Restless Development Tanzania

Monitoring & Evaluation Unit

Retrospective Trends Survey -2010

TRENDS IN YOUTH HEALTH BEHAVIOURS AND COMMUNITY INVOLVEMENT:

Results from 2010 retrospective survey

A survey of the trends in youth development indicators to serve as input for baseline of Restless Development's rural programmes in Tanzania

List of Acronyms

CAGs	**Community Action Groups**
CPE	**Community Peer Education**
CVPE	**Community Volunteer Peer Educators**
HCT	**HIV Counseling and Testing**
IRC	**Information Resource Centre**
KnA	**Kijana ni Afya (Rural Programme)**
M&E	**Monitoring and Evaluation**
MoE	**Ministry of Education**
RPO	**Regional Programme Office**
STIs	**Sexually Transmitted Illnesses**
SRHR	**Sexual and Reproductive Health and Rights**
TACAIDS	**Tanzania Commission for AIDS**
THMIS	**Tanzania HIV and Malaria Indicator Survey**
VCT	**Voluntary Counseling and Testing**
VMAC	**Village Multi-Sectoral AIDS Committee**
WMAC	**Ward Multi-Sectoral AIDS Committee**
CMACs	**Council Multi-Sectoral AIDS Committee**
SPSS	**Statistical Package for Social Science**
TIE	**Tanzanian Institute for Education**

Table of Contents:

I. EXECUTIVE SUMMARY

The retrospective survey conducted by Restless Development-Tanzania between August and October 2010 focuses on the trends of specific indicators of the organization's programmes over the period of 2006 to 2009. The results of this survey are used by Restless Development-Tanzania to develop some baseline information, particularly of a demographic nature.

Restless Development will then undertake annual behavioral surveillance surveys and assessments of most significant changes compared to the baseline to allow measurements of outcomes and impact in its programmes. This process will help the organization move forward and develop new strategic orientations.

1. Trends in Sexually Transmitted Illnesses:

Contrary to National statistics which show an average increase of 1% in reported cases of Sexually Transmitted Illnesses (STIs) between 2003/2004 and 2007/2008 for both genders (THMIS, 2007/8), the Retrospective Survey shows an overall reduction of self-reported[1] cases of STI symptoms in young people of 10.25% in Iringa and 1% in Mbeya[2]. The reduction in reported STI symptoms is higher among men/boys than women/girls (37% and 23% reduction rates respectively)[3]..

The above decline in number of young people reporting STI symptoms is supported by a consistent increase in percentage of young people who seek STI diagnosis and treatment (49% increase overall for Iringa and Mbeya regions between 2007-2009).4 Comparisons by gender show that a higher percent of women/girls go for diagnosis after observing STI symptoms at about 75% compared to men/boys at 21%.

2. HIV Prevalence:

According to THMIS 2008, the annual **prevalence of HIV** among those tested was 3.4% nationally, or 5% among women and 1.1% among men. Regional analysis for Iringa and Mbeya showed that the prevalence rate for Iringa was 15.7% (Women=18.6% and men=12.1%) whereas that of Mbeya was of 9.2% (Women=9.3% and men=9.2%).

The Restless Development Survey confirms higher prevalence rates in Iringa compared to Mbeya, yet identifies an alarming trend of increasing **new HIV infections** of young people in Mbeya consistently over the period (2006-2009). In Mbeya, contrary to national trend records, during the period of 2007-2009, more men than women were newly infected with HIV. In Iringa, more women than men are getting infected over the same period. Overall between 2008 and 2009, one can see that in both regions, the numbers of new HIV infections are increasing[5] (at a rate of 19% and 58% for Iringa and Mbeya respectively, or a rate of 38.4 % on average).

[1] Self reporting of STIs is based on identification of symptoms by individuals; however STIs which do not show visible symptoms may escape notice and thus go un-identified. Respondents may also be embarrassed and shy to admit having STIs may lead to under-estimation.

2 This is due to a significant increase in 2007-8 which is absorbed by a higher decrease in 2008-9

[3] It needs to be noted that the significant decline in reported cases occur in the following districts of Iringa region: Njombe, Mufundi and Kilolo and the following districts of Mbeya region (Ileje, Mbozi, Chunya, Kyela). However increases were also reported in Iringa rural and Ludewa (both in Inringa region) as well as Mbarali and Rungwe (both in Mbeya region).

[4] The increase between 2007 and 2008 was of 12%, followed by a more important increase of 61%, between 2008 and 2009.. These specific increases were recorded in Iringa (Iringa Rural, Ludewa, Makete, Kilolo), and Mbeya regions (Mbozi, Chunya. Rungwe and Kyela)

[5] There is a possibility that there are other underlying drivers of new infections that are not associated with STIs, as it is also a fact that getting infected by HIV is one thing and starting to show symptoms is another that takes a long time based on so many other factors.-Restless Development have prioritized to conduct an Extreme sampling research on factors driving HIV in Southern Highlands in 2011-12)

3. Voluntary Counseling and Testing (VCT)

In Tanzania there were 976 **VCT[6] sites** in 2006, 1035 sites in 2007 (6% annual increase) and 1963 VCT sites in 2008 (47% annual increase), run by government, private sector or civil society. In 2008, the total government-run VCT sites in Iringa was 34(78% of total available VCT sites*[7]) while in Mbeya, there were 90 government-run VCT sites.

The trend analysis shows a sustained increase in **number of VCT sites** in all the regions considered, however the increase in Iringa is significantly higher than in Mbeya (+50% compared to +21% respectively[8] between 2008/2009 and 2009/2010). In some places, such as **Kilolo** (Iringa), **Rungwe** and **Ileje** (Mbeya), there has not been any new VCT site since 2006.

The reported number of young people **testing for HIV** has in total increased consistently from 2006 to 2009. The national statistics[9] indicate that 44.3% of men go for VCT compared to 55.7% of women. This is in line with our findings that on average, between 2006 and 2009, 46% of young boys went for VCT versus 54% of girls/women. All districts considered in the two regions showed increases in number of young people undergoing voluntary counseling and testing in the VCT sites. Most significant increases[10] were seen in Kyela (Mbeya), Njombe and Iringa rural (Iringa). Gender analyses show that in all locations, more women/girls undergo HIV Counseling and Testing (HCT)[11] than their men/boys counterparts, which is comparable to national statistics.

4. Participation of young people in local development committees

Participation of young people in development and their subsequent representation in decision making is critical in national development. The results indicate an average increase of **16.5%** of young people **representation in the village and ward multi-sectoral HIV/AIDS Committees** in Iringa and Mbeya over the period. Within this average, Mbeya recorded a 13% increase between 2006 and-2009 (yet starting with higher absolute numbers of participants), compared to Iringa which recorded a 20% increase (albeit starting with lower numbers of participants).

Although women/girls' representation was traditionally lower than the one of men/boys, the trend is towards stabilization: 42% of women participants in 2008 and 58% of women participation in 2009.

