TERMINAL EVALUATION OF JOINT PROGRAMME 3
Support to Tanzania National Response Against HIV and AIDS

Final Report

Prepared by:
Fatimah Bisola Ahmed & Mkigama Adolph Kapinga
The Consultants wish to express their deepest gratitude to everyone who contributed, in one way or the other, towards making this end of Programme evaluation task easier and successful. We wish to acknowledge Dr. Elly Ndyetabura and his team in UNDP for their continuous support, we also acknowledge Mr. Ishmael Dodoo for his guidance, and all JP3 partner UN agencies under the leadership of Dr. Luc Barrier-ConstantinUNAIDS Country Coordinator for accompanying us along the way. Our special mention goes to Ms. Louise Chamberlain for her commitment on making the Joint Programme work. Our appreciation is extended also to all the implementing partners particularly TACAIDS & ZAC, for their useful feedback that helped make the content of this report, meaningful.

Thank you all!

Consultants Address: -
Fatimah Bisola Ahmed
Basic Education Association
5, Maiduguri road, Daurawa,
Kano State, Nigeria.
Tel: +234 8034513854 & +234 8098513854
Email: fabis1961@yahoo.co.uk

&
Adolph Mkingama Kapinga
P.O.Box 494,
IRINGA, Tanzania.
Tel: +255 755 551175
Email: KMkingama@gmail.com
# Table of Contents

Acknowledgement ...............................................................................................................................................2  
List of Abbreviations .......................................................................................................................................4  
List of Tables  
Table 1: Evaluation Work plan ..........................................................................................................................11  
Table 2: List of individuals/organizations interviewed ......................................................................................13  
Table 3: Total Beneficiaries .................................................................................................................................21  
Table 4: Environmental linkages to the MDGs .....................................................................................................31  
List of Figures  
Figure 1: Sex prevalence of HIV infection ..........................................................................................................25  
Figure 2: Comparison of age specific prevalence .................................................................................................25  
Figure 3: Cumulative Adults and Children in Care and on ART ..........................................................................26  
Figure 4: Trend of PMTCT .....................................................................................................................................27  
Executive Summary .............................................................................................................................................6  
a. Major findings and Recommendations ............................................................................................................6  
b. Relevance .........................................................................................................................................................6  
c. Appropriateness ...............................................................................................................................................6  
d. Efficiency and Effectiveness ..........................................................................................................................6  
e. Outcome/Impact ..............................................................................................................................................7  
f. Sustainability ....................................................................................................................................................7  
g. Partnership and Coordination ........................................................................................................................7  
h. Conclusion .......................................................................................................................................................7  
1.0. Introduction/Background to JP3 ....................................................................................................................7  
1.1. National response to HIV/AIDS on Mainland ..............................................................................................8  
1.2. National response to HIV/AIDS in Zanzibar ...............................................................................................8  
1.3. UN Support ..................................................................................................................................................9  
2.0. Scope of the Evaluation ................................................................................................................................10  
3.0. Evaluation Methodology ................................................................................................................................10  
3.1. Introduction .................................................................................................................................................10  
3.2. Limitations and guiding principles of the evaluation ...................................................................................12  
4.0. Evaluation Findings .....................................................................................................................................13  
4.1. Relevance of the JP3 .....................................................................................................................................13  
4.2. Programme Efficiency and Effectiveness ......................................................................................................15  
4.2.1. Efficiency ...............................................................................................................................................15  
4.2.2. Effective Use of Time .............................................................................................................................16  
4.3. Programme Outcome/Impact .......................................................................................................................16  
4.3.1. Thematic Area: Enabling Environment .................................................................................................16  
4.3.2. Thematic Area: Prevention ....................................................................................................................19  
4.3.3. Thematic Area: Care & Treatment .......................................................................................................20  
4.3.4. Thematic Area: Impact Mitigation .........................................................................................................20  
4.3.5. Thematic Area: Monitoring & Evaluation ............................................................................................21  
4.4. ZANZIBAR ....................................................................................................................................................21  
4.4.1. Enabling Environment ............................................................................................................................21  
4.4.2. Prevention .............................................................................................................................................23  
4.4.3. Care & Treatment ................................................................................................................................23  
4.4.4. Impact Mitigation .................................................................................................................................23  
4.4.5. Monitoring & Evaluation .......................................................................................................................24  
4.5. General effects/Impact of the National Response ......................................................................................24  
4.5.1. Care & Treatment Services ..................................................................................................................25  
4.5.2. PMTCT Services ....................................................................................................................................26  
4.6. Sustainability ...............................................................................................................................................26
4.7. Partnership & Coordination.................................................................................27
4.8. Cross-cutting Issues..........................................................................................28
  4.8.1. Gender Equality & Human Rights Based Approach...............................28
  4.8.2. Result Based Management.......................................................................28
  4.8.3. Systems Strengthening/Capacity Building...............................................29
4.9. Environmental sustainability............................................................................30

5.0. Conclusions......................................................................................................31

6.0. Challenges/Gaps.............................................................................................32
  6.2. Recommendations for Mitigating Challenges..............................................32
  6.3. Programmatic/Technical Challenges & Gaps...............................................33
    6.3.1. Enabling Environment..........................................................................33
    6.3.2. Prevention..............................................................................................33
    6.3.3. PMTCT..................................................................................................34
    6.3.4. Care & Treatment..................................................................................35
    6.3.5. Gender as a Cross-cutting Issue.............................................................35
    6.3.6. Impact mitigation...................................................................................36
    6.3.7. Monitoring & Evaluation........................................................................36

7.0. Lessons Learned/Good Practices...................................................................37

8.0. Recommendations for the UN in Tanzania.....................................................38
  8.1. Areas for Further Research..........................................................................38


Appendix.................................................................................................................41
### LIST OF ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABCT</td>
<td>AIDS Business Coalition of Tanzania</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>AMICAALL</td>
<td>Alliance of Mayors’s Initiative for Community Action on AIDS at Local Level</td>
</tr>
<tr>
<td>ART</td>
<td>Anti Retroviral Therapy</td>
</tr>
<tr>
<td>AWP</td>
<td>Annual Work plan</td>
</tr>
<tr>
<td>BCC</td>
<td>Behavior Change Communications</td>
</tr>
<tr>
<td>CA</td>
<td>Coordinating Agent</td>
</tr>
<tr>
<td>CCE</td>
<td>Community Capacity Enhancement</td>
</tr>
<tr>
<td>CHAC</td>
<td>Council HIV &amp; AIDS Coordinator</td>
</tr>
<tr>
<td>CMAC</td>
<td>Council Multi-sectoral AIDS Committee</td>
</tr>
<tr>
<td>CSOs</td>
<td>Civil Societies Organizations</td>
</tr>
<tr>
<td>CSW</td>
<td>Commercial Sex Workers</td>
</tr>
<tr>
<td>CUF</td>
<td>Civic United Front</td>
</tr>
<tr>
<td>DEDs</td>
<td>District Executive Directors</td>
</tr>
<tr>
<td>DP</td>
<td>Development Partners</td>
</tr>
<tr>
<td>FFT</td>
<td>Food For Therapy</td>
</tr>
<tr>
<td>GBV</td>
<td>Gender Based Violence</td>
</tr>
<tr>
<td>GF</td>
<td>Global Fund</td>
</tr>
<tr>
<td>GoT</td>
<td>Government of Tanzania</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HLI</td>
<td>Higher Learning Institutions</td>
</tr>
<tr>
<td>JFFLS</td>
<td>Juniors Farmer Field and Life School</td>
</tr>
<tr>
<td>JP3</td>
<td>Joint Programme 3</td>
</tr>
<tr>
<td>MA</td>
<td>Management Agent</td>
</tr>
<tr>
<td>M &amp; E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MDA</td>
<td>Ministries Departments and agencies</td>
</tr>
<tr>
<td>MKUKUTA</td>
<td>Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania</td>
</tr>
<tr>
<td>MKUZA</td>
<td>Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Zanzibar</td>
</tr>
<tr>
<td>MOEVT</td>
<td>Ministry of Education and Vocational Training</td>
</tr>
<tr>
<td>MOHSW</td>
<td>Ministry of Health and Social Welfare</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have Sex with Men</td>
</tr>
<tr>
<td>MTEF</td>
<td>Medium Term Expenditure Framework</td>
</tr>
<tr>
<td>MTPs</td>
<td>Medium Term Plans</td>
</tr>
<tr>
<td>NACOPHA</td>
<td>National Council for PLHIV</td>
</tr>
<tr>
<td>NACP</td>
<td>National AIDS Control Programme</td>
</tr>
<tr>
<td>NEHSHP</td>
<td>National Essential Health Sector HIV Intervention Package</td>
</tr>
<tr>
<td>NMSF</td>
<td>National Multi-sectoral Strategic Framework</td>
</tr>
<tr>
<td>NPS</td>
<td>National Prevention Strategy</td>
</tr>
<tr>
<td>OVC</td>
<td>Orphans and Vulnerable Children</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
</tr>
<tr>
<td>PLHA</td>
<td>People Living with HIV/AIDS</td>
</tr>
<tr>
<td>PLWHIV</td>
<td>People Living With HIV</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission of HIV</td>
</tr>
<tr>
<td>RAS</td>
<td>Regional Administrative Secretary</td>
</tr>
<tr>
<td>RBM</td>
<td>Result Based Management</td>
</tr>
<tr>
<td>RH</td>
<td>Reproductive Health</td>
</tr>
<tr>
<td>SW</td>
<td>Sex Workers</td>
</tr>
</tbody>
</table>
TA...........................Technical Assistance
TACAIDS................Tanzania AIDS Commission
TAPAC....................Tanzania Parliamentarian Coalition on AIDS
TB...........................Tuberculosis
TCM........................Tanzania Coordination Mechanism
THMIS.....................Tanzania HIV&AIDS and Malaria Indicator Survey
TOMSHA...................Tanzania Output Monitoring System for Non-medical HIV/AIDS
TOR.......................Terms Of Reference
TOT.......................Training of Trainers
TUCTA...................Tanzania Employees Trade Union
UN...........................United Nations
UNAIDS...................Joint United Nations Programme on AIDS
UNDAF.....................United Nations Development Assistance Framework
UNDAP.....................United Nations Development Plan
UNFPA.....................United Nations Fund for Women
UNVS.......................United Nations Volunteers
VCT........................Voluntary Counseling and Testing
VMACs.....................Village Multi-sectoral AIDS Committee
WETS......................Women Engaging in Transactional Sex
WHO.......................World Health Organization
WMACs....................World Multi-sectoral AIDS Committee
WPP.......................Work Place Programme
ZAC.......................Zanzibar AIDS Commission
ZACP......................Zanzibar AIDS Control Programme
ZNCP......................Zanzibar National Strategic Plan
Executive Summary

This is a report of the Final evaluation of the United Nations Joint Programme on HIV/AIDS in Tanzania (JP3) which was implemented for a period of four years from 2007 to June 2011 with UNAIDS as the Coordinating Agent (CA) and UNDP as the Management Agent (MA). The evaluation was carried out from August to September, 2011.

