatric

8 NACP 2007 HIV/AIDS/STI Surveillance Report, Jan-Dec 2005 Report number 20.

9 NACP 2009. HIV/AIDS/STI Surveillance Report. Report Number 21

ART formulations are currently available in such facilities. However, health workers training, information systems and infrastructure are still not adequately supportive for the routine identification, testing and care and treatment of HIV-infected infants and children. In 2008 10,376 children were tested and by September 2009, 11,289. Out of those diagnosed, 90% were below 12 months.

National Guidelines for the Clinical Management of HIV and AIDS (2007) demand that children who are HIV+ be treated irrespective of their CD4 count in Care and Treatment Centers (CTC) yet these centers are adult oriented and inadequately adhere to this requirement. Little is known about children's mental, emotional, spiritual and social needs and how best these could be met.[10] That aside increasing numbers of orphans who lack supportive systems hence cannot easily access care and treatment services, and poverty in the general population, limits parents/guardians to take their infected children to CTCs compound access and adherence to ARV therapy among children. Retention rate and follow-ups is also weak according to NACP. About 65% of children of up to 12 months and 54% of 24 months are retained for treatment and the remaining are lost for follow-ups.

1.4 UNGASS Indicator Data in an Overview Table

Table 1: Indicator Table

Expenditure

	2007/08	2008/2009	
1: Domestic and International AIDS Spending by categories and financing Sources.	Foreign/Donor: Tshs. Bil. 393	Foreign/Donor: Tshs. Bil. 556	**HIV and AIDS Public Expenditure Review 2008/09 Draft Report**
	Local Tshs Bil. 20	Local Tshs. Bil. 11	

Policy Development and Implementation status.

2: National Composite Policy index (Areas covered: prevention, Treatment, Care and Support, Human rights, civil society involvement, gender workplace programs, Stigma and discriminations and Monitoring and evaluation.	Every 2 years.	**Desk review and key informant interviews**

National Programmes (blood safety, antiretroviral therapy coverage, prevention of mother to child transmission, co management of TB and HIV

10 HIV and AIDS Situational Analysis (SiTAN) of Women and Children in Tanzania (UNICEF).

Treatment, HIV Testing, Prevention programs, services for orphans and vulnerable children, and education).

Indicator	2008	2009	
3: Percentage of donated Blood units screened for HIV in a quality assured manner	33%	33.7%	National blood transfusion services
4: Percentage of Adults and Children with advanced HIV Infection receiving Antiretroviral therapy.	55 % of adult and children	55.2%	NACP 2008 and 2009
5: Percentage of HIV-positive pregnant women who received antiretroviral to reduce the risk of MTCT	55%	68%	**NACP**
6: Percentage of estimated HIV Positive incident TB cases that Received treatment for TB and HIV.	**No data available**	29.68%	**Program monitoring**
7: Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and know their Results.	18.9%.	**No Survey done**	THMIS 2007/08
8: Percentage of most at risk populations that have received an HIV test in the last 12 Months and who know the Results.	No data available	**No Data**	Behavioral survey for the MARPs not carried out
9: Percentage of most at risk Populations reached with HIV prevention Programmes	**No data available**	**No Data**	Behavioral survey for the MARPs not carried out
10: Percentage of orphans and Vulnerable children whose households received Free basic external support in Caring for the child.	16% OVC	**No Data**	TOMSHA
11: Percentage of schools that provided life skills-based HIV	Primary Schools (48%)	Primary Schools (62.5%)	Basic Education Statistics in

education in the last academic year			Tanzania (BEST) Year 2008 and 2009 Reports
	Secondary Schools (75%)	Secondary Schools (80.2%)	

Knowledge and behavior

Indicator	2008	2009	
12: Current school attendance among orphans and among non orphans aged 10-14*	40.23%		THMIS 2007/08
13: Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV Transmission.*			THMIS 2007/08
14: Percentage of most at risk populations who both correctly identify ways of preventing the Sexual transmission of HIV and who reject major misconceptions about HIV Transmission	**No data available**		Behavioral survey for the MARPs not carried out
15: Percentage of young women and men who have had sexual intercourse before age 15	10.49%		THMIS 2007/08
16: Percentage of Adults aged 15-49 who have had sexual intercourse with more than one Partner in the last 12 months.	12.22%		THMIS 2007/08
17: Percentage of Adults aged 15-49 who had more than one sexual partner in the 12 months reporting the use of condom during last intercourse.*	48.76 %		THMIS 2007/08
18: Percentage of female			Behavioral

and male sex workers reporting the use of a condom with their most recent client	**No data available**		survey for the MARPs not carried out
19: Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	**No data available**		Behavioral survey for the MARPs not carried out
20: Percentage of injecting drug users reported using sterile injecting equipment the last time they injected	**No data available**		**Special survey** for the MARPs not carried out
21: Percentage of injecting drug users reporting the use of a condom the last they had sexual intercourse	**No data available**		**Special survey** for the MARPs not carried out

Impact

Indicator	**2008**	**2009**	
22: Percentage of young women and men aged 15-24 who are HIV infected		6.77%	THMIS (2007/08)
23: Percentage of most at risk populations who are HIV infected	No Data	No Data	
24: Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy.	No data	64.54%	NACP 2008
25: Percentage of infants born to HIV infected mothers who are infected.	18%	26.5%	NACP for 2008 and Spectrum Estimates for 2009

2. Overview of the AIDS Epidemic

Compared with HIV prevalence data from the 2003-04 THIS, there has been a slight decrease in overall prevalence of HIV among adults (one percentage point), from 7 percent in 2003-04 to 6 percent in 2007-08. Prevalence has declined for every age group except those 45-49. Recent HIV prevalence data from various sources – HIV prevalence during sentinel surveillance of pregnant women at antenatal clinics, HIV prevalence of blood donors, and HIV prevalence in 2 rounds of population based HIV

surveillance surveys – confirms the recent stabilization of HIV prevalence in Tanzania (Figure 3).

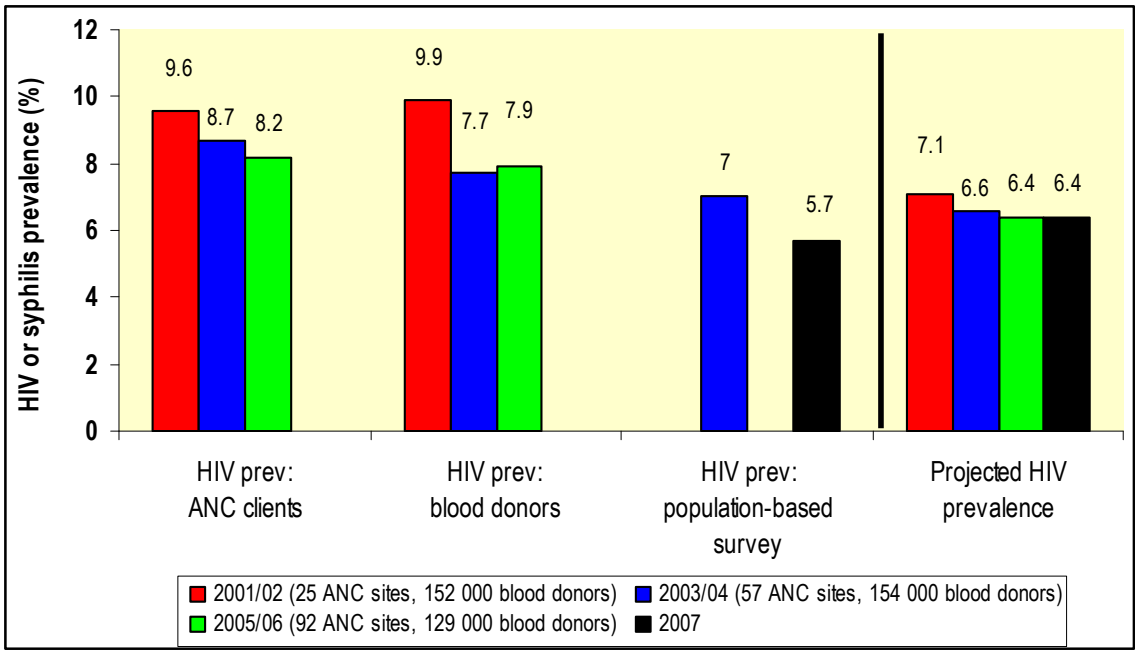
The decline in HIV infection among those aged 15-19 was from 2 percent in 2003-04 to 1 percent in 2007-08.[11] The study reviewing the HIV epidemic in Tanzania mainland shows the following heterogeneity of HIV prevalence:

(a) Heterogeneity amongst men, women and in different age groups

Overall, women are more likely to be HIV positive than men: In both rounds of population-based HIV testing (2003 and 2007), women were overall more likely to be HIV positive (see Figure 2). An extremely high female: male prevalence ratio has been found in Kigoma in 2007. Two exceptions to this general observation of excess female HIV risk are observed:

i. Amongst 'HIV-discordant couples', there are **more male-positive-female-negative couples** than vice- versa; and
ii. among certain **older age groups**, men have higher HIV prevalence than women. This higher risk for older males was less pronounced in the 2007 survey data, compared to the 2003 data. AIDS case reporting data reflect this higher HIV burden in males within the older age groups (see Figure 4). Trend seems to be changing over time – in 2007, women were more likely to be HIV positive in all age groups – except for men aged 34 to 39.

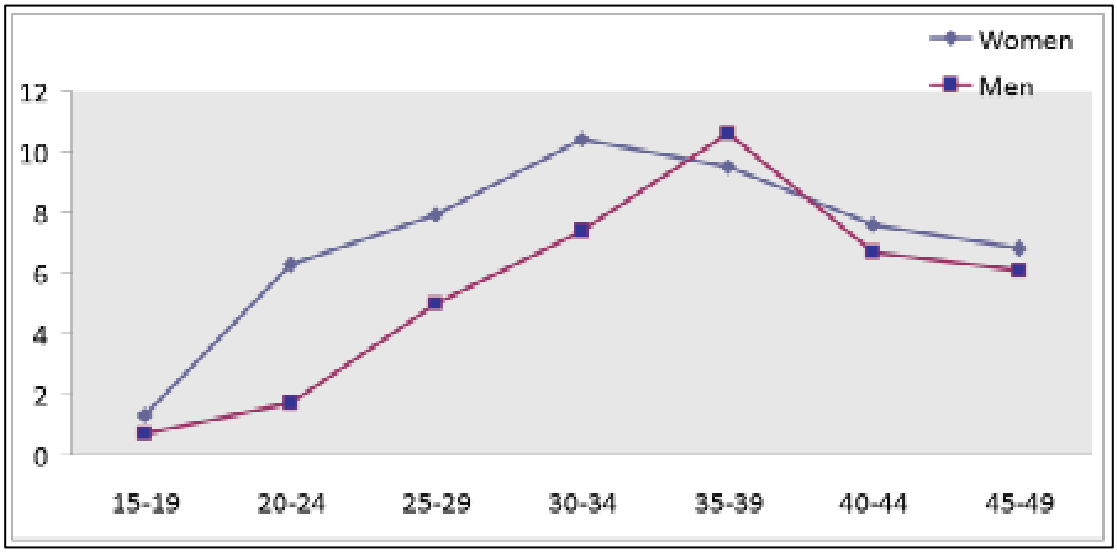
Figure 3: HIV Prevalence Point Values from Different Sources in Tanzania 2000-2007



Source: THIMS 2007/08

[11] THMIS 2007-08

Figure 4: HIV Prevalence among men and Women aged 15-49 in Tanzania, 2007

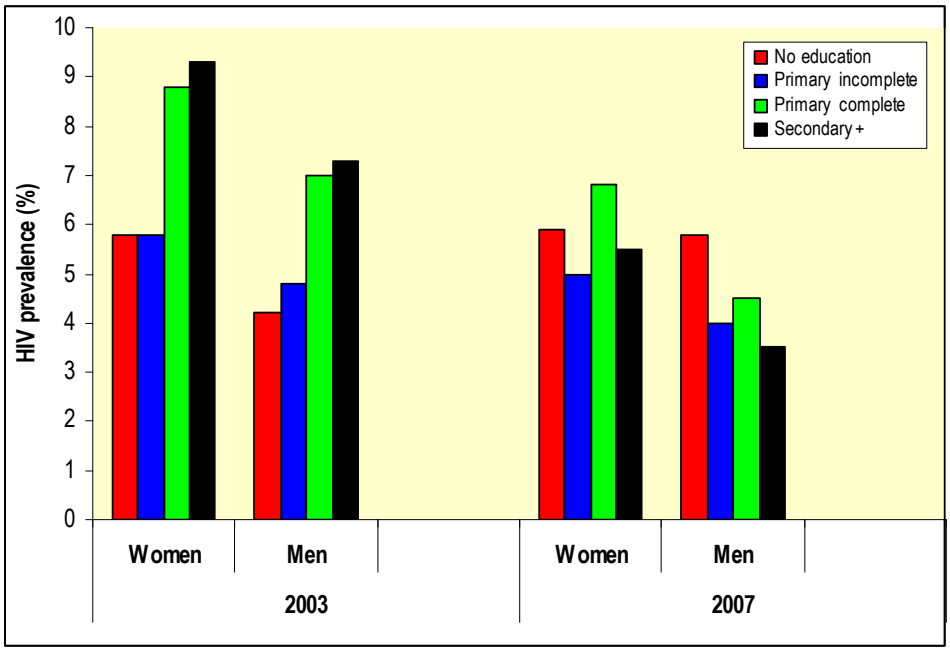


Source: THIMS 2007/08

(b) Heterogeneity across education levels

Patterns of HIV by education level seem to be changing. Up to 2004, at the population level, persons with higher education were more likely to be HIV positive. However, the latest population-based HIV surveillance survey (THMIS 2007-08) showed, for the first time at population level, that HIV prevalence was lower amongst educated than uneducated persons. The difference was larger amongst men (Figure 5).

Figure 5:Changing patterns between HIV prevalence and education levels, Tanzania, 2003 and 2007

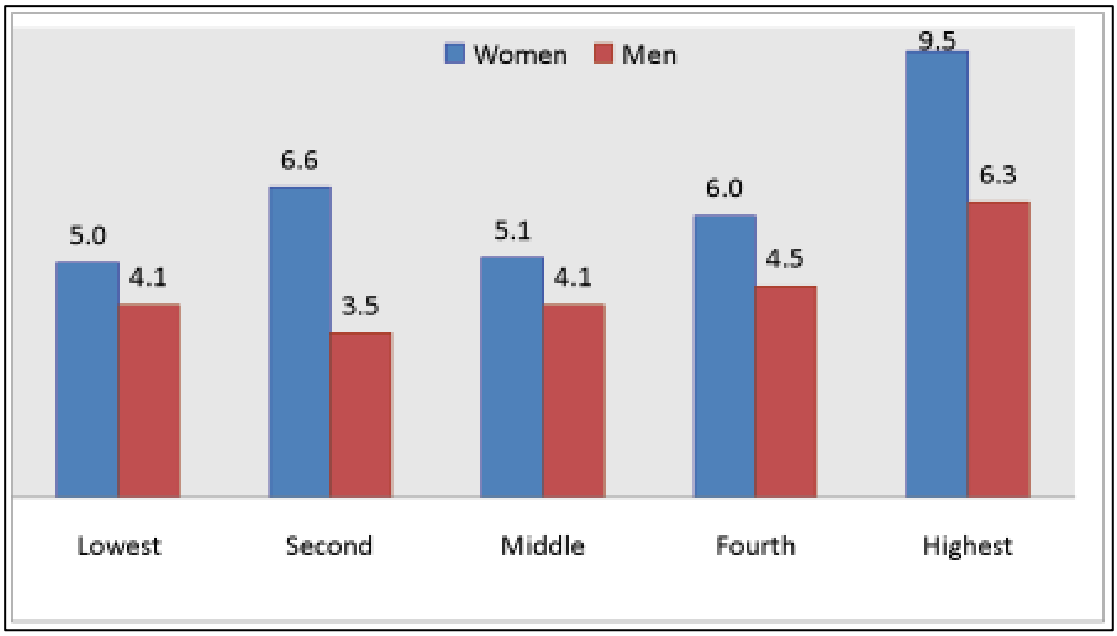


Source: THIMS 2007/08

(c) Heterogeneity across relative levels of wealth

Prevalence of HIV is higher among the richest according to the 2007/08 THIMS and is lower among the poorest (figure 6). This is true for both women and men. The prevalence is high among women compared to men in all wealth categories.

Figure 6: HIV Prevalence by Wealth 2007

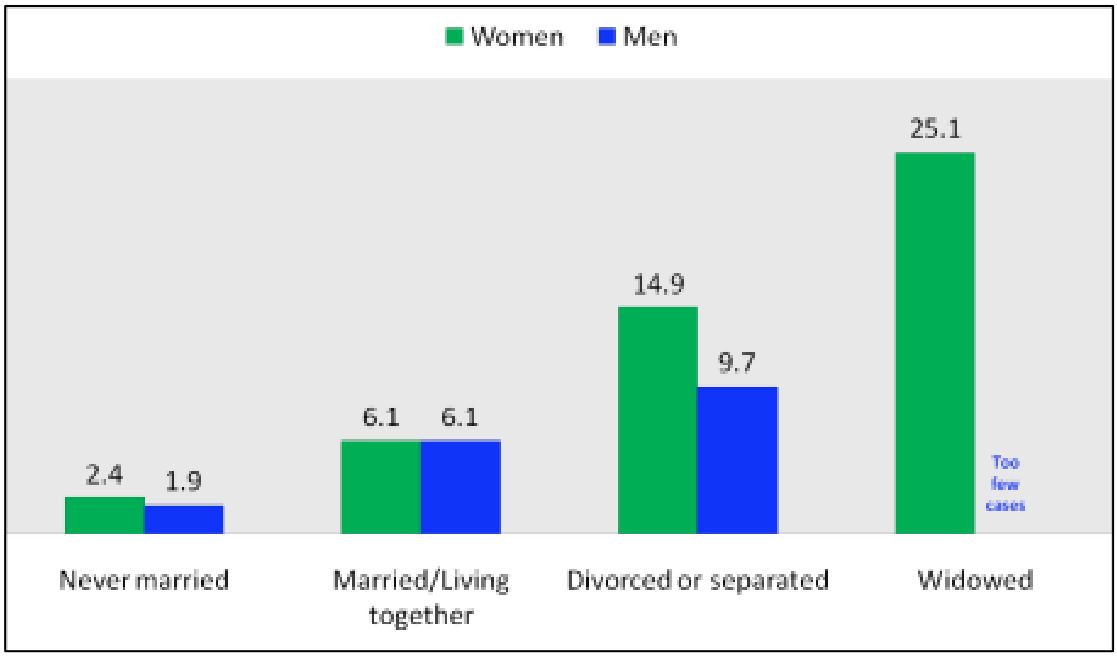


Source: THIMS 2007/08

(d) Heterogeneity relating to marital status

HIV prevalence is highest amongst the widowed women (25.1%) while widowed men are more unlikely to be HIV positive. HIV prevalence is also relatively high among the divorced or separated women (14.9%) compared to the divorced and separated men 9.7%). Prevalence is lowest among those who never married (2.4%) for woman and (1.9%) for men (Figure 7).

