THE UNITED REPUBLIC OF TANZANIA.

TABORA MUNICIPAL COUNCIL HIV AND AIDS STRATEGIC PLAN (2014-2018)

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LIST OF ABBREVIATION.

AIDS:	-	Acquired Immunodeficiency Syndrome.
ALHIV:	-	Adolescents Living with HIV.
ANC:	-	Antenatal Centre.
ARH:	-	Adolescent Reproductive Health.
ARH:	-	Adolescent Reproductive Health.
ART:	-	Antiretroviral Therapy.
BCC:	-	Behavioral Change Communication
BMC,:	-	Bugando Medical Centre,
CCHP:	-	Comprehensive Council Health Plan.
CITC:	-	Client Initiated Testing and Counseling.
CPL:	-	Central Pathology Laboratory
CSO:	-	Civil Society Organization
CTC:	-	Care and Treatment Centers
DBS:	-	Dried Blood Samples
DCPT:	-	District Child Protection Teams
EIC:	-	Education, Information and Communication
EID:	-	Early Infants Diagnosis
EIMC:	-	Early Infant Male Ci-umcision
EMTCT:	-	Elimination of Mother to Child Transmission,
FANC:	-	Focused Antenatal Care
FBO:	-	Faith Based Organization
FSW:	-	Female Sex Worker
GBV:	-	Gender Based Violence
HBC:	-	Home Based Care.
HBCT:	-	Home Based Counseling and Testing,
HCP:	-	Health Care Provider,
HCW:	-	Health Care Workers,

HFs:	-	Health Facilities,
HIV:	-	Human Immunodeficiency Virus,
HLI:	-	Higher Learning Institution,
HSHSP:	--	Health Sector HIV and AIDS Strategic Plan,
HTC:	-	HIV Testing and Counseling,
IDUs:	-	Intravenous Drug Users,
IGP:	-	Income Generating Projects,
IPC:	-	Infection Prevention Control,
IPT:	-	Ionized Preventive Therapy,
IYCF:	-	Infant and Young Child Feeding
KP:	-	Key Population
LGA:	-	Local Government Authority
LGMD:	-	Local Government Monitoring Database
LTFU:	-	Lost to Follow Up.
M and E:	-	Monitoring and Evaluation.
MACs:	-	Multispectral AIDS Committees
MC,:	-	Male Circumcision.
MHASP	-	Municipal HIV and AIDS Strategic Plan.
MNCH:	-	Maternal and New Child Health.
MP:	-	Member of Parliament,
MVC:	-	Most Vulnerable Children,
MVCC:	-	Most vulnerable Children Committee,
NGO:	-	Non Governmental Organization,
NMSF:	-	National Multispectral Strategic Framework,
OVC:	-	Orphaned Vulnerable Children
PLWHIV:	-	People Living With HIV,
PMTCT:	-	Prevention Mother to Child Transmission,
PPM:	-	Planned Preventive Maintenance,-
PPP:	-	Public Private Partnership,

PWID:	-	People who Inject Drugs.
-H:	-	Reproductive Child Health,
RS:	-	Council Secretariat.
RTI:	-	Reproductive Tract Infection,
RTI:	-	Reproductive Tract Infection,
SRH	-	Sexual and reproductive health
STI:	-	Sexual Transmitted Infections
SW:	-	Sex Worker,
TACAIDS:	-	Tanzania Commission for AIDS,
TB:	-	Tuberculosis
THIS:	-	Tanzania HIV and AIDS Indicator Survey
THMIS:	-	HIV and AIDS and Malaria Indicator Survey
TMC,	-	Tabora Municipal Council
TTI:	-	Transmission Transmissible Infection, ,
VCT:	-	Voluntary Counseling and Testing,
VEO:	-	Village Executive Officer.
VMAC:	-	Village Multispectral AIDS Committee,
VMMC,:	-	Voluntary Medical Male Circumcision
WCPT:	-	Ward Child Protection Team
WDC	-	Ward Development Committee,
WEO:	-	Ward Executive Officer,
WHO:	-	World Health Organization,
WMAC	-	Ward Multispectral AIDS Committee
WPP	-	Work Place Program,
YFS	-	Youth Friendly Services,

GLOSSARY OF TERMS.

Key Populations at Higher risk of HIV exposure: Refers to those most likely to be exposed to HIV or to transmit it – their engagement is critical to a successful HIV response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender persons, people who inject drugs, sex workers and their clients. Couples are at higher risk of exposure to HIV than other people. There is a strong link between various kinds of mobility and heightened risk of HIV exposure, depending on the reason for mobility and the extent to which people are outside their social context and norms.

Cryptococcus infection: A disease caused by a yeast-like fungus, which attacks the lung. It may spread to the brain, causing meningitis; this may occur as an opportunistic infection in those suffering from AIDS.

Morbidity: The state of being ill or having a disease.

Behavior Change Communication (BCC): Behavior change communication promotes tailored messages, personal risk assessment, greater dialogue, and an increased sense of ownership.

Community Systems Strengthening: Refers to initiatives that contribute to the development and or strengthening of community-based organizations in order to increase knowledge of and access to improved health service delivery.

Community systems strengthening: This refers to initiatives that contribute to the development and or strengthening of community-based organizations in order to increase knowledge of and access to improved health service delivery.

Health System: A health system consists of all organizations and individuals whose actions are intended to promote, restore or maintain health. A health system involves a broad range of institutions and individuals whose actions help to ensure the efficient and effective delivery and use of products and information for the prevention, treatment, care, and support of people in need of these services.

Age-Disparate Relationships: Refers to relationships in which the age gap between sexual partners is five years or more. The terms ‘intergenerational relationships’ and ‘cross-generation relationships’ generally refer to those with a 10-year or greater age disparity between sexual partners.

Prevention of Mother-to-Child Transmission (PMTCT): PMTCT refers to a four-pronged strategy to prevent new HIV infections in children, and keep mothers alive and families healthy. The four prongs are: halving HIV incidence in women; reducing the unmet need for family planning; providing antiretroviral prophylaxis to prevent HIV transmission during pregnancy, labour and delivery, and breastfeeding; and providing care, treatment and support for mothers and their families.

Sexually Transmitted Infection (STI): STIs are spread by the transfer of organisms from person to person during sexual contact. In addition to the traditional STIs (syphilis and gonorrhea), the spectrum of STIs also includes: HIV, which causes AIDS; Chlamydia trachoma is; human papillomavirus (HPV), which can cause cervical, penile or anal cancer; genital herpes; and cancroids. More than 20 disease-causing organisms and syndromes are now recognized as belonging in this category.

Serodiscordant: Serodiscordant is a term used to describe a couple in which one partner is HIV positive and the other is HIV negative

Transgender Persons: Transgender persons express a gender identity that is different from their birth sex.

Women who have Sex with Women (WSW): It includes not only women who self-identify as lesbian or homosexual and have sex only with other women, but also bisexual women and those who self-identify as heterosexual but who have sex with other women.

Men who have sex with Men (MSM): The term 'men who have sex with men' describes males who have sex with males, regardless of whether or not they have sex with women or have a personal or social gay or bisexual identity. This description includes men who self-identify as heterosexual but have sex with other men.

Mobile Workers and Population: Refers to persons who may cross borders or move within their own country on a frequent and short-term basis for a variety of work-related reasons, without changing place of habitual primary residence or home base. Mobile workers are usually in regular or constant transit, sometimes in (regular) ci-ula. tory patterns and often spanning two or more countries, away from their habitual or established place of residence for varying periods of time.

PREFACE TO THE MUNICIPAL STRATEGIC PLAN ON HIV AND AIDS 2014-2018.

Sipora J. Liana
Municipal Director

TABORA MUNICIPAL COUNCIL.

The first cases of HIV and AIDS in Tanzania were reported in 1983 in Kagera region. Today, the epidemic has evolved and reached all regions, gender, age groups, and social economic classes and became a common problem affecting all Tanzanians.

The first HIV and AIDS epidemic case in Tabora Municipal Council was reported in 1985, and the first person to be identified as HIV and AIDS positive was from Kiloleni Ward.

When the AIDS case was reported in the council was perceived as purely a health problem, most of the people believed that the disease was like other diseases, while others believed that, it was a superstitious disease, this situation instigated rapid spread of HIV and AIDS epidemic. The strategies to prevent the epidemic stated, most of the strategies were to sensitize the community from the grassroots on the disease and various interventions were introduced such efforts include VCT, PMTCT, CTC, CBC, -HS and HBC services. The efforts were directed towards behavioral change for prevention of transmission, treatment of opportunistic infections and use of antiretroviral drugs, the aim being to prolong the lives of the infected individuals, improve quality of life and mitigate the socio-economic impacts of HIV and AIDS epidemic.

HIV infections rate for three years in Tabora Municipality is 6.7% 2012, 4.9% 2013 and 5.1% in 2014 respectively. The trends show the decline and rise, these imply that, there are dynamic changes in HIV testing and counseling and hence more efforts should be put in place to sensitize the community on counseling and testing services. However, the Municipal has realized that despite of all these efforts we also need to increase the coverage of the HIV and AIDS interventions with specific in hard to reach peripheral wards, HIV transmission high risk areas, cover most of the Key Population (KPs), i.e. Sex workers (SW), People who inject drugs (PWIDs), Prisoners, Men who have sex with men (MSM), women and youth.

As we embark on five-year journey guided by the new **Council HIV and AIDS Strategic Plan** (2014-2018), it is necessary to focus on specific measurable and achievable set off results This require concerted efforts and strong commitment at operational levels to ensure

that everyone plays a complementary role in the fight against HIV and AIDS. Furthermore, we will continue with this approach in order to ensure that all Organizations play their role based on their mandate and comparative advantage.

I call upon all our stakeholders and partners to align their plans with the Municipal HIV and AIDS Plan 2014-2018. Tabora Municipal Council is grateful to the support and contribution of international partners, non-governmental organizations, faith based organizations, community based organizations, community leaders and the communities themselves in the fight against HIV and AIDS.