The purpose of the evaluation was to assess the achievement of results (outputs and outcomes) of the JP3 on support of the HIV and AIDS national response in Tanzania mainland and Zanzibar. Specifically, the evaluation assessed the appropriateness, relevance, effectiveness, efficiency, impact and sustainability of the JP3, identifying challenges, and lessons learned and drew conclusions to inform new programmes and also contribute to decision making processes of the GoT and partners.

The evaluation used Primary and Secondary data gathering methodologies and made efforts to triangulate data from different sources, interviewing over 150 stakeholders in different regions and districts of Tanzania Mainland including Temeke, Arusha, Kilimanjaro, Siha, Hai and Tanzania Zanzibar.

a. Major findings and recommendations

The evaluation report comes in nine chapters, the first three chapters gives a description of the JP3 programme, its aims and purpose, it further on relates the programme to the National response in Tanzania and Zanzibar, the chapters also include a description of the methodology used and the different tools developed and their applicability. The rest of the chapters are analysis of the programmes, including results and evidences in the different thematic areas, this area also include conclusions, Lessons Learnt and recommendations both for the UN and government of Tanzania. Below is a summary of the key findings and recommendations based on the criteria as given in the Consultants Terms Of Reference (TOR).

b. Relevance

The JP3 was found to be highly relevant to the achievement of Tanzania National priorities as expressed in the Mkukuta for Tanzania Mainland and Mkuza for Zanzibar, it has also geared Tanzania forward in its vision to achieve the Millennium Development Goals, particularly the HIV/AIDS related goals (6).

c. Appropriateness

With over one million people out of its forty million populations living with HIV, concerted efforts were needed to curb the spread of the infection. The UN joint programme on HIV (JP3) was strategically planned to provide the necessary support to help Tanzania and Zanzibar respond to the HIV/AIDS pandemic.

d. Efficiency and Effectiveness

The evaluation found out that although the programme was highly effective, considering the amount of resources it operated with, however its efficiency was compromised by the slow response systems and processes which delayed programme implementation.
e. Outcome/Impact
The programme was found to have high impact through the results generated from the field. Over eighty percent (80%) of the JP3 work plans were carried out and most of the outcomes have been achieved with evidences.

f. Sustainability
The sustainability of the Programme is mixed, while some systems and structures supported by the JP3 can be sustained, it may be difficult to sustain others, particularly those that affect the use of financial resources to generate impact.

g. Partnerships and Coordination
With a wide range of partners cutting across the country, the JP3 have succeeded in fostering relationship. The technical and management coordination too has been successful except with issues of delay in fund disbursement and the need for more joint initiatives.

h. Conclusion
The evaluation revealed that the JP3 programme has been very successful, the programme is highly appreciated for its accomplishments as enumerated by partners and beneficiaries. There are however several areas that the programme can improve upon.

1.0. Introduction/Background to the Joint Programme 3

Tanzania with an estimated population of 41.9million people (mid 2010 projection) has a total area of 945087 square kilometers with land area 886,037 km², water 59050km² with Mount Kilimanjaro, the highest point being 5892m.
The country is divided into 24 administrative regions in mainland and 5 administrative regions in Zanzibar, these administrative regions are subsequently divided into districts (over 140 in Mainland and 10 in Zanzibar).
The total fertility rate for Tanzania is put at 5.4 children born per woman and infant mortality rate is estimated to be 95.27 deaths/1000 live births. The life expectancy at birth for total population is 46.17 years while age specific for male is 43.85 years and female is 48.57 years.
Since the first three AIDS cases were reported in 1983, the epidemic has reached every district and has spread to the general population. HIV/AIDS has had a devastating impact in all socio-economic sectors in the country especially among the most economically active 15-45 year old populations. Number of people living with HIV is put at 1,400,000 below is a breakdown of the prevalence by age1: -
- Adults aged 15 – 49 prevalence rates 5.6 %
- Adults aged 15 and up living with HIV 1.2 million
- Women aged 15 and up living with HIV 730,000
- Children aged 0 to 14 living with HIV 160,000
- Deaths due to AIDS 86,000
- Orphans due to AIDS (aged 0 to 17) 1,300,000

---

1 Source: WHO Report 2009
1.1. National Response to HIV/AIDS on Mainland

Since the first HIV/AIDS cases were detected in Tanzania significant efforts have been made by the government in addressing the pandemic. Those efforts were mainly concentrated in the Health Sector, thus, the National AIDS Control Programme was formed to spearhead the fight against HIV/AIDS. The response began to be multi-sectoral in 2001 with the establishment of the Tanzania Commission for AIDS (TACAIDS) as the coordinating body for the national response to HIV, which has a mandate to provide strategic leadership in formulating HIV policies, national level advocacy, resource mobilization and coordinating the country’s multi-sectoral response. The national response is guided by the National Multi-sectoral Framework on HIV and AIDS (NMSF); the first of which was from 2003-2007 and the second (current) from 2008-2012. The NMSF priorities are to enhance the enabling environment for prevention, care, treatment, support and mitigate the impact of the pandemic. Programme priorities include targeting higher risk populations such as FSW; women engaging in transactional sex (WETS) MSM, IDUs, Youths, sexually abused children, widows, divorces, prisoners, refugees and displaced people and people with disabilities. Prevention of mother to child transmission of HIV (PMTCT) is another strategy, it was adopted in 2000. The targets of the PMTCT as a programme is to have at least 80% of pregnant women living with HIV receive ART by 2012. Other associated targets include reduction of mother to child HIV transmission during pregnancy, at birth and during breastfeeding; ensure access to care and treatment for mothers and babies and increase child survival among HIV exposed and infected children. Tanzania launched its HIV/AIDS care and treatment plan in 2003 and in 2006, NACP adopted the WHO patient monitoring system. Tanzania’s HIV/AIDS response remains highly dependent on financial and technical assistance from development partners with more than 95% of resources coming from US-PEPFAR (75%) and the Global Fund to fight AIDS, Tuberculosis and Malaria (20%). Other resources come from other multilateral and bilateral organizations and private charities. A bigger proportion of funding from GF and PEPFAR was for care and treatment 58%; followed by prevention 23% for 2009/2010.

1.2. National Response to HIV/AIDS in Zanzibar

In Zanzibar, the first HIV/AIDS cases were identified in 1986 at Mnazi Mmoja National Hospital. A technical committee was formed to address issues of HIV under the Chief Ministers Office. The response to the pandemic has since then gone through a number of coordinated efforts initially using the Medium Term Plans (MTPs). There were differences in scoping among MTP I – II and subsequently MTP III. MTP I & MTP II were health sector based while MPT III was multisectoral. ZACP was established in 1987 with the formation of Technical AIDS Committees in all ministries – ZACP could not easily interact with all sectors as its mandate was limited. The Zanzibar AIDS Commission (ZAC) was formed in 2002 and was multi-sectoral in nature. A situation analysis led by ZAC identified 18 issues which formed the basis for the first multi-sectoral HIV/AIDS strategy in Zanzibar, the Zanzibar National Strategic Plan ZNSP 2005-2009. However the MOHSW still prepared the HSSP for the health sector response responding to the health prevention, care and treatment component of ZNSP. MDAs were also expected to create positions for HIV/AIDS focal persons. Some Ministries such as the Ministry of Health and Social Welfare established
Technical Committees for HIV. Though there was the Zanzibar AIDS Control Programme in the health sector, there was no HIV/AIDS health sector policy. The national response was adversely affected by Donors embargo imposed on Zanzibar during the aftermath of the 1995 past election, which the ruling party CCM won by a small margin and was highly contested by the main opposition party the Civic United Front (CUF). The UN agencies WHO, UNICEF, UNFPA and UNDP continued to provide some assistance to the HIV/AIDS response, and International NGOs such as AFRICARE were also actively involved in HIV/AIDS activities. Most of the responses were focused on awareness raising which reached many (about 96%); but the challenge remained and still remains in translating the awareness into behavioral changes particularly among the vulnerable groups such as sex workers, IDUs and the youths. Other groups identified as vulnerable include; women, house girls and mobile population. The Zanzibar National HIV/AIDS Strategic Plan (ZNSP) 2004/5 – 2008/9 was developed and adopted as the framework for responding to HIV/AIDS, replacing the Medium Term Plans (MTPs), which were implemented from 1987 to 2002. The main focus of the Strategic Plan was to ensure that HIV epidemic is contained through a multi-sectoral involvement of as many partners and actors as possible and also focus attention to priority groups so as to reduce the impact of the epidemic and minimize the spread of HIV transmission to the general population. There was however a programmatic shift from addressing HIV/AIDS as a generalized epidemic to that of concentrated type towards the end of implementing ZNSP I that has evidenced high prevalence rates in certain sub key populations especially MSM with prevalence rates of 12.3%; CSW with prevalence rate of 10.8%; IDUs with prevalence rates of 16%. The revised strategic plan now pays more attention to these groups. This approach has been fully incorporated in ZNSP II.

1.3. UN Support

HIV/AIDS cuts across the mandates of all UN agencies working in Tanzania. There has been a joint UN programme of action on HIV/AIDS long before Tanzania became a pilot country in the Delivery as One principle. The one UN Joint Programme on HIV/AIDS brought together the extensive technical expertise and experience of all UN agencies into a single, streamlined and coordinated programme of support, capitalizing on the comparative advantages of each. The Joint Programme aimed at supporting the strong political commitment and leadership which was shown at the highest levels of Government and Civil Society by putting HIV and AIDS top on the agenda of development for both mainland and Zanzibar. Furthermore the Joint UN programme on AIDS (JP3) focused on assisting relevant/key stakeholders to address the many challenges to an effective National AIDS response. The Joint Programme on HIV and AIDS has enhanced the strategic position of the UN as a critical supporter of the creation of an enabling environment where other partners can effectively play for a common cause of combating HIV and AIDS. Policy level support by the UN is usually readily accepted because it is considered to be free of political bias or influence. The vision of the JP3 was to build partnerships to provide an effective and sustained national response to HIV and AIDS as ONE UN in line with MKUKUTA and MKUZA and support Universal access to prevention, care, treatment and support in Tanzania. The JP3 programme relates to both MKUKUTA and MKUZA crosscutting theme, it also relates to the MDG 6. When the programme was started in 2007, AIDS was the leading cause
of deaths among young adults. In Tanzania Mainland the HIV prevalence rates in adults aged 15-49 was 7% (women 7.7% and men 6.3%). However, in Zanzibar the prevalence rates in the general population was low at less than 1%, although among specific population such as drug users the rates are much higher. About 2 million children have been orphaned or made vulnerable as a result of the epidemic.

The results/efforts of the UN JP3 aligned and supported the national priorities specified in MKUKUTA and MKUZA for Tanzania Mainland and Zanzibar respectively.

