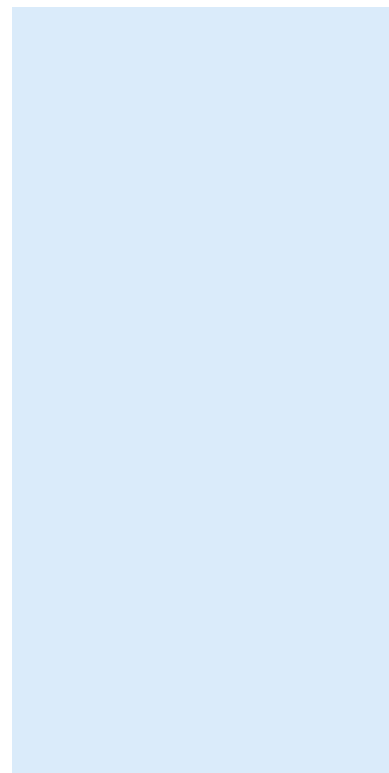


Towards universal access to prevention, treatment and care: experiences and challenges from the Mbeya region in Tanzania—a case study

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Foreword

Tanzania has made substantial progress in the last five years in dealing successfully with the HIV epidemic. Since the Government of Tanzania declared the epidemic a “national disaster” in 1999, efforts have been intensified at all levels to mobilize society against this threat. Following the establishment of the Tanzania Commission for AIDS (TACAIDS) and the adoption of the National Policy on HIV/AIDS in 2001, the country developed and approved the National Multisectoral Strategic Framework for HIV/AIDS for 2003–2007 as the guiding document for all public and private partners. Since then, substantial efforts supported by greatly increased financial contributions from external bilateral and multilateral partners have been undertaken to increase the capacity of the Tanzanian people—especially at district and community levels—to respond to the epidemic and develop their own responses.

This case study on the effort to control HIV in the region of Mbeya describes and summarizes work spanning nearly 20 years. It examines government structures that support HIV control and the commitment of the government, people and external partners to overcoming the threat of HIV to national development. These efforts have not been in vain: prevalence of HIV, which was over 20% in the mid-1990s, has dropped to 13% in 2005, probably as a result of regional programmes and activities.

However, the challenge of AIDS has not yet been won. Prevalence is still unacceptably high and many new HIV infections occur in Mbeya (and the rest of Tanzania) every day. The Government of Tanzania is committed to increasing its efforts even further in the response to HIV and to achieving the internationally accepted benchmark of universal access to prevention, treatment and care by 2010 for all people in need. This is seen as a midpoint on the way to the achievement of the Millennium Development Goals and the targets set by the UNGASS Declaration.

The region of Mbeya has already made very good progress towards this ambitious goal. The lessons learnt in the Mbeya region will inspire other regions of the country to follow. While I would like to thank all those who have participated and supported these efforts over nearly two decades, be they from the government, the private sector or our international partners, we also acknowledge that the challenges in overcoming HIV in our country remain high and we need to maintain our determination and commitment for many years to come.

Retired Major General Lupogo
TACAIDS

Executive summary

Tanzania is facing a major HIV epidemic. For nearly two decades, efforts have been underway to control it without major success. In recent years, renewed national efforts, supported by increased external assistance and new approaches, have been developed to curb the trend of the epidemic and to reduce the impact of HIV on national development.

The Mbeya region in the south-west of Tanzania, home to more than two million people, was and continues to be one of the country's most affected regions. HIV prevalence among the sexually active population reached its peak in the mid-1990s at over 20%. Since that time the trend of the epidemic has been reversed, and HIV prevalence today is estimated at about 13%. It is very likely that the Mbeya Regional AIDS Control Programme (hereafter referred to as the Regional Programme), which started its activities in 1988, contributed to this drop. The backbone of the Regional Programme between 1988 and 2003 was the Ministry of Health and Local Government at regional and district levels through which nationally and internationally recommended strategies were implemented. The continually strengthened and expanded regional Programme supported over the years by external organizations aimed to: (a) continually expand the number of programmes in order to be as comprehensive as possible, and (b) increase the access and the coverage of its programmes to include as many members of the population as possible.

Since 2003, the national response to HIV has been guided by the National Multisectoral Strategic Framework on HIV/AIDS, which calls for a sustained and expanded national response involving as many sectors and players as possible. In 2001, the Tanzania Commission for AIDS (TACAIDS) was created as a new national coordinating body for the multisectoral response. In the last three years, tremendous efforts by TACAIDS, supported by substantially increased external financial and technical resources, focused on the creation and training of local government structures at the district level to coordinate responses to the epidemic throughout the country. With the support of newly created Regional Facilitating Agencies, community organizations were strengthened to expand prevention and mitigation efforts. In addition, in 2004, a national care and treatment plan was launched to provide antiretroviral treatment to an increasing number of people living with HIV.

Based on these new national developments, the Regional Programme expanded its activities, especially in areas such as voluntary counselling and testing and programmes in the workplace, educational sector, and community, in order to include all strategies conceptualized in the National Multisectoral Strategic Framework. This multisectoral approach was to be as comprehensive and rapid as possible to increase access for the entire population of the Mbeya region. At the same time, the roll-out of antiretroviral treatment began. In all districts, new Council Multisectoral AIDS Committees were created and trained, and with the assistance of the Regional Facilitating Agency, community activities were strengthened through capacity building and financial support to civil society organizations.

As captured first in the Millennium Development Goals and then in the 2001 *Declaration of Commitment on HIV/AIDS* made by the United Nations General Assembly Special Session on HIV/AIDS (UNGASS), the international community hopes to reach a major breakthrough in controlling the HIV epidemic by 2015. In addition, G8 countries launched an intermediate goal in 2005, which they renewed in 2006, in the form of a commitment to supporting universal access to prevention, care and treatment by 2010. By ensuring the provision of services and support to at least 80% of the population of each

affected country, it is hoped that not only will the UNGASS and Millennium Development Goals be reached but also that the threat of HIV will be overcome.

By 2006, the region of Mbeya had all major elements in place that were nationally and internationally recommended for controlling the HIV epidemic and was implementing strategies such as treatment of sexually transmitted infections, and condom and health promotion. These efforts are already reaching more than 80% of the population and progress is being made in other areas such as peer education in schools, workplace HIV programmes in the private and public sectors and home-based care activities through the health sector and nongovernmental organizations. The reduction in HIV prevalence since 1994, though apparently slowing since 2001, points to a real turnaround in the region's epidemic.

Thanks to nearly two decades of continual and uninterrupted efforts to implement the national response and sustained and well-integrated external support, the Mbeya region was apparently in a more advantageous position to add the new dimensions of the country's National Multisectoral Strategic Framework and to advance faster than other regions in the country towards the goal of universal access. However, new HIV infections continue at a high rate and prevalence is still a staggering 13%.

The challenges of Mbeya (and for Tanzania as a whole) remain dramatic.

- Will the continual strengthening of existing strategies and programmes combined with the new organizational structure at local levels contribute to a significant and sustained reduction of HIV transmission in the next five to 10 years?
- Can the quality of programmes and services be maintained while increasing access for the population?
- Will the quality of programmes and services suffer in the medium and long term when they become routine activities of relatively weak public and private structures?
- Will the involvement of more sectors and the mainstreaming of HIV into key sectors, e.g. education, agriculture and community development, expand the response substantially?
- Will the new focus on district coordination and capacity building at community level involve population groups that so far have not been sufficiently reached by the prevention and support activities?
- Will sufficient levels of external technical and financial support be maintained for decades to come to provide prevention, care and treatment programmes to significant numbers of people living with HIV, thereby reducing the suffering of families and communities from sickness and premature death?

There is substantial reason to be optimistic that Mbeya and Tanzania can live up to the challenge of achieving universal access by 2010. However, the efforts needed to generalize the level of implementation already reached in Mbeya today throughout the whole country and, at the same time, consolidate, maintain and even strengthen an already strong programme will be tremendous and will need the full support of the national and local government as well as that of external partners in the years to come.

It will be equally necessary to continually monitor and assess the quality and results of programmes at all levels and provide enough technical and strategic support to ascertain that the access of an increased percentage of the population to key services and programmes is not outweighed by a decline in quality and effectiveness of the HIV response.

Introduction

1. Purpose of this study

Tanzania, along with many countries in eastern and southern Africa, is facing a serious HIV epidemic spanning more than 20 years. The impacts of the epidemic are major impediments to the economic development of the country. Since the mid-1980s, efforts have been underway, guided by national and international recommendations, to curb the spread of HIV and to mitigate its economic and social consequences.

The region of Mbeya was and continues to be one of the most affected regions of the country. The Mbeya Regional AIDS Control Programme—more than programmes in other regions of the country—applied the guidelines of the National AIDS Control Programme (NACP) as formulated in the medium-term plans of the country between 1987 and 2001. In the mid-1990s, HIV prevalence peaked at above 20%. Since that time, prevalence has decreased and in 2005 was estimated to be 13%. This success is very likely connected to prevention and control activities which have unfolded in the region since 1988. Efforts between 1988 and 1999 to control the epidemic were documented in 2000 in “Hope for Tanzania: Lessons Learned from a Decade of Comprehensive AIDS Control in Mbeya Region”.¹

The last five years have seen major changes in the response to the HIV epidemic in the country, notably the vigorous development of a decentralized multisectoral approach and, most recently, the start of a nationwide roll-out of antiretroviral therapy. The Regional Programme has continued its past initiatives while expanding its response to include the new approaches and policies. The district focus and multisectoral approach are not completely new elements in Mbeya. The Regional Programme, largely implemented by the Ministry of Health, had for many years collaborated and supported other sectors such as education or community development, and the districts had planned and implemented many of the activities themselves. However, the new national policies have added responsibility, continuity and sustainability to the expanded response by providing political, administrative and financial support to the districts and systematically integrating a wide range of sectors in HIV control.

Although this district-based multisectoral focus is still only in its very beginnings, the expectation by the national and regional authorities is clearly that this focus will contribute significantly to the further reduction of the spread of HIV and the development of approaches that mitigate its impact on the population.

Tanzania and the international community are hoping to control the HIV epidemic by 2015 as stipulated in the Millennium Development Goals and in the *Declaration of Commitment on HIV/AIDS* made by the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) in June 2001. More recently, through an initiative by the G8 countries and reiterated at the UN General Assembly World Summit in September 2005, a new midpoint on the way to reaching these goals was set: universal access to prevention, treatment and care by the year 2010. This newly declared national and international yardstick

¹ Jordan-Harder B et al. (2000). Hope for Tanzania, Lessons Learned from a Decade of Comprehensive AIDS Control in Mbeya Region, Part I: Experiences and Achievements and Part II Guide for HIV/AIDS/STD Interventions in a District of sub-Saharan Africa (Examples from Mbeya Region), Eschborn / Germany – Dar es Salaam.

strives to provide an essential package of programmes and services to at least 80% of the population in need in every country, thereby significantly reducing the threat of HIV.

This study takes stock of the situation in Mbeya in 2005, documenting the region's continuing efforts to build on the Regional Programme's strong comprehensive prevention approaches to further increase their coverage while strengthening the new district focus, expanding multisectoral work and making available antiretroviral treatment. In doing so, this study describes Mbeya's progress towards universal access and identifies ongoing challenges. Through its comprehensive, decentralized and multisectoral approaches and the continuing efforts of a variety of actors, the region appears to be in a better position to reach universal access than other parts of Tanzania and Africa in general. The experiences of the Mbeya region to date can serve as lessons learnt to other parts of the country and, more broadly, the continent.

This publication is neither a scientific study nor an evaluation of the Regional Programme. It is an analytical description of HIV control activities in the region to date and their status to date. Its focus is mainly on access. The programmes presented here follow national and international recommendations. The quality of the individual programmes, however, has not been assessed for the purpose of this publication.

Some hard data such as sexually transmitted infection incidence and HIV prevalence are the results of ongoing surveillance activities. Other results presented here are evidence-informed mostly stemming from routine reports and monitoring. A ten-day fact-finding mission in Mbeya in May 2006, which included numerous interviews of key players and programme observation, generated additional information.

Regional efforts to control HIV and live with its impact span a period of nearly 20 years. The experiences in Mbeya demonstrate that the epidemic can be contained and trends reversed through systematic and continual application of nationally and internationally recommended strategies supported by an effective partnership among national, regional and external partners.

However, the "war", as the Tanzanian authorities characterize the HIV response in the country, has not yet been won, neither in the region nor in the country as a whole. HIV prevalence is still staggeringly high in the region estimated at more than 13% (national adult prevalence estimated at 6.5% [5.8–7.2%]²), having increased in recent years; new HIV infections occur every day.

The challenging question remains: in the next five to 10 years, can a combination of programmes that have been successful in the past be blended with an expanded multi-sectoral approach focusing on districts and communities and the roll-out of antiretroviral treatment to reduce new infections to a minor level and contribute to the well-being of the population so badly affected by the HIV epidemic?