It is my sincere hope that the spirit of cooperation and partnerships, the spirit of oneness that exists, will see us through as we implement this plan to achieve zero new HIV infections; zero discrimination; and zero AIDS-related deaths.

ACKNOWLEDGEMENT.

The Tabora Municipal Council wishes to thank all the people and organizations that contributed to the development of this new HIV and AIDS Strategic Plan 2014-2018. In particular, we extend our appreciation to the organizations that includes representatives from the development partners, civil society organizations and people living with HIV and AIDS.

The Municipal Council appreciation the efforts and commitment of the various districts teams that made valuable technical inputs during the process of developing the strategic plan. Special thanks are dedicated to our **Council Director**, **Head of Departments NGOs, FBOs, CBOs** and **Donors** for their encouragement throughout our first stage till the last stage of completion of this HIV and AIDS Strategic plan. Without their efforts and technical inputs we would not have the strategic plan by now. We wish also to sincerely thank all the development partners who provided funding and technical assistance to support the development of the Strategic Plan.

Finally Municipal Council wishes to extend its appreciation to all the Stakeholders involved in the development of the strategic plan, contributions from **Tabora Council Secretariete**, **Council Coordinator for TACAIDS** and **TACAIDS** for providing logistical and technical assistance and guidance during the preparation of AIDS strategic plan.

The current strategic plan is a reflection of what can be done. Development partners should work together to achieve the 3 zeros, zero new infections, zero Stigma discrimination and zero AIDS related deaths.

Gullam Remtulah
Hon. Municipal Mayor

TABORA MUNICIPAL COUNCIL

EXECUTIVE SUMMARY.

This Strategic Plan document passed through three stages. During the first stage the technical team of HIV and AIDS coordinators and selected implementing partners prepared the first draft of the document based on TACAIDS guidelines. During the second stage, the Council AIDS team (CAT) reviewed the document and authorized it for sharing and a final review and approval by the Municipal HIV and AIDS stakeholders at a meeting which included all segments of society ranging from political (MPs and Councilors), religious and community leaders to NGOs, FBOs, who are so important to the success of the plan's implementation.

This is thus the approved final version by Council HIV and AIDS stakeholders, and is in accordance with the NMSF 111 for HIV and AIDS 2013 and 14 – 2017 and 18 and the 3rd Health Sector HIV and AIDS Strategic Plan (HSHSP 111) 2013 – 2017 as well as health sector surveillances and other data Sources.

The Strategic Plan is intended to guide the Council in achieving three zeroes by June, 2018. The main focus is strengthening the fight against new HIV infections by enhancing prevention, treatment, care and support services and mitigating impact among Tabora's key populations and community members at large. Additionally, this Strategic Plan 2014-2018 is a reflection and continuation of the previously plans namely the HIV and AIDS Operational Plan and Action Plan for the prevention of new HIV infections 2008-2012. It provides priority interventions and targets based on "Zero new HIV infections, Zero stigma and discrimination, and Zero AIDS related deaths".

This plan covers 29 Wards, 31 Villages and 118 Streets of Tabora Municipal Council. It is expected that the Council and stakeholders will mutually collaborate during the implementation period towards achieving our shared objectives set out in this Plan. In order to achieve the three zeroes specific interventions are directed to address target groups such as In-school youths in primary schools, secondary schools, and higher learning institutions and colleges, out-of-school youths, married and unmarried adults; elderly caretakers; populations in hotspots, government and private sector employees; PLHIV and PLWA; orphans and most vulnerable children, widows and widowers, key populations including comme-ial sex workers, men having sex with men and people who inject drugs and pregnant women. To ensure that these key social groups are reached, the Council program will need to empower HIV and AIDS Coordinators, AIDS Committees, HIV and AIDS Implementing Partners, and Leaders (Politicians, Religious, Community opinion and traditional) to work in their zones of influence.

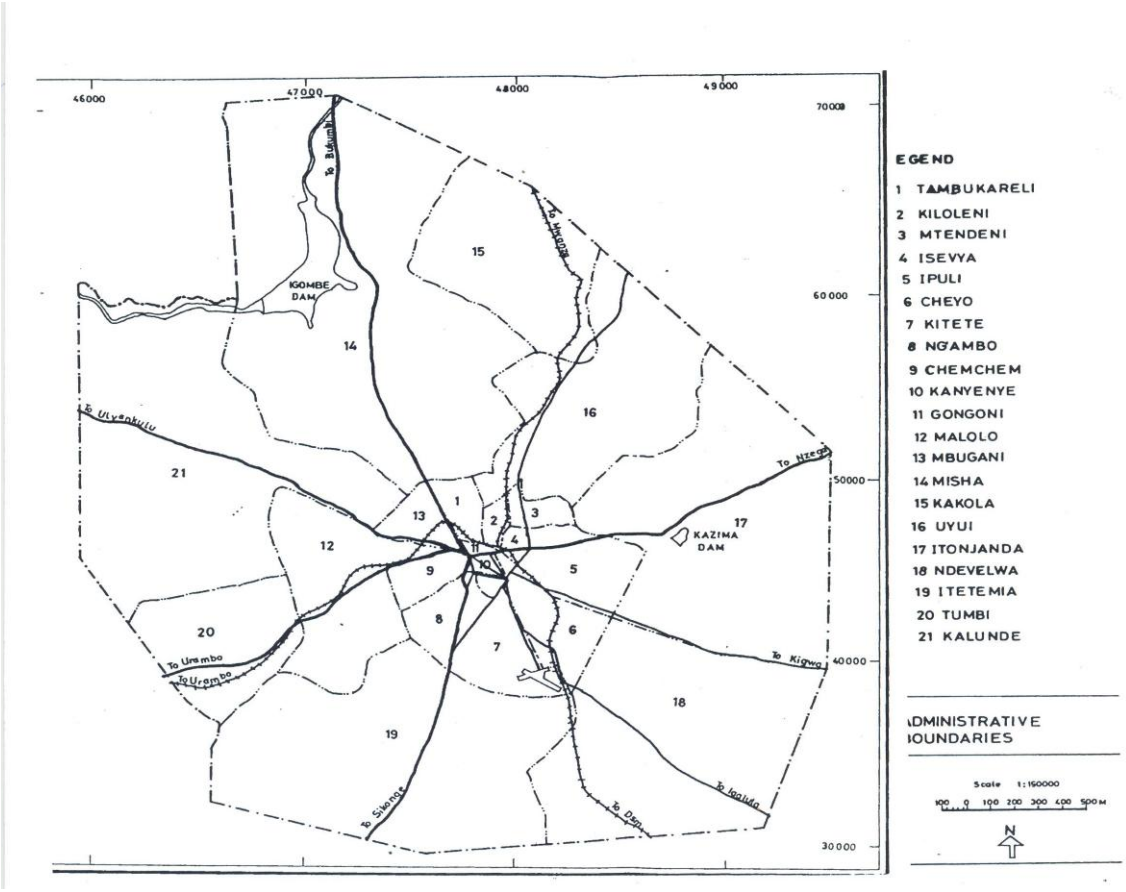
1.0 CHAPTER ONE.

1.1 Tabora Municipality Profile.

1.2.1 Location:

Tabora Municipality is located at the centre of Tabora Council in the western part of Tanzania. It lies between latitudes 4°52' and 5 ° 09' South, and between Longitudes 32 ° 39' and 33 ° 00' East. Also it is located about 800 kms west of Dar es Salaam and about 320 kms East of Kigoma port on the shores of Lake Tanganyika. (Figure 1 below indicates a map of Tabora Municipality).

1.2.2 Figure 1: The map of Tabora Municipality showing administration Boundaries.



1.2.3 Area:

Tabora Municipal is the Headquarter of Tabora Municipal Council with an area of 1092.26 km2 (109.225 hectares) at a radius of about 18.64 km from the town centre with a reference point at Old Boma.

1.2.4 Administrative Boundaries.

Tabora Municipal borders Tabora District Council (Uyui) in the East, North, West and South. Tabora Municipal was established as a Town Council in 1958. On the re-establishment of the Local Government Authorities in July, 1978, the boundary of Tabora

Town Council was re- defined. A ministerial order declaring the boundary was published in the official Gazette as Government Notice No.97 of 30th June, 1978. In July 1988, Tabora Town Council (TTC) was raised to a Municipal status. Hence, Tabora Municipal Town Council continued to Administer 13 wards until 8th June, 1991 when the Government Notice No.484 declared new boundaries to include 8 wards within.
its jurisdiction.

At present, Tabora Municipal Council (TMC,) consists of 25 wards, 35 villages and 118 hamlets which are within the jurisdiction area covering
1,092.26 square kilometers.

1.2.5 Population

According to National census made in the year 2012, Tabora Municipal had a total population of 226,999 Male 111,361 Female 115,638 it is estimated that by 2024 population rate will be 390,262.whilst income per capital is a 1,019,565. Household size is 4.7 and sex ratio is 96 respectively.

1.2.6 Climate.

The climate of the Municipality is highly influenced by its altitude and distance from the sea in the East. It lies between 100m and 1300m above sea level. The prevailing winds blow from East and Northeast. Temperatures range between 22^{o}C and 26^{o}C. Peak temperatures occur during September and October prior to the onset of the rain season.

1.2.7 Rainfall.

Tabora Municipal lies within high rainfall zone. It receives an average rainfall of 800mm per annum. The heavy rains fall between June and April, Rainfall patterns are extremely variable and unpredictable. Showers are often much localized, and there is the risk of long dry spells at any time during the rainy season. From the beginning of the rain season normally in June, the rainfall peak in December is followed by a slight lull in January or February. A second lower peak occurs in February or Ma-h, and the rains then tails off in April. The mean monthly rainfall does not exceed potential evaporation at any time during the rainy season.

The Municipal population distribution by age category and sex shows that there is a decrease in population as age increases. High population is concentrated in Urban areas 160,608 (males 82,950 and females 77,658) than in Rular areas 66,391 (males 33,703 and female 32,688). Table 1 below indicates Council population by age group and sex.