2.0. Scope of the Evaluation

The Final evaluation of the Joint United Nations Programme on HIV/AIDS (JP3) is an independent evaluation, though it was to be completed prior to the completion of the programme but it was not started until the programme ended in July 2011. The result of the evaluation was expected to provide inputs to the development of the United Nations Development Assistance Program (UNDAP 2011-2015) as well as any specific activities or programs which might succeed the JP3 in support of the national response against HIV/AIDS in Tanzania.

The purpose of this evaluation is to assess the achievement of results (outputs and outcomes) and management of the JP3 on support of the HIV and AIDS national response in Tanzania mainland and Zanzibar. More specifically, the evaluation aims to:

- Assess the appropriateness, relevance, effectiveness, efficiency, impact and sustainability of the Joint Programme 3;
- Identify lessons learned and draw conclusions which may inform the new UNDAP programme on HIV/AIDS and which can contribute to decision making processes of the UN, GoT and partners.
- Assess the planning and monitoring of the JP3 and its AWP: the process and methodology used, providing evidences and quality of involvement of each of the 2 Governments aiming at measuring the gained capacity;
- Assess the coordination of the sub recipients by ZAC and TACAIDS for all JP3 related activities;
- Assess the funds management/allocation by UNDP for the One Fund and UN Agencies for their parallel resources: system used its constraints and its advantages.

3.0. Evaluation Methodology

3.1. Introduction

This chapter discusses the methodology used on the evaluation, it includes the different tools developed and its applicability, it also includes the variety of data collected to determine performance and trend of the JP3.

To achieve the evaluation objectives, the Consultants used both Primary and Secondary data sources to collect information. Primary data was generated from Key Informant interviews including (Face to Face and Phone interviews) and Focus Group Discussions, while
secondary data was generated from desk review of documents such as DaO document, UNDAF/JP3 guidelines and standards, Annual Work Plans from 2007 to 2011, Progress, Annual and M&E reports from individual agencies and from the UN as a whole. Other documents from IPs and international donors were also reviewed. The Consultants also carried out reviews of national research surveys, government data, results of evaluations and research reports from TACAIDS, ZAC and other reputable organizations or research institutions.

The data collected during the evaluation process demonstrated how the Joint Programme performed in relation to its goals and strategic directions in the 5 thematic areas. The data also provided insights into what is working and what is not working whether there are lessons learned, benefits and challenges associated with JP3 implementation and outcomes. HIV/AIDS cuts across several sectors, therefore multiple assessment tools were used and due to limited time for the evaluation, a selected sample of institutions, groups and individuals were used. The evaluation mapped the entire programme outputs of the various activities, projects and programmes to the expected outcomes and the five thematic areas were assessed. Also assessed was the Programme Management support/systems strengthening, this is an area that the JP3 had contributed immensely.

Field interviews were conducted in the following areas, Tanzania Mainland (Temeke in Dar es salaam, Shinyanga, Siha in Kilimanjaro) & Tanzania Zanzibar. Evaluation schedule and work plan is presented below:

**Table 1: – Evaluation Work plan**

<table>
<thead>
<tr>
<th>Activities</th>
<th>Dates</th>
<th>No of working days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial preparations and familiarization with the UNDAF/JP3 documents, ...</td>
<td>August 01 – 05, 2011</td>
<td>5</td>
</tr>
<tr>
<td>Communications &amp; Meetings with JP3 team including TACAIDS in Dar es Salaam</td>
<td>August 08 – 12, 2011</td>
<td>5</td>
</tr>
<tr>
<td>Field work in Temeke &amp; Mainland</td>
<td>August 15 – 19, 2011</td>
<td>5</td>
</tr>
<tr>
<td>Field work in Shinyanga, Kilimanjaro &amp; Zanzibar</td>
<td>August 22 – 26, 2011</td>
<td>5</td>
</tr>
<tr>
<td>Continuation of interviews in Dar es Salaam and drafting of Report</td>
<td>August 29 – 09 September 2011</td>
<td>5</td>
</tr>
<tr>
<td>Continuation of interviews and Submission of Draft report</td>
<td>September 06 – 09, 2011</td>
<td>3</td>
</tr>
<tr>
<td>Presentation of Findings in PowerPoint &amp; Submission of Final Report</td>
<td>September 14 – 15, 2011</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>30</strong></td>
</tr>
</tbody>
</table>

Data collection tools were developed with the following considerations:
• The Joint programme (JP3) is multidimensional in terms of intervention areas with multiple implementing partners and a variety of target group (beneficiaries)
• The ongoing UN Reforms of Delivering as One

Semi structured Questionnaires and checklists were developed for surveys and interviews to gather primary data. A specially designed assessment tool was also used to assess the evaluation criteria stated in the Consultants’ Terms of Reference (TOR), this tool was administered to key informants to explore their perceptions, understanding and views on JP3. PUNs also had an opportunity to assess themselves in the listed criteria. Interviews were conducted with key stakeholders at National, Districts and Councils level, consultations were also held with Governments Ministries, Departments and Agencies (MDAs) officials, important implementing agencies and beneficiaries of relevant programme such as CSOs, PLWHA, OVC and IDUs were also interviewed. The PUNs also had opportunities to express themselves particularly on the JP3 implementation, achievements and coordination.

Besides interviewing PUNs from UNAIDS, UNDP, UNFPA, UNICEF, UNESCO, WHO, WFP, IOM & ILO, the consultants visited Temeke, Shinyanga, SIHA, HAI, Kilimanjaro, Arusha and Zanzibar. In Temeke, Shinyanga and Kilimanjaro, the consultants conducted Key informant interviews with the United Nations Volunteers (UNVS), Council HIV/AIDS Coordinators (CHACS) and some District Education Directors (DEDs). In SIHA, HAI and Zanzibar, the consultants had group discussions with PLWHA and OVC. Also a JP3 supported programme (The Junior Farmer Field project) was visited in SIHA. In Zanzibar, the Consultants visited a privately initiated rehabilitation centre for IDU and other drug abusers.

Another method used to generate primary data was the Focus Group Discussions. FGDs were held with key stakeholders (participating voluntarily). This was intended to fully explore stakeholder’s experiences and perceptions of the JP3. FGDs were held with PLWHIV in Mainland, Temeke, Shinyanga, Siha and Zanzibar. FGDs were also conducted for MVC in the Siha district.

Table 2: - List of Individuals/Organizations interviewed

<table>
<thead>
<tr>
<th>S/N</th>
<th>List of Individuals/Organizations interviewed</th>
<th>Interview channel</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>PUNs</td>
<td>In depth interviews</td>
</tr>
<tr>
<td>2.</td>
<td>TACAIDS &amp; ZAC</td>
<td>FGD &amp; In-depth interviews</td>
</tr>
<tr>
<td>3.</td>
<td>MDAs</td>
<td>FGD &amp; In-depth interviews</td>
</tr>
<tr>
<td>4.</td>
<td>PLWHIV (Men &amp; Women)</td>
<td>FGD</td>
</tr>
<tr>
<td>5.</td>
<td>MVC</td>
<td>FGD</td>
</tr>
<tr>
<td>6.</td>
<td>UNVs</td>
<td>In-depth interviews</td>
</tr>
<tr>
<td>7.</td>
<td>CHACS, DED &amp; UNVs</td>
<td>In-depth interviews</td>
</tr>
<tr>
<td>8.</td>
<td>NACP &amp; ZACP</td>
<td>In-depth interviews</td>
</tr>
<tr>
<td>9.</td>
<td>CSOs</td>
<td>FGD and/or In-depth interviews</td>
</tr>
<tr>
<td>10.</td>
<td>Development Partners (DPG Group)</td>
<td>FGD</td>
</tr>
</tbody>
</table>
3.2. Limitations and Guiding principles of the evaluation

During the conduct of this evaluation, there were several holidays like the Eid and the Farmers Day during which interviews could not be conducted. Also, at this period, there was shortage in Automobile and Aviation fuel and this posed a challenge to moving around in Tanzania. The consultants had no choice than to use a Non- Probability sampling method - Convenience sampling in choosing sites to be visited. Also, given the short period of the evaluation and the enormous work due to the fact that most UN agencies in Tanzania are members of the JP3 team as HIV/AIDS is a cross-cutting issue in UN work, moreover, it is also a multi-sectoral issue, it was therefore not possible to get data on all the indicators developed in the evaluation matrix within the time given for the evaluation. The consultants however made sure that available options like reports, interviews etc were fully employed. The consultants ensured that Key stakeholders and implementing partners were reached and relevant documents were obtained. The evaluation is limited to Joint Programme 3 interventions (2007 to 2011).

This evaluation was conducted in accordance with the United Nations Evaluation Group “Norms for Evaluation in the UN System” and “Standards for Evaluation in the UN System”.

4.0. Evaluation Findings

Introduction

This chapter is an assessment of the JP3 outputs and outcomes against the evaluation criteria given in the Consultants TOR. These criteria are: - The relevance or appropriateness of the programme outputs and outcomes in achieving Tanzania’s development goals, the efficiency at which the JP3 delivered its outputs and outcomes, the effectiveness of key results, the impact of the JP3 among host communities including vulnerable groups, sustainability of progress made and key lessons learnt for partnership and coordination processes.

4.1. Relevance of the JP3

The evaluation revealed that the JP3 outputs and outcomes derived from the UNDAF are very relevant to the achievement of Tanzania’s national development goals and the Millennium Development Goals (6). From the vision to build partnership to provide effective and sustained national response to HIV and AIDS as ONE UN in line with Mkukuta and Mkuza to support Universal Access to prevention, care, treatment and support in Tanzania, the UN had supported several activities and interventions: -

The JP3 supported the review of Mkukuta/Mkuza I and initiated the MKUKUTA and MKUZA II, mainstreaming of HIV/AIDS. It also supported the development and costing of the NMSF, which guided the development of an operational plan with dissemination and capacity building both at national and regional levels. The gender operational plan which
guides the mainstreaming of gender in HIV/AIDS responses has been finalized and is currently being implemented through MDAs and District level.

Moreover, to achieve improvement in quality of life and social wellbeing (Mkukuta/Mkuza Cluster 11), the JP3 is working to enhance the livelihood and increase food availability among most vulnerable groups in 12 districts with more than 29,000 beneficiaries. The national HIV/AIDS prevention strategy and a costed plan was finalized in both Swahili and English and disseminated in 10 regions, furthermore, achievements have been recorded in the scaling-up programme for male circumcision in the context of HIV prevention. Guidelines and messages for BCC/SCC interventions have been adopted and disseminated. 52 tutors and 100 teachers were trained for Life Skills education initiatives. With support from JP3, AMICAALL is building the capacity of Local Government and Municipals to participate actively and respond effectively to the HIV/AIDS challenges. Local politicians, Mayors, Chairpersons and Councilors were trained to lead an effective multi-sectoral local response to HIV and AIDS.

