FOLLOW-UP TO THE DECLARATION OF COMMITMENT ON HIV/AIDS (UNGASS)

Reporting period: January 2003 – December 2005
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<tr>
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<th>Full Form</th>
</tr>
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<tbody>
<tr>
<td>ABCT</td>
<td>AIDS Business Coalition Tanzania</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
</tr>
<tr>
<td>ARV</td>
<td>Anti-retro viral (drugs)</td>
</tr>
<tr>
<td>AMREF</td>
<td>African Medical and Research Foundation</td>
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<tr>
<td>ANC</td>
<td>Antenatal Care</td>
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<tr>
<td>CCA</td>
<td>Country Common Assessment</td>
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<tr>
<td>CSO</td>
<td>Civil Society Organisation</td>
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<tr>
<td>FAO</td>
<td>Food agriculture Organisation</td>
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<tr>
<td>HAART</td>
<td>Highly Active Antiretroviral Therapy</td>
</tr>
<tr>
<td>HBC</td>
<td>Home based Care</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>Human Immune-deficiency virus/ Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>IEC</td>
<td>Information Education and Communication</td>
</tr>
<tr>
<td>EPP</td>
<td>Estimation and Projection Package</td>
</tr>
<tr>
<td>GNP</td>
<td>Gross Net Product</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
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<tr>
<td>MKUKUTA</td>
<td>National Strategy for Growth and Reduction of Poverty</td>
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<tr>
<td>MTEEF</td>
<td>Medium Term Expenditure Framework</td>
</tr>
<tr>
<td>NACP</td>
<td>National AIDS Control Programme</td>
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<tr>
<td>NACOPHA</td>
<td>National Council of People Living with HIV/AIDS</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
</tr>
<tr>
<td>NSPF</td>
<td>National Strategic Plan Framework</td>
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<tr>
<td>PEPFAR</td>
<td>President's Emergency Fund for AIDS Relief</td>
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<tr>
<td>PLWHA</td>
<td>People Living with HIV/AIDS</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother-to-child transmission</td>
</tr>
<tr>
<td>RFA</td>
<td>Regional Facilitating Agency</td>
</tr>
<tr>
<td>STI</td>
<td>Sexual Transmission Infection</td>
</tr>
<tr>
<td>THIS</td>
<td>Tanzania Healthy Indicator Survey</td>
</tr>
<tr>
<td>TMAP</td>
<td>Tanzania Multi-sectoral AIDS Project</td>
</tr>
<tr>
<td>TWG</td>
<td>Technical Working Group</td>
</tr>
<tr>
<td>UNDAF</td>
<td>United Nations Development Assistance Framework</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>UN-ISP</td>
<td>United Nations Implementing Support Plan</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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</tbody>
</table>
The United Republic of Tanzania comprises of Tanzania Mainland and Zanzibar with a total population of 34,569,232 million people (33,584,607 and 984,625 respectively) majority of who reside in the rural areas. Tanzania Mainland is among the poorest countries in the world with a GNP per capita of US $ 280 and has a generalized HIV/AIDS epidemic. The main mode of transmission remains heterosexual contacts. The following studies provides the status at glance of HIV/AIDS in Tanzania Mainland in the reporting period 2003 - 2005

1.1 Community and Household HIV/AIDS Indicator Survey

The HIV indicator survey which was carried out in 2003-04 showed HIV prevalence of about 7.0% (i.e. 6.3% for males and 7.7% for females) among adult aged 15-49 years with urban residents having considerably higher infection levels (10.9%) than rural residents (5.3%). Although this rate (7%) is lower than the rate obtained from surveillance data, it does not however infer reduction in prevalence of HIV. More than 60% of the infections occur among young people especially among females.

To date, estimated number of people living with HIV/AIDS is 2 million, and the Government has so far registered 2 million AIDS orphans. These findings shows a substantial increase of about 400,000 case of PLWA since 2003 (which was 1.6 million), and an increase of about 1 million orphans in the same period.

1.2 HIV Surveillance Reports (2003 -2005)

In Tanzania Mainland the HIV infection trends have not changed significantly over the past three years. Available epidemiological surveillance data suggest that 18,929 AIDS cases were reported during the year 2003/04 (prevalence rate was 8.7% with a range of 4.8% to 15.3% in some areas). This resulted into a cumulative total of 176,102 reported cases since 1983 when the first 3 cases were identified in country.

The Ministry of Health -Tanzania Mainland’s, National AIDS Control Programme report that about 4% i.e. 754 of the AIDS cases which were reported during 2003/4, were below 15 years of age and most of them are likely to have acquired the infection through mother to child transmission. The age group 20-49 years remained the most affected for both sexes, an observation which has remained consistent for several years since the beginning of the epidemic in the country.

The predominant mode of transmission has remained heterosexual, constituting up to 77% of all reported cases during 2003/4. Mother to child transmission constituted about 5% whereas blood transfusion was reported at 0.5%. In about 17% of the reported cases, the mode of acquisition of infection was not stated.
Using Estimations and Projections Package (EPP) and the spectrum model developed by World Health Organization, it is estimated that 1,810,000 people (adult and children) were living with HIV/AIDS in Tanzania Mainland in 2003/4. Out of these, 850,000 were males and 960,000 were females and about 645,000 estimated children who have lost their mother/father or both parents to AIDS and who were alive at the end of 2003/4.

On the basis of estimations that only 1 in 4 AIDS cases are reported, a total of 187,940 cases are likely to have occurred in year 2003/4 alone (females being 98,290 and males 89,650). Assuming total absence of antiretroviral (ARV) drugs in the country up to end 2004, the estimated annual deaths in Tanzania Mainland for the year 2003 was 160,000 (UNAIDS, 2004 Report on the Global AIDS Epidemic, July 2004) and NACP report of April 2005, has estimated the number of annual deaths due to AIDS in 2004 as 187,940 (89,650 males and 98,290 females).

