

HIV/AIDS AND PUBLIC ADMINISTRATION: TANZANIA COUNTRY FORESIGHT PAPER

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1.0: INTRODUCTION

1.1: Global Perspective on HIV and AIDS Epidemic

HIV/AIDS is a worldwide problem. According to WHO and UNAIDS (2009), since the beginning of the epidemic, almost 60 million people have been infected with HIV and about 25 million had died of AIDS related diseases. It is estimated that each year around 2.7 million people are being newly infected with HIV (UNAIDS, 2008a). Although the epidemic extends into the general population across the world but it has remained highly concentrated around specific population groups. Globally, there are more women than men living with HIV and AIDS. Young people, between the ages of 15–24, accounted for approximately 40% of new HIV infections (among those 15 and over) in 2011 (UNAIDS 2012). Data indicate that, young women aged 15-24 are most vulnerable to HIV. The infection rate among young women is twice as high as in young men, at 0.6% (Women Out Loud, 2012).

Global reports on the trend of the epidemic in the past three years indicate that the global rate of HIV prevalence has been declining. However, UNAIDS (2012) report has indicated that despite the decline of the HIV prevalence, there has been a striking increase in some parts of the world (UNAIDS, 2012). Since 2001, the number of people newly infected in Middle East and North Africa has increased by more than 35% (ibid). Generally speaking, despite of the downward trend, millions of people are being newly infected every year and there are millions of people who are living with the virus and who will need serious care and treatment when they proceed to AIDS. There were 34 million people living with HIV and AIDS by the end of 2011 (ibid). In the same year, 2.5 million people were newly infected, which is equal to more than 7,000 new infections per day (ibid). UNAIDS estimated that 0.8% of all adults in the world aged 15-49 years are living with HIV. The global look at the epidemic is demonstrated in table 1 below.

Table 1: Global HIV Prevalence 2011

Region	Total No. (%) of people living with HIV in 2011	Newly Infected in 2011	Adult Prevalence Rate 2011
Global Total	34million (100%)	2.5million	0.8%
Sub Saharan Africa	23million (69%)	1.8million	4.9%
South/South East Asia	4.0 million (12%)	280,000	0.3%
Eastern Europe/Central Asia	1.4million (4%)	140,000	1.0%
Latin America	1.4million (4%)	86,000	0.4%
North America	1.4million (4%)	51,000	0.6%

Western/Central Europe	900,000 (3%)	30,000	0.2%
East Asia	830,000(2%)	89,000	0.1%
Middle East/North Africa	300,000(1%)	37,000	0.2%
Caribbean	230,000(0.7%)	13,000	1.0%
Oceania	53,000 (0.2%)	2,900	0.3%

Source: US Global Health Policy (2012) **The Global HIV Epidemic: Fact Sheet**, available at <http://www.kff.org/hivaids/upload/3030-17.pdf> (15/3/2012)

As indicated in table 1 above, although the epidemic has spread in all parts of the world, the sub-Saharan Africa remains the worst affected region in the world. The region, though harbours only 10% of the world's population, but has the highest accumulative death toll of people dying from AIDS. Three quarter of all AIDS related deaths in 2007 occurred in this region. AIDS killed 2 million African people in 2008 and in 2011 out of 1.7 million recorded deaths, 70% were in Africa (UNAIDS, 2012).UNAIDS estimated that by 2011 there were 23million people living with HIV in the sub Saharan Africa and about 1.8million of them were newly affected in the same year. Currently, one in every 20 adults (4.9%) lives with HIV and AIDS in Sub Saharan region

2.0: HIV AND AIDS IN TANZANIA

2.1: The History and Status of HIV and AIDS epidemic in Tanzania

Tanzania is severely affected by the HIV and AIDS epidemic. HIV and AIDS has become a major development drawback and a threat affecting Tanzania's social and economic development. Year 2013 marks exactly 30 years since HIV and AIDS was first discovered in Tanzania in 1983. Historically, the first three cases of HIV and AIDS patients in Tanzania were discovered and documented in Kagera region¹ at Ndolage Mission Hospital in Muleba by the Surgeon named Clint Nyamlyankunge, who was by then working as Kagera regional surgeon (TACAIDS, 2009). It is believed that the reason why Kagera region was the first region to encounter HIV and AIDS epidemic was because it shares a border with Uganda. The mobility of the people due to thriving business across the border and the social disruption caused by the Uganda and Tanzania war which ended in 1979, were the catalysts for the spread of the disease. By 1985, additional cases of HIV and AIDS were diagnosed in Dar es Salaam², Coast, Iringa, Mtwara, Mwanza and Tabora. By 1986, all regions in Tanzania had

¹In Tanzania Zanzibar, the first three cases of AIDS were reported in 1986 at Mnazimmoja Hospital

²A decade later the prevalence rate in Dar es Salaam was higher than anywhere else in the country. According to National AIDS Control Program (NACP) between 1995 -1997, the prevalence rate in Dar es Salaam rose from 13.5% to 14.8% (NACP, 1999)

reported cases of HIV and AIDS. In just a decade, accumulative AIDS cases by region grew from 3 in 1983 to 73,573 in 1993 to 600,000 in 1999³(National HIV/AIDS Policy, 2001; NACP, 2002). Data indicates that between 1986 and 2002 while the first two medium term plans were implemented, there was a two fold increase of HIV prevalence from 7.2% in 1990 to 13.3% in 2000 among female blood donors (URT 2000; URT, 2005). Table 2 gives details on the HIV prevalence in the country from year 2000 to 2012.

Table 2: HIV Prevalence Rates in Tanzania 2000 -2012 (in percentages)

Year	National Prevalence	Women	Men	Source
2000	9.90%	13.30%	9.20%	HIV/AIDS/STI Surveillance Report, Jan -Dec 2000, Report No.15
2001	11.01%	13.70%	10.40%	HIV/AIDS/STI Surveillance Report, Jan -Dec 2001, Report No.16
2002	12.30%	12.30%	9.10%	HIV/AIDS/STI Surveillance Report, Jan -Dec 2002, Report No.17
2003	8.80%	11.90%	8.20%	HIV/AIDS/STI Surveillance Report, Jan -Dec 2003, Report No.18
2003/2004	7.00%	8.00%	6.00%	Tanzania Health Indicator Survey (THIS) 2003/2004
2004	7.70%	10.70%	7.20%	HIV/AIDS/STI Surveillance Report, Jan -Dec 2004, Report No.19
2005	7.90%	-	-	HIV/AIDS/STI Surveillance Report, Jan -Dec 2005, Report No.20
2006/2007	7.4%	-	-	National Multi sectoral Framework II 2008/2012
2007/2008	5.7%	6.8%	4.6%	Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS) 2007/2008
2009	6.50%	7.70%	6.30%	HIV/AIDS/STI Surveillance Report, Jan -Dec 2009, Report No.21
2011/2012	5.0%	6.0%	4.0%	Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS) 2011/2012

Source: Compiled by the author

As illustrated in Table 2 above, HIV prevalence reached its peak in 2002 where surveillance report indicates a rate of 12.3%. However, other sources on the same year indicated prevalence rate to have reached as high as 15% with more than 2 million Tanzania living with HIV and AIDS (Tanzania National Website). The available data also indicate that there has been a slight decline of HIV prevalence in Tanzania from 7.0% reported in the THIS 2003/2004 to 5.7% in THMIS 2007/2008 to 5% reported in THMIS 2011/2012. Nevertheless,

³It should however be noted that it is difficult to obtain accurate numbers and figures on the rates of HIV infections in Tanzania as a result of widespread underreporting. NACP attributes the underreporting of AIDS cases to number of factors such as inadequate diagnosis, high levels of stigma, underutilization of the available health care facilities and other logistics. NACP specifies that only one out of five cases is reported, these estimates may be low on the low side, representing about 20% of the actual cases.

a small increase in prevalence has been projected as a result of an increase in rural incidence and the uptake of ARV services over the last five years (URT, 2012)

There are currently three regions with the highest prevalence rates in Tanzania (THMIS 2011/2012). These are Njombe (14.8%) followed by Iringa (9.1%) and Mbeya (9%). The regions with lowest HIV prevalence are Manyara (1.5%) Tanga (2.4%) followed by Dodoma and Lindi at 2.9% each. In most of Tanzanian regions, HIV prevalence is higher among women than men. In Mtwara for example, the rate of infections among women is five times higher than that of men. However, contrary with other regions which have displayed higher infection rates among women; two regions which are Dodoma and Katavi are exceptional. THMIS 2012/2012 report indicates that, in these two regions the rates of infections are higher among men than women. In Dodoma, HIV prevalence among men is 3.7% compared to 2.1% of the women while in Katavi, the rate of infection among men is 6.7% while that of women is 5.3%. In addition to that, THMIS 2007/2008 had also indicated higher infection rates among men than women in Arusha region. Nevertheless little is known about what could be behind this revelation.

Tanzania is said to have a generalized epidemic⁴ though the epidemic is unevenly distributed across geographical areas, gender, and age groups and social economic classes. However, the Tanzania's National Policy for HIV and AIDS declare heterosexual contact as a predominant mode of HIV transmission in Tanzania. In 2011 this mode of transmission accounted for approximately about 90% of new infections in the country (THMIS, 2011/2012). The predominance of heterosexual transmission is pronounced by percentage of women visiting antenatal clinics diagnosed HIV positive. According to HIV/AIDS/STI Surveillance Report of 2011, the HIV prevalence among pregnant women attending antenatal clinic is 6.9%. The same mode of HIV transmission is also common in many other countries in Africa accounting for about 87% of new infections⁵ (Piot and Bartos, 2002). Vertical infection from mother- to -child (newborn) is another leading form of HIV transmission in Tanzania, which occurs during pregnancy, childbirth and breast feeding. This mode of transmission accounts for 18% of all infections in Tanzania (THMIS, 2007/2008; TACAIDS, 2009). The PMTCT

⁴Generalized epidemic in the classification of HIV epidemic of UNAIDS means "HIV prevalence consistently exceeding one per cent among pregnant women (UNAIDS Terminology Guidelines, 2011).

⁵This is contrast with Europe and USA where homosexual intercourse and injecting drug use are the main sources of HIV infections. See Nana P (2005) *AIDS in Africa: How the Poor are dying*, Polity Press, Cambridge

national guidelines report that, three out of ten infants are infected through the abovementioned ways. On the other hand, Medical transmission, which is another form of HIV transmission accounts for 1.8% of all new infections while less than 1% of infections are due to injecting drug use (IDU), homosexuality and anal transmission (TACAIDS,2012).

2.2: Trend in HIV Prevalence in Tanzania

In Tanzania, the wealthier have been more affected and this had been a trend over time. According to the survey by TACAIDS and Tanzania Bureau of Statistics between 2003 and 2004, infection rates were three times higher among those in the highest wealth quintile than those in the lowest quintile⁶. Wealth and HIV prevalence relationship has been supported by number of empirical studies which have challenged the commonly held assumption about the effect of HIV and AIDS among the poor. A study by Mishra et. al. (2007) for example demonstrates that, HIV infections do not disproportionately affect the poor in sub-Saharan Africa. Furthermore a study by Shelton et. al. (2005) about HIV in Tanzania and Kenya also found that, the highest prevalence was among the wealthier people and particularly among wealthy women as opposed to poor women. Notably, there have not been any signs that this trend is changing.

In Tanzania, marital status and HIV prevalence has been changing overtime. National AIDS Control Program (NACP) reported that in 2006, HIV prevalence was higher among those who were married (NACP, 2006). The THMIS 2011/2012 however reveals some changes in this trend whereby currently, the lowest HIV prevalence is found among those who are married or living with a partner (5%). HIV prevalence is indicated to be higher among those who were formerly married (widowed 25% and divorced 13%). Currently, 15% of women and 9% of men who are divorced or separated are HIV positive (THMIS, 2011/2012).

For a significant period of time since its discovery in Tanzania, HIV prevalence went hand in hand with the education level. Educated people were more likely to be HIV positive than those who were not. Scholars attributed this trend with number of factors including better incomes and increased social activities and contacts which educated people are exposed to as leading to more temptations (Moshi, undated). Moshi adds that the fact that education, especially post primary education occasionally leads people to move away from their

⁶See “2007/2008 Tanzania HIV/AIDS and Malaria Indicator Survey”
<http://www.unaidsrestasa.org/files/UI/Tanzania-HIV-TB-Malaria-Survey.pdf> accessed on 12/03/2013

neighborhoods (and the monitoring eyes of their relatives) hence increasing their freedom to do those things that they would not have otherwise freely done, exposing them to more risk of catching HIV. However, this trend seems to be fast changing since 2004. The Tanzania HIV/AIDS and Malaria Indicator Surveys of 2007/2008 and that of 2011/2012 indicate a reverse trend whereby both reports indicate HIV prevalence to be lower among the educated people than uneducated. Table 3 demonstrates.

Table 3: HIV Prevalence and Education levels in Tanzania, 2001-2012

Education Level	HIV	HIV	THIS	THMIS	THMIS	
	Prevalence 2001/2002 sentinel surveillance	Prevalence 2003/2004 sentinel surveillance			2003/2004	2007/2008
None	6.4	5.2	5.3	5.9	5.4	3.5
Primary incomplete	10.2	9.3	5.3	4.5	6.6	3.4
Primary Complete	n/a	n/a	7.9	5.8	6.7	4.9
Secondary+	n/a	n/a	8.2	4.3	4.9	2.0

Sources: UNAIDS/TACAIDS (2008), THMIS (2011/2012)

As demonstrated in Table 3 above, while for some years HIV prevalence was higher among the more educated, now the trend is changing. The prevalence is lower among the educated than the less educated; a new reverse relationship between education and HIV prevalence is forming but what explains this inverse trend is not yet known.

3.0: IMPACT OF HIV AND AIDS IN TANZANIA

The devastating impact of HIV and AIDS has been experienced throughout our society. It is now one of the major causes of illnesses and deaths in all sectors. It has caused a long prolonged human suffering, increased number of orphans and destabilized family structure, communities and the nation at large. This section aims at providing a discussion on the impact of HIV and AIDS in Tanzania. The section is presented under the following sub headings; demographic and social impact in which the most affected group in society are identified, economic impact and impact on service delivery where examples will be drawn from two selected sectors and the likely political impact?

3.1 The Demographic and Social Impact of HIV and AIDS

One of immediate impacts of the epidemic in the country is the decline of life expectancy. The UN Population Division projected that AIDS would reduce life expectancy in Tanzania by 17% during 2000-2005 period and 14% during 2010-2015 period and 7% during 2045 - 2050 (UN Population Division, 2002). Table 4 illustrates

Table 4: Life Expectancy at Birth with and Without AIDS, 2010-2015 and 2045 - 2050

2010/2015				2045 - 2050			
With AIDS	Without AIDS	Reduction in Life Expectancy	% Reduction	With AIDS	Without AIDS	Reduction in Life Expectancy	% Reduction
46.5	54.1	8	14	63.3	67.8	5	7

Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat (2002) *World Population Prospects: The 2002 Revision Highlights*, New York (<http://www.un.org/esa/population/publications/wpp2002/wpp2002annextables.PDF>)

A similar view is also shared by some local reports. A Gender Audit on Tanzania National Response to HIV and AIDS reports that by 2009, HIV and AIDS had lowered the life expectancy to 47 years for men and 49 years for women (URT, 2009). Although the Tanzania population is projected to grow to over 69 million by 2050, the population is projected to be 15% lower than it would have been without AIDS (UN Population Division, 2002).

Related with reduced life expectancy is an increased mortality. Literature on demographic impact of the disease reveals that annual cumulative AIDS deaths are increasing and the majority would fall on the 15-49 years age group. UN Population Division (2002) projected AIDS to increase the number of deaths in Tanzania by 29% during 2000 – 2015 and 14% during 2015 – 2015. The Second National Multi Sectoral Strategic Framework (NMSF II) on HIV and AIDS in Tanzania 2008-2012 also projected an increase in the annual AIDS deaths from about 99,000 deaths in 2000 to about 175,000 deaths in 2015. This implies an increased number of AIDS deaths per day, that is, from 252 deaths in 2000 to 480 deaths in 2015. The annual number of deaths in 2015 would have been 40% less without AIDS (NMSF II, 2008/2012).

Socially, AIDS has resulted into increased number of orphaned children. Several studies have projected an increase in the number of AIDS orphaned over the years. A study by Garbus (2004) projected an increase in the percentage of orphans attributed to AIDS from 4% in

1990 to 42% in 2001 to 54% in 2010. In a similar view, NMSF II, 2008/2012 estimated the number of AIDS orphaned children to increase from between 260,000 to 360,000 in 1995 to between 490,000 and 680,000 by the year 2010. It was estimated that by 2006, there were 1,100,000 AIDS orphaned children in Tanzania and the estimation for 2010 was 4.2 million AIDS orphaned children (UNAIDS, 2006). Orphaned children left behind are often forced to take care of themselves or depend on some old survivors of their families. Grandparents who were supposed to be cared by their children are now facing the task of caring for their grandchildren left behind by their deceased children. A report by Economic and Social Research Foundation (ESRF, 2003) for example revealed that 34% of the orphan pupils interviewed were being taken care of by grandparents and 51% of those orphans mentioned that their grandparents were also taking care of other orphans. About 71% of these grandparents were taking care of between 1 and 3 other orphans while the remaining 29% were taking care of up to 7 other orphans.

Though the devastation of HIV and AIDS is felt by all social groups, there certain population sectors which have been more affected by the epidemic than other. The Tanzania National Website report that women, youth, the poor and mobile groups are most highly HIV affected population sectors in Tanzania.

Mobile Group

One of the most vulnerable groups to higher HIV infection is the mobile group population. This group includes migrant labors, petty traders, commercial sex workers, long distance truck drivers as well as military personnel⁷. A study conducted by ILO along the transport corridor within the northern and southern highlands of Tanzania focusing on major truck stops and towns (Ilula and Mafinga in Iringa region, Tunduma border in Mbeya region and Rombo and Hai in Kilimanjaro region) revealed how this group of population fuels the transmission of HIV in the country. The study found out that 84% of commercial sex workers, 58% of truck drivers and 48% of barmaids had more than one sex partner. The study further shows that 63% of truck drivers and 55% of barmaids were involved in transactional sex (ILO, 2012). Similar study done by Boerma et al. (2003) in Tanzania and Zimbabwe has the same conclusion that spatial mobility was an important risk factor for HIV infection in both studies, especially for women. Another study by Africa Medical and Research

⁷ Tanzania National Website “HIV/AIDS in Tanzania”

Foundation (AMREF) revealed that sex workers have high HIV infection rates of 60%⁸. Numbers of reasons have been put forward to explain vulnerability of this group to HIV infections. Materu (2007) attributes higher infection rates to poverty and low pay associated with some occupation such as barmaids. She argues that, workers in the drinks and beverage sectors are low paid and hence forced to engage into some transactional sex to supplement their income. Materu links poverty and low income with labour migration. According to her, these situation forces people to move from their vicinities (rural areas) to the urban areas in search for employment leaving their families behind. Ronald Nicolson cited in Materu (2007) had this to say about how labour migration is linked with the spread of HIV and AIDS.