Another very relevant approach used by the JP3 is evidence based approach. Most of the programmes and projects were developed based on a needs assessment and or situation analysis an example is the Organizations Capacity Assessment conducted by Deloitte in 2010 resulting in capacity development of eight network organizations in 2011. Another example is the Assessment on prevalence of high pregnancy rate in Muheza and Handeni districts which resulted in the training of in service primary school teachers in Reproductive Health in the areas in 2011, Assessment on strengthening the country’s coordinating mechanism in 2010 and Gender Index assessment, all of which are being implemented now among other studies.

JP3 is the major Donor supporting HIV/AIDS in Zanzibar, the support was highly appreciated because of its relevance to the achievement of the HIV/AIDS priorities. BCC messages targets the general population and capacity building on MARPs in the public sector has taken place. FBOs, ZAPHA+ and media have been trained in the application of an anti-stigma tool kit. Zanzibar National Strategic Plan has been reviewed and finalized to improve focus on the MARPs. The HIV/AIDS Act has been finalized after a HIV legal audit in Zanzibar. The Zanzibar multi-sectoral M & E system is now functional.

The evaluation noted that all partners were carried along in the development and implementation of the JP3. Those of them who took over office more recently said they found their work plan in line with that of the JP3. Sector wide reviews involving stakeholders and partners have regularly taken place.

Another very relevant achievement of the JP3 is in the assessment and capacity building of nine CSO networks and umbrella organizations working in HIV/AIDS in Tanzania, the assessment revealed areas of weaknesses in the different organizations and capacity development efforts were targeted at these areas. The organizations were also mentored and evaluated to see how they were able to put into practice their newly acquired skills. Though this particular intervention has been criticized for cost-inefficiency, but it said to be the first that development partners would address the issue of capacity building of Umbrella organizations working in HIV/AIDS in Tanzania. Also, assessment of gender related factors
that facilitate risk, vulnerability and impact of HIV/AIDS among women, men, girls and boys have led to the development of a Gender operational plan. A stigma index was also carried out and findings disseminated widely in both public and private sectors.

The Junior Farmers Field and Life Skill Approach is another project that has been judged to be very successful, both in terms of delivering as one among PUNs, and partnering with government and CSOs. The project involved three PUNs namely, UNICEF, WFP and FAO, Vet Aid, KIWAKKUKI and TACAIDS all working together in a united manner to improve food security, reduce stigma, empower and increase the confidence of vulnerable people.

The strengthening of local leadership in multi-sectoral response to HIV/AIDS at the local level is by AMICAALL through funding from the JP3 is another laudable initiative, Through the support of JP3 Leaders at the local level were strengthened to create an enabling environment for stakeholders to actively and effectively participate in prevention, care, support and impact mitigation of HIV/AIDS.

4.2. Programme Efficiency and Effectiveness

The efficiency and effectiveness criteria looks at the extent to which the UN agencies plan together to achieve coherence and deliver as one, the cost effectiveness of the programme in terms of reducing transaction costs internally as well as externally. It also looks at the extent at which key results were achieved and the factors affecting the (none) achievement of the desired results.

The evaluation revealed that the initial planning of the programme (2007 -2008) focused more on prevention, but later on in subsequent years, better planning was done with the involvement of all PUN agencies including ILO and IOM and a wider group of partners.

The JP3 programme has proved to be very effective in supporting the Tanzanian National Response to HIV/AIDS. At the national and sub-national levels, the programme supported the creation of an enabling environment such as the policy and legal frameworks conducive for the development and implementation of micro interventions, these include the development of various technical guidelines, support to national level programming and capacity development (TACAIDS and ZAC) and Behavioral Change Communication Strategies etc. The JP3 upstream interventions especially those of enabling environment in legal, policy framework and technical guidelines were particularly very effective.

Looking downstream at programme effectiveness, results showed that the JP3 have effectively supported the engagement of strong community-based implementing partners in both HIV/AIDS prevention, care and treatment and impact mitigation interventions such as assisting in the improvement of food and livelihood security of HIV positive individuals and orphans.

4.2.1. Efficiency

Efficiency in strict economic sense entails the comparison of costs and outputs, it is regarded as high when costs are minimized and outputs maximized. In JP3, efficiency considers the
operational factors in terms of timing and process/procedure of programme activity implementation that might lead to increase or decrease in costs and or productivity.

By harmonizing work plans and making sure PUNs work in the area in which they have comparative advantage against others, the JP3 has efficiently reduced time and maximized productivity. Agencies are now aware of each other’s activities and location, and issues of duplication no longer exist. However, IPs complained that PUNs sometimes hurry them up to implement programmes or activities though the initial delay may have previously come from the PUNs themselves. In some cases, it was reported that programmes were hurriedly carried out without allowing the IPs to plan properly to beat deadlines, the recent case where the MoE was forced to either implement a programme or return the fund despite the fact that the Ministry was undergoing some problems is an example.

Delay in receiving funds is said to be a major factor that has hampered the efficiency of the programme, most activities are carried out late due to the fact that funds have to go through multiple banks and/or several bureaucratic procedures before getting to IPs.

4.2.2. Effective use of Time

The use of Parallel funds sometimes means agencies bypass the IPs (TACAIDS & ZAC) and fund sub-IPs directly to save time attributed to delays caused by government bureaucracy in accounting and reporting. Such interventions are carried out with direct supervision of agencies. At the same time, GoT and some CSOs complain of UN’s accounting procedure the FACE, which they said was too detailed and cumbersome, this they said brings about delays in submitting financial reports on time. Delay in transferring of funds through multiple banks to the IPs also affects implementation of activities.

The process of working directly without involving TACAIDS/ZAC contravenes the three ones and the one fund process. It also imposes additional pressure on the sub-IPs, who sometimes had to write multiple reports to the different agencies instead of writing one main report to TACAIDS.

4.3. Programme Outcomes/Impact

Though the JP3 programme was carried out with very little fund compared to the US government and the Global Fund, the evaluation noted that due to the relevance of JP3 in addressing government’s identified priorities, it had yielded high impact either directly or indirectly in Tanzania.

The design and implementation of the JP3 was observed to have adopted the structural and operational fit into National Priorities as defined both in MKUKUTA and MKUZA and specifically cluster II focusing on quality of life and social wellbeing. The programme also relates well to MDG 6 the Reduction of the Burden of AIDS, TB and Malaria. Furthermore, it is under the UNDAF outcome of increased access to quality basic social services for all by focusing on the poor and most vulnerable.

The following section summarized the main outputs and evidenced based outcomes and impacts of the programme in the course of its four years of implementation: -
4.3.1. Thematic Area: Enabling Environment

**Output 1:** Development of the NMSF and costed implementation plan and subsequent dissemination to regional and local authorities. This was accompanied by the development of the Essential package for HIV and AIDS intervention - a planning framework for local authorities to develop council multi-sectoral HIV/AIDS plans.

**Evidenced based Outcomes/Impacts**

- Improvement in Local authorities’ development planning and mainstreaming of HIV/AIDS by introducing objective “A” in each sector/department plan.
- Local authorities are now gradually developing the habit of allocating resources for HIV/AIDS interventions from their own sources rather than relying solely on central government grants.

**Output 2:** Capacity for National Response to HIV and AIDS at all levels: The JP3 has significantly contributed in the development of capacity to enhance the response to HIV/AIDS at all levels beginning with TACAIDS.

**Evidenced based Outcomes/Impacts**

- The Technical Assistance provided to TACAIDS has resulted into operational/management systems being instituted at TACAIDS.
- At the local authority level multi-sectoral AIDS committees (CMACs, WMACS and VMACS) have been formed and trained at least up to council level. All 132 local authorities have CMACS and lower level wards and village multi-sectoral committees. The formation of these structures has significantly enhanced the programming of HIV/AIDS interventions as evidenced in the LGAs development plans.
- The placement of UN volunteers in 45 local authorities/District councils has boosted their capacity in the response to HIV/AIDS.
- Community participation has been enhanced through the community capacity enhancement initiatives (CCE). This was particularly evidenced in Temeke Municipal Council and Shinyanga Municipal Council.
- The TAF Strategic Plan was developed and members were organized and oriented to participate in various national HIV/AIDS forums.

**Output 3:** Strengthening capacity of CSOs, particularly NACOPHA (National Council of People living with HIV).

**Evidence based Outcomes/Impacts**

- NACOPHA now have a constitution, a strategic plan and the Chief Executive Officer is supported by the JP3. The organization has 11 registered National networks of PLHIV and 58 District clusters.
- The strengthening of NACOPHA has resulted into increased and active participation of PLHIV through national networks or District clusters in activities of Local government authorities CMACs, WMACs and VMACs.
- Support to PLHIV has increased significantly in terms of availability of ARVs, drugs for opportunistic infections, nutritional and psychosocial support.
Stakeholders providing services to PLHIV have increasingly recognized the need for engaging and involving PLHIV in service delivery programmes at the community level. The most significant impact has been the reduction of stigma which has resulted into PLHIVs coming out openly to engage in productive activities.

The Association of Journalists in Tanzania has also been strengthened to participate in the national response to HIV/AIDS.

**Output 4:** Mainstreaming of HIV and AIDS interventions into sectoral strategic plans and also integrating HIV/AIDS in Medium Term Expenditure Frameworks (MTEF).

**Observable Outcomes/Impacts**

- MDAs at Central level have mainstreamed HIV and AIDS by appointing HIV focal persons and HIV/AIDS Technical committees;
- HIV/AIDS has been mainstreamed in National Strategy for Economic Growth and Poverty Reduction (MKUKUTA);
- MDAs have formulated and do implement HIV/AIDS work place programmes

**Output 5:** Political Leadership shows significant support towards the National HIV and AIDS response.

**Observable Outcomes/Impacts**

- Parliamentary HIV/AIDS committee (TAPAC) has been formed and is leading in advocacy campaigns using the IEC materials produced under the communication strategy.
- National leaders led by his Excellency the President have shown public support particularly towards VCT.
- Parliamentary Standing Committee on HIV/AIDS has been established to ensure that HIV/AIDS is part of Parliamentary deliberation

**Output 6:** Reform of Legal framework in support for the National response has taken place.

**Evidence based Outcomes/Impacts**

- The National HIV and AIDS Act was developed and enacted in 2008. The JP3 was actively involved particularly in facilitating forums for CSOs, PLHIV networks to participate in discussions that generated ideas as inputs to the HIV/AIDS Act
- Technical AIDS Committees have been formed and are operational in the Judiciary Department and affiliated institutions.
- The National Policy on HIV/AIDS was also reviewed.

**Output 7:** Gender sensitive strategies and programmes to combat HIV and AIDS at the workplace based on ILO code of conduct.

**Evidenced based outcomes/Impacts:**

- Workplace policies and programmes have been developed and operational in the Public sector Ministries, Departments and Agencies (MDAs).
- The Private Sector is operationalising the policy through the tripartite, Association of Tanzania Employees, Trade Unions (TUCTA) and the Labour department
The AIDS Business Coalition of Tanzania has been formed and is actively involved in the National Response for HIV/AIDS. The private informal sectors have also been capacitated to mainstream HIV/AIDS in their activities.

