THE UNITED REPUBLIC OF TANZANIA

GLOBAL AIDS RESPONSE COUNTRY PROGRESS REPORT

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LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
AIS	AIDS Indicator Survey
ANC	Antenatal Clinic
ARV	Antiretroviral
BCC	Behavioral Change Communication
CD4	Cluster of Differentiation 4
CDC	Centers for Disease Control
CMAC	Council Multi-Secrotal AIDS Committee
CSOs	Civil Society Organizations
DoC	Declaration of Commitment
EID	Early Infant Diagnosis
FP	Family Planning
FSW	Female Sex Worker
eMTCT	Elimination of Mother to Child Transmission of HIV
GBV	Gender Based Violence
GARPR	Global AIDS Response Progress Reporting
HIV	Human Immunodeficiency Virus
HIVDR	Human Immunodeficiency virus Drug resistance
HLM	High Level Meeting
HSV2	Herpes Simplex Virus Type 2
HSHSP	Health Sector HIV and AIDS Strategic Plan
HTC	HIV Counseling and Testing
IPT	Isoniazid Preventive Therapy
MoHSW	Ministry of Health and Social Welfare
MSM	Men who have sex with men
NACP	National AIDS Control Program

NACOPHA	National Council of People Living with HIV/AIDS
NCPA	National Costed Plan of Action
NGO	Non-Governmental Organization
NMSF	National Multi-Sectoral Strategic Framework
OVC	Orphans and Vulnerable Children
PEPFAR	Presidential Funds for HIV/AIDS
PITC	Provider Initiated HIV Counselling and Testing
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission of HIV
PWIDS	People who inject drugs
RAT	Regional AIDS Management Team
RCH	Reproductive and Child Health
RS	Regional Secretariat
STI	Sexually Transmitted Infection
TACAIDS	Tanzania Commission for AIDS
TATF	Tanzania AIDS Trust Funds
TB	Tuberculosis
TDHS	Tanzania Demographic Health Survey
THMIS	Tanzania HIV and Malaria Indicators Survey
UNAIDS	Joint United Nations Programme on HIV/AIDS
VMAC	Village Multi-Sectoral AIDS Committee
WHO	World Health Organization
WMAC	Ward Multi-Sectoral AIDS Committee

1.0 STATUS AT A GLANCE

1.1 Background

The Global AIDS Response Progress Report 2014 provides a prospect to appraise measures taken by Tanzania in reducing the spread of HIV and AIDS and its impact. A Declaration of Commitment (DoC) on HIV and AIDS at the twenty-sixth United Nations General Assembly Special Session on HIV and AIDS of 2001 was adopted by 189 member states including Tanzania[1]. The Political Declaration on HIV and AIDS of June 2006 was adopted by Heads of States and representatives of Governments based on a comprehensive review of the progress achieved in realizing the targets set out in 2001. This declaration also established a number of goals to be achieved through implementation of country-driven specific, quantifiable and time-bound targets towards universal access to comprehensive prevention, treatment, care and support programs. The high level meeting during the 65th Session of the United nations General Assembly resolution held in June 2011 to review progress made in the HIV and AIDS response, Tanzania was represented and adopted the Resolution 65/277.

This historic agreement reinvigorated previous commitments and set concrete targets for 2015 that Tanzania incorporated in her latest strategic plan for HIV and AIDS.

1.2 The inclusiveness of stakeholders in the report writing process

The writing of this report was coordinated by the Tanzania Commission for AIDS (TACAIDS) with support from the UNAIDS country office, World Health Organization (WHO) and the Ministry of Health and Social Welfare (MoHSW). The country setup Global AIDS Response Progress Report Technical Working Group (TWG), composed of the Tanzania National

[1] Declaration of Commitment on HIV AND AIDS: United Nations General Assembly Session on HIV AND AIDS 25-27 June 2001

Monitoring and Evaluation Advisory Group, a multisectoral group of monitoring and evaluation experts, which includes government, private sector and civil society representatives. TWG created an enabling environment for the data gathering process. An inception report was drafted and discussed by the TWG and comments on various data sources, their validation process were included. Meetings were held with the civil society and public sector ministries, local and international organizations. A desk review of available literature on the country's response efforts to HIV and AIDS was also conducted.

1.3 Status of the Epidemic

During the period 2003/4[2] to 2011/12[3], the HIV prevalence in Tanzania has declined from 7.0% to 5.3% among adults aged 15-49. Statistically significant decline was observed among men in the same age group from 6.3% to 3.9% but not among women. Data from four rounds of antenatal surveillance, two national population surveys and projections indicate that HIV incidence in the age group 15-49 peaked at 1.48% in 1991, declined to 0.6% in 2004 and stabilized at 0.59% up to 2011. This decline in HIV incidence partly explains the observed decline in HIV prevalence.

Despite the decline, the HIV epidemic in Tanzania remain heterogeneous with geographical and population variability. The HIV prevalence ranges from 1.5% in Manyara to a high of 14.8% in Njombe. While HIV prevalence is generally at decrease, 8 regions namely Ruvuma, Kagera, Kigoma, Rukwa, Mtwara, Kilimanjaro, Singida and Arusha have recorded an increase. It is not

[2] Tanzania Commission for AIDS (TACAIDS), Zanzibar AIDS Commission (ZAC), national Bureau of Statistics (NBS), Office of the Chief Government Statistician (OCGS), ICF International (2004). *Tanzania HIV/AIDS and Malaria Indicator Survey 2003-2004. Dar es salaam, Tanzania:* TACAIDS, ZAC, NBS, OCGS, ICF International

[3] Tanzania Commission for AIDS (TACAIDS), Zanzibar AIDS Commission (ZAC), national Bureau of Statistics (NBS), Office of the Chief Government Statistician (OCGS), ICF International (2013). *Tanzania HIV/AIDS and Malaria Indicator Survey 2011-2012. Dar es salaam, Tanzania:* TACAIDS, ZAC, NBS, OCGS, ICF International

clear so far as to what is the cause of the increase but could be due to increased HIV incidence or impact of scaling up care and treatment in these regions.

HIV prevalence's among key populations have been reported to be high. Available data from recent studies gives the prevalence of HIV among people who inject drugs (PWIDS) to be 16%, Men who have sex with men (MSM) to be 22.2% and Female Sex Workers (31.4%)[4]. Although these may not be national representative estimates, they show a decline in HIV infection among key population when compared to earlier estimates among MSM (42%) and PWIDS (51%).

Declining HIV infection rates in the general population and possibly among key population could be an indication of the impact of extensive preventive intervention measures in the country. The government of Tanzania collaborates with partners in the development and scaling up of evidence-based intervention measures aiming at reducing the rate of HIV infection.

1.4 Policy and programmatic response

Since the first case of HIV/AIDS was reported in the country in 1981, the Government of Tanzania has continued to demonstrate great commitment and leadership to the fight against the HIV and AIDS scourge. The Government through the Tanzania Commission for AIDS and National AIDS Control Programme (NACP) has formulated policies that affect every area of the nation's multi-sectoral response to HIV and AIDS. TACAIDS has made great strides and progress to put structures at the national, regional and district levels for the creation of a conducive operational environment for the HIV and AIDS multi-sectoral response. Coordination of the fight against the HIV epidemic at the regional level is done through the Regional

[4] Mmbaga EJ, Moen K, Mpembeni R, Kirei N, Mbwmbo J, Leshabari M. HIV prevalence and risk profile of men who have sex with men and people who inject drugs in Dar es Salaam, Tanzania (2014)

Secretariat (RS) / Regional AIDS Management Team (RAT). The team is responsible for providing technical support and guidance on the coordination of HIV and AIDS interventions in the Local Government Authorities (LGAs). The RS has been supporting the LGAs by carrying out supportive supervisory visits and provision of technical supports that have resulted into improved reporting.