“Male migrant workers leave sexual partners in the countryside, to whom they have at least some degree of responsibility, and take multiple casual partners in the city to whom they have none. The women remaining in the rural areas are dependent on the men to provide them with support, so are in no position to negotiate for safe sex when their husbands return on occasional visits”

The quotation illustrates the sexual behaviour of the migrant men while living in cities and the difficulties the women face to negotiate safe sex with their partners when they return home. Nicolson however assumes that it is the men who go to the cities who are most likely to engage in extramarital affairs. The quotation silently overlooked the sexual behaviour of the women who are left behind. Women who are left behind may also engage in some risky sexual activities potential for the spread of the epidemic. Materu (2007) argues that, if the man who left his family does not provide care, the woman in a desperate situation may be forced to engage in transactional sex in in order to upkeep her family. Materu’s argument is in consonance with the findings of the study by Kishamawe et.al (2006) which found out that among mobile couples, more sexual risk behaviour and an increased risk of HIV infection was increasing not only in the mobile person but also in the partner who remained behind. The study recommended that, interventions aiming at reducing risk behaviour due to mobility should also include partners who stay behind.

Women and the Poor

HIV is not a gender neutral epidemic (URT, 2009). Although both men and women are affected by epidemic, women are more vulnerable to HIV and AIDS epidemic than men. The HIV/AIDSAND Malaria Indicator Survey (THMIS, 2011/2012) puts the adult HIV

⁸ Tanzania National Website “HIV/AIDS in Tanzania”

prevalence in Tanzania to be at 5%, nevertheless, the analysis of the data indicates the spread of HIV persists to be feminized. All the three latest HIV/AIDS indicator surveys have indicated that women are overall more likely to be HIV positive than men

Table 5: HIV Prevalence Tanzania Mainland by Sex, 2003/2004, 2007/2008, 2011/2012

SN	Year	National HIV Prevalence Rate	Women	Men	Source of Data
1	2003/2004	7.00%	7.70%	6.30%	THIS 2003/2004
2	2007/2008	5.70%	6.60%	4.60%	THMIS 2007/2008
3	2011/2012	5.0%	6.0%	4.0%	THIMS 2011/2012

Source: Tanzania Health Indicator Survey (THIS, 2003/2004) and Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS 2007/2008; 2011/2012)

As indicated in Table 5 above, women in Tanzania have been badly affected with HIV and AIDS. In 2011, women comprised nearly 60% of people living with HIV in Tanzania. THMIS 2011/2012 suggests that among women prevalence rate increases with age from about 1% to those between 15 - 19 years to 10% to those between 45 - 49 years of age. It should be remembered that women themselves are not homogenous. HIV prevalence among women also varies significantly. According to THMIS 2011/2012, HIV prevalence among women in urban areas is higher than women in the rural areas at 8.9% and 5.1% respectively. This finding is also confirmed in a research by Mnyika et. al. (1996). Furthermore, women who are in formal employment are more likely to be affected than those who are not. THMIS 2011/2011 reports that HIV prevalence among unemployed women is 4.2% compared to 6.6% of those who are employed.

The Tanzania Government Website identifies the poor as another category of the people most affected by the epidemic. Women constitute the majority of the poor, owing to their low educational levels, unemployment, and the denial of property ownership. Sheeren Usdin cited in Materu (2007) speaks about how poverty fuels HIV, “*Being poor reduces people’s options in life. For example, faced with the prospect of starvation now and illness later, millions of people (most likely women) are forced into sex work to keep their families alive*”. While it is true that poverty is one of the important determinant of HIV epidemic, this view should however be taken with caution. As it has been discussed earlier, reports have indicated a change of trend whereby now the HIV prevalence is higher among the wealthiest households than the poor (THMIS 2011/2012; Mishra et.al, 2007; Shelton et.al, 2005). Remarkably, even

in the state of economic wealth, women continue to be the most affected. THMIS 2011/2011 reports that HIV prevalence among wealth people is higher among wealthiest women than wealthiest men. HIV prevalence increases from 5% (among women) and 3% (among men) in the lowest wealth quintile to 8% and 5% in the highest quintile for women and men respectively. This fact raises one critical question “is it wealth or poverty behind women higher HIV prevalence in Tanzania?”

Youths

In Tanzania, youth are a significant proportion of the population. About two thirds (65%) of the Tanzanian population are under 24 years of age (Tanzania Demographic and Health Survey (TDHS, 2010). According to UNAIDS (2012), over 70% of PLHAs in Tanzania are youth aged between 15-49 years. Gender differences are observed in male and female youths who are infected by HIV and AIDS. The majority of youth infected are female. The 2008 antenatal care surveillance data reported that young women aged 15-24 accounted for 45% of new HIV infections whereas young men aged between 15-24 accounted for 26% of new HIV infections in the general Tanzanian population (age 15-49). A similar trend is also reported in the THMIS 2007-2008 report which indicated HIV prevalence among female youth of age between 20-24 years was almost 6 times higher (at 6.3%) than the rate amongst male youth of the same age (1.7%). In 2011, HIV prevalence among female youth (age 20-24) was 4.4%, which is four times higher than male in the same age group at 1.7% (THMIS 2011/2012). This tends to suggest that girls start to engage in sexual activities earlier than boys. TDHS 2010 indicates that on average, young women (15-24) in Tanzania begin to have sex at about age 18, and 13% of them had their first sexual intercourse by the age of 15 while young men start having sex at about age 20.

3.1.1 Why Higher HIV Infections Levels Among Women and Youths?

Factors associated with higher HIV infections in women

Higher HIV prevalence amongst women has been a common trend in most African countries. In Africa, HIV and AIDS has always been a gendered-issue (Phiri, 2003). She further contends the higher HIV prevalence amongst women in Africa are due to a host of factors such as psychological factors, social and cultural practices, economic and religious reasons.

3.1.1.1: Socio-cultural explanations

To many African societies including those in Tanzania, culture has an important role in daily lives of individual members of the society. While some socio-cultural beliefs and practices are regarded as positive others are discriminative, exploitative and indeed put some members of society, particularly women, at high risk of getting HIV (News, 2013). Some cultural beliefs such as female genital mutilation, early marriage, spousal inheritance laws, polygamy, obligatory marital sex and the encouragement to multiple sexual partners among men have been identified contributors to HIV infection among women in Tanzania (Materu, 2007; Avert⁹; Tanzania Government Website¹⁰). Other cultural practice contributing to the spread of HIV and AIDS is “*mafîga matatu*”¹¹ culture (Mallya and Munishi, 2010). In this cultural practice, young women during initiation ceremonies and brides are taught and highly encouraged to have about three men in order to be sure they can subsist well, one being the husband, another for material provision and the other for fulfilling sexual desires (especially where older men marry younger girls). This cultural practice has been documented to contribute in the spread of HIV and AIDS among young women particularly along the coast regions.

3.1.1.2 Gender Inequality

Gender inequality has also been identified as a factor leading to higher HIV infection rates amongst women. Factors contributing to gender inequality, such as gender-based violence, unequal access to resources, and cultural gender norms, can all contribute to higher HIV infection risk and fewer treatment options for women. Most of African societies in general and Tanzania in particular are characterized by culture which is highly patriarchal. Gender related constraints caused by this patriarchal culture give men not only uneven powers and ownership over resources but also control of major decisions in the household including sex related issues. Gender inequalities in Tanzanian societies prevent women and young women in particular from negotiating safer sexual practices including condom use. For instance, a study by NIRM/TACAIDS/UNAIDS (2010) on the drivers of HIV in Tanzania showed that married women are poor negotiators of safer sex. The study reveals that the unequal gender relationship in the society where the woman is seen as belonging to the man, and man is seen as the master of the woman has culminated in the spread of the disease particularly among

⁹ Avert “HIV and AIDS in Tanzania” www.avert.org/hiv-aids-tanzania.htm

¹⁰ Tanzania National Website “HIV/AIDS in Tanzania” accessed 19/6/2013

¹¹ This literary means having support from at least three different male partners

married women. Marriage is assumed to be a sacred institution designed for people to have children. Married women are not only incapable of negotiating safe sex but also not expected to do so even when they suspect the man has engaged in extramarital relationships.

3.1.1.3 Economic Related Factors

Tanzania is one of the poorest countries in the world. According to 2007 Tanzania Households Budget Survey (HBS,2007) approximately 34% of the Tanzania population live below the basic needs poverty line and 17% live below the food poverty line¹². Women are harder hit by poverty than men owing to the patriarchal social tradition which has excluded women from accessing and owning resources. The Household Budget survey reports that the female –headed households constitutes 24% of the poorest households in Tanzania¹³.

Faced with the growing poverty levels and lack of alternative means of survival, most women find themselves forced to engage in high-risk sex as a means of earning a living for their own survival and that of their children. A desperate respondent in NIMR/TACAIDS/UNAIDS (2010) study on Drivers of HIV/AIDS Epidemics in Tanzania Mainland had this to say about how poverty puts her in the risky of getting HIV infection “***I am at risk because I am practicing this commercial sex and even if I leave it what will my children eat?***” Likewise a study by ILO (2012) found 91% of Commercial Sex Workers who live below the poverty line engaged in transactional sex with multiple partners.

Factors associated with higher HIV infections in young women

Early Sex debut

One of the reasons for higher youth HIV infections in Tanzania is early sex debut. A study by NIMR/TACAIDS/UNAIDS (2010) found out that the majority of the respondents (85.5%) had their first sexual experience between the ages of 10-19 years. Young women experience early sex activities than their male counterparts. Tanzania Demographic and Health Survey (TDHS) reports that 13% of young women age 15 -19 had sex before the age of 15 years. Furthermore, one in every four women age 15 -19 have begun child bearing (TDHS, 2010).

¹² The report reveals an increase of number of people living in poverty from 11.4million during 2000/2001 report to 12.9million people during 2007 report.

¹³This is an increase of 5% from the 2000/2001 where female households constituted 19% of the poor households.

Early sex debut is known to contribute in the spread of HIV because the virus can easily pass to young women because of their immature vaginal tracts and easily torn tissues¹⁴ .

Early Marriages

Another documented factor which has been associated with higher HIV infections rates among youth in Tanzania is the practice of child marriage. In Tanzania, marriage is regulated by the Marriage Act No.5 of 1971. The law stipulates the minimum age of marriage in Tanzania to be 18 years. However, the same law permits 15 years-old girl to be married subject to her parent's consent. This loophole in the marriage law has encouraged early marriages of young girls in Tanzania. According to Tanzania Demographic and Health Survey (TDHS, 2010) among Tanzanian youth, 18% of young women age 15-19 are already married, compared to only 4% of young men age 15-19. A study by Materu (2007) reveals high rates of child marriages between the ages of 11 and 15 in Zanzibar, Coast and Morogoro regions¹⁵. Early marriage increases the spread of HIV among youth and particularly young women in a number of ways. One is that, the knowledge about HIV and AIDS among married child is very little, they know less about HIV. Also, because of their tender age coupled with little knowledge about the disease, young women are less able to negotiate condom use, and are much more unlikely to use any method of protection from HIV¹⁶.

Trans generational Sex

Furthermore, HIV and AIDS among young women and young men have been spreading because of *sugar daddies and sugar mummies*' practices. The sugar daddies and a sugar mummies practice entails a relationship where sex is exchanged for material goods and protection by an older man or woman. While young men and women engage in this kind of relationship for material gain purposes, old men on the other hand are in these relationships out of the belief that young girls are not infected. Related to this is the growing belief that an HIV infected male can "cure" himself by having sex with a virgin girl.

¹⁴Advocates for Youth "Youth and the Global HIV/AIDS Pandemic"
<http://www.advocatesforyouth.org/publications/427> (27/6/2013)

¹⁵ Zanzibar and Coast region are predominantly Muslim. Islamic law of marriage which is a part of the country's Marriage law allow marriage of young girls and boys who have reached puberty as they are regarded as adults.

¹⁶Advocates for Youth "Youth and the Global HIV/AIDS Pandemic"
<http://www.advocatesforyouth.org/publications/427> (27/6/2013)

3.2: The Economic Impact of HIV and AIDS in Tanzania

This section discusses the impact HIV and AIDS has had in the Tanzania's economy. The discussion is divided into the following sub-headings; (i) impact on household level (ii) Impact on GDP growth (iii.) Impact on labor force (iv) impact on firms/organizations and lastly (v) impact on service delivery.

3.2.1: Impact on the Household Level

The impact of HIV and AIDS at the household level is twofold. One is the impact on time utilization to care for the sick rather than in production activities and, two is the financial cost. HIV and AIDS have affected the time allocation of infected and affected households. Time has got to be allocated for the care and treatment of those whom the pandemic has affected. Numbers of studies have been done on the households' impacts of HIV & AIDS. A study by Tibaijuka (1997) which was conducted in Kagabiro village in Kagera region found out that on average 29% of household labour was spent on AIDS related matters such as nursing for sick patients and attending funeral activities. In cases where at least two individuals were involved in caring for the sick, the average total loss was at 43%. Another study on the household impact of HIV and AIDS was done by ESRF in 2003. Using data from six districts (Kinondoni, Mbeya rural, Mbeya urban, Simanjiro, Dodoma urban and Kahama) the study found out that 67% of PLHAs are forced to reduce time for production activities because they either need to seek treatment or because they were too sick to work. The study indicates that PLHAs lost between 1 to 183 working days with an average of 43 days within six months period attending their own illness (ESRF, 2003). There is also the question of attending funerals. In Tanzania, it is noted that in some communities an adult death is mourned for up to a week while a child's death is mourned up to three days. During this time no one does and production work. Therefore a lot of would be productive labour time of affected communities is spend caring for the infected victims and attending their funeral instead of economic activities. This, in many ways might have contributed to increasing poverty in places where HIV and AIDS has raging impact.

Another impact of HIV and AIDS at the household level is the financial cost and loss of family assets. Caring for sick AIDS patient has proven to be way too expensive than most of average families could afford. A study by Tibaijuka (1997) shows that household with an AIDS patient uses almost all of its income to cater for the patient medical expenses. The study also indicates that more often families are forced to sell of their properties or borrow

money to cope with the increased expenses of medical treatment. Households with an AIDS death spend an average 50% more for the funeral than for the medical bills. Another study which indicates how AIDS accelerates consumption of household income is one by Rugalema (1998). This study which was conducted in Kagera region found that catering for medical expenses has stripped off families' income mainly in the process of seeking treatment to the sick member of the family. Consequently households with AIDS victim have are forced to dispose of productive assets to generate funds. HIV and AIDS continues to drain families' income even when the AIDS patient dies. The study by ESRF (2003) found out that funeral costs were often higher than the medical treatment expenses. The study reports an average cost of Tsh. 158,000 per funeral at a household with a range of Tsh. 2,000 to Tsh. 2 million. Individual household members' contribution to this cost ranged from Tsh. 100,000 to TZS 300,000 with a mean contribution of about Tsh. 11,797. And HIV and AIDS continues to stretch household budgets because of the loss of labour and associated family income. To some households the lowered income due to the loss of household labour is not a short-lived phenomenon; it can last be years before the family gets back into its feet again. And, some households fail to return to previous income levels and may be forces to separate to survive.

3.2.2: Impact on GPD growth

Tanzania is one of the poorest countries in the world. In 2011, the United Nation Human Development report ranked Tanzania the 36th country with the lowest human development. Studies have projected that with HIV and AIDS situation the GDP growth of Tanzania will be reversed. A study by Cuddington (1993) had projected that Tanzania GPD to be lower by 15- 20% by 2010 than would have been without HIV and AIDS. The study also projected the country's per capita GDP to be up to 10% lower due to HIV pandemic. Using data from six districts across five Tanzania mainland regions, a study by ESRF (2003) presented a similar projection of a reversed GDP growth but a little optimistic compared by Cuddington estimations. ESRF study projected that by 2015, the Tanzania economy will be 8.3% smaller and per capita GDP to be around 4% lower as a result of HIV and AIDS. According to this study, the main effect on the economy will be due to increasing AIDS related illness which would in turn increase expenditure in health care services, reduce human capital, reduce savings and the reliability of labour. A more recent projection of the impact HIV and AIDS in Tanzania is presented in the study by Hazeen (2010). The study estimated the losses on Tanzania's economy due to HIV and AIDS by comparing GDP performances in two scenarios - with ART and without ART. The study found productivity losses to be \$170 and \$

72 without and with ART respectively. Economic losses due to premature death were found to be higher and equal in both with and without ART scenario at \$ 202. Furthermore, the total losses without ART was found to be \$ 372 and with ART at \$ 274. The study concluded that HIV impact on the economy will be between 1.4% and 1.9% of the GDP largely due to increased premature deaths.

Indeed, the government of Tanzania has directed significant amount of resources including human resource and capital towards promotion of HIV prevention mechanism as well as treatment of opportunistic infection affecting PLHAs. For instance, the government of Tanzania in 2002/2003 allocated 7.2 billion for HIV and AIDS activities for the fiscal year. Government expenditure on HIV & AIDS from 2003/04 to 2007/08 grew remarkably. A study by REPOA (2010) indicates that budgeted expenditure on HIV & AIDS had reached Tsh. 568bn in 2007/8 and that a total of Tsh. 568.2 was expected to be used in financing HIV and AIDS activities in 2008/2009. Currently Tanzania spends 3% of its GDP in HIV and AIDS related activities¹⁷ (ibid, 27). However, with increasing incidences of new infection and increased number of HIV infected person in need of Antiretroviral Therapy the cost of the disease to the nation may significantly increase. For example, the National multi-sectoral framework (NMSF 2008/2012) five year projections from 2009/2010 to 2013/2014 indicated that more resources will be directed to care and treatment of HIV and AIDS which will constitute about 60% -72% of the total resources going to HIV activities (NMSF, 2008/2012).

3.2.3: Impact on the Labour Force

HIV and AIDS has been reported to disproportionately affect individuals in the age group between 15- 49 years. Individuals falling into this age group are the country's most productive population. Studies have indicated that HIV and AIDS will have a significant impact on Tanzania's labour force in terms of reducing the size of the working age population, age and gender composition of the working population as well as skills and experiences. World Bank (1997) had predicted that HIV and AIDS would affect the Tanzania labour force's age composition by leaving the country with less experienced, less educated and a less trained young labour force. It had predicted that the Tanzania labor force will be younger, average of 29 instead of 31 by 2010 due to HIV and AIDS. A study by ILO (2004) conforms to these World Bank projections that AIDS will have age specific impact on the

¹⁷This level is reported to be relatively higher compared to other countries in Africa such as Uganda which spend 1.5% of its GDP in 2006/2007 and Botswana which spend 2% of GDP. See REPOA pp.28

labor force. ILO projections indicates that Tanzania will lose about 6% of labor force in 15 - 24 age group, 5% in the 25 -34 age group, 14% in the 35 – 44 age group and 20% in the 45 – 54 age group by 2020. Table 7 illustrates more

Table 6: Percentage losses in labor force due to HIV and AIDS 2005 -2020

Age group	2005	2010	2015	2020
15-24	0.5	1	3.6	5.6
25-34	6.4	6.6	5.2	5.2
35-44	10.9	14.3	14.9	13.5
45-54	9.2	14.3	18.2	19.9

Source: ILO (2004:5)

As illustrated in Table 6 above, Tanzania is projected to lose a significant percentage of its labour force by 2020 largely between ages of 35 years to 54 years. This implies that by 2020 the country will be left with very young labor force that is likely to be less experienced.