2. National overview

Tanzania: the country

The United Republic of Tanzania is the largest country in East Africa covering 940 000 km² and sharing borders with eight countries: Kenya and Uganda to the north, Burundi, the Democratic Republic of Congo, Rwanda and Zambia to the west, and Malawi

² Report on the global AIDS epidemic (2006), UNAIDS, Geneva

and Mozambique to the south. The mainland of the country is divided into 21 regions, which are further subdivided into 124 districts, and there are five regions on the island of Zanzibar. The total population is approximately 38.3 million people (2005³).

Tanzania is still one of the poorest countries in Africa and the world. According to its own data, 18.7% of its population lives below the national food poverty line and 35.7% below the national basic needs poverty line (2000/2001).⁴ Little progress has been made in reducing poverty in the last 10 to 15 years. Poverty is an overwhelming rural reality; 87% of the population lives in rural areas. However, Tanzania has ambitious plans to dramatically reduce poverty by 2010 in the form of the National Strategy for Growth and Poverty Reduction—MKUKUTA in its Swahili acronym—and by 2025 in its Tanzania Development Vision.

In addition to the differences between the country's urban and rural environments, there are substantial regional disparities resulting from "the distribution of population, endowment in natural resources, climatic conditions, as well as the distribution of infrastructure, such as transport, schools and health facilities".⁵

Tanzania has accomplished remarkable progress in the last 15 years with regard to some social developments for example the primary education net enrolment rate improved to 90.5% in 2004 compared to 58.8% in 1990. However, illiteracy remains high, especially among women (29.3%, estimate 2003⁶). Infant mortality has been reduced from about 100 deaths per 1000 live births in the period 1995–1999 to 68 deaths per 1000 live births in the period 2000–2004, probably partly due to the success of immunization coverage⁷, however, child malnutrition remains widespread.

HIV prevalence: an overview

The first AIDS case was reported in 1983 in Tanzania. Since then the epidemic has spread rapidly throughout the country to all regions, from urban to rural communities. The hardest hit regions are Mbeya, Iringa and Dar es Salaam.⁸ For 2005, UNAIDS estimated the national adult (15–49 years) HIV prevalence to be 6.5% (range 5.8–7.2%) and the number of people living with HIV (15–49 years) to be 1.4 million (range 1.3–1.6 million)⁹. There are large differences in both prevalence and incidence between and inside regions.

According to the National Strategy for Growth and Poverty Reduction, "an increase in HIV and AIDS prevalence over the last decade has further aggravated the health status by eroding the Human Development Index and future prospects of Tanzanians. It has undermined the foundations for the development and attainment of the Millennium Development Goals and national targets".¹⁰

National HIV policies and strategies (1987–2005)

Between 1985 and 2002, AIDS control activities were coordinated by the National AIDS Control Programme of the Ministry of Health, developing and implementing one short-term and three medium-term plans based on WHO and UNAIDS recommendations.

³ UNAIDS *ibid*

⁴ United Republic of Tanzania (2005). *The National Strategy for Growth and Reduction of Poverty*, p. 4.

⁵ *op. cit.* p.5.

⁶ <https://www.cia.gov/cia/publications/factbook/print/tz.html> (accessed 7 February 2006)

⁷ National Bureau of Statistics/ORC Macro (2005). *Tanzania Demographic and Health Survey 2004–2005*, p. xix.

⁸ TACAIDS / MACRO (2005). *Tanzania HIV/AIDS Indicator Survey 2003, 2004, 2005*, p.75.

⁹ Global report on the AIDS epidemic (2006) UNAIDS, Geneva

In 1999, the Government of Tanzania declared HIV a national disaster. A National HIV/AIDS Policy was developed in 2001, and in 2002 TACAIDS was established to oversee and coordinate the national multisectoral response. Subsequently in 2003, the National Multisectoral Strategic Framework on HIV/AIDS was developed and approved covering the period 2003–2007. In its efforts to harmonize planning, coordination and monitoring of the HIV response, Tanzania has made good progress in establishing the “Three Ones” principles (one national HIV action framework, one national coordinating authority, and one country system of monitoring and evaluation).

Funding for HIV has increased substantially in recent years. More than TSH 350 billion (approximately US\$ 270 million) was spent on HIV in the 2005/2006 fiscal year—a tenfold increase over 2001 figures. For the 2006/2007 fiscal year, the Government of Tanzania intends to provide TSH 35 billion (US\$ 27 million) and development partners TSH 346 billion (US\$ 267 million). Funding provided by development partners for HIV programmes amounts to about 10% of all Official Development Assistance funds for Tanzania and is mainly allocated for care and treatment.

Since 2003, with the support of external partners, notably the World Bank, Tanzania has strengthened its HIV responses at the local government level in line with the overall political reform towards decentralization. Local Government Authorities at the district level are now mandated to plan, coordinate and supervise HIV activities and incorporate them into district development plans. (See section 3.2.1).

¹⁰United Republic of Tanzania (2005). National Strategy for Growth and Poverty Reduction, p. 13.

¹¹United Republic of Tanzania (2002). 2002 Census.

Overview of the Mbeya Region

1. General situation: geography, economy and poverty levels

The Mbeya region is one of the bigger regions of Tanzania in terms of size, population and population density. The region is subdivided into eight districts, 163 wards and 687 villages. It is situated in the south-west of Tanzania and borders on Malawi and Zambia. The region covers an area of approximately 64 000 km² and most settlements are at an altitude of between 400 and 1700 metres above sea level. The total population of the region is roughly two million¹¹ (census of 2002) which is about 8% of the total population of the country, with an urbanization rate of approximately 15%. The child-bearing population (15–49 years old) is estimated to be approximately 425 000 (2002).

The main road from the harbour town of Dar es Salaam to the copper belt in Zambia and to Malawi and South Africa passes through the region and Mbeya City, as does the famous TAZARA railway line connecting the port of Dar es Salaam to Zambia. The countryside along the road is densely populated.

Socioeconomic aspects

The overwhelming majority of the population (85%) are farmers, most of them subsistence farmers. Generally they grow a variety of vegetables and cash crops including potatoes, tomatoes, maize, beans, rice and onions. Some farmers grow coffee and tea, tobacco, pyrethrum and cocoa. Mbeya is beside the region of Kilimanjaro, the main producer of coffee in the country. There are a few industrial enterprises in the food production (coffee, tea, soft drinks), building materials (cement) and textile sectors.

Mbeya is not a particularly poor region in the context of Tanzania. None of its districts belong to the 20 districts with the highest percentage of poor households in the country (classified by categories of poverty such as the net primary school enrolment rate, under-five mortality rate, adult literacy rate or percentage of households with access to improved water).

Mbeya City and the district of Mbarali occupy the third and fourth position in the country with the lowest percentage of poor households (see table below). However, while Mbeya City has approximately 12% of poor households, the districts of Ileje, Mbeya (rural) and Rungwe contain over 30%.

Some indicators of the eight districts in the Mbeya Region

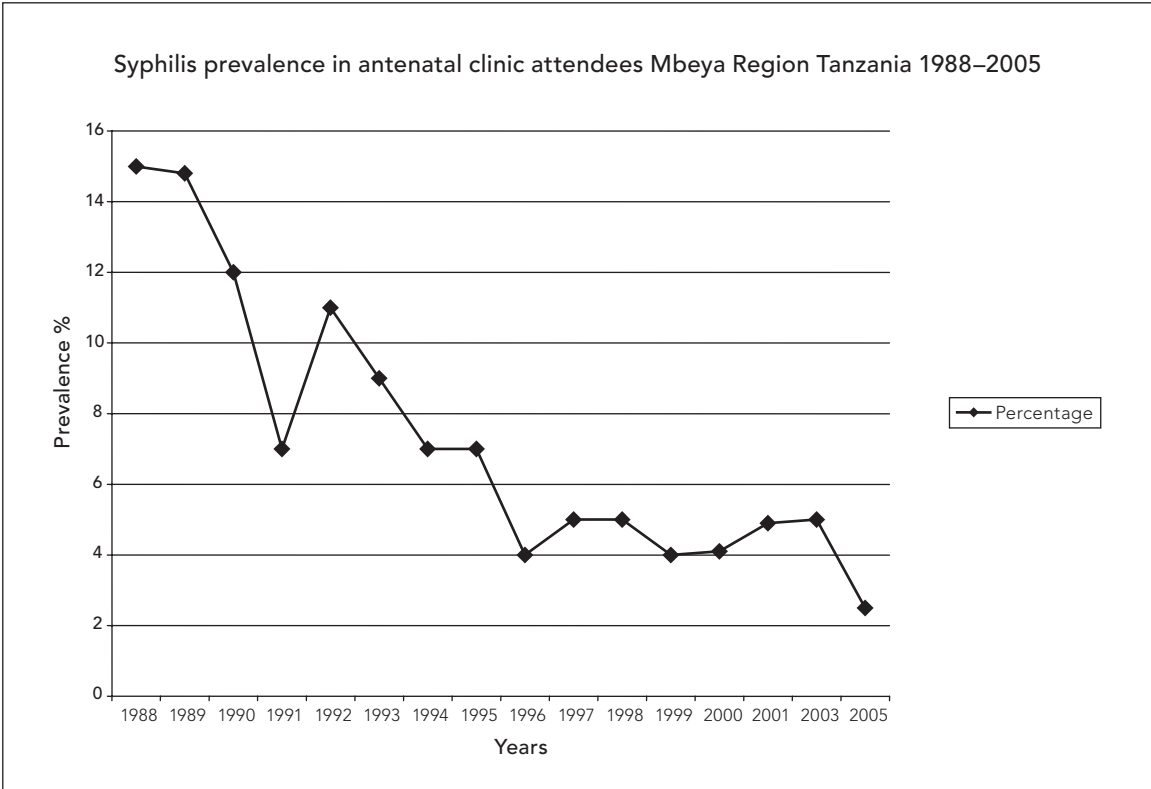
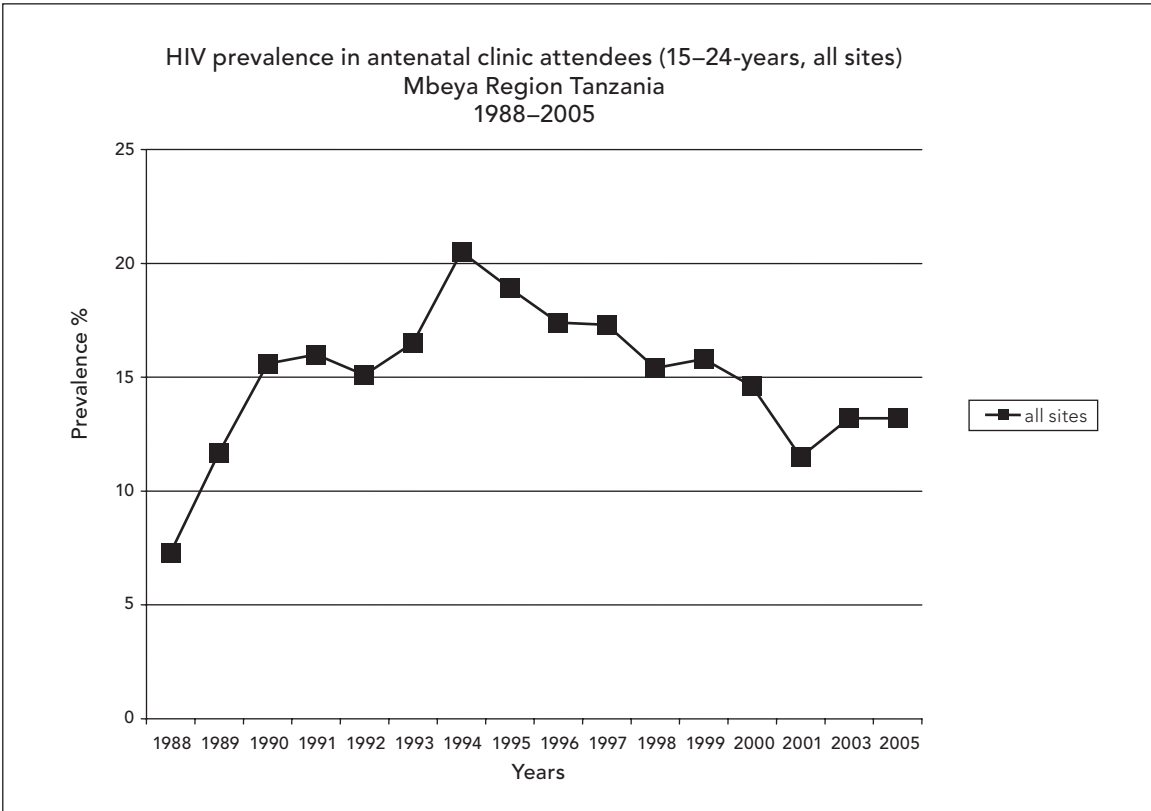
District	Population (2002)	Population per health facility (2002)	Percentage of population below poverty line (2000/01)	Percentage of children under 18 who are orphaned (2002)	Primary education net enrolment rate (2004)	Infant mortality rate (2002)
Chunya	206 615	6056	25	10.1	68	165
Ileje	110 194	4776	31	10.7	81	146
Kyela	174 470	6438	24	19.4	84	172
Mbarali	234 908	4877	13	11.2	72	192
Mbeya (Rural)	254 897	6197	31	13.2	81	–
Mbeya (Urban)	266 422	6640	12	16.2	95	106
Mbozi	515 270	11 944	21	10.2	78	165
Rungwe	307 270	5375	32	17.4	78	170
Total	2 070 046					

Source: United Republic of Tanzania, 2005 Poverty and Human Development Report, p. 108f

The region is characterized by a diversity of religious and ethnic groups, Nyakyusa, Safwa and Wandali to mention only the major ones. Swahili is, however, spoken and understood by nearly everyone. There are no ethnic conflicts in the region.