In Community Action Groups (CAGs)[12] , male participation is still relatively higher than that of women, at a ratio of 2 to 1 in 2009. However there is significant improvement compared to 2006, when the ratio was of 5 to 1.

The overall increase of women participation between 2006 and 2009 in Iringa and Mbeya was **105%.** The trend was essentially led by Mbeya (172% increase) and less by Iringa (only 38% increase over the trend period).

[6] Voluntary Counselling and Testing
[7] National AIDS Control Programme report(2008) states that 78% of all VCT sites in Tanzania are government run and available data by districts on VCT sites includes Mbeya and Iringa Municipalities, where Restless Development does not focus.
[8] This inference is data based but only relevant for the placements that were reported on being Kilolo: (Kitelewasi, Kitumbuka, Utengule, Lugalo, Mawambala, Ukumbi, Ihimbo and Winome villages), Rungwe:(Kapugi, Katumba, Itagata, Ikama, Makandana and Ibungira) and, Ileje: (Shikunga, Kafule, Iali, Isoko, Kapelekesi and Ibaba villages).
[9] Source: TACAIDS (Tanzania Commission for AIDS) 2008 annual report
[10] The increase in both Mbeya and Iringa was on moving average of 602% between 2006-2009 with the moving average for Mbeya being 756% and for Iringa 549%
[11] HIV Counselling and Testing
[12] Community Action Groups are an organized membership group of young people in the village level between the ages of 14-29 who have come together to spearhead community development as well as generate gains as individuals in the collective.

Gender disaggregation aside, there is a 135% increase in total numbers of young people actively participating in CAGs and youth groups (from 1059 in 2006 to 2491 in 2009), with highest increase in Mbozi district. However as numerical participation increase, less number of girls are being included in such important youth community groups.

5. Girls dropping out of school because of pregnancy

The number of girls dropping out of school as a result of pregnancies shows a mixed scenario. There are reported cases of reductions in number of girls dropping out of school due to pregnancy in the following districts: Iringa region (Iringa rural) and Mbeya (Ileje, Mbozi, Mbarali, and Chunya districts), however increases were also reported in Iringa (Njombe, Ludewa and Kilolo) as well as Mbeya(Kyela). A comparison of the data by regions does not show any significant differences in the trends over time, however the moving averages show an overall **2.5%** decrease (1% increase in cases in Iringa compared to a 6% decrease for Mbeya between 2007and 2009).

II. BACKGROUND:

This report was developed by the Monitoring and Evaluation (M&E) unit of Restless Development-Tanzania to assess the trends, mostly demographic, and generate information that will be used to establish baselines. Qualitative information will then be gathered on an annual basis through behavioral surveillance surveys, to keep track of changes compared to this baseline.

The objectives of this exercise were:

1. To develop demographic baseline information for our Rural Programmes in Iringa and Mbeya as a basis to systematically measure the progress made by Kijana ni Afya (KnA) (Rural Programme).
2. To assess the demographic trends within indicators critical to Kijana ni Afya (Rural programme) and identify the gaps that influence outcomes and impact for systematic review
3. To compare trends at the placement level against district level data, and identify areas of significant and insignificant contribution for future planning

III. METHODOLOGY

3.1: Tools and procedures for data collection:

A tool was designed, based on the indicators within the KnA logical framework (log frame), to capture information. This proved to be quite a challenge, since the log frame was developed mid-course and its use so far was rather minimal. The necessity of programme divergence from expected impact was more real than thought before.

This tool was thus developed, shared with programmes, discussed and agreed on, before it was translated into Swahili. The staff was trained on the tool, how to collect the data and the data sources for each indicator.

Data collection was two-fold: it involved community and national volunteers collecting information from the data sources at the placement level and filling the form designed; yet also. the Field officers were tasked to use the same tool to collect data from district sources to ensure comparison of trends.

The data generated by placement and district respectively was then entered into an excel spreadsheet and subsequently analyzed.

3.2: Data Frame and Analysis:

Data was entered from volunteer-filled forms which were collected by Field Officers within existing data management systems in the organization and categorized by each placement.

The records from each placement were then aggregated per district to form the comparison unit against district records. This system was based on the foundation that the contribution of numbers from Restless Development placements added to non-Restless development placements should effectively total the data mined from the districts and thus percent of contribution can be attributed. This assumption is one of the challenges to quality.

The data thus generated was analyzed and reported on.

3.3: Limitations to data quality

The following were challenges that may have impacted the integrity of the data:

- Missing information on some indicators from district level affected interpretation and comparative analysis.
- Lack of systems to ensure data quality at district level may have created over or under-reporting
- Data sources being absent during the reconstruction exercise
- Some data sources not feeding data to the existing national monitoring framework, make them unrecognized by districts as sources and thus interfere with data frames
- Feeling of additional work by volunteers and staff may have caused some bias.

IV. RESULTS AND ANALYSIS OF FINDINGS:

The results of the exercise have been divided based on the variables under which data was collected. Comparisons and analysis have been made at placement level (where data was collected) however comparative analyses have also been made with available national statistics for the regions and nationally, to show to what extent the data collected compares with available national statistics.

4.1: Reported cases of STI symptoms:

The results show an overall reduction in the number of young people reporting having STI symptoms in both regions between 2007 and 2009. In Iringa, significant reductions were observed, with an overall percentage decrease of 10.25% over the period. In Mbeya however, the decrease was only of1% (This is due to a significant increase in 2007-8 which is absorbed by a higher decrease in 2008-9).

District-wise analysis shows that decreases were observed in the following districts: Iringa (Njombe, Mufindi and Kilolo) and, Mbeya(Ileje, Mbozi, Chunya and Kyela), However some increases were also observed in Iringa rural and Ludewa (Iringa) and Mbarali and Rungwe(Mbeya)

