TANZANIA COMMISSION FOR AIDS

UNGASS COUNTRY PROGRESS REPORT

TANZANIA MAINLAND

REPORTING PERIOD: JANUARY 2006 – DECEMBER 2007

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Acronyms

ABCT	AIDS Business Coalition of Tanzania
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Clinic
ARV	Anti Retroviral Drugs
BCC	Behavioral Change Communication
CARF	Community AIDS Response Fund
CBHC	Community Based Health Care
CBOs	Community Based Organizations
CPT	Cotrimoxazole Preventive Therapy
CSO	Civil Society Organizations
CSW	Commercial Sex Worker
DCT	Diagnostic Counseling and Testing
FBOs	Faith Based Organization
HBC	Home Based Care
HIV	Human Immuno Deficiency Virus
IDU	Injecting Drug Users
IEC	Information Education Communication
MARPs	Most-at-Risk-Populations
M&E	Monitoring and Evaluation
MKUKUTA	Mkakati wa Kukuza Uchumi na Kupunguza Umasikini Tanzania (National Economic Growth and Poverty Reduction Strategy)
MoEVT	Ministry of Education and Vocational Training
MoHSW	Ministry of Health and Social Welfare
MSM	Men Having Sex with Men
MTCT	Mother to Child Transmission of HIV
MVC	Most Vulnerable Children
NACP	National AIDS Control Programme
NMSF	National Multisectoral Strategic Framework on HIV&AIDS
OVC	Orphans and Vulnerable Children
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief (Emergency Plan
PLHA	People Living with HIV&AIDS
PMTCT	Prevention of Mother to Child Transmission of HIV
PSI	Private Sector Initiative
RCH	Reproductive and Child Health
RFE	Rapid Funding Envelope
RFA	Regional Facilitating Agencies
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
TACAIDS	Tanzania Commission for AIDS
TMARC	Tanzania Marketing & Communications
TB	Tuberculosis
TDHS	Tanzania Demographic and Health Survey
THIS	Tanzania HIV Indicator Survey
TOMSHA	Tanzania Output Monitoring System for Non-Medical HIV&AIDS Interventions
UN	United Nations
UNGASS	United Nations General Assembly Special Session

USG	United States Government
VCT	Voluntary Counselling and Testing
VMAC	Village Multisectoral AIDS Committees
VNRBD's	Voluntary, Non-Remunerated Blood Donas

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The generation of the 2006-2007 HIV and AIDS status of the national commitment to the UNGASS declaration in Tanzania Mainland involved a systematic consultative and consensus building process. The Tanzania Commission for AIDS (TACAIDS) provided the needed political environment for the data to be generated. TACAIDS would wish to recognize the critically important contributions made by colleagues from the public and private sectors, civil society organizations, faith-based groups, academia and the donor community and more important is their time taken to read, review and comment on earlier and subsequent drafts of this report and who also laboured relentlessly to ensure that the deadline of the report was met.

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To all we say thank you.

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Status at a glance

The Inclusiveness of the stakeholders in the report writing process

The report writing process involved all the stakeholders i.e. the people living with HIV; the government; development partners, the UN Family; Faith Based Organizations (FBOs); the Civil Society Organizations and the private sector. The stakeholders were involved in the data collection process, analysis and report writing. A small team of people representing the government, CSOs, the Joint UN team, and academic institutions did the data collection, analysis and report writing process. The zero and first drafts of the report were circulated to all stakeholders for comments and inputs to fill the information and data gaps. After the incorporation of all the comments and inputs, a meeting with representatives from all the stakeholders was held to validate the report. All the comments raised at the validation meeting were incorporated into this final report for Tanzania Mainland.

The Status of the Epidemic

The prevalence of the disease in Tanzania Mainland was estimated at 7.0% in 2003-4, whereby; it was 6.3% among males and 7.7% among females in the age group 15-49 years. The HIV prevalence rate among the antenatal clinic attendees in 2005/2006 was 8.4%[1] a decrease of about 0.3% from the estimated prevalence rate of 8.7% in 2003.[2] Revised estimates released from UNAIDS in January 2008 using Spectrum EPP indicate a 2007 prevalence of 6.2% (range from 5.8 – 6.6%). The revision represents changes in methodological approach rather than a decrease in prevalence.

Tanzania Mainland has a generalized HIV prevalence and the primary mechanism for HIV transmission in the country is unprotected heterosexual intercourse, which constitutes about 80% of all new infections.[3] Mother to child transmission is estimated to account for about 18% of new infections. About 1.8% of young persons aged 15 to 24 who reported that they never had sex were found to be HIV positive. This suggests that they were infected through blood transfusion, unsafe injections or traditional practices, including male circumcision or female genital cutting.

Data on population-based surveys are not available for 2006 and 2007. The only available data are based on the Tanzania HIV-AIDS Indicator Survey 2003-04 and the Tanzania Demographic and Health Survey, TDHS 2004-05. The data suggest that the most important factor fueling the HIV epidemic in Tanzania Mainland is higher risk sex i.e. having multiple partners and not using condoms. Generally, men are more likely to engage in risky sex behaviour than women. Other reports account trans-generational sex and multiple concurrent partners to be the factors fueling the epidemic in Tanzania.[4]

HIV knowledge and behavior data are summarized in Table 1, below. The status of behavioral changes in 2006 and 2007 is not known. Data collection process for the next report to be released by mid 2008 is underway.

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[1] Ministry of Health and Social Welfare, 2006, Surveillance of HIV and syphilis infections among ante natal clinic attendees 2005-6: National Aids Control Programme NACP, Nov. 2006.

[2] Ministry of Health and Social Welfare, 2005, Surveillance of HIV and syphilis infections among ante natal clinic attendees 2003-4: National Aids Control Programme NACP, April. 2005

[3] National Multisectoral Strategic Framework 2008 - 2012

[4] PEPFAR implementers meeting in Kigali June 2007)

Table 1: HIV Knowledge and Behaviour Changes 2003-4 to 2004-5

Indicator	Status	
	THIS 2003-04	**TDHS 2004-05**
Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.	15-19 (42.6%) 20-24 (56.5%)	15-19 (40.9%) 20-24 (50.1%)
Percentage of most at risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.	Data not Available	Data not Available
Percentage of young women and men aged 15-24 who have had sexual intercourse before age 15.	15-19 (10.1%) 20-24 (11.1%)	Women 15-19 (11%); Men 15-19 (13%)
Percentage of women and men who have had sexual intercourse with more than one partner in the last 12 months.	Women (6%) Men (27%)	Women (4%) Men (30%)
Percentage of women and men aged 15-49 who had more than one sexual partner in the 12 months reporting the use of condom during last sexual intercourse.	Women 15-24 (41.7%) Men 15-24 (49.7)	Women 15-24 (27.5%) Men 15-24 (45.5%)
Percentage of female and male sex workers reporting the use of a condom with their most recent client	Data not available	Data not available
Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Data not available	Data not available
Percentage of injecting drug users reporting the use of a condom the last they had sexual intercourse	Data not available	Data not available
Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	Data not available	Data not available

Source: THIS 2003-04 and TDHS 2004-05

Awareness on the way the virus is spread resulting into changes in sexual behavior are important determinants that contribute to the spread or reduction of HIV & AIDS. Statistics shows that young people are aware on HIV prevention: 44% of young women and 49% of young men know five 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 and 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 risky sexual activity in the past one year, only 47% men and 42% women were more likely to use a condom.

There are several reasons for the tendency of young people to engage in risky sexual behavior including peer pressure, idleness and despair due to either lack of employment or opportunities to advance through education and skills building, lack of coherent information and mentoring on sexual issues, immoral cultural practices/customs promoting promiscuity, and poverty, and at times curiosity. Efforts to disseminate information for behavior change needs to involve a degree of understanding regarding the widely held beliefs and practices in the target audience.

World Bank studies estimated the number of children orphaned by AIDS to be increasing from between 260,000 to 360,000 in 1995 to between 490,000 and 680,000 by the year 2000. Estimates

by UNAIDS put the number of orphans due to AIDS at 1,100,000. Another study by UNAIDS projected that by the year 2010 there will be 4.2 million AIDS orphans in Tanzania (UNAIDS, 2001).[5] However, the latest estimates of the number of OVC in the country shows that there were 946,614 in 2007 and it is projected that there will be 1,044,096 OVC by 2010.[6]

The Policy and Programmatic Response

The Multi-sectoral HIV and AIDS Public Expenditure Review 2005-06 shows that government recurrent spending on HIV and AIDS nearly doubled between 2004-5 and 2005-6. The development partners accounted for around 90% of total public expenditure on HIV & AIDS during 2005/6. Total expenditure on HIV & AIDS (including donors off-budget spending) was equivalent to roughly 5.6% of Government spending in 2005/6, Development partners HIV funding sources includes the Global Fund Round 1 ($ Million US$), Round 3 (8.7 Million US$), and Round 4 (293.3 Million US$); PEPFAR, and the Rapid Funding Envelope (RFE) which is a bilateral development partners pooled resources to support CSO HIV & AIDS responses; and the Joint UN support. Besides, the bilateral development partners also support a number of HIV response programme implemented by individual CSOs and FBOs.

AIDS spending study (on-going)

Currently, the MoHSW in collaboration with partners is carrying out a study on HIV and AIDS spending. Very early preliminary findings are attached as annex (pg 41). The final outcome of the study would provide a more insight on the clear picture of the HIV resource needs and expenditures for both planning and policy decisions.

UNGASS indicator data in an overview Table

The Table below provides the agreed upon UNGASS indicators for Tanzania for the period 2003/04 to 2006/07.

Table 2: Core Indicators for the Implementation of the Declaration of Commitment on HIV & AIDS 2008 Reporting

	INDICATORS BY YEARS		**2003/2004**	**2004/2005**	**2005/2006**	**2006/2007**	**Data Source**
	National Commitments and Action				119.9	62	PER, 2007
1	Domestic and international AIDS spending by categories and financing sources (*Billions TZ. Shillings*)	Domestic			204.2	377.8	PER, 2007
		External					

[5] Final Health Sector Strategy for HIV & AIDS (2008-2012)

[6] Ministry of Health and Social Welfare, 2007, The Costed Most Vulnerable Children (MVC) Action Plan (2007-2010).