**Output 8:** Empowering Young Women and Vulnerable Groups

**Evidenced Based Outcomes/Impacts**
- Life and livelihood skills for personal development guidelines and tools have been developed for use among most vulnerable groups such as In and out of school youths and higher learning institutions (HLI).

**4.3.2. Thematic Area: Prevention**

**Output 9:** The National HIV and AIDS Prevention Strategy has been developed and a 2 year Costed Action Plan is in place. The strategy aims at reducing infection by 25% by the year 2012.

**Evidenced Based Outcomes/Impacts**
- The 2 year Costed Strategic Plan has been disseminated and other partners have been reported to be using it for resources mobilization.
- MDAs and Local Government Authorities have also incorporated pertinent parts of the prevention strategy in their Medium Term Expenditure Framework (MTEF).

**Output 10:** HIV prevention Interventions implemented for vulnerable groups such as in and out of school youths and MARPs.

**Evidenced Based Outcomes/Impacts**
- School HIV prevention programmes have been implemented by the Ministry of Education and Vocational Training with more than 50% of teachers being trained in counseling.
- Counseling guides and circulars have been distributed to all schools and Peer educators have been identified and trained in all schools.
- Higher Learning Institutions have been trained using the developed life skills manuals and tools.
- For out of school youths the Ministry of Health and Social Welfare (MOHSW) has developed a strategy in Adolescent Sexual Reproductive Health which is in use.
- For MARPs particularly men having sex with men (MSM), Injecting Drug Users (IDUs) transactional sex workers studies have been instituted to determine the dimensions of the issue so that it can be adequately addressed.
- A methadone and needle exchange programme has been initiated in DSM.

**Output 11:** Prevention of Mother to Child Transmission (PMTCT): Scaling up of Prevention of Mother to Child transmission of HIV in Tanzania. This thematic area benefited substantially from the JP3 as the National Guidelines were developed and disseminated using JP3 funds among other achievements listed below.

**Evidenced Based Outcomes/Impacts**
- Revised PMTCT guidelines have been disseminated and are in use throughout Tanzania and Training of trainers conducted on PMTCT.
Training of service providers in the 7 UNICEF districts of Hai, Siha, Magu, Mtwara, Temeke, Bagamoyo and Makete.
Training of Teams of Clinical Mentors and supportive supervisors – 100 have been trained. This has been accompanied by the building/formation of clinical mentors and supportive supervision teams in 6 regions. These efforts have contributed significantly to the scale-up of PMTCT services
PMTCT coverage has expanded from 544 sites in 2005 to 4300 sites in 2010
The number of women at ANC counseled for HIV testing has risen from about 200,000 in 2005 to about 1,200,000 in 2010. The number of pregnant women who tested for HIV has all along remained at above 90% and 75% of those who were HIV positive accessed ARV prophylaxis

Output 12: Male circumcision as a strategy for HIV prevention: This innovation was also substantially supported by the JP3.

Evidenced Based Outcomes/Impacts
The National Policy and Operational guidelines were developed with Technical Assistance from WHO. The guidelines are being used to scale-up male circumcision interventions in high HIV prevalence (>5%) regions.

Output 13: Availability of condoms
Condom programming has enhanced the availability of the commodity.

4.3.3. Thematic Area: Care and Treatment
Output 14: The essential package for universal access to HIV and AIDS care, treatment and support including Home based care and nutrition. This includes provision of ARVs and other clinical services for the management of opportunistic infections.

Evidence Based Outcomes/Impacts
Over 5000 Health facilities are now providing care and treatment services, about 78.4% of eligible persons for ART were on treatment by June 2010, 7.5% of all persons on ART are children below 15 years of age.
Quality of care for both PLHIV as well as TB patients. 66% of all HIV patients who received at least one clinical service were also screened for signs and symptoms of Tuberculosis. All TB clinics are also screening for HIV infection
TB Guidelines developed, approved and disseminated
National essential health sector HIV interventions package (NEHSHP) in place
Home Based Care (HBC) has been established in 110 districts and is being implemented by health facilities, NGOs, FBOs and CSOs.
Laboratory Services - All hospitals from referral to district hospitals have CDA machines, chemistry and hematological analyzer.

4.3.4. Thematic Area: Impact Mitigation
Output 15: Guidelines for the identification of most vulnerable groups with particular emphasis on children and women has been developed and disseminated.

Observable Outcomes/Impacts
100 out of 133 councils have completed identification of most vulnerable groups using /or according to National identification guidelines.

National Costed Plan of Action for Most Vulnerable Children has been developed and disseminated to all LGAs (133 local authorities).

Food insecurity related to HIV and AIDS reduced - Support was provided to 8 regions Iringa, Kilimanjaro, Dar es Salaam, Coast, Arusha, Manyara, Dodoma and Tanga

**Beneficiaries by Type:**

<table>
<thead>
<tr>
<th>Type</th>
<th>HBC</th>
<th>MVC</th>
<th>TB</th>
<th>PMTCT</th>
<th>FFT</th>
<th>ART</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number</td>
<td>2934</td>
<td>2753</td>
<td>100</td>
<td>95</td>
<td>110</td>
<td>785</td>
</tr>
</tbody>
</table>

**Table 3:** Total 6777 Beneficiaries²

Life skills programme - The Junior Farmer Field and Life School (JFFLS) Empowerment and capacity building have made possible the transformation of juniors (most of them orphaned by HIV and AIDS) from their vulnerability nature to standard life of meeting basic needs and hence improving their livelihood. A total of 30 children were trained as Junior Farmers. This project involved three PUNs and is one of the best case studies for the UN’s delivery as one process.

**Thematic Area: Monitoring and Evaluation**

**Output 16:** Monitoring and Evaluation Tool to capture the non-health responses to HIV and AIDS at all levels.

**Evidence based Outcomes/Impacts**

- TOMSHA data area electronically captured in 70 councils (LGAs); all of them have been supplied with desktop computers and are submitting reports as per requirement. The target is to have all councils electronically connected by 2012.

4.4. ZANZIBAR

4.4.1. Thematic Area: Enabling Environment

**Output 1:** National Responses to HIV and AIDS strengthened

**Evidence Based Outcomes/Impacts**

- Multi-sectoral AIDS coordinating committees established and operational at all 10 districts (DACCOMs) and all SHEHIAS within District (SHACCOMS). These structures have enhanced HIV awareness, prevention strategies and stigma reduction and mainstreaming of HIV in all development activities at these levels
- HIV and AIDS response has been institutionalized in all MDAs by appointing focal point persons to oversee mainstreaming of HIV and AIDS including gender activities.

² World Food Programme Report 2011
Though with limited budgetary allocations all MDAs have attempted to mainstream HIV/AIDS and also implement workplace interventions according to ILO code of conduct.

Engagement of Religious Leaders has been successful. The Zanzibar Interfaith Association for Development and AIDS (ZIADA) have been very instrumental in the fight against AIDS. It conducts trainings to religious leaders, It also produces informative, educational and communication (IEC) materials and manuals from religious (Christian and Muslim) perspectives. The organization also holds mass campaigns during religious and other cultural festivals. The results/impacts have been encouraging as religious leaders now preach with a positive tone to issues related to HIV and has substantially contributed to the reduction of stigma.

Output 2: Legal Reforms in support for HIV and AIDS Response

**Evidenced Based outcomes/Impacts**

- There have been a number of policy and legal reforms, the most significant being the Zanzibar HIV and AIDS Act 2011.

Output 3: The new Zanzibar National HIV and AIDS Strategic Plan (ZNSP 11) which is presently awaiting approval focuses significantly on most vulnerable groups, MARPS and young people and also on specific areas of stigma, discrimination and BCC.

**Evidence based outcomes/Impacts**

- MARPs especially MSM, and CSW have been strategically reached under the UN JP3 by the establishment and facilitation of network of peer educators for both MSM and CSW. This network through weekly activities has identified most of the entire clientele of MSM & CSW and created awareness on the use of safe sex practices. It has substantially scaled up the use of condoms. Members of this group now feel less stigmatized though they are still not in the open because the law does not allow them.
- For young people, life skills programmes have been developed and are used mainly by CSOs to reach the youth.

Output 4: Capacity building for ZAC and umbrella organizations/CSOs in the HIV/AIDS sub-sector.

**Evidence Based Outcomes/Impacts**

- The capacity of ZAC has substantially been enhanced under the JP3, with M&E and other systems improved and instituted.
- The capacity of umbrella organizations especially ZAPHA+ and ZIADA have also been improved, ZAPHA+ membership has increased and weekly therapy and psychological support/counseling meetings have become popular and now reach more than 200 members. As a result of these efforts PLHA membership has grown as more people are coming out of being stigmatized to participate in active life.
- ZIADA has on the other hand been capacitated and have managed to effectively engage religious leaders and are now positively preaching about HIV and AIDS and particularly stigma reduction.
Output 5: Stigma Reduction Efforts Enhanced

Evidence Based Outcomes/Impacts
- ZAPHA+ have been able to provide information and education (IEC) to communities and the general public and PLHIV are now satisfied that the community sees them as normal members.
- There are regular roundtable discussions with members of Parliament, House of Representatives, Political Leaders, women, youth and PLHIV to discuss and testify on issues related to positive living.

4.4.2. Thematic Area: Prevention
Output 6: National HIV Prevention efforts scaled up

Evidence Based Outcome/Impacts
- 280 Out of School Peer Educators and Better Health Club members have been trained in life skills using resources from the JP3 Programme.
- Capacity of Quoranic school teachers developed in Life skill education

Output 7: Prevention of Mother to Child Transmission (PMTCT)

Evidence Based Outcomes/Impacts
- PMTCT services cover all 10 districts of Zanzibar with 39 sites.
- 85% of targeted pregnant women in Zanzibar were counseled and tested for HIV by 2010, out of cumulative figure of women who tested 304 were found HIV positive and 106 received ARV prophylaxis.

4.4.3. Thematic Area: Care and Treatment
Output 8: Increased access to comprehensive care and treatment of HIV and AIDS and other major diseases.

Evidence Based Outcomes/Impacts
- Health care workers have been trained in the implementation of the IMAI Approach adapted from the global WHO tools and guidelines.
- The WHO generic paedriatic HIV/AIDS care and treatment guidelines have been adapted to suit Zanzibar conditions and health workers have been trained on the use of the adapted guidelines.
- Provider initiated counseling and testing has been initiated and health workers trained and are being implemented.
- Quality diagnostic tests for HIV and AIDS are being performed by trained laboratory personnel.
- Care and treatment centres have scaled up significantly from 0 in 2005 to 11 in 2010.
- Home based care services have been established in 132 health facilities and 280 health care workers trained for providing these services. 280 community volunteers were also trained in line with the HBC guidelines.

4.4.4. Thematic Area: Impact Mitigation
Output 8: Increased access to social services by the poor and vulnerable groups, including those affected by HIV and AIDS.