Figure 7: HIV Prevalence by Marital Status



Source: THIMS 2007/08

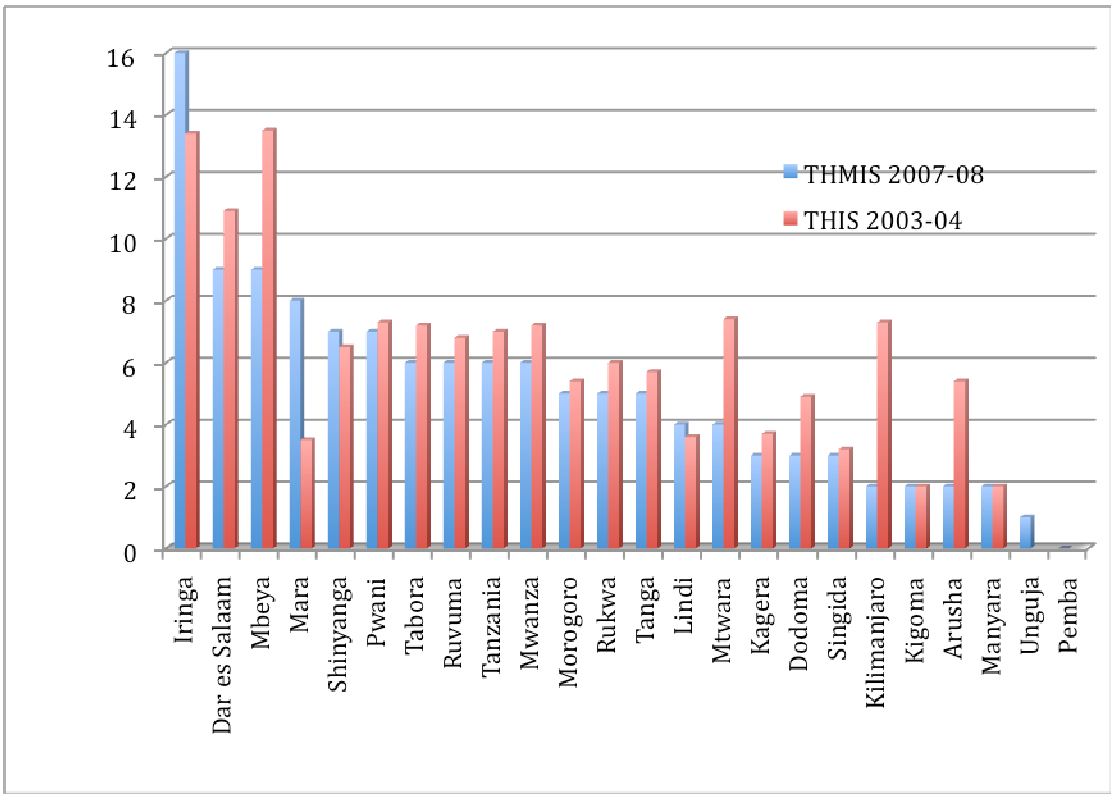
(e) Geographic heterogeneity: Residence

HIV prevalence in urban areas is much higher than in rural areas: According to population-based estimates, HIV prevalence in urban areas has been almost twice as high as in rural areas. Further, the urban HIV epidemic is comparatively older in Tanzania. HIV transmission intensities are high in areas of high mobility (average HIV prevalence in roadside ANC clinics at 15% and in border area ANC clinics at 20%).

(f) Geographic heterogeneity: Administrative regions

There is great regional heterogeneity with adult HIV prevalence ranging from 1% to 15%. There are large differences across the 21 regions in Tanzania – some regions are primarily rural, others are primarily urban; some regions have high circumcision rates, others do not. There are very large differences in HIV prevalence levels across the regions, as Figure 8 shows, with HIV prevalence ranging from 1% in Kigoma Region to 15% in Iringa Region in 2007.

Figure 8: Trends in HIV Prevalence by Region



Source: THIMS 2007/08

3 National response to the AIDS epidemic

3.1 The Existing Policy Environment

A Policy is a framework for decision-making, designing programmatic intervention, assessing and or evaluating performance. It is the basis for making laws and rules and regulations and resource allocation. In this section we review the existing policies and examine the extent to which these policies have attracted political attention, and have provided the driving force for programmatic intervention and resource allocation.[12] Currently policies and resource allocation in principal are supposed to be guided by the National Strategy for Growth and Reduction of Poverty (NSGRP, 2005 or MKUKUTA in Swahili). The NSGRP is the national strategy that is aimed at promoting equitable, broad-based and sustainable economic growth and reduction of poverty and vulnerability through the following three clusters of interventions:

- Growth and reduction of income poverty, through investments in building human capabilities i.e. education, health and nutrition. Investments in physical capital, promotion of the private sector and trade a well as foreign direct investments

[12] See Mhamba 2008, ILO Report on the Review of Child Labour and HIV and AIDS Policies in Tanzania

- Quality of life and wellbeing by ensuring all people, more particularly the poor and vulnerable to essential services including HIV and AIDS prevention and treatment and social protection programs.
- Governance and accountability through reforms to strengthen management of the public sector and building capacity of Tanzanians to claim and exercise their rights as citizens. Furthermore, to provide space and strengthen the capacity and capability of the civil society organizations CSOs in governance and in ensuring effective public sector accountability.

The second cluster has direct relevance to the prevention and addressing the effects of HIV and AIDS in the country, which includes the OVC. However, there is a lack of sectoral strategies to safeguard the rights of the children and to rehabilitate children victims of violence, abuse, neglect and abandonment. The NSGRP does not adequately address the systemic problems that are causing the growing socio-economic inequalities, in terms of access to essential social services and economic assets such as land.[13]

Furthermore, as far as vulnerability and poverty alleviation is concerned, there are multiple priorities identified in the National Strategy for Economic Growth and Poverty Reduction (MKUKUTA). Consequently, choices for strategic targeting of interventions and allocation of the meager public resources across sectors become a big challenge. Accordingly, allocation of resources for protection of the rights of the children, suffer the same consequence.[14]

The Child Development Policy was developed among other things to ensure the alignment of Tanzania to its commitment to the CRC, which Tanzania ratified in 1991. The policy places special emphasis on child's basic right as defined in the CRC. The Policy outlines the major causes of child vulnerability in the country, which includes, poverty, difficult access to essential services, consequently denying them the opportunity to build their capabilities and escaping from the intergenerational transfer of poverty and the culture of gender discrimination which denies girls human rights and exposing them to adult responsibilities at an early age, consequently making them vulnerable to various forms exploitation and abuse including, commercial sex and domestic working.

The policy further provides measures to protect these rights as well as defining the roles of the different actors i.e. the parents, guardians, community, the government and institutions, including the civil society organizations. The policy also proposes a review of the existing legislations as a measure towards ensuring the alignment of the statutes to the best interest of the child.

The child policy does not show synergetic relationship with the other sectoral policies, besides the mention that it will be implemented alongside other sectoral policies. The Child Development Policy has been reviewed and the Child Bill has been finalized. However, the bill is still awaiting endorsement by the parliament, which has taken a long time for that to be done.[15]

[13] Ibid.
[14] Ibid.
[15] Ibid.

The national health policy in Tanzania seeks to improve the health and well being of all Tanzanians with a special focus on those most at risk, and to encourage the health system to be more responsive to the needs of the people. The policy recognizes that, good health is a major resource essential for poverty eradication and economic development. The policy seeks to facilitate meeting the key health related targets of the MDGs, which are also enshrined in the NSGRP. These are reduction of maternal and infant mortality, provision of adequate and equitable maternal and child health services. The policy also provides for more resource allocation for the prevention of HIV and AIDS and other diseases such as malaria and immunization of children under 2 years of age, as well as enhancing the provision of reproductive and Child Health including family planning. In this respect the policy provides for promotion of youth – friendly services so as to improve access to reproductive health information and services for young people.

The policy further provides for exemptions for the poor and vulnerable groups, however, it falls short of specifying who are the vulnerable groups. In addition, it does not explain the modalities for establishment and operation of CHF but rather requires the Ministry of Health and Social Welfare, in collaboration with other departments to put in place mechanisms for risk sharing and cross – subsidization in order to ensure solidarity and equity. Studies have shown that:

a) Further extension of fees to dispensary and health centre levels would work to the disadvantage of the poor
b) There are weak mechanisms for the administration and targeting of exemptions to the vulnerable groups including children, especially the most vulnerable children.[16]

The national policy on HIV and AIDS provides an overall framework for leadership and coordination of the National Multisectoral response to the HIV/AIDS epidemic. This includes formulation by all sectors, of appropriate interventions, which are effective in prevention of HIV and AIDS and other sexually transmitted infections. Besides, the policy provides direction and general principles in the national response interventions, in the prevention, care and support of those infected and affected by the epidemic and mitigation of its social and economic impact.

The policy provides for individual sectors to design and implement measures and programmatic intervention, under the National Multisectoral response to the HIV/AIDS epidemic. The policy also recognizes the vicious circle between HIV and AIDS and poverty, and therefore stresses interventions for control of the epidemic to be simultaneously related to poverty alleviation initiatives. The policy also encourages and promotes the spirit of community participation in HIV and AIDS activities. This includes community representation in national and district for fund raising, strategic planning and implementation by all sectors. It also includes ward level and village level strategic planning for prevention of transmission of HIV/AIDS and STI as well care and support of PLHIV, their dependants/families and orphans.

[16] The MVC Program Impact Assessment in Musoma rural District, 2004, and the Impact Assessment of the MVC Programme in Tanzania, 2006

The government of Tanzania in July 2007, launched its second National Multi-sectoral Framework (NMSF) on HIV & AIDS to cover the period from 2008 to 2010. The second NMSF builds on the achievements and strength of the first NMSF, which covered the period from 2003 to 2007. The second NMSF priority focus is on the enhancement of the enabling environment; prevention; care, treatment and support; and impact mitigation. The NMSF does not provide for strategic interventions to address problems related to impoverishment and the consequent impact on HIV and AIDS and OVC.

However, policy implementation is hindered by systemic problems. Constrained policy implementation process in Tanzania is a major structural problem that thwarts the realization of the intended policy outcomes. In the firsts place government practitioners, especially at the lower levels, and other stakeholders generally lack the sense of policy ownership as policy development process by and large takes place at the central government level. Secondly, policies generally, including the health and the HIV and AIDS policies are not widely distributed in the country especially at the district levels and therefore people do not have a sense of what the policy agenda is all about. Thirdly, policies are inadequately translated and disseminated; consequently awareness of the policy agenda at implementation level is inadequate.

In addition to that, the strategic framework is multi sectoral and comprehensive but the Government's response is mainly concentrated to the Ministries of Health and TACAIDS. Medical interventions and services attract the main part of available resources.[17]

Table 2: Summary of the National Composite Policy Index Responses
Part A

Area	Overall Rating	Comments
Strategic plan	Median (6.5)	Systems and structures for providing services available down to the district level for VCT, Care and Treatment and Impact mitigation.
Political support	Median (6)	Mainstreaming of HIV and AIDS in the political agenda and supporting public resource allocation for HIV and AIDS as well as campaigning for VCT
Prevention	Median (7)	Increasing education and awareness raising campaigns through IEC, increased knowledge and awareness on HIV preventing among the general population and increased proportion of people attended VCT and who know their results
Treatment, care and support	Median (7)	Treatment, care and support available for free, which enables access among the poor and vulnerable population groups

[17] HIV and AIDs Public Expenditure Review (PER) 2008/09 Draft Report

Table 3 Continues: Part B

Area	Overall Rating	Comments
Human rights	5	HIV Policy provides for protection of human rights for the people living with HIV and AIDS
Civil society involvement	5	Platforms for involvement of people living with HIV and AIDS and other CSOs have been provided at all levels of government [both at central and local government levels] decision making structures
Prevention	7	Excellent progress in VCT services across the country and in education and awareness raising campaigns through IEC materials and the Media
Treatment, care and support	4	There is still inadequate treatment, care and support for people living with HIV and AIDS in the rural areas. These services are still urban based

Source: National Composite Policy Index Tools (2010)

3.2 Progress in HIV Policy Making Process in Tanzania

Policy outcomes depends on the policy making process, which refers to the way policies are initiated, developed or formulated i.e. agenda setting process, negotiated, communicated, implemented and evaluated.[18] In addition, policymaking process involves multiple actors, whom do not all of them speak with one voice and whose values and beliefs differ.[19] The interest of individuals, groups and organizations are critical determinants in the decision making process from setting the policy agenda, to implementation and evaluation of outcomes.

The 2001 HIV and AIDS Policy of Tanzania mainland was formulated through a consultative process in which all stakeholders were involved. However, the involvement of vulnerable groups such as People Living with HIV (PLWH) as interest groups was still weak due to the fact that networks and forums for such groups of people were still fragile and inadequately coordinated. Furthermore, processes for involvement of other vulnerable groups such as poor people in rural areas were still non-existent. The Multisectoral HIV and AIDS committees were established in early 2000s. The committees however are still struggling with capacity issues and availability of space to influence in the decision making process. Can influence local governments but processes to influence central government, development partners and local and international CSOs are still fragile. The government in collaboration with stakeholders is currently in the process of reviewing the HIV/AIDS policy to accommodate these gaps. Already the government using the printed media has invited stakeholders provide their contribution of ideas to the process.

[18] Health Policy book
[19] (Buse et al. 2005).

3.3 Implementation of HIV Prevention Programmes

3.3.1 Blood Testing

Tanzania has not yet achieved Universal (100%) screening of donated blood for HIV and other transfusion-transmissible infections. Mechanisms to ensure quality and continuity in screening particularly at the lower levels of the health system are still inadequate. So far only 35.7% of the donated blood in the country is screened for transfusion-transmissible infections, including HIV, i.e. 125,000 out of 350,000 number of donated blood units screened for HIV in blood centres/blood screening laboratories in the country in a quality assured process.

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3.3.2 Prevention of Mother to Child Transmission (PMTCT)

3.3.2.1 Background of the national PMTCT programme

In 2000, the Ministry of Health and Social Welfare in collaboration with UNICEF established the five initial PMTCT pilot sites in four referrals and one regional hospital; Muhimbili National Hospital, Bugando Hospital, Mbeya Referral Hospital, Kilimanjaro Christian Medical Center (KCMC) and Kagera regional hospital located in Dar es Salaam, Mwanza, Mbeya, Kilimanjaro, and Kagera region respectively. The aim of the pilot implementation was to determine the feasibility of integrating PMTCT in routine reproductive and child health services in Tanzania. Ever since, the PMTCT programme has been adopted by the Government of Tanzania as one of the priority interventions in responding for HIV and AIDS. The national PMTCT programme in Tanzania is based on the four-prong model recommended by WHO and other UN agencies.

The implementation of the PMTCT programme is guided by the National PMTCT, Paediatric HIV scale up plan (2009-2013), which has been developed recently. The goal of the national scale up plan for Tanzania is to improve health of parents and their children by scaling up comprehensive PMTCT and Paediatric HIV care, treatment and support services. Program Objectives (as stated in the health sector strategy for HIV and AIDS, 2008) include to:

i. Increase the percentage of HIV positive pregnant women who receive Arts from 34% in 2007 to 80% by 2012 and to reduce the transmission from mothers to their children during pregnancy, birth, and breast feeding and ensure access to care and treatment for mothers and babies.

ii. Improve child survival among HIV exposed and infected children.

3.3.2.2 Achievements of the national PMTCT program

(a) National PMTCT policy guidelines

PMTCT Guidelines were reviewed in 2007 to be in line with National and International recommendations. These Guidelines are available in all sites providing PMTCT services in the country. 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. 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 Paediatric 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.

(b) Training of PMTCT Service providers

By December 2009, the PMTCT Unit, had coordinated and facilitated the training of 234 trainers (National, Regional and District trainers) and 8003 health care workers from 3,626 PMTCT sites. Regional and District Reproductive and Child Health Coordinators are trained as supervisors. Some regions and districts have trained their service providers using existing regional trainers with funding from the United States government, Global Fund, Basket Fund and other development partners, following incorporation of PMTCT in their local comprehensive health plans.

(c)Service Delivery Sites for PMTCT

Overall, about 78% (3,626) of 4,647 health facilities providing RCH services are currently providing PMTCT services (Dec 2009). However, there are still regional variations that are could be attributable to constraints in resources (Financial and Human) despite the "regionalization policy".

(d) HIV testing and counselling:

In year 2009, a total of 1,223,964 new ANC attendees were registered in facilities implementing PMTCT services. Among those ANC clients, 1,194,172 (98 percent) were tested for HIV. During that period 5.8 percent (70,423) of the women tested were identified as HIV infected.

(e) Uptake of ARV Prophylaxis:

In the same period (Jan-Dec 2009), 84% (58,833) of the women who tested positive for HIV received ARV prophylaxis. However when reflected in the total estimated number of HIV infected pregnant women (86,000); the percentage becomes 68%. Infants who received ARV prophylaxis reached 43,119, representing about 50% of estimated exposed infants (children born to HIV infected women).

(f) Early Infant Diagnosis (EID)

The MOHSW in collaboration with development partners, as part of scaling up services, has developed guidelines on early infant diagnosis, including new guidelines for early initiation of ART and equipped the four referral hospitals (Muhimbili National Hospital-MNH, Mbeya, KCMC and Bugando Hospitals) to perform early infant diagnosis using Deoxyribonucleic Acid – Polymerase chain reaction DNA-PCR testing. By June 2009 there were 507 sites providing EID services in the Tanzania mainland. Early infant diagnosis of HIV allows health-care workers to early identify HIV infected children and ultimately offer optimal care and treatment of HIV-infected children, assists in decision-making on infant feeding, and avoids needless stress in mothers and families.

(g) Monitoring and evaluation of PMTCT services

Monitoring of the programme is done on the monthly bases at the level of facility. The registers are filled daily and summaries are filled monthly. The information is aggregated at the district and regional levels on quarterly basis, and sent to the MoHSW. Moreover, there are strategies on ground to evaluate programme by determining number of HIV exposed children who are infected. Plans to conduct a survey to determine this number are underway

3.3.2.4 Implementation Challenges and way forward

Challenges in scaling up PMTCT implementing sites

Despite rapid scale up of PMTCT sites to about 3626 sites (Dec 2009) the pace still is slow in some of the regions and districts; and this can be due to:

- Poor ownership and leadership by the regional and district authorities in terms of planning and allocation of resources (IPs, GF, Basket fund) for PMTCT
- Meager resources for training health care worker for all the sites at the district level

Way forward:

- Continue to build capacity to the district managers on evidence based planning and resource mobilization, to identify priority activities and incorporate them into their CCHPs.

i. Challenges in ensuring pregnant women are accessing PMTCT services

- Reluctance of the health facilities to start provision of combined regimen for PMTCT despite having capacity to do so
- Implementing partner's at the regional and district level do not provide adequate technical assistance to the district authorities (inconsistent data, poor data flow)
- Inadequate human resource to support ideal services (very few clinicians) as ideal services needs clinicians especially for prescription. Many sites have adequate number of nurses.

Way Forward:

- Constant mentoring and supervision is needed to ensure that the knowledge imparted and acquired skills are utilized properly. Timely supportive post-training follow- up needs to be instituted. Readily available technical teams need to be established at Zonal Training Centers. These teams will be responsible for mentoring and trainings of HCWs within a zone under a guided annual calendar
- Policy on prescription of ARV by nurses (task shifting); While awaiting for an institution of policy for task shifting; another strategy is to train as much clinicians (prescribers) as possible on comprehensive PMTCT so as to enable lower facilities also provide/initiate more efficacious combined regimen at primary level where the majority of pregnant women attend.

ii. Challenges in ensuring that exposed babies have access to HIV early Infant Diagnosis (HEID)

- Few health workers have been trained on HEID
- Long time gap between training and service initiation leading to knowledge decay.
- Receipt of results after testing (longer turnaround time)
- Lack of ownership by the regional and district authorities in terms of planning for implementation of HEID
- Inadequate partner support in scaling up HEID

Way Forward:

- Regional target setting for PMTCT and HEID services, this will stimulate focus and goal directed approach towards realization of regional targets, by both regional authority and the regionalized partner.
- Training of new health care workers and initiation of services in sites which are not providing HEID services, approach targeting PMTCT sites
- Trainees from sites, which have not started HEID services, will be provided with HEID kits to immediately start services, but also every training plan should have a post-training follow-up.
- Contracting of local courier in a business approach, with implementing partners supporting sample and results transportation between district and facilities will ensure smooth sample and result transportation and significantly cut down the turnaround time.

Table 3: Some PMTCT Statistics for Tanzania Mainland

	2006	2007	2008	2009 (Jan. Jun
Number of Infants Born to HIV+ Mother Receiving a virological Test within two months	Nil	Nil	Nil	834
Estimated number of women who get pregnant every year	1,400,000	1,509,000	1,560,000	1,611,870
Estimated number of HIV+ Pregnant Women (15-49)	114,800	123,738	127,920	86,000 (Jan-Dece)
Number of infants born to HIV+ mothers receiving a virological test for HIV diagnosis within 12 months of birth	Nil	Nil	10,376	11,289
Number of infants born to HIV+ mothers initiated on contrimoxazole within 2 months after birth	Nil	Nil	Nil	2,329

Source: PMTCT Programme, Ministry of Health and Social Welfare

3.3.2 PMTCT Implementation Challenges

There are two main categories of challenges facing PMTCT implementation in Tanzania, namely health system challenges and PMTCT programming challenges. One of the critical health system challenges is the availability of human resources and their capacities or capabilities. Inadequate availability of physicians is one of the major health systems challenges in the country. This problem is particularly severe in rural areas where health centers and dispensaries are only staffed with non-physician health workers i.e. clinical officers and nurses. This is one of the major challenges not only for the implementation of PMTCT interventions but also for clinical HIV and AIDS responses in general and other diseases. For the PMTCT trained health workers, the major problem is that of rotation of staff within services at health care facilities which often creates gaps in terms of PMTCT trained staff in the PMTCT units. Besides, turnover of staff because of seeking greener pastures and or further training opportunities adds to the problem. Consequently some of the PMTCT centers are not providing services because the trained people with capacity to provide PMTCT services are not there.