Furthermore, ESRF (2003) study findings had also indicated that the size of the labor will be significantly reduced than would otherwise have been without HIV and AIDS. According to this study the Tanzania labour force will be 9% smaller by 2015 than it would have been without AIDS scenario. The ESRF (2003) projections are close to the projections made by ILO (2004) on the Tanzania's labour force. ILO had predicted that Tanzania labour would grow steadily from 14,635,000 in 2000 to 21,922,000 in 2015. However, with the increased mortality rates due to AIDS, Tanzania will have a reduced working population than would be the case in the absence of AIDS cases. It projected that by 2015 Tanzania will experience an 8% loss of its active labour force. Both ESRF (2003) and ILO (2004) projections indicates that gender composition of Tanzania's labour force will also be significantly affected as the epidemic preys more on the female workers than male. ILO for example projected that Tanzania will lose about 1,145,000 female workers due to AIDS compared to 1,098,000 male workers by 2020.

3.2.4: Impact on firms/organizations

Firms and business are reported to have been affected by HIV and AIDS as HIV infected people are usually in the prime working years. The impact of HIV and AIDS on firms and organizations include reduced labour supply and productivity as well as increased cost of doing business as result of increased medical and burial costs.

3.2.4.1: Reduced labour supply and productivity

The fact that the majority of people living with and dying of AIDS are in their productive years (15-49 years) signifies the possible impact the epidemic has on the labour supply both within and outside households. Study by Tibaijuka (1997) in Kabagiro village in Kagera region shows that labour supply was severely affected in households that contained an AIDS patient. The findings of the study indicated that on average, 29% of household labour was spent on AIDS-related matters, including care of the patient and funeral duties. If two people were devoted to nursing duties, as occurred in 66% of the cases, the average total labour loss was 43%. Within organisations, the impact of HIV and AIDS on labour productivity is expressed by three indicators which are; the rate of absenteeism, total years of experience lost, and paid sick leave time. AIDS has resulted in increased rate of absenteeism (and hence a loss of labor time), and a loss of skills and experiences. A study by ESRF (2003) indicated that each person living with HIV and AIDS who was interviewed in the study had lost between 1 to 183 working days with an average of 43 days in the past six months prior to the survey attending their illness. The study further indicates that about 26% of the sick employees in the surveyed health facilities were granted a paid sick leave in the survey period. The average duration of sick leave was 3.6 months with a range of 1-9 months. Another study indicating the impact of HIV and AIDS on Tanzania's organisations and firms is one by ILO in 2004. This study examined the economic impact of HIV/AIDS by studying seven organizations in Tanzania. The study found out that organizations were losing employees at the rate of 0.5-1.5% per year due to AIDS-related deaths. The study further indicated that the age at death for the employees was very young ranging between 31 and 39 years old. If the retirement age is assumed to be 55 years, then years of lost productivity per worker per AIDS death ranges between 16.3 to 24 years (ILO, 2004).

Studies from other countries in Africa bring similar findings on the impact of HIV and AIDS on labour supply and productivity. A study on a tea estate in Kenya provides some evidence on the impact of HIV and AIDS in labour productivity. Company records showed lower output in kilogram of tea leaves plucked and higher use of leave time by the HIV infected workers compared to non-infected workers. Productivity continued to decline as the employee progressed into higher stages of the disease. In the last year of life, workers who died of AIDS produced 38% less tea and took nearly twice as much leave time compared to others (Fox et.al, 2003). Another study of a sugar estate in Swaziland illustrates how HIV results into declined productivity as a result of illnesses and subsequent deaths. The study

indicates that 25% of the estate workforce was living with HIV and AIDS and would die within the next 10 years (Morris et.al, 2000).

3.2.4.2: Increased cost of doing business

The United Nations for Commission on HIV/AIDS and Governance in Africa (CHGA) indicates that HIV and AIDS has significantly increased cost of doing business particularly across the private sector. Reports show that private sector firms are facing such difficulties absolving the costs of lowered productivity due to employee absenteeism, medical insurance and death benefits. Analyses of the report on the mining firms in southern Africa show that HIV/AIDS costs account for 2.5% of company payrolls, a share likely to grow (CHGA, 2008).

Several studies in Tanzania have indicated that indeed HIV and AIDS has increased cost of doing business to most firms and organisations as a result of increased medical and burial costs due to HIV and AIDS pandemic. Finding from surveyed workplaces by the ESRF (2003) study show that 21% of the surveyed companies provide specific medical support to employees living with HIV and AIDS. On average, about Tsh. 11.76 million per company were spent on such services in year 2002 with a minimum of Tsh. 80,250 and maximum of Tsh. 65 millions. The study further indicates that 86% of the surveyed companies provided funeral support for deceased. On average, Tsh. 1.8 million was provided in year 2002 with a range of Tsh. 60,000 to Tsh. 4.6 million. It was further revealed that companies surveyed had supported a total of 12 families of the deceased in year 2002 and they spent an average of Tsh. 7.22 million with a range of Tsh. 100,000 to Tsh. 14 millions. Moreover, 10% of the surveyed companies had employees who retired prematurely due to HIV and AIDS related problems and this was associated with payment of premature retirement benefits. The total benefits paid ranged from Tsh. 1.3 million to Tsh. 16.5 million with an average of TZS 10.3 millions in year 2002.

A study by ILO (2004) offers more evidence on the impact of HIV and AIDS in firms and organisations resources in Tanzania. The findings of the study indicated that some companies have experienced increased cost in their business operations as a result of epidemic. For example, the study shows that medical costs for the Tanzania-Zambia Railway Authority workers associated with AIDS related diseases increased by 64% over a one-year time span. The study also found that at the University of Dar es Salaam, funeral costs increased from

Tsh.1,323 in 1988/89 to Tshs5.8 million in 1992/93, implying that costs in 1988/89 were only 2% of what the costs were in 1992/93. The study assumes that at least 50% of the deaths were due to AIDS. Furthermore a survey of six business firms in Tanzania found that the annual average medical and burial cost per employee increased 3.5 times and 5.1 times respectively between 1993 and 1997 because of AIDS (Clancy 1998, cited in ILO, 2004)

3.3: Impact of HIV and AIDS on Service Delivery in Tanzania

Certainly, HIV and AIDS has affected the delivery of social services to the community. The delivery of social services is affected as a result of loss of human resources due deaths, reduced productivity due to illness and absenteeism and depletion of resources due to increased HIV and AIDS related expenses. The losses in human resources particularly in public service has in turn affected the institutional knowledge and continuity and hence weakening its capacity to deliver (Moran, 2004). The losses of experienced staff affect service provision both in terms of coverage by reducing the number of staff and in terms of quality of service following the loss of skills and experience (ibid). A conclusion of the study report by UNDP and Malawi Institute of Management (2002) on the impact of HIV/AIDS on Human Resources in the Public Sector in Malawi had this to say of the impact of the epidemic on public service

“The loss of experienced staff impacts negatively both on the coverage of service provision, through a reduction in the total number of staff, and on the quality of services, caused by the loss of skills and experience. Whereas the first (shortfall in the number of people) may be relatively easy to deal with, the second (loss of experience) amounts to a substantial organizational loss. Depending on which staff categories are most affected, certain organizational functions and capacities will be eroded, which will inevitably impact negatively on the core business of the organization”.

This section reviews the impact of HIV and AIDS on service delivery in Tanzania focusing on two sectors; education and health sectors.

3.3.1 Education Sector

One of the sectors badly affected by HIV and AIDS in Africa and Tanzania in particular is the education sector. Teachers dying of AIDS related illnesses constitute a considerable proportion of the total number of teachers dying each year. Three factors are put forward to explain teachers' vulnerability to HIV infections compared to other groups in general. First,

is their great mobility. That usually teachers are posted far from homes and because of the accommodation problem they tend to leave their partners behind. Second, is that teachers have relatively higher disposable income and therefore can easily get involved in some risky behaviours such as alcoholism. Third, the fact that teaching is a disproportionately female occupation is said to put teachers more at risk as given that prevalence rates are usually higher amongst adult female (REPOA, 2010).

World Bank (2002) projected the losses of teachers due to AIDS between 2000 and 2010 in Zimbabwe, Zambia, Kenya and Uganda annually to be at 2.1 %, 1.7%, 1.4% and 0.5% respectively. Another study by Bennell et.al (2002) on the impact of the HIV/AIDS epidemic on the education sector in Sub-Saharan Africa projected that 200,000 teachers, 9.4 % of the total employed in 1999 could die of AIDS related illnesses by 2009. According to this report, five countries i.e. Kenya, Nigeria, South Africa, Uganda and Zimbabwe would constitute about two thirds of these deaths among teachers. In addition to that, the education sector is also facing the problem of increased teacher attrition and absenteeism due to HIV and AIDS related illnesses. The Report of the Commission of HIV/AIDS and Governance in Africa (CHGA) shows that in some of the badly affected countries in Africa, such as Zambia, AIDS has nearly doubled the attrition rate of teachers (CHGA, 2008). Table 7 illustrates how HIV and AIDS affect education systems in selected countries of Africa.

Table 7: HIV/AIDS and Education Systems in some selected African Countries

	HIV rate among teachers (%)	Increase in teachers' attrition due to HIV/AIDS (%)	No. of children orphaned by AIDS	Orphans as a share of all children (%)
Eritrea	3.3	11.1	39,000	10
Ethiopia	8.6	28.7	720,000	11
Kenya	17.5	51.1	650,000	11
Mozambique	14.8	48.1	470,000	15
Nigeria	6.8	12.1	1,800,000	10
Tanzania	8.5	27.7	980,000	14
Zambia	22.8	93.1	630,000	19

Source: The Report of the Commission of HIV/AIDS and Governance in Africa, 2008

As illustrated in Table 7 above, the number of teachers infected with HIV is significantly high particularly if the numbers are considered cumulatively. The increasing attrition due to AIDS death places extra burden to the already poor economies of Africa to train more

teachers to replace the lost human resources. The need is great given the fact that most of the teachers lost through AIDS are relatively young. A report by Commission of HIV/AIDS and Governance in Africa (CHGA) indicates higher HIV prevalence rate at 22% among teachers in Kwa Zulu Natal province in South Africa largely affecting those who are below 49 years of age. According to the report, in 1998, 90% of all teachers who died were 49 years or younger. This percentage was reported to increase to 93% in 1999 and 2000, before declining slightly to 92% in 2003. It is undeniably that, increased illnesses and deaths due to HIV and AIDS will require more teacher training. For example a country like Zambia where AIDS has doubled teachers' attrition, an increase in educational investment to compensate for the loss due to the impact of AIDS is urgent. It should however be noted that, the loss of human capital is not something that can always be replaced through formal training. The loss of experienced personnel cannot be easily replaced. However, the impact of HIV and AIDS on provision of education service can be demonstrated in terms of two indicators; the demand for education services and the supply of the education service.

3.3.1.1: The impact of the demand side

The HIV and AIDS impact on demand side is expressed in two ways. The first is in terms of the decrease in the number of school age population (falling enrolments) and the second in terms of the ability of affected students to stay in school. Coombe (undated) theorises how HIV and AIDS reduces the size of school age population. She argues

“Where prevalence is high, rising deaths among adults of reproductive age and declining fertility rates result in fewer children being born. Combined with increased mortality among children infected around the time of birth, most of whom die before they are five years old; this means there are fewer potential learners than there would have been without HIV”.

Indeed, HIV and AIDS has decreased the number of men and women of child bearing age as the disease is mostly transmitted by heterosexual contact between an infected and non-infected person. In most of African countries and Tanzania in particular HIV and AIDS has particularly affected individuals between 20 – 49 years of age. Meaning that if people in their reproductive years are the ones who are dying with AIDS, fewer children are likely to be born. World Bank (2000) has estimated that by 2010 the number of primary school age children will be reduced by 24% in Zimbabwe and 20% in Malawi and Zambia, 14% in Kenya and 12% in Uganda. In addition to that, HIV and AIDS increase child deaths due to mother to child transmission. In Tanzania for example it is reported that, more than 40% of

antenatal women do not have access to PMTCT services (URT, 2009a; UNAIDS, 2012). With more than 1.5million birth annually and HIV prevalence rate among antenatal women of 8.2%, it is estimated that about 123,000 HIV positive women deliver HIV exposed infants annually (URT, 2009a). Most of these HIV exposed infants don't live to see their 5th birthday.

In Tanzania there is a limited data available on the infection rates for the school aged population. Nevertheless, the available data indicates that there is significant impact of HIV and AIDS on school enrolment. A study by Gachuhi (1999) in Tanzania projected that HIV and AIDS would reduce the number of primary school children by 22% and secondary school children by 14% as a result of increased infant and child mortality as well as lower attendance. Another study by Gould and Huber (2003) used data from Tanzania to predict the likely numbers of primary school-age children in the next decade. Gould and Huber studied 470 children at 12 schools in two regions of Iringa and Dodoma. The aim of the study was to discover factors that influenced children's attendance. The finding of this study was that, better school attendance was linked to higher parental income and education levels and that HIV has not greatly affected this pattern. The study also found out that the growth in the school-aged population from 2002 to 2010 was marginally less than 1%. From these findings, the study estimated that in Tanzania, the school-aged cohorts would be smaller by 1 -25% by 2010 than they would have been without the epidemic.

Apart from reducing the size of learners' population, HIV and AIDS has reduced the opportunity for the children to attend schooling by increasing repetition rates and drop outs. This happens for number of reasons. One is that children who are coming from a household with an HIV positive member do not enrol to school or would drop out from school so as to nurse a sick parent or sibling. Secondly, is the inability of the household to meet school expenses of the child. The loss of income of an adult family member who is unable to work because of HIV-related illnesses may make the schooling expenses very high for the family to afford. More often, the child may be forced to quit schooling to engage in income generating activities. For example, in a study by Harris and Schubert (2000) a third of the children reported to have missed school in order to nurse the sick. The study further reported that, the percentage of children who missed school to care for sick doubled for the children with both parents dead. Children who had lost both parents were twice likely to drop out from

school (17.1%) compared to children with one parent alive (9.5%) or with both parents living (9.5%). Furthermore, repetition rates for children who had lost both parents were 5-25% than children with both parents alive.

HIV and AIDS have interfered with the children's ability to learn in school. Studies have indicated that children from AIDS affected household are under emotional strain. These children are most likely to suffer from social exclusion as the disease is highly stigmatised (Helland et.al, 1999). On top of that, the children would constantly worry about their sick parents or sibling or the family financial status. These are not ideal learning conditions. Cahen (2000) reports cases from some hit places where children morale to schooling has decline as a result of the epidemic. He reports that in Kagera region of Tanzania, children's ability to learn has been affected. He attributed children's low motivation for schooling to experiences they have gone through in their families where they have witnessed sickness and deaths of parents and siblings. Considering the fact that the HIV prevalence in Tanzania is still at the epidemic level and there are regions where prevalence rates are very high, a significant number of school children will come from AIDS affected families who would unfortunately suffer the same fate. The impact of HIV and AIDS on education is not limited to just primary and secondary levels but also extents to tertiary level. A study by Victor (2005) demonstrates that institutions of higher education across Africa face a major and increasing threat from HIV and AIDS. Kelly (2001) cited in Victor (2005) reports that an average of two members of immediate community of the University of Nairobi die from AIDS each week. Kelly further points out that, every sixth students drop out of the Western Cape each year for financial or personal reasons which are very likely HIV-related. The University of Dar es salaam lost 31 male students and 10 female students in the period between 1988- 1993 (ILO, 2004).

3.3.1.2: Impact on the Supply side - Quality of education

The quality of education is threatened by teachers' morbidity and mortality. In Tanzania, the number of teachers dying due to AIDS related illness is high. ILO (2004) report reveals that about 100 primary-school teachers die each month due to HIV/AIDS-related diseases. A study by ESRF (2003) shows that AIDS related deaths as percentage of the total number of teachers reported to have died within a year to be significantly large. The findings of the study indicate that perceived proportions by the district officials and teachers from the studied schools for 2001 ranged from 40% to 70%. Perceived district level number of

teachers who died from AIDS related causes in each district shows that, on average 14 and 8 teachers died in 2001 and 2002 respectively per district. In one region of Mbeya it was reported that on average 18 teachers die of AIDS related diseases annually¹⁸. What is more disturbing is the fact that most of teacher who lost their lives to HIV and AIDS are relatively young and in their professional prime. According to ILO (2004), Tanzania had lost 1,045 teachers in 2000-2002. Majority of them (602 teachers) were between 41-50 years of age and obviously in their professional prime. It takes an average of 25 years to replace a lost skill (ibid).

The World Bank (1992) had estimated that, in Tanzania AIDS will cause deaths of almost 15,000 teachers by 2010 and 27,000 by 2020. Basing on the World Bank predictions, a report by Olouch (2006) gives a more elaborated picture. The report estimated that about 20% of teachers in Tanzania are secondary school teachers and teachers training colleges. If 27,000 teachers will die by 2020 that would mean the loss of over 5,400 secondary school teachers and teacher training college tutors. It is undeniable that teachers' attrition mostly by death would have impact of the quality of education offered. The loss of many teachers would increase pupil-teacher ratio to undesirable levels. According to REPOA (2010) though the desired Pupil Teacher Ratio (PTR) at primary school is 1:45; it currently stands at 1:54. Furthermore, while the desired student-teacher ratio in secondary school is 1:35 it currently stands at 1:43. Currently, the shortfall of teachers has been reported to be 30,405 and 7,943 for primary and secondary schools respectively. Although these shortfalls may not be directly caused by HIV and AIDS, the fact AIDS would continue to prey on the available few teachers would have grave consequences on the country's education service.

Furthermore the quality of education is also jeopardized by the increased expenses associated with education provision particularly in a country with a weak economy like Tanzania. A study by Pennap et.al. (2011) estimated that Tanzania will need to train about 45,000 new teachers by 2016 to make up for those that have died or resigned because of HIV and AIDS. UNESCO (2009) on the other hand estimated that Tanzania will need 239,000 additional teachers by 2015. The approximate cost of training replacement teachers by 2006 was made US \$ 37.8million (Helland et.al, 1999). It is obvious that the estimated cost is likely to increase. Nevertheless, there are number of issues here. One is that training for replacement is

¹⁸Afrol News "AIDS killed 193 Tanzanian teachers" <http://www.afrol.com/articles/24888> (19/7/2013)

costly considering the country's weak economy. Two, the training process itself takes years before a trained teacher can be ready to take-up the teaching responsibility. In the intervening years there is educational needs of the student during this period. Furthermore, while the lost personnel can be replaced, the lost experience is not something which can simply be replaced. ILO (2004) estimated that it takes up to 25 years to replace a professional teacher.

3.3.2: Health Sector

The health sector is found to be facing multiple effects. HIV and AIDS is reported to overburdened the health sector by increasing number of patients in need of treatment which in turn increases health expenditures for both medical care and social support at the same time claiming the lives health workers. This section provides a discussion of the impact of HIV and AIDS on the delivery of health services. The discussion is provided under two subheadings (i.) increased number of patients and cost in the delivery of health services and (ii.) loss of health workers.