Evidence based outcomes/Impacts
- Criteria and checklist for identifying eligible PLHIVs who need general support including nutritional food supplements is in place and being used.
- Strengthening of ZAPHA+ has scaled up the support to their members especially through the weekly psychosocial therapy sessions or meetings. These sessions have strengthened the confidence of PLHIVs and have been able to come out to the open and are now participating in normal community activities.
- Facilitation of the transfer of agricultural production, entrepreneurial and marketing knowledge including IGA initiatives and Life skills has resulted in self employment among PLHIV.
- The action plan of the substance abuse, HIV and AIDS strategic plan has been implemented. One significant impact or outcome of the implementation of the Action Plan is the facilitation of CSOs in starting and maintaining Sober Houses where drug addicts are rehabilitated so that they can become normal productive members of the community. There are presently 5 Sober Houses so far in Zanzibar.

4.4.5. Thematic Area: Monitoring and Evaluation
Output 9: The National Monitoring and Evaluation System has been strengthened through UN Joint Programme supported activities.
Evidence based outcomes/Impacts
- Scaling up of service availability mapping which is assisting in monitoring accessibility of HIV/AIDS preventions, care, treatment and support services.
- ZACP National HIV/AIDS and STI surveillance system is in place and operational
- HIV/AIDS indicator survey for Zanzibar was undertaken and has yielded some data.

4.5. General Effects/Impacts of the National HIV/AIDS response
The National response to HIV/AIDS in Tanzania shows some good results in some critical dimensions of the disease. These results are however not only attributed to JP3 but to the overall national response efforts: -
HIV Prevalence Rates - The overall prevalence of HIV infection among voluntary blood donors decreased from 2.6% in 2009 to 1.6% in 2010. HIV prevalence among males and females blood donors was 2.6% and 2.4% in 2009 and 1.6% and 1.7% in 2010 respectively showing slight differences in HIV prevalence among males and females.

Fig 1: Sex-specific prevalence of HIV infection among voluntary blood donor during the period 2009-2010
Fig 2: Comparison of age specific prevalence of HIV infection among voluntary blood donors for the period 2009 and 2010

Source: NACP surveillance Report No. 22 (2011)

4.5.1. Care and Treatment Services - The cumulative number of clients enrolled in HIV Care and treatment increased from 403,378 in 2008 to 594,651 in 2009 to 740,040 in 2010. Cumulative number of clients on ART increased from 202 in 2008 to 303,664 in 2009 and to 384,816 in 2010.

Fig: 3 Cumulative Adults and Children in care and on ART during the three years reporting periods

Source: NACP surveillance Report No. 22 (2011)
4.5.2. PMTCT Services
The gradual expansion of PMTCT since its rollout in 2003 has enabled Ante Natal Care facility coverage of 92% (4647) as of December 2010. During the same period, the programme provided services to 84.9% (1,665,300) of estimated pregnant women. The trend in pregnant women tested for HIV reached by PMTCT services was 96% in 2008, 98% in 2009 and 85% in 2010.

Fig: 4 Trend of PMTCT programme performance Core Indicators from 2008 - 2010

Source: NACP surveillance Report No. 22 (2011)

4.6. Sustainability
A lot has been achieved in the area of systems strengthening and capacity building in Tanzania, that there are strong indications that the development environment necessary for sustainable growth is being established. National institutions now have capacities to generate analyze and disseminate socio-demographic data needed for evidenced base decision making. Government is increasingly giving attention to the formulation of policies, plans, strategies and other needed tools and mechanisms that will provide the platforms for implementation of interventions that address national priorities. Capacities of key umbrella organizations were developed in the area of Fund raising, management and leadership.
4.7. Partnership and Coordination

There is an existing collaboration between UN and GoT, this can be further explored in the next programme. There is significant bilateral arrangement between CIDA, USG, DFID and a number of UN agencies including WFP, UNICEF and UNESCO. There are also coordination bodies such as: - Tanzania Coordination Mechanism (TCM) for the Global Fund on HIV/AIDS, TB and Malaria and the Development and the Rapid Funding Envelope, a funding mechanism agreed to by DPs and TACAIDS for CSOs.

Furthermore, the JP3 is in partnership with a lot of CSOs including: - NACOPHA, ZAPHA+, Tanzania Business Coalition and a host of others in response to the HIV and AIDS challenges. The JP3 is committed to the delivering as one principle and all PUNs are expected to align their plans to have a more coherent and well coordinated one programme.

**National and Regional Level Coordination**

At the National level, the UN partnered with TACAIDS, MoH and ZAC to implement the one UN programme which depicts the country’s HIV/AIDS priorities, while TACAIDS and ZACS worked directly with MDAs, CSOs and others, this was important to conform to the 3ones principle which emphasizes one coordinating organization, one programme and one M&E. However, recent incidents have witnessed PUN’s bypassing TACAIDS and working directly with MDAs and CSOs. These MDAs feel they do not have any commitment to TACAIDS therefore they may necessarily not send them reports. This completely contradicts the DaO and the three ones principles.

At the regional level, the Regional Capacity Building Teams have been established to build the capacity of the regions when it was discovered that the Districts and Councils needed close supervision and TA from the regions in their response against HIV/AIDS. Activities of the teams are coordinated by a TACAIDS Regional Coordinator.

**District, Ward and Village Level Coordination**

The JP3 supports the Councils, Wards and Villages in their HIV/AIDS response through the UNVs. Fifty UNVs were recruited to work with the CHACS, WMAC and CMACS. The CMACs it was discovered were more functional than the WMAC and the VMAC. Although councils are supposed to allocate five percent (5%) of their resources to HIV/AIDS, less than that amount is actually what is contributed.

**One UN Joint Team**

Tanzania was officially endorsed in 2007 as one of eight countries that would pilot the Delivery as One process. The seventeen agencies making up the UN aligned their funds and programmes and came together under UNDAF II to support the development aspirations of Tanzania as outlined in the vision 2025 of Tanzania Mainland and vision 2020 in Zanzibar and also supported specific goals spelt out in the MKUKUTA/MKUZA³. UN agencies working in HIV/AIDS had no difficulty in fitting into a DaO process because, it already had a similar platform existing coordinated under the Joint United Nations Programme on HIV/AIDS (UNAIDS). The UN agencies under JP3 include: UNAIDS as coordinator, UNDP.

---

³ One Programme_Revised Draft 250507
(MA), WHO, UNICEF, UNFPA, WFP, FAO, IOM, UNESCO, UN Women and ILO. These agencies together developed a unified work plan with the GoT to respond effectively to HIV/AIDS menace in Tanzania and Zanzibar. Thus, the joint programme on HIV/AIDS (JP3) is a concerted effort by all UN agencies working in HIV/AIDS to come together and come up with a more coordinated and more harmonized plan to support the Government of Tanzania to curtail the HIV/AIDS epidemic. Thus, the JP3 was supposed to work closely with governments to respond to the HIV/AIDS scourge as expressed in the MKUKUTA and MKUZA and NMSF for Tanzania mainland and ZNSP for Tanzania Zanzibar. It is also aimed at moving Tanzania close to achieving the MDG goals 6. Records show that government’s participation has been effective throughout the whole UNDAF formulation process.

Delivering as One under the UN Joint Programme on HIV and AIDS has progressed during the period (2007 – 2011) under evaluation because of agencies’ sheer determination to do their part to push ahead. However, necessary prerequisites that would have ensured greater success to the efforts deployed are still lacking such as ‘One Fund’, and ‘One Programme’. Though agencies were able to put together interventions without duplicating efforts under one work plan, there is greater need for a more harmonized and more coordinated and coherent ‘One Programme’ that is resulting from ‘One UN’ UNDAP outcomes. Moreover, to have the one fund, all funds (core and vertical) earmarked for HIV/AIDS should be pulled together and managed.

4.8. Cross-cutting Issues (Gender, Human Rights, RBM & Environmental Sustainability)

Cross-cutting issues were incorporated in the one UN programme in 2007. They are: - (i) Human Rights-Based Approach, (ii) Gender Equality, (iii) Environmental Sustainability, (iv) Results-Based Management, and (v) Capacity Building.

4.8.1. Gender Equality & Human Rights-Based Approach

The issues of gender equity and equality has been brought to the public domain and advocates of both sexes now call for gender sensitive and equity in community and national life. With UNIFEM joining JP3 in 2007, Gender mainstreaming became part and parcel of programming with all efforts being geared at gender equality. Capacity development of IPs and sub-IPs were carried out, assessment on gender related factors in HIV/AIDS was conducted and gender operational plans were produced. The establishment of gender desks in TACAIDS and all MDAs is also an indication of the commitment to mainstream gender in all spheres of national development.

4.8.2. Results-Based Management

Subsequent work plans of the JP3 (2008 – 2011) have been RBM compliant, compared with the initial design of the 2007 – 2008 work plan, while the outcomes were specific, it was
difficult to measure the attainment of many of them as most of the targets were not time-bound.

4.8.3. Systems Strengthening/Capacity Building

In conforming to the Paris and Accra declaration\(^5\) the three-one system was established by the GoT, this gave TACAIDS and ZAC legal rights to coordinate and monitor HIV/AIDS activities especially in the non-health sector. In the mainland, both TACAIDS and NACP carries out monitoring of HIV and AIDS intervention while in Zanzibar, M & E activities rests solely on ZAC. The JP3 has tremendously supported these organizations to carry out their functions, by strengthening the existing systems and building capacity where necessary. A lot of the support given by the JP3 has been mentioned in the body of the report, but the following are some key support/assistance given in systems strengthening: -

- Supported Coordination of activities and communication process between GoT, Other IPs and PUNs by establishing the position of Project Coordinators for both TACAIDS and ZAC. It also supported the placement of Gender focal persons in both organizations
- Supported the development of Global Fund proposals, including the Gap analysis, funding of TAs, writers and engendering of the whole proposal. It also funded the coordination meetings
- Supported the establishment of the M & E database in TACAIDS including the development of the TOMSHA
- Provided technical assistance for the workplace policy
- Supported capacity development of nine CSO Umbrella organizations to be able to fulfill their leadership roles effectively.
- Provided technical support in development of the PMTCT National strategy.
- Supported capacity building of Core Team of Clinical mentors in six regions for PMTCT and ARV
- Developed the capacity of UNVs and deployed them to Local Councils to support government at downstream level
- Supported capacity development of Primary school teachers in 6 learning districts in Life skill education
- Supported capacity building of MVC in the acquisition of skills to combat their vulnerability
- Supported capacity building of vulnerable groups to be able to advocate for their rights
- Supported the training of In-service teachers in comprehensive reproductive health and also developed capacity of students from higher learning institutions in sexual reproductive health

\(^5\) Paris declaration on Aid effectiveness (2005)and Accra
4.9. Environmental Sustainability

Ensuring environmental sustainability is the seventh MDG goal and sub-Saharan Africa has been acknowledged as the only region still severely off track from reaching these goals by 2015\(^6\), this off track trend has been attributed, beyond socio-economic constraints, to several biophysical factors, a testimony to the fact that the environment remains the multifaceted life supporting system for human existence and survival. HIV/AIDS activities are yet to be fully linked with environmental sustainability, the impact of climate change etc on vulnerable groups needs to be fully explored. Gas emission, environmental pollution, disaster management and housing issues are areas that were not integrated in JP3.