	INDICATORS BY YEARS		2003/2004	2004/2005	2005/2006	2006/2007	Data Source
2	National Composite Policy Index (Areas covered: gender, workplace, programmes, stigma and discrimination, prevention, care and support human rights, civil society involvement and monitoring and evaluation)				Good (rating between 5 and 10)	Good (rating between 5 and 10)	Questionnaires Part A&B
	National Programmes						
3	Percentage of Donated Blood Units screening for HIV in a quality assurance manner		100	100	100	100	Ministry of Health and Social Welfare
4	Percentage of Adults and Children with advanced HIV infection receiving antiretroviral therapy				20	20	NACP
5	Percentage of HIV-positive pregnant women who received antiretroviral to reduce the risk of MTCT			53	53	55	NACP
6	Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV		13.06	12.87			
7	Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and know their results.		6.02	12		36	THIS and National VCT Campaign
8	Percentage of most at risk populations that have received an			DNA	DNA	DNA	

	INDICATORS BY YEARS		2003/2004	2004/2005	2005/2006	2006/2007	Data Source
	HIV Test in the last 12 months and who know their results						
9	Percentage of most at risk populations reached with HIV prevention programmes			DNA	DNA	DNA	
10	Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child			1.2			
11	Percentage of schools that provided life skills-based HIV education in the last academic year					75	MOEVT
	Knowledge and Behaviour						
	Current school attendance among orphans and among non-orphans aged 10-14	Orphans				73	MoHSW
12		Non-Orphans					
13	Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.	Women	46.3	45.3		49	THIS and DHS
		Men	54.2	41.0		44	THIS and DHS
14	Percentage of most at risk populations who both correctly identify ways of preventing the sexual			NA	NA	NA	

	INDICATORS BY YEARS		2003/2004	2004/2005	2005/2006	2006/2007	Data Source
	transmission of HIV and who reject major misconceptions about HIV transmission.						
15	Percentage of young women and men aged 15-24 who have had sexual intercourse before age 15.[3]	Women		12.7		10.1	
		Men		9.6		10.7	
16	Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months.	Women	5.0	DNA		36 (data for women aged 15-24 only)	
		Men	20.0	DNA		81 (data for men aged 15-24 only)	
17	Percentage of women and men aged 15-49 who had more than one sexual partner in the 12 months reporting the use of condom during last sexual intercourse.	Women		27.4		42	
		Men		51.1		47	
18	Percentage of female and male sex workers reporting the use of a condom with their most recent client			NA	NA	NA	
19	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner		58		NA	NA	
20	Percentage of injecting drug users reporting the use of a condom the last they had sexual intercourse			NA	NA	NA	

	INDICATORS BY YEARS		2003/2004	2004/2005	2005/2006	2006/2007	Data Source
21	Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected			NA	NA	NA	
	IMPACT						
22	Percentage of young women and men aged 15-24 who are HIV infected	Women (ANC Attendees)	8.7		8.2		NACP
		Men	6.3	6.3			THIS
23	Percentage of most at risk populations who are HIV infected			NA	NA	NA	
24	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Adults					
		Children					
25	Percentage of infants born to HIV infected mothers who are infected.						

Note: DNA= Data either not Available or available but not categorized in age groups corresponding to the required UNGASS reporting format

OVERVIEW OF THE HIV & AIDS EPIDEMIC

Trends of Prevalence

So far Tanzania has conducted three rounds of Ante-Natal Care (ANC) Surveillances. The first round of the intensified survey was conducted by NACP in 2001/02, the second survey was conducted in 2003/04, and the third survey in 2005/06. Data from the three survey rounds are used to describe the trends of the epidemic in mainland Tanzania.

The first survey round involved 24 clinic sites in 6 regions; the second involved 57 sites in 10 regions; and the third survey involved 92 sites in 15 regions. The second and third survey rounds incorporated all the 24 sites that were surveyed in the first round, making it possible to relate data of the 24 clinics collected during the three time periods. The total population enrolled for the 1st, 2nd and 3rd surveys were 7,275, 17,813 and 31,224 ANC attendees respectively.

General prevalence

Since the first three HIV & AIDS issues were detected in 1983 in Kagera Region, the figures of reported cases have been on the increase with women being more infected compared to men

(6.3% versus 7.7%). Based on the data obtained recently through the HIV Validation Survey and the Ante-Natal Clinic (ANC) Surveillance, the HIV prevalence rates in Mainland Tanzania's community has remained almost constant since 2001.

The 2005/06 Surveillance report on HIV and Syphilis infections among Antenatal Care attendees suggests that; of the 31,224 women attended, 2,546 tested HIV positive resulting in an overall HIV prevalence of 8.2%. Age-specific HIV prevalence was highest in women aged 25-34 years (9.9%) compared to those aged 15-24 years (6.8%) and 35+ years (8.1%). Single women had higher prevalence than married women (8.9% versus 8.1%). Overall, women with secondary school education or more had the highest HIV prevalence (9.3%), while women with no education had the lowest prevalence (5.5%). This could be attributed to the fact that educated women are more likely to be urban based where HIV prevalence rates are higher as compared to rural areas where women with less education area more likely to reside.

Furthermore the urban inhabitants have considerably higher transmission levels (10.9%) than rural inhabitants (5.3%).[7] Occurrences for both women and men increase with age until it reaches a climax for women at age 30-34 (12%) and ten years later for men at age 40-44 (9.6%) whereby women with the same age in rural areas have 5.8% and men of the same age are at the rate 4.8%. HIV & AIDS prevalence among separated/divorced/widowed persons is significantly higher (15% among men and 19.8% among women) while those currently in unions/remarried are average (men 7.8% and women 6.9%) and among those who are not in union are low (men 3% and women 3.8%). HIV & AIDS prevalence also seems to increase with wealth (poorest men 4.1% and women 2.8%) while the among the richest people are high (men 9.4% and women 11%) Many factors could account for these variations.

Regional prevalence

Prevalence trends of the epidemic have shifted from the North-Western part of the country (Kagera, where it started) to the Southern Highlands and the Eastern Coast. The HIV & AIDS epidemic shows strong regional variation ranging from the highest HIV & AIDS prevalence in Iringa (18.2%) Mbeya (15.9%), and Dar es Salaam (10.9%) to the lowest prevalence in Kigoma (3.5%) and Kagera (4.7%) (Figure1). This shows that while there is a decrease in infection in regions like Kagera which had the highest infection rates in the 1990s these rates have dramatically decreased while on the other hand there is an increase of HIV & AIDS transmission in other region like Mbeya and Iringa. The three highest-ranking regions are also the one in the major travel routes into and out of the country while the regions with the lowest rates do not have major routes.

HIV Infection among TB Patients

Presently about 52% of TB patients in Tanzania are also co-infected with HIV. Subsequently, the trend has changed and death rates have increased among the co-infected TB patients, which makes it difficult for the programme to reach the WHO cure rate target of 85%.[8]

Syphilis Prevalence

The latest surveillance report of ANC attendees (2006) where a total of 30,877 ANC attendees were tested for syphilis, 2126 tested positive. The overall syphilis prevalence was 6.9% (95% CI

[7] (MoHSW, 2006).
[8] Global Fund Round 7 Proposal

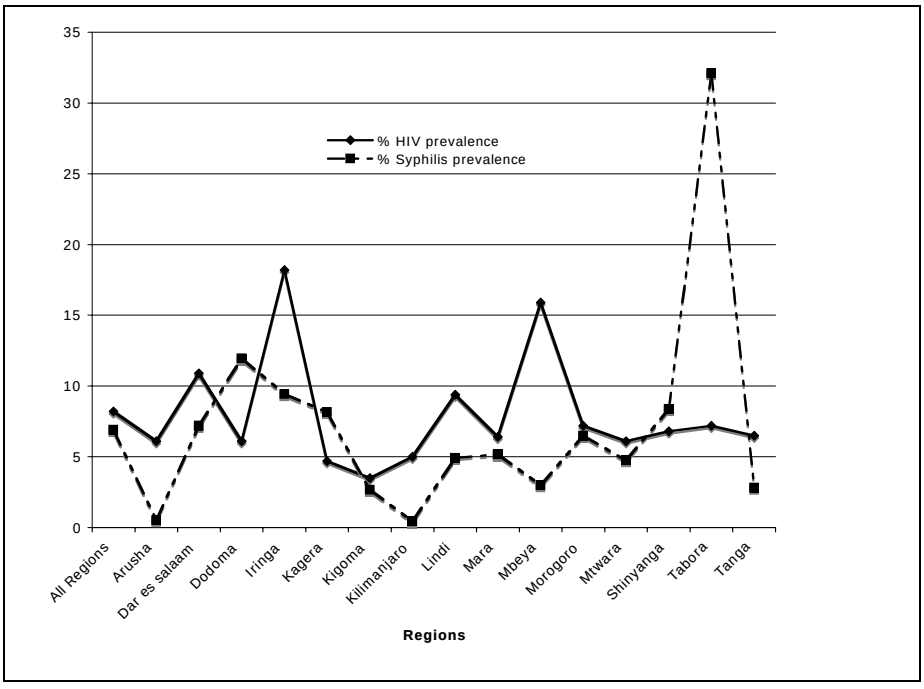
= 6.6-7.1), ranging from a low of 0.43% (95% CI = 0.16-0.9) in Kilimanjaro region to a high of 32.1% (95% CI = 29.0-34.4) in Tabora region (Figure 1).

Furthermore the prevalence of syphilis was highest among attendees from rural clinics 9.7%, than those from urban clinics 6.3% and lowest among semi-urban clinic attendees 5.9% ($p < 0.001$).). The age specific prevalence of syphilis was 6.5% for age group 15-24, 7.3% for age group 25-34 and 7.4% for age group 35-49. However, the observed differences in age-specific prevalence were not statistically significant ($p > 0.05$). In addition marital status did not appear to have a significant influence on the prevalence of syphilis ($p > 0.05$). Prevalence increased with the number of previous pregnancies from 6.3% among those with no previous pregnancies to 9.4% among those with more than five previous pregnancies ($p < 0.001$).

HIV and the Most at Risk Populations

Reports show that there is an increase in the number of Injecting Drug Users (IDUS) in Tanzania.[9] Some CSOs, district health services, the Infectious Diseases Clinic and mental health services at the Muhimbili National Hospital are providing services i.e. counseling and support for drug users in Dar es Salaam. However, these services have never been evaluated and have not been consistent over the years.[10] Studies to establish the magnitude of the problem in other regions are still lacking.

Figure 1: Prevalence of HIV and Syphilis by Regions (2005/2006)



Source: Ministry of Health and Social Welfare (National AIDS Control Program), 2007, Report Number 20.