Table 1: Tabora Municipal Council Population by Age Group and Sex, 2012 population Census.

Age	Urban			Rural			Total		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-4	10,118	10,215	20,364	5,841	5,860	11,701	15,990	16,075	32,065

5-9	9,439	9,775	19,214	5,462	5,248	10,710	14,901	15,023	29,924
10-14	9,421	10,049	19,470	4,629	4,482	9,111	14,050	14,531	28,581
15-19	9,220	10,818	20,038	3457	3134	6,591	12,677	13,952	26,629
20-24	8,615	10,589	19,204	3040	2911	5,951	11,655	13,500	25,155
25-29	7,093	7,914	15,007	2078	2223	4,301	9,171	10,137	19,308
30-34	5,686	5,971	11,657	1768	1715	3,483	7,454	7,686	15,140
35-39	4,509	4,611	9,120	1548	1440	2988	6,057	6,051	12,108
40-44	3,577	3,174	6,751	1170	1120	2290	4,747	4,294	9,041
45-49	2576	2366	4,942	900	931	1831	3,476	3,297	6,773
50-54	2378	2095	4,473	865	817	1682	3,243	2,912	6,155
55-59	1,455	1299	2754	590	572	1162	2045	1871	3,916
60-64	1242	1201	2,443	627	615	1242	1869	1816	3,685
65-69	747	738	1485	434	384	818	1181	1122	2,303
70-74	658	841	1189	506	437	943	1164	1278	2,442
75-79	349	421	770	308	279	587	657	700	1,357
80 +	544	873	1,417	480	520	1,000	1,024	1,393	2,417
Total	**77,658**	**82,950**	**160,608**	**33,703**	**32,688**	**66,391**	**111,361**	**115,638**	**226,999**

Source: *Tanzania Population and Housing Census.*

According to National census made in the year 2012, Tabora Municipal had a total population of 226,999 Male 111,361 Female 115,638 it is estimated that by 2024 population rate will be 390,262.whilst income per capital is a 1,019,565. Household size is 4.7 and sex ratio is 96 respectively as shown in the table below.

Table 2: Population of Tabora Municipal Council by Sex, Number of Households, Average Household Size and Sex Ratio.

POPULATION OF TABORA MUNICIPAL COUNCIL BY SEX, NUMBER OF HOUSEHOLDS, AVERAGE HOUSEHOLD SIZE AND SEX RATIO						
Ward	**Population (Number)**			**Number of Households**	**Average Household Size**	**Sex Ratio**
	Both Sexes	**Male**	**Female**			
Kanyenye	10,063	4,614	5,449	2,225	4.5	85
Gongoni	8,064	3,918	4,146	2,020	4.0	95

Mbugani	15,301	7,221	8,080	3,714	4.1	89
Che-Hem	19,980	9,630	10,350	4,493	4.4	93
Tambukareli	6,783	3,345	3,438	1,546	4.4	97
Kiloleni	14,213	6,943	7,270	3,622	3.9	96
Mtendeni	5,536	3,390	2,146	960	5.8	158
Isevya	13,507	6,360	7,147	3,390	4.0	89
Ipuli	23,444	11,258	12,186	5,011	4.7	92
Cheyo	11,399	5,648	5,751	1,985	5.7	98
Kitete	9,192	4,233	4,959	2,101	4.4	85
Ng`ambo	19,702	9,429	10,273	4,990	3.9	92
Malolo	3,424	1,669	1,755	673	5.1	95
Kakola	3,470	1,764	1,706	614	5.7	103
Uyui	6,262	3,162	3,100	997	6.3	102
Itonjanda	2,714	1,326	1,388	464	5.8	96
Ndevelwa	8,112	4,111	4,001	1,207	6.7	103
Itetemia	4,549	2,247	2,302	954	4.8	98
Tumbi	6,205	3,087	3,118	1,198	5.2	99
Kalunde	8,113	4,307	3,806	1,312	6.2	113
Misha	6,234	3,202	3,032	1,174	5.3	106
Kabila	5,778	2,939	2,839	959	6.0	104
Ikomwa	7,152	3,581	3,571	1,056	6.8	100
Ifucha	3,219	1,650	1,569	555	5.8	105
Ntalikwa	4,583	2,327	2,256	702	6.5	103

Source: *Tanzania Population and Housing Census.*

Tanzania population and Housing Census reports for the past three census indicate that Municipal population trend has been incresing from 93,506 in 1988 to 188,005 in 2002 to 226,999in 2012 as shown in the table below.

Table 3. Tabora Municipality Population distribution over the last three censors (1988, 2002 and 2012).

No.	Council name	Population 1988 Census	Population 2002 Census	Population 2012 Census
1	Tabora Municipal	93,506	188,005	226,999
	TOTAL	**93,506**	**188,005**	**226,999**

Source: *Tanzania Population and Housing Census*

Table 4: Health facilities and services in Tabora Municipal.

Health Facilities and Services in Tabora Municipal Health facilities Year 2010-2014				
Facility	2010 and 2011	2011 and 2012	2012 and 2013	2013 and 2014
Hospitals	1	1	1	3
Health centers	1	1	1	1
Dispensaries	13	13	17	22
CTCs	9	10	13	14

Table 3 above indicates that number of health facilities and services has been increasing per years. In 2010 the Municipal had 1 hospital at present the Municipal has 3 Hospitals. During implementation of this strategic plan the Council is expected to improve the existing health facilities and services hence establish new ones based on the need to reach pregnant women and the general public on services such as **SRHs, CTCs, EMTCT, VMMC, VTCs etc.**

1.2.8 Education facilities.

There has been an increase in number of primary and secondary schools constructed. Number of primary schools has increased from 47 government and 2 private) in 2012 to 71 government and 2 private) in 2015 equals to an increase of 3.1%. In secondary schools the number has increased from 9 government and 3 private) in 2013 to 21 government and 5 private) in 2015 equals to an increase of 9%.

1.2.9 Primary and secondary school enrolments:

PRIMARY SCHOOL:

Primary student's enrolments for the past four years (2012 to 2015) were not satisfactorily as there are setbacks to the situation these include:

i) Early marriage.
ii) Ignorance of the parents on importance of education
iii) Poverty of the parents, lead children to engage in employment as child labour

Regarding the enrolment status the council has taken absolute measures to improve the situation these includes

i) School infrastructure has been improved.
ii) Employment of new teachers for both primary and secondary school to ove-ome the shortage. In 2014 a total of 117 (males 49 and females 68) primary school teachers and 107 (males 42 and females 65) secondary school teachers were employed in the council
iii) Motivation offered to newly employed teachers to maintain them and be committed in training children. The teachers are provided with houses within or outside school compounds.

Table 5: Primary School Enrolments for the Past Two Years.

Year	Expected			Enrolled				Not Enrolled			
	Boys	Girls	Total	Boys	Girls	Total	%	Boys	Girls	Total	%
2012-13	2,822	2,849	5,671	3,373	3,370	6,743	118%	-	-	-	-
2013-14	2,993	2,601	4,994	1,173	2,176	4,349	87%	220	425	645	13%

Reasons for not Enrolled during 2012-2014.

i) Early Marriage.
ii) Poverty: instead of being enrolled to attend schools children are taken to work as house girls and boys, farming etc.
iii) Ignorance: there are still parents who do not consider education as priority area for their children particularly young girls who end up being married or employed as house girls while at little ages etc

Table 6: Secondary School Enrolments for the Past Two Years.

Year	Expected			Enrolled				Not Enrolled			
	Boys	Girls	Total	Boys	Girls	Total	%	Boys	Girls	Total	%
2012-13	6,742	5,530	12,272	6,742	5,530	12,272	100	-	-	-	-
2013-14	5,952	4,838	10,790	5,952	4,838	10,790	100	-	-	-	-

Source: *Council Education Reports 2012-2014*

In secondary schools the situation is not the same as in primary, the table above indicates that, no students who was not enrolled.

Primary school dropouts for the past three years (2011/12 to 2013/14) are shown in the table below:

Table 7: Council Primary school dropouts for the past three years (2011/12 to 2013/14)

Year	**Boys**	**Girls**	**Total**	**%**
2011/12	2,075	1,955	4,029	7
2012/13	1,931	1,812	3,743	6
2013/14	2,281	1,892	4,173	7

Source: *Council Education Report 2011-2014.*

Reasons for dropouts:
Several reasons contribute to the dropouts these include:

i. Early pregnancy for girls students.
ii. Child labour.
iii. Ignorance of parents.
iv. Shortage of primary school
v. Lack of food at schools.

1.2.10 School enrolment in secondary schools:
In 2014 a total of 10,790 students (5,952 boys, 4,838 girls) were selected to enroll form one in secondary day schools, the turnover was satisfactorily since all students selected enrolled, the table below shows:

Table 8: Secondary School Enrolments for the Past three Years.