1.3 Reasons for Spread of the Epidemic

Based on “Surveillance of HIV and Syphilis Infections among Antenatal Clinic Attendees report during 2003/04, sexually transmitted infections (STIs) were stated to be a marker of sexual networking, giving a clue to the extent of unprotected sex in the community and therefore contribute to the spread of the epidemic.

During year 2003/4, a total of 223,388 STI episodes were reported throughout the STI clinics in the country. Of these, 98,129 (43.9%) were genital discharge syndromes; 41,427 (18.5%) were genital ulcers diseases; 42,527 (19%) were pelvic inflammatory diseases; 20,694 (9.3%) were syphilis and other syndromes constituted 20,611 (9.2%). Certainly these reported STI’s episodes are part of the cause of HIV/AIDS.

Other factors influencing the spread of the epidemic in Tanzania include multiple partnership relationships, intergenerational sex, male dominated gender relationships and risky cultural practices.

2.0 OVERVIEW OF THE AIDS EPIDEMIC: TANZANIA MAINLAND

In 2003-4 TACAIDS conducted a community based HIV indicator survey with the full participation of the National Bureau of Statistics. This survey, which included blood testing for HIV, in Tanzania Mainland and covered a larger number of people showed that, adult aged 15 –49 years HIV prevalence is about 7.0% (i.e. 6.3% for males and 7.7% for females). By end of 2004, more than 2 million people were estimated to be living with HIV and AIDS in Tanzania Mainland and over 2 million AIDS orphans had been registered. Awareness of the modes of HIV transmission is high; over 90% of Tanzanian aged 15-49 have heard of HIV/AIDS, and with almost 90% of adults knowing that having only one uninfected, faithful partner can reduce the chance of getting HIV. Furthermore, 4 in 5 adults
know that health looking person may be HIV+. However this does not seem to be accompanied by behaviour change.

The HIV/AIDS epidemic shows strong regional variation ranging from the highest HIV prevalence in Mbeya (14%), Iringa (13%) and Dar es Salaam (11%) to the lowest prevalence in Kigoma (2%) and Manyara (2%). Urban residents have considerably higher infection levels (10.9%) than rural residents (5.3%). Prevalence for both women and men increases with age until it reaches a peak: for women at age 30-34 (13%) and for men ten years later at age 40-44 (12%). The picture also shows that, for both men and women, HIV prevalence increases with education. Adults with secondary or higher education are 50% more likely to be infected with HIV than those with no education (i.e. with no education, males 4.2% and females 5.8% while with secondary and above education the rates are 7.3% for males and 9.3% for females. HIV prevalence among separated/divorced/widowed is significantly higher (men 15% and women 19.8%) while those currently in union/married (men 7.8% and women 6.9%) and never in union (men 3% and women 3.8%). HIV prevalence also seems to increase with wealth (poorest men 4.1% and women 2.8%) while the richest (men 9.4% and women 11.4%). Summary of HIV prevalence by age group is shown below.

Table 1. HIV Prevalence by age group 15-49 yrs

<table>
<thead>
<tr>
<th>Age</th>
<th>Females</th>
<th>Male</th>
<th>Males &amp; Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-19</td>
<td>2.1</td>
<td>2.1</td>
<td>2.1</td>
</tr>
<tr>
<td>20-24</td>
<td>6.0</td>
<td>4.2</td>
<td>5.2</td>
</tr>
<tr>
<td>25-29</td>
<td>9.4</td>
<td>6.8</td>
<td>8.3</td>
</tr>
<tr>
<td>30-34</td>
<td>12.9</td>
<td>8.6</td>
<td>10.9</td>
</tr>
<tr>
<td>35-39</td>
<td>11.6</td>
<td>9.8</td>
<td>10.7</td>
</tr>
<tr>
<td>40-44</td>
<td>9.8</td>
<td>12.3</td>
<td>10.9</td>
</tr>
<tr>
<td>45-49</td>
<td>5.8</td>
<td>6.7</td>
<td>6.3</td>
</tr>
<tr>
<td>Total</td>
<td>7.7</td>
<td>6.3</td>
<td>7.0</td>
</tr>
</tbody>
</table>

Source: TACAIDS (March 2005)

3.0 IMPACT INDICATORS
3.1 Reduction in HIV Prevalence
3.1.1 Indicator: Prevalence of HIV Among Youth

The Community study conducted by TACAIDS during 2003/4 and Surveillance reports by NACP (2005) suggests that HIV infection among youth aged 15-24 represent more recent infections and serves as an important indicator for detecting trends in both prevalence and incidences in a population. In Tanzania Mainland the percentage of young people aged 15-24 who are HIV-infected is 4% (women) and 3% (men). This accounts the overall, prevalence of HIV for the age group 15-24 to be 4%. Urban youth, both female and male are more likely to be infected than those in rural areas (6 verses 3 percent). However, data from NACP sentinel surveillance sites report of 2003 shows that HIV
prevalence among antenatal clinic attendee was 9.6%, whereas in 2004 the HIV prevalence was at 8.7% indicating a decline of the infection by 9.4%.