In additional, the coordination of HIV and AIDS interventions at the LGA level is done through Council Multisectoral AIDS Committee (CMAC); similarly, Ward Multisectoral AIDS Committee (WMAC) and Village Multisectoral AIDS Committee (VMAC) do play major roles of coordination at respective levels. Such coordinating structures, to a large extent, have facilitated the provision of services to the beneficiaries at the community level.

The country has developed a number of policies and strategies to address the epidemic which includes Global Health Initiative Strategy 2010-2015, national HIV/AIDS communication Advocacy strategy (NHACAS), HIV and AIDS care and Treatment plan, health sector HIV strategic plan and the PMTCT Strategic Plan and these were aligned to the overall health sector strategic plan. The country also has recently developed the third National Multisectoral strategic Framework (NMSF III) covering the period 2013/2014-2017/2018. The fight against HIV in the country has focused on the following thematic areas;

1. Prevention of new adults and children HIV infection
2. HIV care treatment and support
3. HIV/AIDS impact mitigation interventions
4. Strengthening local and international partnership in HIV/AIDS response
5. Monitoring and evaluation of HIV/AIDS response

In response to the HIV epidemic, Tanzania has adopted a National multi-sectoral approach for strengthening the partnership and collaboration with the existing key International and National HIV and AIDS stakeholders. For attainment of the national response strategic objectives, the partnership and collaboration continue to be strengthened, aligned and harmonized.

1.5 Indicator data in an overview table

Table 1: Overview of indicators for the period 2012- 2013

Target 1 : Reduce sexual transmission of HIV by 50% by 2015		
Indicators for general population	**2012**	**2013**
1.1 Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	40.2	43.4
1.2 Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	10.2	9.6
1.3 Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	12.8	12.5
1.4 Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse	34.6	27
1.5 Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	35.4	28.4

1.6 Percentage of young people aged 15-24 living with HIV	2.4	2
Sex workers		
1.7 Percentage of sex workers reached with HIV prevention programmes	Data not available	30.7
1.8 Percentage of sex workers reporting the use of a condom with their most recent client	Data not available	78
1.9 Percentage of sex workers who have received an HIV test in the past	Data not available	73
1.10 Percentage of sex workers who are living with HIV	Data not available	31.4
Men who have sex with men		
1.11Percentage of men who have sex with men reached with HIV prevention programmes	Data not available	25
1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Data not available	45.5
1.13 Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	Data not available	62.7
1.14 Percentage of men who have sex with men who are living with HIV	Data not available	22.2
Target 2: Reduce transmission of HIV among people who inject drugs by 50% by 2015		
2.1 Number of syringes distributed per person who injects drugs per year by needle and syringe	Data not available	155

programmes		
2.2 Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	Data not available	29.3
2.3 Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	Data not available	84.2
2.4 Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	Data not available	66.5
2.5 Percentage of people who inject drugs who are living with HIV	Data not available	15.5
Target 3: Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths		
3.1 Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother to-child transmission for themselves or their infants during breastfeeding	71.1	77
3.1a Percentage of women living with HIV receiving antiretroviral medicines for themselves or their infants during breastfeeding		77
3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	29.1	26.0
3.3 Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months		
Target 4: Reach 15 million people living with HIV with lifesaving antiretroviral treatment by		

2015		
4.1 Percentage of adults and children currently receiving antiretroviral therapy	Data not available	37.5
4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	70.1	74
Target 5: Reduce tuberculosis deaths in people living with HIV by 50% by 2015		
5.1 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	25.9	54
Target 6: Close the global AIDS resource gap by 2015 and reach annual global investment of US$ 22–24 billion in low- and middle-income countries		
6.1 Domestic and international AIDS spending by categories and financing sources	Data not available	Data not available
Target 7: Eliminating gender inequalities		
7.1 Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	Data not available	27
Target 8: Eliminating stigma and discrimination		
8.1 Discriminatory attitudes towards people living with HIV	Data not available	33
Target 10 Strengthening HIV integration		

10.1 Current school attendance among orphans and non-orphans aged 10–14	Data not available	86%
10.2 Proportion of the poorest households who received external economic support in the last 3 months	Data not available	Data not available

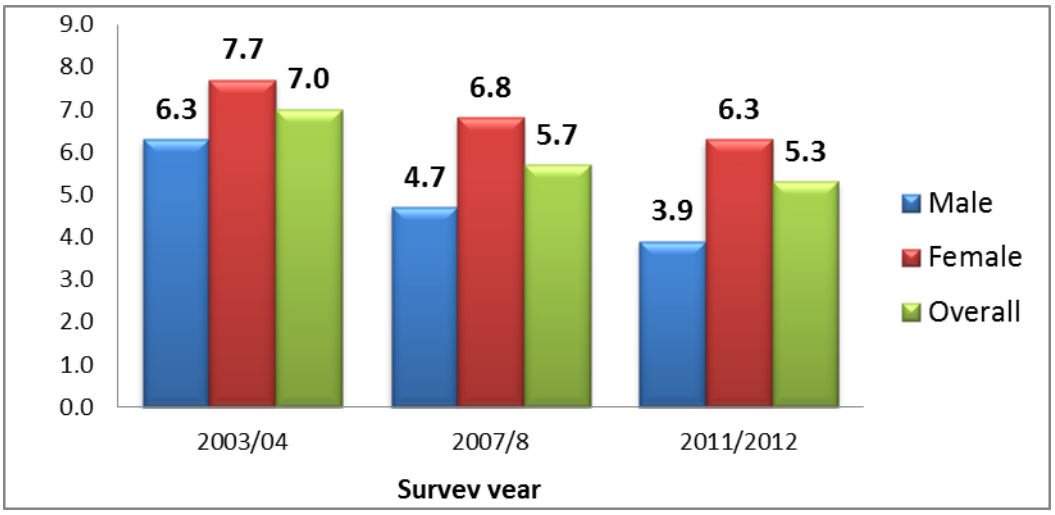
2.0 OVERVIEW OF THE AIDS EPIDEMIC

Tanzania mainland experiences a mature generalized HIV epidemic while in Zanzibar the epidemic remains largely concentrated. Data inducted that as of December 2013, 1,411,829 people were living with HIV and AIDS and a total of 79,338 were infected in the year 2013 in Tanzania. In 2013, 78,843 people died due to AIDS in the country[5]. The HIV epidemic is predominantly heterosexually transmitted with 80% of infections attributable to heterosexual transmission. Mother to child transmission (MTCT) accounts for 18% while blood borne accounts for 1.8% of the infections. During the last decade (2003-2013), HIV prevalence has decreased significantly from an overall prevalence of 7.0% in 2003/04 to 5.1% in 2011/12[6]. However, the last two recent surveys indicate a stabilization of the HIV prevalence with a marked differential spread between and within regions (Figure 2.1).

[5] Spectrum estimates (2013)

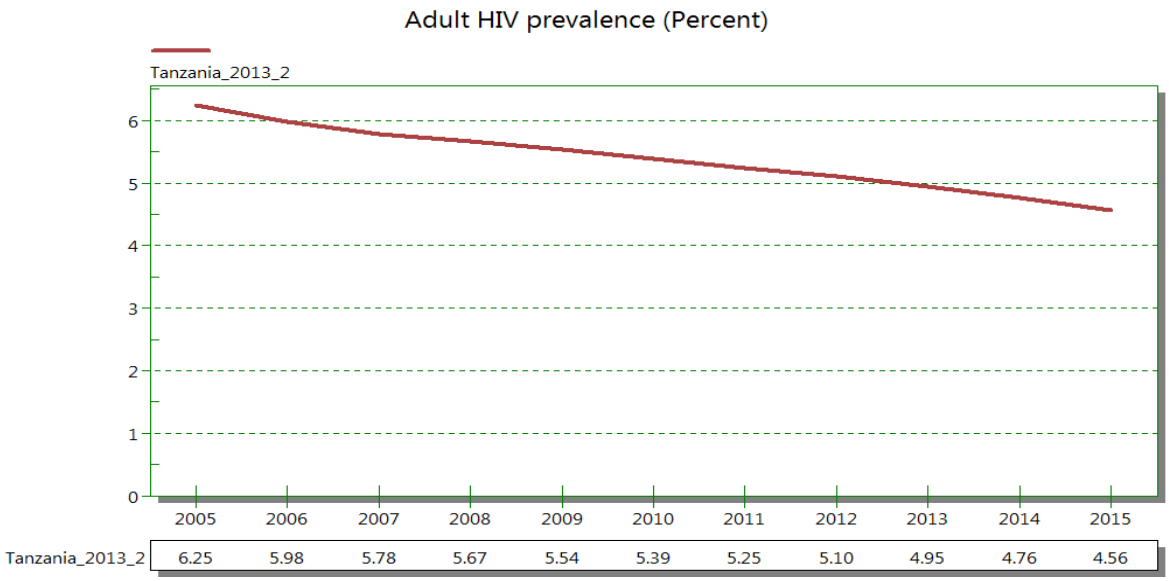
[6] Tanzania Commission for AIDS (TACAIDS), Zanzibar AIDS Commission (ZAC), national Bureau of Statistics (NBS), Office of the Chief Government Statistician (OCGS), ICF International (2013). *Tanzania HIV/AIDS and Malaria Indicator Survey 2011-2012. Dar es salaam, Tanzania:* TACAIDS, ZAC, NBS, OCGS, ICF International