3.3.2.1 Increased number of patients and cost in the delivery of health services

As the rate of HIV infection cases grows, so does the burden it places on the health system. A study by Mubyazi et.al (2012) which covered 36 health facilities in nine regions of Tanzania mainland shows that in all nine regional hospitals visited, there had been an increase in the diagnosis and admissions of the suspected HIV/AIDS infected patients. The study reports that the proportion of HIV/AIDS related admissions at all the nine regional hospitals increased from 4.4% in 1996 to 6.8% in 1998 up to 7.2% in 2000. The average lengths of stay by HIV/AIDS patients in the studied hospital and health care centres were reported to be between 18 and 25 days. While the average length of stay (bed occupancy period) for non-HIV/AIDS patients was 5 days. This means the bed occupancy period of HIV patient was higher therefore burdening the healthy facilities given the need for beds by other non- HIV patients. For example, the Tanzania National Website reports that that in some areas where HIV prevalence has been high, more than 50% of medical wards are occupied by patients suffering from HIV and AIDS related illnesses¹⁹.

Related to an increased number of patients in hospitals and other health facilities is an increased cost. A study by Mubyazi et.al (2012) shows that in all nine regional hospitals visited cost of screening for HIV among the blood donors increased within 10 years period between 1990 and 2000. The study findings indicated that for all regions, the average cost of

¹⁹Tanzania National Website "HIV and AIDS" <http://www.tanzania.go.tz/hiv-aids.html>(20/7/2013)

screening one person to be US\$ 2.8 in 2000 while the overall hospital cost increased almost two-fold from US\$ 2,222.22 in 1990 to US\$ 4,222.22 in 2000. However, more costs are reported in the treatment of HIV. An early study by World Bank in Tanzania shows that in 1993, the annual average cost incurred per adult AIDS patient over the duration of the patient's illness was approximately 50,000 Tanzania shillings. The cost of treating a child with AIDS was Tsh. 34,000 annually (World Bank, 1993). The Tanzania National Website estimates the life time treatment cost for HIV and AIDS to be US \$ 290 for an adult and US \$ 195 for children per paediatric case. The cost of HIV and AIDS treatment vary depending where the patient seeks treatment. Private health facilities are reported to be more expensive. For example, a study by Bollinger and others in 1999 shows that the direct cost of treating an adult with AIDS in Tanzania varied between US \$ 104 and US \$ 631²⁰. The patient incurred lower cost if utilized village or relative health care while higher cost was incurred if patient utilized private health care system (Bollinger et.al, 1999). This amount is overwhelming for a country which spend less than 10% of its total development budget on health care let alone for families which live under US \$ 1 per day.

Furthermore, time utilization in the delivery of health service has been affected. It is reported that health care providers in the health services facilities devote more time with patients suffering from HIV and AIDS, as they work with a lot of caution, compared to the time they take to attend to patients suffering from other diseases (Mallya and Munishi, 2010). In addition to that, more considerable time is spent by health workers in counselling services. The study by Mubyazi (2012) indicated that the average time spend by health workers in the studied hospitals for counselling one client ranged between 30 minutes to 2.25 hours. This in effect negatively impacts on the time available for the provision of the regular services and particularly attending other patients.

3.3.2.2: Loss of Health Workers

The quality of health service is affected by HIV and AIDS by increasing morbidity and mortality of the health workers. The World Bank has estimated that, a country with 5% adult HIV prevalence rate will lose between 0.5% and 1% of its health workers to HIV and AIDS. Indeed AIDS has claimed the lives of many health providers consequently affecting the delivery of health care services both in quality and quantity. A study by ESRF (2003) reports that there was a loss of 31 health care professionals on average of 30-48 years of age in the

²⁰ In a current exchange rate US \$ 1 is equivalent to 1600 TSH.

health care facilities which were visited under the study. A worse picture of how AIDS kills health providers in Tanzania is reported in a study by Muhondwa and Fimbo (2006). This study was commissioned by the Ministry of Health and Social Welfare to assess the impact of HIV and AIDS on the Human resources in the health sector in Tanzania. Its assessment covered 66 health facilities in 8 regions of Tanzania mainland. Some of the findings of this study included the following;

- ✚ 38% of health workers were absent during 2003 and 2004 due to their own sickness or sickness of a relative.
- ✚ 255 health workers died between 2000 and 2004 in 66 health facilities covered by the study.
- ✚ Among those who died, 170 or 67.7% were known or believed to have been HIV/AIDS cases.
- ✚ The large majority of the health workers who died, 158 or 62.2% were women.
- ✚ The age of the health workers who died ranged between 26 and 59 years.
- ✚ The majority of deaths, 70%, were among those who have worked between 10 and 24 years.

A more recent study on the impact of HIV and AIDS in health sector Human resource in Tanzania by Mubyazi and others (2012) provides a more pathetic situation. The study findings indicate that HIV and AIDS accounted for 72% of all health workers deaths in the visited 36 health facilities. The study further reports that 100% of all staff deaths recorded at district hospital of Nyakahanga, Nansio, Same and Arumeru, 74% of similar deaths recorded at Mafinga and Korogwe hospital and 85% of all staff deaths recorded at Mkomaindo during 1998 were HIV and AIDS cases. Certainly, with HIV and AIDS, the delivery of health services is affected. As indicated in the reviewed literature, AIDS has claimed the lives of more experienced personnel (10 to 24 years experiences) whose experiences is not only difficult to replace but also involves huge cost. Secondly, more health workers deaths add to the already available shortages of staff in the country's health sector. Ministry of Health and Social Welfare (2006) indicated that by 2006, the country had required 82,277 health professionals but only 29,063 were available indicating a shortage of 53,214 or 65%. Indeed, more deaths will mean more shortages and less coverage of services.

3.4 AIDS and Political Disorder??

A study by Kessy et. al. (2008) on the impact of HIV/AIDS on the electoral system in Tanzania concluded that the consequences of the epidemic would mainly be economic rather than causing political disorders. The majority of countries in the Southern Africa Development Community (SADC) region will be spending or are already spending a lot more on by-elections as a result of increased deaths at leadership level. Eight (8) of the 14 countries in Southern Africa use the First-Past-The-Post (FPTP) electoral model which requires a re-run of polls when a vacancy occurs. Four countries use the Proportional Representation System (PR) and only one, namely Lesotho uses a combination of the two or the Mixed Member Proportional system (MMP) [Strand et al., 2005]. A pilot study by IDASA in Zambia revealed that the country's number of by-elections has substantially increased in the era of HIV & AIDS (1984-2003) compared to the "AIDS free era" (1964-1984).

When it comes to voters registers as relates to deaths of voters caused by HIV/AIDS, the likelihood of having "dead voters" on the registers is real and may open up the systems to electoral fraud (or provoke perceptions of fraud) through the use of "ghost voters." A particular documented case is the Malawian registration system where verification of births and deaths is done via local chiefs and other prominent members of society. This makes it impossible to ascertain the integrity of the voter's roll with respect to the deceased.

Many Election Management Bodies depend heavily on civil servants especially teachers and nurses to serve as election officers and monitors. The skills, experience and knowledge of election conduct acquired in the relatively brief period of multiparty democracy will be partially lost due to HIV/AIDS deaths.

4.0: PUBLIC POLICY RESPONSE TO HIV/AIDS IN TANZANIA: a review

The Tanzania's national response to HIV and AIDS pandemic comprises the development of strategies aiming at preventing, controlling and mitigating the impact of the HIV/AIDS pandemic through health education, multi-sector responses and community participation. At the national level, this response to HIV and AIDS is guided by the *three ones principle*²¹ of UNAIDS. That is, it includes the implementation of one National Multi sectoral Strategic

²¹Three Ones Principle of the UNAIDS is: One agree **HIV/AIDS Action Framework** that provides basis for coordinating the work of all partners; One **National AIDS Coordinating Authority** with broad based multi-sectoral mandate; and One agreed country-level **Monitoring and Evaluation System**

Framework for HIV and AIDS 2008-2012 (NMSF), one national coordinating body (Tanzania Commission for AIDS) and the single Monitoring and Evaluation system.

4.1: Trends in the Tanzania's Public Policy Response to HIV and AIDS

4.1.1: The Establishment of the National AIDS Control Program

Historically, response to HIV and AIDS in Tanzania has evolved since 1985 with the formation of National Task Force. The Task Force whose members were selected randomly from different organisations played an advisory role to the government (TACAIDS, 2009). This Task force was later on transformed into the National AIDS Control Programme (NACP) in 1988 under the Ministry of Health. In its attempt to confront the growing epidemic, NACP developed three Medium Term Plans for the period between 1987-1991, followed by the second and third medium term plan for the period 1992-1996 and 1998-2002. NACP's initial perception of the HIV/AIDS was that the epidemic was purely a health problem and therefore its campaign involved health sector alone.

During the implementation of the Medium Term Plan I (MTP I), two major decisions were made. One was creating five technical units and one management unit and the other was decentralizing HIV and AIDS activities. The units which were created included those for Information, Education and Communication Unit (IEC), Counselling and Support, Laboratory and Blood Transfusion, Clinical Services, Counselling and Epidemiology and Research and Management. On the other hand, the decision to decentralize HIV and AIDS was affected in a 1987 meeting of Heads of Departments the Ministry of Health and Regional Medical Officers, in which 20 regional AIDS Control Co-ordinators (RACCs) and 103 District AIDS Control Co-ordinators were appointed to ensure an effective implementation of the Medium Term Plan.

An evaluation of the Medium Term Plan I was carried out in 1991. The review team identified constraints and made recommendations for the second Medium Term Plan (MTP II). In its recommendation the review team suggested the main strategies for the Medium Term Plan II to include decentralization, multi sectoral involvement, community mobilization and NGO involvement. The stressing on the multi sectoral approach to combating HIV and AIDS was reached due to the recognition that, the devastation caused by the epidemic is manifested in all aspects of human life and to address it, joint efforts from all sectors is necessary. Therefore, during the implementation of the Medium Term Plan II, other sectors

were involved in the national efforts to control the epidemic. According to the HIV and AIDS National Response report, about 17 public and private organisations were engaged during the implementation of the Medium Term Plan II (1992-1996). The Third Medium Term Plan (MTP III) was implemented in 1998-2002. During the implementation, some important initiatives were executed one being the issuance of the Strategic Frame of Preference for the Prevention and Control of HIV and AIDS and Sexually Transmitted Infections by the Ministry of Health in 1998.

However, despite of their combined efforts, the three Medium Term Plans between 1987 and 2002 could not reverse the trend of the epidemic at the national level (TACAIDS, 2003; TACAIDS, 2009). Surveillance reports indicates that while the first two medium term plans were implemented, there was a two fold increase of HIV prevalence from 7.2% in 1990 to 13.3% in 2000 among female blood donors (URT 2000; URT, 2005). The devastation caused by the HIV/AIDS made the former President Benjamin William Mkapa to declare the HIV/AIDS epidemic as a “National disaster” on 31st December 1999.

4.1.2: The Establishment of Tanzania Commission for AIDS (TACAIDS)

Following the failure of the early day’s efforts to control the epidemic, it was felt that the special department located in the Ministry of Health had insufficient capacity. To provide leadership for the country’s national response to the epidemic, the Tanzania Commission for AIDS (TACAIDS) was established by the government by an Act of Parliament (Tanzania Commission for AIDS Act no 22 of 2001) in 2001. Placed under the Prime Minister’s Office, TACAIDS’s role is intensify the national response through strategic leadership, policy guidance and coordination of the public, voluntary, private and community efforts (TACAIDS, 2009).

4.1.3: The Formulation of the National Policy on HIV and AIDS, 2001

Tanzania adopted its current HIV and AIDS Policy in 2001, about 18 years after the first case of HIV was reported in the country in 1983. The formulation of the national policy on HIV and AIDS was somewhat a delayed and government dominated process. Historically, the development of the National HIV and AIDS policy evolved after the 1991 review of National AIDS Control Program (NACP) which, among other things, recommended for an adoption of a national policy that would provide guidelines for all stakeholders, both public and private for dealing with HIV and AIDS pandemic. The review identified four major policy issues

around that time. They include; care for people with AIDS, pre and post-test HIV counselling, AIDS orphans and AIDS education in schools (Garbus, 2004; Mutembei, 2008). During 1992 -1996, NACP implemented the second medium term plan which reiterated the need for a national policy on HIV and AIDS. The second medium term plan added several other key policy issues which needed to be addressed including support for family members of the people who have died from AIDS, loss of productivity, protection of the legal rights of AIDS patients and PLHAs and condom promotion. With absence of specific policy or legislation addressing HIV and AIDS in the country, it was difficult for NACP to address these issues. The need for national policy on HIV and AIDS became evident. The government mandated NACP to develop a national policy.

In the execution of this mandate, NACP commissioned some experts to write expertise papers on 11 key components. The commissioned experts presented the papers at a 7 days national policy formulation workshop in 1995 from which the draft of the policy was made. However, the participation of the “public” in the policy formulation was very constrained. In the policy formulation process, most opportunities for participation came during the pre-drafting and drafting stage. For the case of Tanzania, the drafting of the policy proposal was a commissioned worked of some experts with terms of references. Furthermore, the quality of participation process also depends on the diversities represented by those involved in the formulation process. This however, was also not the case in Tanzania. Although the commissioned experts presented their papers in a 7 days policy formulation workshop which included 28 people, most of whom were government officials and only two represented NGOs (Stover and Johnson, 1999). Stover and Johnson further reports that although NACP made efforts to solicit input from other sectors of society, including PLHA and commercial sex workers, but received few responses.

Nevertheless, NACP came up with the first draft of the National Policy on HIV/AIDS/STIs in 1995. Yet, until mid-1999, draft of the national policy on HIV/AIDS was not approved. Two factors are said to have contributed to the lack of momentum for approval. One is the lack of widespread participation in the development of the policy itself and two, is the period in which the policy was developed. The draft was prepared in the period when the country was at the peak of the transition from single party democracy to a multiparty democracy. During this period, government efforts were directed at ensuring a smooth sail through to multipartism and little attention was dedicated to advancing the AIDS policy through the

approval channels (Stover and Johnson, 1999; Garbus, 2004). Consequently, NACP stayed with the draft proposal for 5 years from 1995 to 2001 when the second draft of the National Policy on HIV/AIDS was finally launched in November 2001, by President Benjamin William Mkapa.

In terms of its content, The National Policy on HIV and AIDS, 2001 comprises of ten chapters. They include; background, HIV/AIDS situation, overall goals of the policy, rights of Persons living with HIV and AIDS, prevention of HIV sexual transmission, HIV testing, care for people living with HIV and AIDS, Research, Sectoral roles and Financing and Institutional and Organisation Structure of the TACAIDS. The overall objective of the National policy on HIV and AIDS “is to provide for a framework for leadership and coordination of the national multi-sectoral response to the HIV and AIDS epidemic. This includes formulation, by all sectors, of appropriate interventions that will be effective in preventing transmission of HIV and other sexually transmitted infections, protecting and supporting vulnerable groups, mitigating the social and economic impact of HIV and AIDS. It also provides for the framework for strengthening the capacity of institutions, communities and individuals in all sectors to arrest the spread of the epidemic” (National Policy on HIV/AIDS, 2001). The specific objectives of the National policy are;

- a. Preventing the transmission of HIV/AIDS
- b. Promoting early diagnosis of HIV infection through voluntary testing with pre-and-post-test counselling.
- c. Providing counselling and social support services for PLHAs and their families.
- d. Sectoral Roles and Financing through strengthening the role of all the sectors, public, private, NGOs, faith groups, PLHAs, CBOs and other specific groups to ensure that they are actively involved in HIV/AIDS work and to provide a framework for coordination and collaboration.
- e. Participating in HIV/AIDS research, nationally and internationally.
- f. Creating a legal framework by enacting a law on HIV/AIDS
- g. Monitoring the efforts towards community mobilization for living positively with HIV/AIDS in order to cope with the impact of the epidemic while safeguarding the rights of those infected or affected directly by HIV/AIDS in the community.
- h. Safeguarding the rights of people living with HIV and AIDS so as to improve the quality of their lives and minimize stigma.

- i. Providing appropriate treatment for opportunistic infections at all levels of health care system.
- j. Fighting against drugs and substance abuse that increases the risk of HIV transmission.
- k. Prohibiting misleading advertisements of drugs and other products for HIV and AIDS prevention, treatment and care.

4.1.4: Formulation of National Multi- sectoral Strategic Frameworks (NMSF I 2003-2007 and NMSF II 2008-2012)

In order to translate the policy into action, the government through TACAIDS launched the National Multi-Sectoral Strategic Framework (NMSF) 2003-2007. The Framework translated the National HIV/AIDS policy by providing strategic guidance to the planning of programmes, projects and interventions by various stakeholders in the fight against HIV/AIDS. It delineated the basic approaches and principles that guide the National Response to HIV/AIDS as well as identifying goals, objectives and strategies. It also outlined a Monitoring and Evaluation system of the National Response (TACAIDS, 2003). The NMSF I had nine specific goals; i) to reduce the spread of HIV by 30% by 2007, ii) to reduce HIV transmission to infants by 20% by 2007, iii) to ensure that political and government leaders consistently give high visibility to HIV/AIDS in their proceedings and public appearance, iv) to ensure that public and private projects and interventions address stigma and discrimination , v) to ensure that HIV/AIDS concerns are fully integrated in the country's Poverty Reduction Strategy , vi) reduce the prevalence of Sexually Transmitted Diseases (STIs) by 80% by 2007, vii) increase access to care and support from home and community for people living with HIV/AIDS and viii) to reduce the adverse effect of HIV/AIDS on orphans. According to TACAIDS (2003) these NMSF nine goals conform to the international commitment by the government of Tanzania as incorporated in the Millennium Development Goals (2000) and the Declaration of Commitment of the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) of June 2001. Nevertheless, the National Multi Sectoral Framework was criticized for overlooking gender issues which are central to the transmission of the pandemic (Materu, 2007).

In 2008-2012 TACAIDS implemented the second National Multi sectoral Strategic Framework for HIV/AIDS (NMSF II). This Framework was built upon the 2003-2007 Framework. Like its predecessor, the NMSF II also had nine objectives. These objectives

basically focused on creating an enabling environment for national response to HIV/AIDS, prevention, care and treatment for people living with HIV/AIDS and those affected by the epidemic including orphans and other vulnerable groups (TACAIDS, 2008b). The NMSF II also focused in mitigating HIV infection among the risky population group. These include women engaging in commercial and transactional sex, sexually abused children, widows, divorcees, prisoners, refugees, displaced people, people with disabilities and intravenous drug users.