These important linkages of the environment and its impact on the attainment of all the MDGs have been well demonstrated as illustrated in the table below:

Table 4: Environmental linkages to the MDGs\(^7\)

\begin{tabular}{|p{0.4\textwidth}|p{0.5\textwidth}|}
\hline
Improving quality of life & Poverty  
1. Eradicate extreme poverty and hunger.  
Gender and Education & 2. Achieve universal primary education.  
& 3. Promote gender equality and empower women.  
Health & 4. Reduce child mortality.  
& 5. Improve maternal health.  
Governance & 7. Environmental Sustainability.  
& 8. Develop a Global Partnership for Development.  
\hline
Enhancing livelihoods & 
Sustainable management of natural resources (land, water, coasts, forests, fisheries).  
Preventing and reducing environmental health risks &  
access to adequate water supply and sanitation; indoor air quality; reduced presence of disease vectors and persistent pollutants.  
Reducing people’s vulnerability to environmental hazards &  
prevention of ecological fragility; stabilizing or reducing the frequency of extreme weather events.  
Improving the quality of growth &  
Supporting policy, regulatory, and institutional frameworks for sustainable environmental management; property rights to environmental assets; access to environmental information and education; adequate institutions to deal with environmental problems.  
Supporting sustainable private sector development. &  
Protecting the quality of regional and global commons.  
Climate change prevention; &  
Preservation of the Ozone Layer; conservation of biodiversity.  
\hline
\end{tabular}

Source: Adapted from Federal Ministry of Environment (2008; 4) GON, Abuja.

\(^6\) UN stats/Millennium indicators: Official UN site for MDG indicators (January 2008).
\(^7\) Federal Ministry of environment (MDG office) Abuja, 2008
5.0 Conclusions

1. The evaluation has observed and subsequently concludes that the Joint Program 3 has excelled in performance in relation to its overall goal of supporting the national responses to the HIV/AIDS epidemic both in Tanzania Mainland and Zanzibar as illustrated below: -

Policy, Legal, Political and Structural framework for the National response to the HIV/AIDS epidemic has substantially been enhanced under the unique support of JP3. This has been achieved by:

- Enacting and or revising relevant laws and policies related to HIV/AIDS: - The JP3 programme provided support in the process, specifically by supporting stakeholder groups, CSOs, PLHIV clusters etc. to contribute ideas as critical beneficiaries.
- Defining of the response structural framework through ensuring development and operationalization of the NMSF for Mainland and ZNSP for Zanzibar.
- Supporting the development of response structures at the levels of MDAs, LGAs, wards and villages for Mainland. For Zanzibar similar structures, the DACCOMS, SHACCOMS at district and Shehia levels respectively.
- Political will has been enhanced by the formation and subsequent training of the Tanzania Parliamentarians Coalition on AIDS (TAPAC); the Parliamentary AIDS Standing Committee for Union Parliament and members of the Zanzibar House of Representatives.
- The mainstreaming of Gender and HIV/AIDS in MDAs, LGAs and Business Coalitions and the informal sectors was facilitated to a large extent by JP3 efforts. These institutions now have work place programmes (WPP).

2. The foundation for effective HIV and AIDS interventions was laid through the support of JP3 efforts. This was achieved by supporting the development and dissemination of guidelines, tools/Job aids in the areas of PMTCT, Male circumcision, Care and Treatment, Prevention Strategies focusing on the drivers of the epidemic and gender mainstreaming. The development of these tools has had a substantial multiplier effects as other partners have used them to scale up services provision in the respective areas throughout Tanzania.

3. Impact Mitigation and De-stigmatization (through Stigma Index) of HIV: - Through the support given to associations of PLHA, notably NACOPHA and ZAPHA+, more PLHAs are coming out in the open and there is an increase in awareness raising among the general populace on stigma and discrimination.
6.0. Challenges/Gaps

The achievements outlined above were however not without challenges and or gaps. The following are the main challenges.


- **Low rate of implementation due to late release of funds and other bureaucracy:** The bureaucratic processes of both the UN system and that of the governments, coupled with lack of understanding of the fund transfers systems leads to enormous waste of time and results in low rate of implementation of work plans.

- **Direct transfer of funds to CSOs:** Some PUNs sometimes transfer funds directly to CSOs and even MDAs without the knowledge of TACAIDS. This is contrary to the three ones and may affect TACAIDS leadership role.

- **Protection of Individual identities:** PUNs are still trying to keep their individual identities by doing isolated activities instead of concentrating on joint programming as one UN. Besides sub-IPs complain that dealing with different UN agencies has increased their transaction cost.

- **Inadequate human resources in TACAIDS:** TACAIDS as the coordinating agency vested with the responsibility of coordinating the multi-sectoral response to HIV/AIDS in Tanzania mainland is understaffed. The capacity to monitor disbursement of funds and financial reporting by sub-IPs is needed.

6.2. Recommendations for mitigating Challenges

- Address delay in disbursement of funds and endeavor to keep to work plan

- Fill up vacancies promptly for smooth running of activities, e.g. Position of Technical Assistance for Fund disbursement and accounting will help in reducing delay in fund disbursement and reporting.

- Need for TACAIDS, ZAC and MoH especially (NACP) to work closely and develop strategies for commodity coordination. A 2008 Condoms Needs Assessment carried out in Tanzania\(^8\) revealed that condom distribution is only limited to health facilities in Tanzania. There is not enough collaboration within the social sector in condom distribution.

- There is a need for the GoT at all levels (National, Regional, District) to carry out Donor mapping and coordination. Since lots of donors are now operating directly at the grassroots through CSOs and CBOs, it is necessary to know who is doing what with who and where? To avoid duplication of resources and for transparency.

\(^8\): Condom needs assessment (2008)
6.3. Programmatic/Technical Challenges and Gaps

The evaluation of JP3 has revealed the following programmatic/technical challenges based on each thematic area.

6.3.1. Enabling Environment

Legal Framework
Both Tanzania Mainland and Zanzibar have enacted laws on HIV and AIDS which have played a role in backing the response to the epidemic.

The Issue/Challenge
The real challenge remains in the inadequacy of these laws to address some of the major drivers of the epidemic and especially the MARPS (MSM, CSW, IDUs). Because the laws do not allow these people to operate, they are therefore unable to come out openly to participate in the responses to combat the HIV virus.

Recommendation
Innovative approaches should be used to carry along some of the MARPs like the MSM and IDUs. The case of Zanzibar MSM and CSW Peer educators group should be scaled up. Here the MSM/CSW networks have been clearly identified, peer educators were identified and trained under JP3 and are effectively reaching out to each other promoting and adhering to safe sex practices.

HIV and AIDS response structures
The HIV and AIDS structures have been created at all levels (MDAs, LGAs, and lower level wards, villages/Shehias).

Issue/Challenge
These structures are not functioning fully for two reasons (a) some of them especially the lower level Wards, Villages/Shehia have not been trained on their roles and responsibilities (b) inadequate funds allocated for the HIV/AIDS objective “A” for mainland limits them from designing and implementing HIV/AIDS interventions.

Recommendations
• Capacity building for these structures should be rolled out to cover all levels
• Adequate funds should be allocated for HIV/AIDS activities by enforcing the 5% budgetary allocation directive.

6.3.2. Prevention

Issue/Challenge
The primary goal of prevention is to adequately and unequivocally address the drivers of the HIV and AIDS epidemic in both Mainland Tanzania and Zanzibar but:

• Some political and religious leaders still perceive HIV and AIDS as a disease of prostitution and or immorality and therefore do not deserve the desired attention.
• Key populations which include the youth, MSM, commercial/transactional sex workers have not been adequately reached.
• Inadequate human resources in terms of skills and numbers for designing high quality evidence based HIV specific interventions to where transmission is actually occurring e.g. by focusing on key populations.

• Inadequate resources to finance preventive interventions to the required scope and quality.

Recommendations
• Operationalize the national HIV prevention strategies by targeting high quality evidence based intervention where HIV transmission is actually occurring.

• Combining behavioral, biomedical and structural HIV prevention interventions in order to reduce new infections and improve service coverage among the key populations. Addressing these groups might require revising the current legal/policy framework which in certain cases limits their direct engagement especially MSM and CSW.

• Strategically and proactively engage religious leaders to become champions of the response to the epidemic in a framework similar to the Zanzibar Interfaith AIDS and Development Association (ZAIDA).

• Develop programmes that aim at engaging the youth in the response to fight new HIV/AIDS infections. Young people (aged 15-24) need better, more consistent access to prevention, diagnosis and treatment services – The “Youth Friendly Services”

• Reduce HIV risk and vulnerability in settings of humanitarian concerns such as refugee camps etc

• Develop strategies that will make condom accessible to all besides health facilities

6.3.3. PMTCT
Issue/Challenges
Efficacy of PMTCT requires acceptance of the diagnosis and adherence to PMTCT intervention as well as maintenance in the continuum of care. The following are the major challenges in this area:
• Lack of or limited male involvement
• Gaps in linkage to care and treatment services
• Inadequate follow-up
• Stigma and disclosure difficulties

Recommendations
PMTCT in Tanzania is in transition from single NVP to multidrug regiment. The following innovations might complement the efficacy of the PMTCT clinical/health interventions.

• Introduce or scale up peer support methods such as the Family Support Groups (FSG) Mother to Mother (M2M). These peer groups have proved to best provide psychosocial support tailored to the needs of pregnant/Postpartum women and their children.
6.3.4. CARE AND TREATMENT

Issue/Challenges
The needs or demand for care and treatment services is overwhelming. With reduced stigma the number of PLHIVs coming in the open for services has increased substantially basically surpassing the targets set in the CTC scale up plan. The following are the major challenges encountered.

- Inadequate skilled or trained Human Resources for Health (HRH) to deliver care and treatment services.
- Inadequate infrastructure to provide HIV/AIDS clinical services. This ranges from the service delivery points/facilities to equipment notably CD4 machines, DBS etc.
- Weak monitoring and evaluation system for care and treatment. This includes general CTC patient monitoring for PMTCT, follow-up of HIV positive pregnant women to ensure they adhere to ARV treatment and subsequently deliver in a health facility. Currently only about 50% of expectant mothers deliver in a health facility
- Home-based Care (HBC) services seem not to be harmonized as various CSOs and FBOs have programmes which differ substantially in the package of services offered along the standard WHO continuum of care.
- Although all LGAs have started to allocate funds for HIV/AIDS according to the 5% own sources directive the current allocations are basically very little taken in nature and insufficient to adequately respond to the HIV/AIDS epidemic including support for PLHIV and OVC.