3.2. HIV Treatment: Survival after 12 Months on Antiretroviral Therapy

3.2.1. Indicator: Percentage of adults and children with HIV still alive and known to be on treatment 12 months after initiation of antiretroviral therapy

In Tanzania Mainland HIV treatment through ART started in few sites in October 2004. To date (end of 2005) 96 sites are currently providing ART after training of 142 clinicians, 95 pharmacists, 101 laboratory technicians and 38 nurses. ART national coverage rate has quadrupled from 2000 people accessing ART at the beginning of 2005 to over 22,024 by 15th December 2005. Of the total, women are estimated to be >50% and children are 10%. Actual figures on the survival after 12 months on antiretroviral therapy is yet to be established.

3.3 Reduction in Mother-to-Child Transmission

3.3.1 Indicator: Percentage of HIV Infected Infants born to HIV-Infected Mothers

Mother-to-child transmission remains the leading cause of HIV infection in children. In Tanzania Mainland, PMTCT programs have provided a package of services that include: counseling and testing for pregnant women; short-course preventive ARV regimens to prevent mother-to-child transmission; counseling and support for safe infant feeding practices; family planning counseling or referral; and referral for long-term ART for the child. So far there are 334 PMTCT centres in the whole country.

UNAIDS (2003) estimates that percentage of HIV-infected infants born to HIV-infected mothers was 25% (UNAIDS 2003 Annex 18 pg 102). However, for the subsequent years, actual estimation has been recognized to be a complex exercise due to the fact that, of those children who test HIV positive, for example 500 case annually, return rate for HIV testing would normally be about 20 cases, whom only about 2 cases of the children affirm HIV positive. This scenario makes it difficult to draw valid conclusions (verbal discussion with PMTCT management on 22/12/2005).

4.0 NATIONAL RESPONSE TO THE AIDS EPIDEMIC

4.1 National Response on HIV/AIDS
While there are encouraging signs of increasing awareness and interventions from different parts of the country by various public and private institutions, and civil society organizations more serious and targeted interventions are necessary to have an impact on slowing down the rate of new infections and protect the 85 – 90 per cent of HIV free people in the community. Emphasis in the national response is
therefore directed towards increasing individual and community awareness on the risk of HIV infection of the individual and families and its serious implications on the individual, the family and community.

Government Ministries, Departments and Agencies are developing plans for mainstreaming HIV/AIDS intervention into routine activities, including workplace interventions and integrating HIV/AIDS control activities in the ministry’s Medium Term Expenditure Framework. Many private enterprises have workplace HIV/AIDS interventions including provision of anti retroviral treatment. There is much potential for more involvement of the private sector in the national response to the epidemic.

In order to ensure that communities at the grass root level have sustained HIV/AIDS interventions, local government authorities are being supported in developing comprehensive HIV/AIDS programmes that involve all stakeholders. Regional Facilitating Agencies (RFAs) are providing technical assistance to local government authorities and civil society organisations to empower communities in rural and urban areas in responding to the epidemic.

Guidelines for the establishment of District AIDS Committees have been disseminated to all local government authorities aimed at facilitating more community mobilisation and involvement in the fight against HIV/AIDS. Modules for training members of the District AIDS Committees and technical functionaries have been developed and training has been ongoing since November 2003.

Efforts to mainstreaming HIV/AIDS in the planning/budgeting process in the public sector have been initiated. This has aimed at ensuring regular budgetary allocations for the sectors HIV/AIDS activities.

In terms of partnership, the National response initiative enjoys good partnership with Development Partners, Civil Society Organisations, the Private sector and Faith based organisations in the fight against the HIV/AIDS. In recognition of the existing partnership and transparency in the National response initiatives, the development partners and the Government signed a Memorandum of Understanding (MOU) to reaffirm their joint commitment and support to the National Multisectoral Strategic Framework on HIV/AIDS.

The main thrust of the MOU is to enhance and harmonize partnership between the Government of Tanzania and the development partners in the implementation of the National Multi-sectoral Strategic Framework on HIV/AIDS through a common Program of Work for planning, management, resource mobilization and allocation, and monitoring and evaluation.

The World bank funded TMAP agreement was signed on 27 August 2003 for providing US$ 65 million and US$ 5 million for Tanzania mainland and Zanzibar respectively for five years. Rapid Funding Envelope that has mobilized over US$ 2.5million from willing partners to finance short term quick impact projects by civil society organisations and institutions is one of the innovative approaches in the national response.
Tanzania has enjoyed three rounds of the Global fund’s, aimed at scaling-up access to quality voluntary counselling and testing for tuberculosis and HIV/AIDS by filling gaps in critical areas in scaling up the national response. The areas include (a) impact mitigation for orphan and venerable children (b) adequate supply of condoms through the public and social marketing (c) support for the care and treatment plan, incorporating the WHO 3 by 5 imitative to scale up ART (d) initiating a new system for monitoring ART program and (e) the national coordination framework for the multi sectoral partners and district response initiatives. Multi-sectoral bodies known as Tanzania National Coordinating Mechanism coordinate all these projects

Collaboration with Civil Society Organisations in the national response has been strengthened. A network of AIDS service organizations has been formed (TANASO). Also, people living with HIV/AIDS (PLHAs) are in the process of forming their Council, which will cater for the welfare of all PLHAs regardless of their organisations.

Tanzania in year 2005 witnessed the inauguration of ABCT (HIV/AIDS Business Coalition - Tanzania) . The ABCT has been able to carry out a number of activities. These includes: Organized a meeting on ‘Scaling up ARV’S Treatment’ for ABCT members, organized a meeting to develop generic policy for ABCT members and conducted peer health education training.