2. Development of the HIV epidemic in the region

In 1988, the first round of HIV sentinel surveillance of pregnant women visiting antenatal clinics was performed and an HIV prevalence of 3.4% identified. In the following years, prevalence increased continually and reached over 20% in 1994. In 1995, HIV prevalence levelled off and then started to decrease in all demographic-characterized sites. In the beginning, the decrease was quite pronounced but then slowed, though it continued; prevalence had dropped to 13.2% by 2005, indicating an incidence reduction of more than half. This trend was observed in young women 15–24 years of age, who represent an important sexually active part of the population which is most likely to have been recently infected. Declines in HIV prevalence in this growing population may be due to mortality, it is more likely they are due to a real reduction in new HIV infections (incidence), suggesting that the course of the epidemic in the region has changed.



Other sexually transmitted infections, such as syphilis, chancroid, chlamydia and gonorrhoea, were widespread in the region with genital ulcer diseases and discharge diseases having an approximately equal distribution. Due to the availability of sexually transmitted infection services in every health facility, the number of patients first increased and then started to drop. Due to these control measures, syphilis infection has decreased as well. The annual sentinel surveillance for syphilis in pregnant women attending antenatal clinics showed a prevalence of 15% in 1989, which had reduced to 2.5% by 2005.¹²

¹²For a more detailed presentation of the evolution of the HIV epidemic in Mbeya, see Jordan-Harder B et al. (2004). Thirteen Years HIV-1 sentinel surveillance and indicators for behaviour change suggest impact of programme activities in south-west Tanzania, *AIDS*, 18:287–294.

The multisectoral response to HIV in the region

1. The Mbeya Regional AIDS Control Programme: an historical overview (1987–2000)¹³

The Mbeya Regional AIDS Control Programme started in 1988 as part of the National AIDS Control Programme of Tanzania. In the context of the country's National HIV/AIDS Medium-term Plans I, II and III, the region built up its programme relying largely on the existing structures of the Ministry of Health at regional and district levels. The main actors at that time were the Regional Medical Officer, the Regional AIDS Control Coordinator, the District Medical Officers, the District AIDS Control Coordinators and the trainers of trainers (one per district). In line with the recommendations at that time, the Regional Programme was mainly health-sector driven with a few activities in other sectors such as education and community development.

Since its inception, the Regional Programme has been supported by Germany through GTZ and the University of Munich, which provided about 80–90% of the financial and material resources available for HIV and sexually transmitted infection work between 1989 and 2000. Other external partners were the Department for International Development (DFID) of the United Kingdom (for support of the physical health infrastructure and training); the European Community, which assured the continuous delivery of drugs to treat sexually transmitted infections; and the Danish International Development Agency (DANIDA), which supported the transportation system essential for supervision and other tasks.

The main strategies and areas of work implemented by the Regional Programme during this period were:

- control of sexually transmitted infections;
- health promotion for safer sexual behaviour and reduction of discrimination and stigma for the general population and specific groups such as youth and sex workers;
- condom promotion including social marketing;
- counselling services and home-based care for people living with HIV and their families;
- HIV/sexually transmitted infection laboratory support;
- promotion and establishment of safety procedures in the health system including safe blood transfusion;
- monitoring of trends in sexually transmitted infections and HIV prevalence through annual sentinel surveillance;
- advocacy among political decision-makers of the region and in the districts; and
- regular training, supervision and operational research.

¹³For a more detailed description and analysis of the work and structures of the Programme between 1988 and 2000, please consult the publication by Jordan-Harder B et al. (2000). *Hope for Tanzania: Lessons Learned from a Decade of Comprehensive AIDS Control in Mbeya Region*.

Through this comprehensive health-sector based approach, the Regional Programme was in a position to:

- cover nearly the entire region of two million inhabitants with essential HIV/sexually transmitted infection programmes;
- provide sexually transmitted infection services in 85% of the health facilities of the region;
- reduce HIV prevalence among women attending antenatal clinics from over 20% in 1994 to 15% in 1999;
- reduce the prevalence of syphilis among pregnant women attending antenatal clinics from 15% in 1989 to 4% in 1999;
- provide counselling and testing to nearly 9000 people annually by 1999;
- increase condom use (through free distribution and social marketing) by 10% per year making Mbeya the region in Tanzania with the highest self-reported condom use in 1999; and
- provide around 60% of all estimated AIDS patients with home-based care.

These impressive results demonstrated that the control of HIV was possible in a largely rural region with high HIV prevalence and incidence through the systematic and continuous implementation of the recommended prevention and control strategies of that time. The Regional Programme relied largely on existing regional and district capacities and was supported continuously by external partners.

By the time of the creation of TACAIDS in 2001 and the development of the National Multisectoral Strategic Framework for HIV/AIDS in 2003, Mbeya had laid the groundwork to make this new approach very effective. At the same time, new legal structures at district and community levels were created—specifically the Council Multisectoral AIDS Committees, which were established as standing committees under the direction of District Councils. While the Regional Programme, which had been largely health-sector driven, had in the past collaborated with other sectors such as education and community development, this collaboration was mainly stimulated by the health sector. Now the different sectors were charged with developing their own HIV mainstreaming approaches. Equally, while the districts in Mbeya region in the past had been sensitized and had undertaken many of the HIV activities, their role was now politically and administratively codified and the responsibility formally shifted onto their shoulders.

Section 3.2 describes the new elements of the multisectoral, district and community-based approach as well as the continuation of the existing successful programmes.

2. Towards a comprehensive multisectoral regional programme (2001–2005)

2.1 Organizational dimension and plans

The Regional Programme operated at the regional level.¹⁴ In line with the Local Government Reforms of 1997 and 1999, regions ceased to be implementers of projects and programmes, and began to build capacity within Local Government Authorities by providing technical advice, monitoring development and coordination, and ensuring a favourable climate to implement and deliver services to the public. In short, the role of the region changed from that of being a provider to a facilitator.

2.1.1 *Local Government Authority at district, ward and village levels: the role and functioning of the AIDS Committees*

Prior to 2003, some districts had already been very much involved in HIV control activities. The Council Health Management Team with the District Medical Officer and the District AIDS Control Coordinator as the core staff members were key to HIV work in a number of districts. District Councils and multisectoral District Management Teams discussed HIV at regular intervals, and their members had undergone a significant process of HIV sensitization over the years. District Primary Health Care Committees also contributed to the HIV response, but their capacities and levels of commitment varied widely among districts; few functioned regularly.

Since 2003, Local Government Authorities have been the focal points for scaling up HIV programmes. In order to have an effective coordinating mechanism for the multi-sectoral response on HIV, it was found necessary to establish AIDS committees within the organizational framework of local government authorities at city, municipality, township, district, ward, “Mtaa” village and “Kitongoji” levels. In January 2003, on the instruction of the President’s Office of Regional Administration and Local Government, the membership and roles of the committees at different levels were defined.

District level

In 2003 and 2004, a Council Multisectoral AIDS Committee was established as the fourth standing committee¹⁵ in each District Council throughout Tanzania.¹⁶ These new committees were seen as the engine of the district and community response to HIV thanks to their closeness to the communities and their capacity to adapt to local circumstances.

Members of the Council Multisectoral AIDS Committees include:

- One chairperson: the Honourable Deputy Council Chairperson or Mayor;
- One secretary: the Council Executive Director;
- Two selected members of parliament at council level; and
- Two selected ward councillors (one man and one woman).

¹⁴For a detailed analysis of the role of the regional and district level of the MRACP at that time, see “Hope for Tanzania”, p. 29.

¹⁵The other standing committees are: Financial, Administration and Planning, Health, Education and Water Work, Natural Resources and Environment.

¹⁶For the structure of the district organization see the chart in Annex 1.

Co-opted members:

- One chairperson of the HIV Council;
- Two youth representatives (one boy and one girl);
- Two religious representatives (one Muslim and one Christian);
- Two representatives of people living with HIV (one man and one woman);
- One representative of nongovernmental organizations involved in HIV activities; and
- Five representatives from other relevant sectors (education, health, social welfare, planning and community development).

The key roles and functions of the Council Multisectoral AIDS Committees are to:

- supervise formation of AIDS committees at all levels (ward, village, etc.);
- increase awareness of HIV among communities and individuals;
- assess and understand the HIV situation within the district: number of affected persons (sick, orphans, widows), incidence and the particular factors that contribute towards the spread of HIV;
- provide advice on by-laws and policies concerning HIV programming at different levels; and
- assess the capacity and interests of different stakeholders in HIV control activities, including nongovernmental, faith-based, community-based, governmental and international organizations.

Based on these assessments, the Council Multisectoral AIDS Committees are charged with ensuring that District Councils develop comprehensive plans incorporating HIV prevention, care¹⁷ and mitigation involving the different stakeholder groups and that communities coordinate and monitor the implementation of the plans. These comprehensive plans are expected to be an integral part of the overall District Development Plan.

Although the District Councils had been involved in HIV control in at least some districts in the past, this new focus gave them new responsibility. With the exception of the District AIDS Control Coordinator and in some instances trainers of trainers who had been active in the district, there was little HIV-specific capacity at the district level. Consequently, capacity building at the district level was the main challenge. With support from GTZ and the University of Heidelberg, TACAIDS developed and organized a huge national training programme for members of the Council Multisectoral AIDS Committees and regional authorities.¹⁸ As in all other districts of Tanzania, members from the Mbeya region participated in this training in 2004 and 2005.

In the past, District Councils had limited funding for HIV control activities. Even meetings could not be held regularly as no allowances were budgeted and available. In the 2006-2007 fiscal year, districts will receive approximately TSH 330 (or US\$ 0.25) per capita through an AIDS grant from the Ministry of Finance. The amount of money allocated for each district will vary from one district to another depending on set criteria such as the poverty index and population size. Additional funding will be available from the Community

¹⁷The roll-out of antiretroviral treatment is a nationally organized and implemented programme. The districts do not establish their own targets or undertake the preparation of treatment sites themselves.

¹⁸The training modules, which were developed with the assistance of the EVAPLAN from the University of Heidelberg in Germany, concentrated on advocacy, basic facts on HIV and AIDS, sociocultural factors of the epidemic, participatory management and effective communication.

AIDS Response Fund for the support of civil society organizations (see the subsection below entitled Community Level). For the first time, districts and communities will have a substantial funding base for HIV control.

The new District Councils started to work in 2004 and 2005 as they were formed and trained. In August 2005, TACAIDS charged the group of trainers that had conducted the training to undertake a first assessment of performance through a supportive follow-up visit concentrating on achievements and strengths as well as gaps and challenges. All Council Multisectoral AIDS Committees in the country were visited. The most important findings of this assessment were as follows.

- General guidelines such as membership, regularity of meetings, minutes of meetings etc. had been respected by most of the Committees. Participation was good with the exception of the Members of Parliament.
- The different roles of Committee members had been clarified.
- Members had taken part in an assessment of civil society organizations organized by the Regional Facilitating Agency (see the subsection below entitled Community Level).
- The majority of the Committees had ensured that HIV was mainstreamed into Council Development Plans.¹⁹
- No feedback or information was available from the Committees about the functioning of ward and village committees. As there were no funds available in the budgets of the district councils in 2005/2006, no systematic capacity building or training had been undertaken for ward and village levels. However, training has apparently been included in the budget for 2006/2007 for most wards and villages.

In a national workshop in August 2005 where the assessment's findings were discussed, the Council Multisectoral AIDS Committees were broadly criticized for being slow and regarding HIV as "business as usual", and also for lacking leadership and vigour. The nearly universal absence of Members of Parliament was cited as a key example of the lack of leadership. This criticism may also apply to the Committees in Mbeya, as the local Members of Parliament did not participate in regular meetings. However, as there is no comparative national assessment of performance, it is unknown whether the Council Multisectoral AIDS Committees in Mbeya are more effective than those in other regions.

One of the Committees' key activities is the development of an integrated HIV action plan for the district. TACAIDS had provided some general guidelines on planning but no guidance on an essential or core package of HIV programmes to be pursued by the districts.²⁰ Thanks to the past experiences of the Mbeya Regional AIDS Control Programme and the work of GTZ as the Regional Facilitating Agency in Mbeya (see the subsection below entitled Coordination, Support and Supervision at the Regional Level), GTZ organized a two-day workshop for all Committees and other organizations in the region on how to include essential and effective programmes in their plans.