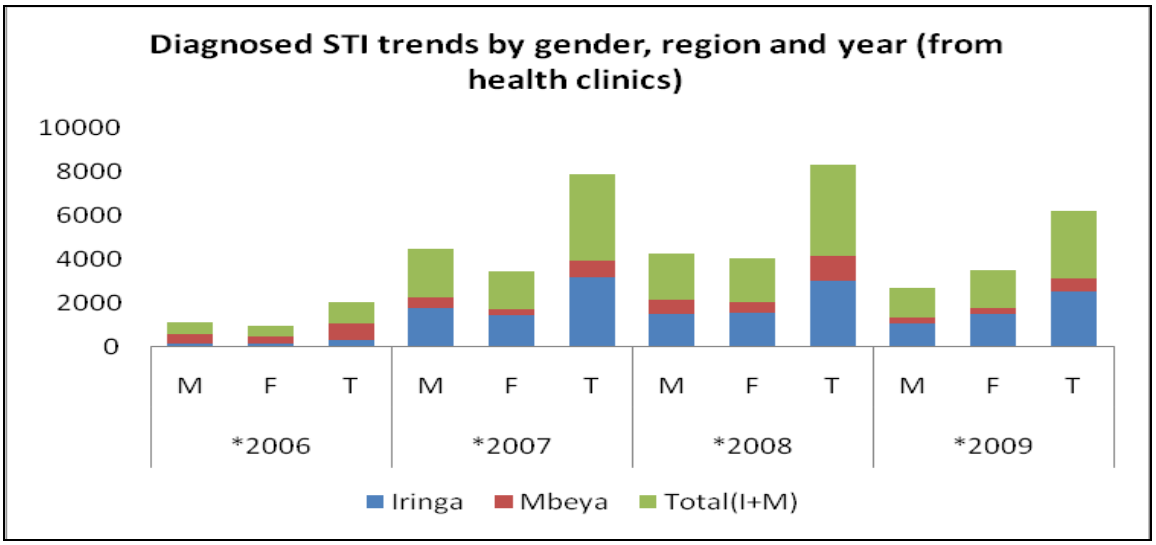
SURVEY AREAS		2009			2008			2007			2006		
REGION	DISTRICTS	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
IRINGA	Iringa rura	87	135	222	43	80	123	33	42	75	70	73	143
	Njombe	504	707	1211	900	850	1750	1200	900	2100	0	0	0
	Ludewa	14	34	48	20	21	41	13	27	40	14	23	37
	Mufindi	410	535	945	421	534	955	431	417	848	22	21	43
	Kilolo	51	58	109	79	52	131	82	46	128	51	38	89
		1066	**1469**	**2535**	**1463**	**1537**	**3000**	**1759**	**1432**	**3191**	**157**	**155**	**312**
MBEYA	Ileje	8	14	22	12	11	23	11	10	21	6	9	15
	Mbozi	82	78	160	503	334	837	315	135	450	218	152	370
	Mbarali	97	121	218	76	72	148	68	69	137	47	58	105
	Chunya	9	13	22	14	16	30	19	12	31	26	18	44
	Rungwe	57	36	93	42	22	64	31	23	54	34	59	93
	Kyela	21	18	39	25	19	44	40	25	65	38	50	88
		274	**280**	**554**	**672**	**474**	**1146**	**484**	**274**	**758**	**369**	**346**	**715**
Total (All districts)		**1340**	**1749**	**3089**	**2135**	**2011**	**4146**	**2243**	**1706**	**3949**	**526**	**501**	**1027**

*Data was not available for Mbeya Rural and Makete

Comparative analysis by region (i.e. in figure.1 below) shows that the Iringa region contributes to almost three quarter of reported STI cases (or 74%, Mbeya cases representing the other 26%).

Gender based analysis shows a significant reduction among males between 2008 and 2009 (37% decrease for males compared to 23% decrease for females over the same period).

Fig 1: Diagnosed STI trends.



National statistics for Tanzania report an average increase of 1% for both sexes of people reporting having had STI symptoms between 2003/4 and 2007/8[13]. In the first years, the numbers tended to increase (of 6% and 5% for male and female respectively in 2003-4 and 7% and 6% respectively in 2007-8). A decrease was then observed at the end of the period.

From the trend analysis of Iringa and Mbeya based on STI diagnosis records collected from health clinics at the placement level, there is a consistent decrease in number of diagnosed STI cases for men between 2007-9, however the consistent decrease for females in both regions is recorded beginning 2008-9.

In both regional and national statistics the trends show that more males have reported STI symptoms (either self reported or diagnostic) than females.

Number of people receiving STI diagnosis and treatment from Health clinics:

There is a consistent significant increase in the percentage of young people who seek STI diagnosis and treatment (49% overall for Iringa and Mbeya regions between 2007- 2009). In 2007 to 2008, the increase was of 12%, which then stepped up to 61% in 2008/9.

The most significant increases were observed in the following districts: Iringa (Iringa Rural, Ludewa, Makete, Kilolo), and Mbeya region (Mbozi, Chunya. Rungwe and Kyela)

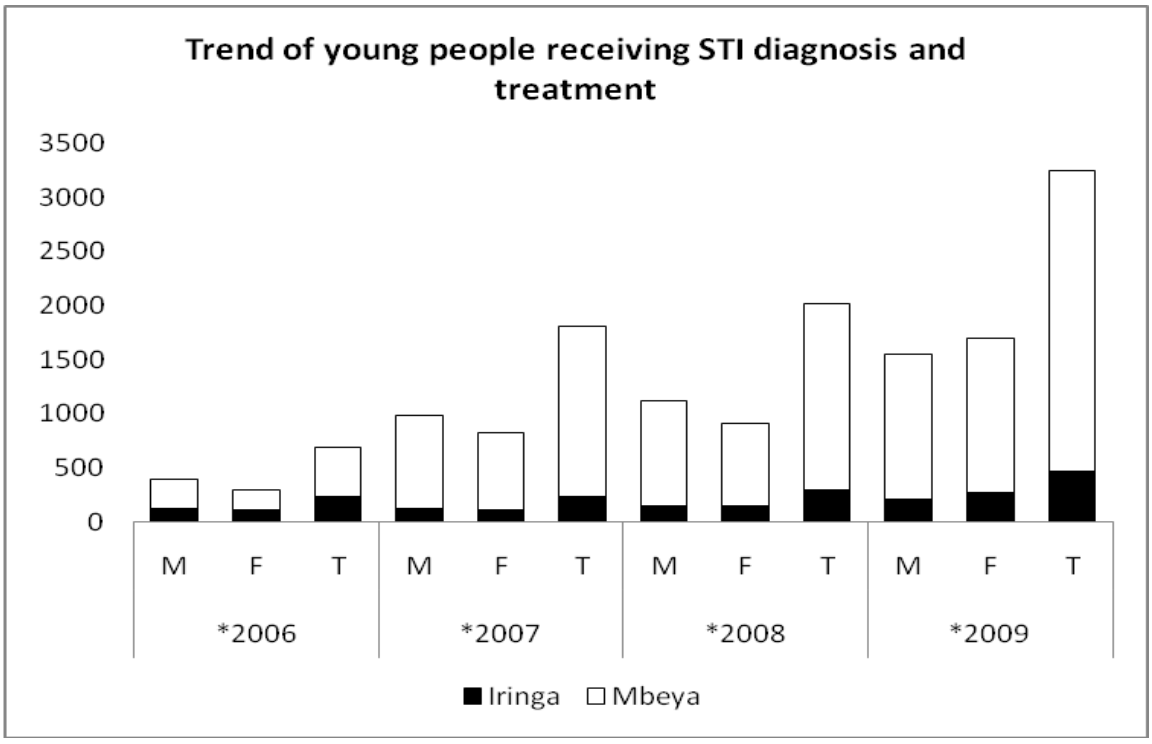
When desegregated by gender, the data show that a higher percentage of women/girls have received STI diagnosis in Iringa and Mbeya than men/boys. The range for Men/boys is between 15%-28% for Iringa and Mbeya respectively whereas for women/girls it is at 48%-82% respectively.

This implies that women recognize more the need for STI diagnosis after observing STI symptoms than men, however both gender are keen to pursue treatment.