[9] Editorial, 2007, Harm reduction in Tanzania: An urgent need for Multisectoral intervention. International Journal of Drug Policy, (18) 155-159.

[10] Mndeme, Magimba, Kaaya, Mbwambo and Kilonzo, 2006, cited in the Editorial, 2007, Harm reduction in Tanzania: An urgent need for Multisectoral intervention. International Journal of Drug Policy, (18) 155-159

Factors fueling the HIV epidemic in Tanzania Mainland

Tanzania Mainland has a generalized HIV prevalence and the primary mechanism for HIV transmission in the country is unprotected heterosexual intercourse. The most important factor fueling the HIV epidemic is higher risk sex. According to the Tanzania HIV Indicator survey 2003-04, among women and men who were sexually active in 12 months preceding the survey, 23 percent of women and 46 percent of men engaged in higher risk sex in 12 months preceding the survey. It was further found out that, about 4 out of 10 women (38%) and half of the men (50%), reported using a condom in the most recent higher risk sexual behaviour.[11]

National response to the AIDS epidemic

Policy Level Responses

Tanzania is committed to the Three Ones principle by having one HIV & AIDS coordinating body, one national multi-sectoral strategic framework providing strategic direction to the implementation of HIV & AIDS activities, and one monitoring and evaluation (M&E) framework to monitor and measure the national HIV & AIDS response initiatives at country level

The Tanzania Commission for AIDS (TACAIDS) is the HIV & AIDS coordinating body established in 2001 to provide strategic leadership on the national multi-sectoral response to HIV & AIDS by leading stakeholders in the formulation of related policies, coordination of multi-sectoral AIDS responses, advocacy and resource mobilization. The coordination and management of the health sector's HIV & AIDS response, including care and treatment and preventive services including voluntary counseling and testing (VCT) is undertaken by the National Aids Control Programme (NACP) under the Ministry of Health and Social Welfare.

The government of Tanzania in July 2007, launched its second National Multi-sectoral Framework (NMSF) on HIV & AIDS to cover the period from 2008 to 2010. The second NMSF builds on the achievements and strength of the first NMSF, which covered the period from 2003 to 2007. The second NMSF priority focus is on the enhancement of the enabling environment; prevention; care, treatment and support; and impact mitigation. The new critical areas addressed in the second NMSF includes the Most at Risk Populations (MARPs) including protocols for performance measurement. The main concern on MARPs is the reduction of HIV infection among those most vulnerable due to gender inequality, sexual abuse, socio-cultural factors, women engaging in commercial as well as transactional sex, sexually abused children, widows and divorcees, men having sex with men (MSM), prisoners, refugees and displaced people, people with disabilities and intravenous drug users.

Funding of HIV Responses

The Multi-sectoral HIV & AIDS Public Expenditure Review (PER) 2005-06 shows that government recurrent spending on HIV and AIDS nearly doubled between 2004-5 and 2005-6. The denvelopment partners accounted for around 90% of total public expenditure on HIV & AIDS in 2005/6. Total expenditure on HIV-AIDS (including donors off-budget spending) was equivalent to roughly 5.6% of Government spending in 2005/6. The 2006-07 HIV & AIDS PER shows that total government plus donor spending on HIV & AIDS increased by two thirds in real inflation adjusted terms in 2006/7 (Table 3).

[11] Tanzania HIV Indicator Survey (THIS) 2003-04.

Table 3: Total HIV & AIDS Expenditure and Financing

Tanzanian Shillings Billions	2005/6 Actual	Budget 2006/7	Actual 2006/7	Budget 2007-8
Total Budget expenditure on HIV & AIDS	119.9	71.7	62.0	157.2
Total ODA for HIV & AIDS	204.2	330.6	377.8	568.2
Estimated Total Public & Donor Expenditure on HIV & AIDS	226.0	354.9	399.2	595.7

Source: 2006-07 HIV & AIDS PER

Aid increased by three quarters, and now finances 95% of Government plus donor spending. The increase has been from off-budget sources of finance, and only 19% of expected aid in 2007/8 is included in the budget. HIV & AIDS is now taking a staggering one third of all aid to Tanzania[12]

Tanzania has already benefited from HIV funds from the Global Fund in Round 1 ($ Million US$); round 3 (8.7 Million US$); and round 4 (293.3 Million US$); which included components to scale up VCT, TB, HIV & AIDS care, treatment, and support services, and mitigate the impacts of the epidemic on orphans and vulnerable groups (OVC). Global Fund support also includes the procurement of ARVs and laboratory equipment. In addition, Tanzania is one of the rapid scale-up programmes for PEPFAR. PEPFAR partners are working directly with service providers i.e. CSOs and FBOs at the district and local community levels.

According the 2006-2007 PER, care and treatment represented 64% of combined US and Global Fund spending in 2006/7. Prevention was just 15% of total expenditure; economic and social support about 8%. Spending on care and treatment by these two donors alone represents 55% of all expenditure on HIV/AIDS in 2006/07.

Table 4: HIV-AIDS and TB Funding from the Global Fund

Round	Year	Component	Amount Requested USD	Approved USD	Disbursed USD
1	2002	HIV-AIDS	5,400,000	4,647,000	4,646,000
3	2003	HIV-TB	83,466,904	83,466,904	20,432,050
4	2004	HIV-AIDS	283,092,248	79,741,826	75,599,427
6	2006	TB	35,111,404	16,498,946	7,699,656
7	2007	Malaria RCC	59,900,000		
Total			**466,970,556**	**184,354,676**	**108,377,133**

Source: TACAIDS

The Multi-sectoral HIV & AIDS Public Expenditure Review (PER) 2005-06 also suggests that the World Bank and GFATM Round 3 has been the main sources of funding of LGA budgets. Furthermore, funding has been unpredictable with respect to both timing and amount. The 2006-07 PER indicated that Health-related HIV/AIDS expenditure at LGA level is mostly off budget except for some health basket funding. GFATM provides about half of central funding for LGAs, but less than half of LGAs benefit from this funding. This is mainly because funds

[12] HIV & AIDS Public Expenditure Review

from the GFATM are earmarked to a specific number of districts as originally stipulated in the GFATM proposals.

Furthermore, the Civil Society Organizations (CSOs) are receiving funding to respond to HIV & AIDS from the World Bank financed Community AIDS Response Fund (CARF), administered by Regional Facilitating Agencies, each of which has been contracted to both administer the grants and provide capacity building support to councils and CSOs.[13] CSOs are also funded by PEPFAR and other partners through the Rapid Funding Envelope (RFE).[14] Around US $5 Million have already been given to 50 CSOs countrywide through the RFE between 2002 and 2006.

Community Level HIV Prevention Services

There has been a broad and growing recognition of the need to intensify and accelerate actions towards universal access to comprehensive HIV prevention, treatment, care and support. The summery of the various efforts are provided in (Table 5 below). The government of Tanzania recognises the importance of wide involvement of stakeholders at the community level in scaling-up HIV responses and ensuring access to essential services by the PLHAs. To this effect the Government of Tanzania in collaboration with stakeholders have established Multisectoral AIDS Committees at District, Ward and Mtaa (in urban areas) and Village levels.

The establishment of the Multisectoral AIDS Committees has facilitated scaling up HIV & AIDS responses from a social-cultural-and behavioural change point of view as opposed to the medical-epidemiological focus. The Multisectoral AIDS committees are composed of stakeholders from the community members, government departments and agencies, CSOs, FBOs, and CBOs. In 2004, training to build the capacity of the committees was undertaken in all the districts countrywide. Capacity building training continues from 2005 to 2007 for the Ward, Mtaa and village levels, though coverage varies from district to district depending on the number of Wards, and Villages as well as "Mitaa" in the district.

Table 5: Type of community-based HIV prevention provided in the period 2006 to 2007

	Type of community-based HIV prevention provided	Situation as of December 2007
1	**Establishment of Multisectoral AIDS Committees at District, Ward, and Village and Mtaa levels**	The Government of Tanzania in collaboration with stakeholders have established Multisectoral AIDS Committees at District, Ward and Mtaa (streets in urban areas) and Village levels to facilitated scaling up and involvement of all stakeholders at the District and community level in HIV &AIDS responses.
1	**Information, Education and Communication (IEC) programmes**	(i) The most popular form of communication is TV, and radio, daily newspapers, posters and billboards Messages on HIV & AIDS (ii) Message about condom use have been more prominent than messages on abstinence and being faithful (iii) IEC materials to facilitate awareness-raising and clinic-based services demand creation among the MARPs to use HIV & AIDS related services (VCT, PMCT, STI, Care and Treatment), as well as Sexual Reproductive Health (SRH) services are still lacking

[13]TACAIDS, 2007, Multi-sectoral—HIV-AIDS Public Expenditure Review 2005-06,

[14] Funds for the RFE are contributed by The Canadian International Development Agency; Ireland AID; The Swiss Agency for Development and Co-operation; The Embassy of Finland; The Royal Netherlands Embassy; The Royal Danish Embassy; The Royal Norwegian Embassy; The United States Agency for International Development (USAID).