A critical analysis of the HIV components of the District Development Plans will provide further insight into the capacity of the Council Multisectoral AIDS Committees

¹⁹No Council Development Plan with HIV mainstreaming was available for review and documentation as they were still (in May 2006) under review by the appropriate financial and technical committees.

²⁰TACAIDS is in the process of identifying such an essential package and will likely provide the districts with an orientation for the planning for the 2007/2008 fiscal year.

to be the engine of HIV work at local levels. The final test will then be the capacity of the Committees to advance from planning to implementation, to promote and support quality activities, to reach more people and to expand prevention, care and mitigation efforts beyond the existing structures and networks. However, as the experiences of the Mbeya Regional AIDS Control Programme in the years 1988–2000 have shown, it may take years to develop sufficient capacity at the local level and to demonstrate that the Council Multisectoral AIDS Committees can live up to the expectations invested in their creation.

Ward and village levels

The ward and village level committees follow, in their composition and functions, those of the district level. Although 100% of ward and village committees have been officially created in the Mbeya region, few of them have started to be active as they still lack the necessary training and guidelines. Some ward committees such as the one in Mbeya City have participated in sensitization efforts and are supporting people who are living with HIV.

Community level: civil society organizations

At the community level, civil society organizations are expected to be the main movers and “transmission belts” of community awareness and mobilization. The main advantage of these grassroots organizations is their closeness to their respective communities. They know the people well; through them care and support of both people living with HIV and children orphaned by AIDS are likely to reach those most in need. At the same time, as support reaches the community, more and more people living with HIV are acknowledging that they are infected. In this way a discussion on HIV is initiated and stigma is likely to be gradually reduced, with the result that more people may accept care and treatment services.

With support from the World Bank, TACAIDS had at its disposal a Community AIDS Response Fund through which civil society organizations and community initiatives could be funded. Although these groups play an important role, they are often lacking the necessary technical knowledge on HIV prevention and how to initiate and involve communities in changing behaviours to reduce risk of HIV exposure. Many of these groups only started their involvement in HIV prevention and care when funding became available. A critical assessment of the capacities and the potential of civil society organizations was therefore necessary. TACAIDS and GTZ together developed a Civil Society Mapping and Capacity Assessment Tool in order to analyse the potential of these groups and provide, where necessary, support for capacity building.

In each region, a Regional Facilitating Agency was charged with leading this assessment in concert with members of the Committees and civil society organizations. The early involvement of members of local governments and civil society in the assessment enhanced the development of partnerships between these stakeholders. In each district of the Mbeya region, three to eight of the most promising civil society organizations were identified and capacity-building support provided. Of these organizations, only one-third had previous experience in HIV-related work. Some were part of national or international organizations or networks of nongovernmental organizations. For capacity reasons, the Regional Facilitating Agency could only concentrate on larger organizations in the first year of assessment.

In each district, all selected organizations developed proposals with the support and review of the Regional Facilitating Agency and their proposals were accepted by TACAIDS for funding. Most civil society organizations focus either on HIV prevention through information and education—especially among out-of-school youth—or providing home-based

care to individuals and families infected and affected by HIV, including small projects focusing on basic support to orphans and widows. Some bigger civil society organizations have also been charged with acting as an umbrella for smaller groups and training them.

Community-based organizations in Mbeya Region: two examples

Upendo (which means “love” in Swahili) in Rungwe district is engaged in care for orphans and people living with HIV. After a short training on community-based approaches of support to orphans developed by the Tanzanian Ministry of Social Welfare, the group mobilized the community to support orphans, widows and people living with HIV. Bank accounts in each village in the area of operation were opened and support is now being undertaken by community members with minimal external help. This project shows that community-based groups can be very helpful in initiating self-help efforts.

SHDEPHA+ (the Tanzanian umbrella organization of people living with HIV) has branches in most districts in Tanzania. The branch in Mbarali district is active in home-based care in several villages. The group first discusses the importance of giving support to people living with HIV with the villagers, conducts training for some members and provides home-based care kits. In addition, information on HIV is given to community members. Assessment revealed that communities are very satisfied with the information and support and that they very much appreciate the work these groups do.

Coordination, support and supervision at the regional level

Nongovernmental roles

- **Regional Facilitating Agency**

The most interesting and innovative development at the regional level is the creation of the Regional Facilitating Agency, commissioned by TACAIDS and financed through the World Bank T-MAP Project. These agencies, which can be run either by Tanzanians or by those from outside the country, collaborate under the supervision of TACAIDS in strengthening the processes of district and community responses, as noted by retired Major General Lupogo of TACAIDS at a workshop for the agencies held in November 2005:

We need to work with the regional leadership to effectively reach the districts and communities. The RFAs [Regional Facilitating Agencies] were purposely conceptualized as an extension of TACAIDS. RFAs are the arms, eyes, and ears of TACAIDS in forging the vital coordination between regions, districts and communities, while building the capacity of the CSOs [civil society organizations] in carrying out various community interventions. We strongly believe that RFAs’ effective execution of their roles and responsibilities will not only add new vigour and energy in our multisectoral initiatives, but will also provide the needed speed in developing relevant community-based interventions through the public and private partnerships at community level.²¹

The Regional Facilitating Agencies are charged with:

- undertaking civil society mapping;
- receiving, screening and advising on proposals from civil society organizations;
- assuring disbursement of funds, accountability and a regular audit of the Community AIDS Response Fund;
- providing quality technical assistance to implementing organizations;

- strengthening the capacity of local government authorities, Council of Multisectoral AIDS Committees and civil society organizations.

The selection of the Regional Facilitating Agencies was done through a competitive bidding process. GTZ, which had been a de facto facilitating agency 1988 and 2002, won the contract for Mbeya (and Rukwa).²² The Regional Facilitating Agency for Mbeya was established in 2005 and became fully operational in February 2006. It consists of a team leader, a medical officer with a public health background, a social scientist, an accountant and the necessary support staff (secretary, driver, etc.). The initial contract is for three years.

The performance of each Regional Facilitating Agency is assessed against the number of implementing agencies trained and the number of approved grant applications as a percentage of received applications. During the assessment of civil society organizations carried out in Mbeya's eight districts in August 2005, it was found that the work of the Regional Facilitating Agency in Mbeya was valued by the local government authorities and Council Multisectoral AIDS Committees as well as by civil society organizations.

Civil society mapping, capacity building (including proposal writing) and support were completed on schedule, and civil society organizations' proposals were screened and forwarded to TACAIDS. In the Mbeya region, 49 proposals (28 nongovernmental organizations, 18 faith-based organizations, three community-based organizations) were developed with a total value of more than TSH 250 000. All 49 were accepted for funding. In addition, the Regional Facilitating Agency provided support for the planning processes of the eight Council Multisectoral AIDS Committees in Mbeya.

Governmental roles

The Regional Facilitating Agency is not a structure of the Tanzanian Government at the regional level. Although the regions lost some power and influence with the local government reforms of 1997 and 1999, they still play a role in the support and control of the lower Local Government Authorities.

- **Regional Commissioner**

As principal representative of the government in the region the Regional Commissioner performs and coordinates all development and ministerial support services to local authorities and other organizations within the region. Through the Regional Secretariat the Regional Commissioner provides policy and technical support to local authorities, facilitates coordination between the private and public sectors, supervises and monitors performance, and promotes an environment that enables all actors in the region to function effectively.

- **Regional Administrative Secretary**

The Regional Administrative Secretary is the head of the Regional Secretariat and principal advisor to the Regional Commissioner concerning the performance of all development and administrative support services to local authorities and other local organizations within the region.

²¹TACAIDS (2005). Proceedings of the Lessons Learnt Workshop for Regional Facilitating Agencies, November 2005.

²²Each Regional Facilitating Agency had to assume responsibility for two regions at a time (with the exception of Dar es Salaam).

- **Assistant Administrative Secretary as Head of Cluster**

The Assistant Administrative Secretary coordinates capacity-building work with Local Government Authorities and provides leadership and capacity-building support to the respective cluster, which in the case of HIV control is the Social Cluster.

- **The Regional Secretariat**

The Regional Secretariat is the representative of the central government within the region. It offers a multi-skilled technical resource for supporting local development initiatives and linking central and local governments. The Secretariat assists Local Government Authorities in the region to undertake their responsibilities and supervises, supports and monitors their activities and those of the Council Multisectoral AIDS Committees. This function is supposed to be mainstreamed into regular support to the districts so that supervision and support are carried out along with regular regional activities and meetings. There is neither an advisory committee nor an extra structure nor a separate budget for HIV support. However, a focal person has been appointed to oversee HIV control activities in the districts and to coordinate regional support.

The Regional Facilitating Agency also supports the Regional Secretariat through capacity building. This is especially important as outside the health sector most staff members of the Regional Secretariat have only limited experience in the field of HIV. To build up capacity, the Regional Facilitating Agency works closely with the appointed focal person and other key members of the Regional Secretariat—for example, the social welfare officer who coordinates support for orphans. These members are included in training, supervision and monitoring.

2.1.2 The role and contribution of external partners

The German Government

The German Government has continually supported HIV control activities in the Mbeya region since September 1989 through to the present time. Since 2002, support has been given as part of the Tanzanian-German Programme to Support Health (TGPSH). In addition to specific HIV-related components, other components such as reproductive and sexual health, quality management and health financing complement and synergize the approach.²³ At the same time, TGPSH advises and supports national policy and strategy development by validating experiences from the regions.

German support for the Mbeya Regional AIDS Control Programme has been crucial in two ways.

1. Financial support. Until 2002, when substantial funds and resources for HIV activities became available at district and regional levels through global funding mechanisms, the German contribution accounted for 80–90% of the resources available in the region. The national contribution at that time was confined to a few specialized staff, the provision of a building for the project office and occasional (often unreliable) financial support via the National AIDS Control Programme and the Ministry of Health. Since 2002, funds amounting to approximately US\$ 250 000 per annum have been channelled through TGPSH and have paid for the local coordinator, activities for specific programmes, training, supportive follow-up and coaching, development and implementation of innovative approaches, health promotion material and additional project support (such as secretaries, drivers, cleaners, cars).

2. Technical advice and managerial capacity. From 1989 until 1998 there was always a German coordinator in Mbeya who was involved in all aspects of HIV work. This long-standing participation of German experts provided a crucial element of support and inspiration for regional partners, helping to solve problems and assure quality standards in technical, financial and management aspects. In 1998, a national coordinator took over, supported with advice from the German coordinator.

Since late 2002 the regional programme has been fully coordinated by the regional national team. Support is provided by staff from the TGPSH three times a year for one week.

Support of other partners

1987–2001

In the early years until 2001, the Mbeya Regional AIDS Control Programme was also directly or indirectly supported by other partners. The UK Overseas Development Department/Department for International Development (DFID), contributed to the maintenance and rebuilding of many of the peripheral health facilities, the training of staff and important activities in the field of family and reproductive health. DANIDA from Denmark supported the vital area of the national transport system. The European Community funded provision of drugs for the treatment of sexually transmitted infections through the national Sexually Transmitted Infections Project. Other organizations and players such as UNICEF and voluntary groups provided support for health education, social services and infrastructure, all of which contributed to HIV activities. At the time of writing (2006) all these foreign donors have ended their support in the region.

2001–2006

With the increased availability of funds globally, more partners have become involved in the Regional Programme since 2001.

The University of Munich started a basic science research programme accompanied by relevant operational research focusing mainly on bar workers, many of who are at high-risk of exposure to HIV (see the box in section 3.2.2).

The Walter Reed Foundation, present already as a collaborative partner in the research project with the University of Munich and preparing the region for an HIV vaccine trial, has become one of the implementers of the US President's Emergency Program for AIDS Relief (PEPFAR) in the HIV Care Programme for the Southern Highlands. The Foundation's main focus is providing support to the roll-out of antiretroviral treatment through funds and technical assistance. Some HIV prevention activities, albeit without technical assistance, are also supported by the Foundation.

The region has profited from funds provided by the Global Fund to Fight AIDS, Tuberculosis and Malaria for tuberculosis control, voluntary counselling and testing services, and provision of antiretroviral treatment in all eight districts.

Axios International, established by Abbot Laboratories, supports voluntary counselling and testing and care for orphans in two districts of Mbeya and prevention of mother-to-child transmission in one district.

²³TGPSH also supports the regions of Tanga, Lindi and Mtwara with a similar approach using the experience gained in Mbeya.

The international nongovernmental organization “Students’ Partnership Worldwide” supports HIV transmission prevention education activities in secondary schools in two districts.

External cooperation in the Mbeya Regional AIDS Control Programme is therefore characterized by two elements: the long continuity of one major partner (the German Government), especially in the first 15 years, and an increasingly complex web of partners in recent years. Although there is no formal structure in which all partners sit together to review the activities and plans for the next phase, over the years Mbeya has developed harmonious working relationships in which the different regional and external players know each other, share information and cooperate to a high degree for the benefit of the region. The decade-long commitment of external partners and their orientation on the national guidelines and strategies is a significant element of the Mbeya Regional AIDS Control Programme.