Figure 2.1: HIV prevalence among adults aged 15-49 years in Tanzania over the past decade



In contrary, modeling of the HIV epidemic indicates that the epidemic will be taking a downward trend as we approach 2015 bringing down the prevalence to 4.56%(Figure 2.2)[1].

Figure 2.2: Spectrum estimates of HIV prevalence in Tanzania



From 2011 to 2012, HIV incidence decreased by 5.8% (from 0.34% to 0.32%). Estimates also indicate that the number of new infections will likely remain at the same level for both men and women from 2012 to 2015.

Women bear the brunt of the epidemic and the Tanzania HIV and Malaria Indicator survey of 2012 (THMIS) shows that women aged 23-24 were almost three times (6.6%) more likely to be HIV seropositive as compared to their counterpart men. The prevalence increased by age from 1% among those aged 15-19 to 10% among women aged 45-49, and 7% among men aged 30-49 (Figure 2.3). HIV prevalence among key populations such as, men who have sex with men (MSM) (12.3% to 41.0%), people who inject drugs (PWIDS) (34.8% to 42.0%), and female sex workers (FSW) (31.4%) is very high with a large proportion of MSM (32%-63.1%) also engaging in heterosexual relationships[7],[8],[9]. However, two recent studies in Dar es Salaam indicate a possible decline in HIV prevention among key population. A study involving 753 MSM gave an HIV estimate of 22.2% (a decline from a maximum of 41% reported previously) while another study if 620 PWIDS gave an estimate of 15.5% (a decline from previous estimate of 50%).

[7] Williams ML, McCurdy SA, Bowen AM, Kilonzo GP, Atkinson JS, Ross MW, Leshabari MT (2009). HIV Prevalence in a sample of Tanzanian Intravenous drug users. AIDS Education prevention, 21: 474-483

[8] Dahoma M, Johnson L, Holman A, Millar LA, Mussa M, Othman A, Khatib A, Issa R, Kendall C, Kim AA (2011). HIV and related risk behavior among men who have sex with men in Zanzibar, Tanzania: results of a behavioural surveillance survey. AIDS and Behaviour, 15:186-92.

[9] Mmbaga E.J, Dodo M, Leyna G.H, Moen K, Leshabari M.T (2012). Sexual Practices and Perceived Susceptibility to HIV Infection among Men Who have Sex with Men in Dar Es Salaam, Mainland Tanzania. Journal of AIDS Clinical Research, S1:012.

Figure 2.3: HIV prevalence by age groups and sex among adults aged 15-49 in Tanzania

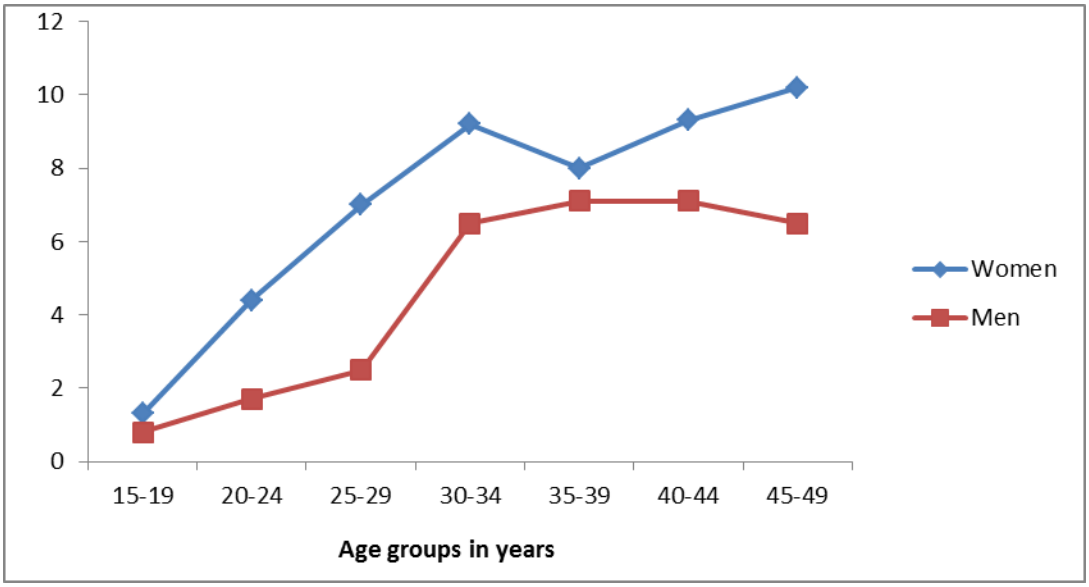
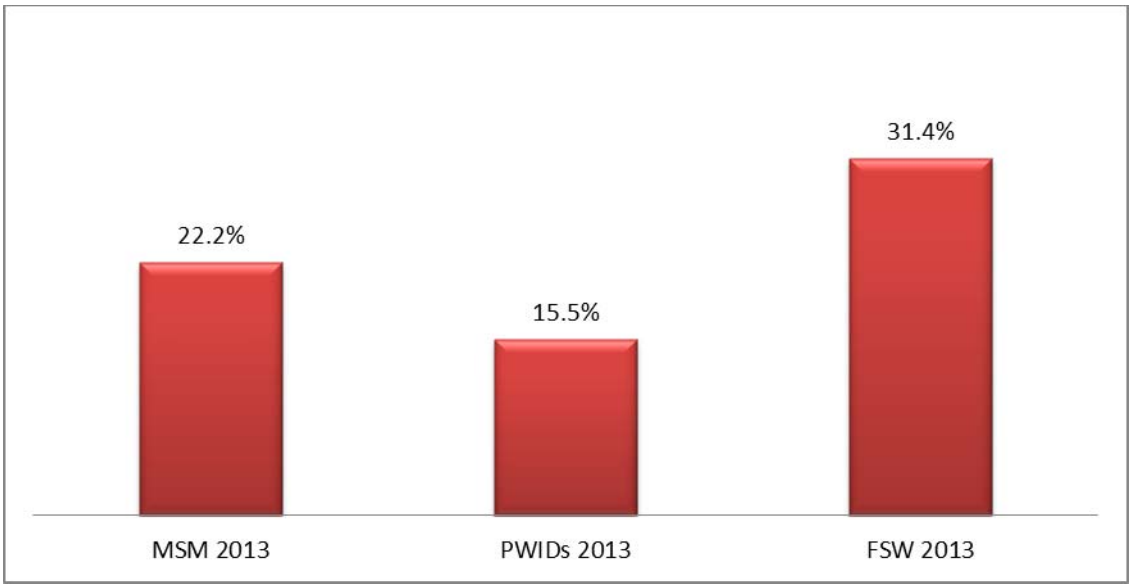


Figure 2.4: Current Prevalence of HIV infection among Key population in Dar es Salaam



Studies indicate that the modifiable risk factors attributable for the transmission of HIV infection in the country comprise of education level, multiple concurrent unprotected sexual partnerships, early sexual debut, transactional and cross-generational sex, low and inconsistent use of

condoms, low male circumcision, low levels of testing and disclosure of HIV sero-status, mother-to-child HIV transmission, risks associated with substance abuse, sexual violence and negative socio-cultural norms , inequality in wealth, and infection with sexually transmitted infections (STI) mainly Herpes Simplex virus type 2. The non-modifiable drivers of the epidemic are divorced, widowed or separated marital statuses, older age groups, urban residence and being a female[10, 3].