	Type of community-based HIV prevention provided	Situation as of December 2007
2	**Peer Education**	(i) Peer education is a strategy that has been shown to have some success in promoting positive SRH behaviour, but it is inadequately used. (ii) There is still limited community-level IEC/BCC efforts and a weak linkage of IEC/BCC to health services.
3	**Condom promotion and distribution**	*i) Promotion of condom access points:* Condom promotion is undertaken by the Population Services International (PSI) Tanzania (a condom social marketing agency), as well as by other CSOs. Condom promotion is done through TV and use billboards, promotional materials or stickers to inform the public about condoms. There is an increase in the proportion of the sexually active population, especially in the urban and rural areas, who use condoms consistently and correctly. Promotion and expansion of the availability of female condoms as a female controlled and dual protection method is taking place though very few people have received such knowledge. Table 5 shows condom distribution in Tanzania Mainland *(ii) Demand for condoms:* Statistics shows that **68 percent** of young women (20-24) had sex by the age of **18**; 14% of young women (15-24) used a condom at first sex; **43 percent** of young men (20-24) had sex by the age of **18**; 20% of young men (15-24) used a condom at first sex. *(iii) Supply of Condoms:* 75,041,214 and 121,020,692 male condoms were distributed in the fiscal years 2006 and 2007 while 526,060 and 1,127,909 female condoms were distributed in the same fiscal years respectively (iv) According to the TDHS, 2004), 60% of all new HIV infection in Tanzania occurs among youth aged 15 – 24 years (TDHS, 2004). However, half of all women and almost one-quarter of men aged 15-24 still do not know where to get a condom and more critical is in many areas in rural set-ups. This is an area requiring efforts by all
4	HIV Workplace Programmes	(i) *Public sector:* There is a HIV focal person in each of the Ministries, Departments and government Agencies. *(ii) Private Sector:* The AIDS Business Coalition of Tanzania (ABCT) which represents businesses, private sector institutions and labor organizations in matters relating to HIV & AIDS, offers services and advice and lobbies for private sector interests to facilitate the introduction of HIV workplace programmes. (ii) TOMSHA HIV M&E routine monitoring system reports from 500+ organization for the April to June 2007 quarter indicated that 747 organizations had an annual work plan for HIV workplace programmes; 371 approved budgets for the work plans; 231 organizations had funds available for implementing and coordinating the activities; and 292 organizations were already implementing their work plans. (iii) A comprehensive status of HIV Workplace programme is yet to be known. The government plans to undertake workplace survey of 30 largest employers, 25 from the private sector, and 5 from the public sector
5	**HIV Prevention for out-of-school and in-school youth**	(i) According to the National Adolescent Health and Development Strategy (2004-2008), adolescents constitute a significant proportion of the population estimated at about 31%. A high percentage of adolescents are sexually active and practice unsafe sex. This constitutes a major factor for vulnerability to sexual and reproductive health problems. These problems include adolescent pregnancy and child bearing, complications of unsafe abortion, sexually transmitted infections and HIV & AIDS. (ii) Health facilities in public, private and NGOs offer a range of health services including those needed by adolescents. However, available reproductive and STI/HIV services are adult-centred thus making them less friendly and accessible to adolescents. Adolescents especially those in rural areas, most vulnerable adolescent groups (adolescents with disabilities, girls, street children, adolescents living with HIV, younger adolescent's age 10-14 yrs etc.), constitute a big number of an underserved population group (iii) Situation to date (Implementation effort or level) • National RCH communication strategy 2002-2007 implemented and

	Type of community-based HIV prevention provided	Situation as of December 2007
		due for revision. • Draft National documents on peer education standards in the development process. • Peer Education training curriculum and manual is being pre-tested by actual application • Para-professional curriculum and manual is being pre-tested by actual application • National RCH community theatre guide developed but not yet printed.
7	**Pre-marital voluntary HIV counseling and testing**	It is common practice now for people to go for premarital voluntary HIV counseling. Premarital voluntary HIV counseling is emphasized in all religions in the country
8	**HIV prevention for The Most at Risk Populations (MARPS)**	(i) Surveillance of Most At Risk Populations (MARPs) has not been done yet and Centre for Disease Control and Prevention (CDC) is currently training NACP staff on methodology of how to conduct a MARPs survey. (ii) The only available data is the proportion of men, by age group, who have sex with sex workers (1.5%), which is provided in the Tanzania HIV & AIDS survey (2004). (iii) The MARPs as vulnerable groups are being recognized in the national health services strategies. The new Health Sector HIV & AIDS Strategic Plan (2008-2012) provides for strategic intervention for the MARPs. (iv) In addition, the CSOs are providing condoms to sex workers and counseling services to MARPs. However, these services are still limited and are mostly urban based

Source: NMSF, 2008-2012; Global Fund Round 5, 6, and 7 proposals, TACAIDS Annual Reports

The government also through a loan from the World Bank has established the Community HIV & AIDS Response Fund (CARF), with a view to both complementing and strengthening the support envisioned through existing government systems. CARF is one of the four components of the World Bank funded Tanzania Multi-sectoral AIDS Project (TMAP), with the other components being the Public Sectors Fund (PSF), Support to TACAIDS and Support to Zanzibar. Specifically, CARF is aimed at enhancing the capacity of communities and local government authorities (councils) to respond determinedly to the HIV & AIDS epidemic, which is consistent with the strong emphasis placed on the communities and local government councils in the first National Multi-sectoral Strategic Framework (NMSF) on HIV & AIDS for 2003-07 and the second NMSF 2008-2012.[15]

The CARF is earmarked for providing technical support to Regional Secretariats (RSs), Local Government Authorities (LGAs) and the Village Council Multi-sectoral HIV & AIDS Committees (VMACs). CARF also is intended to facilitate the provision of technical and financial support to NGOs, FBOs, CBOs and Community Groups in order to improve their performance and competence in HIV & AIDS interventions.

Between April 2005 and September 2007 a total of 6.1 Billion Tanzanian shillings were distributed to 12 regions for enabling CSOs respond to the HIV pandemic at the community level. Activities for prevention of HIV constituted the largest share i.e. 38% of the total funds disbursed to the CSOs, followed by impact mitigation (30%) (see Table 6).

[15] Community HIV & AIDS Response Fund, (CARF) guidelines, TACAIDS

Table 6: Distribution of Disbursed Funds for District Community Response April 2005 to September 2007

	Prevention	Care & Support	Impact Mitigation	Enabling Environment	Total Tshs
Iringa	388,358,490	139,609,700	413,522,380	207,879,700	1,152,370,270.00
Ruvuma	263,903,105	28,372,240	240,550,845	21,096,850	553,923,040.00
Kagera	156,157,445	65,026,075	159,831,615	48,558,150	429,573,285.00
Mwanza	312,744,517	102,636,200	273,351,693	212,503,050	901,235,460.00
Tabora	73,514,492	59,171,496	80,059,750	30,456,400	243,202,138.00
Kigoma	275,499,690	112,185,000	92,014,050	94,991,250	574,689,990.00
Arusha	120,288,784	78,994,145	41,331,950	20,762,000	261,376,879.00
Manyara	154,471,550	77,065,500	95,409,250	18,023,600	344,969,900.00
Coast	152,079,370	67,071,205	126,094,950	30,895,600	376,141,125.00
Morogoro	204,613,420	25,540,480	129,133,630	52,185,370	411,472,900.00
Singida	71,217,650	272,143,988	78,284,166	17,674,600	439,320,404.00
Dodoma	147,824,543	149,024,325	68,587,300	10,987,275	376,423,442.50
Total	**2,320,673,056**	**1,176,840,354**	**1,798,171,579**	**766,013,845**	6,064,698,833.50
%	**38**	**19**	**30**	**13**	100

Source: TACAIDS

Development partners have also established the Rapid Funding Envelope (RFE) as a funding window to support community level responses to HIV by the CSOs. The RFE provides 6-to-12 month grants of $50,000 to $200,000 to civil society organizations for urgent activities that bring quick results and which fall within the national response to the HIV epidemic.[16] Between 2002 and 2006, around 5 Million US$ have already been given to 50 Organizations.

Home Based Care and Support for People Living with HIV &AIDS

Currently there are several HIV & AIDS and RCH interventions going on in communities such as home based care services (HBCs) for people living with HIV, community based reproductive and child health services (CBD) providing family planning and other RCH services and community based integrated management of childhood illnesses. A total of 6800 community based health workers have been trained to provide such services. Of these 5400 are CBD and 1400 are HBC providers.[17]

However, generally Home Based Care (HBC) initiatives in Tanzania mainland are public health orientated and not adequately mainstreamed into other community based development programmes. At the community level, home based care providers are still few and under capacitated. In addition the village HIV committees supposed to guide them are also ART illiterate. With the exception of CSOs supported HBC in some few areas, the government supported HBC providers in many areas are unable to respond to many of the social support needs of people living with HIV-AIDS e.g. food, transport, medicines, education, and economic support.

[16] RFE Funds contributed by The Canadian International Development Agency; Ireland AID; The Swiss Agency for Development and Co-operation; The Embassy of Finland; The Royal Netherlands Embassy; The Royal Danish Embassy; The Royal Norwegian Embassy; The United States Agency for International Development (USAID).
[17] Global Fund Round 7 Proposal for Tanzania Mainland

Condom promotion and distribution

Tanzania is implementing a $22 million "*Tanzania Marketing & Communications (TMARC)"* project under the funding of USAID for five-years. The primary objectives of the TMARC Project are:

a) Develop and manage a cost-effective marketing, sales and distribution network that improve access by key populations to branded products related to HIV & AIDS prevention and care, reproductive health and child survival.
b) Develop and manage a broad-based communications initiative that enhances the knowledge of Tanzanians about core issues related to HIV & AIDS, reproductive health and child survival, including accurate information about relevant products and services as well as persuasive information to encourage and sustain healthy behaviors.
c) Establish and maintain practical partnerships with one or more locally controlled organizations from Tanzania's commercial, non-governmental and/or faith-based sectors for key roles in the ongoing management and implementation of the project.
d) Work closely and purposefully with other organizations and agencies engaged in similar programmatic areas to address issues of coverage and consistency related to the distribution of dependable products and the dissemination of accurate information.

The T-MARC initiatives have achieved demonstrable results over the last three years. There has been a progressive increase in the distribution of condoms in the country by 27% (from 59,000,000 to 75,041,214 condoms) between 2005 and 2006 fiscal year and by 61% (from 75,041,214 to 121,020,692 condoms) between 2006 to 2007 fiscal year (Table 7). Condoms are stocked in 94% of Bars and 80% of Bear groceries. The market share of different brands of condoms consumed by the Most-at-Risk however is still small.

TOMSHA has been rolled out and already around 40% of CSOs reported to TACAIDS on the condom distribution in the communities. A comprehensive status of condom distribution at community level will be provided in the year 2007/08 Annual HIV-AIDS response report.