2.2 Scaling up AIDS prevention, treatment and mitigation

The following pages outline key prevention programmes and strategies that have been implemented in Mbeya. Many of these strategies were developed and introduced many years ago.²⁴ Some of them—such as prevention of mother-to-child transmission and workplace programmes—have been developed and initiated in recent years to complement existing programmes. They all are in accord with nationally and internationally recommended strategies to curb HIV transmission and form part of the National Strategic Framework.²⁵ The focus here is on coverage, or increasing access, to capture the process of expanding these key programmes and services to more and more people in the region. The programmes and services follow national-level technical guidelines and recommendations. There is an obvious need for ongoing technical discussions on issues such as how to maximize access to voluntary testing or how best to retain and motivate peer educators. Future national or regional reviews will have to assess the quality as well as the coverage aspects of programmes and services.

Prevention

- **Sexually transmitted infection control**

Control of sexually transmitted infections—most of them treatable and curable—is among the most effective actions that can be undertaken to assist in reducing HIV transmission. Sexually transmitted infection programmes in Mbeya comprise two different activities: (i) screening pregnant women attending antenatal clinics and, if possible, also their partners, for syphilis and offering treatment where necessary, and (ii) sexually transmitted infection case management using the syndromic approach, including the promotion of safer sexual behaviours. Health promotion at the community level includes providing information and education about the signs and symptoms of sexually transmitted infections and promoting understanding of the benefits of early treatment to improve the speed at which people seek necessary health care.

- **Syphilis screening for pregnant women**

It is estimated that 98% of all pregnant women in the region attend antenatal services at least once during their pregnancy. In 1989, the Mbeya Regional AIDS Control Programme

²⁴Some of these strategies are described in more detail in “Hope for Tanzania, Lessons Learned from a Decade of Comprehensive AIDS Control in Mbeya Region, Part I and II”. The figures about activities mentioned in the different tables in this section are collected from information provided in the Annual Reports of the Regional AIDS Coordinator and from the publication “Hope for Tanzania”.

²⁵See discussion in Section 4.

decided to implement the national policy for routine syphilis screening of pregnant women attending antenatal clinics. Health facilities were equipped with the necessary material, and laboratory assistants were trained to perform syphilis (RPR) tests. Initially, health facilities with a larger catchment area and a high rate of antenatal attendees were selected, informing the surrounding dispensaries of the available service for referral. By 2005, syphilis screening was done routinely in 77 health facilities in the region. Syphilis prevalence among pregnant women attending antenatal clinics has reduced from 15% in 1989, to 4% in 1999, and 2.5% in 2005.

- **Sexually transmitted infection case management**

In 1993, services for the management of sexually transmitted infections started in the outpatient departments of all hospitals. Materials and equipment as well as training and drugs were provided, and a supply and monitoring system for drugs was introduced. Since then, services have been extended to district health facilities, where medical staff members undergo training for syndromic case management. Diagnosis for sexually transmitted infections is also routinely included in family planning and antenatal clinic services. Supportive supervision is carried out regularly for trained staff. Sexually transmitted infection case management has been continually expanded to cover nearly all health facilities in the entire region, including government and private or voluntary agency facilities.

Condom promotion and distribution as well as contact tracing of partners is undertaken as part of these services. Regular supervision and surveys undertaken certify that quality of the services provided is high. Since 1997, the necessary drugs have been provided by the national programme with initial support from the European Union and in recent years from Japan.

Number of health facilities offering sexually transmitted infection services and number of patients served

	Number of health facilities offering sexually transmitted infection services	Percentage of health facilities offering sexually transmitted infection services	Number of patients with a sexually transmitted infection (contacted/ treated)
	6	NA	NA
	15	NA	22 782
	201	201/237 85%	79 000
	295	295/335 88%	64 178
	311	311/340 91%	34 313

- **Condom promotion and distribution**

Since its inception, ensuring the availability of high quality and affordable male latex condoms has been a priority for the Mbeya Regional AIDS Control Programme. In the region, providing both free and socially marketed condoms is carried out alongside community and individual sensitization on proper and consistent use.

The condom social marketing project—organized by the international nongovernmental organization Population Services International (PSI), which received financing from the United States, the Netherlands and most recently from Germany—was begun in 1995. Ever since, albeit with fluctuations due to logistical problems, changes in price and brand-names, overall condom availability has increased in the region, making Mbeya the region (after Dar es Salaam) with the highest condom sales in the country. Today, there are over 5000

condom selling points in the region covering even remote rural areas. Condom promotion and distribution is a continual and integrated activity in all health promotion and education activities.

Number of condoms sold through the social marketing project and freely distributed

Year	Condoms sold through social marketing project	Condoms freely distributed	Total condoms sold and distributed*
1995	1 118 592	1 422 871	2 541 463
1999	1 891 008	361 700	2 252 708
2002	2 484 288	919 560	3 403 848
2003	3 113 280	1 947 634	5 060 914
2004	3 817 152	1 857 494	5 674 646
2005	3 532 032**	1 243 809***	4 766 831****

* These numbers do not include condom sales by private pharmacies or selling points that are not part of the social marketing project.

** Due to a change in the distribution and recording system, it is estimated that the figures for condoms in the social marketing project are underreported for 2005.

*** No condoms available for half a year.

**** Total estimates for 2005 include insufficient data.

● **Voluntary counselling and testing**

Counselling services specific to HIV tests were introduced as early as 1992 in the Mbeya Referral Hospital. By 1995, all district hospitals offered services with counsellors trained in psychosocial counselling. This service has now been extended to 114 health facilities, including dispensaries, making voluntary counselling and testing services widely available in rural areas as well. The total number of trained counsellors in the region is 234. With the arrival of antiretroviral treatment in the region in 2004, the demand for counselling and testing has increased substantially according to local observation. Additional capacity is needed not only to include those who are eligible for antiretroviral treatment, but also to counsel all people who wish to know their serostatus.

Number of health facilities with counselling services, number of trained counsellors and number of persons tested for HIV

Year	Number of health facilities with counselling services	Number of active trained counsellors	Number of people attending counselling services*
2002	55	132	23 297
2003	67	145	27 868
2004	67	145	39 034
2005	114	234	42 041

* This number includes people attending voluntary counselling and testing services, people sent for testing for diagnostic reasons and women tested as part of prevention of mother-to-child transmission services.

● **Prevention of mother-to-child transmission**

Before antiretroviral treatment became available in the region, services for the prevention of mother-to-child transmission (PMTCT) of HIV were introduced and subsequently expanded into “PMTCT Plus”, combining child-transmission prevention with the long-term treatment of infected parents and siblings. This project component started in 2002 with the support of the Government of Germany and the technical advice of the Tropical Institute of the University of Berlin. Implementation started in two districts: the City of Mbeya and Mbozi.

By 2005, the region managed to expand services to include all districts. The total number of sites has now risen to 27 from the initial four. Additional support was provided by the Ministry of Health, UNICEF, Axios International and the Walter Reed Foundation. In all eight districts, there is at least one site.

Major achievements of the PMTCT Plus programme.

- Between April 2002 and December 2005, a total of 19 101 pregnant women received pre-test counselling and 15 355 (80.3%) agreed to be tested; of these, 2367 (15.4%) were found to be HIV-positive.
- 1027 mother and child pairs were given antiretroviral treatment.
- 94 infants were tested for HIV, and 12 were found to be HIV-positive.
- 510 partners received pre-test counselling, 501 of them accepted HIV testing; of these 126 (25%) were found to be HIV-positive.
- Antiretroviral drugs were given to HIV-positive family members of pregnant women.
- A total of 89 clients were provided with antiretroviral treatment between November 2003 and December 2005.

Future challenges for this programme include:

- combining the PMTCT Plus programme with the regional roll-out of antiretroviral treatment (see below) without losing the particular aspects of infection prevention that are unique to this programme.
- expanding the service to more antenatal sites in order to offer easier access to counselling and testing for pregnant women in the region.
- increasing partner involvement by increasing community awareness and offering couples counselling.
- **Health promotion and information, education and communication materials**

The region produces its own education materials and also distributes materials developed by other regions and at the national level for different population groups. Over the years, the region has developed its own capacity for design, pre-testing and production of diverse materials. Among the materials produced and /or distributed were:

- leaflets on sexually transmitted infections, antiretroviral treatment, prevention of mother-to-child transmission, condom use and counselling services;
- booklets such as “Questions and Answers on AIDS”, and a series of eight booklets on reproductive and sexual health and problems relevant to adolescents and developed with the participation of young people;
- a peer-education guide for primary schools on HIV and reproductive health for standard five, six and seven;

- billboards and posters; and
- video cassettes, t-shirts and calendars.

Although impressive numbers of varied materials have been produced and distributed, the demand for more and diverse materials always outstrips the supply. Broadcasts by local radio stations have only been used infrequently.

- **Health promotion through drama groups, film and video shows at community level**

Traditional drama shows are very popular in the region. Groups write their own stories based on local situations, and in most cases discussions are initiated with the audiences after the performances. There are five drama groups in five different districts performing on a regular basis. Their members have received extensive training on the use of drama in promoting messages related to HIV. Districts without formal drama groups are planning to establish them. Films are shown throughout the region, and TV and VCR sets in public places, and even in households, enable people to see different videos at home, in bars, health facilities and guesthouses. Formal film screenings accompanied by a guided discussion for the audience have been conducted for many years in all districts.

Preventive efforts targeting adolescents in schools

Peer education on reproductive and sexual health in primary schools started in 1997 after the Ministry of Education introduced AIDS education in the syllabus for primary schools, standard five to seven. Primary schools are an ideal place to reach adolescents who may start their sexual activities as early as between the ages of 10 and 12 years. With an enrolment rate of 90%, programmes can reach a large number of young people—more than through programmes at secondary schools as only 5% of pupils progress to secondary school. Pupils in standard five to seven (ages 11–15) are included in the activities. Trainers of trainers (TOT) from both the education and health sector have been selected and trained. Parents have been closely involved in the development of the activities from the beginning and support them, understanding the threat of HIV to their children and difficulties in talking about these sensitive issues at home. In recent years, advocacy and information for decision makers in the education sector have increased and more training is provided to school inspectors and trainers of trainers to ascertain the sustainability of the approach.

Primary schools with peer education in the Mbeya Region

Year	Primary schools	Schools with peer education
12/2002	885	309 (35%)
04/2004		313 (35%)
04/2005	(12/2004) 960	330 (34%)
04/2006		545 (57%)

Out-of-school-youth are more difficult to reach. Between 1992 and 1996, the region experimented with a Youth Information Centre in Mbeya City. Due to high costs and fewer than expected visits from young people, this centre was closed in 1996. Since 2004, renewed efforts have been made in a few wards together with the District Community Development Officers and the health sector to identify existing peer education groups, review their structure and capacity, and provide training and supervision.

- **Working with vulnerable groups: female sex workers**

As major communication and transportation lines run through the region (the principal road connecting Malawi and Zambia to the port of Dar es Salaam and the TAZARA railway line), special attention to HIV prevention and support was given to the highly mobile and vulnerable group of female sex workers and their clients in so-called “high-transmission areas” (such as bus stops, bars, lodges, hotels). This programme was started in 1994 under the umbrella of the international nongovernmental organization the African Medical and Research Foundation (AMREF) mainly using a peer education approach. Between 1994 and 1995, 14 high-transmission areas in the region were identified and about 60 peer educators trained who reached approximately 1500 sex workers during that time.

Until 2005, 52 high-transmission areas were identified in all eight districts, where 88 peer educators were active. However, retaining the peer educators is a challenging task. Many of them move away to other places, change professions or drop out for other reasons.

The potential of this type of programme to control and reduce sexually transmitted infections and HIV was demonstrated recently in a study combined with a programme undertaken by the Mbeya Medical Research Programme with support from the London School of Hygiene and Tropical Medicine and the University of Munich.

Decline in sexually transmitted infection prevalence and HIV incidence in female bar workers in Mbeya Region

An open cohort of 600 bar workers was offered three monthly information and education sessions on HIV/sexually transmitted infections and reproductive health, confidential voluntary HIV counselling and testing, and clinical check-ups including sexually transmitted infection syndromic management with simple laboratory support.

Over a period of 30 months, the project demonstrated the reduction of gonorrhoea and other sexually transmitted infections and reproductive tract infections (with the exception of genital herpes and bacterial vaginosis) as well as a reduction of HIV incidence from 13.9/100 to 5.0/100 person-years.

Source: Riedner G et al. (2006). Decline in sexually transmitted infection prevalence and HIV incidence in female bar workers attending prevention and care services in Mbeya Region, Tanzania. *AIDS*, 20: 609–615.