Integration of HIV/AIDS activities into national long, medium and short term plans. eg vision 2025, National Strategy for Growth and Reduction of Poverty (MKUKUTA), Medium Term Expenditure Framework (MTEF) has been conducted

As a result of the above mentioned efforts, the positive signs in the national response are ongoing:-

All sectors are involved in HIV/AIDS interventions. This includes the formal and informal private sector and religious organizations, civil society organizations as well as the informal voluntary groups. While the commercial companies have formed their coalition to combat HIV/AIDS in their companies, networks of informal sector groups have also organized themselves in strengthening their response to the epidemic.

There is increased demand for voluntary counselling and testing services and condoms beyond government ability to satisfy.

Stigma is gradually declining as attitudes towards people living with HIV/AIDS are now becoming more positive
In order to ensure that the grassroots communities are involved and empowered in the response, Regional Facilitating Agencies have been assigned to mobilize all HIV/AIDS related civil society organizations at the Local Government Authorities level to work with and assist communities in rural and urban areas in designing and implementing own interventions to control HIV/AIDS according to their social and cultural environment.

Further to the above mentioned, the government in close collaboration with stakeholders has made a number of initiatives in response to the HIV/AIDS epidemic during 2003 – 2005. These initiatives include the following:-

4.2 Formulation of a National HIV/AIDS Care and Treatment Plan

Since October 2003, the Tanzania Mainland Government has formulated a national HIV/AIDS care and treatment. The goals of the care and treatment plan are: -

a) Provision of quality, continuing care and treatment to as many HIV+ residents as possible,

b) Contribute to strengthening the health care structure of Tanzania, through expansion of health care personnel, facilities and equipment and comprehensive training in care and treatment of PLWHA

c) Fostering information, education and communication efforts focused on increasing public understanding of care and treatment alternatives, reducing the stigma associated with HIV/AIDS, and supporting ongoing prevention campaigns

d) Contribute in strengthening social support for care and treatment of PLWHA in Tanzania, such as home-based care, local support groups and treatment partners.

4.3 Supports for the Implementation of the Three Ones Principle

In the process of implementing the three in one principles, several initiatives have been made including;

4.3.1 One national AIDS Coordinating Authority

The Government has now in place a national institution that is the Tanzania Commission for AIDS (TACAIDS), which was established by an Act of Parliament number 22 of 2001. This institution is under the Prime Minister’s Office entrusted with the role of coordinating the national multi-sectoral responses to free Tanzania from the threat of HIV/AIDS and to support all those who are infected by HIV/AIDS.

Tanzania has enjoyed very healthy cooperation and support from the development partners in the fight against HIV/AIDS. This has further being strengthened by the regular forums for consultation and information sharing that facilitates coordination, harmonization and transparency. The forums include the Joint Meetings of Tanzania Commission for AIDS and the Development Partners Group on HIV/AIDS every two months, and the Tanzania National Coordinating Mechanism for HIV/AIDS, Tuberculosis and Malaria. We restructured the Global Fund Country Coordinating Mechanism to
National Coordinating Mechanism, so that we can coordinate resources from other sources like World Bank’s Tanzania Multi-sectoral HIV/AIDS Project (TMAP) and PEPFAR and not only the Global Fund.

TACAIDS is supported by various task forces and groups, namely:-

a) Tanzania National Coordinating Mechanism Coordinates all funding for HIV/AIDS
b) M&E Task Force chaired by TACAIDS exists and meets for specific purposes.
c) UN Theme Group meets monthly. The Chairperson rotates every year and current chair is FAO Country Representative.
d) Development Partners Group on HIV/AIDS meets monthly and is chaired by GTZ.
e) Joint Development Partners Group for TACAIDS meets bi-monthly.
f) National Council of People Living with HIV/AIDS (NACOPHA) is being established.
g) Poverty Reduction Strategy Monitoring thematic working groups
h) National Coordinating Mechanism has a multi-sectoral membership and is chaired by the Prime Minister’s Office
i) AIDS Business Coalition Tanzania has been established and is operational
j) NGO Policy Forum is functional

4.3.2 One Agreed AIDS Action Framework

Tanzania Mainland has in place a National Multi-Sectoral Strategic Framework on HIV/AIDS (2003/2007) focussing on the following priority areas:

1) Reduce the spread of HIV/AIDS
2) Reduce HIV transmission to infants
3) Political and government leaders consistently give high visibility to HIV/AIDS in their proceedings and public appearances
4) Political leaders, public and private programmes, projects and interventions address stigma and discrimination and promote the respect for the Human Rights of persons living with HIV/AIDS
5) HIV/AIDS concerns are fully integrated and prioritised in the National Poverty Reduction Strategy and Tanzania Assistance Strategy
6) Reduce the prevalence of STIs in the population
7) Increase the knowledge of HIV transmission in the population
8) Increase the number of persons living with HIV/AIDS who have access to a continuum of care and support from home/community to hospital levels
9) Reduce the adverse effects of HIV/AIDS on orphans
4.3.3 One Agreed Country Level monitoring and Evaluation System

Ensuring and managing the coordination of M&E of the national Multi-sectoral responses on HIV/AIDS is a core function under TACAIDS. Several achievement have been made as it will be covered in the section on M&E in this report

4.4 Development Partners Joint Support to National Responses on HIV/AIDS

4.4.1 CCA/UNDAF
Tanzania is currently developing the UNDAF 2007-2010 for supporting the National Growth and Reduction of Poverty Strategy where HIV/AIDS is treated as cross cutting theme.