Recommendations:

- Strengthen Monitoring and Evaluation System to include patient monitoring. This should include aspects of clinical management of individual patients while at the group level aggregated data may be used to measure performance of quality improvement.
- Facilitate the use of adapted and standardized Home based care services based on the standard WHO continuum of care.
- Integration of HIV/AIDS services into the overall health services delivery system particularly reproductive health.
- To address the inadequacy of resources, an endowment/trust fund could be formed whereby LGAs can draw resources to supplement their MTEF allocations for HIV/AIDS activities.

6.4. GENDER AS A CROSS-CUTTING ISSUE

Issue/Challenges
Gender based issue affecting ARV adherence and PMTCT in general
- HIV +ve women are in most societies perceived as promiscuous/CSW.
- Women may not disclose status to their partners out of fear of abandonment or violence. In some cases women risk losing inheritance of properties
Women lack the financial resources needed to travel to clinics especially in rural areas and the number of service delivery points is insufficient to meet the needs of rural women.

Women face more serious financial constraints to nutrition

Most often women discover their HIV status through PMTCT which usually have inadequate capacity for follow-up on treatment once they return home.

**Recommendations**

Continuous engagement of the public in awareness raising in order to address these gender based stigma issues and discrimination.

### 6.3.6. IMPACT MITIGATION

**Issue/Challenges**

Most local authorities have completed the identification of MVC and most vulnerable households and attempts have been made to provide the basic support, but:

- The response in terms of providing food and other materials is not sustainable
- The cash loans dished by some local authorities for purposes of starting IGAs have been inadequate
- General support to PLHAs groups has not been consistent and in most cases inadequate

**Recommendations**

- Mainstream HIV/AIDS impact mitigation into the agricultural extension services and scale up the Farmer field school programme which has proved very successful in Siha and Arumeru Districts.
- Managerial and Vocational training for PLHAs, Widows, Orphans and vulnerable youths
- Help bridge the knowledge gap and expand employment/income generating activities especially by linking up to informal and formal local institutions such as SACCOS and primary cooperative societies for small loans and expansion of cash resources. The small cash advances dished by LGAs can thus be used as seed money for such schemes.
- Proactively engage target population by strengthening critical support services and purposefully link health services with aggressive monitoring system by focusing on the following indicators the number of OVC in household, gender of participants, age of household head and history of household illness/death
- Promote actions to facilitate prevention, transfer knowledge, preserve assets and encourage actions to improve food security

### 6.3.7. MONITORING AND EVALUATION

**Issue/Challenges**

The monitoring and evaluation system TOMSHA for Tanzania mainland has been successfully introduced and linked up with 70 local government authorities. The following are some of the major challenges:

- The M & E system is not linked up in all the 132 local government authorities
• Even where it is linked up it is not comprehensive in capturing all the critical HIV and AIDS related information particularly those generated by CSOs, FBOs etc.
• The M & E system has not been able to develop a research agenda and framework for generating information which can be used in planning HIV and AIDS interventions.

Recommendations
• M & E system should be rolled out to all the local government authorities and at the same time enhanced to be comprehensive so as to capture information from all stakeholders.
• With combined operational research TOMSHA should be able to generate data for decision making in the process of responding to the HIV and AIDS epidemic.

7.0. Lessons Learned/Good Practices

• Flexibility pays off. The JP3 decision to harmonize with the GoT’s budgeting and planning cycle has been commended.
• The use of UNV’s to support downstream interventions in the regions, districts, Municipal councils and wards is a positive initiative that should be encouraged. But adequate on the job incentives should be provided.
• Consistent advocacy/dialogue with government is a veritable tool in engendering commitment by government as seen in the implementation of the Gender operational plan, Conference on MARP and the HIV and AIDS Act in Zanzibar.
• Technical assistance to government and emphasis on strengthening institutional frameworks has led to Government buy – in on use of evidence based decision making leading to availability of policies, plans, databases and reports.
• Building capacities of institutions is crucial for sustenance of programmes as shown by improvement in the ability of TACAIDS, MoH and ZAC in coordinating the HIV and AIDS response in Tanzania.

8.0. Recommendations For The UN In Tanzania

• Though efforts are being made to improve yearly, there is need to look beyond individual identity and see the advantages of being one UN, only then can the one programme be conceived and developed, presently, there are more joint activities from one plan than one programme.

• Consistent dialogue with government is necessary to discuss and agree on issues especially bothering on late transfer of resources to IPs so more efficient ways can be agreed upon. As a matter of fact, the National Steering Committee of JP3 should be
made more functional with meetings held when scheduled. This is a very important forum through which a lot of challenges can be overcome.

- As the UN operates on meager resources compared to other donor agencies like USAID, DANIDA and Global Fund, improving the effectiveness of resources becomes imperative. PUNs can utilize their large size with different expertise fully by concentrating its efforts and resources on doing few things very well than doing many things and not well enough (spread thinly).

- Continuation of awareness raising and capacity building of policy makers and MDAs in the use of gender sensitive and sectorally disaggregated data in evidenced based decision making. Recent development in Tanzania has also showed the need to target the group in HIV/AIDS Education and Strategic Behavior Change.

- The accessibility of Tanzania to citizens from neighboring countries with high HIV prevalence rate (Kenya – 6.3%, Uganda – 6.5%, Malawi – 11% and Zambia\(^9\) – 16.5%)\(^10\) makes it imperative to focus on cross-border threats. Perhaps a joint border programme on HIV/AIDS or a corridor project could be agreed upon by all partners.

- PUNs should develop sustainability/exit strategies with their partners including sub-IPs to ensure that programmes are sustained even after funding stops. Successful pilot projects should be scaled up to encourage achievements and not dampen hope. Recommended strategies to sustain programmes include, Proposal development, Fundraising, Mentoring and Capacity Building.

### 8.1. Areas for Further Research

Need to look at possibility of synergizing Maternal Health with HIV/AIDS

Exactly how much resources (Human & Material) the Government of Tanzania contributes to HIV/AIDS is not known, there is need to research into this for advocacy and planning purpose, for example, exactly how much each development partners commit to HIV/AIDS in Tanzania is documented, but the real amount involving structures, salaries etc that is contributed by GoT is not documented. Perhaps more in-depth analysis is needed on how DaO can be made to work effectively in Tanzania.

---


Introduction

The evaluation of the UN Joint Programme on support to the National response to HIV and AIDS came at a time when the United Nations Development Assistance Plan is already Operational, nevertheless, the results of the evaluation may form a critical input to the Implementation of the UNDAP. In the HIV and AIDS results area UNDAP 2011 – 2015, Eight (8) Outcomes have been identified which are to be achieved from about 22 output areas. The following are a few comments which the evaluation of JP3 has found to be critical while implementing the UNDAP:

Outcome 1:
Relevant CSOs and PLHIV networks effectively coordinated to participate in decision making

Comments: There is need to emphasize capacity development of these CSOs and PLHIV Networks to enable them continue being relevant and coordinated. Emphasis is needed on skills and knowledge transfer for sustainability purpose.

Outcome 2:
TACAIDS and ZAC provide effective guidance to National response based on evidence and per agreed human rights standards

Comments: There is inadequate capacity at both national and sub-national levels for the coordination of IPs, CSOs, MDAs, LGAs -

- PLHIV networks coordination is critical particularly now that they are evolving from passive recipients of services to active participants in service delivery.
- MDAs in-spite of having a focal point for HIV and AIDS need to take the issue of HIV/AIDS seriously by allocating to it required resources. Most MDAs still perceive it solely as a health issue only for the responsibility of the Health Ministry.
- Emphasis should be on knowledge/skills transfer to PLHIVs, groups and individuals their families and the community in general to ensure sustainability. The surge in the number of PLHIV clearly puts a pressure on the current humanitarian approach as plans are usually not made to meet the increase in the number of PLHIV
- Gender is still very critical factor in disclosure and may continue affecting the effectiveness of PMTCT and CTC interventions.

Outcome 3
Relevant, MDAs, LGAs, NSA, increasingly mainstream HIV and AIDS work place programme.

Comments: MDAs have in spite of having focal persons for HIV and AIDS not taken the issue seriously by allocating to it required resources, most still considers it a health issue meant for the sole responsibility of the Health Ministry.
• More efforts need to be put to involve the business coalition who are not only having large workforce capturing large proportion of the Tanzanian population (if their families are included) but the sector can also significantly contribute to the proposed HIV and AIDS Trust Fund through their corporate responsibility interventions.

Outcome 4:
Selected MDAs, LGAs, and NSA, implement evidence based HIV prevention programmes
Comments: The focus should be to combine the behavioral, biomedical and structural interventions directly to where the transmission occurs particularly among key populations.
• Build the capacity of multi-sectoral AIDS committees particularly below the district level.

Outcome 5:
Selected MDAs, LGAs, and NSAs deliver quality HIV/AIDS care and treatment services
Comments: Expand HIV counseling and testing by accelerating rights based counseling and testing services for adults and children for prevention, early diagnosis and referral to care, treatment and support including safe disclosure of HIV Status -
• Expand HIV treatment and care for children, adolescents and adults and update national protocols on the basis of evidence based global protocols e.g. Placing patients with CD4+ cell counts of <350/mm on early ART so as to reduce HIV related morbidity and mortality and maximize preventive impact
• Reduce co-infection and co-morbidities among people living with HIV (PLHIV) especially the diagnosis and treatment of: -
  o Pneumonia
  o Diarrhea
  o Malaria
  o Viral hepatitis
  o Malnutrition
• Decrease the burden of TB for PLHIV by observing the three Is
  o Intensified care finding for active tuberculosis
  o Ionized prevention therapy in individuals with latent tuberculosis
  o Infection control to minimize transmission
• Provide comprehensive care for PLHIV
  o Should include a multidisciplinary approach to identify assess and treat pain and meet other physical, psychosocial and spiritual needs of PLHIV
  o Strengthening community care systems e.g. capacity of careers
• Make components of positive health, dignity and prevention available to PLHIV

Outcome 6:
Relevant MDAs, LGAs, and NSA, effectively operationalize the NCPA for MVC
Comments: Emphasis should be on a shift from the current humanitarian approach of handouts to strengthening economic base of households particularly food security by rolling out the evidence based success of JFLS for rural households. A similar framework probably through informal groupings (Artisans, Machingas) and formal groupings (Primary Cooperatives/Saccos) could be developed.
• The current IGA framework of handing over token amounts of money to individuals has in many cases proved not only unrealistic but also unsustainable either
Outcome 7:
MDAs and CSOs mobilize MARPs to utilize appropriate user friendly HIV/AIDS services
Comments: This is critical, there is a need to scale up and replicate Zanzibar’s experience with the informal MSM, CSW networks -
  • It is also important to cautiously consider sensitive legal framework while engaging MARPS.

Outcome 8:
MOHSW, ZAC and CSOs mobilize PLHIV, MVC and other affected groups to greater utilization of HIV/AIDS services
Comments: The critical issue here is that the mobilization should be accompanied by increased HIV/AIDS services supply commensurate with the created demand.