Training on PMCT service provision has been provided in all the 3,420 PMTCT cites in the country, which are mainly public and private not-for-profit health care facilities. Given the fact that people make their own choices in accessing health care services, provision of PMTCT services in the private for profit health care facilities is also necessary. Provision of training to the private-for-profit health care facilities was done in Temeke district with support from the UNICEF. Support was provided to this district because Temeke district is one of the UNICEF's learning districts. However, training for private hospitals in other districts just started in 2008 in Illa and Kinondoni Districts in Dar es Salaam. Further plans to scale-up this training to other private hospitals in other regions are underway.

PMTCT implementation is also constrained by the availability of financial resources for the PMTCT activities in the districts. Districts do not have PMTCT priority in their district plans and consequently local governments do not allocate resources to support PMTCT activities in the district. This problem is currently been addressed by developing a planning temperate that will facilitate district planers to include PMTCT activities in the budgetary process.

The second set of challenges is related to PMTCT Programming. This includes challenges to identify HIV+ pregnant women in terms of either "*high transmitters*" i.e. those with low CD4 count and should be put on ART immediately or "*low transmitters*" i.e. those with high CD4 count for receiving prophylaxes. Children born to HIV+ women are given HIV early infant diagnosis using the DNA – PCR machine which are only available four referral hospitals in the country, i.e. Muhimbili National Hospital in Dar es Salaam, Bugando Hospital in Mwanza, Mbeya Hospital in Mbeya regions and KCMC, in Kilimanjaro region. This means that blood samples taken from infants from all the district PMTCT centers have to be taken to these four centers. Considering inadequate human resource capability to handle such samples and the inadequacies in the system network for transporting samples from the districts hospitals to the four hospitals with viral load testing capabilities and bringing back the

results to the district PMTCT centers, poses a major challenge for early HIV diagnoses for infants.

CHAI is leading the process of diagnosing infants for HIV. So far there are 509 out of 3420 (15%) PMTCT centers in the country conducting HIV Early Infant Diagnosis (HEID). Children are diagnosed during the normal attendance for immunization as PMTCT functions within the normal child immunization system in the country. Infected children are referred to ART. Generally availability of ART is not a problem in the country. However, the policy does not dictate that children born from infected mothers should be tested for HIV, but, in order to protect children's right for life, the policy should require all infected women to bring their children for testing in both public and private hospitals, so that, early treatment is initialized for infected child

3.3.3 HIV Prevention among the Youth

HIV prevention among the youth includes among others HIV/AIDS life skills education for in and out of schools. However, prevention of HIV among the youth including out-of school youth is still facing the following challenges:[20]

i. Besides being sexually active, this population group is mobile and therefore reaching them becomes difficulty. CSOs have been active actors in targeting out of school youth through youth groups, youth clubs and associations most of which constitute young people above 18 years. These efforts have remained poorly coordinated with different actors using their own Life Planning Skills (LPS) manuals and techniques to empower youth with behaviour change techniques.
ii. Poor Monitoring and coordination of interventions: The Ministry of Labour, Sports and Youth Development acknowledges poor monitoring of such programs and is currently developing a prevention strategy and a national LPS standard manual to ensure consistency in messages and the overall approach. However, there is still a great need to effectively address the 15-17 age children who have just finished school and are rarely found in youth clubs or associations

3.4 Implementation of Care, Treatment and Support Programmes

The government of the United Republic of Tanzania launched a HIV/AIDS Care and Treatment plan in October 2003 and since 2004 a rapid and large scale roll-out of anti-retroviral treatment has been ongoing. In 2006 the National AIDS Control Program (NACP), with technical and financial support from WHO and in collaboration with various national and international partners, adopted the WHO patient monitoring system (PMS). By December 2007 all care and treatment clinics (CTC) in the country had been trained to use this system. It consists of a patient-held card (CTC-1), clinic kept form (CTC-2) and pre-ART and ART registers for data collection, and a monthly, quarterly and cohort report forms for data reporting.

Access to care and treatment services program has expanded to those who had not been able to afford for ART. A number of partners have joined the government in this undertaking. These included the governments of Sweden, Canada, Norway, the Netherlands and Japan, the UN Agencies UNDP, UNAIDS and WHO and international partners such as the Clinton

[20] UNICEF, 2009, HIV and AIDS SiTAN for Women and Children in Tanzania

Foundation, PEPFAR and GFATM. The support of implementation of C&T services at health facility level has been regionalized, with partners AIDS Relief, CHAI, EGPAF, FHI, ICAP, MDH and Walter Reed each supporting one or multiple regions and Pharm Access International supporting the armed, prison and police forces

The operational target was to provide ART-drugs to 440,000 AIDS patients by the end of 2008. To achieve this objective, the MOHSW established care and treatment units starting from referral hospitals followed by regional and district hospitals and then to health centres and dispensaries. As of March, 2009, the cumulatively reported number of patients ever started on ART was 235,012 and a total of 454,681 patients were reported to have been enrolled in care. The number of clients started on ART represents 53.4% of the target ever enrolled in care represents 21.5% of the estimated 2,113,158 PLHIV.

The proportion of people HIV and AIDS/TB co-infected people on treatment is till very small. As shown in the indicator table, the number of adults with advanced HIV infection who are currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) and who were started on TB treatment (in accordance with national TB programme guidelines) within the reporting year is 5,918 against 19, 940 estimated number of incident TB cases in people living with HIV. This represents only 29.68% of the estimated number of incident TB cases in people living with HIV who are on HIVand AIDS/TB treatment programme.

3.5 Knowledge and Behaviour Change

The recent data on knowledge and behavioral change are obtained from the THMIS 2007-08. The survey results indicate that over 98 percent of Tanzanians age 15-49 years have heard of AIDS. The proportion is similar with results from the 2003-04 THIS and the 2004-05 TDHS. Overall, awareness of AIDS is very high in both Mainland Tanzania and Zanzibar, amongst men and women in all age groups, and across background characteristics, with at least 90 percent of people having heard of AIDS.

Early sexual debut compounded by early marriage practice of children below 18 years subject adolescents in this age category to early HIV infection. It is estimated that 11% of girls and 10% of boys have had sexual intercourse before age 15.21 By age 18, 50% of young women and 43 % of young men have had sexual intercourse. Studies have shown that once they become sexually active, young people tend to have multiple partners.22 And the fact that a third of victims of unsafe abortions are teenagers of whom almost half are 17 years and below reflect unsafe sexual practice hence high vulnerability to infection.23

The indicator on the percentage of young women and men aged 15–24 years who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission shows there is still little achievement in this area. Still less than 50% of young men and women in the country have knowledge about HIV infections and precisely reject major misconceptions about HIV (See figure 9 – 12 for knowledge and behavioral changes in Tanzania 2007-08 Population based survey). Besides, young men are more likely than women to have comprehensive knowledge and are able to identify ways of preventing the sexual transmission of HIV

21 THMIS 2007/08

22 Health Sector HIV/AIDS Strategic Plan (HSH SP 2008-2012)

23 Ibid

and reject major misconceptions about HIV transmission. Almost over 55% of the population group aged 15-24 do not have this knowledge.

Figure 9: Comprehensive HIV knowledge amongst 15 to 24 years old Tanzanians Mainland (2008)

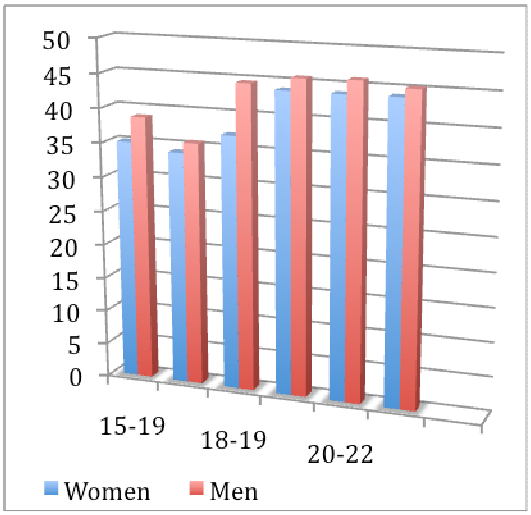


Figure 10: Percentage of young women and men aged 15–24 years who have had Sexual intercourse before the age of 15 years

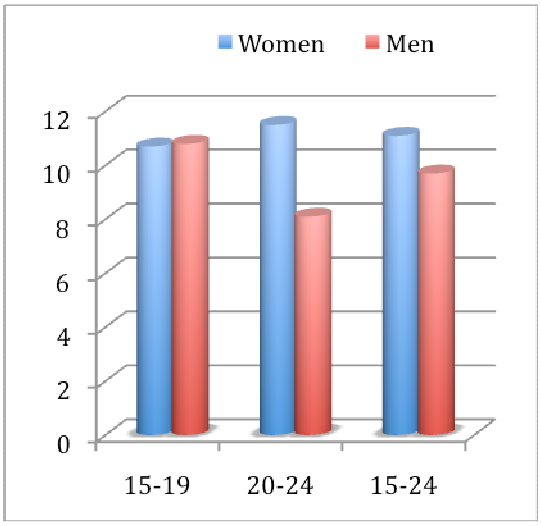


Figure 11: Percentage of women and men aged 15–49years who have had sexual Intercourse with more than one partner in the last 12 months

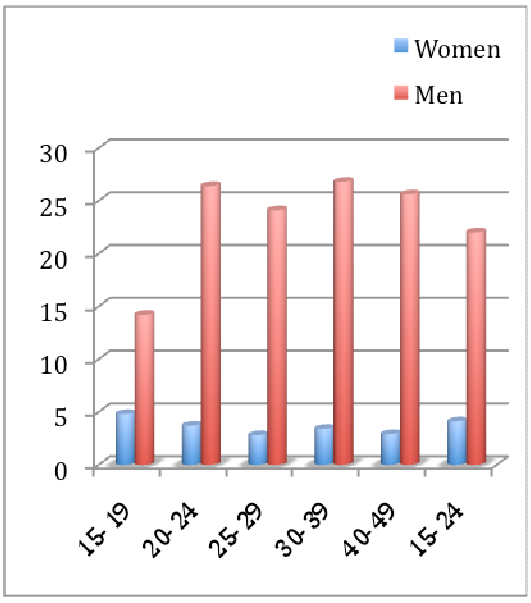
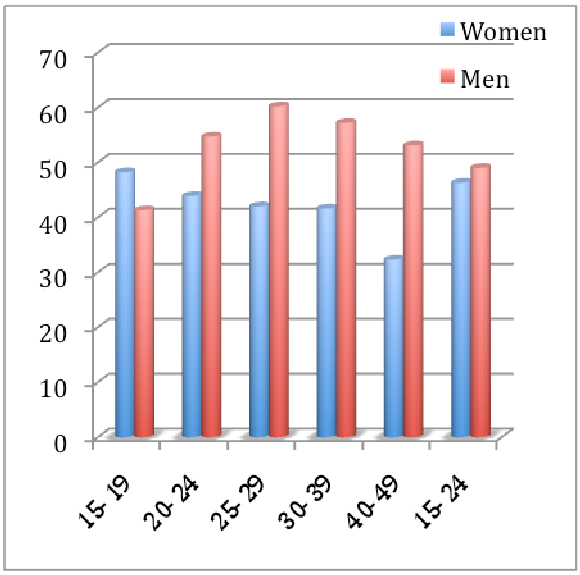


Figure 12: Percentage of women and men aged 15-49 years who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse



Source: THMIS 2007-08

The results further shows that men are more than five times likely to have sexual intercourse with more than one partner (Figure 9). Generally, less than 5% of the sexually active population in the country is likely to have sex with more than one partner. The implication here is that HIV transmission through sexual intercourse is more likely caused inadequate behavioral change among men.

Women between the age group of 15-19 are more likely to engage in safe sex than men (42.8% and 41% of women and men in this age respectively used condoms during sex with non-marital, non cohabiting partners in the last 12 months preceding the survey. Women are generally more likely to engage in high-risk behavior than men between the age of 20 and 49 as the use of condom by women during risky sex encounters is less than that of men (Figure 10).

The use of condoms as an effective means of preventing HIV transmission is less commonly cited amongst the identified ways of HIV prevention, especially among women in the Southern Highlands Zone (50 percent). Urban residents are more likely than rural residents to know about all three methods mentioned to prevent HIV infection, except for condom use, which is cited by more rural than urban men. Furthermore, knowledge of all HIV prevention methods mentioned generally increases with increasing level of education and wealth quintile.

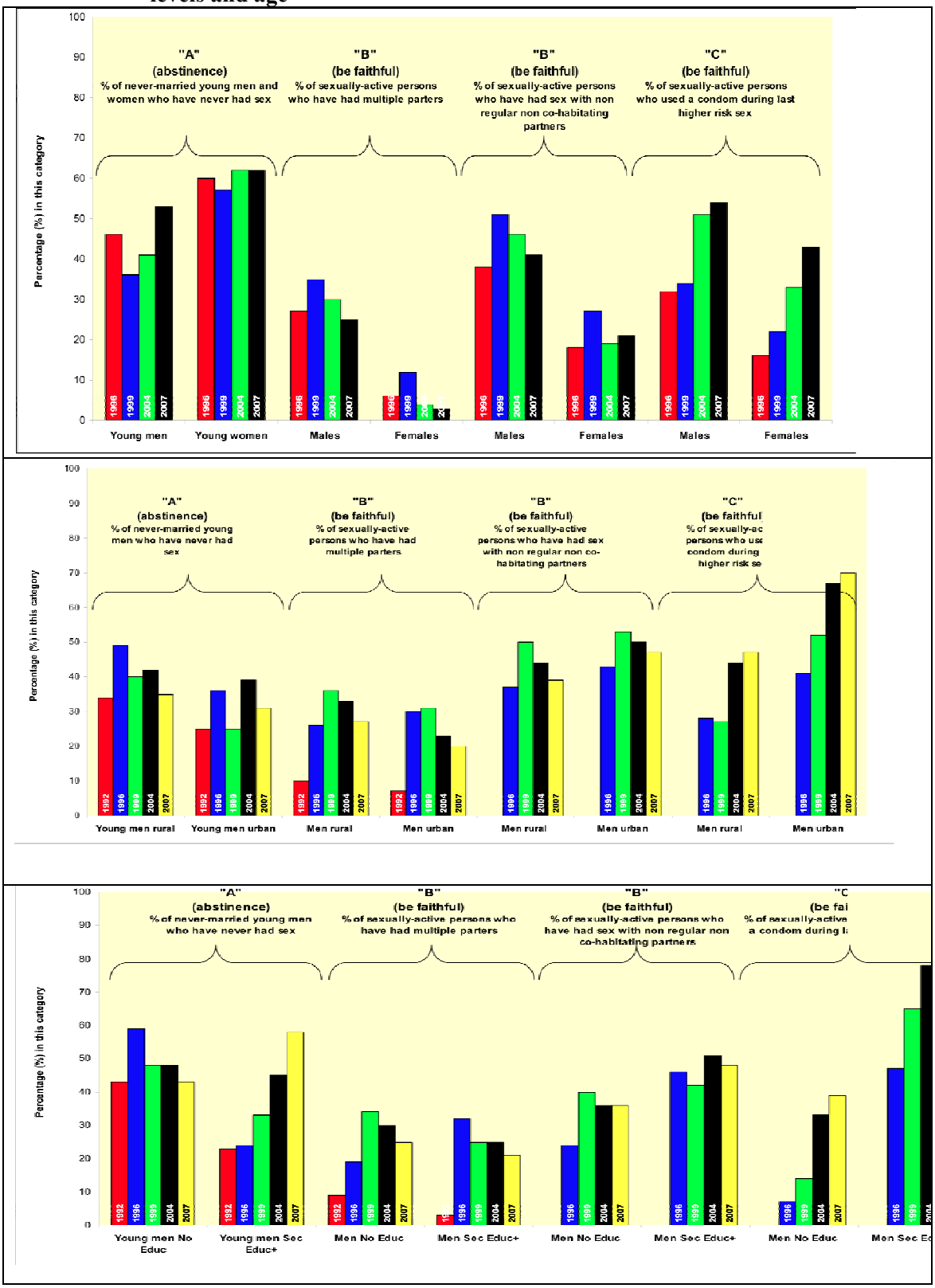
Studies show that Sexual behaviour patterns in Tanzania have changed significantly over the last 15 years.[24] Accordingly, The changes in HIV prevalence over time are consistent with the changes in sexual behaviour observed in the two surveys: positive behaviour changes (reduction in frequency of multiple sexual partners, reductions in the frequency of sex with casual partners, later sexual debut and increased condom use) have been more marked among young men and women than older adults. The following key points provides a summary of what we know about sexual behaviour in Tanzania at the national level[25] (Also see Figure 14):

i. More young men and young women are delaying sexual debut. This change is most visible amongst educated and urban-resident young men
ii. Opposite trends are visible in rural areas and amongst persons with no education, where more young men and young women are having sex (i.e. not abstaining)
iii. Across the board, men and women are having fewer sexual partners. This change is most visible amongst women of all ages, all education levels and in all residences, than amongst men
iv. Fewer men and women are having non-regular sexual partners. This change is more visible amongst women in urban areas
v. Condom use amongst men and women has increased.
vi. The change is more pronounced amongst women than men

[24] ASAP and UNAIDS, 2009, The HIV epidemic in Tanzania Mainland: Where have we come from, where is it going, and how are we responding? Tunakotokea, tunaelekea wapi na tunachokifanya ni nini?

25 Ibid

Figure (14) Changes in HIV behaviour patterns over time amongst men and women in Tanzania, 1996, 1999, 2004 and 2007 (national, rural/urban, education levels and age



Source: ASAP and UNAIDS, 2009, The HIV epidemic in Tanzania Mainland: Where have we come from, where is it going, and how are we responding? Tunakotokea, tunaelekea wapi na tunachokifanya ni nini?'

3.6 HIV and AIDS Impact Alleviation

In Tanzania mainland it is estimated that the number of OVC is 970,000 in 2008, which is about 11% of the total child population. OVCs are more likely to drop out of school hence is pertinent to assess the extent to which the OVCs remain in schools. By the end of 2008 school attendance among all OVCs was 88 % (90% OVC in urban and 86% in rural settings) in Tanzania mainland that has increased by 15% as compared to 73% of 2007.

Children are the most vulnerable to the multiple effects of poverty and HIV/AIDS, both of which have far reaching implications on households and the nation at large (Halima). Households are currently experiencing unemployment and reduced earnings, which further affects the nutritional status of families exacerbating the vulnerability of most children. Low nutritional status hastens the progression of HIV and AIDS particularly among children below 18 years who account for about 50% of the country's population, which is growing at an annual rate of 2.9%.

4 Best practices

The district approach has demonstrated to be the best approach for scaling up PMTCT services and realization of public health outcomes through its strategic approach in the following aspects of programming:

i. Building local capacity for PMTCT programming while fostering greater ownership and sustainability
ii. Enabling rapid scale-up of new PMTCT services through integration with existing structures and systems
iii. Facilitating health system strengthening and integration and supporting quality

5 Major challenges and remedial actions

The major challenges in HIV and AIDS responses in Tanzania mainland include human resources shortages and inadequate capacity or capabilities. This is a critical health system challenges generally. As mentioned area this problem is particularly severe in rural areas where health centers and dispensaries are only staffed with non-physician health workers i.e. clinical officers and nurses. Human resources cannot be built overnight – it requires long term planning and investment. However, some short-term solutions are possible – like internship, rapid capacity building, mentoring, secondment, etc. are some of the approaches that could be used to address this problem.

Availability of adequate funds for effective and efficient response among the stakeholders is also still a major challenge. HIV and AIDS response is overwhelmingly still dependent on donor funding who focus more attention on their priorities, which may not necessarily be the priority agreed upon by the local stakeholders. More lobbying at an international level is still required to resolve this problem, not only for Tanzania but also for other developing countries.

Treatment provided to PLWHIV concentrates mainly on the provision of ARTs. Mechanisms for financing essential medicines for opportunistic diseases are still not in place, especially for people in the rural areas and in the informal sector, who most of them are not enrolled in any health insurance schemes. This problem could be addressed by designing a comprehensive package for treatment of PLWHI that includes both ART and other essential medicines for the treatment of opportunistic diseases other than TB.