- **HIV workplace programmes (public and private sectors)**

HIV workplace programmes form one element of a strategy to broaden health promotion measures and to assist private companies and public institutions to develop health and social responsibility programmes for their employees, families and sometimes the surrounding communities. The first workplace programmes were started in 1994. By 2000, approximately 200 peer educators in 36 workplaces had been trained, reaching an audience of about 3000 people. The workplaces included road construction and soft drink bottling companies.

In 2005, the Mbeya Regional AIDS Control Programme estimated that there were 59 private and public companies in the region, each with a workforce of more than 20 to 50 persons. Of these 59 companies and organizations, 32 have HIV workplace programmes. Not all companies have all major elements in place (see box on Mbeya Cement Company below), but peer educators play a role in all of them. These peer educators were trained by the Regional Programme and in turn acted as trainers of trainers (TOT) for companies in

other regions of the country such as Dar es Salaam, Mwanza and Tanga. Nearly all of the companies financially support their own workplace programmes. The Regional Medical Officer's office and GTZ provide technical support.

In the public sector, one of the more comprehensive workplace programmes was started at the Mbeya Referral and Regional Hospital. These programmes include information for the employees, selection and training of peer educators, regular sessions of peer education in the hospital, distribution of education materials and availability of condoms, workshops for partners, family days for children, and provision of post-exposure prophylaxis. The establishment of comprehensive workplace programmes in all district hospitals followed on this model.

Mbeya Cement Company

Mbeya Cement Company (MCC) is a subsidiary of the Lafarge Group. It has a workforce of 250 and is one of the bigger private employers in the region. It launched its HIV/AIDS Workplace Programme on World AIDS Day in 2003. Its programme is technically and, to a small extent financially, supported by GTZ. MCC is also a member of the AIDS Business Coalition Tanzania (ABCT). MCC has all elements of a comprehensive HIV Workplace Programme in place.

Programme structure and policy

MCC has an HIV Coordinator and an HIV Committee whose members include senior employees. A group of peer educators (16 permanent employees and six contractors) has been trained, and the lead educator meets with the HIV Committee monthly. MCC has had an HIV Policy since November 2002. An English/Kiswahili summary of the policy was communicated to all employees and can be found on all notice boards. In addition, a Management Guide on HIV has been developed in English, and communicated to MCC management and to South African colleagues. A business impact assessment in the form of a Cost-Benefit-Analysis was undertaken in 2003.

Transmission prevention activities

MCC distributes free condoms to its employees and provides information on various topics related to HIV. Monthly schedules are set up for peer education sessions in the various departments though sessions are occasionally postponed due to the demands of the business. In addition, several campaigns have been conducted to date. An anonymous HIV testing campaign resulted in an 80% participation rate, though a voluntary counselling and testing campaign was only partially successful due to tense industrial relations at the time of the campaign. In all campaigns, MCC has invited local nongovernmental organizations and people living with HIV to be involved.

Medical care and treatment

MCC has trained two in-house counsellors and provides confidential voluntary counselling and testing within the factory or the contracted health dispensary. However, it has been found that this service is used more by the community than by Mbeya Cement employees. The company provides treatment of opportunistic infections through its medical scheme which consists of contracts with five health care providers in the area. MCC employees have access to antiretroviral treatment (one person was provided with antiretroviral treatment in 2004/2005) and prevention of mother-to-child transmission. MCC also provides first aid kits including latex gloves to protect against HIV transmission.

Community outreach

A 'family day' was conducted as part of the voluntary counselling and testing campaign in 2005. One of the counsellors is frequently visited by persons from the community, and HIV Committee members have carried out various volunteer sensitization efforts in their church communities.

Monitoring

A Knowledge, Attitudes and Practices (KAP) survey on HIV was conducted in January 2004 and another survey with KAP elements was done as part of a voluntary counselling and testing study in November 2004. The prevalence study conducted in December 2004 had the participation of 80% of employees and found HIV prevalence of 8.2%. The company regularly reports on achievements via the Lafarge "Dashboard", a corporate roadmap for all African branches on HIV. Internal reporting to Board members and the Executive Committee was started in 2005.

(Information based on HIV WPP Coordinator Reports 2006)

Among the bigger private companies of the region with workplace programmes are Mbeya Cement Company (see box below) and Wakulima Tea Company.

Wakulima Tea Company

In 2004, a workplace initiative was launched to provide essential HIV education and access to care and support to the Rungwe Smallholders Tea Growers Association (RSTGA) and surrounding communities. Founded in 1998, the Association is an organization of 15 000 small-scale tea growers spread over 108 villages; it also owns 25% of the shares of the Wakulima Tea Company.

Through peer educators and in cooperation with contracted health centres that provide essential care, the tea growers and their communities—totalling about 60 000 people—have been reached. RSTGA has developed an HIV/AIDS policy and put a professional coordinator in place; condoms are distributed; and group and individual education and information sessions are organized. Peer educators travel by bicycle and receive an allowance for the community sessions. With support from "Capital for Development Cooperation" (the United Kingdom Government's mechanism for investing in the private sector in developing economies), transportation allowances are also paid to people who are on antiretroviral therapy.

- **Blood safety**

Attempts to establish a regional blood bank were started in 1995 but were given up soon after. As a result, hospitals screen donors for their own blood and blood products supply. According to the annual report of the Regional AIDS Coordinator for 2005, no blood is transfused in the region without being tested for HIV and syphilis. In 2005, a total of 3769 blood donors were screened in hospitals and of these, 570 were found to be HIV-positive. This figure does not include the number of donors from the Zonal Blood Bank in the Mbeya Referral Hospital, which was started in 2004.

- **Safety procedures in health facilities**

To reduce transmission risks in health care settings, health workers have been educated and trained since the late 1980s in appropriate safety measures. All health facilities use disposable syringes, needles and gloves and implement effective sterilization procedures

where applicable. In addition, health care workers are reminded regularly about measures to take to protect themselves from possible exposure to HIV, and also procedures to follow to avoid possible accidental transmission of HIV between patients.

Treatment and care

- **Regional antiretroviral treatment plan and implementation**

In accordance with the National Care and Treatment Plan,²⁶ provision of antiretroviral treatment was begun in October 2004 in the region spearheaded by the Walter Reed Foundation. Capacity building for health care workers at the centre of excellence in Mbeya Referral Hospital was undertaken in cooperation with GTZ and the University of Berlin. The following sites are currently offering antiretroviral therapy: the Regional and Referral hospitals in Mbeya City, district hospitals in Tukuyu, Kyela and Mbozi and the Iogwe mission hospital. For other sites such as Chunya, Isoko and Chimala, initial training on antiretroviral therapy has started and they intend to offer this service from 2006. By the end of December 2005, 1186 patients were on treatment with antiretroviral drugs.

- **Home-based care**

Home-based care was initiated in the region in 1993 by two mission hospitals using trained hospital-based counsellors as service providers. These services were continually expanded to more hospitals and health facilities in the region. Community-based counsellors were trained to better link the community to health care workers in health facilities. Counsellors visit patients and their families, provide care and advice, and supply them with drugs and materials for symptoms that can be handled at home. They also encourage the community to support affected families and to contribute to the reduction of stigma and discrimination. In 2005, home-based care was provided to 6336 clients.

As stigmatization and discrimination are reduced, more clients are requesting counselling, testing and care, and more community-based providers and health care workers have been trained as counsellors. As well, existing counsellors have been given refresher training on antiretroviral therapy follow-up. In addition to the health facility-based and home-based care providers, there are a few nongovernmental organizations that have also been involved in this service. The most well known and active is KIHUMBE, which is based in Mbeya City.

KIHUMBE: 15 years of nongovernmental organization development for home-based care and other social services in Mbeya City

KIHUMBE started in 1991 with support from GTZ. In the first year of existence, it provided supportive counselling, home visits and nutritional support to 213 home-based care patients and 25 children and orphans. At that time there were no full-time staff members and about 11 part-time volunteers.

In 2006, KIHUMBE is not only properly installed in its own premises, including its own voluntary counselling and testing centre and staff, but also provides HIV education, voluntary counselling and testing, supportive counselling, impact mitigation projects, provision of basic needs and orphan care and support. The organization cares for: 577 clients through home-based care; 733 orphans and children in need; and supports 80 adult and 17 child patients who are on antiretroviral drugs. It covers all 32 wards of Mbeya city and has started an extension of services in Mbeya rural and Rungwe districts.

²⁶United Republic of Tanzania (2003). HIV/AIDS Care and Treatment Plan 2003–2008.

KIHUMBE now includes a full-time work force of nearly 15 people and many volunteers (including its well known drama group). Approximately four hundred people living with HIV, who openly talk about their infection, are involved in home-based care and education activities. They meet regularly in the centre, which maintains a workshop for young orphaned girls where they can learn tailoring and batik-making, providing, among other things, school uniforms for the children of the project. A live-stock project raising goats, pigs and chickens began in 2006, which will provide nutritional and income support to affected families. A major project for carpentry and car repair services for the male youth is planned but has not yet received the necessary funding.

KIHUMBE is now supported by the Mbeya City Council and grants from the AIDS Community Fund as well as the Walter Reed Foundation and GTZ.

Mitigation

- **Income generation and support**

Income-generating projects for individuals and families infected and affected by HIV are still relatively few in the region. KIHUMBE has started a livestock project (see box above), and there are a few community-based organizations that provide chickens or other small animals for people living with HIV. In March 2005, GTZ, DANIDA and the District Agricultural Development Support started a pilot research project to mitigate the impact of HIV on rural households. In four villages of the region, up to 20 poor households affected by HIV were selected through a participatory process and provided with either livestock or improved plant seedlings for gardening to increase their agricultural production for direct consumption (nutritional support) or to market the surplus production (income generation). Other necessary materials and equipment as well as training and technical advice were included in the project.

The project seems to have generated good results for most families after a short time. Most of the families supported have agreed to share their increased knowledge as well as surplus products with other families in their communities, potentially widening the positive effects of the project. The results of this pilot were due to be assessed in late 2006.

Orphans and vulnerable children are at the centre of community impact-mitigation projects. While the relationship between orphans and poverty appears to reflect that between poverty and HIV, the relationship is not always very strong, as the national report on Poverty and Human Development points out. Only slightly more children from households with orphans live below the poverty line compared to children from households without orphans. Even in education, the difference between orphaned and non-orphaned children is only marginal.²⁷ As already mentioned, nongovernmental organizations such as KIHUMBE have started small projects for orphans and vulnerable children. On the one hand the emphasis is to provide schooling and continuous education (the first “KIHUMBE”-child has been accepted for university studies!); on the other hand there is training given to provide technical skills such as the tailoring and batik-making.

²⁷United Republic of Tanzania (2005). Poverty and Human Development Report, p.43.

Conclusion—towards universal access to prevention, treatment and care in Mbeya Region by 2010: achievements to date and challenges for the future

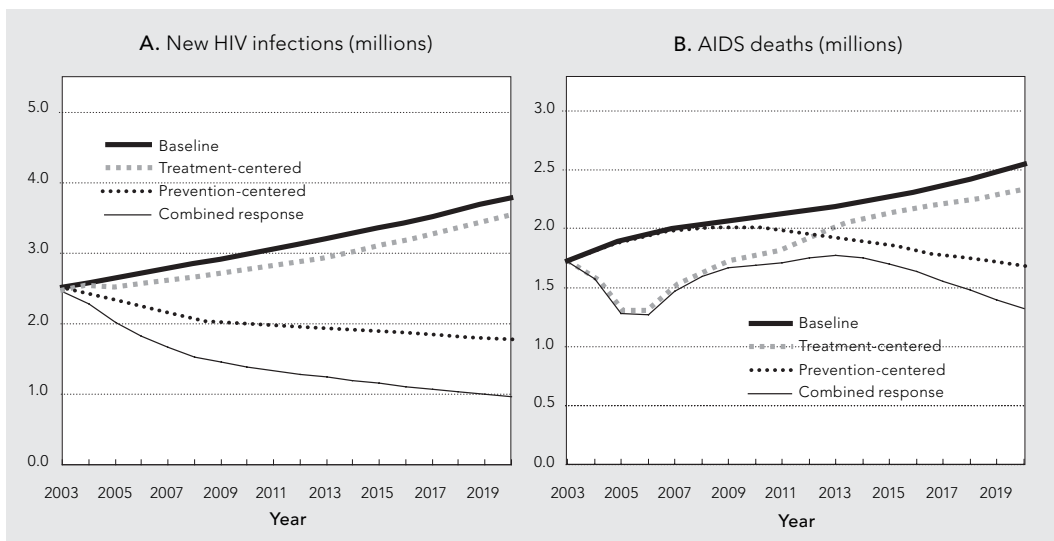
Despite nearly 20 years of national and international efforts to control the HIV epidemic in developing countries, very few success stories have been reported on a national scale.