Year	Expected			Enrolled				Not Enrolled			
	Boys	Girls	Total	Boys	Girls	Total	%	Boys	Girls	Total	%
2012-13	6,742	5,530	12,272	6,742	5,530	12,272	100	-	-	-	-
2013-14	5,952	4,838	10,790	5,952	4,838	10,790	100	-	-	-	-

The Council status regarding dropouts in secondary schools has been decreasing yearly from 4% in 2011 to 1% in 2014; this is due to the following factors:

i) Provisión of food in some schools.
ii) Improved infrastructures for example hostels
iii) Increased community/ parents awareness on the importance of education
iv) Improved close follow up of students who do not attend school regularly from teachers
v) Improved colaboración among teachers and parents

The table below shows secondary school dropouts for the past three years (2011/12 to 2013/14)

Table 9: Council Secondary school dropouts for the past three years (2011/12 to 2013/14)

Year	Boys	Girls	Total	%
2011/12	1,351	1,015	2,409	4
2012/13	96	84	180	2
2013/14	34	26	60	1

Source: *Council Education Report 2012-2014 and Council Consultative Committee report 2012*

1.2.11 Reasons for dropouts:

i. Long distance form home to schools
ii. Early Marriages
iii. Child Labour (House Girl/Boy)
iv. Truancy
v. Lack of motivational environmental for example provvision of food at schools.
vi. Ignorance of paren

1.2.12 Higher learning institutions and Colleges:

The Council has 3 higher learning institutions and 13 colleges. The higher learning institutions are the TEOFIL Kisanji Universaty, Saint Augustine Universaty of Tanzania and the Open Universaty of Tanzania. The colleges are the Ministry of Agriculture Training Institute (MATI) Tumbi, Musoma Utalii College, Tanzania Public Service College, Tanzania Teachers College (Tabora and Ndala), Vocational Education Training Authority (Tabora and Ulyankulu), Ardhi Institute, Tanzania Railway College, Tabora Bee keeping College, Nzega Nursing College, Igunga Nkinga Nursing and laboratory colleges, Nkinga Focal Development Colleges (Nzega, Mwanihala, Urambo and Sikonge) Every year these institutions enrol new students from within and outside the Council. Socialization is high among the students and population outside the institutions.

1.3 COUNCIL VISION AND MISSION.

1.3.1 Vision:

Tabora Municipal Council aspires to have a community that has high quality livelihood

1.3.2 Mission:

To provide high quality social economic services to the community through efficient and effective use of reSources and good governance for improving living standards.

1.4 COUNCIL HIV AND AIDS VISION AND MISSION STATEMENTS:

1.4.1 Vision statement:

A generation with no new HIV infection, no stigma and discrimination, AIDS related deaths and the quality services for people affected by HIV and AIDS.

1.4.2 Mission statement.

To effectively coordinate, supervise, and implement Multi-sectoral HIV and AIDS activities provided by Council and CSOs to ensure quality HIV and AIDS prevention, care and treatment, and support services to the infected and affected people in the Council.

1.5 HIV and AIDS trends in the Council.

The first HIV and AIDS epidemic case was reported in Tabora Municipal Council in 1985, and the first person to be identified as HIV and AIDS positive was from Kiloleni Ward.

When the AIDS case was reported the epidemic was pe-eived as purely a health problem, most of the people believed that the disease was like other diseases, while others believed that, it was a superstitious disease, this situation instigated rapid spread of HIV and AIDS epidemic. The strategies to prevent the spread of epidemic stated, most of the strategies were to sensitize the community from the grassroots on the disease and various interventions were introduced in areas of prevention, Impact mitigation care and support services.

Traditional beliefs also contributed much to the spread of epidemic, because people believed on traditional medicines instead of attending in hospitals and Health Facilities. Increase number of People Living with HIV and AIDS in the municipal Council led the council to provide insufficient services to the people.
Tabora Municipal infections rate has been decreasing yearly, in 2012 infections were 6.2%, in 2013 were 5.5% and in 2014 were 3,7 however the repe-ussions behind HIV and AIDS epidemic are at high risk these includes prolonged illness and death among productive individuals, increased number of orphans, for instance by December, 2014 Tabora Municipal has identified 3,558 (female 1,682 and male 1876), increased number of people

living with HIV,DATAS reduced household income as a result of increased expenditure on medical care and food.

1.6 The Council response on HIV and AIDS:

Various programs and interventions have been adopted to control the spread of new HIV infections and mitigate its impact to the families. The Council and Civil Society Organizations (CSOs) have implemented various National Multi sectoral programs like National HIV prevention strategy (2009 - 2012), NMSF II (2008-2012), NMSF III (2013-2017) and Gender Operational Plan for HIV Response (2010 to 2012). During implementation of these National programs four thematic areas were targeted, namely prevention of new HIV infection, Care, treatment and support, impact mitigation and enabling environment. During implementation of the National strategies the role of the Council was on coordination, monitoring and evaluation of HIV and AIDS interventions in and CSOs.

Health sector has also involved in the implementation of the National AIDS Control Program in the Council under the coordination of the Council AIDS Control Coordinators (CHAC) and District AIDS Control Coordinators (DACC). Most of the health workers have been trained on safe practices, STIs treatment and HIV testing and counseling. The various trainings offered to health workers improved their skills in practicing health issues related to HIV and AIDS.

Different media are also used to raise community awareness on HIV and AIDS. The Messages like Abstinence, faithfulness and consistent, correct condom usage (ABC) are provided to the people. Condom procurement, promotion and distribution are also taken into consideration.

Multi sectoral AIDS control committees have been established for coordination of HIV and AIDS response at the Council. The committees are Council Multi-sectoral AIDS Committees (CMAC), Wards Multi sectoral AIDS Committees (WMACs), Villages Multi sectoral AIDS Committees (VMACs) and Mitaa Multi sectoral AIDS Committees (MMACs), at present active are committees are CMAC, 5 WMACs, 7 MMACs, more efforts are needed to train and establish more committees so as to scale up HIV and AIDS activities effectively.

1.6.1 Challenges encountered in addressing the epidemic.

Many civil society organizations exist to support people living with AIDS however, they are donor dependants. The shortage of funds for HIV and AIDS activities coupled with delay in disbursement resulted to in adequate accessibility of HIV and AIDS services for the needy specific groups as well as general population. Other challenges are loss to follow up, low up take of ARV services, non adherence to ARVs and lack of effective transportation services to the Council.

2.0 CHAPTER TWO.

2.1 HIV and AIDS Situation, Risky Environments, Drivers, Responses, Challenges, Achievements and Lessons learnt

This section highlights the currently existing Municipal enormity and trend of HIV infection including risk drivers for HIV transmission. Auxiliary the section provides information on Municipal response, challenges and achievements on HIV and AIDS epidemic. The Strengths, Weaknesses, Opportunities and Threats in relation to the epidemic are also highlighted.

2.2 The Municipal situational analysis on HIV and AIDS.

Tabora Municipal Council is among the 7 councils in the council which has been facing with the Challenges and impacts of HIV and AIDS epidemic since 1985. The Municipal infections rate has been decreasing yearly, in 2012 infections were 6.2%, in 2013 were 5.5% and in 2014 were 3,7 however the repe-ussions behind HIV and AIDS epidemic are at high risk these includes prolonged illness and death among productive individuals, increased number of orphans, for instance by December, 2014 Tabora Municipal identified 3,558 (female 1,682 and male 1876), increased number of people living with HIV, reduced household income as a result of increased expenditure on medical care and food.

2.3 Risk environment for HIV and AIDS infections.

Risky environments in Tabora Municipality vary from other councils due to the fast growing of town and modernization of social services. These risky environments include areas such as markets (mobile and non mobile), fishing camps, high way packing centers for long distance truck drivers, Roads construction projects, Universities and Colleges. The risky environments involves gathering of many people who interacts and socialize putting themselves at high risk of HIV infection. Most at risk groups involved in HIV transmission include Sex Workers (SWs) found operating at risk areas. Some of the SWs are engaged in different businesses like saloons, food vendors, shop sales, bar maids, guest house and hotels attendants. These risky groups operating at various levels acts as drivers of the epidemic in the Municipality.

2.4 Drivers of the plague:

Dynamics of HIV transmission in Tabora Municipality are divided into three groups namely, individual behavioral, social cultural factors and biomedical factors. The enormity of each factor fuelling HIV transmission in the municipal is explained below:

2.5 1NDIVIDUAL BEHAVIORAL DRIVERS.

2.5.1 Early Sexual Debut:

Early sexual debut is big challenge to young people, especially to girls In Tanzania Mainland THMIS 2007-08 showed that 11.4% of young women and 10% of young men aged 15-24 had sexual inte-ourse before aged 15, while THMIS 2011-12 revealed 9.7% and 10.2% respectively. For age group 18-24 years THMIS indicated that in Tanzania mainland 51.6% of young women and 43.9% of young men had sexual inte-ourse before 18. The situation in the council is so alarming more efforts are needed to rescue the situation and protect young people from getting new HIV and ADIS infections.

2.5.2 Alcoholism/Substance Abuse:

Alcohol use in conjunction with sex is associated with increasing risky behavior and low condom use. Alcohol impairs thinking capacity affecting power in decision making. According to THMIS 2007-08 among young people in Mainland of Tanzania, 4.4% of women and 1.5% of men had sexual inte-ourse during the previous 12 months when drunk or when a partner was drunk. The consumption of alcohol is common in the council, varying from local brews to industrial liquors. Alcohol consumption is high during festivals and gets together events.

2.5.3 Multiple concurrent Sexual partnerships:

Multiple and concurrent sexual relations exists in the Council and are the main cause of new HIV infections and sexual transmitted infections. THMIS report 2011/12 revealed that the Council has 16.3% men and 6.0% women who had sex with more than one partner in the year prior to the survey, Tanzania mainland was 21.2% men and 3.9% women. Multiple concurrent partnerships are driven by factors including poverty, frequent travel, working away from homes, peer pressure. The main HIV transmission factor is unprotected sexual inte-ourse.

2.5.4 Cross- Generational Sexual Relations:

Cross- Generational sex between young women and older men was estimated at 7.6% in women aged 15- 19 in mainland Tanzania in 2010. There was a notable difference between urban and rural populations, with 10.4% of Mainland urban young women at risk and 6.7% of Mainland rural young women (NMSF III 2013). In Tabora Municipality Cross-Generational sexual behaviors exists and concerted efforts are needed to scale up the situation.

2.5.5 Low rate of condom use.

The use of condoms provides protection against HIV infections and STIs. The protection provided depends on consistent and correct use. Infrequent and inconsistent use of condoms often lower protection among individuals in long standing relationships including married and cohabiting individuals (NMSF III 2013). In Tabora Council male condoms are widely distributed at all levels from the Council to and wards. Female condoms are not widely distributed as male condoms and they are not commonly used. The main suppliers of condoms are the Medical Stores Department (MSD) and Population Services International (PSI).