Lastly, but not least is the fact that HIV+ prevalence is increasing only in three regions of Iringa, Mara and Shinyanga at a time when prevalence is decreasing in all the remaining 19 Regions in Tanzania mainland. There is a need to examine and determine the factors that are fueling this increase in the three regions and design measures that could effectively reverse the trend.

6 Support from the country's development partners

By and large pending on HIV and AIDS is still donor dependent. 93% of all foreign funding comes from two donors: GFATM 20% and PEPFAR 73%. The remaining 7% from 13 other multi- and bilateral, politically significant groups as almost all are part of the GBS dialogue. Of the total foreign funded, 12% is on-budget, 88% is off-budget. Care and treatment takes the largest proportion of foreign spending. (Table 4 & 5). Challenges in the off-budget financing include low transparency and weak domestic accountability, as the Parliament is not involved in the off-budget.

Table 4: HIV and AIDS Spending 2007-2009, from GFATM and PEPFAR

HIV and AIDS Area Sported	Percent
Care and Treatment	58%
Prevention	23%
Impact Mitigation	9%
Cross-cutting/enabling environment	9%

Source: HIV and AIDS Public Expenditure Review 2008/09. Draft Report

Table 5: **GFATM and PEPFAR HIV and AIDS Spending Forecast for the next 3 Years**

HIV and AIDS Area Sported	Percent
Care and Treatment	51%
Prevention	22%
Impact Mitigation	7%
Cross-cutting/enabling environment	20%

Source: HIV and AIDS Public Expenditure Review 2008/09. Draft Report

7 Monitoring and evaluation environment

Monitoring and evaluation of HIV and AIDS interventions in the country is guided by the National Monitoring and Evaluation Framework and its operational plan( ). These documents provide the multisectoral and multilevel architecture of the national monitoring and evaluation as per three ones principles and forms basis for sector specific M&E frameworks and operational plans.

Data and information flow and use, from the implementation level to national level and feedback from the national level to lower levels for each data source is clearly described. Data collection method and frequency of collection for each indicator on the National Indicator list is also specified.

Program monitoring data for HIV and AIDS interventions are collected mainly through HMIS for medical interventions especially patient monitoring system and through TOMSHA for non-medical/ community based interventions.
The country undertakes sentinel surveillance among pregnant women attending ANC and carries out population-based surveys (THMIS and TDHS) every three to four years. These survey and surveillance provide valuable information on behavioral and biological outcomes and impacts of HIV and AIDS interventions

Tanzania has made several improvements in strengthening the Monitoring and Evaluation System for HIV and AIDS. Some of the notable achievements are:

1. Routine data is regularly analyzed to produce reports for the needed indicators
2. Two rounds of AIDS indicator surveys (2004/05 and 2008/09) were successfully conducted
3. Harmonization of indicators for reporting, data collection tools, and information flow among partners
4. Systems for data collection and analysis have been revised to facilitate data use at a point of collection in order to encourage evidence-based planning.
5. Availability at all levels of guidelines and protocols for data collection, analysis and quality improvement including training materials and supportive supervision and mentoring manuals

Challenges

1. Data use especially at sub national level is inadequate
2. Mismatch between recording and reporting requirements and the available human resources
3. Lack of needed skills mix for M&E as well as capacity building strategies for M&E especially at sub-national levels
4. Inadequate investment in M&E infrastructure especially electronic data management equipments and information and communication technology (ICT) at all levels
5. Lack of sustainable strategies for data quality improvement applicable and acceptable to local setting
6. Lack of data for specific population groups and interventions including MARPs and workplace interventions

Areas needing technical support:

1. Development of mechanisms and tools for improving data use at sub-national levels
2. Data quality improvement strategies and tools

3. Development of sustainable skills building strategies for M&E

NCPI PART A:

	Respons es
1. Has the country developed a national multisectoral strategy to respond to HIV?	YES
1.1 How long has the country had a multisectoral strategy?	5 Years
1.2 Which sectors are included in the multisectoral strategy with a specific HIV budget for their activities?	
Health	YES
Health	YES
Education	YES
Education	YES
Labour	YES
Labour	YES
Transportation	YES
Transportation	YES
Military/Police	YES
Military/Police	YES
Women	YES
Women	YES
Young people	YES
Young people	YES
Other*:	YES
Other*:	YES
1.3 Does the multisectoral strategy address the following target populations, settings and crosscutting issues?	
a. Women and girls	YES
b. Young women/young men	YES
c. Injecting drug users	YES
d. Men who have sex with men	YES
e. Sex workers	YES
f. Orphans and other vulnerable children	YES
g. Other specific vulnerable subpopulations*	YES
h. Workplace	YES
i. Schools	YES
j. Prisons	YES
k. HIV and poverty	YES
l. Human rights protection	YES
m. Involvement of people living with HIV	YES
n. Addressing stigma and discrimination	YES
o. Gender empowerment and/or gender equality	YES
1.4 Were target populations identified through a needs assessment?	YES
Year:	2005

1.6 Does the multisectoral strategy include an operational plan?	YES
1.7 Does the multisectoral strategy or operational plan include:	
a. Formal programme goals?	YES
b. Clear targets or milestones?	YES
c. Detailed costs for each programmatic area?	YES
d. An indication of funding sources to support programme implementation?	YES
e. A monitoring and evaluation framework?	YES
1.8 Has the country ensured "full involvement and participation" of civil society* in the development of the multisectoral strategy?	YES
1.9 Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?	YES
1.10 Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?	PARTNERS
2. Has the country integrated HIV into its general development plans such as in: (a) National Development Plan; (b) Common Country Assessment / UN Development Assistance Framework; (c) Poverty Reduction Strategy; and (d) sector-wide approach?	YES
2.1 ***IF YES***, in which specific development plan(s) is support for HIV integrated?	
a. National Development Plan	YES
b. Common Country Assessment / UN Development Assistance Framework	YES
c. Poverty Reduction Strategy	YES
d. Sector-wide approach	YES
e. Other:	NO
2.2 IF YES, which specific HIV-related areas are included in one or more of the development Plans?	
HIV prevention	YES
Treatment for opportunistic infections	YES
Antiretroviral treatment	YES
Care and support (including social security or other schemes)	YES
HIV impact alleviation	YES
Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or	YES
Reduction of income inequalities as they relate to HIV prevention/treatment, care and /or	YES
Reduction of stigma and discrimination	YES
Women's economic empowerment (e.g. access to credit, access to land, training)	YES
Other: [write in]	YES
3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?	YES
3.1 IF YES, to what extent has it informed resource allocation decisions?	HIGH
4. Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers,	YES

prison staff, etc)?	
4.1 IF YES, which of the following programmes have been implemented beyond the pilot stage to reach a significant proportion of the uniformed services?	
Behavioural change communication	YES
Condom provision	YES
HIV testing and counselling	YES
Sexually transmitted infection services	YES
Antiretroviral treatment	YES
Care and support	YES
Others:	YES
5. Does the country have non-discrimination laws or regulations, which specify protections for most-at-risk populations or other vulnerable subpopulations?	NO
5.1 IF YES, for which subpopulations?	
a. Women	YES
b. Young people	YES
c. Injecting drug users	YES
d. Men who have sex with men	YES
e. Sex Workers	YES
f. Prison inmates	YES
g. Migrants/mobile populations	YES
h. Other:	YES
6. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations or other vulnerable subpopulations?	YES
6.1 IF YES, for which subpopulations?	YES
a. Women	YES
b. Young people	YES
c. Injecting drug users	YES
d. Men who have sex with men	YES
e. Sex Workers	YES
f. Prison inmates	YES
g. Migrants/mobile populations	YES
h. Other: [write in]	YES
7. Has the country followed up on commitments towards universal access made during the High-Level AIDS Review in June 2006?	YES
7.1 Have the national strategy and national HIV budget been revised accordingly?	YES
7.2 Have the estimates of the size of the main target populations been updated?	NO
7.3 Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy? Estimates of current and future needs Estimates	NO
7.4 Is HIV programme coverage being monitored?	YES
(a) IF YES, is coverage monitored by sex (male, female)?	YES
(b) IF YES, is coverage monitored by population groups?	YES

(c) Is coverage monitored by geographical area?	YES
7.5 Has the country developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs?	YES
Overall, how would you rate strategy-planning efforts in the HIV programmes in 2009?	Median (6.5)
1. Do high officials speak publicly and favourably about HIV efforts in major domestic forums at least twice a year?	
President/Head of government	YES
Other high officials	YES
Other offi cials in regions and/or districts	YES
2. Does the country have an officially recognized national multisectoral AIDS coordination body (i.e., a National AIDS Council or equivalent)?	YES
2.1 IF YES, when was it created?	2002
2.3 IF YES, does the national multisectoral AIDS coordination body:	
have terms of reference?	YES
have active government leadership and participation?	YES
have a defined membership?	YES
IF YES, how many members? [write in]	11
Include civil society representatives?	YES
IF YES, how many? [write in]	2
include people living with HIV?	YES
IF YES, how many? [write in]	
include the private sector?	YES
have an action plan?	YES
have a functional Secretariat?	YES
meet at least quarterly?	YES
review actions on policy decisions regularly?	YES
actively promote policy decisions?	YES
provide opportunity for civil society to influence decision-making?	YES
strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	YES
3. Does the country have a mechanism to promote interaction between government, civil society organizations, and the private sector for implementing HIV strategies/programmes?	YES
4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?	--
5. What kind of support does the National AIDS Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?	
Information on priority needs	YES
Technical guidance	YES
Procurement and distribution of drugs or other supplies	YES
Coordination with other implementing partners	YES
Capacity-building	YES
Other: [write in]	YES
6. Has the country reviewed national policies and laws to determine	YES

which, if any, are inconsistent with the National AIDS Control policies?	
6.1 ***IF YES***, were policies and laws amended to be consistent with the National AIDS Control policies?	YES
Overall, how would you rate the political support for the HIV programme in 2009?	Median (6)
1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the general population?	YES
1.1 IF YES, what key messages are explicitly promoted?	
a. Be sexually abstinent	YES
b. Delay sexual debut	YES
c. Be faithful	YES
d. Reduce the number of sexual partners	YES
e. Use condoms consistently	YES
f. Engage in safe (r) sex	YES
g. Avoid commercial sex	YES
h. Abstain from injecting drugs	YES
i. Use clean needles and syringes	YES
j. Fight against violence against women	YES
k. Greater acceptance and involvement of people living with HIV	YES
l. Greater involvement of men in reproductive health programmes	YES
m. Males to get circumcised under medical supervision	YES
n. Know your HIV status	YES
o. Prevent mother-to-child transmission of HIV	YES
Other: [write in]	YES
1.2 In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?	YES
2. Does the country have a policy or strategy promoting HIV-related reproductive and sexual health education for young people?	YES
2.1 Is HIV education part of the curriculum in:	
primary schools?	YES
secondary schools?	YES
teacher training?	YES
2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women?	YES
2.3 Does the country have an HIV education strategy for out-of-school young people?	YES
3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions *for most-at-risk or other vulnerable sub-populations?*	YES
3.1 ***IF YES***, *which populations* and *what elements of HIV prevention* do the policy/strategy address?	
Targeted information on risk reduction and HIV education IDU*	YES
MSM**	YES
Sex workers	YES
Clients of sex workers	YES
Prison inmates	YES
Other populations*	

Stigma and discrimination reduction IDU*	YES
MSM**	YES
Sex workers	YES
Clients of sex workers	YES
Prison inmates	YES
Other populations*	YES
Condom promotion IDU*	YES
MSM**	YES
Sex workers	YES
Clients of sex workers	YES
Prison inmates	YES
Other populations*	YES
HIV testing and counselling IDU*	YES
MSM**	YES
Sex workers	YES
Clients of sex workers	YES
Prison inmates	YES
Other populations*	YES
Reproductive health, including sexually transmitted infections prevention and treatment IDU*	YES
MSM**	YES
Sex workers	YES
Clients of sex workers	YES
Prison inmates	YES
Other populations*	
Vulnerability reduction (e.g. income generation) IDU*	
MSM**	
Sex workers	YES
Clients of sex workers	
Prison inmates	
Other populations*	
Drug substitution therapy IDU*	YES
MSM**	
Sex workers	
Clients of sex workers	
Prison inmates	
Other populations*	
Needle & syringe exchange IDU*	YES
MSM**	
Sex workers	
Clients of sex workers	
Prison inmates	
Other populations*	
Overall, how would you rate policy efforts in support of HIV prevention in 2009?	7
4. Has the country identified specific needs for HIV prevention programmes?	YES

4.1 To what extent has HIV prevention been implemented?	
Blood safety	AGREE
Universal precautions in health care settings	AGREE
Prevention of mother-to-child transmission of HIV	AGREE
IEC* on risk reduction	AGREE
IEC* on stigma and discrimination reduction	AGREE
Condom promotion	AGREE
HIV testing and counselling	AGREE
Harm reduction for injecting drug users	AGREE
Risk reduction for men who have sex with men	AGREE
Risk reduction for sex workers	AGREE
Reproductive health services including sexually transmitted infections prevention and	AGREE
School-based HIV education for young people	AGREE
HIV prevention for out-of-school young people	AGREE
HIV prevention in the workplace	AGREE
Other: [write in]	AGREE
Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2009?	Median (8)
1. Does the country have a policy or strategy to promote comprehensive HIV treatment, care and support? (Comprehensive care includes, but is not limited to, treatment, HIV testing and counselling, psychosocial care, and home and community-based care).	YES
1.1 IF YES, does it address barriers for women?	YES
1.2 IF YES, does it address barriers for most-at-risk populations?	YES
2. Has the country identified the specific needs for HIV treatment, care and support services?	YES
2.1 To what extent have the following HIV treatment, care and support services been implemented?	
HIV treatment, care and support service The majority of people in need have access	
Antiretroviral therapy	AGREE
Nutritional care	AGREE
Pediatric AIDS treatment	AGREE
Sexually transmitted infection management	AGREE
Psychosocial support for people living with HIV and their families	AGREE
Home-based care	AGREE
Palliative care and treatment of common HIV-related infections	AGREE
HIV testing and counseling for TB patients	AGREE
TB screening for HIV-infected people	AGREE
TB preventive therapy for HIV-infected people	AGREE
TB infection control in HIV treatment and care facilities	AGREE
Cotrimoxazole prophylaxis in HIV-infected people	AGREE
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	AGREE
HIV treatment services in the workplace or treatment referral systems through the workplace	AGREE
HIV care and support in the workplace (including alternative working	AGREE

arrangements)	
Other: [write in]	AGREE
3.Does the country have a policy for developing/using generic drugs or parallel importing of d f HIV?	YES
4.Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy drugs, condoms, and	YES
Overall, how would you rate the efforts in the implementation of HIV treatment, care and i 2009?	Median (7)
5. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?	YES
5.1 ***IF YES***, is there an operational definition for orphans and vulnerable children in the country?	YES
5.2 ***IF YES***, does the country have a national action plan specifically for orphans and vulnerable children?	YES
5.3 ***IF YES***, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?	YES
Overall, how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2009?	6
1. Does the country have one national Monitoring and Evaluation (M&E) plan?	YES
1.1 IF YES, years covered: [write in]	5
1.2 IF YES, was the M&E plan endorsed by key partners in M&E?	YES
1.3 IF YES, was the M&E plan developed in consultation with civil society, including people living with HIV?	YES
1.4 IF YES, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?	NO
2. Does the national Monitoring and Evaluation plan include? a data collection strategy	PARTNERS
IF YES, does it address: routine programme monitoring	YES
behavioural surveys	YES
HIV surveillance	YES
Evaluation / research studies	YES
a well-defined standardised set of indicators	YES
guidelines on tools for data collection	YES
a strategy for assessing data quality (i.e., validity, reliability)	YES
a data analysis strategy	YES
a data dissemination and use strategy	YES
3. Is there a budget for implementation of the M&E plan?	YES
3.1 IF YES, what percentage of the total HIV programme funding is budgeted for M&E activities?	30.52
3.2 IF YES, has full funding been secured?	YES
3.3 IF YES, are M&E expenditures being monitored?	YES
4. Are M&E priorities determined through a national M&E system assessment?	YES
5. Is there a functional national M&E Unit?	YES
5.1 IF YES, is the national M&E Unit based in the National AIDS Commission (or equivalent)?	YES

in the Ministry of Health?	YES
Elsewhere? [write in]	YES
5.3 IF YES, are there mechanisms in place to ensure that all major implementing partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?	YES
6. Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities?	MEETS IRREG ULAR
6.1Does it include representation from civil society?	YES
7. Is there a central national database with HIV- related data?	YES
7.2 IF YES, does it include information about the content, target populations and geographical coverage of HIV services, as well as their implementing organizations?	OF THE ABOVE
7.3 Is there a functional* Health Information System? At national level	YES
At subnational level	YES.5
8. Does the country publish at least once a year an M&E report on HIV and on, including HIV surveillance data?	YES
9. To what extent are M&E data used	
9.1 in developing / revising the national AIDS strategy?:	HIGH
9.2 for resource allocation?:	3
9.3 for programme improvement?:	HIGH
10.Is there a plan for increasing human capacity in M&E at national, subnational and service level?	levels
10.1 In the last year, was training in M&E conducted At national level?	YES
IF YES, Number trained:	74
At subnational level?	YES
IF YES, Number trained:	
At service delivery level including civil society?	YES
IF YES, Number trained:	
10.2 Were other M&E capacity-building activities conducted other than training?	YES
Overall, how would you rate the M&E efforts of the HIV programme in 2009?	7

NCPI PART B

	Responses
1. Does the country have laws and regulations that protect people living with HIV against discrimination? (including both general non-discrimination provisions and provisions that specifically mention HIV, focus on schooling, housing, employment, health	yes
2. Does the country have non-discrimination laws or regulations, which specify protections for most-atrisk populations and other vulnerable subpopulations?	yes
2.1 IF YES, for which populations? a. Women	yes
b. Young people	yes
c. Injecting drug users	yes

d. Men who have sex with men	No
e. Sex Workers	yes
f. Prison inmates	yes
g. Migrants/mobile populations	yes
h. Other: [write in]	
3. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations and other vulnerable subpopulations?	yes
3.1 IF YES, for which subpopulations? a. Women Yes No	yes
b. Young people	yes
c. Injecting drug users	
d. Men who have sex with men	yes
e. Sex Workers	yes
f. Prison inmates	yes
g. Migrants/mobile populations	yes
h. Other: [write in]	yes
4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?	yes
5.Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, most-at-risk populations and/or other vulnerable subpopulations?	yes
6. Has the Government, through political and financial support, involved people living with HIV, most-at-risk populations and/or other vulnerable subpopulations in governmental HIV-policy design and programme implementation?	yes
7. Does the country have a policy of free services for the following: a. HIV prevention services	yes
b. Antiretroviral treatment	yes
c. HIV-related care and support interventions	yes
8. Does the country have a policy to ensure equal access for women and men to HIV prevention, treatment, care and support?	yes
8.1 In particular, does the country have a policy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?	yes
9. Does the country have a policy to ensure equal access for most-at-risk populations and/or other vulnerable subpopulations to HIV prevention, treatment, care and support?	No
9.1 IF YES, does this policy include different types of approaches to ensure equal access for different most-at-risk populations and/or other vulnerable sub-populations?	yes
10.Does the country have a policy prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?	yes
11.Does the country have a policy to ensure that HIV research protocols involving human subjects are reviewed and approved by a	yes

national/local ethical review committee?	
11.1 IF YES, does the ethical review committee include representatives of civil society including people living with HIV?	yes
12.Does the country have the following human rights monitoring and enforcement mechanisms?	

Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work	yes
Focal points within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in areas such as housing and employment	yes
Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts	yes
13.In the last 2 years, have members of the judiciary (including labour courts/ employment tribunals) been trained/sensitized to HIV and human rights issues that may come up in the context of their work?	No
14.Are the following legal support services available in the country? Legal aid systems for HIV case work	No
Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV	No
Programmes to educate, raise awareness among people living with HIV concerning their rights	yes
15.Are there programmes in place to reduce HIV-related stigma and discrimination?	yes
Media	yes
School education	yes
Personalities regularly speaking out	yes
Other: [write in]	yes
Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2009?	**5**
Overall, how would you rate the effort to enforce the existing policies, laws and regulations in 2009?	**4**
1. To what extent has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?	High
2. To what extent have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?	**4**
3. To what extent are the services provided by civil society in areas of HIV prevention, treatment, care and support included in a.the national AIDS strategy?	High
b. the national AIDS budget?	Yes
c. national AIDS reports?	No

4. To what extent is civil society included in the monitoring and evaluation (M&E) of the HIV response? a. developing the national M&E plan?	High
b. participating in the national M&E committee / working group responsible for coordination of M&E activities?	Low
c. M&E efforts at local level?	Low
5. To what extent is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. networks of people living with HIV, organizations of sex workers, faith-based organizations)?	Medium
6. To what extent is civil society able to access: a. adequate financial support to implement its HIV activities?	Low
b. adequate technical support to implement its HIV activities?	Low
7. What percentage of the following HIV programmes/services is estimated to be provided by civil society? Prevention for youth <25%	>75%
Prevention for most-at-risk-populations Injecting drug users	25% - 50%
men who have sex with men	51% - 75%
sex workers	51% - 75%
Testing and Counseling	>75%
Reduction of Stigma and Discrimination	51% - 75%
Clinical services (ART/OI)	25% - 50%
Home-based care	<25%
Programmes for OVC**	<25%
Overall, how would you rate the efforts to increase civil society participation in 2009?	**5**

1.Has the country identified the specific needs for HIV prevention programmes?	yes
1.1 To what extent has HIV prevention been implemented? HIV prevention component The majority of people in need have access	
Blood safety	Agree
Universal precautions in health care settings	Agree
Prevention of mother-to-child transmission of HIV	Agree
IEC* on risk reduction	Agree
IEC* on stigma and discrimination reduction	Agree
Condom promotion	Agree
HIV testing and counselling	Agree
Harm reduction for injecting drug users	Don't agree
Risk reduction for men who have sex with men	Don't agree
Risk reduction for sex workers	Don't agree

Reproductive health services including sexually transmitted infections prevention and treatment	Agree
School-based HIV education for young people	Agree
HIV Prevention for out-of-school young people	Agree
HIV prevention in the workplace	Agree
Other: [write in]	Agree
Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2009?	**7**
1. Has the country identified the specific needs for HIV treatment, care and support services?	yes
1.1 To what extent have HIV treatment, care and support services been implemented? HIV treatment, care and support service The majority of people in need have access Antiretroviral therapy	
Nutritional care	Agree
Paediatric AIDS treatment	Agree
Sexually transmitted infection management	Agree
Psychosocial support for people living with HIV and their families	Agree
Home-based care	Agree
Palliative care and treatment of common HIV-related infections	Agree
HIV testing and counseling for TB patients	Agree
TB screening for HIV-infected people	Agree
TB preventive therapy for HIV-infected people	Agree
TB infection control in HIV treatment and care facilities	Agree
Cotrimoxazole prophylaxis in HIV-infected people	Agree
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Agree
HIV treatment services in the workplace or treatment referral systems through the workplace	Agree
HIV care and support in the workplace (including alternative working arrangements)	Agree
Other programmes: [write in]	
Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2009?	**5.5**
2. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?	yes
2.1 IF YES, is there an operational definition for orphans and vulnerable children in the country?	yes
2.2IF YES, does the country have a national action plan specifically for orphans and vulnerable children?	yes
2.3 IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?	yes

Names of Organizations Filling the National Composite Policy Index Tool

Tool A

S/N	Names of Ministries that Filled and Returned the Questionnaire
1	Ministry of Labor, Sports and Youth Development
2	Ministry of Energy and Minerals
3	Ministry of Finance and Economic Affairs
4	Ministry of Home Affairs
5	Ministry of Trade, Industry and Management
6	Ministry of Labor, Employment and Youth Development
7	Ministry of Water and Irrigation
8	Ministry of East African Co-operation
9	Ministry of Education and Vocational Training
10	Ministry of Agriculture, Food Security and Co-operative

Tool B

S/N	Names of Organizations that Filled and Returned the Questionnaire
1	The National Council for People Living with HIV and AIDS (NACOPHA)
2	Human Development Trust (HDT)
3	AIDS Business Coalition Tanzania (ABCT)
4	African Medical and Research Foundation (AMREF)
5	Management Science for Health (MSH)

ZANZIBAR UNGASS REPORTING

2010

Table of Contents

Acknowledgements

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Various stakeholders provided insightful and challenging comments and inputs during the stakeholders' validation workshops and at various stages of writing the report. Their inputs enriched the document.

Finally we wish to extend our special appreciation to the other HIV&AIDS stakeholders and ZAC staff members who in one way or the other contributed towards making this important report a reality.

To all we say thank you.

ASHA A. ABDULLA
Executive Director
Zanzibar AIDS Commission (ZAC)
Zanzibar - TANZANIA

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti Retroviral Therapy
ARV	Anti Retroviral Treatment
BCC	Behaviour Change Communication
CBOS	Community Based Organizations
CSOS	Civil Society Organizations
CTC	Care and Treatment Clinic
DACCOMS	District AIDS Coordinating Committee
DSW	Department for Social Welfare
DUs	Drug Users
FBOs	Faith Based Organizations
GFATM	Global Fund for AIDS Tuberculosis and Malaria
HBC	Home Based Care
HIV	Human Immuno Deficiency Syndrome
IEC	Information, Education and Communication
M&E	Monitoring and Evaluation
MARPs	Most At Risk Populations
MDAs	Ministries, Departments and Agencies
METTHAZ	Monitoring and Evaluation Task Team for HIV&AIDS in Zanzibar
MOEVT	Ministry of Education and Vocational Training
MSM	Men Having Sex with Men
MVC	Most Vulnerable Children
NGOs	Non Governmental Organization
PLHIV	People Living With HIV&AIDS
PMTCT	Prevention of Mother to Child Transmission of HIV
RGOZ	Revolutionary Government of Zanzibar
SHACOMS	Shehia AIDS Coordinating Committee
STI	Sexually Transmitted Infection
SW	Sex Workers
THMIS	Tanzania HIV&AIDS and Malaria Indicator Survey
UNGASS	United Nations General Assembly Special Session on HIV&AIDS
VCT	Voluntary Counselling and Testing
ZAC	Zanzibar AIDS Commission
ZACP	Zanzibar AIDS Control Programme
ZAMEA	Zanzibar Monitoring & Evaluation Association
ZAPHAR+	Zanzibar Association for People with HIV&AIDS
ZHAPMoS	Zanzibar HIV&AIDS Programme Monitoring System
ZNSP	Zanzibar National HIV&AIDS Strategic Plan
ZPRP	Zanzibar Poverty Reduction and Economic Growth Plan

1. Status at a Glance

1.1 Inclusiveness of Stakeholders in the Report Writing Process

Stakeholders were involved in the report writing process from the stage of data collection process to the finalization and validating of the final report. The stakeholder consultation provided the opportunity for stakeholders to participate and provide the initial input for the draft report. Stakeholders were purposefully samples to represent the central and local governments, development partners, the private sector and the Civil Society Organizations.[26]

Two joint National Workshops that includes Tanzania mainland and Zanzibar were organized to provide platform for further stakeholder consultation and engagement with the technical people in the writing process. The first workshop was aimed at confirming the data and indicators provided in the draft report as well as to examine and analyze the validity of the narrative content. The second workshop provided an opportunity for stakeholders to review the second draft report in the perspective of the deliberation of the first workshop and to finalize and validate the indicators, qualitative data and consistency of reporting.

A technical meeting was also held with the UN experts from within the country, East and Central Africa and UN headquarters with local experts from the Tanzania Commission for HIV and AIDS (TCAIDS) to provide technical input into the report. The UN experts also participated in the second workshop with other stakeholders to provide further technical support in the report finalization process.

1.2 The Status of the Epidemic

Current estimates from the Tanzania HIV and Malaria Indicator Survey (THMIS) 2007-08, and the HIV Validation surveys show the following HIV prevalence in Zanzibar: The general prevalence of HIV/AIDS in the sexual active population in Zanzibar is 0.6%. Projections from these observations translate into 7200 Zanzibaris to be living with HIV. HIV infection has been recorded to be slightly higher among females compared to males (0.7% by 0.5% respectively); The prevalence is higher in Unguja compared to Pemba (0.8% by 0.3 %) and the HIV infection among young Zanzibaris aged 15-24 years is at 0.2 percent, being three times higher in females compared to males (0.3% by 0.1% respectively). From 1999 to 2008, Zanzibar has been documenting an HIV prevalence of not more than 1percent among the ante-natal clinic (ANC) attendees (ZACP, 2008).

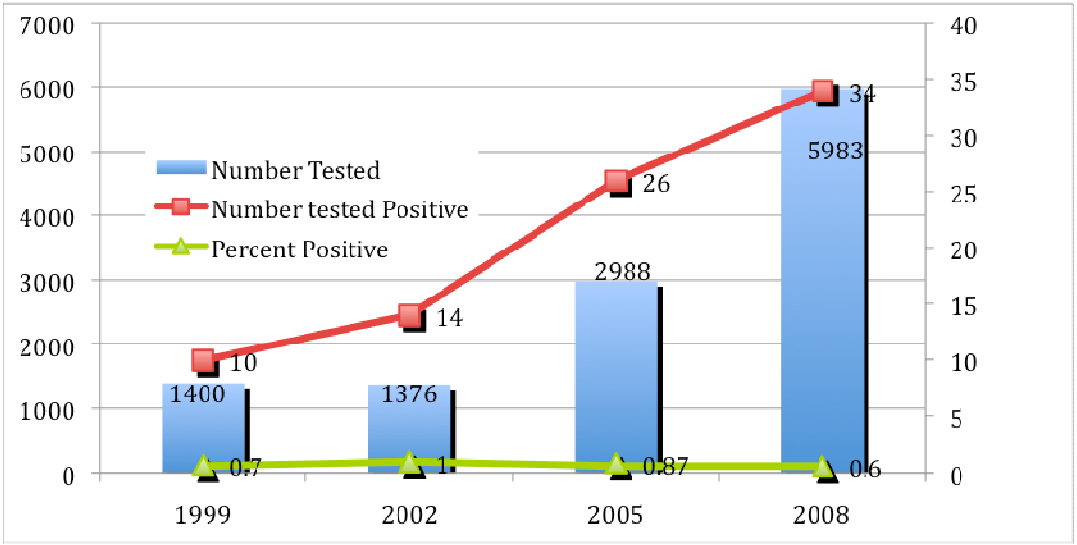
The major findings in ANC surveillance survey using a PMTCT approach in 2008 show:27

26 See Annex for the list

27 Revolutionary Government of Zanzibar, 2009, ZANZIBAR NATIONAL HIV AND AIDS STRATEGIC PLAN-II 2009/10 – 2013/14

a. HIV infection is higher in Unguja compared to Pemba Island (0.9 percent by 0.1 percent respectively) with an urban rural predilection of 0.6 percent by 0.4 percent respectively.
b. HIV infections peaks up with age increase from 0.5 percent in 15-24 years category to 0.8 percent amongst those in the age category of 25-34 years and decrease thereafter with increasing age.
c. Relatively high HIV infection among divorcee women (10%) compared to singles and those who are married (3.7% by 0.5% respectively).
d. HIV infection higher among women with primary education compared to those with secondary education (0.8% by 0.5%) respectively.

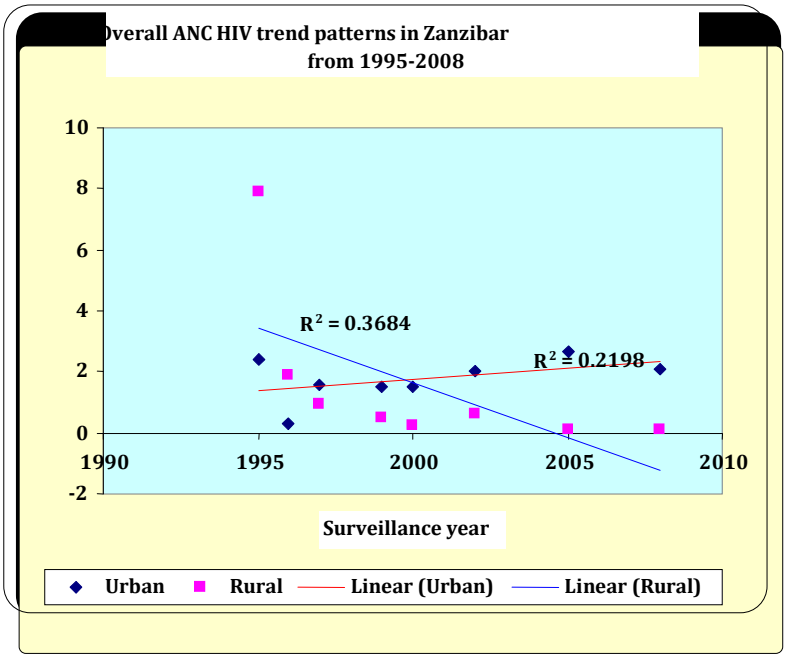
Figure 1: Trend in HIV prevalence among ANC attendees from 1995 -2008



Source: (ZACP, 2008)

e. Trend analysis of HIV prevalence among ANC attendees from 1995 -2008 Suggests general decline in rural areas with a slight upward trend in urban sites.

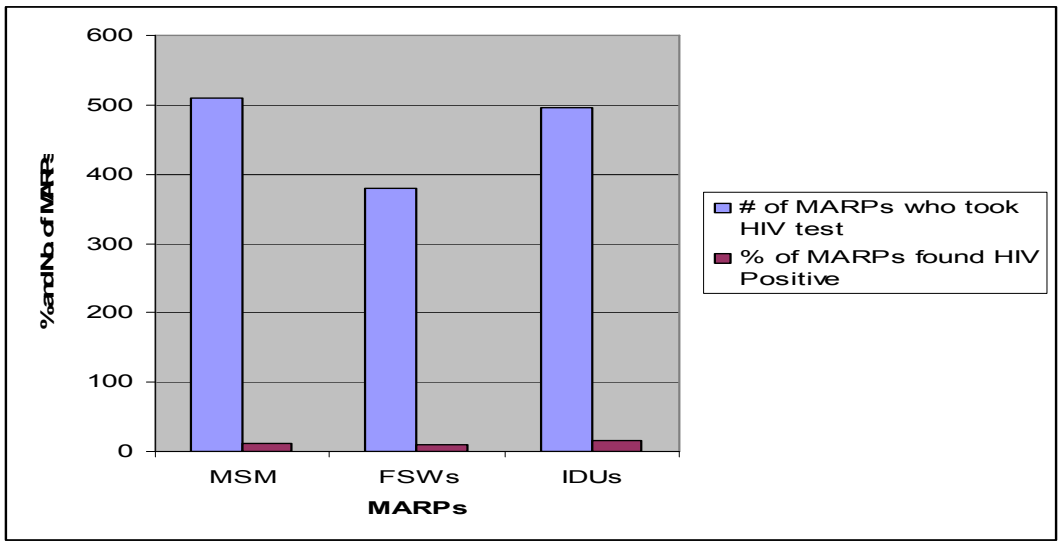
Figure 2: Overall ANC Trend Patterns in Zanzibar 1995 - 2008



Source: ZACP, 2009

As far as most at risk populations (MARPs) are concerned, evidence on MARPs 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 MARPs 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.

Figure 3: HIV Among the MARPS



Source: ZAC, 2009

The cross-over (bridging) potential to the general population has been documented in MARPs through the Integrated Behavioral 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.

1.3 The Policy and Programmatic Response

The government of Zanzibar has strived to provide an enabling environment for HIV&AIDS programs demonstrated through various government policies and regulatory actions that include the approval of Zanzibar National Multisectoral Framework, National HIV&AIDS Policy, Mainstreaming HIV and AIDS in the Public Sectors' Strategic Plan, formulation of Sectoral HIV and AIDS Strategic Plan and the integration of HIV/AIDS into the National Strategy for Growth and Poverty Reduction for Zanzibar – MKUZA (2006-2010). MKUZA serve as the foundation for facilitating realisation of international commitments, such as those embedded in the Millennium Development Goals (MDGs). It guides the processes towards an equitable society by laying out operational targets for infant health, child survival, improved health of women and other vulnerable groups placing emphasis on the reduction of maternal and child mortality resulting from various factors including HIV and AIDS. Zanzibar also guided by the Joint Assistance Strategy to Tanzania (JAST), receives support from the UN Joint Program on HIV and AIDS (2007-2012) that responds to government priorities.

The Zanzibar National HIV and AIDS Strategic Plan (ZNSP) for 2004/5-2008/9 came to an end in June 2009. With the expiry of the ZNSP I, a second Zanzibar National Strategic (ZNSP II), is being developed to continue to drive and align all stakeholders and partners and their investments for the next five years (2009/10-2013/14) and to capture the new

developments that occurred after the development of the first ZNSP. The second ZNSP, which covers the period 2009/10 - 2013/14 is aimed at redefining the key technical priority areas for the national response and make a big programmatic shift from a generalized type of response to the one that respond to the concentrated epidemic. Zanzibar is also in the process of developing the HIV Bill which will safeguard the rights of the people infected and affected by HIV&AIDS.

1.4 UNGASS Indicator Data in an Overview Table

	Indicator by years	**2006/2007**	**2007/08**	**2008/2009**	**Data source**
1.	Domestic and International AIDS spending by categories and financing Sources,	Domestic (4%)	Domestic (8%)	Data not available	HIV and AIDS Public Expenditure Review 2008/09
2.	National Composite Policy Index				
	Gender,	100%			
	Workplace programs,	100%			
	Stigma and Discrimination,	100%			
	Prevention,	100%			
	Care and Support,	100%			
	Human Rights,	60%			
	Civil Society,	100%			
	Monitoring and Evaluation	71%			
3.	Percentage of donated blood units screened for HIV in a quality assured manner	100%		100%	ZACP,2009
4.	Percentage of Adults and Children with advanced HIV	48%		48%	ZACP,2009 Numerator= no. of adults and

	Indicator by years	2006/2007	2007/08	2008/2009	Data source
	receiving Antiretroviral therapy				children with advanced HIV who are receiving ART (1908) Denominator= Estimated number of adults and children who receiving ART (3952)
5.	Percentage of Adults and Children with advanced HIV Infection receiving Antiretroviral therapy	72%%		72%	ZACP,2009 Numerator = no. of adults and children who are currently receiving ART (1577) Denominator= Estimated number of adults and children with advanced HIV infection (2160)
5	Percentage of HIV-positive pregnant women who received antiretroviral to reduce the risk of MTCT	22%%		84%	ZACP, HIV Sentinel Surveillance for pregnant women ,2008
6.	Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV,	100%		100%	ZACP,2009
7	Percentage of women and men aged 15-49 who received an HIV test	Women 4.2% Men 2.4%		Women 12.2 %	THMIS 2007/08

	Indicator by years	2006/2007	2007/08	2008/2009	Data source
	in the last 12 months and know their Results			Men 10.9 %	
8	Percentage of most at risk populations that have received an HIV test in the last 12 months and know their Results	26%		26%	ZAC, 2008. MARPs Survey not done in 2009
9	Percentage of young women and men aged 15-49 who have more than sexual partner in the past 12 months	No data		0.3% women 10.6 % men	DHS 2005 & THMIS 2008
	Indicator by years	**2006/2007**		**2008/2009**	**Data source**
10	Percentage of most at risk Populations reached with HIV prevention Programmes	No data		No data	MARPs Survey not done in 2009
11	Percentage of orphaned and Vulnerable children aged 0-17 whose households received free basic external support in caring for the child	12%		12%	THMIS 2007/8 Numerator = 6 Denominator= 50
12	Percentage of schools that provided life skills-based HIV education in the last academic year.	37.5		58%	MOEVT,2007 37.5% (120 out of 320 – for public schools only) and 58% for public and private schools