The TDHS 2010 and THMIS 2012 indicate that the proportion of female and male population groups with comprehensive knowledge about HIV transmission and prevention has not changed (female from 48.6% to 42%; male from 46.5% to 50%). The two reports also reveal that the proportion of female and male population groups who reported to have ever tested for HIV and received the results of their HIV test increased from 55% to 62% among female and 40% to 47% among male, respectively indicating that more than half of the male and about 40% of the female population do not know their HIV status[11, 2]. New data has indicated that about 5% couples are sero-discordant with HIV-negative partners – hence a focus on identification of such sero-discordancy through scaling up HIV counseling and testing (HTC), promotion of condom use and initiating early ART in the HIV + partner reducing up to 96% the transmission to the uninfected partner (treatment for prevention) within cohabitating sero-discordant couples are needed[12].

[10] Mmbaga EJ (2013). HIV Prevalence and Associated Risk factors: Analysis of Change over time in mainland Tanzania. DHS working paper No. 85
[11] National Bureau of Statistics (NBS) and ICF Macro (2011). Tanzania Demographic and Health Survey 2010. Dar es Salaam, Tanzania: NBS and ICF Macro.

[12] Bellan SE, Fiorella KJ, Melesse DY, Getz WM, Williams BG, Dushoff J. Extra-couple HIV transmission in sub-Saharan Africa: a mathematical modeling study of survey data. Lancet. 2013 Feb 4. pii: S0140-6736(12)61960-6. doi: 10.1016/S0140-6736(12)61960-6. [Epub ahead of print]

Data indicate that during the past 5 years, condom use has increased at last higher risk sex among the 15-49 age group (women 48.6% to 57.6% ; men 48.7% to 58.7%), however condom use among young men who pay for sex has declined, and the national male circumcision is at 72%[2, 13].

HIV testing facilities have increased to 2137 with the integration of prevention of mother to child transmission (PMTCT) services into Reproductive and Child Health (RCH) facilities has reached 96% of facilities. But currently, 77% of HIV positive pregnant women are receiving Antiretroviral Therapy (ART) and the national goal is to reach 90% by 2017. Besides this, more than 18% of children are born HIV infected due to inefficient regimens (single dose nevirapine in some facilities), drug stock outs or poor adherence to treatment, or simply lack of access to PMTCT services during pregnancy. The same report revealed that 30% of health facilities in the country provide Early Infant Diagnosis (EID), and that 26% of HIV exposed infants accessed EID. The national target is to provide prophylaxis to 70% of HIV exposed infants by 2017, and currently of those accessing EID, 57% receive such a MTCT prophylaxis. A 2013 UNAIDS report points to a higher percentage of women receiving ARV for their own health: 53%. The same report shows a substantial excess of pregnancy-related mortality, 18% of all women death and most are associated with HIV, which highlights the importance of integrating HIV and reproductive health services in areas of high HIV prevalence to impact pregnancy-related mortality[14].

[13] Tanzania Commission for AIDS (TACAIDS), Zanzibar AIDS Commission (ZAC), national Bureau of Statistics (NBS), Office of the Chief Government Statistician (OCGS), ICF International (2008). *Tanzania HIV/AIDS and Malaria Indicator Survey 2007/8. Dar es salaam, Tanzania:* TACAIDS, ZAC, NBS, OCGS, ICF International

[14] Calvert C, Ronsmans PC. The contribution of HIV to pregnancy-related mortality: a systematic review and meta-analysis. AIDS. 2013 Feb 25. [Epub ahead of print]

A recent stigma index survey indicates a high level of stigma in various sectors and even more in health facilities, hindering access to prevention and treatment for People Living with HIV (PLHIV) and Key populations[15].

3.0 NATIONAL RESPONSE TO THE HIV EPIDEMIC

3.1 Policy Response

Since the beginning of the HIV epidemic in Tanzania, various national and sectoral policies have been developed in response to HIV and AIDS within specific sectors. These have also been complemented by strategies and work plans which emphasize the importance of prevention in the response to HIV epidemic.

Recently, the Third National HIV and AIDS Strategic Framework (2013/14 – 2017/18) was developed in order to guide the national HIV and AIDS response. The NMSF III was developed after a comprehensive review of National HIV and AIDS Policy of 2012, stakeholder's consultation and evaluation of the achievement made since the previous framework. The rationale of the NMSF III was to provide an agenda for all HIV and AIDS interventions in Tanzania.

Tanzania is further committed to fulfil international and regional obligations including the Millennium Development Goals, the 2001 United Nations Declaration of Commitment commonly known as the UNGASS Declaration, Maseru Declaration, Maputo Plan of Action, 2006 Political Declaration on HIV AIDS, 2011 Political Declaration on HIV and AIDS and the Global Plan towards elimination of new HIV Infections in children and keeping mothers alive.

[15] NACOPHA (2013). HIV/AIDS Stigma Index Survey. Dar Es Salaam, United Republic of Tanzania

The government and political commitment to support all national and international initiative to fight the epidemic has been high and has created conducive environment for implementation of various interventions.

3.2 HIV programming

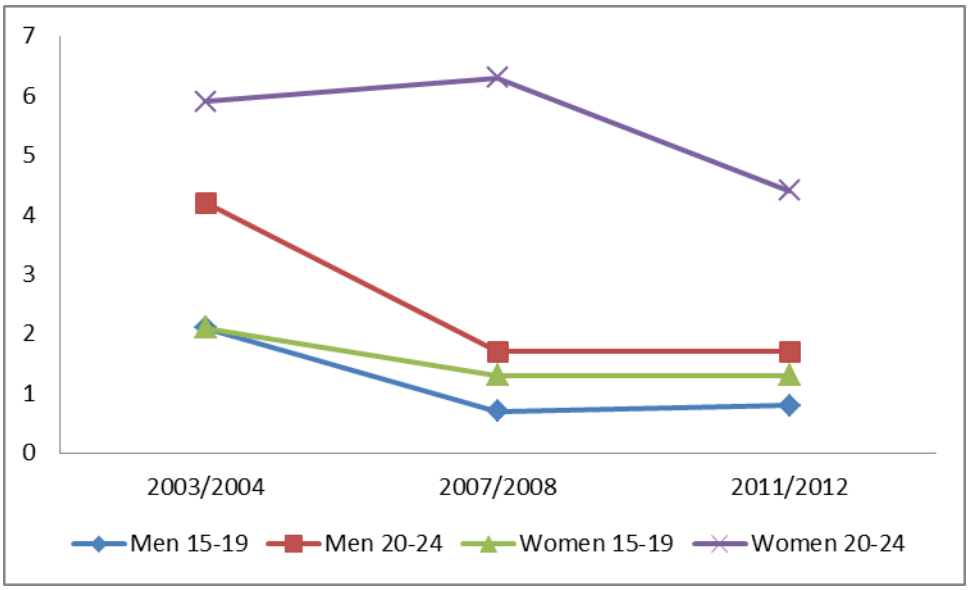
3.2.1 HIV Prevention

Tanzania has adopted an integrated strategy for the implementation of the prioritized HIV prevention Interventions. Prevention of new HIV infections remains the national priority in the fight against HIV and AIDS. Among the aims of NMSF III 2013/14-2017/18 are reductions or prevention of new infections if exposure has occurred, reduction of the probability of infection if transmission has occurred and finally influence behavior change where social or cultural norms, values and practices remain barriers to adopting effective prevention behaviors.