2.5.6.Heterosexual/ Anal Inte-ourse:

Penile – anal inte-ourse is associated with male homosexual relationships. In this relationship the risk of contracting HIV is higher than from vaginal inte-ourse. The high risk is contributed to lack of or insufficient lubricants during anal inte-ourse resulting to abrasions that facilitate HIV transmission. Men who have sex with men (MSM) are found in the municipal 10 were identified.

2.6 SOCIAL CULTURAL FACTORS:

2.6.1Stigma and discrimination against PLHAs:

Stigma and discrimination towards people infected with HIV or living with AIDS is widely spread in Tanzania. THMIS 2011-12 reveal that only 25% of women and 40% of men expressed accepting attitudes on all four standards indicators used to measure stigma. In

Tabora Municipality there is a high stigma and discrimination against PLHIV. THMIS report 2011-12 show that in Tanzania mainland 20.2% of women and 31% of men express accepting attitudes to PLHIV on all standard indicators. Community acceptance of PLHIV is very low in the Municipality.

2.6.2 Population mobility:

Mobile population groups such as seasonal laborers in road construction sites, mobile markets, truck drivers, and fishermen are vulnerable to HIV infection because they often practice higher risk sex with non-marital or co-habituating partners. Studies have found samples of long-distance truck drivers with high HIV infections. These results are consistent with the findings in the THMIS 2007/08 and 2011/12, which found that individuals that travel away from home frequently are more likely to be HIV-positive than those who remains at home. The more people are mobile the high at risk of HIV infection.

*2.6.3. G*ender inequality:

*In Tabora Municipal Council w*omen and girls are more vulnerable to HIV infection than male counterparts due to biological, socio-cultural and economic factors. According to UNAIDS, up to 80 pe-ent of HIV-positive women in long term relationship acquired the virus from their partners. This inequality sometimes results in gender based violence, such as rape, sexual assault and battery.

2.7 BIOMEDICAL FACTORS.

2.7.1 Low level of Voluntary Medical Male Ci-umcision (VMMC):

In Mainland Tanzania, HIV infections among ci-umcised men was 3.5% compared with 5.2% of unci-umcised men (NMSF III 2013). Male ci-umcision has been associated with a decreased risk of HIV infection by men, presumably because of physiological differences that reduce the susceptibility to HIV infection among HIV- negative, ci-umcised men.

2.7.2 Sexually transmitted infections (STIs):

It has been established that STIs such as gonorrhoea and syphilis increase an individual's chances of becoming infected with HIV during unprotected sex. STIs contribute to increased vulnerability of PLHIV to Human Papilloma Virus (HPV), which causes cervical cancer. Tanzania is a country with high infections of cervical cancer; yet, women's knowledge of HPV screening and cervical cancer varies greatly by education (52% of women with no education compared to 75% with secondary education) and wealth (53% of the lowest quintile compared to 82% of the highest quintile) NMSF III.

2.7.3 Mother to child transmission of HIV infection

TDHS (2010) reported that Mother to Child Transmission (MTCT) is the second most common cause of HIV transmission within the Country. There are two notable gaps; these include low levels of attendance of ante-natal clinics (out of the 4 recommended visits) and lack of full integration of Prevention of Mother to Child Transmission (PMTCT) services in Maternal and Child Health services. Approximately, 24 pe-ent of HIV positive pregnant women that attended antenatal clinics were not reached by PMTCT services and 43 pe-ent of HIV exposed infants who needed ARVs to prevent MTCT did not receive it due to limited

access to treatment, stock outs of commodities, or attrition from the programme (NMSF III, 2013). The effectiveness of antiretroviral drugs (ARVs) in preventing mother to child transmission necessiates for HIV screening in pregnant women as a tool for reducing HIV transmission.

2.7.4 Low level of HIV and AIDS testing.

Partners engaged in unprotected sex without knowing their HIV status are at an increased risk of acquiring HIV. According to THMIS survey 2011-12 among the general population, 5 pe-ent of couples were discordant that is, one partner was HIV positive and the other was not. In 3 pe-ent of couples the male partner was infected and the female was not. Where as in 2 pe-ent of couples showed that the female partner was infected and the male was not, more efforts should be put to educate women and men on the importance of HIVand AIDS Testing.

2.8 COUNCIL AL RESPONSE AND CHALLENGES:

2.8.1 Voluntary Medical Male Ci-umcision (VMMC)

The Council has prioritized and is scaling up VMMC, in all Wards. VMMC, has been reasonably well accepted, especially among boys 10 and above in the Council. Experience indicates that VMMC, campaigns are more successful when they are Conducted during the dry season and at times convenient to adults. Both fixed and mobile services have made these services more accessible. VMMC also provides an important opportunity for HIV counseling and testing and serves as an entry point for access to early HIV care and treatment services by males Ci-umcision.

Challenge:

- In order to ensure that all Council residents requiring VMMC, and EIMC, services receive them, it is crucial that the Council and the council's plan, budget and build capacity for VMMC, and EIMC, services, and integrate this service into routine services. The steady supply of test kits must also be assured.

2.8.2 Elimination mother-to-child transmission (PMTCT/eMTCT):

According to THMIS III (2011/12), 84.5% of citizen of Tabora Municipal have knowledge that HIV can be transmitted by Breast Feeding, also 73.1% have knowledge that when Pregnant Mother take ARVs drugs can reduce transmission of HIV to her baby by 73.1%. Council PMTCT report December, 2014 shows that a total of 20, 259 pregnant women were counseled and tested for HIV out of them 520 (1.9%) were found positive.

Challenges:

i. Despite of the mentioned services to continue, there has been inconsistency data reporting from lower health facilities, untimely reports submission. Data collection, analysis and use of the option B+ from dispensary and heath centre to District level is also one of the important activities to be followed upon closely.
ii. Low male involvement in utilization of PMTCT services

2.8.3 Early Infant Diagnosis of HIV.

The MOHSW, with support from its partners has established DNA-PCR laboratories for EID of HIV at the central pathology laboratory (CPL) Muhimbili national hospital (MNH), Bugando medical centre (BMC,), Kilimanjaro Christian medical centre (KCMC,) and the Mbeya referral hospital (MRH).

Dried blood samples (DBS) from Tabora Municipal Council are transported to Bugando medical centre (BMC,) laboratory for testing, and results are sent back to health facilities through district and Council laboratories. Health workers at -H clinics that are providing EMTCT services have been trained in the collecting, packing, storage and transportation of DBS samples for EID to Bugando medical centre (BMC, The use of an electronic database and SMS technology in the DNA-PCR laboratories for sending results to SMS printers has shortened the time it takes to release results to the sites, but sometimes results are delayed.

Challenges:

- Strengthening of EID services in the Council will require significant scale up of training and supplies for provision of EID services, and sustainable solutions to issues of DBS kit availability and transport for laboratory processing.
- Other challenges include effective transportation of samples from sites to the EID testing labs; return of results from EID labs to the sites and to care givers; and immediate enrolment and initiation of ART for the HIV infected infants,
- Linkage of data and service delivery for exposed children from PMTCT to CTC and vice versa.

2.8.4 Sexually Transmitted Infections (STI) and Reproductive Tract Infections (RTI)

Among challenges encountered in the management of STIs and RTIs in Tabora Municipal include inappropriate diagnosis, poor clinical management, and ineffective over- the – counter or self – medication using antibiotics for STIs and RTIs. Efforts to scale up STI and RTI treatment and screening at ANC have contributed to increased availability of services. However, inadequate and irregular supply of syphilis test kits, drugs and other supplies hinder the provision of STI services to ANC attendees and their spouses and and or sexual partners. Also prevention of HIV by proper management of STI and RTI is no longer given priority as much support shifted to HIV care and treatment services.

Services to manage sexually transmitted infections (STI) and reproductive tract infections (RTIs) are provided at all health centers, and some dispensaries in the Council. However, the infections of untreated STI and RTI is still high. About 1.9 % of sexual active women and 2.0 % men reported having STIs in the past 12 months, but only 50% of women and 62% of men sought treatment from a qualified health care provider (THMIS III 2011 and 12).

Challenge:

- STI and RTI services, information and referrals require improvement through strengthened data systems, quality improvement and mentoring of providers in diagnosis and management, client and public education of the risks of improper treatment, and incorporation, where possible, of cancer screening, prevention and referral systems.

2.8.5 Condom Programming:

When male and female condoms are used correctly and consistently, they can play a significant role in the prevention of HIV and other STIs. In the period of 2008-14, free and subsidized condoms were distributed through government facilities and social marketing schemes. However, the availability of free and subsidized condoms to people in need is still limited, particularly in rural areas. Female condoms are very limited in comme-ial outlets.

Free condoms are currently limited to health facilities, thus requiring potential users to go in person to the health facility during day time. This is particularly problematic for key populations and young people.

Challenge:
Comprehensive condom programming in the Council, especially targeting key populations and young people, will require expansion of outlets beyond the health facility, education and myth-busting around condom use and effectiveness, and even promotion of a new image for condoms.

2.8.6 HIV Testing and Counselling (HTC)

Voluntary counselling and testing (VCT) services in Tabora Municipality started in year 2000 with only 3 sites, and by year 2014, the number of sites had grown to 22. Furthermore, provider initiated testing and counselling (PITC) services were introduced in year 2007, which operate in all health facilities aimed at curbing the intensification of HIV infections across the general population. PITC and VCT serve as entry points to prevention, care and treatment for people who agree or voluntarily decide to test their HIV serostatus.