Knowledge and behavior

13.	Current school attendance rate Of children aged 10-14 both of whose parents are alive and who live with at least one parent	88.2%		88.2%	THMIS 2007/08. Numerator = 112, Denominator= 127
14	Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.	Women 59.5% Men 65.0%		Women 59.5% Men 65.0%	THMIS 2007/08
15	Percentage of most at risk populations who both correctly identify ways of preventing the Sexual transmission of HIV and who reject major misconceptions about HIV Transmission	No data		No data	MARPs Survey not done in 2009
16	Percentage of young women and men who have had sexual intercourse before age 15	Women 3.4% Men 1.7%		Women 3.4% Men 1.7%	THMIS 2007/08
17	Percentage of Adults aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months.	Women 0.5% Men 19.9%		Women 0.5% Men 19.9%	THMIS 2007/08
18	Percentage of Adults aged 15-49 who had more than one sexual partner in the 12 months reporting the use of Condom during Last intercourse.	Women 20.3%* Men 31%		Women 20.3%* Men 31%	THMIS 2007/08
19	Percentage of female				ZACP,

	and male sex workers reporting the use of a condom with their most Recent client.	76.8%		76.8%	2008. This is for Female Sex Workers Only (291 FSWs out of 379)
20	Percentage of sex workers who are HIV infected	10.8%		10.8%	ZACP MARPs study, 2008 (41 ut of 37 9)
21	Percentage of children aged 14 years or younger that are accessing antiretroviral therapy	10%		10%	ZACP,200 9
22.	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	28.9%		28.9%	ZACP MARPs study, 2008 (147 of 50 9)
23	Percentage of injecting drug users reported using sterile injecting equipment the last time they injected	No data		No data	MARPs Survey not done in 2009
24	Percentage of injecting drug users reporting the use of a condom the last	No data		No data	MARPs Survey not done

	they had sexual intercourse				in 2009

Impact

25	Percentage of young women and men aged 15-24 who are HIV infected	Women 0.3% Men 0.1%		Women 0.3% Men 0.1%	THMIS 2007/08
26	Percentage of MSM who test positive for HIV	12.4%		12.4%	ZACP MARPs study,2008 (63 out of 509)
27	Percentage of IDUs who test positive for HIV	16%		16%	ZACP MARPs study,2008 (80 out of 499)
28	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	20%		85.4%	ZACP, 2008
29	Percentage of infants born to HIV infected mothers who are Infected.	8.6%		10%	ZACP, 2009 (18 out of 178)

2 Overview of the AIDS Epidemic

In the absence of a robust sero-surveillance system, there are no clear estimates of the number of people living with HIV.[28] However, current estimates from the Tanzania HIV and Malaria Indicator Survey (THMIS) 2007-08, show that the prevalence of HIV/AIDS in Zanzibar is 0.6%.[29] HIV infections among the general population reveal high infection rates (86%) among people aged between 20-49 years. Sexual transmission accounting for 90%. Infection among women aged 15-29 years are reported to be five times higher than

[28] Swasti Health Resource Centre, 2009, Gap Analysis Of the Zanzibar HIV and AIDS Response Initiatives
[29] Ibid

their male counterparts. HIV infection has been recorded to be slightly higher among females compared to males (0.7% by 0.5% respectively). The prevalence is higher in Unguja compared to Pemba (0.8% by 0.3 %). HIV infection among young Zanzibaris aged 15-24 years is at 0.2 percent**,** being three times higher in females compared to males (0.3% by 0.1% respectively). In respect to urban-rural context, the IV infection is higher in Unguja compared to Pemba Island (0.9 percent by 0.1 percent respectively) with an urban rural predilection of 0.6 percent by 0.4 percent respectively. Relatively high HIV infection among divorcee women (10%) compared to singles and those who are married (3.7% by 0.5% respectively), and HIV infection is higher among women with primary education compared to those with secondary education (0.8% by 0.5%) respectively.
The epidemic is concentrated with prevalence rates ranging between 10.8%, 12.3% and 16% among the most- at- risk- populations (MARPs)[30] namely, females sex workers, men having sex with men (MSM) and Intravenous Drugs Users (IDU). For the past two decades, Zanzibar has been grappling with a parallel IDU epidemic which mostly affects youth of both genders.[31] The epidemics have markedly affected and increased the burden to families, communities and the entire nation at large.

3 National Responses to the Aids Epidemic

3.1 The Existing Policy Environment

In 2005, Zanzibar developed the Zanzibar HIV and AIDS Policy, which serves as an important milestone in the fight against HIV and AIDS. The policy addresses HIV and AIDS in Zanzibar and incorporates most of the current international policy principles. It lays down the administrative and the legal framework for all programmes and interventions which are to: "Prevent new HIV infections in the population, Treat care for and support those who are infected; and Mitigate the impact of HIV and AIDS on the social and economic status of individuals, families, communities of all those living in Zanzibar. Enhance the institutional capacity/key implementers' capacity to develop/implement HIV/AIDS interventions with gender and human rights approaches".

The HIV and AIDS public expenditure review PER for 2008/2009 shows that real per capita actual and budgeted expenditure on HIV and AIDS activities has increased over the past two financial years despite population growth rates of 3.1% and average inflation of 11% to 13.1%. Taking these inflation and population growth rates into account means that nominal HIV and AIDS expenditure is required to grow at 14% to 16.1% in order to maintain the current real level of expenditure. If funding and expenditure grows at less than this rate, then the real amount of resources available to fight HIV and AIDS in Zanzibar decreases. In 2007/08, per capita expenditure on HIV and AIDS did increase by 69% to US$4.92; spending on HIV and AIDS accounted for 37% of all health expenditure in Zanzibar. Further, as a percentage of GDP actual expenditure on HIV and AIDS activities grew from 0.79% of nominal GDP to 1.19% of nominal GDP.

30 Ibid

31 Zanzibar Substance Abuse –HIV and AIDS Strategic Plan (2007-2011)

The Gap Analysis of the Zanzibar HIV and AIDS Response Initiatives shows that, HIV and AIDS response in Zanzibar, designed for a generalized epidemic, is comprehensive and plans to cover all target groups, bridge populations and all others through prevention and care and treatment initiatives. However, in the absence of clear evidence and an overall sense of what drives the epidemic, the Programme design is broad, all- inclusive, endeavouring to cover all populations with equal vigor (Swasti Health Resource Centre, 2009).

Fundamentally, even defining MARPs has had its problems – with the definitions extending to disabled, school children, etc. Although at one level, these are populations at risk, extending the logic to everybody risks getting the program diluted and not prioritized or focused. Zanzibar does not necessarily suffer from lack of strategies – in fact there are many strategies trying to achieve several things. It's the lack of prioritization and focus on implementation i.e. implementation process inadequacies which is a gap.32 The Zanzibar National HIV/AIDS Strategic Plan (ZNSP) provides for strategic Prevention interventions among vulnerable groups, among general population and workplaces, and in the Health Sector, which also includes treatment care and support.

The ZNSP also requires sectors to develop sector strategic plans for HIV and AIDS interventions. Such strategic plans have been developed in the following key Ministries and sector Ministries like the Chief Ministers' Office ; ministry of Regional Administration and Special Departments; Ministry of Education, and vocational trainings; Ministry of Communication and Transport ; Ministry of Finance & Economic Affairs ; Ministry of Tourism, Trade and Investment; Ministry of Water, Construction, Energy and Lands; Ministry of Labor, Youth, Women and Children Development ; Ministry of Constitutional Affairs and Good Governance; Ministry of Agriculture, Livestock and Environment; Ministry of State President's Office; Ministry of culture, information and sports; and the Ministry of Health and Social Welfare.

Furthermore, though various social policies and the MKUZA provide for response and prevention of social insecurity through support for the vulnerable poor and disadvantaged groups, expected policy outcomes are inadequately realized. This is mainly due to fragmented and overlapping institutional processes during policy implementation, coupled with inadequate capacity especially at the district and Shehia levels. As the result policy implementation gaps occurs and therefore state commitments for social provisioning for the PLHWA and OVC are inadequately realized.

Social Policy that involves targeting income or consumption transfers to the poor, disadvantaged and most vulnerable population groups, protects them against livelihood risks including exposure to HIV, and enhances their social status and human rights by reducing their economic and social vulnerability. However, there is a limited definition of the disadvantaged and most vulnerable population groups in the policies, development strategies and various plans in Zanzibar. For instance goal 7 of the Social Service and Well-being cluster in the MKUZA, that aims at strengthening and expanding social

[32] Swasti Health Resource Centre, 2009, Gap Analysis Of the Zanzibar HIV and AIDS Response Initiatives shows that HIV and AIDS response in Zanzibar

security and safety nets for the disadvantaged and most vulnerable population groups, is only limited to responding to orphans at Forodhani Children's Home and aged people living in old people's homes.33

Other vulnerable children and their caregiver in Zanzibar both in rural and urban areas are not covered by any state social provisioning scheme. However, arrangements for assisting the needy people started in 2007/08.34 The current status of this arrangement is still limited to social provisioning for the elderly as budget for the MVC still does not exist in the budget of the Department of Social Welfare.

The reasons for these shortcomings are that policy provisions in Zanzibar inadequately provide a comprehensive social protection system and procedures for the vulnerable groups particularly PLWHA and the OVC. The policies do not provide or guarantee social transfers both in terms of regular, contributory and non-contributory disbursements (cash or in-kind) from governments or NGOs to individuals or households that are considered most vulnerable. The existing policies also do not guarantee a delivery of family or community social welfare service package to support most vulnerable families and alternative care and support for children outside family environments; and or additional measures to enable all children to access basic services and entitlements. The consequence of these social protection shortcomings is the exposure of children to risks of HIV and AIDS, exploitation, abuse and violence in the process of fending for their survival.

In order to resolve this policy constraint, the government in collaboration with the development partners (Save the Children) is in a process of revisiting the Child Policy (2001). Furthermore, UNICEF is supporting the government to develop the most vulnerable children (MVC) policy, which, in addition to addressing the policy constraints on children, will facilitate the implementation of the Zanzibar MVC Plan of Action that is currently being developed. UNICEF and Save the Children are also providing technical and financial support to develop National Guidelines for the Protection and Welfare of the Children. All these measures are aimed at consolidating the Zanzibar child protection and social protection systems, resource allocation and processes.

3.2 Implementation of HIV Prevention Programmes

The Zanzibar National HIV/AIDS Strategic Plan (ZNSP) for 2004/5-2008/9 clearly stipulates the promotion of safe sexual norms and positive sexual behavior among young people including the options of abstinence and delayed sexual activities, faithful partnership [marriage] and condom use. It further demands provision of education to the community on the importance of young people accessing appropriate STD/HIV/AIDS information in mitigating STI.

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[33] See MKUZA Cluster II Goal 7 and MKUZA Annual Implementation Report 2007/2008 (MKUZA AIR)

34 Revolutionary Government of Zanzibar, 2008, MKUZA Annual Implementation Report 2007/08 (MKUZA AIR)

HIV & AIDS in Zanzibar is concentrated epidemic. However, estimates of MARPs are not robust and without clear and reliable denominators, which constitutes a major challenge in targeting prevention responses. Currently, there are no figures available for reach and coverage of the MARPs, which is, in itself an indication of the depth of the prevention programme, which tries to address everybody, but does not address the key populations.35

With regard to Stigma and discrimination, ZAPHA+ reports an existence of stigma towards PLHA, including from family members. To counter this, there have been several initiatives:36

- Anti-stigma campaign launched in Pemba.
- ZAC provides support to district activities for anti-stigma campaign
- Production and distribution of IEC/BCC materials in the community, like T-shirts, brochures, pamphlets, flyers, caps, and car stickers.
- Radio and TV programmes; interviews with experts, religious leaders, community leaders and personal testimony from PLHA
- Radio and TV spots focusing on reduction of stigma related to HIV and AIDS.
- Radio soap opera with a focus on reduction of stigma related to HIV and AIDS.
- Articles in the Zanzibar Local news papers (*Zanzibar Leo*), and *JIHADHRI* Magazine produced biannually by the Zanzibar AIDS Commission, with a focus on reduction of stigma related to HIV and AIDS
- Support to various theatre groups in the community to perform drama and music shows focusing on reduction of stigma related to HIV and AIDS.

Other prevention measures includes the provision of life skills education to population groups considered to be at high risk particularly drug users, commercial sex women and men having sex with men. Life skills education offered to young people is believed to be a crucial part of the national response to HIV in Zanzibar. Throughout 2008 to 2009 more prevention efforts were placed on increasing the number of peer educators, extend life skills education to teachers and school inspectors, as well as improve and extend the life skills component of the HIV/AIDS education in religious schools. Out-of-school and other hard to reach youth were targeted through livelihood programs.

3.3 Implementation of Care, Treatment and Support Programmes

In 2006, 5.1% of health care facilities have the capacity and conditions to provide care and treatment services, while in 2009, the amounts have increased to 6.4% in Zanzibar.37 Care and treatment services are offered in 8 Centers (CTCs), in which 5 CTCs are in Unguja and 3 CTCs in Pemba. CTCs are conducting defaulters tracing, adherence monitoring system and some CTCs have transport for HBC and defaulter tracing. There is also a provision for STIs and OIs management and RH services within CTCs.

[35] Ibid
[36] Ibid.
37 Zanzibar AIDS Commission (ZAC) Annual HIV and AIDS Monitoring and Evaluation Report 2008

As far as MARPs are concerned, the Qualitative in depth knowledge on risk behaviors and MARPs needs and gender relations not well known, and interventions to date are small scale and urban based. MARPs access to Health and in Particular RCH/HIV service as well as an access to female and male condoms are available. Certain groups such as the military have routinely provided condoms and access to HCT.

Six CSO's (ZAIADA, ZAYEDESA, ZYF, ZANGOC, ICAAP & Zapha+) are working intensively on MARPs and Peer educators trained and fully engaged to undertake various interventions. Zanzibar has developed an integrated Substance Use and HIV strategic plan and recovery programmes, counseling and peer education takes place in urban-west region communities where the HIV infection is mostly concentrated.

3.4 Prevention of Mother to Child Transmission (PMTCT)

In the last five years PMTCT services have grown in reach with 29 centers (representing 19% of public and private health facilities providing RCH services) covering all districts in Zanzibar. The percentage of HIV-infected pregnant women who are receiving a complete course of antiretroviral prophylaxis to reduce mother to child transmission has increased from 22% (which is the baseline) to 84% in 2009 (ZACP, HIV Sentinel Surveillance for pregnant women, 2008).

3.5 HIV prevention among young people

HIV interventions have been organized for out of school youth using music, entertainment and education and a number of health and community youth friendly facilities are underway. The Ministry of education and vocational training has developed a curriculum for middle and secondary schools and anti-AIDS/Health clubs are active in 37.5% (120 out 320) primary and secondary schools which have life skills programmes. The higher learning institutes have organized a number of initiatives and health clubs have been set up in some and HIV issues are being embraced in the curriculum of selected subjects at tertiary level.

3.6 Knowledge and Behavior Change

The 2007-08 THMIS shows that the percentage of women aged 15 to 49 who had more than one partner in the last twelve month in Zanzibar were 0.3%, those with higher risk intercourse with the same age in the past twelve month in Zanzibar were 6.2%. Percentage of women aged 15-49 who used a condoms in higher risk intercourse in the last twelve months in Zanzibar were 20.3%, and women who ever had sexual intercourse 1.7% (mean number of sexual partners in lifetime). Respondent with more than one partner in the past twelve months does none vary much by age for women; however, it generally increases with age among men.

Observation from the THIMS 2007 shows the following behavioural characteristics among men and women in Zanzibar that have implications to the spread of HIV:

i. among men in the age group 10.6%, had more than two partners in the past twelve months preceding the survey.
ii. the percentage of those having higher risk intercourse in the past twelve months were 11.9%,
iii. the percentage of those who used condoms during the last sexual intercourse was 4.2% and those who used a condoms at higher risk intercourse was 32.9%.
iv. Among women who reported having had higher-risk intercourse and used condoms at the last higher risk sex was 20.3. For men the comparable figure is 32.9%.
v. The proportions of men who pay for sex in Zanzibar is very low. The percentage of men that paid for sexual intercourse in the past twelve months was only 0.7%.
vi. With regard to voluntary HIV Counseling and Testing; in Zanzibar, the vast majority of adults know where to get VCT (82.0%). However most of the people in Zanzibar (72.1%) have not been tested and consequently do not know their HIV status
vii. Generally, the data shows that women are far less likely than men to report having had two or more sexual partners in the past twelve months.

In addition to that, findings from the study that examined and analyzed factors for HIV re-infection among PLHIV shows that

i. *Loosing hope and having an attitude of revenge among the PLHIV by spread HIV contributes to re-infection and further spread of HIV in Zanzibar*:

   Some interviewed PLHIV reported instances of being stigmatized by their relatives and neighbors. In response to this, the interviewed PLHIV reported that some PLHIV lose hope and commit themselves to acts of revenge, targeting the relative of a person who mistreats them and therefore infecting them with HIV as a means of payback. Though the act may be practiced by a few PLHIV, it however, has a greater potential for spreading the epidemic in the general population.

   The PLHIV who feel that they have given up because they are already infected with HIV and re-infection may not therefore be a major concern to them, engage in unprotected sex and end up exposing themselves to HIV re-infection through unprotected sex.

ii. *Denial of HIV status due to misconceptions of HIV as being bewitched or possessed by evil spirits:*

   Although most PLHIV in Zanzibar are aware that witchcraft is not a means of HIV transmission, some believe in being bewitched and reject their HIV status. 12% PLHIV interviewed believe that HIV could be transmitted through

witchcraft…Those who believe in witchcraft end up not seeking treatment and exposing themselves to re-infection with HIV through unprotected sex.

iii. *Engagement in unprotected sex with multiple partners:*

12% of PLHIV interviewed reported that they have had more than one sex partner in the last one year. Although the age at first-sex for most PLHIV was above 15 years, PLHIV interviewed expressed concern that a number of PLHIV are engaged in unprotected sex with multiple partners. Unprotected sex with multiple partners places PLHIV at a high risk of HIV re-infection and contracting opportunistic infections.

iv. *Engaging in unprotected anal sex:*

3% of PLHIV interviewed reported that hey had engaged in anal sex in the last one year. Persons who engage in anal sex are categorized as most at risk populations in Zanzibar. PLHIV interviewed noted that there are PLHIV who are involved in unprotected anal sex, and are therefore most at risk of HIV re-infection

v. *Engaging in substance abuse:*

15.2% of PLHIV interviewed reported having used substances in the last one year. Substance users have been categorized as most at risk populations in Zanzibar. Using substances impairs judgment and expose PLHIV to unprotected and even non consensual sex which leads to HIV re-infection

Box 1: HIV Prevention and Behavioral Change among PLHIV in Zanzibar

Only 21% of PLHIV interviewed reported that they had no sexual partner in the last one year. In order to avoid re-infection with HIV, a number of PLHIV use condoms and remain faithful to one partner; others have opted to completely abstain from sex. However some PLHIV in Zanzibar are still exposed to HIV re-infection mainly as a result of their living conditions, social interactions, attitudes, practices and behavior.

PLHIV interviewed highlighted certain conditions which facilitate HIV re-infection among PLHIV in Zanzibar. PLHIV within communities face challenges in accessing information, condoms and negotiation skills which they need to protect themselves for HIV re-infection. Poverty also drives other PLHIV to engage in unprotected sex for survival. There are moments when some PLHIV may be infected and re-infected yet not knowing HIV status. Inadequate counseling also leads to lack of openness among sexual partners about their HIV status, coupled with reluctance to use condoms for protection, some sexually active PLHIV are therefore exposed to HIV re-infection.

Certain attitudes were also noted by PLHIV interviewed as facilitating HIV re-infection among PLHIV in Zanzibar. Due to stigma or mistreatment, some PLHIV lose hope and might revenge by spreading HIV to people within their communities. In other cases some PLHIV deny their HIV status claiming to be bewitched or possessed by evil spirits. PLHIV who opt to spread HIV or deny their HIV status often engage in unprotected sex which exposes them to HIV re-infection.

The PLHIV who were interviewed reported certain practices among PLHIV in communities, which also predispose them to HIV re-infection. Engagement in unprotected sex with multiple partners and engaging in unprotected anal sex were mentioned as exposing certain PLHIV to HIV re-infection. It was also noted that PLHIV who abuse substances at times engage in risky sexual behavior which predisposes then to HIV re-infection due to impaired senses.

HIV&AIDS knowledge varies between PLHIV who are members and those who are not Zanzibar Association of People Living with HIV&AIDS (ZAPHA+) members. ZAPHA+ members are trained, informed and knowledgeable on HIV. PLHIV who are based in the rural area also have relatively less access to

3.7 HIV and AIDS Impact Alleviation

There is an increased recognition of the nexus between HIV and AIDS and wide spread poverty and vulnerability to impoverishment. Widespread poverty and vulnerability to impoverishment has been considered to be one of the root courses of the spread of HIV and AIDS in Africa south of the Sahara. It is also recognized that HIV and AIDS has been one of the root courses for misery and impoverishment. As such, social protection systems that are designed to address problems of disadvantaged and vulnerable groups including children living in poverty and vulnerability necessarily must take into consideration, the mitigation of the HIV and AIDS impact. Fostering social policy that ensures access to basic services, addressing discrimination and exclusion that affect self-esteem and psychological development, among others, is central to addressing poverty particularly child poverty and vulnerability and thereby supporting prevention and response to protection-related risks.[38]

Social policy is implied in Zanzibar Strategic for Growth and Poverty Reduction (MKUZA), which provides for interventions for preventing and responding to address destitution and extreme poverty. Interventions are focused on ensuring access to essential services including education and health care provision, shelter, food security, water and sanitation. Such interventions are critical in enhancing human capabilities of the target groups. Such antipoverty interventions are also enshrined in the Zanzibar Development Vision 2020, and the sectoral policies generally[39] and in particular the relevant social sector policies.[40]

However, the realization of such social policy endeavors are constrained by inadequate and or absence of processes and instruments to realize them given the neo-liberal policy context under which they were developed. The overriding neo-liberal policy agenda emphasizes on reduction of government expenditures and introduction of cost sharing on social services; and liberalization of such provisions to allow greater private sector participation. The policy agenda falls short of prescribing a process through which such services could be purchased by the state from the private sector for social provisions to the disadvantaged and vulnerable groups. This includes for instance payment of water bills, health care services including access to essential medicines from the private sector and educational materials that are not provided in schools as well as access to food and other basic needs.