Since the mid-1990s, the experiences of Brazil, Thailand and Uganda have been often mentioned in international studies as examples of successful national efforts. More recently, stabilizing or even declining trends of HIV infection have been reported from other parts of the (developing) world and include countries as diverse as Haiti, Zambia and Zimbabwe. In none of these reported cases do clear relationships appear between the strength of a national programme and the good outcomes. Very few, if any, comprehensive evaluations or assessments of national efforts have existed in the last ten years to link the implementation of national strategies and programmes with the control efforts of a country.²⁸

Until most recently, the lack of sufficient funding for HIV prevention and treatment, and the barriers to making antiretroviral treatment available on a massive scale in countries such as Tanzania, were regarded as the two major impediments to advancing the HIV response. With the availability of greatly increased funding and the most recent mobilization of efforts to include substantial numbers of people living with HIV in the national antiretroviral therapy programmes catalysed by the “3 by 5” initiative, this situation has changed in many countries, including Tanzania.

The most recent modelling done by UNAIDS estimates a significant decline of new HIV infections in sub-Saharan Africa through a combination of treatment and prevention-centred programmes.

Figure 2: Projected new adult infections and total adult deaths in sub-Saharan Africa, in millions, by the year 2020: Impact of three scenarios compared to baseline



²⁸A national review of the HIV efforts in Thailand in 2005 largely focused on Ministry of Health efforts and was not concerned with the contribution of other sectors of the Thai society in controlling the epidemic.

There is now renewed optimism that through the application of the most recent international recommendations on strategies for prevention and treatment on a national scale, the trend of the HIV epidemic will not only be reversed but there will be a sustainable process for the continual reduction of new infections and most people infected and affected by HIV will receive treatment and care.

Tanzania has already gone a long way in this direction. The policy framework is available in the form of the National HIV/AIDS Policy; the National Multisectoral Strategic Framework and the National HIV/AIDS Care and Treatment Plan. National coordination mechanisms are in place and effective as is the commitment of the national government.²⁹ Substantial increases in resources (largely externally funded) for HIV work have emerged in the last five years, and commitments exist to maintain the level of support until at least 2008. The challenge now is the implementation of the policies, strategies and programmes in quality and scope.

The Mbeya region is probably the region most advanced in Tanzania in implementing all these different elements. Since its inception, the Mbeya Regional AIDS Control Programme has continually strengthened and expanded its activities. The following section summarizes the efforts, using universal access as a yardstick, that contribute to the national vision of Tanzania being “free of the threat of HIV/AIDS and...[with adequate] care and support [for] all those who are infected and affected by HIV/AIDS”.³⁰ This section also identifies the remaining challenges.

1. Overcoming past limitations

In 2003, Tanzania’s National Multisectoral Strategic Framework on HIV/AIDS identified major obstacles to the implementation of strategies to control the HIV epidemic in the past. These problems included:

- limited scope and coverage;
- the restriction of programmes to pilot areas or a few wards or districts;
- infrequency;
- quality assurance problems;
- insufficient coordination; and
- inadequate documentation and communication.³¹

The Mbeya Regional AIDS Control Programme is addressing these limitations, and, in some areas, has made real progress over the past few years.

Limited scope and coverage

As shown in the 2000 study (“Hope for Tanzania”), two main features of the Regional Programme in Mbeya have been comprehensiveness and coverage. Although the Regional Programme started in the late 1980s with only a few programmes concentrated in few sites, over time it has continued to expand its coverage and shape its work in accordance with recommended strategies and programmes. This is especially true in areas such as identification and treatment of sexually transmitted infections, promotion of condoms, access

²⁹Reporting for the National Scaling Up Towards Universal Access, UNAIDS noted that advocacy, public policy and the legal framework in Tanzania are to a large degree “existing and sufficient” while certain areas (e.g. non-discrimination laws or laws to protect people living with HIV) still need to be developed.

³⁰National Multisectoral Strategic Framework on HIV/AIDS of Tanzania (2003). The Vision, page 22.

³¹National Multisectoral Strategic Framework on HIV/AIDS of Tanzania (2003), The Vision, page 19.

to confidential voluntary counselling and testing, provision of health promotion information and activities, home-based care and working with vulnerable populations where the coverage is now at least 80% of those in need.

However, in other areas such as mitigation and economic support projects, and access to antiretroviral treatment, coverage is still much less. Enormous efforts will be needed to expand programmes and services to all people in need.

Restricted to pilot areas or a few wards or districts

While many of Mbeya's programmes started on a limited scale, most were planned with the goal of going to scale. The new organizational structures of the Council Multisectoral AIDS Committees are in place and fully operational at the district level in the entire region, and new committees in wards and villages have been established also. Although most committees are not yet fully operating at ward and village levels, it will merely be a matter of time and continuing financial and technical support and supervision to build up the necessary capacity of these structures across the region.

The same applies for civil society organizations. Due to capacity limitations, only a few organizations (from three to eight) have been trained in each district, but if financial and technical support continues, more capacity will be added in the coming years. As capacity increases, the net of organizations providing care and services will become denser and fewer people will go without support.

Infrequency

While many ongoing services are offered through established structures such as the health care system, others are more sporadic. The drama groups, for example, are still not present in all districts and the regularity of their performances remains limited. Peer education programmes often face challenges to maintain their intense schedules due to administrative disruptions and people not continuing to participate for many different reasons. In general, all voluntary programmes are more fragile and prone to unforeseen interruptions in their service provision or activities than services provided through professional structures such as health or education facilities.

Quality assurance problems

The Mbeya Regional AIDS Control Programme has two main mechanisms to tackle quality assurance problems: the existing structure of supervision, retraining and applied research; and the continual support of external technical bodies such as the Regional Facilitating Agency, GTZ or the Walter Reed Foundation, which are mainly responsible for supporting capacity building and quality assurance. These aspects are connected: the routine system of supervision and retraining needs input and monitoring from the outside to combat the inertia inherent in all bureaucratic or routine processes and services.

Coordination

Coordination was never a major problem in Mbeya. Thanks to the existing structure in the Ministry of Health, and in recent years the Local Government Authorities as well as the limited number of external partners facilitating contacts and interaction, the Regional Programme had a sufficiently integrated structure to plan and coordinate its activities. With the advent of the Local Government Authorities and the diminishing role of the regional structures, some adjustments needed to be made. The assignment of new roles in the district committees, the creation of the Regional Facilitating Agency and the continual involvement

of technical and administrative regional structures are elements which must be considered for further increasing the effectiveness of collaboration and coordination.

Documentation and communication

Not much of what happened in the Regional Programme was documented or communicated outside the region and even the National AIDS Control Programme in Dar es Salaam often had a very limited and incomplete knowledge about processes and achievements in the south-west of the country. However, this lack of communication has been corrected in recent years. As an external partner with a 20-year history in Mbeya, GTZ has played a major role in assisting the region to document and summarize its experiences and to communicate them at the national level. It is not surprising that many of the structures and tools recently developed at the national level, such as capacity assessments for civil society organizations and training modules for Council Multisectoral AIDS Committees, have a strong Mbeya flavour. Many of the successful experiences of the region have found their way into national policy and strategy discussions. However, as in the rest of Tanzania, the Council Multisectoral AIDS Committees could profit from a more rigorous, external assessment and evaluation of the entire programme or key parts in order to improve its own performances.

2. The comprehensiveness of the Regional Programme

The National Multisectoral Strategic Framework on HIV/AIDS 2003–2007 incorporates four thematic areas that are regarded as key elements in the national strategy to control the HIV epidemic. These areas comprise:

- cross-cutting issues;
- prevention including gender;
- care and support; and
- social and economic impact mitigation.

2.1 Cross-cutting issues

Although some of the aspects mentioned may have a more substantial bearing at the national level, they also apply to the regions.

Strategy	Implementation/Results	Comment
Advocacy	Largely done for years among political leaders at regional and district levels	The non-participation of Members of Parliament in the district councils is still a clear sign of the lack of political leadership at local levels
Addressing stigma and discrimination	The elements were included from the beginning in most activities and materials in the region	The increasing numbers of people on antiretroviral treatment as well as the increased use of confidential voluntary counselling and testing services and growing numbers of people receiving home-based care will also probably contribute to the decrease in stigma and discrimination
District and community response	Developed in the region through national decentralization efforts: district, village and ward AIDS Committees have been created and many civil society organizations strengthened	The contribution of the district and community focus in enlarging HIV prevention and support efforts will need to be monitored and assessed through the application of the national monitoring and evaluation system at this level

Mainstreaming HIV	Mainstreaming has started in some sectors (education, agriculture, community development, health)	More sectors need to mainstream HIV activities and the effectiveness and results of these efforts must be assessed
HIV, development and poverty reduction	HIV is now included in all District Development Plans	The quality of these plans and their implementation must be assessed

2.2 Prevention including gender³²

Strategy	Implementation/Results	Comment
Sexually transmitted infection control and case management	Universal access achieved; services are available in all health facilities	Efforts needed to maintain the quality of services
Condom promotion and distribution	Universal access achieved; nearly five million male condoms sold and distributed	Continual efforts need to be deployed to further increase male condom use and promote female condoms
Confidential voluntary counselling and testing	Access for 50% of the population (18–49 years) in need; in the last four years more than 160 000 persons have been counselled and tested for HIV	Confidential voluntary counselling and testing will become increasingly important with the expansion of the antiretroviral treatment in the region
Prevention of mother-to-child transmission of HIV	Estimated coverage is 11% of infected pregnant women; programme expanded in 27 sites	Prevention of mother-to-child transmission may be integrated into the antiretroviral therapy roll-out at the regional level
Health promotion for specific population groups: children and youth, girls and women, men and disabled persons	The percentage of women and men who have a “comprehensive knowledge” ³³ of HIV in the region are 31.6% and 47.3% respectively	See footnote 33 below on the issue of knowledge in the region. Continual efforts are needed to maintain and increase appropriate knowledge and understanding—especially among youth

³²The national prevention strategies of Tanzania are very similar to the latest international recommendation by UNAIDS on the “Essential Programmatic Actions for HIV Prevention”. UNAIDS (2005). *Intensifying HIV Prevention*, UNAIDS Policy Position Paper, p.22. UNAIDS lists 11 action areas:

1. Prevent sexual transmission of HIV; 2. Prevent mother-to-child transmission of HIV; 3. Prevent the transmission of HIV through injecting drug use, including harm reduction measures; 4. Ensure the safety of blood supply; 5. Prevent HIV transmission in the health-care setting; 6. Promote greater access to voluntary HIV counselling and testing while promoting principles of confidentiality and consent; 7. Integrate HIV prevention into AIDS treatment services; 8. Focus on HIV prevention among young people; 9. Provide HIV-related information and education to enable individuals to protect themselves from infection;
10. Confront and mitigate HIV-related stigma and discrimination. 11. Prepare for access and use of vaccines and microbicides. With the exception of the 3rd area on injecting drug use, all the listed elements are included in the national strategy (either under cross-cutting elements or directly under prevention efforts) and implemented in Mbeya region. Even the last one: prepare for access and use of vaccines is already in place with the Walter Reed Foundation project.

³³TACAIDS et al. (2005). Tanzania HIV/AIDS Indicator Survey, p. 35. “Comprehensive knowledge” is defined in this survey as: “Knows that consistent use of condoms and having just one uninfected, faithful partner can reduce the chance of getting the AIDS virus, knows that a healthy-looking person can have the AIDS virus, and knows HIV cannot be transmitted by mosquito bites or by sharing food with a person who has AIDS”. These results contradict TACAIDS’ general findings about knowledge of HIV and AIDS in Tanzania in the same survey (p.31):

“Key findings:

- Over 99% of Tanzanians age 15–49 have heard of AIDS.
- Awareness of the modes of HIV transmission is high, with almost 90% of adults knowing that having only one uninfected, faithful partner can reduce the chance of getting AIDS.
- Rejection of misconceptions related to HIV is also widespread; 4 in 5 adults know that a healthy-looking person may be HIV positive, and almost the same proportion know that HIV cannot be transmitted by witchcraft or by sharing food with someone who has AIDS.”

The response rate to each element of comprehensive knowledge of HIV when the questions are asked separately is much higher in Mbeya than in the entire country. The national results for comprehensive knowledge are 46.3% for women and 54.2% for men. Similar results were reported in the last Demographic and Health Survey (DHS). It is difficult to believe that the knowledge in Mbeya region on HIV and AIDS should be below the national average. That contradicts other elements such as the seriousness of the epidemic, the number of condoms sold and distributed, the participation in voluntary counselling and testing of the population and the amount of health promotion materials produced and distributed. More research in this area is needed.