4.4.2 UN-ISP
There is a UN joint Implementation Support Plan for both Tanzania Mainland and Zanzibar for year 2005 – 2006 on priority HIV/AIDS activities (a bridge to the next UNDAF 2007 – 2010)

4.4.3 UN Coordinating Entity – UN Theme Group on HIV/AIDS and UN Technical Working Group (UNDAF) on HIV/AIDS are all supporting the national response on the epidemic at the country level

Other supportive programming responses to the national efforts include the following;

4.5 Response to the Most at Risk Populations - HIV Testing
Under the national HIV/AIDS policy, the government aim to promote early diagnosis of HIV infection through voluntary testing with pre and post-test counselling. The main aim is to measure and encourage the 85-90% of population who are HIV/negative to take definitive steps not to be infected, and those who are HIV positive to receive the necessary support in counselling and are to cope with their status, promoting their levels and not to infect others.

4.5.1 Voluntary Counselling and Testing (VCT)
Since the introduction of VCT services in Tanzania, there has been rapid uptake of services reflection that the demand for VCT is relatively high. So far 527 VCT centres have been established throughout the country and about 1201 counsellors offered a 6 weeks training course between 2002-2004. At least every district has one VCT centre. The scaling up of the VCT services has being in line with the understanding on how the different population groups and categories are likely to accept VCT and its driving forces.

4.5.2 Number of Clients Requesting VCT Service is Increasing
More and more people have turned up for voluntary counselling and testing during the reporting period. For instance, the NACP (2003) reported that in 2002 there were a total of 57,223 clients who made use
of VCT services that year, 83% (n=47,956) of whom consented to taking the HIV test. This was a four times increase in the number of clients who made use of the VCT services and six times increase in the number of clients who consented to taking the test compared to figures for the previous year, 2001\(^{\text{NACP 2003}}\). In 2003 and 2004 the number of persons who were counseled and tested were 139,972 and 227,973 respectively. 25,754 people in 2003 and 22,121 people tested HIV+ve in 2004, making prevalence rates of 18.4% in 2003 and 9.7% in 2004 respectively. There has also been an increase in the number of people donating blood between 2002 and 2004.

4.6 Response to Most at Risk Populations: Prevention Programs

Several studies have shown high prevalence of HIV amongst vulnerable/high risk populations in the country such as sex workers, men having sex with men, injecting drug users, the military and mobile populations. Currently there are very few initiatives aimed to address the issue of HIV prevention among the risk groups apart from very small scale NGO.CSO driven interventions that are in place. The effectiveness of interventions is not well documented.

4.6.1 Care, Treatment and Support

His Excellency the former President, Mr William Benjamin Mkapa intensified the government efforts by declaring HIV/AIDS a national disaster in 1999. The Ministry of Health took the lead in developing health sector responses, including the formation of the National HIV/AIDS Control Programme (NACP). Initially, HIV/AIDS was perceived purely as a health problem and the campaign to deal with it involved the health sector only through the National AIDS Control Programme. The national responses consisted of developing strategies to prevent, control and mitigate the impact of HIV/AIDS epidemic, through health education, decentralization, multi-sectoral response and community participation. However, the response had no much impact on the progression of the epidemic as was expected.

During year 2000, the government further focused its attention and energy by expanding the nation’s efforts to all entities and levels of the government. This action included the formation of the Tanzania Commission for AIDS (TACAIDS) with a mandate to lead the Multisectoral response.

Two important documents ie ‘National Multi-sectoral Strategic Framework on HIV/AIDS’ and TACAIDS and the Ministry of Health developed ‘Health Sector HIV/AIDS Strategy for Tanzania’ respectively. The Health Sector Strategy laid out an ambitious five-year plan of activities, which included provision of care and treatment (ie care and provision of antiretroviral therapy) to a significant portion of Tanzanians.

4.6.2 Care and Treatment Plan for HIV/AIDS.

Tanzania’s HIV/AIDS Care and Treatment Plan was developed in 2003 and has four main components:
i To provide quality, continuing care and treatment to as many HIV+ residents of the United Republic of Tanzania as possible, building on the careful planning already completed by the Ministry of Health and the Tanzania Commission for AIDS

ii To Contribute to strengthening the health care structure of Tanzania, through expansion of healthcare personnel, facilities and equipment and comprehensive training in the care and treatment of PHWHA

iii To foster information, education and communication efforts focused on increasing public understanding of care and treatment alternatives, reducing the stigma associated with HIV/AIDS, and ongoing prevention campaigns

iv To contribute in strengthening social support for care and treatment of PLWHA in Tanzania, through home-based care, local support groups, and treatment partners

The plan build on the existing health care infrastructure ie both public and non-public while ensuring quality standard and efficient provision of services without radical changes on policy. The operational plan has been designed to allow more than 400,000 Tanzanian residents to be on treatment with ART by end of the fifth year of the programme. At the same time, some 1.2 million HIV+ persons not clinically eligible for Highly Active Antiretroviral Therapy (HAART) would be treated and monitored to track disease progression.

A strong management team at national level supplemented by additional programme managers working with Regional Medical Officers will oversee a “strengthening and certification programme” designed to prepare facilities to prescribe ARVs and monitor their use, launch effective counselling and adherence efforts, and follow significant numbers of HIV+ patients not on HAART.

The public will be prepared through a major IEC programme particularly on supporting the counselling efforts to educate patients, their families, and those who support them in fundamentals of ART and the key role adherence plays in its success. The IEC programme will further focus on reducing stigma associated with HIV/AIDS in order to encourage citizens to learn their sero status, and PLWHA to enter the healthcare system for care and treatment

Local advisory groups that will include PLWHAs will be utilized in every district, which hosts a Care and Treatment clinic.

4.7 Response to the Reduction in Mother-to-Child Transmission

Various achievements in the implementation of PMTCT activities have been the following:

4.7.1 Formulation of a National Policy on PMTCT
A comprehensive National Policy on PMTCT addressing all sensitive ethical and social/cultural issues has been formulated and is now in place.