Table 10: Tabora Municipal HIV testing and counselling by District year 2014

District	Number of facilities	Estimated population	Average number of people per facility	Average number of HIV tests Conducted per facility per year
Tabora MC	30	226,999	7,567	933

Soures: *Municipal Health Report 2014.*

Table 11: Number cumulatively enrolled in HIV care, started on ART, and currently on ART, by Tabora Municipal Council, 2012-2014

		2012			2013			2014		
District	**No. of CTC sates**	**Cumulative Number enrolled in HIV care**	**Cumulative Number started on ART**	**Number currently on ART**	**Cumulative Number enrolled in HIV care**	**Cumulative Number started on ART**	**Number Currentl y on ART**	**Cumulative Number enrolled in HIV care**	**Cumulative Number started on ART**	**Number currently on ART**
Tabora MC	14	10,910	2,018	6,129	11,224	6,702	3,946	12,848	8,220	4,706
TOTAL	**14**	**10,910**	**2,018**	**6,129**	**11,224**	**6,702**	**3,946**	**12,848**	**8,220**	**4,706**

Soures: *Municipal Epidemiological profile report, 2014*

Table above shows that the number cumulatively enrolled into HIV care has been increasing The high numbers enrolled in care is attributed by clients coming from other districts such as Uyui, this is due to easy accessibility of health services. The above table indicates that number of persons cumulatively started on ART and currently on ART has been increasing The reason for this include health care workers having a good understanding of eligibility criteria to initiate ART to clients sites.

Challenges:

i. Limited accessibility of CTC services due to few number of CTC sates
ii. Stigma and discrimination causing PLHA not to access the services

2.8.7 Provision of Home-based Care (HBC) services.

The Council in collaboration with implementing partners such as Red Cross and Care International has been providing HBC services to PLHIVs. HBC community volunteers have been trained. New initiatives have been launched in the Council to link these clients to services for economic strengthening and food security.

Challenge:

- HBC will be effective in providing and increasing retention in care and treatment as well as linking to non-health services if more community volunteers are trained and supported; communities address AIDS stigma and discrimination which hinders early disclosure; and programs and linkages for IGAs are established among PLHIV groups.

2.9 ACHIEVEMENTS OF COUNCIL AL RESPONSE ON HIV AND AIDS

1. Reduction in HIV infections rate from 6.2%, in 2012 to 3.7 in 2014
2. Establishment of 10 HIV and AIDS clubs in secondary schools.
3. PLHAs economic status improved. Number of supported PLHAs with IGAs increased from 12 in 2012 to 23 in. 2014
4. PLHA children psychosocial clubs increased from 2 in 2012 to 5 in 2014.
5. Increased awareness about HIV epidemic, means of spread and prevention in the country
6. Early infant diagnosis is provided at 14 sites

2.10 MUNICIPAL STRENGTH AND WEAKNESSES ON HIV AND AIDS:

2.10.1 Strengths:

- Availability of HIV and AIDS guidelines /tools for improved planning, implementation, supervision, coordination and management of NMSF Grant
- Trained and skilled health personnel who provide health services and those responsible for coordination (CHAC, DACC.)
- Established Multi sectoral AIDS Committees (6 WMACs, 7 VMACs and 1 CMAC)
- Established PLHAs economic based unity groups and network in the
- 112 Skilled Community HBC providers
- Partnership between public and private sector for HIV and AIDS
- 5 clubs for children living with HIV and AIDS established
- Financial support from donors on HIV and AIDS.
- TOMSHA reporting system (electronic and hard copy) in place

2.10.2 Weaknesses

- HIV and AIDS Council response highly depend on donors. Always funds disbursed are not adequate.
- Shortage supply of health commodities and working tools
- In adequate contributions from own Source to support HIV and AIDS
- The majority of WMACs and VMACs are not functioning
- Poor infrastructures, most of the remote areas are not easily accessed during rainy season
- Duplication of activities and reSources among implementing stakeholders
- Supply of TOMSHA reporting books (forms) not reliable and inadequate
- Shortage of HBC providers and high number of lost to follow up

2.10.3 Gaps:

- Council al requirement for trained/qualified heath personnel is 3,293 available is 1,627 gap is 1,666 (51%)
- Inadequate funding support from own Sources on HIV and AIDS activities.
- Inadequate coordination contributed to lack of vehicles for - CHACs. To conduct intensive supervision.
- Lack of coordination in HIV and AIDS at wards and villages due to MACs not functioning
- Existence of cultural activities fuel the spread of new HIV infections such as *Chagulaga* at open market and *Matanda* traditional dance for *Sukuma tribe*

2.10.4 Lessons gained:

- financial support projects to PLHAs groups add to improved health, income, disclosure of HIV status, follow up on ARVs uptake and socialization,
- Stakeholders review meetings Inadequate contributions of own Source to support AIDS interventions implies that without Donor funding support no HIV and AIDS activities would have been implemented

3.0 CHAPTER THREE.

LISTING, RANKING AND PRIORITIZATION OF DRIVERS

3.1 List of drivers of HIV in Tabora Municipal Council.

- Multiple simultaneous Sexual partnerships
- Early Sexual entrance
- Alcoholism/Substance Abuse.
- Infrequent and incoherent use of condoms
- Unprotected Penetrative Heterosexual/ Anal Intercourse
- Stigma and discrimination against PLHIV
- Population Movement
- Gender inequality
- Poverty.
- Low coverage of Voluntary Medical Male Circumcision (VMMC)
- Sexually transmitted infections (STIs)
- Mother to child transmission of HIV infection
- Socio economic activities – cultural practice chagulaga, open markets, night Clubs
- Unsafe blood transfusion.

3.2 Ranked and Prioritized Drivers.

Drivers have been ranked according to its great contribution to HIV and AIDS infections; number 1 means a driver has high risk than the other hence it needs great attention and required interventions, the table below shows:-

No.	Driver	Ranking status
1	Multiple simultaneous Sexual partnerships	1.
2	Infrequent and incoherent use of condoms	2.
3	Early Sexual entrance	3.
4	Alcoholism/Substance Abuse.	4.
5	Socio economic activities ,cultural practice chagulaga, open markets, night Clubs.	5.

6	Population Movement	6.
7	Low coverage of Voluntary Medical Male Circumcision (VMMC)	7.
8	Sexually transmitted infections (STIs)	8.
9	Stigma and discrimination against PLHIV	9.
10	Unprotected Penetrative Heterosexual/ Anal Intercourse	10.
11	Mother to child transmission of HIV infection	11.
12	Gender inequality	12.
13	Poverty.	13.
14	Unsafe blood transfusion.	14.

Source: Municipal HIV and AIDS key Players 2014

4.0 CHAPTER FOUR.

4.1 Tabora Municipal Council HIV and AIDS Strategic Plan Matrix

This chapter presents three areas of focus in addressing HIV/AIDS epidemic, the community target group that is being addressed and the tentative root causes fuelling the infection, stigma and discrimination and AIDS related death to that particular target group.

TABORA MUNICIPAL COUNCIL HIV AND AIDS STRATEGIC PLAN MATRIX ADDRESSING ZERO.

ADDRESSING ZERO NEW INFECTIONS.							
Outcome 1: New HIV infections reduced from 3.7 to 1.9 by June 2018. ***Outcome Indicator 1:*** *Pe-entage of new HIV infections* ***Outcome Indicator 2:*** *% of adolescent and young people with comprehensive knowledge on HIV prevention and SRH issues among adolescent aged 10 – 15.*							
COMMUNITY GROUP.		**ROOT CAUSES OF NEW HIV INFECTIONS**	**FIVE YEARS OBJECTIVES**	**ACTIVITIES**	**KEY PERFORMANCE INDICATORS**	**TIME FRAME**	**RESPONSIBLE PERSON**
In-school Youth – Primary Schools	Females and Males	Multiple simultaneous Sexual partnerships i. Limited sexual reproductive and Health civilization, ii. Pear pressure iii. Family destitution iv. Low sexual and reproductive and Health	To train and familiarize 12,000 primary school Youth in life skills. Reproductive health and HIV and AIDS education by June 2018.	Identify 240 (Gender balance) pear educators students on HIV and AIDS	Number of peer educators identified.	July 2014 June 2018	TMC and Stakeholders
				To carry out 14 days training to 240 pear educators students on HIV and AIDS prevention, life skills and reproductive health.	Number of peer educators trained.		

		Education v. Influence due to long distance to/from School vi. Harassment from older stronger pupils vii. carelessness at home making pupils loose					

				Carry out classroom sessions on HIV and AIDS prevention, life skills and reproductive health two times per Month in 30 primary schools	Number of classroom sessions Conducted		
					Number of schools reached		
				Identify 120 teachers (Gender balance) to be trained on HIV and AIDS prevention, life skills and reproductive health	Number of teachers to be trained identified		
				To carry out 7 days training to 120 primary school teachers on HIV and AIDS prevention, life skills and reproductive health	Number of primary teachers trained		
				Sensitize 30 primary school committees on establishing school feeding Programs	Number of primary school committees sensitized		
				To train 6.000 male and 6,000 female primary school pupils on reporting of sexual assault actions	Number of males and females trained		

COMMUNITY GROUP		ROOT CAUSES OF NEW HIV INFECTIONS	FIVE YEARS OBJECTIVES	ACTIVITIES	KEY PERFORMANCE INDICATORS	TIME FRAME	RESPONSIBLE PERSON
				To carry out 80 awareness meeting in 29 wards on proper care, support and protection of children	Number of awareness meeting Conducted		
In-school Youth – Secondary Schools	Females and Males	Multiple simultaneous Sexual partnerships i. Limited sexual reproductive and Health civilization, ii. Pear pressure iii. Family destitution iv. Low sexual and reproductive and Health Education v. Influence due to long	To train and sensitize 1,800 secondary school Youth in life skills reproductive health and HIV and AIDS education by June 2018	Identify 120 (Gender balance) secondary students peer educators on HIV and AIDS	Number of peer educators identified		TMC and Stakeholders
				To carry out 14 days training to 120 secondary students peer educators on HIV and AIDS prevention, life skills and reproductive health	Number of peer educators trained		
				To carry out classroom sessions on HIV and AIDS prevention, life skills and reproductive health two times per Month in 15 schools	Number of classroom sessions Conducted		
					Number of schools reached		

		distance to/from School vi. Harassment from older stronger pupils carelessness at home making pupils loose		Identify 60 secondary teachers (Gender balance) to be trained on HIV and AIDS prevention, life skills and reproductive health	Number of teachers to be trained identified		
				To carry out 7 days training to 60 secondary school teachers on HIV and AIDS prevention, life skills and reproductive health.	Number of primary teachers trained		