Table 7: Impact of T-MARC interventions on the "Total Market" for Condoms

Item	Fiscal Year 2005	Fiscal Year 2006	Fiscal Year 2007
Male Condom Supply Market (units)			-
Social Marketing	22,000,000		
Dume (Shelys)		4,152,456	8,302,058
Salama (PSI)		55,196,928	64,422,265
Raha/Life Guard (Marie Stopes)		1,429,830	2,854,076
Commercial Sector (Various)			2,209,167
Public Sector	37,000,000	14,262,000	43,233,126
Total Market	**59,000,000**	**75,041,214**	**121,020,692**
Male Condom Market Share (based on units supplied)			-
Social Marketing	37%		
Dume (Shelys)		6%	7%
Salama (PSI)		74%	53%
Raha/Life Guard (Marie Stopes)		2%	2%
Commercial Sector (Various)			2%
Public Sector	63%	19%	36%
Female Condom Market (units)			
Social Marketing			
Care (PSI)	129,950	141,840	271,229
Lady Pepeta (Shelys)	-	384,220	856,680
Total Market	**129,950**	**526,060**	**1,127,909**
Female Condom Market Share (based on units)			
Social Marketing			
Care (PSI)	100%	27%	24%
Lady Pepeta (Shelys)	0%	73%	76%
Male and Female Condom Market Share (based on user surveys)			
Male Most-at-Risk Groups: Police, Truck Drivers, Miners			
Salama (PSI)		43%	
Dume (Shelys)		21%	
Rough Rider (Ansell/JD Pharmacy)		3%	
Raha (Marie Stopes)		26%	
Other*		8%	
Female Most-at-Risk Groups: Sex Workers, Barmaids			
Salama (PSI)	44%		
Dume (Shelys)		23%	
Rough Rider (Ansell/JD Pharmacy)		17%	
Raha (Marie Stopes)		2%	
Lady Pepeta (Shelys)		2%	
Care (PSI)		2%	
Other*		9%	
Male Condom Market Share (based on user surveys)			
Private Sector		80%	

Item	Fiscal Year 2005	Fiscal Year 2006	Fiscal Year 2007
Public Sector		20%	
Percentage of target groups who have positive attitudes toward condoms sold by the private Sector			
Social marketing brands		69%	
Commercial brands		56%	
Number of retail outlets that stock condoms (PEPFAR)			
Dume		10,729	32,400
Lady Pepeta		307	926
Percentage of retail outlets that stock condoms			
Percent of retail outlets that stock condoms			
All Outlets			81%
Nightclubs			10%
Bars			94%
Beer groceries			80%
Condom availability in all retail outlets by brand			
Salama			74%
Dume			38%
Raha			10%
Life Guard			21%

Source: T-MARC

HIV prevention at facility level

Screening of donated blood units for HIV in a quality assurance manner

The National Blood Transfusion Service (NBTS) was established in Tanzania in response to call from the World Health Assembly Resolution WHA 28.72 (1972) that urged all member states to develop comprehensive and well-coordinated blood transfusion services based on voluntary, non-remunerated blood donation. Currently Tanzania has a total of seven (7) Zonal Blood Transfusion Service centres of which six are located in Tanzania Mainland and one in Zanzibar (Table 8). Available statistics suggest that, all (ie 100%) voluntary, non-remunerated blood donated is screened for HIV in a quality assurance manner. HIV sero-positive is currently below 4% in the voluntary, non-remunerated blood donated between July 2006 and December 2007 (Table 9).

Table 8: Zonal Blood Transfusion Services in Tanzania

	Blood Transfusion Services in Tanzania	Location
1	Lake Zone	Mwanza
2	Western Zone	Tabora
3	North Zone	Moshi
4	Eastern Zone	Dar es Salaam
5	Southern Highlands Zone	Mbeya
6	Southern Zone	Mtwara
7	Zanzibar Zone	Zanzibar

Source: National Blood Transfusion Services, Ministry of Health and Social Welfare

Table 9: Rate of HIV sero-positive in the voluntary, non-remunerated blood donated between July 2006 and September 2007

Period	Blood Units Collected from VNRBDs	HIV Sero-positive report (in %)
July – September 2006	14,482	2.37
October – December 2006	12,337	2.33
January to March 2007	20,117	3.07
April – June 2007	13,485	3.74
July – September 2007	27,680	2.77

Source: National Blood Transfusion Services, Ministry of Health and Social Welfare

Counseling and Testing

Tanzania is currently implementing a national HIV testing campaign that was inaugurated by His Excellency, President Jakaya Mrisho Kikwete on 14th July 2007. The president, other top government leaders, members of the community as well as people from the community of development partners took the test on the launching day of the campaign. The inauguration was followed by campaigns allover the country to open new testing sites and to encourage people to go for VCT using the media and posters. By the end of December 2007, a total number of 3.2 million people had already undergone the testing. This is 78% of the targeted number of 4.2 Million people by the end of the year (Table 10). The number of VCT sites increased from 1,027 in 2006 to 1,981 by end November 2007.

Voluntary Counselling and Testing (VCT) is the predominant approach in HIV testing in Tanzania Mainland. "Provider Initiated HIV Testing and Counseling" (PITC) is provided in the public health care facilities using the WHO developed package of interventions to reduce the burden of HIV among TB patients.

Table 10: Statistics on VCT Campaigns in Tanzania Mainland

	Regions	Male	Female	Total	Male : Female Ratio	Targeted Number of People to be Tested	Level of Achievement as of December 1, 2007 (%)	VCT Campaign Launching Date by Region	HIV Positive			Infection Rate		
									Male	Female	Total	Male	Female	Total
1	Dar es Salaam	95,451	118,233	213,684	0.81	326,602	65.4	14/07/07	5,374	7,237	12,611	5.6	6.1	5.9
2	Pwani	27,226	28,864	56,090	0.94	108,013	51.9	08/09/07	1,334	2,132	3,466	4.9	7.4	6.2
3	Manyara	49,033	52,076	101,109	0.94	133,449	75.8	08/09/07	593	1,026	1,619	1.2	2.0	1.6
4	Tanga	54,800	64,000	118,800	0.86	194,835	61.0	08/09/07	1,063	1,861	2,924	1.9	2.9	2.5
5	Arusha	55,612	59,360	114,972	0.94	167,118	68.8	08/09/07	1,248	1,746	2,994	2.2	2.9	2.6
6	Mtwara *	51,324	57,436	108,760	0.89	133,381	81.5	08/09/07	1,267	2,012	3,279	2.5	3.5	3.0
7	Lindi	54,250	61,098	115,348	0.89	92,426	124.8	08/09/07	932	1,755	2,687	1.7	2.9	2.3
8	Kilimanjaro	75,818	99,679	175,497	0.76	162,598	107.9	08/09/07	1,064	1,848	2,912	1.4	1.9	1.7
9	Singida*	36,261	58,311	94,572	0.62	131,987	71.7	22/09/07	922	2,052	2,974	2.5	3.5	3.1
10	Tabora	96,089	123,699	219,788	0.78	218,644	100.5	22/09/07	3,739	6,091	9,830	3.9	4.9	4.5
11	Mara*	78,466	74,580	153,046	1.05	166,906	91.7	22/09/07	2,463	4,016	6,479	3.1	5.4	4.2
12	Shinyanga	115,131	161,958	277,089	0.71	352,958	78.5	22/09/07	6,284	6,653	12,937	5.5	4.1	4.7
13	Dodoma	94,720	114,058	208,778	0.83	205,586	101.6	22/09/07	2,417	3,610	6,027	2.6	3.2	2.9
14	Kagera*	82,808	90,020	172,828	0.92	253,899	68.1	22/09/07	2,988	3,617	6,605	3.6	4.0	3.8
15	Kigoma	85,582	108,340	193,922	0.79	223,781	86.7	22/09/07	1,203	1,429	2,632	1.4	1.3	1.4
16	Mwanza*	107,352	109,038	216,390	0.98	368,708	58.7	22/09/07	7,570	8,370	15,940	7.1	7.7	7.4
17	Rukwa	25,895	24,545	50,440	1.06	145,314	34.7	06/10/07	1,465	1,779	3,244	5.7	7.2	6.4
18	Ruvuma	47,125	57,841	104,966	0.81	142,186	73.8	06/10/07	2,115	3,336	5,451	4.5	5.8	5.2
19	Mbeya*	82,214	114,501	196,715	0.72	251,466	78.2	06/10/07	8,691	15,026	23,717	10.6	13.1	12.1
20	Morogoro	73,498	97,312	170,810	0.76	215,454	79.3	06/10/07	3,476	4,897	8,373	4.7	5.0	4.9
21	Iringa	80,024	108,535	188,559	0.74	175,348	107.5	06/10/07	9,616	15,156	24,772	12.0	14.0	13.1
	Total	**1,468,679**	**1,783,484**	**3,252,163**	**0.82**	**4,170,659**	**78.0**		**65,824**	**95,649**	**161,473**	**4.5**	**5.4**	**5.0**

* Regions reported up to 1st December 2007

NB: Kilimanjaro HIV positive data not updated

Source: National AIDS Control Programme Records

Provision of Antiretroviral (ART) therapy

The HIV & AIDS Care and Treatment Plan's goal is to provide ART to 400,000 patients by end 2008. In 2006, 363,265 and in 2007, 373,584 total number of adults and children with advanced HIV infection who received antiretroviral therapy in accordance with the nationally approved treatment protocol. This is about (20%) of adults and children with advanced HIV infection as shown in Table 11.

Table 11: Antiretroviral (ART) Therapy coverage (2006 to 2007)

	January – December 2006	January - December 2007
Number of all Adults and Children with advanced HIV infection	1,816,326	1,867,918
Number of all Adults and Children with advanced HIV infection receiving antiretroviral therapy	363,265	373,584
Percentage of all Adults and Children with advanced HIV infection receiving antiretroviral therapy	20	20
Number of all Children (<15) with advanced HIV infection receiving antiretroviral therapy	5,985	10,834
Number of all Adults (15+) with advanced HIV infection receiving antiretroviral therapy	54,356	127,895

Source: National Aids Control Programme, Ministry of Health and Social Welfare

Prevention of Mother to Child Transmission (PMTCT)

The Government of Tanzania started offering PMTCT services in 2002.[18] Generally accepted standard for PMTCT services include the following:

- Pre- and post-HIV test and counselling for pregnant women
- Counselling HIV-positive women on infant feeding practices and family planning
- Providing prophylaxes ARV drugs to HIV-positive women during labor and delivery and to the newborn within 72 hours of birth, and
- Providing family planning counselling and/or referrals

Addition services (referred to as PMTCT plus) includes making ART available to all eligible women identified through PMTCT as HIV-positive, as well as their families

Currently 467 out of 2,509 health facilities provide PMTCT, which is about 12% of the total facilities from the 11 designated regions. The percentage of HIV-infected pregnant women who received antiretroviral during the last 12 months as an intervention toward the reduction of mother-to-child transmission in 2006 and 2007 is still very low at 12.3% and 8.2% respectively as shown in Table 12. Besides, there is still a weak integration of PMTCT into existing community health service

[18] Tanzania Service Provision Assessment (TASPA) Survey, 2007:pp.184

provision interventions. The integration has been predominantly one-way i.e. HIV & AIDS into reproductive and child health care services (RCH services.[19]).