4.2.2 Capacity Building Conducted for Service Providers:
Health care providers responsible for delivering PMTCT services in the districts that have started to implement PMTCT services have been trained.

4.7.3 Promotion of PMTCT services
Advocacy work to sensitize the public at all levels on PMTCT continues to be conducted by the MoH and the focus now is PMTCT. Volunteers working under HBC services are also active in advocating for PMTCT and during ANC visits, there are special sessions to educate women in the importance of PMTCT. Such efforts have resulted into the increase in the number of male partners seeking information on PMTCT service.

4.7.4 Research into PMTCT
In order to enhance monitoring and evaluation of PMTCT interventions there has been an initiative to research on the long-term benefits of PMTCT interventions.

5.0 KNOWLEDGE AND BEHAVIOR INDICATORS

Knowledge of how the virus is spread and consequent changes in sexual behavior are important determinants that contribute the spread of HIV. The following are current statistics as regard to knowledge and behavior as reported by community based HIV indicator survey.

5.1 Young people: Knowledge of HIV Prevention
- 44% of young women and 49% of young men know 5 of the most important elements of HIV/AIDS transmission
- Over 50% of young women and 75% of young men know a place to get condoms
- 17% of young women and 26% of young men aged 15-24 said to have used condoms the first time they had sexual intercourse
- Among sexually active youth aged 15-24 years, 37% of women and 81% of men engaged in higher risk sexual activity in the past one year – (only 47% men and 42% women were more likely to use a condom)

5.2 Higher Risk Sex Among Women and Men
Available data on higher risk sex among men and women suggest that 23% of women and 46% of men engage in higher risk sex. Of those, 38% of women and 50% of men reported using condom in the most high-risk sex. In urban setting, women and men are more likely to engage in high-risk
sex (32% verses 51% respectively). Less than 2% of the males reported to have had sex with a prostitute in the last 12 months.

5.3 Young people: Condom Use with Non-Regular Partners

Among sexually active youth aged 15-24 years, 37% of women and 81% of men engaged in higher risk sex. Young men who engaged in higher risk sex were slightly more likely than women to use condom (47% verses 42%). Urban youth, both women and men are more likely than their rural counterparts to engage in higher risk sex (49% for women and 86% for men in urban verses 41% for women and 79% for men in rural).

6.0 MAJOR CHALLENGES FACED AND ACTIONS NEEDED TO ACHIEVE THE GOALS/TARGETS

6.1 The Health Sector

a. Weak/gaps existing within the health system in the areas of: - a skilled health sector workforce; well-managed and regular supply of drugs and other commodities to ensure uninterrupted supplies; and ART literacy and stigma.

b. Sound information systems; M&E system to monitor drug adherence, and treatment success and resistance. Establishing linkages between TB and HIV/AIDS care and involving communities for home-based care

6.2 Challenges in Managing the HIV/AIDS Responses

a) The problem of orphans and vulnerable children whose number is increasing by the day is formidable. It is estimated that there are about 2.5 million orphans and vulnerable children in Tanzania. Efforts that need to be taken at the local government level is to ensure that orphans and vulnerable children are identified early and supported through the extended family structure and ensure that they access basic social services.

b) Another challenge is social and economic support to people living with HIV/AIDS. The need for nutritional support to some of the AIDS patients was not perceived in the early days of epidemic. With access to ARVs, many patients from poor families need nutritional support before and during the time they are on ARVs. Some affected families need some small grants for income generating activities

c) Coordination and harmonization of donor supported activities. Modalities for coordinating and harmonization of donor inputs for HIV/AIDS initiatives need to be synchronized.
6.3 Prevention Programs: Mother to Child Transmission of HIV

6.3.1 Inadequate Coverage of PMTCT Services:
So far the number of health facilities offering PMTCT services is still low. There is a high demand for these services. The number of health care workers already trained by end of 2005, i.e. 142 Clinicians, 95 Pharmacists, 106 Laboratory personnel, 38 Nurses, 155 Counsellors and Home Based Care workers is still low to meet the demand. Counselling skills relevant to all aspects of PMTCT services are still inadequate. There is therefore a need to institutionalise capacities for responding to the pandemic at all levels of implementation.

6.3.2 High Stigma and Discrimination
Fear of abandonment and rejection by spouses and families after disclosing their HIV status lead to low opting to PMTCT, dropouts and non-adherence to necessary treatment schedules. For example a mother who does not breastfeed her child is discriminated by the community and faces the threat of rejection and domestic violence. Community advocacy should be a priority of intervention.

6.3.3 Absence of Affordable Alternatives to Breast-feeding
Majority of Tanzanians live within the poverty line. Many cannot afford their own food, let alone alternative feeding for their babies. This in turn forces those who are infected to continue breastfeeding their babies despite the risk of infection.

6.3.4 Poor Integration of PMTCT with Other Support Services:
The link between PMTCT interventions, access to drugs initiatives, other treatment programs and other supportive services such as VCT, supportive counselling and follow-up of clients has not been very effective. The scattered location of service points and low economic statuses of clients also make it difficult to engage in other support services for PLHAs as well as make it difficult to conduct a follow up of clients and to link them with other support services. However, under the PMTCT 2 and increased availability of ARV, the current situation will be improved.

6.3.5 Prevention programs: Voluntary Counseling and Testing (VCT)
Despite the progress already achieved, there are a number of challenges that require action for improvement:

(i) Coverage of VCT services in still low compared to the increasing demand and most of the VCT services are urban based.

(ii) While number of VCT is being increased, there is also need to look at possible access barriers such as distance especially in rural poor areas, which might have implications on travel costs, and in the end fetter the willing clients to access the services.
(ii) Fear, stigma and inadequate reliable information. Besides the good news of availability of ARVs there are so many other factors that determine life after discovery of HIV infection.