3.2.1.1 HIV prevention among young people

HIV infection among young people aged 14-25 is an important proxy indicator for determining trend in HIV incidence and prevalence. The overall change in HIV prevalence among young people aged 15-24 from 2007/08 (2.4%) to 2011/12 (2.0%) is equivalent to 17% decrease during the past 5 years. In comparison to three HIV indicator survey there is decline of HIV prevalence among youths aged 15 -19 for both girls and boys. In the first survey there was an increase of HIV prevalence among girls aged 20 – 24 years while the third survey show a decline in prevalence. Comparison of THMIS results of (2003/2004 and 2007/2008) indicates that there has been a sharp decline (4.2% - 1.7%) in HIV prevalence among boys aged 20 – 24 and it remained constants towards third survey 2011/2012.

Figure 3.1: HIV prevalence among young people aged 15-24 from 2004/5 to 2011/2012

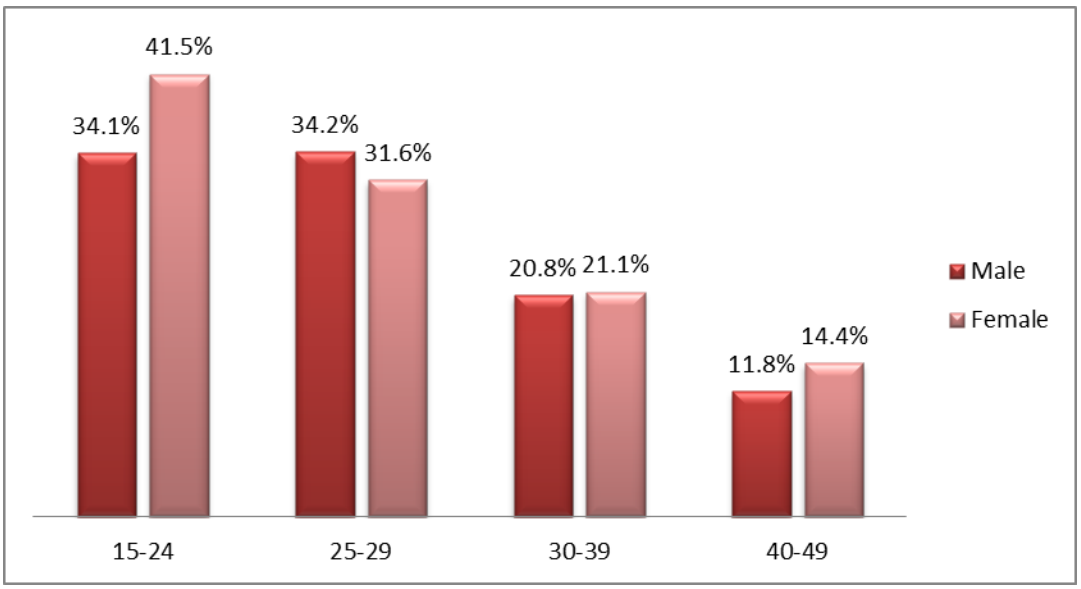


According to THMIS 2011/2012, 9.4% of women and 9.9% of men aged 15-24 reported to have started sexual intercourse before the age of 15. Reporting of sexual experience before the age of 15 remained unchanged between 2003/2004 and 2007/2008 for both sexes but recorded a decline among female (11% to 9%) and remained stable among males (10%) throughout 2012. This stabilization or decline could be attributed to various ongoing interventions focusing youths. Practice of multiple sexual partnership was reported by 45% of women and 14% of men aged 15-24 years in 2012. Condom use during last sex increased from 46.3% and 49% in 2008 to 58% and 59% in 2012 among women and men, respectively. This is an indication of positive results of intensified condom programming among young people in Tanzania [2, 3].

Practice of risk sexual behaviors shows gender and regional variations. Overall, men were more likely to report having sex with more than one sexual partner as compared to women. During the past two surveys, increase in the proportion of men and women reporting having more than one

sexual partners was noted. The proportion increased from 2.6% and 17.9% in 2007/8 to 3.8% and 20.8% in 2011/12 among women and men respectively. In 2011/12, men from Ruvuma (34%) and Iringa (31.4%) were more likely to have more than one sexual partner compared to men in Kilimanjaro (2.6%), while women from Mtwara (9.6%), Mara (8.7%) and Lindi 8.3%) had the largest proportion of reported practice of multiple sexual partnership. Despite the variation, among the achievements documented in the recent THMIS 2012 survey was the increase in the reported condom use at last higher risk sex among the 15-49 age group and among youth (women 48.6% in 2007-08 to 57.6% in 2011-12; men 48.7% in 2007-08 to 58.7% in 2011-12) [2, 3].

Figure 3.2: Condom use during among people aged 15-49 reporting more than sexual partner during the past 12 months



Health education interventions and HTC campaigns have been ongoing. However, recent reports still indicate that the proportion of women and men with comprehensive knowledge about HIV has not changed (female from 48.6% to 42%, male from 46.5% to 50%). The two reports also

revealed that the proportion of women and men who reported to have ever tested for HIV and received the results of their HIV test increased from 55% to 62% among women and 40% to 47% among men, respectively, resulting in more than half of the male population and about 40% of women not knowing their HIV status. Less coverage and the comprehensive nature of available interventions on health education, HTC and condom promotion could be responsible for the observed gaps.

Efforts to roll out voluntary medical male circumcision are ongoing and reports indicate that, the overall proportion of men reporting circumcision is at 72%, gradually increasing to meet the national target of 80% in 8 high burden regions or 2.8 million new circumcisions by 2015 [3, 16].

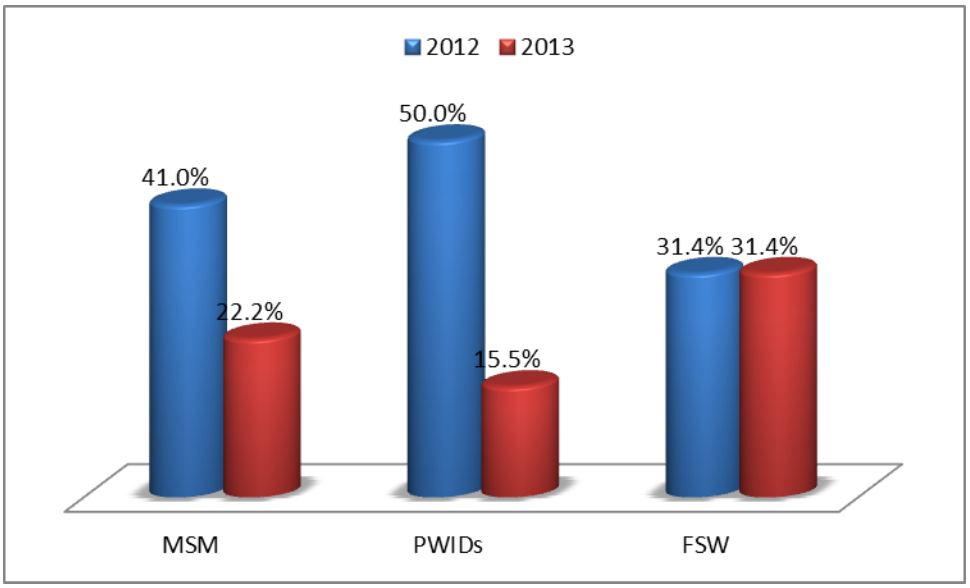
3.2.1.2 Prevention among Key population

Based on few available studies from mainland Tanzania and Zanzibar, the HIV prevalence among PWIDS decreased from 50% to 15.5% by 2013. This decline was also noted among men who have sex with men with a decrease from 41% to 22.2% (Figure 3.3)[4]. A number of high risk transmission behaviours such as sharing of needles and syringes through "blood flush" as well as engaging in multiple unprotected sexual partnerships and MSM unsafe behaviours have been reported. Small scale harm reduction interventions such as syringe distribution (2000 PWIDS) and bleach kits for decontamination (6000 kits) are implemented in Temeke Municipality of Dar es Salaam. Methadone Substitution therapy with a daily recommended maintenance dose (60 mg methadone) has been implemented at the Muhimbili National Hospital in Dar es Salaam at a small scale (900 PWIDS) with plans to expand to other hospitals, such as in Kinondoni Municipality. Additionally, in Zanzibar interventions such as sober houses, peer support, overdose management, and behavioral interventions for PWIDS are implemented. Guidelines for

[16] National AIDS Control Programme (2012). Male circumcision status in Tanzania. NACP

expanding access to prevention and treatment have been developed. Bio-behavioral and size estimation surveys for all key populations are ongoing and other studies are planned, which will provide crucial data for programming.