[13] Source: THMIS 2007/2008

Number receiving STI diagnosis and treatment													
REGION	Districts	2009			2008			2007			2006		
		M	F	T	M	F	T	M	F	T	M	F	T
Iringa													
	Iringa Rural	48	82	**130**	19	34	**53**	29	40	**69**	17	18	**35**
	Njombe	25	44	**69**	0	0	**0**	0	0	**0**	0	0	**0**
	Ludewa	27	31	**58**	27	26	**53**	19	16	**35**	23	23	**46**
	Mufindi	17	32	**49**	33	31	**64**	30	27	**57**	22	22	**44**
	Makete	41	41	**82**	35	39	**74**	14	12	**26**	18	19	**37**
	Kilolo	47	36	**83**	35	16	**51**	29	14	**43**	45	24	**69**
	6 Districts	205	266	**471**	149	146	**295**	121	109	**230**	125	106	**231**
Mbeya													
	Ileje	8	14	**22**	12	11	**23**	11	10	**21**	6	9	**15**
	Mbozi	101	87	**188**	89	68	**157**	76	73	**149**	56	37	**93**
	Mbarali	101	87	**188**	89	68	**157**	76	73	**149**	56	37	**93**
	Chunya	185	214	**399**	81	54	**135**	120	79	**199**	139	85	**224**
	Rungwe	74	46	**120**	63	33	**96**	29	14	**43**	15	21	**36**
	Kyela	879	980	**1859**	632	526	**1158**	554	467	**1021**	0	0	**0**
	6 districts	1348	1428	**2776**	966	760	**1726**	866	716	**1582**	272	189	**461**
Total(I+M)		1553	1694	**3247**	1115	906	**2021**	987	825	**1812**	397	295	**692**
	*Data from Mbeya Rural unavailable												

Fig 2: Trends of STI diagnosis and treatment among young people



4.3: HIV incidences:

HIV incidences was measured by collecting the number of new HIV infections (HIV positive) recorded for the year from VCT centers at the placement level.

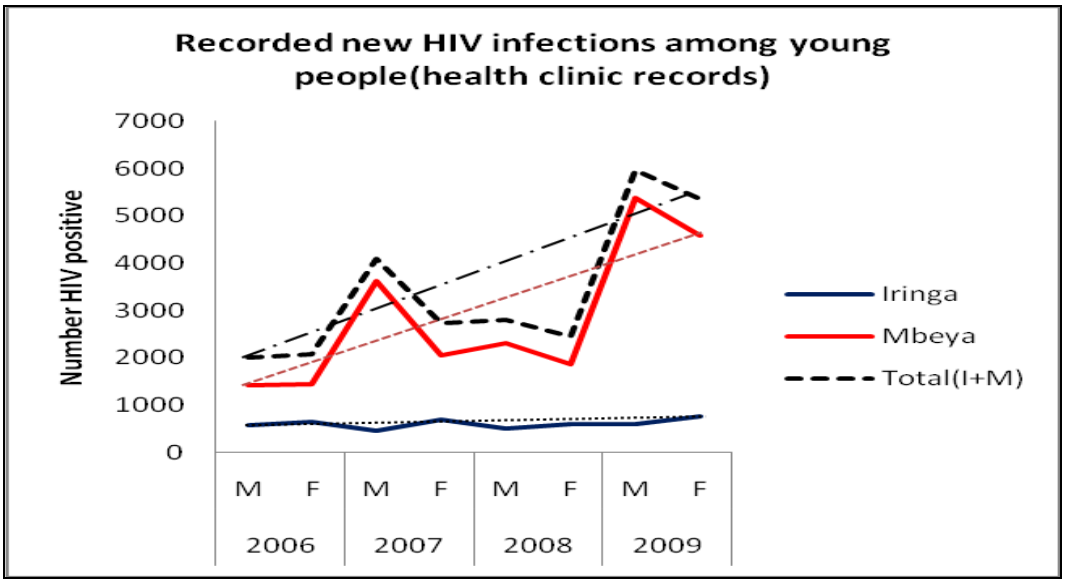
Cognizance is made of the fact that the data presented below was collected from VCT centers and does not include data from provider-Initiated Counseling and Testing, Home based counseling and testing and mobile testing from other players who are not government providers[14].

New HIV infections:

REGION	Districts	2009			2008			2007			2006		
		M	F	T	M	F	T	M	F	T	M	F	T
Iringa													
	Iringa Rural	74	137	**211**	34	45	**79**	52	39	**91**	52	46	**98**
	Njombe	2	6	**8**	4	9	**13**	0	0	**0**	0	0	**0**
	Ludewa	140	204	**344**	159	235	**394**	161	253	**414**	194	245	**439**
	Mufindi	77	67	**144**	59	57	**116**	34	24	**58**	21	10	**31**
	Makete	68	95	**163**	88	122	**210**	129	256	**385**	152	248	**400**
	Kilolo	235	256	**491**	152	133	**285**	91	112	**203**	167	94	**261**
	6 districts	596	765	**1361**	496	601	**1097**	467	684	**1151**	586	643	**1229**
Mbeya													
	Ileje	19	21	**40**	17	17	**34**	15	10	**25**	8	16	**24**
	Mbozi	1224	410	**1634**	124	10	**134**	60	34	**94**	30	20	**50**
	Mbarali	27	65	**92**	25	38	**63**	32	41	**73**	0	0	**0**
	Chunya	803	1029	**1832**	479	249	**728**	1193	237	**1430**	76	29	**105**
	Rungwe	13	4	**17**	7	11	**18**	33	4	**37**	2	5	**7**
	Kyela	5	4	**9**	7	5	**12**	10	13	**23**	8	9	**17**
	Mbeya Rural	3283	3063	**6346**	1651	1532	**3183**	2277	1707	**3984**	1296	1365	**2661**
	7 districts	5374	4596	**9970**	2310	1862	**4172**	3620	2046	**5666**	1420	1444	**2864**
Total(I+M)*	**13 districts**	**5970**	**5361**	**11331**	**2806**	**2463**	**5269**	**4087**	**2730**	**6817**	**2006**	**2087**	**4093**

Fig 3: Reported new Infections from Health clinics/centers (refer to annex)

[14] It could be that data collected from these instances was incorporated into the VCT register at the government VCT facilities (in which cases they would be reflected in the table), yet this is rather unlikely.



Note: These numbers should be read with caution as there is a probability of newly testing numbers mixed with repeat cases and also the numbers are not adjusted for rates of population increase over the period.

According to THMIS 2008, the annual prevalence of HIV among those tested was 3.4% nationally (representing 5% among women and 1.1% among men). Regional analysis for Iringa and Mbeya showed that the prevalence rate for Iringa was 15.7% (Women=18.6% and men=12.1%) whereas that of Mbeya was 9.2% (Women=9.3% and men=9.2%)

Overall, Mbeya recorded higher testing rates at 89.7% compared to Iringa at 87.6%, however more women were tested in Mbeya than Iringa, and more men tested in Iringa than Mbeya. In both regions more women were tested than men.