### 6.3.5 Other Challenges on Prevention programs

i) Marginalization of the sex workers, drug user and men having sex with men (these practices are against the government policies

ii) Low access to STI treatment and other HIV/AIDS prevention, care and treatment services responding to their specific needs

### 7.0 SUPPORT REQUIRED FROM COUNTRY’s DEVELOPMENT PARTNERS

The Public Expenditure review (May, 2005) suggest that for Tanzania, the fight against HIV/AIDS would require an estimated US $ 160 million per annum. While the government has managed to increase its local resources going into the fight against HIV/AIDS to US $ 22.1 million during 2004/05, combined with the development partners input, the prospective resource gap therefore stands at US $ 50 million. These estimates are highly sensitive to assumptions on the actual cost of scaling up ART and on the level of aid, which actually materialise.

### 8.0 MONITORING AND EVALUATION ENVIRONMENT

TACAIDS is currently in the process of developing a National HIV/AIDS M&E System to allow the country track its progress towards the goals and objectives as stated in the National HIV/AIDS Strategic Plan Framework (NSPF).

Preliminary developments that have been made in the process leading to the establishment of the M&E system include an assessment and review of current efforts on M&E in Tanzania. The primary objective of the assessment and review was to understand the nature and functions of existing M&E systems that are being implemented, and on the basis of this understanding, propose measures that would contribute to an improved HIV/AIDS M&E systems including meeting the needs of TACAIDS.

The assessment revealed that, most agencies implementing HIV/AIDS activities have no M&E system. Additionally, among implementing agencies that indicated that they have an M&E system, there appeared to be no consistency on the definitions and identification of a core set of indicators to measure key HIV/AIDS interventions. Overall, implementing agencies admitted that they have insufficient capacity to monitor and evaluate their HIV/AIDS programme activities. M&E capacity inadequacies are attributed to (ii) lack of computer equipment and software for M&E; (ii) lack of M&E training
manual; (iii) lack of staff training in M&E; (iv) inadequate financial resources for M&E; and (v) lack of M&E facilities.

Following these recommendations, TACAIDS, in collaboration with UNAIDS, UNDP, World Bank and few other development partners started implementing a participatory approach to establish a national M&E system. The first step involved was to convene a working meeting where a framework for the M&E system was developed, followed by a larger working meeting where few selected members were invited to contribute core set of indicators under their respective program themes. Members of the M&E Technical Working Group (M&E – TWG) then collated the input from the various sectors and groups and produced the first draft of the M&E national framework.

In recognition of existing gaps in M&E skills and infrastructure, UNAIDS and other development partners are currently supporting TACAIDS to facilitate the development and strengthening of existing M&E systems to support the realization of the M&E plan. The strategy includes institutional capacity building, strengthening of existing structures and systems, building linkages between ongoing systems, and development of procedures and guidelines for implementation.

Planned sustainability measures will include technical guidance, close supervision, periodic and continued capacity building through on site mentoring and coaching. Infrastructure development based on assessments and lessons learned during implementation and may have to be phased based on resources available. However, a Master Plan for nation wide roll out is a prerequisite and should be acquired through a thorough assessment survey to identify informatics, logistics and capacity needs.

Based on a review of various systems including global reporting on HIV/AIDS it has been recommended that The Country Response Information System (CRIS), be adopted in the National M&E System. CRIS will provide TACAIDS with a complementary and user-friendly system consisting of an M&E indicator database, a project/resource-tracking database and a research inventory database. In particular, the indicator database provides countries with a tool for reporting on country performances vis-à-vis national indicators and follow-up to the UNGASS Declaration of Commitment on HIV/AIDS. Other software’s have also been developed and are currently used. Also a comprehensive list of data collection tools, indicators and reporting requirements and a consolidated plan on indicators to be collected at district, regional and national levels has been developed.

The Monitoring and Evaluation Technical Working Group under the TACAIDS will continue to coordinate future efforts in the development of the M&E system.

**9.0 OPPORTUNITIES:**

1) There is widespread willingness by leaders, private & public sector including CSOs and communities to participate in care and treatment interventions
2) Created high level of awareness among communities and individuals on HIV/AIDS (refer THIS report)

3) Conducive strategic environment with (a) high donor support (b) global and bilateral focused initiatives (c) policy and strategic support framework (d) Government increased budgetary allocation to HIV/AIDS activities through MTEF and (e) political stability

10.0 TANZANIA GOVERNMENT HIV/AIDS POLICIES

Tanzania National policies, strategies and guidelines on HIV/AIDS include the following:-


c) VCT - HIV/AIDS Policy (2002)


e) Nutrition and AIDS – National health Policy (1990 and revised on yearly basis)

10.1 Networks of Organizations working on HIV/AIDS

In Tanzania we do not have network of organizations working on HIV/AIDS but AIDS services organizations which include: - AMREF, WORLD VISION, PASADA, WAMATA, VUKA, KIWAKUKKI, DARDAR HEALTH CLINIC, WAPO MISSION FARAJA TRUST FUND, TADEPA, TANESA, AIDS Business Collision for Tanzania (Private sector)

10.2 Networks of People Living with HIV/AIDS

These include: - SHDEPHA*, TANEPHA, TANOPHA, NETWO* and TNWP*

NACOPHA is a proposed council being established to coordinate all networks of PLWHA