Figure 3.3: Change in the prevalence of HIV infection among key population in Dar es salaam 2012-2013



3.2.1.3 Mother to child transmission

The country has adopted a virtual elimination of MTCT strategy with four prongs which are to reduce HIV incidence among women, increase access to Family Planning (FP) among women, reduce vertical transmission to <5%, and maternal and child mortality by 90% by 2015. To improve efficiency in health services delivery, integration of PMTCT services in the routine RCH services has been implemented with a remarkable 93% integration. A significant proportion (85%) of pregnant women is tested for HIV during ANC visits. Decrease in MTCT from 26,000 children in 2009 to 15,000 in 2012, a 48% reduction. Data for 2013 indicate that a total of 23,312 infants tested positive for HIV infection. These unstable estimates could be

attributable to previous ineffective regimen. Plans are underway to roll out effective option B+ regimens to replace the current ineffective regimens. To guide and facilitate eMTCT, the country has prepared an elimination strategy for PMTCT to reach access to ARVs treatment for 90% of eligible women by 2017.

3.2.2 HIV care treatment and support

The main focus of care, treatment and support thematic area has been to strengthen and scale up comprehensive care and treatment services in public and private facilities through facility based, community based and TB/HIV collaborative activities with a focus on quality improvement.

The Ministry of Health and Social Welfare in collaboration with partners finalized the National Comprehensive HIV Testing and Counselling (HTC) Guideline which combines all approaches of HTC into one document. In order to facilitate smooth entry to care and treatment services, new HIV testing approaches such as Provider-Initiated Testing and Counseling (PITC) and home-based counseling and testing have been introduced. This is expected to increase the number of access to the care and treatment services through increased service outlets. The number of people receiving ARV has been increasing steadily since 2010 and by December 2013, a total of 1,366,402 were enrolled in care and treatment centers, 512,555 PLHIV were receiving ARV of whom 8% were children[17]. Simplification of regimens and phasing out plans of multiple treatment regimens from 8 to 3, and a move to fixed-dose combination (FDC) has started. New guidelines are being issued that increase the eligibility to sero-discordant couples, all pregnant women who tested HIV+, and key populations. With high-quality, life-saving and life-enhancing medicines, commodities and services in place, accessibility becomes the next

[17] NACP (2014) Care and treatment report for 2013

priority. To ensure optimal supply, USAID assisted in the assessment of the supply chain to identify bottlenecks and inform improvement plans. In addition, the national Care and treatment subcommittee has set up a task force well in advance of the release of the 2013 consolidated WHO guidelines to explore and guide the possibility and effective ways of adaptation of anticipated changes (e.g. CD4 threshold of 500 etc.) The current Health Sector HIV and AIDS strategic plan III (2013-17) is focusing to improve the access and enrollment of HIV infected children in care from the current 25% to 70% by 2017. The Ministry plans to revise the national HIV Drug Resistance strategy this year, which helps monitor and address factors associated with drug resistance, among them, adherence measures at CTC sites.

Table 2: HIV care and treatment status by region, sex and age

	Cumulative number enrolled in HIV care				Cumulative number on ART				Current number on ART			
Region	**Children**		**Adult**		**Children**		**Adult**		**Children**		**Adult**	
	Female	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**
DSM	7,398	6,880	140,064	57,338	7,064	4,919	91,794	41,598	2,556	2,425	53,625	20,993
Shinyanga	2,969	3,037	52,780	32,139	1,851	1,917	29,071	18,675	1,196	1,275	22,011	12,524
Iringa	5,819	5,693	72,957	45,214	3,465	3,526	47,366	29,651	1,983	1,933	31,592	17,811
Arusha	2,016	1,888	29,733	11,914	1,365	1,407	17,859	8,598	604	569	8,853	3,514
Mbeya	7,861	7,780	109,824	70,187	4,816	4,365	66,935	43,365	6,863	2,901	48,486	26,539
Kagera	1,721	1,640	31,990	17,962	1,144	1,179	17,513	10,273	679	684	12,682	6,466
Kigoma	581	523	8,105	3,761	351	312	4,399	2,185	188	163	2,778	1,290
Kilimanjaro	2,682	2,444	25,695	11,478	1,710	1,605	16,412	8,083	718	654	8,559	3,652
Lindi	882	829	16,562	6,895	524	524	8,496	3,713	309	296	5,530	2,100
Manyara	528	533	8,127	4,936	267	370	5,305	2,277	193	188	2,791	1,085
Mara	1,410	1,187	29,092	14,283	897	780	21,305	9,264	550	430	11,707	4,897
Mwanza	4,438	3,666	73,221	42,399	2,206	2,142	42,204	24,221	1,051	872	27,438	13,680
Mtwara	1,240	1,137	24,670	10,505	751	731	14,012	6,365	361	329	8,399	3,323
Morogoro	1,828	1,743	31,210	14,702	1,192	1,139	20,195	9,911	450	443	9,810	4,265
Pwani	1,763	1,427	27,123	11,847	1,010	888	14,640	6,905	561	501	9,027	3,596
Rukwa	1,145	933	18,828	11,599	570	495	11,644	7,335	399	328	7,526	4,150
Singida	762	714	10,636	4,919	462	440	6,953	3,531	245	229	4,250	1,890
Tanga	2,292	2,041	31,187	12,800	1,572	1,444	20,576	8,808	917	850	13,317	4,925
Tabora	2,778	2,732	45,502	25,387	1,631	1,620	24,068	14,178	873	878	14,829	7,967
Dodoma	1,550	1,499	20,320	8,316	913	911	14,613	6,615	500	510	7,482	3,005
Ruvuma	1,498	1,457	24,037	13,213	1,020	949	14,536	8,383	630	564	10,138	5,205
Total	**53,161**	**49,783**	**831,663**	**431,794**	**34,781**	**31,663**	**509,896**	**273,934**	**21,826**	**17,022**	**320,830**	**152,877**

	Cumulative number enrolled in HIV care				Cumulative number on ART				Current number on ART			
Region	**Children**		**Adult**		**Children**		**Adult**		**Children**		**Adult**	
	Female	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**

Source: NACP program data 2013

3.2.3 HIV and TB co infection

The country target to reduce TB deaths is 50% by 2015. A number of guidelines and protocols developed by WHO or CDC are in operation in the country. This includes TB/HIV integration, case-finding and Isoniazid Preventive Therapy for PLHIV in resource poor country, procurement of treatment of tuberculosis for national programmes, and guidelines for the prevention and treatment of opportunistic infections. Initiation of TB/HIV integration of services has been successful covering 90% of health facilities offering HIV services in Tanzania.

Data from the National TB and Leprosy program indicate that of the 63,892 TB cases notified, 52,499 (82%) were counselled and tested for HIV. Among those tested, 20,269 (39%) were found to be co-infected with HIV. Further analysis suggests that of the co-infected cases, 17,224 (85%) were registered at HIV care and Treatment clinics for care and treatment services, while 19,501 (96%) were put on Co-trimoxazole Preventive Therapy (CPT) and 10,993 (54%) were initiated on ART in both TB clinic and CTCs. Major improvement realized is the increase of patients initiated on ART from 38% to 54%.