Despite HIV prevalence being higher in Iringa than Mbeya, more young people recorded higher new HIV infections in Mbeya consistently over the trend period (2006-9). In Mbeya, contrary to national trend records, during the period of 2007-9, more men than women are newly infected by the HIV virus. This is inversely proportional to Iringa where more women are getting infected than men over the same period.

The trends show a mixed kind of observations on overall rates of new HIV infections, however it is discernable from 2008-9 that in both regions the numbers of new HIV infections are increasing. There was a percent increase of 19% and 58% in Iringa and Mbeya respectively averaging and increase of 38.4 percent in the two regions.

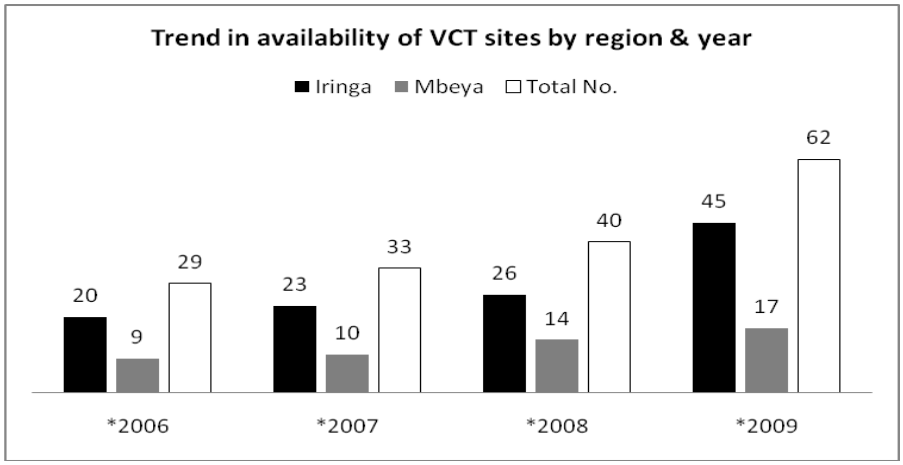
4.4: Availability of HIV Counseling and testing outlets/sites

Region	Districts	*2009	*2008	*2007	*2006
Iringa	Iringa Rural	13	6	6	6
	Njombe	5	3	3	1
	Ludewa	8	5	5	4
	Mufindi	11	4	1	1
	Makete	0	0	0	0
	Kilolo	8	8	8	8
		45	**26**	**23**	**20**
Mbeya	Ileje	2	2	2	2
	Mbozi	6	4	4	3
	Mbarali	3	3	1	1
	Chunya	2	1	1	1
	Rungwe	2	2	2	2
	Kyela	2	2	0	0
		17	**14**	**10**	**9**
Total(I+M)		**62**	**40**	**33**	**29**

There is a sustained increase in number of VCT sites in all the regions considered, however the increase in Iringa is quite significant (more than 50% increase between 2008/2009 and 2009/2010) compared to Mbeya (21% increase).

In Kilolo(Iringa), Rungwe and Ileje(Mbeya), there hasn't been any new VCT site established since 2006[15].

Fig 4: Availability of VCT sites



In Tanzania there were 976 VCT sites in 2006, 1035 sites in 2007 and 1963 VCT sites in 2008 representing either government, private sector or civil society. Between 200 and 2007, there was a small increase of 6%, yet the more significant increase was between 2007 and 2008 (annual increase of 47%).

15 This information is data based but only relevant for the placements that were reported on, being Kilolo: (Kitelewasi, Kitumbuka, Utengule, Lugalo, Mawambala, Ukumbi, Ihimbo and Winome villages), Rungwe :(Kapugi, Katumba, Itagata, Ikama, Makandana and Ibungira) and, Ileje: (Shikunga, Kafule, Iali, Isoko, Kapelekesi and Ibaba villages).

In 2008 the total government VCT sites in Iringa was 34 (78% of total available VCT sites*[16]) while in Mbeya, there were 90 government VCT sites.

Number of VCT sites available by Region and district compared to placement information in 2008

Region	District	Number by district(NACP 2008)	Number from placements (Retrospective survey)	Variance
Mbeya	Municipality	18	*	#VALUE!
	Rural	0	0	0
	Chunya	32	1	31
	Ileje	5	2	3
	Kyela	15	2	13
	Mbarali	7	3	4
	Mbozi	8	4	4
	Rungwe	31	4	27
Iringa	Municipality	9	*	#VALUE!
	Rural	11	6	5
	Kilolo	5	8	-3
	Makete	5	0	5
	Ludewa	3	5	-2
	Njombe	6	3	3
	Mafinga	5	*	#VALUE!
	Mufindi	0	4	-4

The high increase in number of young people undergoing HCT correlates to the significant increases in numbers of VCT in Iringa but not to the same grain for Mbeya. This indicates that there are other significant drivers of access to HCT services in both Mbeya (to a higher degree) and Iringa (lesser degree) apart from increases in number of available VCT sites.

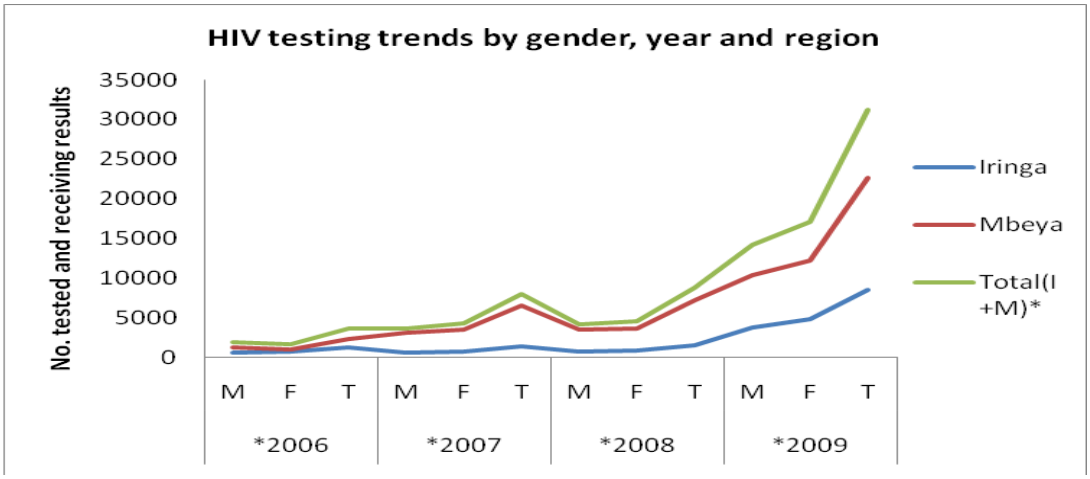
[16] NACP programme report 2008 states that 78% of all VCT sites in Tanzania are government run and available data by districts on VCT sites includes Mbeya and Iringa Municipalities, where Restless Development does not focus.

Number of young people undergoing HCT within national and international standards.