Table 12: Prevention of Mother to Child Transmission (PMTCT)

	2005	2006	2007
Estimated pregnant women annually	1,444,000	1,383,164	1,400,000
HIV Prevalence in Pregnant women attending ANC	8.7	8.7	8.2
Estimated HIV+ Pregnant women in the population	122,000	120,000	114,800
Pregnant women reached at ANC by PMTCT services	255,913	363,516	608,077
Pregnant women who received pre testing counseling	222,031		
Pregnant women tested for HIV (ANC+LD)	206,721		519,287
Pregnant women who received post testing counseling at ANC	202,909		317,303
Pregnant women tested HIV positive	13,873	28,043	57,731
Pregnant women intended to choose Replacement breast feeding	956		1,345
Infant received ARV Prophylaxis	7,424		21,093
Number of HIV-infected pregnant women who received antiretrovirals during the last 12 months to reduce mother-to-child transmission	11,435	14,758	31,863
Estimated number of HIV-infected pregnant women in the last 12 months	122,000	120,335	114,800
Percentage of HIV-infected pregnant women who received antiretrovirals during the last 12 months to reduce mother-to-child transmission	9.4 (11,435/122,000)	12 (14,758/122,00)	28.0 (31,863/114,800)

Source: National Aids Control Programme, Ministry of Health and Social Welfare

HIV positive incident TB and Treatment for TB and HIV

Tanzania Mainland started implementing collaborative HIV&TB activities in July 2005 as a pilot in three districts (i.e. Temeke, Iringa Urban and Korogwe districts). The piloting of collaborative HIV-

[19] Global Fund Round 7 Proposal for Tanzania Mainland

TB activities in the three districts were aimed at providing an opportunity for learning, gaining experience and gathering the best practices for scaling-up the activities in other districts countrywide. In the first half of 2006 policy guidelines, training materials and tools needed for scaling up this work were developed.[20]. In 2006, the collaborative HIV and TB activities were introduced in 20 additional districts.

Table 13: TB-HIV Notification in the Three Collaborative HIV &AIDS Activities Pilot Districts (2006)

Indicators	Cases Notified
Number of All Registered TB Patients	3,239
Number of TB Patients tested for HIV	1,613 (49.8%)
Number tested HIV Positive	841 (52.1%)
Number Registered for HIV Care	568 (67.6%)
Number started ART	188 (22.3%)
Number started CPT	418 (49.7%)

Source: Ministry of Health and Social Welfare

Significant progress in the implementation of the collaborative HIV&TB activities has been realized though more efforts are still desired. The 2006 estimates from the four pilot districts suggest that almost half of the registered TB patients tested for HIV. Out of 1,613 TB patients who tested for HIV, about 841 (52.1%) were co-infected with HIV (Table 13). Only 67.6% of them registered for HIV care; 22.3% started ARV treatment and 49.7% started CPT.

Table 14: Facility Level HIV Prevention (details as of end May 2007)

	Type of Facility level HIV prevention service provided	Situation as of May 2007
1	**Condom Procurement and Distribution**	The available data on Condom distribution from 500+ implementers, who reported on TOMSHA, shows that 674,898 male condoms and 158,281 female condoms were distributed to end users outside the health facilities in the quarter April to June 2007.
2	**Safe blood supply**	Tanzania has a total of 7-Zonal Blood Transfusion Service centres (ZBTC) and six of then being in Tanzania Mainland and one in Zanzibar (Table 2). All (100%) voluntary, non-remunerated blood donated is screened for HIV in a quality assurance manner.
3	**PMTCT**	(i) Tanzania has prioritized PMTCT as a major area of HIV & AIDS intervention. This is reflected in the first National Multisectoral Strategic framework on HIV & AIDS (2003-2007) and the second NMSF (2008-2012) as well as in Health Sector Strategy for HIV & AIDS (2003-2006). (ii) It is estimated that 90% of children below 15 years acquired the infection through mother to child transmission (NACP, 2006, PMTCT Progress Report) (iii) Currently there are 656 facilities providing PMTCT services

[20] These were developed by the Ministry of Health and Social Welfare in collaboration with partners i.e. WHO, CDC, GF-ATM, PATH, Clinton Foundation and the Muhimbili National Hospital

	Type of Facility level HIV prevention service provided	Situation as of May 2007
		within RCH services in the country (i.e. 12% of all health facilities) however the integration has been predominantly one way (HIV & AIDS into RCH services). Integration of education and counseling on sexuality with family planning and antenatal care is a critical component currently not adequately addressed.
5	**TB-DCT**	(i) HIV counseling and testing in TB clinics in Tanzania has been scaled-up. This has included the use of provider-initiated diagnostic counseling and testing (DCT (which started in July 2005. (ii) Public health care facilities are using the WHO developed package of interventions to reduce the burden of HIV among TB patients, which includes • offering provider initiated diagnostic counseling and HIV testing (DCT) to all TB patients with an option to opt out. • referring all HIV-positive TB patients to care and treatment centers for registration and assessment of eligibility to ART. • offering all TB /HIV co-infected patient's cotrimoxazole preventive therapy (CPT). • offering HIV infected client's isoniazid preventive therapy (IPT).
6	**STI Control**	(i) The MOHSW has a policy to test all pregnant women for syphilis as well as to treat all women tested positive for syphilis. The syphilis sero-prevalence among ANC attendees is 6.9% (NACP report 2005/06), equivalent to 1,088,714 of the sexually active population. In the "National Road Map Strategic Plan to Accelerate Reduction of Maternal and Newborn Deaths in Tanzania 2006 – 2010" effective interventions for maternal and newborn care include treatment of syphilis. The government's goal is to reduce the syphilis sero prevalence from 6.9% to 2.0% by 2012. The aim is further to integrate syphilis testing and treatment as part of PMTCT. The strategy is further specified in the National Guidelines for screening and treatment of syphilis during pregnancy (April 2004).
7	**ART**	(i) 363,265 and 373,584 Adults and Children with advanced HIV infection received antiretroviral therapy in 2006 and 2007 respectively.
8	**Universal Precautions and PEP**	The MoHSW has developed a policy and guidelines for post-exposure prophylaxis (PEP) as well as for waste management and safe hospital waste disposal. Despite the existence of a policy on PEP, the procurement and distribution of PEP kits has been limited. Similarly, no significant efforts have been made to provide home-based care givers with guidelines and necessary gear to protect themselves while caring for their sick relatives.

Source: National Multisectoral Strategic Framework on HIV& AIDS (2008-2012); Global Fund Round 5, 6 and 7 Proposals; National AIDS Control Programme (NACP) & Ministry of Health and Social Welfare .

Care and Support

The Orphans and Vulnerable Children (OVC)

It is estimated that the number of OVC in Tanzania Mainland was 930,000 in 2006, which is five per cent (5%) of the total child population.[21] It was also estimated that in 2006, the cost of bridging the expenditure gap for the 930,000 children considered to be most vulnerable would be Tanzanian Shillings (TShs) 37.8 billion (US $31.5 million). Of this amount, TShs 30.7 billion is needed for food, TShs 7.1 billion for non-food items. The number of OVC is projected to reach 1, 044,097 by year 2010. The number of OVC receiving any external support has been increasing over time. For instance the impact assessment of the Most Vulnerable Children (MVC) Programme implemented by the Department of Social welfare with support from the UNICEF showed that by 2005 and 2006, almost 30 per cent of surveyed children in the sample districts reported support from the programme.[22] The Tanzania HIV & AIDS Indicator Survey (THIS) 2003-04 indicated that only 4 to 6 percent of the orphans and vulnerable children lived in households that received various types of external support and support services were more prevalent in urban areas than in rural areas.

Results for key HIV & AIDS Indicators for Tanzania

The national responses to HIV & AIDS have generally resulted into noteworthy achievements. There has been a significant increase in the number of pregnant women who received HIV counseling and testing for PMTCT and received their test results over the last three years (2004/05-2006/07). The number almost tripled from 174,364 in 2004/05 to 535,849 in 2006/07 (Table 15). In the same period, the number of pregnant women provided with a complete course of antiretroviral prophylaxis for PMTCT has been almost doubling every year for the last three years.

Though the implementation of collaborative HIV-TB activities have not yet been scaled up to all the districts in the country, the number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease during the reporting period increased by 31.6% from 6,159 in 2005/06 to 8,108 in 2006/07.

Despite the fact that provision of comprehensive care and support to PLHA and OVC is still a big challenge in Tanzania, due to among others, resource constraints, the number of PLHAs and OVC reached with care and support services is increasing.

The number of individuals provided with facility-based, community-based and/or home-based HIV-related palliative care including those HIV-infected individuals who received clinical prophylaxis and/or treatment for tuberculosis (TB) during the reporting period increased by 58% from 173,528 in 2005/06 to 274,097 in 2006/07 (See table 15). The number of OVC served by an OVC program increased by 38% (from 286,419 to 395,290) between 2004/05 and 2005/06 and by 19% (from

[21] Wietze Lindeboom, Robert Mhamba, Blandina Kilama and Valerie Leach, 2007, Towards Revising the Costed National MVC Programme. A Report for the Ministry of Health and Social Welfare: REPOA; Ministry of Health and Social Welfare, 2007, The National Plan of Action for Scaling Up OVC Responses

[22] Robert Mhamba, Wietze Lindeboom, Francis Omondi and Valerie Leach, 2007, Social Protection in the Context of the MVC Programme in Tanzania: An Assessment of the Impact of Implementing the MVC Programme and the Operation of the MVC Funds and the Potential for Scaling Up to Provide National Coverage of Social Protection for Children. A report for the UNICEF: REPOA

395,290 to 471,315) between 2005/06 and 2006/07. This results implies that almost (50%) of the estimated number of 946,614 OVC in 2007 are served by an OVC programme.

The estimated number of individuals receiving antiretroviral therapy at the end of the reporting period (i.e. currently on treatment) also doubled during the reporting period from 44,323 in 2005/06 to 96,699 in 2006/07. This achievement is attributed to both increased efforts and funding for ART.