Furthermore, the envisaged social security responses in the MKUZA and the implied social policy in other sectoral policies as well as the provisions in the legislations are not defined to guarantee a statutory minimum level of wellbeing through social provisioning.

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[38] Alberto Minujin, Enrique Delamonica, Alejandra Davidziuk and Edwald D. Gonzalez (2006), The Definition of Child Poverty: Discussion of Concepts and Measurements. Environment and Urbanization. Vol. 18(2) 481-500

[39] Agricultural Sector Policy (2002), Small and Medium Enterprise (SME) Policy (2006), Zanzibar Water Policy (2004) , Zanzibar Tourism Development Policy of (2004), Trade Policy (2006), Zanzibar Industrial Policy (1998), and Zanzibar Investment Policy (2005)

[40] Zanzibar Child Survival, Protection and Development Policy (2001), The Policy on Protection and Development of Women (2001), Education Policy (2006), Zanzibar Health Policy of 2000, and the HIV and AIDS Policy (2007).

Social Policy is defined in terms of social security provisions through non-statutory guaranteed access to health and education for the disadvantaged people. Social service delivery to address vulnerability in Zanzibar is premised on targeting the "deserving poor rather than universal access. This constitutes the following social assistance that includes transfer of cash, in-kind goods and services (e.g. user fee waivers, food, clothing and educational materials) to the poor unconditionally:

a) user-fee waivers in access to essential services such as education and health care,
b) The Most Vulnerable Children Programme, (MVC), which excludes other children and women considered poor but not vulnerable. The approach involves targeting the MVC through community based identification process of the most vulnerable children and their caregiver. The MVC programme consists of unconditional cash transfers and in-kind transfers of materials support to the identified target people. Sustainability of the approach is also limited due to the fact that the Most Vulnerable Children Committees established at the District and Shehia levels are not statutory and in addition, there is limited contribution from the members of the community in terms of resources and time.[41]
c) Unconditional cash transfers to the elderly taken care in old peoples' houses. Targets only those who are provided care in public facilities, but there is a need of having a proper programme for caring for those in individual families by their relatives. The government runs four "old people's house" facilities and one for the people with leprosy. People living in these facilities are provided with all the life necessities and in addition are given a pocket allowance. However, there has been no consideration in terms of social provisioning for teenage girls, who are single parents and for the grandparents taking care of the single-parent-teenage girls, orphans and vulnerable children. Such social provisioning are also critical for this group of vulnerable children as impoverishment is identified to be one of the major driving forces for factors that puts children at risks of violence, abuse and exploitation in Zanzibar.[42]

Available data from reports and anecdote evidence shows that lack of financial resource has prevented Zanzibaris generally and children in particular, from benefiting from social provisioning.[43] Consequently, poverty driven child protection issues such as dropping out of school, child abandonment and neglect by biological parents, and subsequent risks of early pregnancies, child abuse, violence and exploitation, and other problems such as risk to the effect and impact of HIV and AIDS, and dug abuse, are yet to be adequately addressed.[44]

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[41] Ministry of Health and Social Welfare, (2009), The Situation Analysis of the Most Vulnerable Children in Zanzibar. Department of Social Welfare, Zanzibar

[42] Ibid.

[43] The Revolutionary Government of Zanzibar, (2008), Report to the House of Representatives on the Status of Implementation of the CRC at the Celebration to mark the Day of the African Child, June 16, 2008. Ministry of Labor, Youth Development, Women and Children,

[44] Ministry of Health and Social Welfare, (2009), The Situation Analysis of the Most Vulnerable Children in Zanzibar. Department of Social Welfare, Zanzibar

Efforts to build the capacity of the communities to provide support to the Most Vulnerable Children (MVC) have included establishment of Most Vulnerable Children Committees (MVCC). The UNICEF office in Zanzibar in the year 2000 assisted local NGOs (ZASO, ZAWCO, ZAMWASO, ZAPHA+, PIRO, ZANGOC and the Department of Social Welfare (DSW) to establish the Most Vulnerable Committees (MVCC) in various Shehias in both Unguja and Pemba for MVC responses. Responses provided mainly through UNICEF support, included food items (to some MVC and during critical times of the years); educational materials (exercise books, pens/pencil, uniform /shoes, text books); and health materials mostly ITNs; mattresses; detergents and sports gears.

However the established MVCC had inadequate capacity for MVC responses including identification, and recording and keeping MVC data. The main reasons being that their creation did not involve capacity building and follow-up. There was inadequate involvement of the DSW and hence DSW did not take the lead. When the UNICEF funding came to an end, the committees became dysfunctional and in some places died. Currently, the MVCC are being revived with an element of capacity building. A pilot programme is being implemented in two districts i.e. Unguja West and Wete Pemba.

The government also recognizes the importance of Zakkat collection, storage and distribution in supporting the needy. The Wakf Commission has the dual role (administrative and spiritual) to provide guidance on the Zakkat collection and distribution to those in need that includes widows, orphans, children living with single parents and or grand parents, the poor and the elderly. Inadequate collection of Zakkat and the increasing number of those in needs for support has reduced the effectiveness of the Wakf commission in offering social protection.[45] As one of the strategies to strengthen and expand social security and safety nets for the disadvantaged and Most Vulnerable Population Groups, the government through the Office of the Registrar General in collaboration with the Wakf Commission, and other non-state organizations, are in a process of strengthening Zakkat collection process and distribution to those in need.[46]

Caring for people living with HIV and AIDS in Zanzibar is mostly provided by the Ministry of Health and Social Welfare. In addition, the CSO's (ZANA, ZACA, ZASO, ZAMWASO, TUISHI & ZAPHA+) are providing the HBC to PLWHA in all districts of Zanzibar. ZAPHA+ is dedicated to safeguarding the rights and welfare of PLHIV in both Unguja and Pemba, and strives to ensure better livelihood to PLHIV. To realize this important role, ZAPHA+ has extended its office to Pemba and has one sub branch in each district. This initiative has given PLHIV a wider chance to meet and discuss as well as undertake issues related to their social and health situation within their localities. So far ZAPHA+ has committed the following:

- Training of 46 Community Home –Based Care Volunteers (CHBC) who in collaboration with the community leaders including parents and care takers identifies patients and provide them with support according to their needs.

[45] Responses from the representative of Zanzibar Mufut's Office and from representative of TUNAJALI Programme, PEPFAR supported HIV and AIDS response through the Family Health International

[46] Revolutionary Government of Zanzibar, 2008, MKUZA Annual Implementation Report 2007/08

- Community caregivers have been educated in order to serve their patients by observing those directives that are required in the provision of community quality of care services.

4 Best practices

One of the best practices in Zanzibar includes advocacy and communication. The advocacy and communication and dissemination strategy are in place in Zanzibar. ZAC, and particularly has a few mechanisms to disseminate its achievements, like its quarterly newsletter, website and release of key documents which inform the stakeholders, and the broader public of the kind of work carried out and the results. Systematic dissemination and projection of the work carried out within the AIDS response, including celebrating some of the successes (and heroes) within programmes, is essential. (SWASIT 2009).
Other best practices include the following HIV prevention measures:

i. Multitude of invested HIV prevention efforts at various levels in public sector, civil society and higher learning institutions and community at large.
ii. FBOs have started embracing HIV prevention and condone use of condoms for discordant couples that are married. Capacity enhancement and sensitization programmes for Imams and Madrasa leaders, youth, young parents and married women.
iii. Organization of out of school HIV interventions through folk media, edutainment, music groups and Youth friendly facilities.
iv. Pre-marital HIV testing has adopted as among pre-requisite for marriage eligibility (criteria).
v. The MoEVT has developed a curriculum for middle and secondary schools and anti-AIDS/Health clubs have been set up in a number of schools

5. Major Challenges and Remedial Actions

5.1 Challenges at the Organizational and Managerial level

A review of the organizational structure of the key partners in the gap analysis of the Zanzibar HIV and AIDS Response Initiatives, indicates gaps in function vis–a-vis Structure, and a need to analyse roles / functions and develop a detailed Organogram.

i. The design of the two key structures of ZAC and ZACP – the way they currently operate individually is fine, but collectively, problems exist. There is a need to go deeper into the issues of roles, responsibilities, boundary issues, reporting, sharing of information and co-ordination. Without this being tackled, there is bound to be substantial tension in actual roll out.
ii. The ZAPHA+ structure has many unfilled positions, largely due to lack of funding and not being able to find the right candidates.

iii. In the case of ZAC, while the structure is reported to be adequate, the workload is high and the numbers of staff inadequate.
iv. In the case of ZACP, the structure seems appropriate for a centralised Programme. But for a Programme of its size, the workload is also an issue.
v. None of the key structures have in place people for Supportive Supervision and quality control. Most positions are key programme people and they alone are not enough for day-to-day supervision and hand- holding support
vi. The realignment of national M&E system to reflect to the programmatic shift from vulnerable and general population to MARPs

5.2 Resource and Capacity Challenges

The challenge cuts across human and financial resources. Human resource availability, in Zanzibar is a major challenge, particularly for technical positions. Shortage of staff occurs due to two reasons – inadequate budgeting for staffing, and inability to secure the required number of staff. In the case of the first, most planning does not include a careful analysis of workload before deciding on staffing issues. In addition, there is no ongoing review of structure and staffing issues. While role and work has been expanding for key partners, concurrent expansion of staff has not been happening. Serious under- budgeting of activities has also led to this situation.

6. Support from the country's development partners

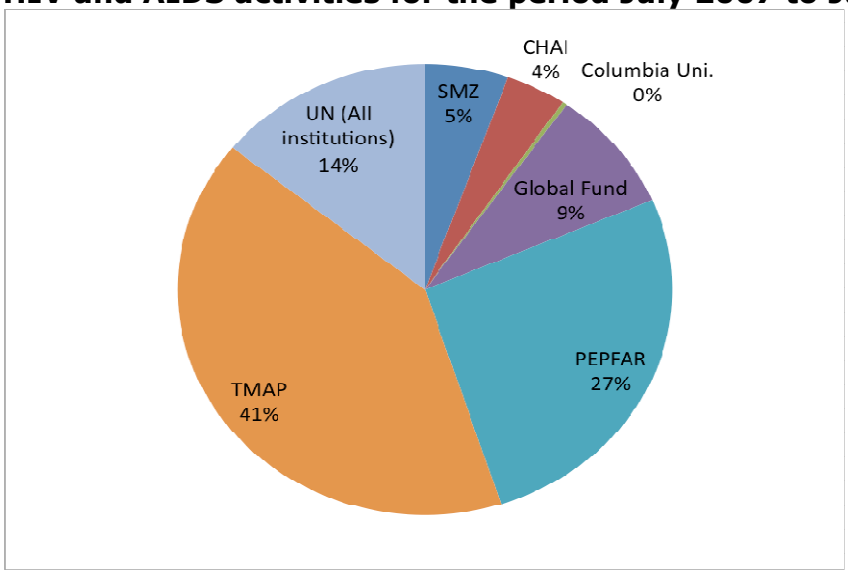
The HIV and AIDS response is largely funded by external sources through the government. The key funders of the response are the World Bank, The Global Fund for AIDS, TB, and Malaria, PEPFAR and the UN Joint Programme. Other partners provide support for CSOs through the Rapid Funding Envelope (RFE).
Under the Tanzanian Multi-sector AIDS Program (TMAP), the World Bank provides grant funding to Zanzibar for the use in three areas: the Community AIDS Response Fund (CARF) component, the public sector component, and the ZAC component. ZAC is the principal recipient of TMAP funds.
Zanzibar has received Global Fund support in Rounds 2 and 6 to address the HIV and AIDS pandemic. Round 2 focused on the Participatory Response to HIV and AIDS for Youth in Zanzibar (PRAYZ) while Round 6 focuses on Joint Accelerated Access to HIV and AIDS Initiatives (Prevention, Treatment, Care and Support) in Zanzibar (JAHAZI).
The UN is a significant donor for HIV and AIDS activities in Zanzibar, providing finance either through the UN Joint Programme for HIV and AIDS (UNJP), or through its individual agencies. The formation of UNJP has simplified the request and disbursement process, with ZAC acting as the principal recipient. ZAC coordinates the various sub-recipients into a participatory planning approach, producing an annual plan. This annual plan is submitted to UNJP for approval and once agreed UNJP provides ZAC with a commitment for funding. Additional to the pooled funding from UNJP, some UN agencies also grant parallel funding for specific activities.
The Rapid Funding Envelope (RFE) was established in 2002 as a method of filling gaps that occur between the large donor programmes. Specifically, the RFE focuses on filling gaps in technical and geographical support, funding innovations, testing replication, and supporting institutional strengthening. The RFE is a partnership between TACAIDS, ZAC nine bilateral donors and one private foundation[47], with financial oversight by Deloitte & Touche and technical oversight by Management Sciences for Health,

[47] The Bernard Van Leer Foundation, the Canadian International Development Agency, The Embassy of Finland, Irish Aid, The Royal Danish Embassy, The Royal Netherlands Embassy, The Royal Norwegian Embassy, The Swiss Agency for Development and Cooperation, The UK Department for International Development, and USAID.

providing grants to CSOs, academic institutions and civil society partnerships for short-term projects aligned with ZNSP. Funds are disbursed to six priority areas:

- Prevention, advocacy, information/education/communication, and behaviour change communication
- Care and support for HIV and AIDS, and related opportunistic infections
- Impact mitigation of the effects of the epidemic, including orphans and vulnerable children
- Research to provide baseline information or assess effectiveness
- Institutional strengthening, including capacity building in monitoring and evaluation
- Interventions for children under 8 years old who are infected or affected by HIV and AIDS.

Figure 4: Relative significance of donor funding of expenditure on HIV and AIDS activities for the period July 2007 to June 2008



Source: PER 2008/09

7. Monitoring and evaluation environment

An annual work plan 2008 – 2009 have shown that, a total of Ths. 2,835,062,651/= has been budgeted for the implementation of all activities under the World Bank (TMAP) and the Civil Society Organizations (CSO's) have managed to spent a total of 478,988,005/=, which is equivalent to 17% of the total budget. For the year 2008/09, the total HIV programme funding budgeted for M&E activities was 596,362,150/=, this is equivalent to 21.04% the total HIV programme funding budgeted for M&E activities. Within that allocation ZAC Monitoring & Evaluation Unit has managed to spend a total of Ths. 111,608,282/= which equivalent to 4% of the total budget. The spent money has help in implementation of planned M&E activities and the following achievements have been

reached. Eleven out of twelve components of a functional M&E system in Zanzibar are now fully operational with the exception of research component; M&E focal persons and staff have been placed among most of the organizations undertaking HIV activities in Zanzibar; Capacity in M&E was strengthened through training, mentorship and shared learning forums; M&E Task Team for HIV&AIDS in Zanzibar met severally and shared technical input and feedback on M&E for the AIDS response; Many planned activities within the national M&E framework and costed road map were implemented; Routine monitoring and reporting took place through Zanzibar HIV&AIDS Programme Monitoring System (ZHAPMoS), health sector monitoring system and other programme monitoring system; Various research, surveys and surveillance took place including THMIS II, MARPs surveys, life skills assessment and others; The national HIV database is functional, storing and generating data to inform the evidence-based national response to HIV&AIDS; Data auditing and supportive supervision sessions have been conducted by ZAC, ZAMEA, Districts and MOH; Reports have been developed and disseminated using data from the M&E system and these reports were referenced during national planning activities like gap analysis for the national AIDS response, and clear and functional information flow and reporting and communication channels.

The goal of Zanzibar's National Multi-sectoral HIV M&E System is to enable ZAC and its partners to monitor the spread and impact of the epidemic in Zanzibar, to monitor the efficiency of the national response to HIV, and to evaluate the effectiveness of the national response to HIV, using relevant and accurate HIV data for use in planning effective interventions. This would result in an evidence based multi-sectoral approach towards planning for the interventions against HIV. During the year 2008/2009, ZAC has managed to implement M&E activities and about 84% i.e. 315 of 375 HIV implementers have been reporting in ZHAPMoS forms, and at the national levels ZAC, umbrella organizations, Government ministries, departments and agencies have established structures for M&E with adequate human resource, knowledge and skills and M&E plans. However there are inadequate linkages and harmonization of information systems, and a national evaluation and research agenda is not yet in place. The national HIV M&E system is primarily focused on the general population, therefore enough knowledge and skills required for HIV M&E among MARPs has not been built in-country. Districts are the link point between national and community level M&E activities, therefore Districts and Shehia levels have adequate human resources and plans for M&E. However, the Districts and Shehias face funding shortage and delays, coupled with inadequate data dissemination and information use. At the community service delivery points there is a clear and functional information flow, with stipulated reporting and communication channels. HIV&AIDS data are collected at community service delivery points, though various data collection tools which are not yet harmonized nationally. Therefore data provided by some community outreach workers are not accurate, complete, confidential, precise, reliable, timely and with integrity. Nationally harmonized data collection tools exist with data collection taking place at the health facilities; this is facilitated with clear and functional information flow and reporting and communication channels. However, like in the case of community outreach programs, the quality of data generated at some health facilities could be further strengthened.

7.1 Challenges

ZAC and its partners have invested substantial time and effort in setting up and rolling out the ZHAPMoS - Zanzibar HIV and AIDS Programme Monitoring System, and health monitoring system. These systems have been providing Programme monitoring information from a variety of partners on an ongoing basis. It is an important development, as it is the one national level M&E system for all stakeholders to contribute to, and use. A review of the M&E system indicates the following challenges:

i. M&E system works; but outputs of the system are not fully utilized by key partners
ii. The predominance of the system is quantitative data. Qualitative information and analysis is limited
iii. Elements of community-friendly and community-led monitoring is absent
iv. Lack of basic equipment and funding (e.g. for travel) affects the reporting
v. Web-based monitoring has not fully taken off; the website to be set up and managed by Tanzania University has taken much time
vi. There is no back up of M&E data; the server holding all the AIDS response data has not been backed up
vii. M&E frame only includes Programme data – it does not fully integrate research, surveillance, financial information and other aspects that need to be monitored.
viii. Compliance by partners, particularly those who do not receive direct funding from ZAC, is limited.

7.2 Way Forward

In line with the priority areas, during the ZNSPII the main outcomes for the national HIV&AIDS M&E system will include the realigning and strengthening HIV M&E system, structures and human capacity to support ZNSP II strategies and interventions including the programmatic shift and focus on MARPs; providing adequate and reliable financial, human, technological and material resources for implementing the realigned ZNSPII M&E system; Harmonizing and strengthening the capacities for monitoring, data collection and data management at all HIV&AIDS community service delivery points and health facilities; and enhancing and supporting HIS, poverty monitoring and other monitoring systems for HIV&AIDS data packaging, dissemination, demand and utilization at all levels of the national HIV response. ZAC will continue to lead and coordinate the M&E component of the national AIDS response. Sufficient resources will continue to be mobilized so that the M&E system is sustained and maintained at all levels.