The National Multi-sectoral Frameworks 2008-2012 divides HIV and AIDS policy interventions in Tanzania under the following four thematic areas. These are

A: Cross cutting issues

- ✚ Advocacy
- ✚ Fighting stigma, denial and discrimination
- ✚ Regional, District and community responses
- ✚ Mainstreaming HIV and AIDS
- ✚ HIV and AIDS and Development/Poverty Reduction Policies

B: Prevention

- ✚ STI control and case management
- ✚ Condom promotion and distribution
- ✚ Voluntary HIV Counseling and Testing
- ✚ Prevention of Mother to Child Transmission (PMTCT)
- ✚ Health promotion for specific groups; -children and youth, women and girls, men and disabled
- ✚ School based prevention for primary and secondary level
- ✚ Health Promotion for vulnerable population groups
- ✚ Work place interventions
- ✚ Safety of blood, blood products and universal precautions health care and non-health care settings

C: HIV and AIDS Care and support

- ✚ Treatment of common opportunistic infections including provision of ARVs
- ✚ Home and community based care and support

D: Social and Economic Impact Mitigation

- ✚ Economic and social support for persons, families and communities
- ✚ Support for orphans

Nevertheless, the focus of the national HIV and AIDS response has been on care, treatment and support than in prevention or any other thematic areas. The Public Expenditure Report on HIV and AIDS TACAIDS reports that, in the period between 2008 and 2010, 59% of HIV and AIDS resources has been used on HIV and AIDS care, treatment and support compared to 23% which was used on HIV and AIDS prevention and 9% on impact mitigation and cross-cutting issues²² (TACAIDS, 2012).

4.2: Care, Support and Treatment for PLHAs

Provision of and access to treatment and care, is crucial to the country's response to HIV/AIDS pandemic. This includes not only the provision of medication to PLHAs, but also social care, including protection from discrimination and stigmatisation. Globally, care, support and treatment of HIV-infected persons is regarded as both a human right and as a crucial measure to slow the spread of the epidemic. Historically, Tanzania began to provide care, support and treatment services for HIV and AIDS patients including the provision of Anti-Retroviral drugs (ARVs) in October 2004 under the coordination of the Ministry of Health and Social Welfare (MoHSW). The main focus of the program is to improve access to Care and treatment at facilities and through Home-Based Care (HBC) for as many PLHIV as possible. In overall, the provision of care, support and treatment service is guided by wide range policy frameworks and strategies including, the National Health Policy 2007, Primary health care services Development Program, Health Sector Strategic Plan III (HSSP-III) and the Health Sector HIV/AIDS Strategic Plan II (HSHSP-II) (2008).

Since the establishment of Care, support and treatment services the numbers of AIDS patients' enrolled as well as health care facilities involved have been increasing. For example, in its first year of the implementation, 96 care and treatment providing facilities were involved. In 2007, the number of facilities providing care and treatment services reached 200. It is reported that, the end of 2010, a total of 1100 health facilities had begun providing care and treatment services. Out of those, 220 are hospitals and 880 are primary health facilities²³. In consonance with the increased treatment and care providers, is the increased number of patients enrolled. According to Ministry of Health and Social Welfare (2013), the number of

²²Even the major financier of HIV and AIDS national response, the US government through PEPFAR, has directed much of its support to care and treatment than prevention of HIV and AIDS. In the period 2008-2010, the US government through PEPFAR allocated the largest share, about 63.5% of its resource on treatment and care followed by prevention 22.6% and the remaining funding was allocated to crosscutting issues.

²³ "Treatment and care" available at <http://www.tacaids.go.tz/hiv-and-aids-information/treatment-and-care.html> (15/8/2013)

patients enrolled into HIV care and treatment rose from 37782 in 2005 to over half a million in 2012. Table 10 illustrates.

Table 8: Cumulative Number of PLHA Enrolled in HIV Care and On ARV 2005- 2012

Year	Enrolled in Care			On ARV		
	Adult	Children	Total	Adult	Children	Total
2005	33878	3904	37782	14806	1393	16199
2006	112576	12563	125139	54356	5985	60341
2007	241469	22231	263700	124522	11007	135529
2008	369956	33422	403378	186509	15672	202181
2009	547607	47044	594651	280875	22789	303664
2010	681795	58245	740040	355359	29457	384816
2011	721561	61514	783075	380377	31731	412108
March2012	919219	77799	997018	521640	43083	564723

Source: Ministry of Health and Social Welfare (2013) *Health Sector HIV Response*; National AIDS Control Program

As demonstrated in table 8 above, the number of patients enrolled and those on ARVs have been increasing year after year. Nevertheless, Tanzania is far from providing universal treatment access to all PLHAs. Issues of equity, accessibility, affordability, comprehensiveness and sustainability of treatment services in the country are questionable. While the number of the enrolled patients seems to be increasing, in the actual sense the increase represents just a small percentage of the people who are in need of HIV treatment services. HIV Country Progress Report asserts that, the number of clients who were enrolled in HIV care in 2010 represented only 31% of the country's estimated PLHAs. Furthermore, while the data indicates an increase in adults in accessing ART, the number is not matched by children accessing ART. The report further indicates that, the number of patients who remain in treatment after twelve months after initiation of ARVs drops significantly in subsequent years, while the number of adults drops between 65% to 70% the number of children drops around 72% to 77% (URT,2012).

With regards to care, the national policy on HIV and AIDS asserts that the main purpose is to "promote appropriate nutritional, social and moral support to PLHAs to enable them to enjoy a good quality of life, remain productive and live much longer with HIV and AIDS". However, government has not been able to create systems which can provide such support and care. In joining hands with the government as well as addressing inadequacies in government response to the HIV/AIDS pandemic community-based organisations (CBOs),

faith based organisations, donors, businesses and employers as well as nongovernment organisations (NGOs) have risen to the challenge. TACAIDS (2012) estimates that in 2011/2012 there were over 6,000 Community Based Organisations and Civil Society Organisations (CSOs) that provide HIV and AIDS services to communities in Tanzania (TACAIDS, 2012). The initiatives by CBOs and NGOs are reported to be a valuable contribution to improving basic health status in poor communities particularly when they are built on the already existing community structures such as churches, women's groups and schools. Mukangara and Koda (1997) observes that most of the HIV and AIDS activities by NGOs are directed at adults specifically commercial sex workers, truck drivers and workers in public sectors. Although, these identified groups are categorized as most at risk and hence needing more attention, still, focusing in them alone means ignoring youth especially those out of school, workers in the informal sectors and the rural based population. Furthermore, the initiatives by the community based organisations are generally inadequate due to lack of resources and high levels of poverty.

Home based care for PLHIV is a major component of care, support service. In Tanzania Home Based Care (HBC) has been implemented since 1996. National HIV policy substantiates the cost for home care will be "reflected in the national and local councils' budgets for health care social welfare services". Yet, local councils have been unable to support local communities and families in providing home based care for HIV patients. A study by Mutembei (2008) for example reveals that the AIDS committees at ward and village levels have not been adequately funded by councils. Consequently, the burden is left to the family members whom, because of the traditional gender-based division of labour fall disproportionately to women. Community based organisations, faith-based organisations and NGOs also provides care within the community. However, the support of these organisations has number of constraints. One is that, they are offering care services on voluntary basis. As such they can easily stop doing so. Two, care service by these HBC providers are unstructured and therefore lack uniformity (Materu, 2007; Mutembei, 2008). It is also reported that traditional healers play a key medical role particularly in rural areas, but they are marginalized or they are suspicious of the intentions of government (Kayombo et. al., 2007) and do not have sufficient knowledge regarding the handling of HIV and AIDS patients (Mutembei, 2008). Some of traditional healers have been claiming to have a cure for HIV/AIDS while WHO says there is no cure to the virus. There are those who have gone further and make sensational advertisements in the media about their ability to cure

HIV/AIDS. It is clear that, while the government has policies on HIV care, support and treatment, it does not have practical measures which can enable this care and treatment giving to take place.

Besides, a contradiction also exist between the HIV and Policy and the HIV and AIDS act with regards to the provision of basic health services and adequate standard of living to PLHAs and orphans. The provisions in the policy states that a PLHAs is entitled to all basic rights, however the Act states that, this can only happen where (and when) government resources allow it (Article 19(1) and 33 (1) of the Act). The Act, by subjecting the rights to basic health service of PLHAs and orphans to “when and where government resources allow it” removes the obligatory mandate on the part of the government in the provisions of such services. The government may use this loophole as an excuse not to provide such services. By the fact that resources are not available in abundance, would be more logical for the Act to impose an obligatory duty for government to prioritize the provision of basic health services to PLHAs and orphans.

5.0: RESPONSE TO HIV AND AIDS FROM OTHER SECTORS

5.1: Civil Society Organisations

It is undisputable that the National Response to HIV cannot be implemented by state actors alone. The success and effectiveness of the response would greatly depend on the full participation of actors both inside and outside the government machinery. The National Multi Sectoral Strategic Framework II 2008- 2012 recognizes the importance of the participation of the Tanzanian societies through different organisations in the national response. Civil society organisations through their umbrella organisations such as, the Tanzania AIDS Forum have been playing vital role in the national response. Civil society organisations have taken up a range of activities involving HIV and AIDS prevention, treatment and care, impact mitigation, advocacy. CSOs have been offering a helping hand to the public hospitals which are overburdened with AIDS patients particularly in highly affected areas. In some areas CSOs have assumed the role of health care providers and in many areas they are offering HIV and AIDS counselling and testing services as well as pioneering home- based care for the sick. CSOs have proved to be more useful in providing HIV services particularly among the “most vulnerable and hard to reach population group” such as sex workers, men who have sex with men (MSM) and injecting drug users (Peersman, Ferguson, Torres et.al, 2009).

CSOs have been in the forefront in promoting respect and protection of the rights of PLHAs by championing drafting and adoption of the HIV/AIDS Act.

However, there are number of challenges. Number of CSOs has tremendously increased. TACAIDS (2012) reports that, by the end of 2011, there were there were over 6,000 Community Based Organisations and Civil Society Organisations (CSOs) that provide HIV and AIDS services to communities in Tanzania. While this may be seen as positive in one hand, it also raises number of challenges on the other hand. The NMSF II (2008/2012) reports that the rapid development and increase in numbers of CSOs involved in HIV activities has created problems of control of quality and supervision. Furthermore, most of the CSOs operating in Tanzania are urban based and donor dependent (Kamata and Mwendah, 2011). This implies that, while their number might be increasing, they are in fact reaching relatively fewer people residing in urban than the majority who are in the rural areas. Being donor dependent, the sustainability of the HIV and AIDS activities by these organisations is questionable. More often the activities would cease once the flow of aids from donors is cut off (ibid).

Furthermore, because of their values and convictions some CSOs have been contradicting with some elements proposed by the national HIV and AIDS strategic framework. Some Faith Based Organisations and religious leaders in particular have had strong views against condom promotion as a strategy in combating HIV and AIDS. What's more even those who have attempted to rationalise with these types of FBOs have faced harsh feedback (See table below). Religious groups are also in opposition to sex education for HIV prevention. For example, in 2006 a war of words broke out between Catholic and Muslim religious groups on one hand and the government on the other, over the introduction of Sex Education Curriculum in primary schools²⁴. These religious groups criticized the government decision to introduce sex education in primary schools claiming it was nothing more than an attempt to promote immorality. Given the fact that Tanzanian society is relatively religious society (mostly Christians and Muslims), continuing contradictions between FBOs, religious leaders and government on the prevention strategies proposed may have great impact in the implementation of the national response.

²⁴The decision to introduce sex education in Tanzania's Primary School Curriculum was prompted by a 2005 study by the Ministry of Education which among other things revealed that nearly 30% of students in primary schools have had sexual experience and that a significant number of primary school girls who dropped out of school because of pregnancies were HIV positive.

"Condoms Condemned"

The former President Ally Hassan Mwinyi on the Maulid Day of 2009 at Diamond Jubilee Hall tried to advise muslim clerics to discuss the use of condom to help reduce the impact of AIDS. One Mr Ibrahim Saidi got so angry that he climbed on the platform and slapped the face of the former President. Mr Saidi was arrested and sentenced to one year in prison. A fatwa (edict) was then issued by the Islamic Association (Jumuiya) in Dar es Salaam which said that extra-marital sex had been forbidden by God and no human being had the authority to amend the Koran. The question of condom use could be discussed in the case of married couples or in case of life and death but not otherwise.

Source: Tanzania Affairs "Condoms Condemned" available at <http://www.tzaffairs.org/2009/05/condoms-condemned/> (30/8/13)

5.2: Business/Private Sector

Owing to its former socialist ideology, Tanzania has a relatively small business/private sector. NMSF II (2008/2012) estimated there were about 800 companies which form Tanzania's business sector. However, like many other sectors, the business sector is losing personnel through premature deaths or early retirement. As such, the sector is concerned about the impact of HIV and AIDS and have expressed desire to support the national response. The Public Expenditure Review 2011 indicated that, private Sector contributes about 6.5 bn. TZS (2%) for the HIV and AIDS. According to the review many of the businesses which were surveyed have indicated that, in response to HIV and AIDS pandemic, they have increased their corporate social responsibility through investment in HIV and AIDS prevention programs focusing particularly on employee education and condom distribution. Other companies reported to be supporting Home Based Care, PLHAs, support for orphans other vulnerable children (OVCs), and control of mother-to-child transmission (PMTCT). Overall, the 29 companies surveyed reported to have invested TZS 4,317 million (USD2.9 million) in their workplace programs in period between 2009- 2010, out of this, 1,859.9mil was used on prevention, control and treatment (TACAIDS, 2012).

Furthermore, business/private sector in Tanzania have responded to HIV and AIDS pandemic by developing and implementing corporate HIV and AIDS policies in consonance with "*Tri-partite Code of Conduct on HIV/AIDS at the Work Place for Tanzania Mainland*" produced

by Ministry of Labour, Employment and Youth Development in 2008. Internally, an umbrella organisation, the AIDS Business Coalition Tanzania (ABCT) formed in 2004 has been mandated by its members to coordinate workplace HIV interventions by private sector. ABCT and also serves as human resource centre as well as technical information centre for businesses/organisations regarding workplace HIV programs. In its functions, ABCT works in collaboration with other business organizations such as TUCTA (Trade Union Confederation Tanzania), ATE (Association of Tanzanian Employers), CTI (Confederation of Tanzanian Industries) and TCCIA (Tanzanian Chamber of Commerce and Industry) under the forum called Tripartite Plus Forum which was formed in 2009.

The strategic objective defined in the NMSF II (2008/2012) with regards to work place interventions is “**to increase the proportion of public, private enterprises and informal sector operators developing and implementing comprehensive workplace interventions with special attention for mobile and migrant workers**”, however, this has not been achieved. Most of businesses operating in Tanzania do not have workplace HIV policies as required by the NMSF. HIV and AIDS Public Expenditure Review 2011 surveyed 29 companies operating in Tanzania. The findings of the review indicated that, 55% of the surveyed companies do not have an HIV and AIDS policy (TACAIDS, 2012). Missing HIV and AIDS policies in workplaces is a serious issue. For example, because of inexistence of HIV policy in the workplace, accessing care and treatment by employees would be regarded as favour rather than a right of an employee. Furthermore, since the rights of HIV positive employees are not guaranteed due to missing policy, the possibility of employees living with HIV being ridiculed and mistreated by their fellow staff or employer is extremely high. This also has a potential of reducing the number of people who would declare their HIV status²⁵.

5.3: Development Partners (Donors)

Development Partners has also extended their support in the national response to HIV and AIDS pandemic. Public Expenditure Review on HIV and AIDS reports that, more than 95% of funds directed to HIV and AIDS programs in Tanzania are donor funded (TACAIDS, 2012). These include the US government through PEPFAR and the Global Fund for AIDS,

²⁵ Commission for Human Rights and Good Governance (CHRAGG), HIV and AIDS Situation Analysis, Draft Report, undated

Japan International Cooperation Agency (JICA), Canadian International Development Agency (CIDA), German Development Cooperation (GIZ), the Danish International Development Agency (DANIDA), Swedish International Development Agency (SIDA), the World Bank and the Clinton Foundation. Others include the governments of Norway (NORAD), Ireland (DCI), UK (DFID) and the United Nations Joint Program. These development partners have been supporting the NMSF II 2008/2012 four thematic areas which are HIV prevention, Care, support and Treatment for PLHIV, mitigation and cross cutting issues. Though data indicate that, much of the donor funding is directed towards care and treatment.

However, several challenges are highlighted with regard to coordination of partners support to the national response. One is there is weak domestic accountability over the funding. It is reported that, over 80% of the donor funding is off budget financing and does not appear in government budget. The funds are managed by the donor governments themselves or by their implementing partners. The challenge with off-budget financing is low transparency and weak domestic accountability, as the Parliament is not involved in the off-budget. Furthermore, even the implementing partners who are entrusted by donors do not always share this information with the TACAIDS as required by the policy and therefore difficult for the government to keep track of all donors' funding (Mutembei, 2008). Also, the fact that donor funding is off budget, means it is not always that they are aligned with the goals set out in country's National Policy on AIDS or priorities determined by the country's NMSF (TACAIDS , 2012). The Public Expenditure Review on HIV and AIDS , 2011 for example asserts that, despite the fact that NMSF has highlighted HIV prevention as the key focus, less than a quarter of PEPFAR and Global Fund funding has been directed to HIV prevention.

Furthermore, most of development partner prefers to work through their implementing partners. However, these implementing partners are not uniformly distributed to the regions/districts in Tanzania (ibid). For example, there are over 22 PEPFAR implementing partners in regions and districts in Tanzania. Some districts have more than 6 partners and others have as many as 13 (Arusha) while others have less than 3 partners (Rukwa and Ruvuma). This means resource spending by some development partners in Tanzania is not geographically equitable and does not follow the severity pattern of the epidemic (TACAIDS, 2012).

6.0: IMPLEMENTATION OF HIV AND AIDS NATIONAL RESPONSE

This section is about the implementation of HIV and AIDS public policies in Tanzania. It highlights factors affecting the implementation process. Some key questions addressed in the discussion include the extent to which the HIV and AIDS framework has been operationalized, human and financial resource issues as well as the institutional and organizational arrangement for implementation.

6.1: Public Policy Framework and Operationalization

The HIV and AIDS policy and the National Multi sectoral Strategic Framework provide a comprehensive approach for responding to HIV and AIDS pandemic. There are also numbers of supporting policies such as the National Child Development Policy, the Community Development Policy of 1996, the Food and Nutrition Policy of 1992, the Education and Training Policy of 1995, Youth Development Policy of 2008, Social Security Policy of 2008, Women and Gender Development Policy and National Ageing Policy of 2003 among others. These policies, though are general, provide a framework where the HIV and AIDS policy is implemented. However, there are serious gaps existing in some key policies which have the potential to limit effective implementation of the country's response to HIV and AIDS pandemic. In a serious note, there are some omissions, inconsistencies and gaps in these policies which leave some particular groups vulnerable to HIV and AIDS infections. For example, there is a serious inconsistency in the use of the term orphan in Tanzania's policy framework. The National HIV and AIDS policy defines an orphan as a child below the age of 15 years while the Constitution of Tanzania and a number of other policies define a child to be below the age of 18 years. Furthermore, while the policy refers to an orphan as a child who has lost both parents, the Department of Social welfare uses multiple terminologies for orphaned children, including maternal orphans, paternal orphans and double orphans. Furthermore, marriage law (Marriage Act No.5, 1971) stipulates that a minimum age of marriage in Tanzania is 18 years. However, the same law allows a girl to be married at the age 15 years with the consent of the parents and at 14 with court's permission. A girl married at 15 or 14 years contradicts with national and international definition of a child which sees a child as an individual below 18 years of age. But there is more danger to this. Under these provisions by the Marriage Act, it clear that the girl child is not protected from HIV as the minimum age stipulated is age of a minor. It is without a doubt that majority of girl children are not well informed about HIV and therefore incapable of making sound decisions such as requesting for premarital HIV testing. Furthermore, although the National Policy on

HIV/AIDS encourages voluntary premarital testing, it prohibits premarital mandatory testing. As such a girl child is more exposed to HIV infection.