Peer education	More schools participating	Needs expansion and consolidation; difficulty as new generations of pupils need to be trained and supervised
Health promotion for vulnerable populations	Good coverage of female sex workers through high-transmission focus	Quality and results of peer education and health promotion approach including sexually transmitted infection treatment could be enhanced through more person-intensive support
Workplace interventions (public, private and informal sector)	More than 50% of the bigger private companies have workplace programmes on HIV; some public institutions (hospitals) also have their own programmes	Commitment and quality of workplace programmes on HIV in the private sector often depend on the economic performance and market pressure of companies
Safety of blood, blood-products, and practice of universal precautions in health care and non-health care settings including waste management	Continually promoted in all health settings	Appropriate supply of equipment is necessary but not always available

2.3 HIV care and support

Strategy	Implementation/Results	Comment
Treatment for common opportunistic infections including antiretroviral drugs	Approximately 1200 patients receive antiretroviral treatment (approximately 8.6% of estimated persons in need); the antiretroviral treatment roll-out programme started in 2004; by the end of 2006 nine hospitals and selected health centres will offer services	Speed and coverage depend on National Programme; technical support available in the region
Home/community-based care and support	In 2005, home-based care provided approximately 6400 clients (approx 46% of persons in need)	Well organized and covered in Mbeya City, but needs strengthening in other districts

2.4 Social and economic impact mitigation

Strategy	Implementation/Results	Comment
Economic and social support for persons, families and communities affected by AIDS	Few projects exist through civil society organizations and bilateral support projects	These activities and projects could profit from the involvement of other sectors, especially agriculture and livestock
Support to orphans	Many civil society organization projects concentrate on orphan support; special training for orphan care undertaken	Although the orphan situation may not be dramatically different from the one of young persons in poor households, the focus needs to be maintained as mortality from AIDS will increase in the next years

3. The challenges ahead towards achieving universal access to prevention, treatment and care

The region of Mbeya faced a major HIV epidemic in the mid-1990s with prevalence of above 20%. Thanks to the continual implementation and expansion of nationally and internationally recommended strategies by the Mbeya Regional AIDS Control Programme,

in the late 1990s the region achieved its first major success: reversing the trend of the epidemic. By 2004, prevalence had dropped by more than half over a ten year period.

In the last five years, the region experienced three major developments:

- the expansion of strategies and programmes based on the new National Multisectoral Strategic Framework on HIV/AIDS;
- the reorganization of HIV work to focus on the district and community levels with the participation of more sectors and players; and
- substantial increases of funds available for HIV work.

These elements have certainly strengthened and invigorated the Regional Programme. All major elements are now in place, and many of them have already matured in quality and quantity to come close (or even reach) the new internationally recommended benchmark of universal access.

However, these elements have not yet resulted in accelerating results. In the last five years, HIV prevalence in the region has shown a decline of only 2%.³⁴

Many of the changes—especially related to the Council Multisectoral AIDS Committees, the integration of HIV-related activities in District Development Plans and the strengthening of community responses—are still too new and fragile to demonstrate their added value in responding to the epidemic's challenges.

The strengths of the Mbeya Regional AIDS Control Programme may be summarized as:

- the continual and systematic development of a comprehensive approach to HIV prevention since 1989;
- the high quality of services in key areas;
- the substantial coverage of key services for the entire population;
- the number and quality of local actors, especially in the health care sector, which provided the backbone of the expansion of services;
- the significant support of external technical and financial support from a long-term source (GTZ, Germany), which encouraged the development of close mutual collaboration, understanding and shared responsibility;
- the expansion to more sectors and actors through a district and community focus from a national and regional focus; and
- the availability of greater financial resources through international funding mechanisms and national arrangements.

However, the strength of the Regional Programme should not mask the very large challenges ahead. HIV prevalence and new infections occurring in the region are still terribly high. Among the most obvious challenges for the Regional Programme in the future are:

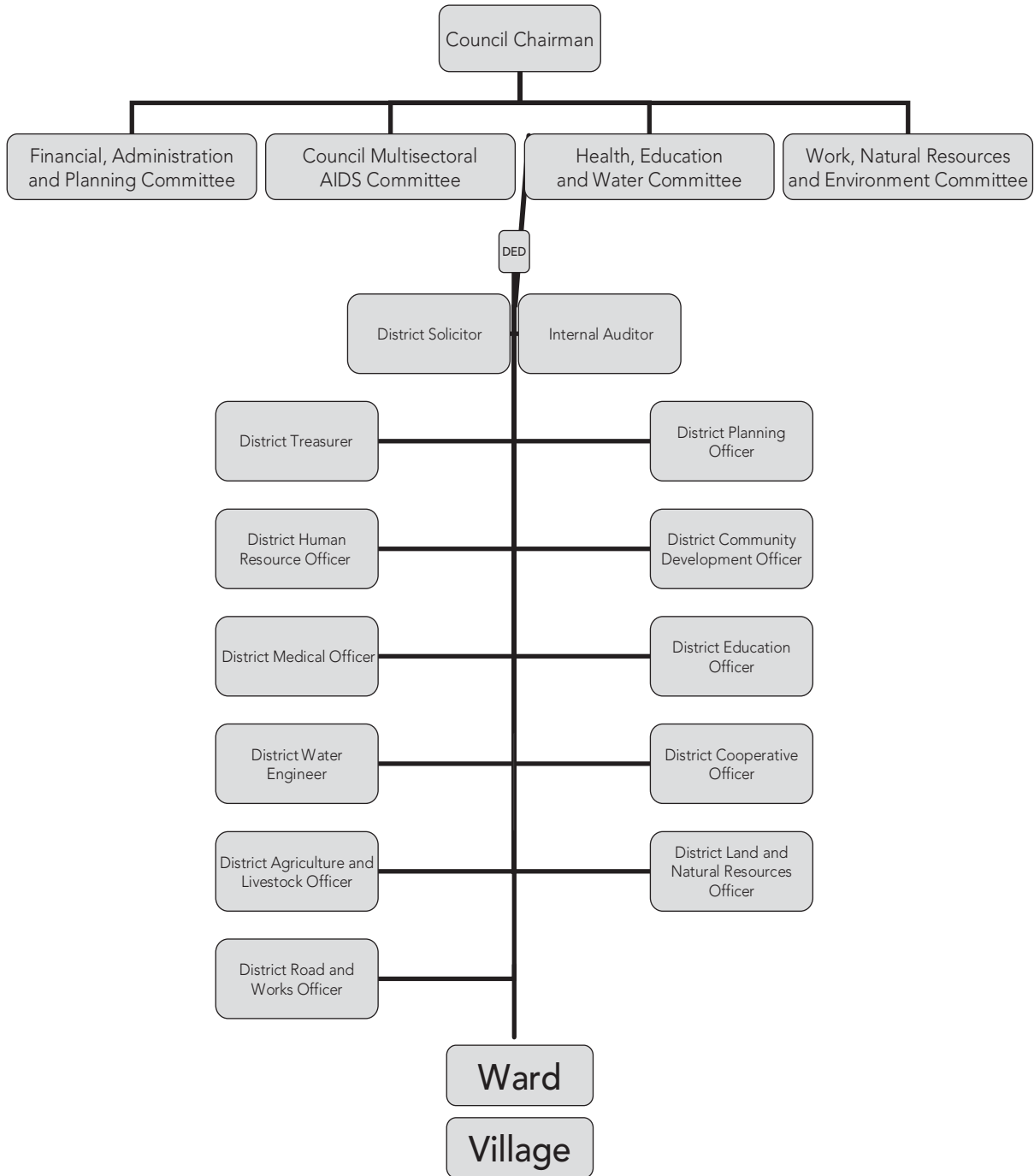
- the necessity of continuing, expanding and consolidating existing strategies and programmes;
- demonstrating that districts and communities have the capacity to expand prevention efforts;

³⁴The regional average, like the national average, masks important local differences. In some of the sentinel sites, the reduction of HIV prevalence among 15–24-year-old pregnant women was much more pronounced than in others, pointing to the fact that even in Mbeya there is not one single epidemic and that HIV transmission is influenced by many specific local factors.

- securing sustained financial resources for HIV activities;
- ensuring the continual recruitment and motivation of local actors in institutions, organizations and voluntary work;
- obtaining ongoing technical support from the outside to advise and encourage local actors;
- addressing the need for more specific local research into conditions of vulnerability; and
- undertaking continuous monitoring and assessment of the quality of programmes and analysing their results.

The prospects for the continued improvement and strengthening of an already strong programme are excellent. If, as it is confidently hoped, that by 'going to scale' the burden of the epidemic in the Mbeya Region can be once again further significantly decreased in the next five to ten years then lessons learnt can be applied to other regions and countries. Success in Mbeya will be an inspiration not only to other regions in Tanzania but also the rest of sub-Saharan Africa.

Annex 1: Organizational structure of the district



Annex 2: Regional indicators based on the new national Monitoring and Evaluation Framework

The box below provides prevention indicators and results from the Monitoring and Evaluation Framework developed by TACAIDS in May 2006³⁵ where they are applicable to the regional situation in Mbeya, and where information is already available through routine reports or estimates by informed sources. Some of the indicators have been modified to suit the information available in the Mbeya region.

Indicator in the Monitoring and Evaluation Framework	Closest regional equivalent	Result
PREVENTION		
Impact Indicators		
No. 2: Syphilis prevalence among pregnant women	Same	2.5% (2005)
Outcome Indicators		
No. 9: Percentage of patients with sexually transmitted infections at health care facilities who are appropriately diagnosed, treated and counselled (UNGASS)	Same	80% (2003)
No. 10: Percentage of HIV-positive pregnant women receiving a course of prophylaxis to reduce mother-to-child transmission in accordance with nationally approved protocols in the last 12 months (UNGASS)	Same	11% (2005)
No. 11: Number of voluntary counselling and HIV testing sites per population per district	Same	1. Rungwe District = 30/314 765 2. Chunya = 16/217 674 3. Mbeya Rural = 16/273 757 4. Mbarali = 7/241 328 5. Municipal = 17/299 689 6. Mbozi = 8/566 336 7. Ileje = 5/114 906 8. Kyela = 15/187 3336 Total sites = 114
Output indicators: Information, education and communication and behaviour change communication		
No. 12: Number of schools with teachers trained in lifeskills-based HIV education who taught it regularly (twice per week) in the preceding 12 months (UNGASS)	Same	170 (2005)
No. 15: Number of information, education and communication materials distributed in the last 12 months	Same	201 216 booklets and leaflets
Output indicator: condom		
No. 18: Number of male and female condoms distributed to end users in the last 12 months	Number of male condoms sold and distributed	4 766 831

³⁵TACAIDS (2006). National Multisectoral HIV Monitoring and Evaluation System, Operational Plan Vol 1 + 2, 1 July 2006–30 June 2008.

Output indicator: voluntary counselling and testing		
No. 19: Number and percentage and number of the general population receiving an HIV test, the results and post-test counselling in the last 12 months	Same	42 041 approximately 10% of population 15–49 years old
No. 20: Percentage of health facilities that have the capacity and conditions to provide basic HIV counselling and testing and to manage clinical services	Percentage of health facilities that have the capacity and conditions to provide HIV counselling and testing	33% 114/340
Output indicator: workplace programmes		
No. 21: Percentage of large (20 persons or more) workplaces (public and private) that have prevention and care policies and programmes (UNGASS)	Percentage of large (20–50 persons or more) workplaces that have prevention and care policies and programmes	64% 38/59
Output indicator: prevention of mother-to-child transmission		
No. 22: Percentage of venues offering the minimum package for preventing HIV in infants and young children which have specific written guidelines on how to make referrals to facilities offering long-term care and support services	Percentage of health facilities which offer prevention of mother-to-child transmission services according to national guidelines	27/341 7.9%
Output indicator: blood safety and universal precautions		
No. 23: Percentage of transfused blood units screened for HIV	Same	100%
	Output indicator: sexually transmitted infection care	
No. 26: Percentage of health facilities with both trained staff to treat sexually transmitted infections and an uninterrupted stock of drugs to treat sexually transmitted infections	Same	311/340 91%

Annex 3: Key literature

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18. TACAIDS (2006). *National Multisectoral HIV Monitoring and Evaluation System, Operational Plan Vol. 1 and 2*. 1 July 2006–30 June 2008.
19. RFA Rukwa/Mbeya (2006). *Annual Draft Report 2005–2006*.
20. GTZ (2006). *Bringing the AIDS Response Home, Empowering District and Local Authorities in Lesotho, Tanzania and Mpumalaga, South Africa*. Eschborn.
21. WHO/Ministry of Health Tanzania/GTZ (2006). *Equity and Fair Process in Scaling up Antiretroviral Treatment: Potentials and Challenges in the United Republic of Tanzania, Case Study*. Geneva.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) brings together ten UN agencies in a common effort to fight the epidemic: the Office of the United Nations High Commissioner for Refugees (UNHCR), the United Nations Children's Fund (UNICEF), the World Food Programme (WFP), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations Office on Drugs and Crime (UNODC), the International Labour Organization (ILO), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO), and the World Bank.

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- provides a voice to those working to combat the epidemic and mitigate its effects;
- provides information about what has worked in specific settings, for the benefit of others facing similar challenges;
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Tanzania has made substantial progress in strengthening the national response to HIV in recent years. This case study describes different aspects of the response made in the Mbeya region over the last 20 years. More than two million people live in the region and it was, and continues to be, one of the worst-affected parts of the country. However, HIV prevalence which reached an estimated high of 20% in the mid-1990s has been in decline since then. It is very likely that the work of the Mbeya Regional AIDS Control Programme which began in 1988 has made an important contribution to reversing the trend of the epidemic.

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