3.2.4 HIV and AIDS Impact mitigation interventions

HIV and AIDS mitigation has been a priority and aimed at reaching those infected and affected by HIV/AIDS and who are in need for support to enable them live normal and productive lives. There have been concerted efforts by households, communities, the Government of Tanzania and partners are implementing a number of interventions to mitigate the impact of the epidemic and to improve the quality of lives of PLHIV and other vulnerable groups.

The National Costed Plan of Action (NCPA) for Orphans and Vulnerable Children (OVC) notes that 5% (more than two million) of children in Tanzania are OVC. This population is considered to be vulnerable with poor or minimal access to care, protection, education, health care, nutrition

and shelter. The increasing numbers of most vulnerable children in the country is due to a number of factors such as poverty and HIV/AIDS. The number of children requiring support is increasing rapidly, though, and in many instances the increase in response is not keeping up with the increase in need. Responses from various implementers are still needed for that matter, and this caters for increases in both financial resources and commitment over the next few years.

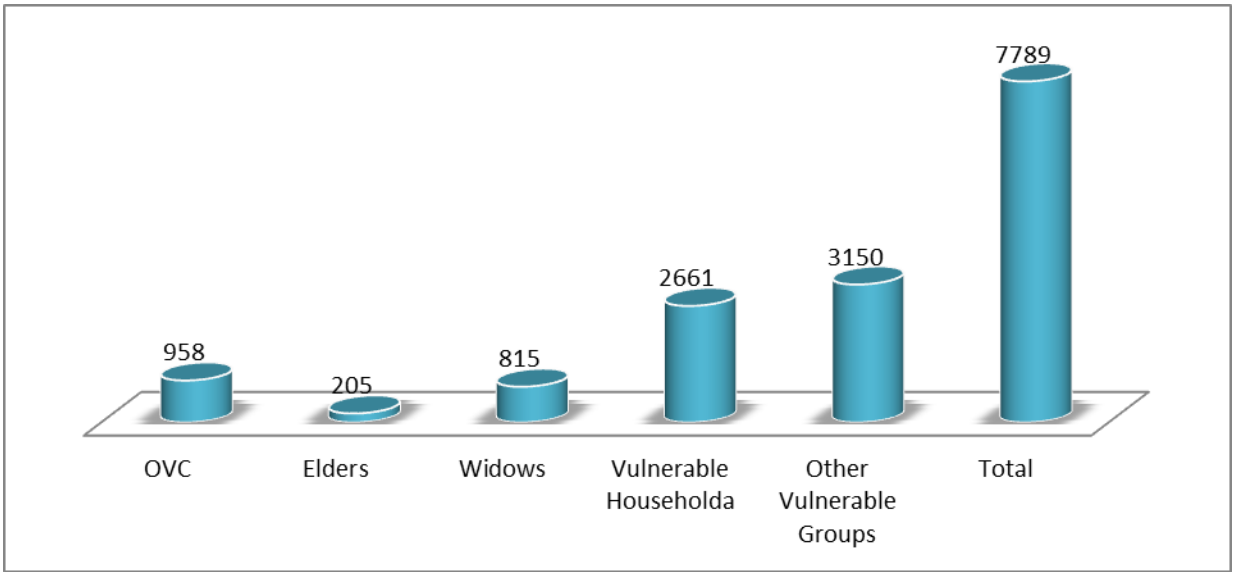
According to the data obtained through TOMSHA report (2013)[18], only 26,670 OVC were supported with health care, food, educational supplies, nutritional and psychological services. Moreover ,a number of impact mitigation interventions were implemented mainly covering Orphans and Vulnerable Children (OVC) support, stigma and discrimination, income generating activities, home based care and capacity building.

Ministry of Education and Vocational Training statistics shows that in 2013 a total of 956,044 OVC students were enrolled in both primary and secondary schools, among which 49.9% (477,458) were males and 50.1% (478,586) were females. Data from the 2011/2012 THMIS indicate that 84% of OVC are enrolled in both primary and secondary education in the country and this did not differ by sex (83.4% for males and 84.4% for females).

TOMSHA report showed that a total of 7,789 individuals from groups of OVC, elderly, widows/widowers, vulnerable households and other groups had benefited from support provided with various income generating programs implemented in 2013.

[18] TOMSHA (2013) report

Fig 3.4 Number of beneficiaries who received income generating support in 2013



The report also indicated that a total of 2,149 PLHIV groups were established. The National Council for People Living with HIV and AIDS (NACOPHA) in collaboration with other HIV and AIDS stakeholders managed to establish 56 PLHIV functional clusters in 2013. In response to the scope of PLHIV support services the report eludes that 10,575 PLHIV support groups received two or more support services. These support services were aimed at meeting holistic PLHIV's needs in areas of health care and supplies, emotional and psychological support, nutritional support, financial support, income generating activities and school fees related assistance.

Income generation support was also implemented to PLHIV where 4,848 people living with HIV and AIDS were provided with skills training on income generation, advocacy, National code for HIV/AIDS and employment, positive living and management and coordination of support groups.

4.0 BEST PRACTICES

4.1 Leadership and Political commitment

The government of Tanzania has been at the forefront in the fight against the HIV epidemic with the epidemic marked as a national disaster. Further strengthening of political commitment to respond to the HIV and AIDS epidemic has been observed during the reporting period. Most addresses by the President of the United Republic of Tanzania have had HIV and AIDS components. The President has each month made state of the nation address where HIV and AIDS has featured. Meanwhile, commemorations for the World AIDS Day have been held annually at all levels including districts. The Tanzania Parliamentarians committee for the fight against HIV and AIDS has been supporting all national initiative to the epidemic including attendance and making key note speeches on all AIDS commemoration days. The President's strong and exemplary leadership qualities on HIV issues have been cascaded to various levels of Government and the community at large as evidenced by high involvement of traditional, opinion leaders, political leaders including parliamentarians, business persons and religious leaders in promoting open dialogue and speaking against risky behaviors and negative cultural practices that fuel HIV infection. Consequently, there are reports of reduction of risky sexual behavior and most importantly HIV counseling and testing.

The government has continued to provide funding for HIV/AIDS interventions in the country and support the implementation of those interventions.

4.2 Establishment of Tanzania AIDS Trust Funds

Tanzania has aligned its resources so as to address the HIV global agenda of getting to zero with commitment to increase the contribution to the national response programme. A health financing strategy proposing a national insurance scheme, fiscal contributions and taxation models, and public private partnerships for health financing has been finalized. To decrease donor

dependence in financing HIV interventions in the country, Tanzania is finalizing the establishment of the Tanzania AIDS trust fund (TATF). A percent of taxable income will be set for TATF and this will ensure smooth funding of various intervention addressing prevention, HIV testing and treatment, care and support.

4.3 Key population programming data

Compared to the situation during the last report, a number of studies addressing key population have been carried out and more undergoing. These studies have shed light in the development of NMSF III which has included a special section on key population. This is a step forward particulary at this time where HIV infection is at decrease in the general population making prevention among key population an important step to sustain the gain achieved so far.

4.4 Prevention of mother to child transmission

Prevention of mother to child transmission has recorded a major step of adoption of Option B+ which is effective than the previous options. This step taken in 2013 will ensure further decrease in the number of infants infected with the virus. The adoption will also ensure that more women are put on treatment for their own health and reduce maternal death with the ultimate achievement of the virtual elimination of MTCT.

4.5 HIV integration

HIV and AIDS cannot remain a vertical program; hence there is a need to integrate the HIV response with other programs. This is an approach that Tanzania has adopted with 96% integration of SRH and PMTCT, and 90% HIV and TB integration.

4.6 HIV testing and counselling campaigns

Community based HIV testing campaigns have resulted in mass uptake of HIV testing resulting in to an increased number of people knowing their HIV sero-status. The opt-out testing approach in various health services including Reproductive and TB has been instrumental in increasing the testing coverage.