11. GOVERNMENT FUNDING FOR HIV/AIDS

In line with the National Multisectoral Strategic Framework for HIV/AIDS, all Ministries, Departments Agencies and Local Government Authorities are required to mainstream HIV/AIDS in their annual plans and budgets. Ministerial and regional HIV/AIDS budgetary allocations have increased from USD 5,601,691 in financial year 2003/04 to USD 22,122,290 in financial year 2004/05 (S. Tax and U. Philipp, October 2004). This is an increase of about 75%. A functional analysis of the prospective HIV spending for financial year 2004/05 in seven Ministries, Departments and Agencies suggest that, 35% was spent on care and treatment, 8% on prevention, 56% on multi-purpose activities and 8% was on prevention.
12.0 RESOURCES

The infrastructure and the smooth working relationship with our partners have facilitated substantial resources for HIV/AIDS during the last five years from USD 17m in 2001/02 to 124m in 2005/06. This includes the Government contribution from USD 2.8m in to 45m in the same period. The main sources of resources include:

Multilateral and Bilateral agencies
These have been our main source of support since the onset of the epidemic in the country.

The Global Fund - USD 400m
Tanzania has managed to obtain three grants based on proposals approved by the Global Fund amounting to about USD 400 million in the last three years. This has made remarkable impact on the control of the three diseases. This includes the support to the ongoing Care and Treatment plan, provision of subsided treated mosquito nets to pregnant women and children under five years and the combined drugs treatment for malaria.

World Bank USD USD 65m for Tanzania mainland
The Tanzania Multisectoral AIDS Project (TMAP) is supporting the interventions in all sectors including communities since 2003 to-date

PEPFAR
Since last year PEPFAR is providing substantial contribution in comprehensive package which includes prevention, care and treatment and impact mitigation. We do not details of its actual budget and expenditures in the country as these resources have not been captured in the National budget.

It is through this cooperation and support that we have been able to scale up the national response including the provision of anti retroviral drugs to people living with HIV/AIDS from October 2004 initially with funds from the Government, Canada, Norway and Sweden. Over 11,700 PLHAs are accessing ARVs. We have also been able to improve the quality of blood safety facilities and services, and expand voluntary counselling and testing and prevention of mother to child transmission and other health sector interventions. Apparently up to now we have not received any anti retroviral drugs from the PEPFAR.
REFERENCES


10) Tax, Stergomena and Philipp, U. ‘An update of the assessment of commitments by development partners in regard to the National Multi-Sectoral Strategic Framework on HIV/AIDS’


ANNEX 1: Consultation / Preparation process for this national report

This report was generated from several methodologies. Namely; literature review (Background documents about UNGASS reporting including the National Multi-sectoral Strategic Framework, MKUKUTA etc), interviewing officials and M&E focal persons from Tanzania Commission for AIDS, NGO, CSO, Members of the private sectors, Faith Based organisation, Ministry of Health, National AIDS Control Programme, Ministry of Education and Culture and in-country discussion/briefing with HIV/AIDS stakeholders for validation/inputs on the report.

The major source of data included in this report are from the current Tanzania population based HIV/AIDS Indicator survey conducted by TACAIDS in collaboration with National Bureau of Statistics and HIV/AIDS/STI surveillance reports carried out by the National AIDS Control Programme under the Ministry of Health. Several other documents (reference attached) were critically synthesised for input.

A community and household based study (THIS) by the TACAIDS formed a major base for providing preliminary HIV/AIDS indicator source in writing the report.

The objective of THIS
i) To measure HIV prevalence among women and men aged 15-49
ii) To assess levels and trends in knowledge about HIV/AIDS, attitude towards those infected with the disease, and sexual behaviour practices
iii) To collect information on the proportion of adults who are chronically sick, the extent of orphan hood, and care and support levels, and
iv) To gauge the extent to which this indicators vary by characteristics of the individual such as age, sex, region, education, marital status and poverty status

More importantly, the survey data was used to calculate the population projections and estimate indicators developed by the United Nations General Assembly Special Session (UNGASS), the UNADS Programme, and the World Health Organization (WHO)

With HIV/AIDS/STI surveillance data, this has provided a case in determining HIV and syphilis sero-prevalence as well as trends among antenatal clinic attendee and examines factors associated with the infections

Process

TACAIDS in collaboration with UNAIDS Tanzania Country (M&E Advisor) secured the service of a consultant who together with officials from TACAIDS carried out the study to review on the available HIV/AIDS information and data from Tanzania Mainland and Zanzibar (ie TACAIDS, ZAC Government Ministries and Department and Agencies, CSO on Multi-sectoral HIV/AIDS country response) as a basis for the preparation and finalization of the UNGASS report.

Visits to Zanzibar to meet ZAC, ZNCP, and MOHSW officials including CSOs were made. Discussion and suggestions as regard to current updated data on HIV/AIDS from different source was harmonised while preparing Tanzania-Zanzibar county report

In addition, a consultant with technical support from M&E Advisor (UNAIDS Country Office) carried out a one day dissemination meeting to mainstream stockholder’s input into the report writing.

The meeting was successfully attended by different stakeholders and accomplished accordingly. Qualitative inputs from stakeholders were incorporated into the report prior to submission to final review by TACAIDS and ZAC and finally submitted to UNADS Country Office for onwards transmission to UNAIDS Geneva.

Major observations by stakeholders:

The CRIS has laid the desired foundation for country reporting on UNGASS, however:-
Due to inadequate of data within the health systems and particularly in compliance with the CRIS indicators, the exercise in 2005 has been difficulty since this was also our first time to use CRIS. However, awareness has now been created on the type and nature of indicators that need to be reported on the annual basis through the use of CRIS.

We recommend that, for future quality UNGASS reporting, both ZAC and TACAIDS officials should be trained on the application of the CRIS in future reporting.