Besides, the National HIV and AIDS Policy does not spell out the mechanisms to protect people with disabilities against HIV and AIDS infection. Likewise, the rights of people with disabilities who are also infected with HIV and AIDS are not covered in the policy. People with disabilities are likely to suffer “double discrimination”. One is that, they are discriminated because of their disabilities but two, an HIV positive status would expose a disabled person to more stigma associated with the virus. Indeed, people with disabilities require special educational aid and protection measures that will create supporting environment for them to apprehend protection measures against HIV/AIDS. The fact the rights of this special group is not well covered in the policy for HIV and AIDS does not only put them in risk of catching HIV virus but also expose them to more stigma and discrimination. Generally, these inconsistencies, gaps and omissions in the policy frameworks may pose some limitations to the effective implementation of HIV and AIDS policy programs as they include limited protection of vulnerable groups such as women, vulnerable children, people with disability and youths.

6.2: Organizations and Institutional Arrangement for Implementation

How well organizations and institutions are arranged, coordinated and functioning is critical for an effective implementation of the national response to HIV and AIDS. With regards to organisations and institutional arrangements for the implementation of the national response, the NMSF II 2008/2012 provides one strategic goal “*to provide well – coordinated, effective, transparent, accountable and sustainable leadership and management structures based on the “Three Ones Principle” at central, regional and LGA levels to deliver the National Response as well as involving stakeholders from the public, private and civil society sectors*”. As such, a nation-wide structure of committees and focal points for the HIV response has been established in almost all MDAs and at the regional and district levels. In the MDAs level, these structures are known as HIV and AIDS focal points and are responsible for the management HIV related activities within their mandates. Structures in the regions and districts levels are more extended. Within each region, there is a Regional Secretariat, Regional HIV and AIDS Coordinator (RACC) and HIV and AIDS committees. At the district level, there is Council Multisectoral AIDS committee (CMAC), a Council HIV and AIDS Coordinators (CHAC) who coordinates all non-medical interventions and District

Aids Coordination Committee (DACC). In sub district level, there is Ward Multisectoral AIDS Committee (WMAC) and Mtaa²⁶/Village Multisectoral AIDS committee.

At political level, the Parliament has a special Standing Committee on HIV and AIDS to oversee the governance and accountability issues of the national multi sectoral response. In addition there is a voluntary Tanzania Parliamentarians' AIDS Coalition (TAPAC) that is composed of paid multiparty membership of 210 Members of Parliament. TAPAC conducts advocacy work at various levels and sectors. The Tanzania National Coordinating Mechanism (TNCM) also serves as important multi-sectoral forum for sharing information and coordination of resources within Tanzania from various sources. TACAIDS serves as the secretariat for the TNCM.

However, literatures highlight some serious weaknesses with this organisational and institutional arrangement as well as their functioning. A study by Mutembei (2008) shows that while structures for the implementation of the national response have been established in almost all MDAs and at the regional, district and sub district levels, there are several challenges in their functioning. According to her some of the structures are underfunded and less trained. She further argues that, MDA structures for the implementation of the national response are weakly functioning due to lack of political support from higher decision making bodies, insufficient technical guidance and follow up from the TACAIDS itself. Similar findings are provided in the HIV and AIDS Public Expenditure Review (PER) of 2011. According to the review, most of the MDAs have established an HIV and AIDS Strategic Plan but the actual implementation was recorded to be very low. The review attributed the low implementation to lack of adequate funds. The review further reports that, HIV and AIDS activities have not only been accorded low priority and but in fact, there are some ministries which have stopped budgeting government resources to address the HIV and AIDS epidemic (TACAIDS, 2012).

In addition to that, the functionality and capacity of the committees in the lower levels, including whether they can sustainably coordinate HIV and AIDS at local government level is questionable (TACAIDS, 2012; Mutembei, 2008; Taylor 2006). In decentralised approach to coordinating HIV and AIDS responses, these committees are responsible for promoting local public sector and civil society responses to HIV/AIDS as well as coordinating local

²⁶Swahili word for Street

funding mechanisms to support such responses. Studies have revealed worrying weaknesses on the committees' capacity to uphold such role. Studies by Taylor (2006; undated) which focused on the coordination of rural response to HIV and AIDS in Tanzania reveals that the capacity of AIDS committees at village level is strikingly low. Members of village AIDS committees were found to be less educated with no prior administrative experience which is needed in coordinating community AIDS response²⁷. The study's responses to the knowledge and attitudes by the village HIV committee members also indicated worrying weaknesses in basic technical knowledge. According to the study, all six of the questioned HIV/AIDS committee members claimed that it was possible to identify someone who is HIV positive by sight alone. Five out of six committee members questioned agreed or strongly agreed with the statement that people living with HIV/AIDS were being punished for something bad that they had done. With this low basic technical knowledge on the part of committee members it is worrying for these committees to be taking substantial educational role about HIV and AIDS. Furthermore, the implementation of the national response is challenged by the weak control TACAIDS has on HIV and AIDS committees operating in different levels. For example, while the Tanzania Commission for AIDS Act, 2001 establishes AIDS committees at every local government level, Ministry or other sectors to coordinate and implement AIDS activities, the Act does not specify how members of the committee are to be elected or appointed. In addition to that, under the Local Government Act, 1982, these committees, including the coordinators at regional levels are accountable to local government. The fact that, the committees as well as important focal persons in local levels do not report to central coordinating body i.e. TACAIDS implies that, there is no direct link between local level structures and the central coordinating body (TACAIDS). This also raises some questions to TACAIDS's mandate to coordinate national response at local level as stated in the national HIV and AIDS policy.

6.3: Human Resource for the Implementation of the National Response

Another major challenge in the implementation of HIV and AIDS responses in Tanzania include human resources shortages and inadequate capacity particularly in the health system (MoHSW, 2006). Despite increased demand for care and support for PLHIV, the health sector has been experiencing decline in number of both health and non- health staff. The

²⁷The study indicates that, in both studied committees, there was no village chairperson or executive officer, teacher, health or community development expert as members of the committees. Furthermore, there were no representatives of religious institutions, locally active NGOs, young people or people living with HIV/AIDS.

number of health staff has declined by 20% from 67,000 in 1994/1995 to 54,245 in 2002 a further decline of 48,800 is projected by 2015 (NMSF II 2008/2012). Experience shows that the problem is so severe particularly in rural areas where health centres and dispensaries are only staffed with non-physician health workers i.e. clinical officers and nurses. These geographic imbalances and shortages of skilled health (as well as non-health staff) and inadequate utilisation of trained staff have been affecting almost all areas of the national response (ibid). The NMSF II 2008/2012, reports the existence of few professionals with skills in behaviour change communication which in turn affects HIV prevention efforts. It further asserts that under the current national Care and Treatment Programme, the country needs additional 10000 health care workers which represent about 25% of the available workforce in the health sector.

6.4: Financing of HIV and AIDS National Response

The financing of HIV and AIDS programs by the Tanzanian government is very low. What is more disturbing here is the fact that, the spending on the HIV and AIDS national response by the government is not only very low but also has been declining over time. Table 9 demonstrates.

Table 9: Total Real Expenditure on HIV and AIDS (Billion TSH.)

	2006/07	2007/08	2008/09	2009/10	2010/11
Government	22.0	23.0	14.0	12.5	11.0
Development Partners	282.0	383.3	566.9	566.3	431.8
Total	304.0	406.3	580.9	578.8	442.8
% of total from donors	92.80%	94.30%	97.60%	97.80%	97.50%

Source: TACAIDS (2012) *Public Expenditure Review, 2011 HIV and AIDS*

As demonstrated in Table 9 above, the real spending on national HIV and AIDS response by the government is low, less than 3% and has been declining overtime. The spending by the government on HIV and AIDS national response fell from 23 billion Tanzania shillings in 2007/2008 to 11 billion in 2010/2011. The low spending by the government entails that the financing of the country's response to the epidemic is largely donor dependent. The 2011 Public Expenditure Review on HIV and AIDS indicates that donors' support to HIV activities was over 97% in the period between 2010/2011. However, even with the current support donor support, the national HIV and AIDS response is still under- funded. TACAIDS reports that, there is huge financing gap in HIV and AIDS national responses in Tanzania. It

indicates that while over 1 trillion Tsh. (US \$ 670 is needed per year to finance national response to HIV, currently only Tsh. 550 billion (US \$ 67mil) are made available each year from all sources which is just a 50% of the total required funding. While there is this huge financing gap, Public Expenditure Review Survey indicates that situation is about to get even worse. Table 10 illustrates

Table 10: Projected HIV/AIDS Resource Needs and Financing Gap (BNTsh.)

	2010/2011	2011/12	2012/2013	2013/2014	2014/2015
Resource needs	710.0	1,076.8	1,130.6	1,187.2	1,246.5
Projected available funding	442.8	658.6	582.0	114.9	107.4
Unmet gap	267.2	418.2	548.6	1,072.3	1,139.1
Gap as % of requirement	37.6%	38.8%	48.5%	90.3%	91.4%

Source: TACAIDS (2012) Public Expenditure Review 2011, HIV and AIDS

As the table illustrates, the projections indicate that significant amount of resources will be required to finance HIV and AIDS activities in Tanzania. However, these projections reveal a huge financing gap amounting to more than 90% of the would-be required resources. Financing gap between 2013/2014 and 2014/2015 are reported to be 90.3% and 91.4% respectively. More uncertainties rise from the fact that donors who have been major financiers of HIV and AIDS activities such as the US government and Global fund are reported to scale down their support beyond 2012/2013. The low government contribution coupled with declining donors' support signals a red-alarm on the sustainability of the country's HIV and AIDS national response program. The reduced fund is likely to make it difficult for the country to expand HIV treatment and care services unless the domestic finance for HIV and AIDS is significantly increased. Furthermore, funding decline may also result in an increase in new infections, due both to declines in effective HIV and AIDS prevention programs and decline in treatment access. The declines in effective HIV and AIDS prevention programs and increased in new infections are potential to reverse any successes which have been achieved so far in controlling the epidemic. Therefore, unless Tanzania begins to seriously mobilize its domestic resources, the fate of HIV and AIDS fight in Tanzania is in jeopardy.

7.0: POLICY CONSEQUENCES

This section reviews the success and failures of the HIV and AIDS public policies in Tanzania. In the process, the factor behind policy success and failure are also highlighted.

7.1: Policy Success

Stabilized HIV Prevalence

The available data indicates that, the Tanzania HIV prevalence has been stabilized at around 5% since 2007. Furthermore, a slight decline of 2% is observed from period between 2003/2004 and 2011/2012 from 7.0% to 5% respectively. The decline is also indicated in terms of gender. The HIV prevalence among women declined from 7.7% in 2003/2004 to 6% in 2011/2012 while that on men declined for 2.3% from 6.3% in 2003/2004 to 4% in 2011/2012. In correlation with stabilized HIV prevalence is the wide spread knowledge of HIV and AIDS prevention methods²⁸. According to THMIS 2011/2012;

- ✚ 69% of women and 77% of men know that an individual's chance of getting HIV and AIDS can be reduced by using condoms.
- ✚ 84% of women and 87% of men know that the chance of becoming infected with AIDS virus is reduced by limiting sexual intercourse to one uninfected partner who has no other partners.
- ✚ 64% of women and 55% of men are aware that HIV can be transmitted through breastfeeding and that the risk of MTCT can be reduced by taking ARTs.

Tanzania policy success is linked with several factors but most importantly its ***decentralized approach*** to combating HIV and AIDS. Tanzania has developed an interesting decentralised approach in the combating of HIV and AIDS pandemic. In this approach, local structures are recognized as back born of national response to HIV and AIDS. This recognition is stated in NMSF that

“Community mobilisation, empowerment and support to communities to respond effectively are the key elements of the National Response. It is

²⁸The paradox with Tanzania's widespread knowledge of HIV and AIDS prevention methods is that it does not correlate with behavior change. This is demonstrated in the data indicating that educated, wealthy, and urban residents are most likely to be knowledgeable about HIV prevention, but have higher rates of risk-taking behaviours and HIV infection. Furthermore, despite reporting higher HIV and AIDS knowledge among Tanzanians, the THMIS 2011/2012 shows that the proportion of men and women having more than one sexual partner in the 2011/2012 is basically higher than reported in THMIS 2007/2008.

in the communities and at local level where the fight against AIDS will be decided” (NMSF 2003/2007: 31)

The approach involves establishing HIV and AIDS committees at each level of government aim at giving local communities powers and access to planning and delivery of HIV interventions. These local structures include ; Village Multi sectoral AIDS Committees (VMACs), Ward Multisectoral AIDS Committees (WMACs), Council Multisectoral AIDS Committees (CMACs), Council HIV and AIDS Coordinators (CHACs) and District AIDS Coordinators (DACs). These local structures have been charged with responsibility of promoting local public sector and civil society responses to HIV/AIDS and coordinating the funding mechanisms to support such responses (NMSF 2008/2012). Decentralizing the fight against HIV and AIDS to people including those in the grassroot (village) means “localizing the national response” which is important in the combating of HIV and AIDS. This is so because the adoption of preventive measures is partly determined by how local communities perceive the disease, how culturally and socially acceptable are the proposed preventive measures. Decentralized approach has helped to link local perceptions and ownership of the HIV programs to those who are targeted.

7.2: Policy Failures

Higher New HIV Infections

After over 25 years of campaign against the spread of HIV and AIDS Tanzania is ranked 12 in the world in terms of HIV prevalence with more than 1.4 million Tanzanians living with HIV and AIDS; and although the HIV prevalence appears to be stabilizing, the occurrence of new HIV infections is very disturbing. On average more than 200,000 Tanzanians are newly infected by HIV each year (TACAIDS, 2009; URT, 2009a, UNAIDS, 2012) which is equivalent to *more than 400 new infections every day* (UNAIDS, 2012). Furthermore, although for long time prevalence rate has been higher in urban areas than the rural areas; several studies have established that the gap is slowly closing (Boerma et.al 1999; Mwita et.al 2007, Nyoni, 2012). For example, out of 217,704 approximated new infections occurred in 2008; about 139,970 of these new infections were in the rural areas (TACAIDS, 2012). This situation implicitly indicates that the existing prevention interventions are not having the desired impact and in the long run, may overwhelm efforts to provide care and treatment of PLHAs

Stigma and HIV/AIDS

Despite many efforts in fighting the epidemic and breaking silence on HIV/AIDS at all levels, stigma against HIV/AIDS remains significantly strong and has been playing a major role in fuelling HIV infection in Tanzania. Four out of ten women and a third of men surveyed in the 2007-2009 HIV and Malaria Indicator Survey (THMIS 2007/2009) reported that they would not buy fresh vegetables from a shopkeeper who has HIV, and half of all women and 40% of men said they would feel it necessary to keep it a secret if a family member was infected with HIV. A THMIS 2011/2012 also report higher levels of stigma and discrimination. According to this report, only 25% of women and 40% of men have expressed accepting attitudes on all four indicators used to measure stigma²⁹. Lack of knowledge³⁰ and fear are said to be the root cause of HIV stigma and discrimination. In most Tanzanian societies, HIV and AIDS continues to be associated with promiscuous behaviour and therefore seen as a “punishment”. In a study by Zou et. al. they concluded that religious beliefs strongly influence the way many Tanzanians think about HIV/AIDS. A significant percentage of those surveyed believed that people who are HIV-infected have not followed the Word of God, that HIV is a punishment from God, and that through prayers it can be cured. This attitude has placed PLHIV into hostile and difficult situations, but there is more danger to this. In the first place, stigma and discrimination lead to secrecy and denial which often make people hesitant to seek for HIV counselling, HIV testing or disclose their HIV status to their families (Ngozi et.al, 2009). A study by USAID (2005) conducted in Dar es Salaam revealed that only half of HIV positive respondents had disclosed their status to intimate partners. The study also found that average time from receiving results to disclosing them was 2.5 years for men and 4 years for women. Fear of abandonment, loss of job, property and violence were reasons for this delay. Increased fear and delay in disclosing one’s status implicitly indicate greater chances that HIV will be transmitted to a partner as preventive precautions are unlikely to be adopted. This leaves hundreds of thousands of apparently healthy looking people who are infected with HIV transmitting the infection to uninfected people.

²⁹ If they would be willing to (i) care for a family member sick with AIDS in their own homes (ii) buy fresh food from a shopkeeper with AIDS virus (iii) allow a teacher with AIDS virus to continue teaching (iv) not keep the HIV positive status of a family member a secret.

³⁰ In both two surveys (THMIS 2007/2009 and 2011/2012) indicated that respondents’ accepting attitude attitudes towards PLHIV increases with levels of education and wealth.

Furthermore, stigma and other HIV associated beliefs such as “HIV positive person has been bewitched” reduced and significantly delay the seeking of treatment. Studies by Mshana et.al (2006) and Roura (2009) which observed the uptake of the national antiretroviral treatment programme in Tanzania in rural Kisesa found out that, fear of being stigmatized was the major barrier to taking up free antiretroviral treatment in rural areas. Stigma also has on-going effects on the adherence to ART by PLHIV thus affecting their quality of life and increasing complications.

7.3: Factors for Failure

Poor availability and access to HIV services

The coverage of HIV services in Tanzania is uneven. THMIS 2011/2012, TACAIDS and ZAC (2012) and Prime Minister’s Office and TACAIDS (2012) elaborate how pathetic the situation is

- ✚ 33% of women and 50 % of men in Tanzania have never been tested for HIV (THMIS, 2011/2012).
- ✚ More than 40% of antenatal mothers do not have access to PMTCT services, and the uptake of anti-retroviral prophylaxis by HIV-exposed infants and their mothers is only 57% (THMIS, 2011/2012).
- ✚ Less than half of risky sexual acts are protected by condoms and about 42% of women and 50% of men do not have comprehensive knowledge of HIV prevention (THMIS, 2011/2012).
- ✚ About one third of STI clients are not appropriately managed according to national guidelines, including being provided with preventive counselling on condom use and partner notification, and less than half are referred to or provided HIV counselling and testing services (Prime Minister’s Office and TACAIDS, 2012)
- ✚ Less than half of blood transfused in the country is channelled through the national quality assured system, while only 5% of facilities met the minimum requirements for infection control in health facilities in 2007 (Prime Minister’s Office and TACAIDS, 2012).
- ✚ 70% of health facilities do not provide Early Infant Diagnosis (EID) services and 43% of HIV exposed infants do not receive any prophylaxis to prevent MTCT. On the

other hand only 21% of HIV exposed infants access EID (TACAIDS and ZAC, 2012).