5.0 MAJOR CHALLENGES AND REMEDIAL ACTIONS

5.1 Lack of Human Resource for Health

Lack of HRH has been the major hindrance to sustaining government efforts to address HIV/AIDS and other disease in the health sector. The government has establish a good network of health facilities to the village level to ensure that people have an opportunity to access health services including HIV prevention, care and treatment wherever they are. However, most of these facilities do not have skilled health care workers hence resulting in to missed opportunities for HIV prevention and care. Recent study revealed that the country had only 2200 medical doctors of whom 40% do not work in the mainstream public sector. Few available health care workers are overburdened by the large number of patients seeking health services increasing the probability for many patients to miss the opportunity to test for HIV or initiated on treatment. Living condition and remuneration of health care workers has been limited due to government financial constraints.

5.2 TB and ART integration

Despite the concerted efforts to increase HIV and TB integration, ART integration in TB clinics still lack behind with only 54% of co-infected patients initiated on both ART and TB treatment. Efforts to further integration are a priority in the new NMSF III and this is expected to bring better results in the future.

5.3 Lack of optimal stakeholders involvement

To realize the desired achievement in the response to the epidemic, all stakeholders need to play their role in a timely and effective manner. All sectors – including partners and stakeholders needs to be aware of the important role they play in realizing a holistic national response to the epidemic. Despite a coherent and comprehensive policy framework in place, it is known by only few and has limited support. The HIV/AIDS response in the critical sectors such as trade, infrastructure, minerals and natural resources, fisheries and culture is still weak. Given the fact that the nature of activities carried out in these sectors contributes to the spread of HIV, these sectors are also highly affected by the epidemic

5.4 Inadequate funds for the national HIV/AIDS response

Current development in HIV intervention and treatment demands more resources. Adoption of option B+ and new treatment guidelines increase demands in the supply of ART, human resource, facility spaces and HIV counselling and testing. Most HIV programming has been donor dependent and decreasing donor funds threaten service provision and sustainability. The off –budget nature of various HIV funding has posed a problem in tracking resources dedicated to the fight against the epidemic despite reports that the intervention are in line with the NMSF. More efforts to increase transparent and reporting harmonization are ongoing to ensure tracking of HIV/AIDS financing.

5.5 Lack of an Integrated Database for HIV Programmes

This is an important area in HIV response amid the challenges. There was no integrated database for tracking clients' referrals across all Health Sector programmes. As a result, clients are often lost across health sector programmes. Besides resource mobilizing to fund an integrated database

to track clients' referrals, programme managers in the health sector should be firmly committed to make the patient tracking system a success. Integration of HIV financing has been a challenge due to the multiplicity of donors and project approaches, and differing service delivery protocols. There are no incentives for donor funded vertical programmes that work to be integrated with less performing systems. Efforts in bringing HIV and FP, cervical cancer screening, and nutrition have been implemented along various algorithms and models owing to the multiplicity and fragmented donor-driven and project-based approaches. Major efforts are being exerted by RCH to develop national guidelines to be put in place and monitored. The government is working on harmonising reporting requirements to facilitate public and donor funded care and treatment facilities' reporting.

6.0 SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS

6.1 The state of support

Donors are the major financiers of HIV and AIDS in Tanzania and contributed about 94.9% of the total available resources in 2010/11. Government resources constituted the rest (5.1%) of the total available resources for HIV and AIDS activities in Tanzania. About 8% is defrayed by Development Partners other than PEPFAR and Global Fund. For the Global Fund a larger percentage of treatment resources have supported drug and commodity purchases, while PEPFAR resources have supported service delivery. However, government contributions on human resources, infrastructure and public outlets running costs are not all included in the estimates. Since donors' estimated contributions include administrative costs, drawn at the source, and do not necessary trickle down to the local intended beneficiaries, the accurate resources reaching the grass roots is unclear.

6.2 Actions that need to be taken by Development Partners to ensure achievement of the target

Development partners need to work with the Government guided by the NMSF III 2013/14-2017/18 and other national strategic plans in identifying funding gaps for HIV and AIDS programmes. Following this, development partners need to align themselves behind the objectives of NMSF III and undertake coordinated mobilization of resources in collaboration with the government. Development partners need to coordinate, simplify procedures and share information to avoid duplication according to the Paris declaration on AID effectiveness (2005) and the Accra Agenda for Action (2008). Furthermore, the focus by development partners should be on delivering measurable impact results in terms of the HIV epidemic in Tanzania. To achieve this, a monitoring system to assess progress and ensure that donors and government hold each other accountable for their commitments should be put in place. Additionally, development partners should build capacity of Tanzania to manage her own future regarding HIV response.

7.0 MONITORING AND EVALUATION ENVIRONMENT

7.1 An overview of the current monitoring and evaluation system

The National HIV and AIDS Monitoring and Evaluation system continued to be implemented and information generated provided strategic information to support HIV and AIDS programming and decision making. M&E activities continued to be coordinated through existing government structures at national and sub-national levels. The routine monitoring information systems mainly focus on needs, service coverage and some limited amounts of behavioural trends. Within the health care delivery facilities, clinical data are collected and reported through the MoHSW, managed and coordinated by Health Management Information System (HMIS) and NACP through routine monitoring system. Within the community based interventions, non-

medical HIV and AIDS data is collected by outreach workers and subsequently channelled to the national levels through TOMSHA.

The M&E partnership is strengthened through active Technical Working Group with members from different institutions including MDAs, NGOs, DPGs and Research institutions. TACAIDS serves as the secretariat of the TWG working group. The TWG continue to provide support in the review and development of major M&E focus areas of NMSF III and development of NMSF III.

Regular surveillance are undertaken to generate information related to the NMSF implementation. These include ANC surveillance, THMIS, TDHS, workplace survey, and behavioural surveillance among selected key population groups. This strategic information concerns HIV related behaviour, risk, vulnerability and impact. More detailed information generated periodically includes prevalence, vulnerability, risks, behavioural trends, demographic factors like size estimation, geographical locations, sexual networks, needs, service coverage and access factors. Research is also undertaken on priority basis as per the National HIV and AIDS Research and Evaluation agenda of 2010.

HIV and AIDS stakeholders have continued to allocate 5-10% fund from their respective budgets for M&E activities. However the majority of organizations have continued to spend less of the amount budgeted; this is due to their inadequate funds they receive which are also delayed /unreliable.

7.2 Challenges faced in the implementation of the a comprehensive M&E system

Well-functioning M& E system is crucial as it may threaten strategic planning that is evidence based, better understand the HIV epidemic with its driving factors by key stakeholders, and

inability to determine if intervention activities are on track as per NMSF III. The following challenges need to be addressed to reduce the above a foreseen problems;

7.2.1 There is lack of adequate human resource to carryout M&E activities at all levels, specifically at sub national levels. Many community HIV/AIDS committee members have not been trained on TOMSHA reporting and there is frequent change of TOMSHA officers. Supportive supervision is also not optimal due to lack of lack of supervision plans in most council.

7.2.2 Data emanating from lower level reporting have been of poor quality due to poor documentation on implemented HIV and AIDS activities by various civil society organizations (CSO). Data management at service delivery points have not been carried out in a systematic manner. This has been cemented by the inadequate capacity on management of TOMSHA electronic database by most of the Councils HIV Coordinators. Non-medical HIV programs have not been reporting regularly as required resulting in problems in tracking programme implementation and coverage.

7.2.3 Systematic collection and reporting of data on key population has not been possible. Routine collected data are not disaggregated by population characteristic to be able to identify key population. This limit tracking service access among key population.

7.3 Remedial Actions Planned to Overcome the Challenges

TACAIDS and partners plan to invest on M&E skills development and at all levels. The National Multi-Sectoral HIVAIDS Monitoring and Evaluation Plan is under implementation and addresses most important challenges identified. Most Council are being supported to develop M&E plans including newly established districts and regions. Discussion with HIV and AIDS implementers is underway to ensure that they retain TOMSHA trained staff to be able to maintain quality data collection and reporting. Regular data quality assessment and supportive supervision are planned to ensure that collected information are valid to be able to inform policy and programme planning.