				Sensitize 15 secondary school committees on establishing school feeding Programs	Number of secondary school sensitized		
				Train to 900 male and 900 female secondary school students on reporting of sexual assault actions	Number of males and females trained		
In-school Youth – Higher learning	Females and males	Multiple concurrent sexual partnerships i. Pear demands ii. Delay of loans from Governmen t iii. Coe-ion from Tutors	To educate and sensitize 1,500 students in three higher learning institutions and 11 Colleges on life skills reproductive health and HIV and AIDS education by June 2018	Identify 150 students (Gender balance) peer educators on HIV and AIDS education in 14 higher learning institutions and colleges	Number of peer educator identified		TMC and Stakeholders
				To carry out 14 days training to 150 students peer educators on HIV and AIDS, Behavior change, gender norms, life skills reproductive health, proper use of condom in 14 higher learning institutions and colleges	Number of peer educators trained		

				Identify 85 tutors/lectures (Gender balance) pear educators on HIV and AIDS education in 14 higher learning institutions and colleges	Number of peer educator identified		
				To carry out 7 days training to 85 tutors/lectures peer educators on HIV and AIDS, Behaviour change, gender norms, life skills reproductive health, proper use of condom	Number of peer educators trained		
				To carry out one peer education meetings once a month.	Number of peer education meetings held		
				Sensitize establishment of 14 HIV and AIDS students clubs in 14 higher learning institutions and colleges	-Number of higher learning institutions and colleges sensitized -Number of higher learning institutions and colleges with students clubs		
				Distribute 50 condoms each quarter to 3 Universities and 11 colleges	Number of condoms distributed		

				To carry out mobile voluntary HIV and AIDS testing twice a quarter 3 Universities and 11 colleges	Number of times mobile voluntary HIV and AIDS testing Conducted		

COMMUNITY GROUP		ROOT CAUSES OF NEW HIV INFECTIONS	FIVE YEARS OBJECTIVES	ACTIVITIES	KEY PERFORMANCE INDICATORS	TIME FRAME	RESPONSIBLE PERSON
Out of School youth	Males and Females	i. Threat working environment in the private and informal sector ii. Unemployment and risk peers influence/ Pressure, injecting drugs	To sensitize and equip 8,500 females and Males youths out of school with working laws and regulations and working environment risks which lead to HIV and AIDS infections by 2018.	Identify 428 peer groups of out of School youth working in risk environment	Number of peer groups identified		TMC and Stakeholders
				Train 428 peer groups on entrepreneur, working laws and regulations, working environment risks which lead to HIV and AIDS infections by 2018.	Number of peer groups trained		
				Sensitize Out of School youth quarterly on voluntary HIV and AIDS testing and proper use of condom	Number of Sensitization events		
Adult femeale (married, un married)				Train 70 tradition healers on HIV and AIDS education	Number of tradition healers trained		
				Facilitate establishment of early referral system.	Number of referral system established		
		i. Unsafe traditional	To enhance HIV and AIDS education	Spot out 30 traditional male ci-umciser in 29 wards.	Number of traditional male ci-umciser		TMC and Stakehol

		male	during tradition		identified		ders
				Train 30 tradition male ci-umciser on HIV and AIDS education.	Number of traditional male ci-umciser trained.		

COMMUNITY GROUP		ROOT CAUSES OF NEW HIV INFECTIONS	FIVE YEARS OBJECTIVES	ACTIVITIES	KEY PERFORMANCE INDICATORS	TIME FRAME	RESPONSIBLE PERSON
	Hotspots and key Population (KP) or High Transmission Area	i. Market Days 1. (Magulio na Minada) ii. Fish camps and markets iii. Construction sites iv. Mining areas v. Brothels [Madanguro] vi. Sex Workers vii. Night Clubs	To boost HIV and AIDS education in 15 market days, 1 fishing camps, construction site by June 2018.	To carry out 7 promotions events on VMMC using road and cinema shows, radio program in 29 wards	Number of events Conducted		TMC and Stakeholders
				To carry out 29 meetings events to traditional leaders on risk traditional ceremonies and HIV and AIDS education in 29 wards.	Number of meeting event Conducted		
				Carry out 60 HIV and AIDS education events though cinema shows at Fishing Camps, Markets, and mining and constructions projects.	Number of events Conducted .		
				To carry out 80 times HIV testing and counseling and Condom promotions and distribution at Fishing Camps, Markets, mining and constructions projects in 29 wards.	Number of events Conducted .		
				Carry out 20 advocacy meeting events on HIV and AIDS to Bodaboda and tax drivers leaders	Number of advocacy meeting events Conducted .		

				To carry out 23 life skills training sessions to bodaboda, daladala and tax drivers	Number of bodaboda, daladala and tax drivers trained		
				To carry out 45 HIV voluntary counselling and testing events to Bodaboda, daladala and tax drivers	Number of bodaboda, daladala and tax drivers tested		

COMMUNITY GROUP		ROOT CAUSES OF NEW HIV INFECTIONS	FIVE YEARS OBJECTIVES	ACTIVITIES	KEY PERFORMANCE INDICATORS	TIME FRAME	RESPONSIBLE PERSON
				Prepare and install 400 bill boards in HIV and AIDS prevention messages.	Number of Sign Boards Prepared and installed		
				Identify at least 20 brothels and 600 sex workers in 29 wards.	Number of Brothels and sex workers identified		
				To carry out 50 HIV and AIDS education events and promote and distribute condom to all sex workers in 29 wards.	Number of events Conducted .		
LGA employees	Females and Males	i. Extra working hours ii. Sex enticement iii. Enfo-ed sex [coe-ion] iv. Risky working environment v. Complacence among the staff	To reduce new HIV infections from 4.1% to 1.1 % among employee in the council by 2018.	Identify 20 peer employees' educators Female/Male to be trained on HIV and AIDS risk working place.	Number of peer educators identified		TMC and Stakeholders.
				To carry out 7 days training to 20 peer employees educators Female/Male on HIV and AIDS risk working place in 29 wards	Number of peer educators trained		
				To carry out 2 work place session quarterly on HIV and AIDS in the council and 29 wards	Number of sessions Conducted		
				To carry out quarterly HIV and AIDS counseling and testing and condom promotion in the council and 29 wards	Number of times counseling and testing Conducted		

ADDRESSING ZERO STIGMA AND DESCRIMINATION							
Outcome 1: HIV and AIDS Stigma and Discrimination among community members, employees and PLHI reduced from 10% to 3% by 2018 ***Outcome indicator:*** *Percentage of HIV and AIDS stigma and discrimination reduced*							
COMMUNITY GROUP		**ROOT CAUSES OF NEW HIV INFECTIONS**	**FIVE YEARS OBJECTIVES**	**ACTIVITIES**	**KEY PERFORMANCE INDICATORS**	**TIME FRAME**	**RESPONSIBLE PERSON**
Self Stigma	PLHIV and PLHA Key Population (PWID,MSM and SEX WORKERS, PRISONERS) IDUS	i. Fear of humiliation and discrimination. ii. Lack of self-confidence to reveal HIV status ii. Fear of apprehension	To reduce HIV and AIDS, Stigma and Discrimination from 10% to 3% by June 2018.	1. To carry out 5 days training on negative effects on Stigma and Discrimination and copying skills to 150 PLHIV by June 2018.	Number of PLHIV trained.		TMC and Stakeholders
				2. Provide user friendly services on HIV and AIDS at hot spots areas including open markets.	Number of hot spot areas and open markets provided with user friendly services Number of KP accessed with friendly services.		
				3. Promote and support entrepreneurship. education, livelihood, savings and financial literacy etc. to promote	Number of KP provided with entrepreneurship education, livelihood, savings and financial		

				income-generation for 40 support groups, including SWs, PWID, MSM in 29 wards areas inclu ser friendly	literacy		

COMMUNITY GROUP		ROOT CAUSES OF NEW HIV INFECTIONS	FIVE YEARS OBJECTIVES	ACTIVITIES	KEY PERFORMANCE INDICATORS	TIME FRAME	RESPONSIBLE PERSON
				Establish and strengthen income generating activities to 50 PLHA group in 29 wards	Number of income generating PLHA groups Establish and strengthened		
				To carry out 500 regular sensitization meetings against stigma and discrimination in 29 wards	Number of sensitization meetings Conducted		
				Establish and maintain 500 PLHIV psychosocial groups in 29 wards	Number of PLHIV psychosocial groups established		
Community Stigma	All Community age and sex groups	i. Fear of been infected ii. Ignorance		To carry out 50 regular HIV and AIDS ant stigma awareness events in 29 wards	Number of events Conducted		
Discrimination	All Community by Gender	i. Ignorance of modes of infection ii. Lack of tolerance iii. Lack of sense of humor		To carry out 29 awareness creation meetings to WMACs on the modes of HIV infection in 29 wards	Number of awareness creation meetings Conducted		

COMMUNITY GROUP		ROOT CAUSES OF NEW HIV INFECTIONS	FIVE YEARS OBJECTIVES	ACTIVITIES	KEY PERFORMANCE INDICATORS	TIME FRAME	RESPONSIBLE PERSON
Stigma and Discrimination	i. Orphans and Most Vulnerable Children; Widows; Widowers and Elderly Care Takers ii. Employees at the Council al and level	i. Lack adequate social and economic services ii. Lack of laws and regulations protecting PLHIV and PLHA		To carry out quarterly community awareness campaign to families taking care of O/MVC in 29 wards	Number of Campaign Conducted		
				To carry out quarterly meeting with 30 Police Gender desk officers to advocate child protection and gender based violence in 29 wards	Number of meetings Conducted		
				Establish 8 Child protection teams in 29 wards	Number of established child protection teams		
				Provide social economic support in collaboration with other stakeholders to 3,659 OVCs	Number of OVCs supported		
				To carry out 4 stake holders meeting annually on sharing information on reSources mobilization	Number of stake holders meeting Conducted		
				Support 8 children homes with basic social needs in 29 wards	Number of children homes supported		