In addition to this, HIV services in Tanzania are geographically uneven distributed and accessed. According to THMIS 2011/2012, only 34% of Tanzanian households live less than 2kilometers from a health facility. It is believed that urban residents usually enjoy better and more accessible services than the rural population. CD4 tests are reported to be available at districts and referral hospitals only and result can take days to process (UNDP, 2011). This means, the rural population would need to walk several kilometres to access health facilities. While HIV services are unequally distributed and highly concentrated in the urban areas, over 80% of Tanzania population live in the rural areas.

Weak Involvement of Some Affected Groups

Other reason given for continued new HIV infections is weak involvement of affected groups in the national efforts to combating HIV and AIDS. Most at risk population (MARPs) such as sex workers, injecting drug users (IDUs) and Men having sex with Men (MSMs) have been known to contribute in the fuelling of HIV and AIDS in the country. Some statistics of MARPS in Tanzania shows how devastated this group is;

- ✚ In Zanzibar, HIV prevalence amongst men having sex with men is higher than that of the general population at 11% compared to 0.6% in the general population (TACAIDS and ZAC, 2012)
- ✚ 27% of male and 58% of female IDUs in Tanzania are HIV positive (HIV Prevention Strategy for Tanzania Mainland, 2009/2011)
- ✚ 9% of men reported paying for sex in the last 12 month (THMIS, 2011/2012).
- ✚ In Dar es Salaam, HIV prevalence among Female Sex Workers (FSW) is 31.4% compared to 10.4% among the women in the general population of Dar es Salaam (Ministry of Health and Social Welfare, 2011).

The NMSF recognizes the importance of focusing on the most at risk population group such as sex workers, injecting drug users (IDUs) and men having sex with men (MSMs). However, the policy and legislative environment in Tanzania do not provide for the protection under the law for these most at risk population. Criminalization of the sex trade and homosexuality for example prevents funding or policy programming aimed at protecting this particular group (Kagarura, 2011). Nongovernmental organizations, on the other hand, have programs designed to improve the conditions of MARPs; however, they cite some difficulties. A study by UNAIDS (2011) which reviewed the governance of HIV and AIDS

response in Dar es Salaam city reports that, CBOS, NGOs and other civil society organizations find it difficult to work with these groups as it implicitly indicate supporting groups of people i.e. sex workers, injecting drug users and MSMs who are otherwise criminalized. Increasing the participation of key populations including the MARPs in planning and implementation of the national HIV and AIDS response processes would help in controlling the epidemic.

Financial Resource Shortage

TACAIDS reports that, there is huge financing gap in HIV and AIDS national responses in Tanzania. It indicates that while over 1 trillion Tsh. (US \$ 670 is needed per year to finance national response to HIV, currently only Tsh. 550 billion (US \$ 67mil) are made available each year from all sources which is just a 50% of the total required funding. The huge financing gap implicitly indicates that the country's has been facing difficulties in expanding HIV services including prevention and treatment services. Furthermore, studies have shown that, even the available financial resources are not evenly distributed. The HIV resource mapping exercise has shown inequalities in the distribution of expenditure favouring urban areas despite the fact that most people live in rural areas (Candelaria, 2007).

7.4: Lessons from the Tanzania's National Response to HIV and AIDS

Number of lessons can be drawn from the review of responses to HIV/AIDS in Tanzania

- ✚ Civil society Organisations both local and international are playing an important role in providing support to households struggling to cope with the impact of HIV/AIDS.
- ✚ The role of Development Partners (donors) in the national response is commendable. However, the existing huge financial gap threatensthe sustainability of the Tanzania HIV programs especially with donors cutting off their support beyond 2015.
- ✚ There are serious gaps exiting in some key policies which have the potential to limit effective implementation of the country's response to HIV and AIDS pandemic. These omissions, inconsistencies and gaps leave some particular groups vulnerable to HIV and AIDs infections.
- ✚ There is need to strengthen the resourcing and coordination among and between different organisations and institutions for the implementation of the national response at all levels.

8.0: HIV AND AIDS: EXPERIENCES FROM SOUTH AFRICA AND UGANDA

Tanzania, Uganda and South Africa are all experiencing generalized HIV epidemics. Nonetheless, amongst the three countries, the HIV prevalence is significantly high in South Africa at 17.3% which is about 3% times higher than that of Tanzania at 5% and over two times higher than Uganda at 7.3% (South Africa UNGASS Report, 2012; THMIS 2011/2012; Uganda AIDS Indicator Survey, 2011). Data indicate that while HIV prevalence has stabilised in Tanzania and South Africa at 5% and approximately 17% respectively, the prevalence rate in Uganda has significantly risen from 6.4% in 2005 to 7.3% in 2011 (Uganda AIDS Indicator Survey, 2011). Adult prevalence in these countries varies greatly acrossage, gender, socio-economic status and geographical location³¹. Women and girls have been disproportionately infected with HIV/AIDS in these countries. However, each of these countries has responded to the epidemic differently with varying degree of success. This section provides a discussion on the HIV and AIDS responses from Uganda and South Africa and in the process some lessons derived from their experiences are highlighted.

8.1: South Africa's Experience

A case of AIDS in South Africa was reported in first time in 1982 in a homosexual man. In its early years the virus remained predominant among this group with prevalence as high as 12.8% in 1983³². Consequently, the apartheid government perceived HIV/AIDS as a disease of promiscuous and devious homosexual men (Nirav, 2007). This perception defined HIV actions implemented under the apartheid government such as listing HIV and AIDS in the list of country's communicable diseases and quarantined individuals suspected or suffering from AIDS³³. Nevertheless, when the first national antenatal survey to test for HIV was carried out in 1990, 0.8% of pregnant women were found to be HIV-positive. By 1991, the number of diagnosed heterosexually transmitted HIV infections equaled the number transmitted through sex between men³⁴. The number of recorded HIV infections was reported to have increased by 60% in the two years (1991 -1992) and the number doubled in 1993. The failure of the apartheid government to control the epidemic is attributed to its narrow perception about the nature of the virus that it was "a gay disease". Therefore its response to responses to the HIV virus and AIDS were "*overwhelmingly restricted to and directed against*

³¹Race seems to be a factor in South Africa and less in Tanzania and Uganda.

³²HVSA "HIVAIDS IN SOUTHAFRICA" <http://www.hvsa.com/static/hiv-aids-in-south-africa>

³³ South African History Online " A history of Official Government HIV/AIDS Policy in South Africa"

<http://www.sahistory.org.za/topic/history-official-government-hivaids-policy-south-africa>

³⁴ ibid

homosexual men, thus enabling the virus to stealthily enter and inhabit the majority heterosexual population” (Nirav, 2007).

Mandela’s administration came into power on 10 May 1994. The role played by Mandela’s administration in combating HIV and AIDS in South Africa has been both widely commended and criticized. It is reported that upon coming into power, his administration included combating of HIV and AIDS as one of 22 lead projects of the government’s Reconstruction and Development Programme (RDP). Three new structures; the HIV/AIDS and STD Advisory Group, a Committee on NGO Funding and a Committee of HIV/AIDS and Sexually Transmitted Disease Research were proposed in the RDP. Other important efforts included the launching of ‘The National AIDS Plan for South Africa’ by NACOSA which focused on national wide HIV prevention, reducing transmission of HIV through appropriate care, treatment and support for PLHIV, and mobilization of resources both domestically and international for the fight against the epidemic. The National AIDS Control Programme’ and the Inter-Ministerial Committee (IMC) on AIDS were also established to provide political leadership of the epidemic and coordination of response from a multitude of different government’s departments. These efforts however could not lower the number of people being infected. In the four years period of Mandela’s administration, HIV prevalence among pregnant women grew from 7.6% in 1994, to 14.2% in 1996 to 22.8% in 1998 with 1500 new HIV infections occurring every day (National HIV and Syphilis Sero-Prevalence Surveys, South Africa, 2005; 2007).

Scholars attributed the rapid increase of HIV prevalence during the Mandela’s administration with three factors. One is the government narrow view about the threat of HIV. Critics argued that despite the growing threat, government continued to view the epidemic as merely a health problem rather than a major crisis that required broader government involvement³⁵. For example the director of HIV/AIDS and STD programming was placed under the Health Department administration and not within the intersectoral capacity as was provided in the National AIDS Plan (Nirav, 2007). As a result, HIV/AIDS issue “*lost its special status at the bureaucratic level*” argues Nirav. Furthermore, the unsettled political environment is also accused of foul-played the South African efforts to combating HIV. The most rapid increase in HIV prevalence took place during the time when the country was distracted by political transitions from apartheid hence less attention was paid to the spread of the epidemic. South

³⁵ *ibid*

African History Online³⁶ asserts that “*Mandela worked throughout his tenure on promoting national reconciliation and inter-racial unity in South Africa, the crisis was de-emphasized by his administration*”³⁷. Third is the politicization of ARVs drug provision (AZT) particularly to pregnant women. Despite the known fact that AZP reduces chances of MTCT, it is reported that the Mandela’s administration was hesitant to make the drug available arguing it was too costly to distribute and that South African government’s policy focus was on prevention rather than treatment³⁷. The pressure group Treatment Action Campaign (TAC) protested against the government refusal to distribute ARVs and demanded access to HIV treatment in South Africa for all those in needy.

Five major events defined Mbeki’s administration response to HIV and AIDS. They include

- ✚ Denialism by President Mbeki about HIV and AIDS relation
- ✚ Establishment of the National AIDS Council (SANAC) in 2000
- ✚ Mass protest by pressure group Treatment Action Campaign (TAC) which protested against the government refusal to distribute ARVs and demanded access to HIV treatment in South Africa for all those in needy.
- ✚ Successfully protection of a law to allow the domestic production of cheaper HIV drugs against a lawsuit filed by transnational pharmaceutical companies
- ✚ South Africa's High Court order to the government to make ARVs available to pregnant women to prevent mother to child transmission of HIV.
- ✚ The development of 5 years National Strategic Plan in May 2006 which called for a multi-sectoral response focusing in four key priority areas which are Prevention, Treatment, care and support, Human and legal rights; and Monitoring, research and surveillance.

Nevertheless, despite mass protest by pressure groups and high court’s order to make ARVs available number of people receiving treatment was reported to remain very low. In fact, even the HIV prevalence among the general population continued to grow from 15.6% in 2002 to 16.8% in 2008 (South Africa UNGASS Report, 2012). President Mbeki’s outright denial that HIV cause AIDS is among factors attributed to an increased HIV prevalence around this time. According to Population Reference Bureau (2002), President Mbeki’s contradiction with the existing scientific evidence delayed the provision of ARVs for PMTCT programme.

³⁶South African History Online “ A history of Official Government HIV/AIDS Policy in South Africa”

<http://www.sahistory.org.za/topic/history-official-government-hivaids-policy-south-africa>

³⁷ ibid

8.2: Uganda's Experience

Uganda was one of the first countries to experience an AIDS epidemic in Africa. The first case was first identified in 1982 in a fishing village on the western shores of Lake Victoria. Since then, the epidemic has had an overwhelming effect on the country's demographic, economic and governance structures. The country experienced a full-blown epidemic from 1980's and peaked at about 15% in 1991 with antenatal prevalence ranging between 25-30% in major urban areas (Putzel,2004: Kusiima, 2006).

Uganda's response to the epidemic was early and relatively well organized. Unlike many African countries which were in the *state of denial about HIV and AIDS*, the Ugandan political regime expressed high level of commitment to HIV and AIDS prevention and care involving a wide range of partners in all sectors of the society (Putzel, 2004; Moran, 2004). Shortly after coming into power in 1986, President Yoweri Museveni organized a countrywide mass communication campaign promoting the "ABC" for AIDS prevention. In the same year, Uganda established a National AIDS Control Program (ACP) and the national sentinel surveillance system, which has monitored the epidemic since 1987. Uganda developed one of the first Multisectoral programs when it established the Uganda AIDS Commission (UAC) within the Office of the President in 1991. In the effort to coordinate and monitor the country's Multisectoral framework, the UAC prepared a National Operational Plan to guide implementing agencies, sponsored task forces and encouraged the establishment of AIDS Control Programs in all ministries. Uganda was the first country in sub-Saharan Africa to open a voluntary counselling and testing (VCT) clinic called AIDS Information Centre and pioneered the concept of voluntary HIV testing centres.

Apart from early response and high political commitment, the Ugandan government using a Multisectoral approach developed an early strong relationship with other partners outside the government including religious leaders, donors, media, and traditional healers, NGOs, CBOs and FBOs and networks of people living with HIV and AIDS in the fight against the epidemic. For example, a small grass-roots organisation, TASO (The AIDS Support Organization) began peer education initiative on HIV and AIDS as early as 1987 (Tumushabe, 2006).

A nationwide declining prevalence particularly in urban areas was observed in Uganda from 1993. During this time, the HIV prevalence declined from 18% in 1993 to 6.1% in 2000 and

further stabilization of HIV prevalence between 6%-7% since 2000 (Kusiima , 2006). The decline in HIV and AIDS prevalence in Uganda was attributed partly to Multi-sectoral approach and involvement of various partners including civil society, Non- governmental Organizations (NGOs), local and international donors, media, religious leaders, youth groups, traditional leaders, people living with HIV and AIDS (PLHIV). Other factors included the high political commitment spearheaded by the President of Uganda, openness in society in discussing matters of sexuality and reproductive health and strong institutional framework (Moran 2004; Putzel 2004: Kusiime , 2006; Tumushabe,2006).

Although Uganda has achieved some commendable results in combating HIV and AIDS pandemic, challenges remain.

- ✚ Despite a significant decrease in the national HIV/AIDS prevalence rates in the period from 1993 to 2001, the country is currently experiencing a reversal in the trend in new HIV/AIDS infections. According to the Uganda AIDS Commission, the new infections rates nearly doubled from 73,000 in 2002 to over 130,000 by 2009 (UAC, 2009). The prevalence rates rise from 6.4% in 2005 to 7.3% in 2011 (Uganda AIDS Indicator Survey, 2011).
- ✚ Despite a tremendous increase in voluntary HIV testing in Uganda from 13% in 2004-05 to 66% in 2011, a substantial proportion of infected individuals have never been tested. Only 45% of male in Uganda have ever been tested for HIV (Uganda AIDS Indicator Survey, 2011).
- ✚ Whereas male circumcision has been shown to have a protective effect on HIV transmission (Urassa et. al. 1997), the proportion of Ugandan men age 15-49 that are circumcised is low at 26% and it has been almost unchanged since 2004 (Uganda AIDS Indicator Survey, 2011).
- ✚ 20 % of new HIV infections in Uganda are occurring through Mother-to-Child Transmission (Uganda: UNGASS Country Progress Report, 2012)
- ✚ Only 54% of those in need are receiving antiretroviral treatment (UNAIDS , 2012)
- ✚ Low uptake of treatment among Ugandan children where by only 32% of children who are eligible for treatment are able to access it (UNGASS,2012)
- ✚ Reliance on external funding in financing of the national HIV and AIDS programs. Currently, nearly 85% of the cost of HIV prevention and treatment are borne by donors. This threatens the sustainability of the country's HIV programs.
- ✚ Lack of comprehensive HIV/AIDS Policy

Notwithstanding the above challenges, the Uganda's HIV and AIDS experience seems to concurs with UNAIDS, Global Fund and World Bank model to confronting HIV and AIDS in developing country which suggest that "in addition to presidential/prime ministerial leadership, successful action requires the full involvement of civil society, decentralized and democratic government organisations, and wide participation of all government agencies on an equal footing" (Putzel, 2004). In fact, there several lessons to be derived from the country's experience in combating the epidemic.

8.3: Lessons from Uganda and South Africa's HIV and AIDS Experiences

Role of Politics

One lesson derived from Uganda's and South Africa's experience is "*politics matters*" in the war against HIV and AIDS. The WHO's Health a Key to Prosperity asserts that Uganda's success in reducing the prevalence of HIV and AIDS is by large a result of broad based national efforts backed up by firm political commitment including the personal involvement of the President. Studies report that while many states in Africa were in a state of denial, in Uganda there was an early response by the government and a proactive commitment to HIV prevention by President who declared the fight against AIDS as a "patriotic duty (Tumushabe 2006; Broadbent, 2012). This early, high level political support by the government helped in fostering a "multi-sectoral response, prioritizing HIV/AIDS and enlisting a wide variety of national participants in the fight against HIV and AIDS" (Green et.al, 2006). Furthermore, the adoption of "open approach" to HIV by political regime increased levels of awareness among the population. An open approach to HIV/AIDS implies that HIV/AIDS-related issues enjoyed wide public debate as it creates a space to generate a "broad-based consensus on how to proceed" (Tumushabe, 2006; Broadbent, 2012). It also helps in reducing stigma and other stereotypes about the virus as well as providing "*local solutions to the epidemic*" (Green et.al 2006; Broadbent, 2012). In contrary though, the "denial attitude" adopted by the state in South Africa fuelled the spread of the virus dangerously. The apartheid government in South Africa construed HIV and AIDS as homosexual disease. It ignored evidence that the nature of HIV/AIDS (dominant mode of transmission) in Africa is fundamentally heterosexually transmitted. By undertaking this perception, the apartheid state contributed not only to the stigma of HIV/AIDS and also facilitated its entry into the general heterosexual population (Nirav, 2007). Similarly the adoption of unconventional views about the disease by Mandela and Mbeki's administration prevented millions of South African women from accessing

ARVs to protect their unborn babies from the risk of being infected. Indeed, high levels political commitment by Uganda's political regime and the South African state denial demonstrated what difference politics can make in the country's success in the fight against the epidemic.

Inclusive Approach

Another lesson learned from Uganda's experience in confronting HIV and AIDS include the importance of "*inclusive strategy based on broad social mobilization*" (Moran, 2004). There is a massive body of literature suggesting that the effectiveness of responses to HIV requires the involvement of those most affected. In Uganda, HIV/AIDS struggle has largely been shaped by the work of on non-state actors, including PLHIV, NGOs, Community-based organizations (CBOs), Faith-based organisations (CBOs), sensitized traditional healers, the mass media and private sector operators. Uganda recognized the importance of involving 'everyone' from the onset of the epidemic. Civil organisations such as, the AIDS Support Organization (TASO), National Community of Women Living with HIV/AIDS, UWESO, and the Traditional and Modern Health Practitioners Together Against AIDS (THETA) among others, worked shoulder to shoulder in support of government's efforts to tackle the spread of the epidemic. In their inclusive strategy, Uganda ensured opposition toward the patriotic duty to fight the virus is reduced. Uganda recognized the importance of involving religious leaders and organisations on the onset of the epidemic so as to deal with their common conservative stance. Speaking of this Putzel (2004) argues that "*not only were they (FBOs) needed to help influence the population but the government needed to ensure that they would be part of, rather than in opposition to, efforts to discuss the epidemic*" . Generally having those affected on-board is critical in the ensuring the effectiveness of the national response. Suggestions from Uganda experience correspond to this. This is a challenge to Tanzania to ensure it implement an inclusive strategy as apparently some affected groups i.e. MARPs are not effectively involved due to policy and legal constraints.