The trend analysis data was collected from 75 health centers/clinics at the village level: 37 villages in Iringa and38 villages in Mbeya(the list of villages is attached in annex)

REGION	Districts	2009			2008			2007			2006		
		M	F	T	M	F	T	M	F	T	M	F	T
Iringa													
	Iringa Rur	674	1333	**2007**	63	34	**97**	105	98	**203**	107	42	**149**
	Njombe	2059	2644	**4703**	53	71	**124**	25	33	**58**	42	85	**127**
	Ludewa	545	204	**749**	159	235	**394**	161	253	**414**	194	245	**439**
	Mufindi	177	214	**391**	131	170	**301**	100	150	**250**	85	115	**200**
	Makete	39	68	**107**	10	8	**18**	0	0	**0**	0	0	**0**
	Kilolo	283	337	**620**	271	326	**597**	200	227	**427**	214	192	**406**
	6 Districts	**3777**	**4800**	**8577**	**687**	**844**	**1531**	**591**	**761**	**1352**	**642**	**679**	**1321**
Mbeya													
	Ileje	438	501	**939**	422	398	**820**	385	354	**739**	929	708	**1637**
	Mbozi	406	140	**546**	318	170	**488**	179	199	**378**	0	0	**0**
	Mbarali	228	236	**464**	80	103	**183**	60	51	**111**	43	48	**91**
	Chunya	125	204	**329**	103	152	**255**	276	187	**463**	196	176	**372**
	Rungwe	214	240	**454**	156	171	**327**	45	212	**257**	106	115	**221**
	Kyela	8965	10921	**19886**	2453	2682	**5135**	2127	2525	**4652**	0	0	**0**
	6 Districts	**10376**	**12242**	**22618**	**3532**	**3676**	**7208**	**3072**	**3528**	**6600**	**1274**	**1047**	**2321**
Total(I+M)	**12 district**	**14153**	**17042**	**31195**	**4219**	**4520**	**8739**	**3663**	**4286**	**7952**	**1916**	**1726**	**3642**

Fig 5: Trends in number tested for HIV and receiving results



The number of young people reporting testing for HIV has in total increased consistently from 2006-2009. All districts in the two regions showed increases in number of young people undergoing VCT in the VCT sites. Most significant increases were seen in Kyela (Mbeya), Njombe and Iringa rural (Iringa)

The increase in both Mbeya and Iringa was on running average 602% between 2006-2009 with the moving average for Mbeya being 756% and for Iringa 549%. Mbeya recorded high numerical figures at the same time compared to Iringa.

Desegregation by gender show that in all the cases reported more women/girls undergo HCT than their men/boys counterparts (Comparable to national statistics). The national statistics (source-TACAIDS 2008 annual report) states that by number, 44.3% of men go for VCT compared to 55.7% of women. This compares favorably with our findings that on average, between 2006 and 2009, 46% of boys (young people) went for VCT versus 54% of girls/women.

4.6: Number of young people participating in Community Action Groups

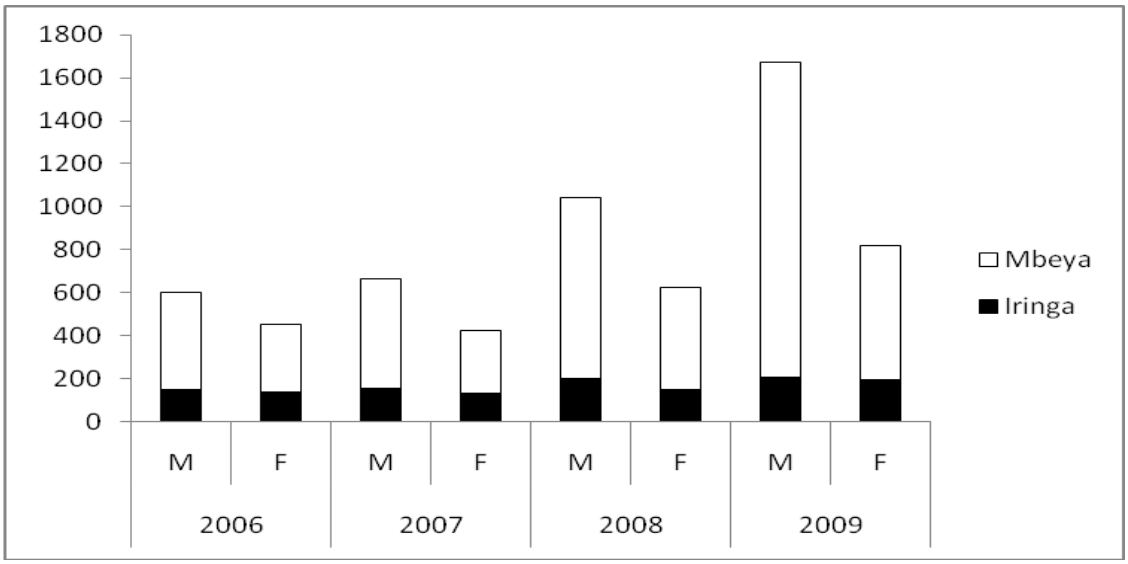
Male participation in Community action groups is still relatively higher than women at a ratio of 2:1 in 2009. This reflects a significant improvement from 2006, during which the ratio was of 5: 1. There are significant gains in 77% of the 13 districts between 2008-2009 thus; Mbozi, Iringa rural, Ludewa, Mufindi, Makete, Kilolo, Ileje, Mbarali, Rungwe and Mbeya rural.

REGION	All districts	2009			2008			2007			2006		
		M	F	T	M	F	T	M	F	T	M	F	T
Iringa													
	ringa Rura	39	33	**72**	31	31	**62**	42	31	**73**	44	25	**69**
	Njombe	17	24	**41**	28	24	**52**	15	18	**33**	19	49	**68**
	Ludewa	24	16	**40**	19	13	**32**	14	15	**29**	17	11	**28**
	Mufindi	32	47	**79**	35	27	**62**	21	16	**37**	21	33	**54**
	Makete	21	15	**36**	23	10	**33**	23	18	**41**	3	0	**3**
	Kilolo	76	58	**134**	62	46	**108**	42	32	**74**	46	22	**68**
	6 districts	**209**	**193**	**402**	**198**	**151**	**349**	**157**	**130**	**287**	**150**	**140**	**290**
Mbeya													
	Ileje	126	59	**185**	119	63	**182**	126	54	**180**	94	35	**129**
	Mbozi	1113	319	**1432**	504	209	**713**	159	16	**175**	139	72	**211**
	Mbarali	50	47	**97**	60	34	**94**	57	45	**102**	51	35	**86**
	Chunya	13	19	**32**	21	23	**44**	17	19	**36**	19	16	**35**
	Rungwe	81	85	**166**	48	55	**103**	50	61	**111**	61	48	**109**
	Kyela	59	75	**134**	76	73	**149**	71	72	**143**	63	81	**144**
	Meya Rura	23	20	**43**	19	18	**37**	29	25	**54**	27	28	**55**
	7 districts	**1465**	**624**	**2089**	**847**	**475**	**1322**	**509**	**292**	**801**	**454**	**315**	**769**
Total(I+M)		**1674**	**817**	**2491**	**1045**	**626**	**1671**	**666**	**422**	**1088**	**604**	**455**	**1059**

The overall increase between 2006-2009 in Iringa and Mbeya was **105%.** Highest increases in the above were contributed differently by the two regions where Iringa contributed an increase of 38% and Mbeya of 172% over the trend period. There is 135% increase in total numbers of YP actively participating in CAGs and youth groups from 1059(2006) to 2491(2009) with highest gain in Mbozi district.