ADDRESSING ZERO AIDS RELATED DEATHS.						
Outcome 3: HIV and AIDS deaths reduced in Tabora Council						
COMMUNITY GROUP	**ROOT CAUSES OF NEW HIV INFECTIONS**	**FIVE YEARS OBJECTIVES**	**ACTIVITIES**	**KEY PERFORMANCE INDICATORS**	**TIME FRAME**	**RESPONSIBLE PERSON**
New born babies, Infants and children	i. Lack of appropriate health care service during pregnancy and after [prenatal and post natal health services ii. Limited number of exposed infants and children identified iii. Moderate malnutrition iv. Un reliable transportation of DBS from Lower level Health facilities to District and District to lower level Health facilities	To improve pediatric services in all Health facilities in the council by June 2018	To carry out 12 days train to 200 Health Care Workers on Management of HIV and AIDS paediatric in 29 wards	Number of Health Care Workers trained.		TMC and Stakeholders
			To train 200 Health Care Workers in Paediatrics on PITC for competency attainment and performance in 29 wards	Number of Health Care Workers trained.		
			To carry out HIV testing to 10,000 children from all paediatric entry point in the Council.	Number of Children HIV tested		

COMMUNITY GROUP	ROOT CAUSES OF NEW HIV INFECTIONS	FIVE YEARS OBJECTIVES	ACTIVITIES	KEY PERFORMANCE INDICATORS	TIME FRAME	RESPONSIBLE PERSON
			To carry out training to 500 Community Health Workers on importance of early referral of Paediatrics in 29 wards	Number of Community Health Care Workers trained.		
			Provide nutrition support to 33% of under five year children with moderate malnutrition	Pe-entage of under five year Children supported		
			Procure 10 Motor ci-le for instant Transportation of DBS from lower level Health facilities to District	Number of motor ci-le procured		
			Procure 10 LAPTOPs for MAT	Number of LAPTOPs Procured		
Pregnant Women	Inadequate of appropriate health care service during pregnancy and after [prenatal and post natal health services	To improve maternal health service in all 298 Health facilities by June 2018	Identify poorly performing maternal health facilities in 29 wards	Number of poorly performing maternal health facilities identified		TMC and Stakeholders
			To carry out 50 mentoring and coaching for maternal and new born quarterly to identified health facilities through supportive supervision in 29 wards	Number of mentoring and coaching Conducted		

			To carry out 50 orientation session on early ANC booking to villages Health committee	Number of orientation sessions Conducted		

COMMUNITY GROUP	ROOT CAUSES OF NEW HIV INFECTIONS	FIVE YEARS OBJECTIVES	ACTIVITIES	KEY PERFORMANCE INDICATORS	TIME FRAME	RESPONSIBLE PERSON
PLHIV, PLHA	i. Stigma and Discrimination making PLHIV and PLHA to shy from treatment ii. None adherence to drugs prescription iii. Drop out from continuum of care	i. To reduce Stigma and Discrimination for PLHIV and PLHA from 10% to 3% by June 2018. ii. To improve continuum of care among the PLHIV and PLHA by June 2018	To carry out 2 days 50 orientations session to health care provider on Medical ethics in 29 wards	Number of orientations Conducted		TMC and Stakeholders
			To carry out 60 Orientation sessions quarterly to PLHAs on adherence to treatment in 29 wards	Number of Orientation session Conducted		
			To carry out 60 sensitizations session quarterly on the importance of adherence to ARTs to care takers in 29 wards	Number of sensitization session Conducted		
			Trace back 60% of PLHIV LTF regarding clinic appointment.	Pe-entage of PLHIV LTF traced back		
Youth and Teenage	Fear and shyness in seeking treatment	To improve disclosure of HIV status and adherence of care and treatment by June 2018.	Establish 80 youth friendly services in health facilities in 29 wards	Number of youth friendly services Established		TMC and Stakeholders

AIDS Related deaths to employees at the council al office and	i. Stigma and Discrimination ii. Denial iii. Drop out from ARVs iv. Polite language to youths attending services v. faith Leaders	To reduce stigma and discrimination, denial and Drop out from ARVs at work places by June 2018	To carry out 20 HIV AND AIDS work place meeting quarterly at Public and Private Institution in 29 wards	Number of work place meetings Conducted		TMC and Stakeholders
			Establish 15 PLHAs clubs at Public and Private Institution in 29 wards	Number of clubs established		
			To carry out 60 Orientation session quarterly on adherence of ARV's in 29 wards	Number of Orientation session Conducted		
			To carry out 20 sensitization meeting annually to Employers on the significance of budgeting for PLHAs Staff at work place	Number of sensitization meeting Conducted		

ENABLING ENVIRONMENT **Outcome 4:** Increased number of political, religions, Tradition leaders and committee members committed in HIV and AIDS Interventions ***Outcome indicator:-*** *Number of political, religions, Tradition leaders and committee members committed in HIV and AIDS Interventions*.						
-,DC,MPs, Councilors	**ROOT CAUSES OF NEW HIV INFECTIONS**	**OBJECTIVE**	**ACTIVITY.**	**INDICATOR**	**TIME FRAME**	**RESPONSIBLE**
-,DC,MPs, Councilors	Inadequate political commitment.	To increase involvement and participation of Politicians, Council al & District level leaders, Religious leaders in HIV and AIDS by 2018.	To carry out 20 annual sensitization meeting to political leaders and District leaders on HIV and AIDS issues.	Number of annual meetings Conducted.		TMC and Stakeholders
			To carry out 20 annual review meetings on HIV and AIDS status to the, Council al & District Political leaders.	The number of annual meetings Conducted		
Faith Leaders	Reluctance in supporting the C part of ABC.		To carry out 20 annual sensitization meeting to Religious leaders on HIV and AIDS specific on ABC	Number of annual meetings Conducted		
			To carry out 60 Biannually advocacy meetings to Religious leaders on importance of HIV testing and counseling to believers.	Number of advocacy meetings Conducted		
HIV and AIDS Coordinators at the Council and all levels.	I. Inadequate knowledge and skill for HIV and AIDS Coordination	To improve coordination and implementation of HIV and AIDS activities by 2018	To carry out coordination and implementation of HIV and AIDS interventions.	Number of training session Conducted		TMC and Stakeholders
			To carry out 20 days mentorship training sessions on coordination	Number of days Conducted		

	ii. Inadequate coordination between CHAC and DACC Offices iii. Incomplete and un timely reporting iv. Lack of appropriate Coordination tools and equipments		and implementation of HIV and AIDS interventions to CMACs in 29 wards			
			To carry out 20 quarterly review coordination, progress of implementation)	Number of meeting Conducted		

COMMUNITY GROUP	ROOT CAUSES OF NEW HIV INFECTIONS	FIVE YEARS OBJECTIVES	ACTIVITIES	KEY PERFORMANCE INDICATORS	TIME FRAME	RESPONSIBLE PERSON
Coordination Committees	i. Misunderstanding of roles. ii. Committee structure counterproductive to its functions.	To improve performance of Multi sect oral AIDs Committees by June 2018.	bring back 200 wards multi-sect oral AIDS Committees in line with the given guidelines	Number of established MACs		TMC and Stakeholders
			To carry out 3 days training to 118 MACs on their roles and responsibilities in each wards.	Number of MACs trained		
			To carry out 118 MACs quarterly meetings on HIV and AIDS interventions	Number of MACs meeting Conducted		

5.0 CHAPTER FIVE.

5.1 MONITORING AND EVALUATION.

The Municipal Strategic Plan will be measured in terms of outcome indicators derived from the three Zeros (Zero New HIV infections, Zero AIDS related deaths and Zero Stigma and discrimination) and Output indicators derived from activities to be implemented. The Monitoring will be carried out quarterly through supportive supervision at Council level by involving CSOs, Evaluations of the Strategy will be done twice (during midterm and final stage) and the results obtained will inform the stakeholder's on areas of improvement and form the basis for development of the next Municipal Strategic Plan.

The productivity results will be reported based on the data from THMIS, CTC, HTC, ART, PMTCT and VMMC. Non medical results will be reported through TOMSHA and EMIS on quarterly basis. DAC and CHAC will summarize these data on quarterly basis and submit to the RS for compilation and submission to PMO - RALG and TACAIDS.

5.2 FINANCING OF THE MUNICIPAL HIV AND AIDS STRATEGIC PLAN (MHASP)

MHASP is not a strategy to be implemented by the Municipal Council itself, it is a strategy to be implemented in concerted efforts by different implementing partners operating HIV and AIDS interventions in Tabora Municipality, Donor funders will be important for many of the interventions while in a great extent the plan depends rigorously to Local Partners among which are:-

EGPAF, TDFT ,TACEDE, HUNAMA, TABORA NGO CLUSTER, JAMII SALAMA, SUDESO, CHAUMUTA, SHIDEFA , TLC, SLIC, MLEACO, ACOC, GOODNESS, JINAMA, AICT PAMOJA TUWALEE ,TAS, GREPO, CHAWATA, CESOCE, ABLAMA, SHIDEPHA, RED CROSS, NDD, FADICE,TAVICO,TIDO,TAHONE,YDF,PLATHA,PEDICAMA, KONGA

5.3 CONCLUSION.

This Municipal HIV and AIDS strategic plan 2014 -2018 is a dynamic document that is informed by the many initiatives and responses that address various challenges that are posed by the epidemic. The strategic plan as indicated in different sections of the document is based on the key principle which is putting people, especially the infected and affected, at the centre of all initiatives. This document is not a conclusive response to the challenges posed by the pandemic but it seeks to provide guidance to all stakeholders so that we avoid duplication and waste of the limited reSources on the fight against the epidemic.

It is our belief that the successful implementation of this plan depends on stakeholders' determination with greater involvement of communities, and civil society organizations on behalf of whole population.