Table 15: Results for key HIV & AIDS Indicators for Tanzania 2003 to 2007

	Source	October 1, 2003 - September 30, 2004	October 1, 2004 - September 30, 2005	October 1, 2005 - September 30, 2006	October 1, 2006 - September 30, 2007
PREVENTION					
Number of pregnant women provided with a complete course of antiretroviral prophylaxis for PMTCT	**MoHSW-PMTCT**	1,782	6,766	13,471	25,503
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	**MoHSW-PMTCT**	42,815	174,364	366,437	535,849
CARE					
Care total	**Total**	25,365	412,642	568,818	745,412
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease during the reporting period	NACP	200	387	6,159	8,108
Number of individuals provided with facility-based, community-based and/or home-based HIV-related palliative care including those HIV-infected individuals who received clinical prophylaxis and/or treatment for tuberculosis (TB)	NACP	13,376	126,223	173,528	274,097
Number of OVC served by an OVC program	DSW	11,989	286,419	395,290	471,315
Counseling and Testing					
Number of individuals who received counseling and testing for HIV and received their test results	NACP	105,132	524,398	680,520	1,349,198
TREATMENT					

	Source	October 1, 2003 - September 30, 2004	October 1, 2004 - September 30, 2005	October 1, 2005 - September 30, 2006	October 1, 2006 - September 30, 2007
Number of individuals receiving antiretroviral therapy at the end of the reporting period (CURRENTLY on treatment)	NACP	1,518	14,706	44,323	96,699

Source of compiled data: PEPFAR. Totals combine PEPFAR downstream (direct) and upstream (indirect). Original data sources: Government of Tanzania

National Composite Policy Index Rating of National Responses to the AIDS Epidemic

The questionnaires were filled by representatives from eight government ministries, departments and agencies and 11 representatives from nongovernmental organizations, bilateral agencies and the UN organizations. Considerable progress between 2005 and 2007 has been achieved in almost all aspects of HIV & AIDS Care and support and treatment. Tanzania Mainland was generally rated good in most of the key areas (more information is available on CRIS template).

Best Practices

Policy and Enabling Environment

Government leaders are in the forefront in the national response efforts against HIV pandemic. The government led VCT campaigns started by the topmost government leaders publicly testing for HIV on the campaign-launching day. This has encouraged people all over the country to seek for the VCT services.

In Addition, the Tanzanian National Council of People Living with HIV & AIDS (NACOPHA) was functionally established in 2007 by groups of people living with HIV with the support of the Tanzanian Commission for AIDS (TACAIDS). The role of NACOPHA is to advocate for the rights of people living with HIV & AIDS, to coordinate the activities of its members, to strengthen the capacity of members and to contribute to the national multi-sectoral response to the AIDS epidemic in prevention, care, treatment and impact mitigation, as laid out in the National Multisectoral Strategic Framework for HIV & AIDS (NMSF) 2003-2007 and the revised version 2008-2012. A secretariat has been established in Dar es Salaam to support the activities of NACOPHA. The NACOPHA secretariat serves as an information hub for the coordination of NACOPHA under the leadership of a Board of Directors.

Furthermore, Tanzania has adopted a regionalization approach in the coordination of partners providing support for HIV & AIDS care and treatment i.e. ART and PMTCT and TB & HIV.

Tanzania also enjoys good working and collaborative support of development partners and CSO's which are always on the forefront in supporting the response initiatives and interventions at all levels of implementation.

Major Challenges and remedial actions

i. Levels of sexual and reproductive ill-health remain high; HIV prevalence is increasing among adolescents and women and risk sex behaviors continue despite the scaling-up of HIV prevention efforts including awareness raising campaigns through IEC/BCC materials, and VCT. Existing IEC/ BCC interventions have minimum impact on the desired behavior change among the adolescents. This is mainly due to limited knowledge on adolescent behavior and their information and education needs. The methods and approaches used and existing in IEC/BCC interventions are not adequately segmented to address the problems and needs of adolescent SRH/HIV according to their stage of development and circumstances. There is a need for operational research to be conducted in this area and to integrate HIV & AIDS and Sexual and Reproductive Health (SRH) services.

ii. A commendable zeal to mobilize resources for scaling up HIV & AIDS responses has been demonstrated by both government and other stakeholders. These efforts however are hampered by slow absorption capacity and poor oversight of funds in the government ministries, departments and agencies and in some of the Civil Society Organization (CSOs). This problem is attributed to low levels of capacity throughout the government system.

iii. While stigma and discrimination still persist and negatively impact work on HIV & AIDS, even among service providers, there is also a low capacity at district and community level to implement HIV & AIDS interventions. This problem significantly hinders intended achievements of the programmatic milestones.

iv. Already weak health care systems are now struggling with the additional burden of HIV and AIDS, which in turn further impedes the provision of quality services. Besides, there is a limited capacity of the health sector to roll-out provision of ARVs and drugs for the Prevention of Mother-to-Child Transmission (PMTCT). Even though Tanzania Mainland has demonstrated significant achievements in the provision of ARVs and PMTCT, this problem is encumbering further progress.

v. Additional challenges includes the following:

- Serious shortage of human resources – especially in the health sector to expand testing, counseling, treatment and care services
- The high level of national awareness raising efforts not matched with commensurate positive behavioral change
- Sustaining the care and treatment as well as the prevention strategies
- The increasing need for nutritional support to poor community members who are infected and affected
- Identifying and supporting the increasing number of needy orphans and other vulnerable persons
- Accountability and judicious use of the HIV & AIDS resources from Government and development partners
- Stigma militating against access to prevention, testing, treatment care and support services.

Support from the Country's Development Partners

According to the public expenditure review 2005/2006, development partners accounted for close to 90% of total public expenditure on HIV & AIDS in 2005/6. PEPFAR alone accounted for 59% of public spending on HIV & AIDS. Total (Government plus donor partner) expenditure had been expected to nearly double in 2005/6, but actually increased by a little less than half, though

Government recurrent spending nearly doubled. Spending was expected to continue to grow strongly in 2006/7, with donor indications consistent with a further 77% increase on 2005/6 levels. Total expenditure (including donors off-budget spending) was equivalent to roughly 5.6% of Government spending in 2005/6, and may reach 8% of Government spending and over 15% of expected Government revenue in 2006/07.

In addition a joint UN Team on HIV & AIDS, was established in June 2006. The Team comprises officers from UN agencies working on HIV & AIDS in Tanzania and officially designated by their Heads of Agencies, to support Joint Programming. The Joint Team works through four thematic areas covering Prevention, Care, Treatment and Support, Impact Mitigation, and Cross-Cutting Issues/Enabling Environment, reflecting the broad priorities of the national strategic plans of both the Mainland and Zanzibar. This team is facilitated by UNAIDS under the guidance of the UN Theme Group on HIV & AIDS (UNTG).

The joint UN Team on HIV & AIDS has developed a United Nations Joint Programme of Support to Tanzania on HIV & AIDS covering the period 2007-2010. This period coincides with the implementation period for the United Nations Development Assistance Framework (UNDAF) for Tanzania. The UNDAF itself has been prepared through careful consideration of the poverty reduction strategy documents of the Tanzania Mainland ('MKUKUTA') and Zanzibar ('MKUZA'), both of which focus on: economic growth and reduction in income poverty; social services and well-being; and governance. The Joint Programme has been also careful to ensure that it is fully consistent and aligned with the UNDAF and Government priorities as expressed through MKUKUTA and MKUZA, as well as with the Mainland's National Multi-Sectoral Strategic Framework on HIV & AIDS.

Since 2004, the Government of Tanzania (GoT) provided HIV Care and Treatment through 22 sites in 9 regions with support from 6 USG partners. Most of these sites were referral and urban hospitals in major towns, selected because of high demand, capacity to implement rapidly, and USG and partners' preferences. This created significant challenges: difficulties in coordination, duplication of support in some areas and lack of support in others, and low cost-effectiveness, all leading to a wide gap in quality and services between sites.

In meeting these challenges the government of Tanzania in collaboration with the United States Government USG adopted the National HIV Care and Treatment C&T Program concept of '*Regionalization*'.[23] The intent of regionalization was to facilitate the continued scale up of C&T services in a more equitable distribution of services and ensures standardized approaches and effective referrals across a continuum of care. Regionalization entailed shift from 'facility-base' partner support to one of expanding the delivery of services across a range of health facilities within a geographic area. Each USG partner has been assigned to support care and treatment sites on a geographical grouping- all certified facilities at all levels of medical facilities in one or more Regions down to all districts of the Region and where possible to extent to the health centre level.

By September 2006 all sites in a given region were only dealing with one USG partner for support (Table 16). An initial experience show great appreciation by the regional/district medical authorities and facilities and ensures more efficient and less costly implementation of scaling up coverage and as

[23] This is clearly expressed in a letter from the Permanent Secretary dated September 26, 2005)

well linking the referral network from village unit to district to regional referral site in a consistent and standardized way.

The advantages of regionalization include the following:

a) It has facilitated equal distribution of partners support across the country, and prevented partner overlap.
b) Greatly facilitated logistics for program rollout and service delivery.
c) Working with one partner in a region with geographic perspective has facilitated linkages between hospitals, health centers and communities.
d) Ensured standardized approaches and effective referrals across a continuum of care for each region/district
e) A cost effective approach - training, program management and supportive supervision. Significant savings have been made in training; program management; and supportive supervision, and the cost per patient is expected to drop from the current average of US$300 per patient to less than US$150.
f) Building of ownership and teaming among region/district based stakeholders, to map the various resources and programs.

Table 16: Regionalization of USG Partners

Regions	USG Partner
Dodoma, Singida, Iringa, Morogoro	Tunajali - Family Health International FHI/Deloitte
Tabora, Shinyanga, Arusha, Kilimanjaro	Elizabeth Glaser Pediatric AIDS Foundation – EGPAF
Mwanza, Mara, Manyara, Tanga	AIDS Relief
Rukwa, Mbeya, Ruvuma	Walter Reeds
Pwani/Cost, Kigoma, Kagera	Columbia University
Dar es Salaam	Mhimbili University College of Health Sciences (MUCHS), Dar es Salaam City, HARVARD-MDH
Lindi, Mtwara	Clinton HIV & AIDS Initiatives-CHAI

Source: Regionalization Map

Monitoring and Evaluation Environment

Tanzania Multisectoral National HIV& AIDS M&E System (HIV-MES) is based on the 3rd of the Three Ones HIV response initiative principles. The Tanzania HIV-MES is a set of documented tools and processes that define all aspects of monitoring and evaluating the HIV response in Tanzania.[24] The national M&E framework was developed and launched in 2004; the M&E Operational plan was developed in 2005, and in the same year an M&E situational analysis was undertaken by World Bank/GAMET in collaboration with UNAIDS and TACAIDS. The findings

[24] Rapid Situational Assessment of the HIV M&E System in Tanzania Mainland, February – March 2007.

of this analysis were used to revise the M&E operations plan and to develop the Tanzania Output Monitoring System for HIV & AIDS (TOMSHA) and the costed national HIV M&E Road Map.