As the number of participation increase, less number of girls are becoming included in such important youth community groups, however more girls were participating than boys in Mbeya(Kyela, Rungwe and Chunya) and Iringa(Mufindi and Njombe)

Fig 6: Trends in young people participation in CAGs



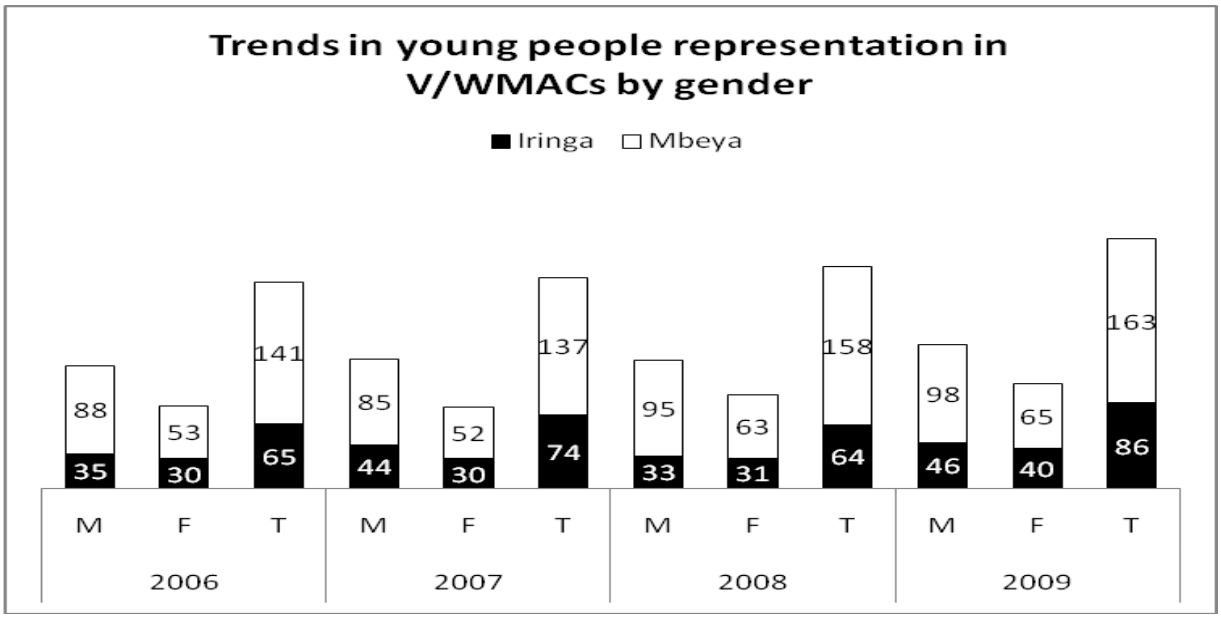
Participation is overall higher in number in Mbeya as compared to Iringa

4.7: Representation of YP in Village and Ward Multi-Sectoral AIDS Committees

Trends in representation of young people in V/WMACs

REGION	Districts	*2009			*2008			*2007			*2006		
		M	F	T	M	F	T	M	F	T	M	F	T
Iringa													
	Iringa Rural	7	8	**15**	4	6	**10**	5	6	**11**	5	6	**11**
	Njombe	11	9	**20**	10	10	**20**	18	8	**26**	6	0	**6**
	Ludewa	10	6	**16**	7	4	**11**	7	6	**13**	5	5	**10**
	Mufindi	4	3	**7**	5	4	**9**	8	4	**12**	13	13	**26**
	Makete	5	7	**12**	2	2	**4**	2	2	**4**	2	2	**4**
	Kilolo	9	7	**16**	5	5	**10**	4	4	**8**	4	4	**8**
	6 Districts	**46**	**40**	**86**	**33**	**31**	**64**	**44**	**30**	**74**	**35**	**30**	**65**
Mbeya													
	Ileje	27	19	**46**	32	17	**49**	32	17	**49**	32	17	**49**
	Mbozi	5	9	**14**	4	8	**12**	2	2	**4**	2	2	**4**
	Mbarali	9	6	**15**	4	2	**6**	4	2	**6**	6	3	**9**
	Chunya	4	3	**7**	4	3	**7**	3	3	**6**	3	2	**5**
	Rungwe	28	15	**43**	25	16	**41**	21	12	**33**	18	16	**34**
	Kyela	22	10	**32**	22	15	**37**	20	14	**34**	23	12	**35**
	Mbeya Rural	3	3	**6**	4	2	**6**	3	2	**5**	4	1	**5**
	7 districts	**98**	**65**	**163**	**95**	**63**	**158**	**85**	**52**	**137**	**88**	**53**	**141**
Total(I+M)		***144***	***105***	***249***	***128***	***94***	***222***	***129***	***82***	***211***	***123***	***83***	***206***

Fig 7: Regional comparison of representation of young people in V/WMACs



There is an average increase of **16.5%** of young people representation in the village and ward multi-sectoral HIV/AIDS Committees in Iringa and Mbeya. Within this average, Mbeya recorded a 13% increase between 2006 and 2009 but with higher numbers as compared to Iringa which recorded a 20% increase with lower numbers.

Comparisons of representation by gender in V/WMACs by regions and average show that in all the cases considered during the period of 2006 to 2009, women/girls representation, which is in the beginning quite low, greatly improves at the end of the period: in 2008-2009, the participation is balanced - reaching42% ando 58% respectively.