NCPI PART A:

	Responses
1. Has the country developed a national multisectoral strategy to respond to HIV?	YES
1.1 How long has the country had a multisectoral strategy?	5 Years
1.2 Which sectors are included in the multisectoral strategy with a specific HIV budget for their activities?	
Health	YES
Health	YES
Education	YES
Education	YES
Labour	YES
Labour	YES
Transportation	YES
Transportation	YES
Military/Police	YES
Military/Police	YES
Women	YES
Women	YES
Young people	YES
Young people	YES
Other*:	YES
Other*:	YES
1.3 Does the multisectoral strategy address the following target populations, settings and crosscutting issues?	
a. Women and girls	YES
b. Young women/young men	YES
c. Injecting drug users	YES
d. Men who have sex with men	YES
e. Sex workers	YES
f. Orphans and other vulnerable children	YES
g. Other specific vulnerable subpopulations*	YES
h. Workplace	YES
i. Schools	YES
j. Prisons	YES
k. HIV and poverty	YES
l. Human rights protection	YES
m.Involvement of people living with HIV	YES
n. Addressing stigma and discrimination	YES
o. Gender empowerment and/or gender equality	YES

1.4 Were target populations identified through a needs assessment?	YES
Year:	2005
1.6 Does the multisectoral strategy include an operational plan?	YES
1.7 Does the multisectoral strategy or operational plan include:	
a. Formal programme goals?	YES
b. Clear targets or milestones?	YES
c. Detailed costs for each programmatic area?	YES
d. An indication of funding sources to support programme implementation?	YES
e. A monitoring and evaluation framework?	YES
1.8 Has the country ensured "full involvement and participation" of civil society* in the development of the multisectoral strategy?	YES
1.9 Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?	YES
1.10 Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?	PARTNERS
2. Has the country integrated HIV into its general development plans such as in: (a) National Development Plan; (b) Common Country Assessment / UN Development Assistance Framework; (c) Poverty Reduction Strategy; and (d) sector-wide approach?	YES
2.1 ***IF YES***, in which specific development plan(s) is support for HIV integrated?	
a. National Development Plan	YES
b. Common Country Assessment / UN Development Assistance Framework	YES
c. Poverty Reduction Strategy	YES
d. Sector-wide approach	YES
e. Other:	NO
2.2 IF YES, which specific HIV-related areas are included in one or more of the development Plans?	
HIV prevention	YES
Treatment for opportunistic infections	YES
Antiretroviral treatment	YES
Care and support (including social security or other schemes)	YES
HIV impact alleviation	YES
Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or	YES
Reduction of income inequalities as they relate to HIV prevention/treatment, care and /or	YES
Reduction of stigma and discrimination	YES
Women's economic empowerment (e.g. access to credit, access to land, training)	YES

Other: [write in]	YES
3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?	YES
3.1 IF YES, to what extent has it informed resource allocation decisions?	HIGH
4. Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)?	YES
4.1 IF YES, which of the following programmes have been implemented beyond the pilot stage to reach a significant proportion of the uniformed services?	
Behavioural change communication	YES
Condom provision	YES
HIV testing and counseling	YES
Sexually transmitted infection services	YES
Antiretroviral treatment	YES
Care and support	YES
Others:	YES
5. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations or other vulnerable subpopulations?	NO
5.1 IF YES, for which subpopulations?	
a. Women	YES
b. Young people	YES
c. Injecting drug users	YES
d. Men who have sex with men	YES
e. Sex Workers	YES
f. Prison inmates	YES
g. Migrants/mobile populations	YES
h. Other:	YES
6. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations or other vulnerable subpopulations?	YES
6.1 IF YES, for which subpopulations?	YES
a. Women	YES
b. Young people	YES
c. Injecting drug users	YES
d. Men who have sex with men	YES
e. Sex Workers	YES
f. Prison inmates	YES
g. Migrants/mobile populations	YES
h. Other: [write in]	YES
7. Has the country followed up on commitments towards universal	YES

access made during the High-Level AIDS Review in June 2006?	
7.1 Have the national strategy and national HIV budget been revised accordingly?	YES
7.2 Have the estimates of the size of the main target populations been updated?	NO
7.3 Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy? Estimates of current and future needs Estimates	NO
7.4 Is HIV programme coverage being monitored?	YES
(a) IF YES, is coverage monitored by sex (male, female)?	YES
(b) IF YES, is coverage monitored by population groups?	YES
(c) Is coverage monitored by geographical area?	YES
7.5 Has the country developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs?	YES
Overall, how would you rate strategy planning efforts in the HIV programmes in 2009?	Median 6
1. Do high officials speak publicly and favourably about HIV efforts in major domestic forums at least twice a year?	
President/Head of government	YES
Other high officials	YES
Other officials in regions and/or districts	YES
2. Does the country have an officially recognized national multisectoral AIDS coordination body (i.e., a National AIDS Council or equivalent)?	YES
2.1 IF YES, when was it created?	2002
2.3 IF YES, does the national multisectoral AIDS coordination body:	
Have terms of reference?	YES
have active government leadership and participation?	YES
have a defined membership?	YES
IF YES, how many members? [write in]	11
include civil society representatives?	YES
IF YES, how many? [write in]	2
include people living with HIV?	YES
IF YES, how many? [write in]	
include the private sector?	YES
have an action plan?	YES
have a functional Secretariat?	YES
meet at least quarterly?	YES
review actions on policy decisions regularly?	YES
actively promote policy decisions?	YES
provide opportunity for civil society to infl uence decision-making?	YES

strengthen donor coordination to avoid parallel funding and duplication of effort in i d i ?	YES
3. Does the country have a mechanism to promote interaction between government, civil society organizations, and the private sector for implementing HIV strategies/programmes?	YES
4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?	--
5. What kind of support does the National AIDS Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?	
Information on priority needs	YES
Technical guidance	YES
Procurement and distribution of drugs or other supplies	YES
Coordination with other implementing partners	YES
Capacity-building	YES
Other: [write in]	YES
6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National AIDS Control policies?	YES
6.1 ***IF YES***, were policies and laws amended to be consistent with the National AIDS Control policies?	YES
Overall, how would you rate the political support for the HIV programme in 2009?	Median (7)
1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the general population?	YES
1.1 IF YES, what key messages are explicitly promoted?	
a. Be sexually abstinent	YES
b. Delay sexual debut	YES
c. Be faithful	YES
d. Reduce the number of sexual partners	YES
e. Use condoms consistently	YES
f. Engage in safe(r) sex	YES
g. Avoid commercial sex	YES
h. Abstain from injecting drugs	YES
i. Use clean needles and syringes	YES
j. Fight against violence against women	YES
k. Greater acceptance and involvement of people living with HIV	YES
l. Greater involvement of men in reproductive health programmes	YES
m. Males to get circumcised under medical supervision	YES
n. Know your HIV status	YES
o. Prevent mother-to-child transmission of HIV	YES
Other: [write in]	YES
1.2 In the last year, did the country implement an activity or	YES

programme to promote accurate reporting on HIV by the media?	
2. Does the country have a policy or strategy promoting HIV-related reproductive and sexual health education for young people?	YES
2.1 Is HIV education part of the curriculum in:	
primary schools?	YES
secondary schools?	YES
teacher training?	YES
2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women?	YES
2.3 Does the country have an HIV education strategy for out-of-school young people?	YES
3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions *for most-at-risk or other vulnerable sub-populations?*	YES
3.1 ***IF YES***, *which populations* and *what elements of HIV prevention* do the policy/strategy address?	
Targeted information on risk reduction and HIV education IDU*	YES
MSM**	YES
Sex workers	YES
Clients of sex workers	YES
Prison inmates	YES
Other populations*	
Stigma and discrimination reduction IDU*	YES
MSM**	YES
Sex workers	YES
Clients of sex workers	YES
Prison inmates	YES
Other populations*	YES
Condom promotion IDU*	YES
MSM**	YES
Sex workers	YES
Clients of sex workers	YES
Prison inmates	YES
Other populations*	YES
HIV testing and counselling IDU*	YES
MSM**	YES
Sex workers	YES
Clients of sex workers	YES
Prison inmates	YES
Other populations*	YES
Reproductive health, including sexually transmitted infections prevention and treatment IDU*	YES

MSM**	YES
Sex workers	YES
Clients of sex workers	YES
Prison inmates	YES
Other populations*	
Vulnerability reduction (e.g. income generation) IDU*	
MSM**	
Sex workers	YES
Clients of sex workers	
Prison inmates	
Other populations*	
Drug substitution therapy IDU*	YES
MSM**	
Sex workers	
Clients of sex workers	
Prison inmates	
Other populations*	
Needle & syringe exchange IDU*	YES
MSM**	
Sex workers	
Clients of sex workers	
Prison inmates	
Other populations*	
Overall, how would you rate policy efforts in support of HIV prevention in 2009?	7
4. Has the country identified specific needs for HIV prevention programmes?	YES
4.1 To what extent has HIV prevention been implemented?	
Blood safety	AGREE
Universal precautions in health care settings	AGREE
Prevention of mother-to-child transmission of HIV	AGREE
IEC* on risk reduction	AGREE
IEC* on stigma and discrimination reduction	AGREE
Condom promotion	AGREE
HIV testing and counselling	AGREE
Harm reduction for injecting drug users	AGREE
Risk reduction for men who have sex with men	AGREE
Risk reduction for sex workers	AGREE
Reproductive health services including sexually transmitted infections prevention and	AGREE
School-based HIV education for young people	AGREE
HIV prevention for out-of-school young people	AGREE
HIV prevention in the workplace	AGREE

Other: [write in]	AGREE
Overall, how would you rate the efforts in the implementation of HIV prevention programmes i 2009?	Median (8)
1. Does the country have a policy or strategy to promote comprehensive HIV treatment, care and support? (Comprehensive care includes, but is not limited to, treatment, HIV testing and counselling, psychosocial care, and home and community-based care).	YES
1.1 IF YES, does it address barriers for women?	YES
1.2 IF YES, does it address barriers for most-at-risk populations?	YES
2. Has the country identified the specific needs for HIV treatment, care and support services?	YES
2.1 To what extent have the following HIV treatment, care and support services been i l d?	
HIV treatment, care and support service The majority of people in need have access	
Antiretroviral therapy	AGREE
Nutritional care	AGREE
Pediatric AIDS treatment	AGREE
Sexually transmitted infection management	AGREE
Psychosocial support for people living with HIV and their families	AGREE
Home-based care	AGREE
Palliative care and treatment of common HIV-related infections	AGREE
HIV testing and counseling for TB patients	AGREE
TB screening for HIV-infected people	AGREE
TB preventive therapy for HIV-infected people	AGREE
TB infection control in HIV treatment and care facilities	AGREE
Cotrimoxazole prophylaxis in HIV-infected people	AGREE
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	AGREE
HIV treatment services in the workplace or treatment referral systems through the workplace	AGREE
HIV care and support in the workplace (including alternative working arrangements)	AGREE
Other: [write in]	AGREE
3.Does the country have a policy for developing/using generic drugs or parallel importing of d f HIV?	YES
4.Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy drugs, condoms, and	YES
Overall, how would you rate the efforts in the implementation of HIV treatment, care and i 2009?	Median (7)
5. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable	YES

children?	
5.1 ***IF YES***, is there an operational definition for orphans and vulnerable children in the country?	YES
5.2 ***IF YES***, does the country have a national action plan specifi cally for orphans and vulnerable children?	YES
5.3 ***IF YES***, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?	YES
Overall, how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2009?	6
1. Does the country have one national Monitoring and Evaluation (M&E) plan?	YES
1.1 IF YES, years covered: [write in]	5
1.2 IF YES, was the M&E plan endorsed by key partners in M&E?	YES
1.3 IF YES, was the M&E plan developed in consultation with civil society, including people li i i h HIV?	YES
1.4 IF YES, have key partners aligned and harmonized their M&E requirements (including i di) ih h i lM&E l ?	NO
2. Does the national Monitoring and Evaluation plan include? a data collection strategy	PARTNERS
IF YES, does it address: routine programme monitoring	YES
behavioural surveys	YES
HIV surveillance	YES
Evaluation / research studies	YES
a well-defined standardised set of indicators	YES
guidelines on tools for data collection	YES
a strategy for assessing data quality (i.e., validity, reliability)	YES
a data analysis strategy	YES
a data dissemination and use strategy	YES
3. Is there a budget for implementation of the M&E plan?	YES
3.1 IF YES, what percentage of the total HIV programme funding is budgeted for M&E activities?	30.52
3.2 IF YES, has full funding been secured?	YES
3.3 IF YES, are M&E expenditures being monitored?	YES
4. Are M&E priorities determined through a national M&E system assessment?	YES
5. Is there a functional national M&E Unit?	YES
5.1 IF YES, is the national M&E Unit based in the National AIDS Commission (or equivalent)?	YES
in the Ministry of Health?	YES
Elsewhere? [write in]	YES
5.3 IF YES, are there mechanisms in place to ensure that all major implementing partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?	YES
6. Is there a national M&E Committee or Working Group that	MEETS

meets regularly to coordinate M&E activities?	IRREGULAR
6.1Does it include representation from civil society?	YES
7. Is there a central national database with HIV- related data?	YES
7.2 IF YES, does it include information about the content, target populations and geographical coverage of HIV services, as well as their implementing organizations?	OF THE ABOVE
7.3 Is there a functional* Health Information System? At national level	YES
At subnational level	YES.5
8. Does the country publish at least once a year an M&E report on HIV and on, including HIV surveillance data?	YES
9. To what extent are M&E data used	
9.1 in developing / revising the national AIDS strategy?:	HIGH
9.2 for resource allocation?:	3
9.3 for programme improvement?:	HIGH
10.Is there a plan for increasing human capacity in M&E at national, subnational and service level?	levels
10.1 In the last year, was training in M&E conducted At national level?	YES
IF YES, Number trained:	74
At subnational level?	YES
IF YES, Number trained:	
At service delivery level including civil society?	YES
IF YES, Number trained:	
10.2 Were other M&E capacity-building activities conducted other than training?	YES
Overall, how would you rate the M&E efforts of the HIV programme in 2009?	7.5

NCPI PART B

	Responses
1. Does the country have laws and regulations that protect people living with HIV against discrimination? (including both general non-discrimination provisions and provisions that specifically mention HIV, focus on schooling, housing, employment, health	yes
2. Does the country have non-discrimination laws or regulations, which specify protections for most-at risk populations and other vulnerable subpopulations?	yes
2.1 IF YES, for which populations? a. Women	yes
b. Young people	yes
c. Injecting drug users	yes
d. Men who have sex with men	No
e. Sex Workers	yes

f. Prison inmates	yes
g. Migrants/mobile populations	yes
h. Other: [write in]	
3. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations and other vulnerable subpopulations?	yes
3.1 IF YES, for which subpopulations? a. Women Yes No	yes
b. Young people	yes
c. Injecting drug users	
d. Men who have sex with men	yes
e. Sex Workers	yes
f. Prison inmates	yes
g. Migrants/mobile populations	yes
h. Other: [write in]	yes
4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?	yes
5.Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, most-at-risk populations and/or other vulnerable subpopulations?	yes
6. Has the Government, through political and fi nancial support, involved people living with HIV, most-at-risk populations and/or other vulnerable subpopulations in governmental HIV-policy design and programme implementation?	yes
7. Does the country have a policy of free services for the following: a. HIV prevention services	yes
b. Antiretroviral treatment	yes
c. HIV-related care and support interventions	yes
8. Does the country have a policy to ensure equal access for women and men to HIV prevention, treatment, care and support?	yes
8.1 In particular, does the country have a policy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?	yes
9. Does the country have a policy to ensure equal access for most-at-risk populations and/or other vulnerable subpopulations to HIV prevention, treatment, care and support?	No
9.1 IF YES, does this policy include different types of approaches to ensure equal access for different most-at-risk populations and/or other vulnerable sub-populations?	yes
10.Does the country have a policy prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?	yes

11.Does the country have a policy to ensure that HIV research protocols involving human subjects are reviewed and approved by a national/local ethical review committee?	yes
11.1 IF YES, does the ethical review committee include representatives of civil society including people living with HIV?	yes
12.Does the country have the following human rights monitoring and enforcement mechanisms?	

Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work	yes
Focal points within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in areas such as housing and employment	yes
Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts	yes
13.In the last 2 years, have members of the judiciary (including labour courts/ employment tribunals) been trained/sensitized to HIV and human rights issues that may come up in the context of their work?	No
14.Are the following legal support services available in the country? Legal aid systems for HIV case work	No
Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV	No
Programmes to educate, raise awareness among people living with HIV concerning their rights	yes
15.Are there programmes in place to reduce HIV-related stigma and discrimination?	yes
Media	yes
School education	yes
Personalities regularly speaking out	yes
Other: [write in]	yes
Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2009?	**6**
Overall, how would you rate the effort to enforce the existing policies, laws and regulations in 2009?	**4**
1. To what extent has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?	High
2. To what extent have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?	**4**
3. To what extent are the services provided by civil society in areas of HIV prevention, treatment, care and support included in a.the national	High

AIDS strategy?	
b. the national AIDS budget?	Yes
c. national AIDS reports?	No
4. To what extent is civil society included in the monitoring and evaluation (M&E) of the HIV response? a. developing the national M&E plan?	High
b.participating in the national M&E committee / working group responsible for coordination of M&E activities?	Low
c. M&E efforts at local level?	Low
5. To what extent is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. networks of people living with HIV, organizations of sex workers, faith-based organizations)?	Medium
6. To what extent is civil society able to access: a. adequate financial support to implement its HIV activities?	Low
b. adequate technical support to implement its HIV activities?	Low
7. What percentage of the following HIV programmes/services is estimated to be provided by civil society? Prevention for youth <25%	>75%
Prevention for most-at-risk-populations Injecting drug users	25% - 50%
men who have sex with men	51% - 75%
sex workers	51% - 75%
Testing and Counseling	>75%
Reduction of Stigma and Discrimination	51% - 75%
Clinical services (ART/OI)	25% - 50%
Home-based care	<25%
Programmes for OVC**	<25%
Overall, how would you rate the efforts to increase civil society participation in 2009?	**3**

1.Has the country identifi ed the specifi c needs for HIV prevention programmes?	yes
1.1 To what extent has HIV prevention been implemented? HIV prevention component The majority of people in need have access	
Blood safety	Agree
Universal precautions in health care settings	Agree
Prevention of mother-to-child transmission of HIV	Agree
IEC* on risk reduction	Agree
IEC* on stigma and discrimination reduction	Agree
Condom promotion	Agree
HIV testing and counselling	Agree

Harm reduction for injecting drug users	Don't agree
Risk reduction for men who have sex with men	Don't agree
Risk reduction for sex workers	Don't agree
Reproductive health services including sexually transmitted infections prevention and treatment	Agree
School-based HIV education for young people	Agree
HIV Prevention for out-of-school young people	Agree
HIV prevention in the workplace	Agree
Other: [write in]	Agree
Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2009?	**7**
1. Has the country identified the specific needs for HIV treatment, care and support services?	yes
1.1 To what extent have HIV treatment, care and support services been implemented? HIV treatment, care and support service The majority of people in need have access Antiretroviral therapy	
Nutritional care	Agree
Paediatric AIDS treatment	Agree
Sexually transmitted infection management	Agree
Psychosocial support for people living with HIV and their families	Agree
Home-based care	Agree
Palliative care and treatment of common HIV-related infections	Agree
HIV testing and counseling for TB patients	Agree
TB screening for HIV-infected people	Agree
TB preventive therapy for HIV-infected people	Agree
TB infection control in HIV treatment and care facilities	Agree
Cotrimoxazole prophylaxis in HIV-infected people	Agree
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Agree
HIV treatment services in the workplace or treatment referral systems through the workplace	Agree
HIV care and support in the workplace (including alternative working arrangements)	Agree
Other programmes: [write in]	
Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2009?	**5.5**
2. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?	yes
2.1 IF YES, is there an operational definition for orphans and vulnerable children in the country?	yes
2.2IF YES, does the country have a national action plan specifically for	yes

orphans and vulnerable children?	
2.3 IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?	yes

Names of Organizations Filling the National Composite Policy Index Tool
Tool A

S/N	Names of Ministries that Filled and Returned the Questionnaire
1	**Chief Minister's Office- ZANZIBAR AIDS COMMISSION (ZAC)**
2	**MINISTRY OF HEALTH AND SOCIAL WELFARE (MoHSW)-ZANZIBAR AIDS CONTROL PROGRAMME (ZACP)**
3	**MINISTRY OF LABOUR, YOUTH, WOMEN AND CHILDREN DEVELOPMENT**
4	**MINISTRY OF REGIONAL ADMINISTRATION, LOCAL GOVERNMENT AND SPECIAL DEPARTMENTS**
5	**MINISTRY OF EDUCATION & VOCATIONAL TRAININGS**
6	**MINISTRY OF FINANACE & ECONOMIC AFFAIRS**
7	**MINISTRY OF STATE PRESIDENT OFFICE**
8	**MINISTRY OF WATER, ENERGY, LAND & CONSTRUCTION-**

Tool B

S/N	Names of Organizations that Filled and Returned the Questionnaire
1	**ZAPHA+ --**
2	**ZANGOC**
3	**ABCZ**
4	**CVM**
5	**UN Joint**