Likewise in South Africa, the commended role of civil society is demonstrated. In middle of the state denial to provide treatment to HIV infected South Africans, CSOs protested and demanded for universal treatment. The work of CSOs such as the Treatment Action Campaign which organized a mass protest including a march of hundreds of people on parliament to demand an access to ARVs led to the country's universal treatment policy.

References

1. Bennell, P., Hyde, K. and Swainson, N. (2002) *The Impact of the HIV/AIDS Epidemic on the Education Sector in Sub-Saharan Africa: A Synthesis of Findings and Recommendations of Three Country Studies*, University of Sussex
2. Boerma, J. T. et.al (1999) "Spread of HIV Infection in a rural area of Tanzania", in *AIDS*, 1999, Jul 9; 13(10):1233-40
3. Boerma, J. T., Gregson, S., Nyamukapa, C., and Urassa, M. (2003) "Understanding the Uneven Spread of HIV Within Africa: Comparative Study of Biologic, Behavioral, and Contextual Factors in Rural Populations in Tanzania and Zimbabwe" *Sexually Transmitted Infections* Vol. 30 no. 10: 779 – 787.
4. Bollinger L; Stover J and Riwa P (1999) "*The Economic Impact of AIDS in Tanzania*"; The Policy Project available at <<http://www.policyproject.com/pubs/SEImpact/tanzania.pdf>> (20/7/2013).
5. Broadbent, E. (2012) *Research-based evidence in Africa Policy Debates-Uganda's HIV/AIDS Prevention and Control Bill*; Evidence Based Policy and Development
6. Candelaria, D. (2007) *Resource Mapping for HIV and AIDS*; TACAIDS
7. CHGA (2005) *HIV/AIDS and economic growth in Africa: Preliminary projections*; Backgroundpaper for CHGA, Addis Ababa, Ethiopia
8. CHGA (2008) *Securing Our Future*, United Nations Economic Commission for Africa
9. Cohen, D., (2000) *Report on the Workshop on the Impact of HIV/AIDS on Education*; International Institute for Educational Planning, UNESCO
10. Coombe, C. (undated) "*Mitigating the Impact of HIV and AIDS on Education Supply, Demand and Quality*", available at <http://www.unicef-irc.org/publications/pdf/aids_book/chapter9_coombe.pdf>(20/7/2013)
11. Cuddington, J. (1993) "Modelling the Microeconomic effects of AIDS with an application to Tanzania"; *World Bank Economic Review*, 25, 963-975
12. Economic and Social Research Foundation (ESRF) (2003) "*The Social and Economic Impacts of HIV in Tanzania.*" Research Report Submitted to SIDA, DSM
13. Fox M; Rosen S; McLeod W; Wasuma M; Foglia M.B and Simon J (2003) *The Impact for International Health and Development*, The Boston University School of Public Health Discussion Draft
14. Gachuhi, D. (1999) *The Impact of HIV/AIDS on Education Systems in the Eastern and Southern Africa Region and the Response of Education Systems to HIV/AIDS: Life Skills Programs*; UNICEF, Eastern and Southern Africa Regional Office (ESARO) Consultant
15. Garbus, L. (2004) *HIV/AIDS in Tanzania; Country AIDS Policy Analysis Project*, AIDS Policy Research Centre, University of San Francisco
16. Global AIDS Response Progress Report 2012, South Africa (**South Africa UNGASS Report, 2012**)
17. Gould and Huber (2003) *Estimating school enrolment demand in HIV & AIDS affected populations*, DFID Research Project Summary Research Report.
18. Green, E., Halperin, D.T, Nantulya, V. and Hogle, J.A. (2006) "Uganda's HIV Prevention Success: The Role of Sexual Behaviour Change and the National Response" *AIDS and Behaviour*, Vol.10,No.4, July 2006
19. Haazen, D (2010), *the Economic Cost of HIV & AIDS*, World Bank Country Office, Dar es Salaam

20. Harris, A. and Schubert, J. (2000) ***Defining Quality in the midst of HIV/AIDS: Ripple Effect in the Classroom***; Report of the Improving Educational Quality (IEQ) Project; American Institute for Research
21. Helland, A., Lexow, J. and Carm (1999) ***The Impact of HIV/AIDS on Education*** ; LINS Report 1999-4, Oslo
22. ILO (2004) ***"Tanzania: HIV/AIDS, Work and Development"*** available at <<http://www.tanzaniagateaway.org/docs/en-work-and-development-tz-2004-07.pdf>> (19/7/2013)
23. ILO (2012) ***"Study on the Role of Economic Empowerment in reducing HIV risk and vulnerability among women and men in selected areas in Tanzania"***, available at tacaids.go.tz/.../47-study-on-the-role-of-economic-empowerment-in-red (17/7/2013)
24. Kagarura, W. (2011) "Hits and Misses in the Fight Against HIV/AIDS in Uganda"; ***AfricaPortal Backgrounder***, No.13, October 2011
25. Kamata, N. and Mwendah, H. K. (2011) "The role of Civil Society Organizations and Business community in Governance at the Grassroots level in Tanzania"; in ***Democratic Transition in East Africa: Governance and Development at the Grassroots***; (Dar es Salaam: REDET).
26. Kayombo, E. J., Uiso, F. C., Mbwambo, Z. H., Mahunnah, R. L., Moshi M. J. and Mgonda Y. H. (2007) "Experience of initiating collaboration of traditional healers in managing HIV and AIDS in Tanzania" ***Journal of Ethnobiology and Ethnomedicine*** 3: 6.
27. Kessy, F. Mallya E.T. and Mashindano O. "Tanzania" in Kondwani Chirambo (ed.), ***The Political Cost of AIDS in Africa: Evidence from Six Countries*** (Pretoria: IDASA): 211 - 260.
28. Kishamawe, C., Vissers, D.C , Urassa, M., Isingo, R., Mwaluko, G., Borsboom, G.J, Voeten, H.A., Zaba, B., Habbema, J.D. and de Vlas S.J " Mobility and HIV in Tanzanian Couples: both mobile persons and their partners show increased risk", in ***AIDS*** ,2006 Feb 28, 20(4): 601-8 available at <<http://www.ncbi.nlm.nih.gov/pubmed/16470125>> (4/7/2013)
29. Kusiima, A. (2006) ***"The impact of HIV and AIDS care and support interventions on household welfare in Uganda: A case study of Kyanamukaaka and Buwunga sub- counties, Masaka district"***, MA Economic Policy and Planning dissertation, Makerere University
30. Mallya E.T. and Munishi G.K. (2010) ***PRA Report: Bagamoyo, Tanzania; Community Bases Systems for HIV and AIDS Care and Treatment Project***
31. Materu, R. (2007)***The Response of the Northern Diocese of the Evangelical Lutheran Church in Tanzania to HIV/AIDS***; Unpublished Ph.D. Dissertation submitted to University of Kwazul Natal, School of Religion and Theology
32. Mishra, V; Greener S.B; Vaessen, M; Hong, R.; Boerma J.T; Van Assche A; Khan S; Rutstein, S. (2007) "HIV Infection does not disproportionately affect the poorer in Sub Saharan Africa", in ***AIDS***, Vol.21, pp17-28.
33. Mnyika, K. S., Klepp, K-I., Kvåle, G. and Ole-King'ori, N. (1996) "Risk Factors for HIV-1 Infection Among Women in the Arusha Region of Tanzania" ***Journal of Acquired Immune Deficiency Syndromes & Human Retrovirology*** Volume 11 - Issue 5 - pp 484-491
34. Moran, D. (2004) "HIV/AIDS, Governance and Development: The Public Administration Factor"; ***Public Administration and Development*** 24, 7-14(2004).

35. Morris C; Burge, D. and Cheevers, E. (2000) "Economic Impact of HIV/AIDS infection in cohort of Male Sugar Mill Workers in South Africa from the Perspective Industry" *International AIDS Economics Network Symposium*, Durban South Africa
36. Moshi H.P.B. (undated) "***The Impact of AIDS on the National Economy: the case of Women Labour Force in Tanzania***" available at <http://www.codesria.org/IMG/pdf/24LMOSHI_.pdf> (18/8/2013)
37. Mshena G.H et.al (2006) "Barriers to accessing Antiretroviral Therapy in Kisesa, Tanzania; a qualitative study of early rural referrals to the national program"; *AIDS Patients Care STDS*, 20(9):649-57
38. Mubyazi, G. M., Mwisongo, A. J., Makundi, E. A., Pallangyo, K., Malebo, H.M, Mshana, J.M., Kesheni, P. Senkoro, W., Kisinza, N., YahyaIpuge, Phillip, H. Magesa, S. M., Andrew Y., Kitua A. Y., and Malecela M. N. (2012) "Analysis of Cost Impact of HIV/AIDS on Health Service Provision in Nine Regions, Tanzania: Methodological Challenges and Lessons for Policy", *Rwanda Journal of Health Sciences* (2012), Vol.1, Issue 1
39. Muhondwa E.P.Y and Fimbo B.N. (2006) *Impact of HIV/AIDS on Human Resources for Health in Tanzania*; Assessment Report submitted to Ministry of Health and Social Welfare and ECSA Health Secretariat (Dar es Salaam: MOHSW).
40. Mukangara, F. and Koda B. (1997) *Beyond Gender Inequalities: Women in Tanzania*, (TGNP/SARDC: Dar es Salaam).
41. Mutembei, K. B. (2008) *The Structural, Policy and Legal Environment: Achievement and Challenges*; Joint Annual Program Review; A consultancy Report submitted to TACAIDS
42. Mwita, W. et.al. (2007) "***HIV Prevalence and Incidence in Rural Tanzania: Results from 10 years of follow-up in an open cohort study***" available at <<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2842883/>> accessed on 26/02/2012
43. News, Irin (2013) "East Africa: Feature-Traditional Cultural Spreading HIV/AIDS" <file:///F://Traditional_culture_spreading_HIV-AIDS.htm>accessed 19/6/2013
44. Ngozi, C.M., Van de Borne, B., and de Vries N.K. (2009) "Stigma of People with HIV/AIDS in Sub-Saharan Africa: A Literature Review"; *Journal of Tropical Medicine*, Volume 20 (2009)
45. NIMR/TACAIDS/UNAIDS (2010) *Drivers of HIV/AIDS Epidemics in Tanzania Mainland: Case study of Makete, Temeke, Geita, Lindi, Kigoma and Meru Districts*; The National Institute for Medical Research, Dar es Salaam
46. Nyoni, J. (2012) *Community Based Systems on HIV Treatment (CoBaSys): Strengthening Community Health Systems for HIV Treatment, Support and Care: Case of Iringa Tanzania*, (Dar es Salaam: COBASYS).
47. Olouch, E. (2006) "Policy Choices in Secondary Education in Africa: Challenges seen from different Perspectives in an African country: A case study of Tanzania Mainland as see by Teachers' Union (TTU)"; A paper presented at the launch seminar of the Norwegian Post Primary Education Program for Africa (NPED), Volsenasen Culture and Conference Hotel, Oslo Norway 13-14th September 2006
48. Pennap, G.R.I, Chaanda, M. and Erizike, L. (2011) "A review of the Impact of HIV/AIDS on Education, the Workforce and workplace: The African Experience" in *The Social Sciences*, 6 (2) pp. 164- 168, 2011
49. Phiri, Isabel (2003) "African Women of Faith Speak Out in an HIV/AIDS Era" in Phiri Isabel, Beverley Haddad and MazipoaneMasenya (eds.) *African Women, HIV/AIDS and Faith Communities*, (Pietermaritzburg, Cluster Publications).
50. Piot, P and Bartos, M (2002) "The Epidemiology of HIV/AIDS" in Max, S et.al (eds.) *AIDS in Africa*, New York: Kluwer Academic)2nd edition

51. Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat (2003) *World Population Prospects: The 2002 Revision Highlights*, New York available at <http://www.un.org/esa/population/publications/wpp2002annextables.PDF>>(4/7/13)
52. Population Reference Bureau (2002) “Africa’s Political Response to HIV/AIDS” <<<http://www.prb.org/Publications/Articles/2002/AfricasPoliticalResponsetoHIVAIDS.aspx>>> 14/09/2013.
53. Putzel, J. (2004) “The Politics of Action on AIDS: A Case Study of Uganda”, *Public Administration and Development*, (24); 19-30.
54. REPOA (2010) *Assessment of the Impact of HIV/AIDS on the Economy in Tanzania*; Final Report, (Dar es Salaam: REPOA).
55. Roura, M. (2009) “Barriers to Sustaining Antiretroviral Treatment in Kisesa, Tanzania: A follow-up study to Understand Attrition from the Antiretroviral Program”; *AIDS Patients Care STDS* 23(3); 203-210.
56. Rugalema G (1998) “*It is not only the loss of labour: HIV/AIDS, loss of assets and household livelihood in Bukoba district, Tanzania*”; A paper presented at the East and Southern Africa Regional Conference on Responding to HIV/AIDS, Harare, June 8-9.
57. Shelton J.D et.al (2005) *Is Poverty or Wealthy at the root of HIV?* Available at <http://www.thelancet.com/pdfs/journals/lancet/PIIS0140673605674016.pdf>
58. Stover J and Johnson A (1999) *The Art of Policy Formulation: Experiences from Africa in Developing National HIV/AIDS Policies*; The Policy Project.
59. Strand, P., Matlosa K., Strode A. and Chirambo K. (2005) *HIV and AIDS and Democratic Governance in South Africa: Illustrating the Impact on Electoral Processes* (Cape Town: IDASA).
60. TACAIDS (2003) *National Multi sectoral Strategic Framework 2003-2007(NMSF I 2003/2007)*.
61. TACAIDS (2008b) *National Multi sectoral Strategic Framework 2008-2012(NMSFII 2008/2012)*.
62. TACAIDS (2009,) *The History, Trends of Prevalence and Efforts Towards Prevention and Control of HIV/AIDS in the last 25 Years in Tanzania Mainland from 1983-2009*, Tanzania Commission for AIDS.
63. TACAIDS (2012) *Public Expenditure Review, 2011 HIV/AIDS Tanzania Mainland*. Dar es Salaam, Tanzania and Health Systems 20/20 project
64. TACAIDS and ZAC (2012) *Country Progress Reporting 2012*
65. Tanzania HIV/AIDS and Malarial Indicator Survey 2007/2008 (THMIS 2007/2008)
66. Tanzania HIV/AIDS and Malarial Indicator Survey 2011/2012 (THMIS 2011/2012)
67. Tanzania Households Budget Survey 2007 (HBS 2007) available at <http://www.nbs.go.tz/tnada/index.php/ddibrowser/2/download/39>> (27/6/2013)
68. Taylor B (2006) “*Coordinating Rural Response to HIV/AIDS: Tanzania’s Decentralized Approach*”; A dissertation submitted to the University of Manchester for the degree of MA International Development, Faculty of Humanities
69. Taylor B (undated) “*Tanzania’s Decentralized Approach to HIV/AIDS Governance: A case study from Ludewa District*”; HakiElimu Working Paper No.6
70. The National Antenatal Sentinel HIV and Syphilis Prevalence Survey, South Africa, 2011, National Department of Health.
71. The Tanzania Demographic and Health Survey 2010 (TDHS,2010)
72. Tibaijuka, A. K (1997) “AIDS and Economic Welfare in Peasant Agriculture: Case studies from Kabagiro Village Kagera region, Tanzania”; *World Development* 25: pp. 963 – 975

73. Uganda AIDS Commission (2009) *Uganda HIV/AIDS Control Project: Progress Report of the CHAI Component for the period 2006*; (Kampala: Uganda AIDS Commission).
74. UNAIDS (2008a) *Global Report: UNAIDS Report on the Global AIDS Epidemic 2008*
75. UNAIDS (2008b) *The HIV Epidemic in Tanzania Mainland: Where have We Come From, Where is It Going and How Are We Responding?* Available at <www.tacaids.go.tz/.../Tanzania%20Epidemiological%20Review%20Report>
76. UNAIDS (2012) *Global Report: UNAIDS Report on the Global AIDS Epidemic 2012*; <http://www.unaids.org/en/resources/campaigns/20121120_globalreport2012/globalreport/>
77. UNDP (2011) *HIV&CITIES:A review of the governance of HIV and AIDS responses in selected cities in Eastern and Southern Africa, Dar es Salaam Review*; Oxford Policy Management Ltd, Oxford
78. UNDP/Malawi Institute of Management (2002) *The Impact of HIV/AIDS on Human Resources in the Public Sector in Malawi*, <www.undp.org/.../publication/.../publications/hiv-aids/...impact-of-hiv-aids-...>(17/7/2013)
79. UNESCO (2009) *Projecting the global demand for teachers: Meeting the global universal primary education by 2015*; UNESCO Information Sheet No. 3
80. Urassa, M.; Todd, J.; Boerma, J.T.; Hayes, R. and Isingo, R. (1997), "Male circumcision and susceptibility to HIV infection among men in Tanzania" *AIDS: Official Journal of the International AIDS Society* Vol 11 No 1: 73 – 80.
81. URT (2000)*HIV/AIDS/STI Surveillance Report Jan-Dec 2000*;National AIDS Control Program, Report No.15.
82. URT, (2006) *Tanzania Service Provision Assessment Survey*.
83. URT (2005) *Surveillance of HIV and Syphilis Infections among Antenatal Clinic Attendees 2003/2004*; National AIDS Control Programme.
84. URT (2009) *Gender Audit on Tanzania National Response to HIV and AIDS*; Tanzania Commission for AIDS.
85. URT (2009a) *HIV Prevention Strategy for Tanzania Mainland and a Two Year Action Plan for HIV Prevention in Tanzania Mainland*.
86. URT, (2011) *HIV Behavioural and Biological Surveillance Survey among Female Sex Workers in Dar es Salaam, 2010*; National Aids Control Program (Dar es Salaam: NACP).
87. URT (2012) *HIV Country Progress Reporting 2012*, TACAIDS/ZAC.
88. URT (2012) *National Behavior Change Communication Guidelines on HIV and AIDS Interventions*; (Dar es Salaam: PMO/TACAIDS).
89. US Global Health Policy (2012) *The Global HIV Epidemic: Fact Sheet*, available at <<http://www.kff.org/hivaids/upload/3030-17.pdf>> (15/3/2012).
90. USAID (2005) *Working Report Measuring HIV Stigma: Result of a field Test in Tanzania*.
91. Women Out Loud (2012) *How Women Living with HIV will help the World Ends AIDS*, Joint United Nations Programme on HIV/AIDS.
92. World Bank (1992)*Tanzania: AIDS Assessment and Planning Study*; The World Bank, Washington DC
93. _____ (1993) *World Development Report: Investing in health*; World Bank, Washington DC.
94. _____ (1997) *Confronting AIDS: Public priorities in a global epidemic*; World Bank, Washington, D.C.

95. ____ (2000) “*Exploring the Implication of HIV/AIDS epidemic for educational planning in selected African countries: The demographic questions*”. World Bank
96. Zou, J., Yamanaka, Y., Muze J., Watt, M., Ostermann J., and Thielman N. (2009) “Religion and HIV in Tanzania: influence of religious beliefs on HIV stigma, disclosure, and treatment attitudes” *BMC Public Health* 2009, 9:75