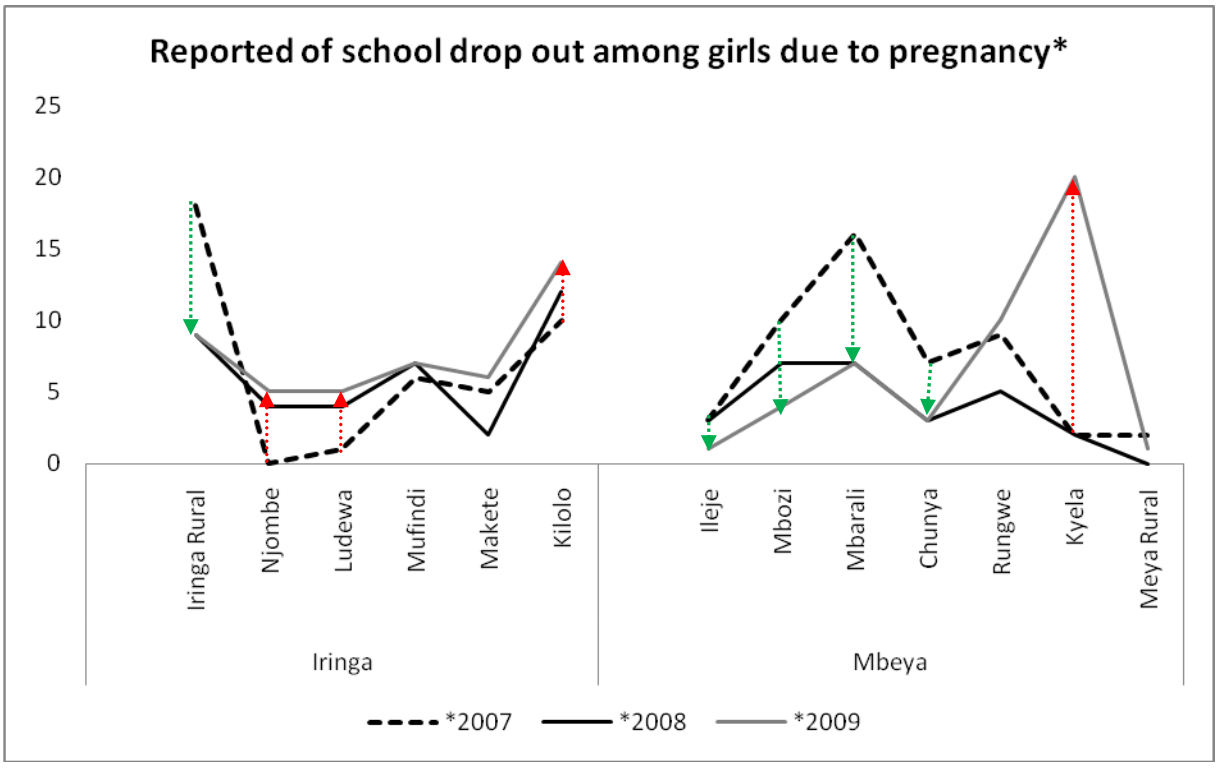
Despite the near stabilization of rations of women/men representation at 2:3(for every 2 women, there are 3 men in the committee) respectively, Iringa shows a higher ration of women in the committees than Mbeya, thus fast approaching parity though with lower numbers.

4.8: Pregnancy related school drop-out rates among girls (Reported through schools interviews):

The number of girls dropping out of school as a result of pregnancies shows a mixed scenario. There are reported cases of reductions in number of girls dropping out of school as a result of pregnancy in the following districts: Iringa region (Iringa rural) and Mbeya (Ileje, Mbozi, Mbarali, and Chunya districts), however increases were also reported in Iringa(Njombe, Ludewa and Kilolo) as well as Mbeya (Kyela).

Number of girls who dropped out through pregnancy				
REGION	Districts	*2007	*2008	*2009
Iringa				
	Iringa Rural	18	9	9
	Njombe	0	4	5
	Ludewa	1	4	5
	Mufindi	6	7	7
	Makete	5	2	6
	Kilolo	10	12	14
Mbeya				
	Ileje	3	3	1
	Mbozi	10	7	4
	Mbarali	16	7	7
	Chunya	7	3	3
	Rungwe	9	5	10
	Kyela	2	2	20
	Meya Rural	2	0	1
Total(I+M)	13 districts	89	65	92

A comparison of the data by regions does not show any significant differences in the trends over time, however the moving averages show an overall 2.5% decrease thus; a 1% increase in cases in Iringa compared to a 6% decrease for Mbeya between 2007-2009(refer to the figure below)



These districts will be assessed more keenly to ascertain the drivers of such differences.

ANNEX:

1. Names of placements by District and Region

List of all placements per Region where Retrospective survey information was collected.

a) Iringa:

Iringa rural: Ilalasimba, Kibena, Lumuli, Mibikimitali, Muwimbi, Nyamihuu, Udumka.
Kilolo: Ihimbo, Kitelewasi, Kitumbuka, Lugalo, Mawambala, Ukumbi, Utengule, Winome.
Mufindi: Iramba, Kitelewasi, Luhunga, Lwing'ulo, Maduma, Nyanyembe, Nyigo.
Makete: Mago, Bulongwa, Iwawa, Ugabwa.
Ludewa: Lugarawa, Mdilidili, Masimbwe, Itundu, Mkongobaki, Lupande.
Njombe: Ikuna, Isutu, Itowo, Igosi, Igelehedza.

Placements missing information (4): Makoga, Ihanja, Igula in Njombe district and Ukemele in Mufindi district.

b) Mbeya:

Rungwe: Ibungila, Ikama, Itagata, Katumba, Kapugi, Makandana.
Mbeya R.: Inyala, Idunda, Imezu.
Kyela: Ibungu, Ikolo, Kasumulu, Konjula, Mbula, Muungano, Mwalisi, Sinyanga.
Mbalali: Mkombwe, Utyego, Ilongo, Mahongole, Nsonyanga.
Ileje: Ibaba, Isoko, Kafule, Kapelekesi, Lali, Shikunga.
Mbozi: Itaka, Insani, Hang'omba, Mpapa, Kamsamba.
Chunya: Kiwanja, Makongolosi, Matundasi, Mbugani, Mkola.

Placements missing information (2): Mwakaganga and Lupasu in Mbalali district

2. List of health centers by placements where information was collected.

- Ilalasimba 1
- Kibena 1
- Lumuli
- Mibikimitali 7
- Muwimbi 3
- Nyamihuu
- Udumka 1
- Ihimbo 2
- Kitelewasi
- Kitumbuka 1
- Lugalo
- Mawambala 2
- Ukumbi 1
- Utengule 2
- Winome
- Iramba 3
- Kitelewasi 3
- Luhunga 1
- Lwing'ulo 2
- Maduma
- Nyanyembe 1
- Nyigo 1
- Mago
- Bulongwa
- Iwawa
- Ugabwa
- Lugarawa 1
- Mdilidili 1
- Masimbwe 1
- Itundu
- Mkongobaki 2
- Lupande 3
- Ikuna 2
- Mbula 1
- Sinyanga
- Mkombwe
- Utyego 2
- Ilongo
- Mahongole
- Nsonyanga
- Ibaba
- Isoko 1
- Kafule
- Kapelekesi
- Lali 1
- Shikunga

- Itaka 2
- Insani 2
- Hang’omba 1
- Mpapa
- Kamsamba 1
- Kiwanja
- Makongolosi 2
- Matundasi
- Mbugani
- Mkola
- Isutu 1
- Itowo 1
- Igosi
- Igelehedza 1
- Ibungila
- Ikama
- Katumba
- Kapugi 1
- Muungano
- Makandana
- Inyala
- Idunda
- Imezu
- Ibungu
- Ikolo
- Kasumulu 1
- Konjula
- Mwalisi
- Itagata 1