There are several data sources within Tanzania National M&E system. The main data source for evaluating impact and outcomes include the Biological HIV surveillance; Behavioural Surveilance; Population based surveillance; Quality of Health related HIV services; Condom quality and Condom availability survey; the Workplace survey; and other small surveys. For input and output data sources include: TOMSHA; the MOHSW Medical HIV services monitoring data; Ministry of Education and Vocational Training (MOEVT) programme monitoring data; Public Expenditure Review (PER) and; TACAIDS financial system data.[25]

The following are the key strengths and weaknesses of the HIV & AIDS M&E System in Tanzania[26]

Strengths:

- M&E documentation (specifically the M&E Operational Plan: 2006-2012) is thorough and linked to NMSF and other international guidelines such as UNGASS
- The MOHSW Management Unit has written and standard data recoding and reporting tools and guides (including instructions/clarifications on frequency of reporting and flow of reports)
- There is a systematic mechanism to track inventory level and stock out at the service points
- Existence of standard tool (TOMSHA) for reporting on non-health and community level program data

Weaknesses:

- Limited capacities to ensure data quality (including training and program data and to avoid double counting)
- Inadequate capacity at sub-national levels in data management, processing, documentation, analysis and reporting.
- There is no clear lines of responsibility and accountability in the MOHSW information management unit and lower levels under the Ministry of Local Government Authority.
- Inadequate resources for supportive supervision and mentoring to enrich systematic feedback to all levels of implementation
- Limited capacities at sub-national levels in data collection, management, analysis and reporting.
- National database system not yet fully operational at TACAIDS. However, currently it is under development for operationalization during 2008.
- TACAIDS M&E Unit capacity is inadequate given its workload (only four staff are currently in place)
- The existing M&E system at MoHSW does not capture or identify drop out specifically PMTCT
- Not all service points for VCT and care and support use standardized data collection and reporting forms and no standard guideline for filling them

[25] *Source*: Assessment of the Status of the National HIV M&E System in Tanzania
[26] *Source*: Summary Report on the HIV & AIDS M&E Assessment (23-25 October, 2007)

- Poor implementation on tracking inventory and stock out at service points and there is no systematic mapping on availability HIV/AIDS services
- No single channel of data flow for the different programs (VCT, PMTCT, ART,…) from the lower level to the national level

Key strengthening measures:

- Developing guidelines/tools on how to rectify and ensure data quality (programme, training and supply chain management)
- In budgeting for the NMSF, ensuring that at least 7% of budget is set for M&E
- Capacity building plan to train the staff at all levels in data management
- Develop organizational chart at the national and sub national levels which defines lines of accountability (including job descriptions at lower levels)
- To integrate the health related HIV/AIDS data to feed into one national HIV M&E system
- To finalize the development of the national HIV M&E database system for capturing information from all levels
- Regular supportive supervision, mentoring and feedback
- Capacity building training on data management and protocols, processes and data analysis at all levels
- TACAIDS should allocate more fund for TOMSHA implementation
- Strengthen the TACAIDS M&E Unit in human capacity
- TACAIDS and M&E Unit need to be upgraded for enhanced functioning and decision making
- Dissemination of existing standardized data collection and reporting tools and guidelines
- Finalizing the revised PMTCT data collection and reporting tools
- Conduct service availability mapping for the whole country
- Develop and reinforce one conceptual framework/guideline for information/report flow

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The report writing process involved all the stakeholders i.e. the people living with HIV; the government; development partners, the UN Family; Faith Based Organizations (FBOs); the Civil Society Organizations and the private sector. The stakeholders were involved in the data collection process, analysis and report writing. A small team of people representing the government, CSOs, the Joint UN team, and academic institutions did the data collection, analysis and report writing process. The zero and first drafts of the report were circulated to all stakeholders for comments and inputs to fill the information and data gaps. After the incorporation of all the comments and inputs, a meeting with representatives from all the stakeholders was held to validate the report. All the comments raised at the validation meeting were incorporated into this final report for Tanzania Mainland. The stakeholders scrutinized the final report as a final validation process before the report was submitted.

COUNTRY: Tanzania Mainland

Name of the National AIDS Committee Officer in charge: **Dr Fatma Mrisho**

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Date of submission: 29 Jan 2008

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Names of Organizations Filling the Questionnaires

PART A: Government Officials

Ministry of Education and Vocational Training
Ministry of Planning and Economic Empowerment
Ministry of Lands
Presidents Office, Ministry of Civil Services
Ministry of Labor, Employment and Youth Development
Ministry of Youth, Women, and Children,
Ministry of Health and Social Welfare
Ministry of Finance

PART B: Nongovernmental organizations, bilateral agencies and UN Organizations

BAKWATA
Tanzania AIDS Society
Tanzania Network for Women Living with HIV-AIDS
Tanzania Youth Team for Campaign Against AIDS (TAYOTA)
National Council of People Living with HIV-AIDS (NACOPHA)
Tanzania Women Lawyers Association (TAWLA)
Campaign for Good Governance CGG
Family Health International (FHI), Tanzania
CARE International (Tanzania)
World Conference on Religious for Peace (Tanzania) WCRP
Norway Embassy
Canadian High Commission

Data Measurement Tool	Financing Sources																				
Are you reporting for the calendar year or fiscal year																					
Please indicate month and year (M/YYYY)																					
Name of Local Currency																					
Average Exchange Rate for the year (local currency to USD)	TOTAL (Local Currency)	Public Sources							International Sources												
											International Sub-Total	Bilaterals	Multilaterals								
AIDS Spending Categories		Public Sub-Total	Central / National	Sub- National	Dev. Bank Reimbursable (e.g. Loans)	All Other Public	Social Security (Publicly Managed)			UN Agencies	Global Fund	Dev. Bank Non-Reimburseable (e.g. Grants)	All Int								

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TOTAL (Local Currency)	**322,677,108,993.0**	**119,590,000,000.0**	**21,800,000,000.0**	**1,790,000,000.0**	**0.0**	**96,000,000,000.0**	**0.0**	**203,087,108,993.0**	**6,699,269,800.0**	**21,100,000,000.0**	**75,100,000,000.0**	**0.0**	1			
1. Prevention (sub-total)	**13,425,826,212.0**	**8,607,449,412.0**	**8,607,449,412.0**	**0.0**	**0.0**	**0.0**	**0.0**	**4,818,376,800.0**	**4,818,376,800.0**	**0.0**	**0.0**	**0.0**				
1.1 Mass media	**0.0**								17,000,000.0							
1.2 Community mobilization	**0.0**								556,200,000.0							
1.3 Voluntary counselling and testing	**0.0**								2,591,000,000.0							
1.4 Programs for vulnerable and special populations	**0.0**															
1.5. Youth in school	**0.0**								565,061,400.0							
1.6 Youth out of school	**0.0**								5,000,000.0							
1.7 Prevention programs for PLHA	**0.0**															
1.8 Programs for sex workers and their clients	**0.0**								21,000,000.0							
1.9 Programs for MSM	**0.0**															

1.10 Harm reduction programs for IDUs	**0.0**															
1.11 Workplace activities	**0.0**								206,269,200.0							
1.12 Condom social marketing	**0.0**															
1.13 Public and commercial sector condom provision	**0.0**															
1.14 Female condom	**0.0**															
1.15 Microbicides	**0.0**															
1.16 Improving management of STIs	**0.0**								799,100,000.0							
1.17 Prevention of mother-to-child transmission	**3,375,013,140.0**	3,375,013,140.0	3,375,013,140.0						53,746,200.0							
1.18 Blood safety	**5,232,436,272.0**	5,232,436,272.0	5,232,436,272.0						4,000,000.0							
1.19 Post-exposure prophylaxis	**0.0**															
1.20 Safe medical injections	**0.0**															
1.21 Male Circumsicion	**0.0**															
1.22 Universal precautions	**0.0**															
1.99 Others / Not-elsewhere classified	**0.0**															
2. Care and Treatment (sub-total)	**9,683,526,167.0**	**9,683,526,167.0**	**9,683,526,167.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**126,893,000.0**	**0.0**	**0.0**	**0.0**				
2.1 Outpatient care	**0.0**															
2.2 Provider initiated testing	**0.0**															

2.3 Opportunistic infection (OI) prophylaxis	**0.0**															
2.4 Antiretroviral therapy	**9,683,526,167.0**	9,683,526,167.0	9,683,526,167.0													
2.5 Nutritional support	**0.0**															
2.6 Specific HIV laboratory monitoring	**0.0**															
2.7 Dental care	**0.0**															
2.8 Psychological care	**0.0**															
2.9 Palliative care	**0.0**															
2.10 Home-based care	**0.0**								47,000,000.0							
2.11 Additional/informal providers	**0.0**															
2.12 Hospital care	**0.0**															
2.13 Opportunistic infection (OI) treatment	**0.0**															
2.99 Others / Not-elsewhere classified	**0.0**								79,893,000.0							
3. Orphans and Vulnerable Children * (sub-total)	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**				
3.1 Education	**0.0**															
3.2 Basic health care	**0.0**															
3.3 Family/home support	**0.0**															
3.4 Community support	**0.0**															

3.5 Administrative costs	**0.0**															
3.9 Others / Not-elsewhere classified	**0.0**															
4. Program Management and Administration Strengthening (sub-total)	**572,069,559.0**	572,069,559.0	**572,069,559.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**54,000,000.0**	**0.0**	**0.0**	**0.0**				
4.1 Programme management	**544,891,744.0**	544,891,744.0	544,891,744.0						20,000,000.0							
4.2 Planning and coordination	**0.0**															
4.3 Monitoring and evaluation	**0.0**															
4.4 Operations research	**0.0**															
4.5 Sero-surveillance	**0.0**															
4.6 HIV drug-resistance surveillance	**0.0**															
4.7 Drug supply systems	**0.0**															
4.8 Information technology	**0.0**															
4.9 Supervision of personnel	**0.0**								11,000,000.0							
4.10 Upgrading laboratory infrastructure	**0.0**															
4.11 Construction of new health centres	**0.0**															
4.99 Others / Not-elsewhere classified	**27,177,815.0**	27,177,815.0	27,177,815.0						23,000,000.0							
5. Incentives for Human Resources (sub-total)	**511,445,248.0**	**511,445,248.0**	**511,445,248.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**				

5.1 Monetary incentive for physicians	**0.0**															
5.2 Monetary incentive for nurses	**0.0**															
5.3 Monetary incentive for other staff	**0.0**															
5.4 Formative education and build-up of an AIDS workforce	**0.0**															
5.5 Training	**511,445,248.0**	511,445,248.0	511,445,248.0													
5.9 Others / Not elsewhere classified	**0.0**															
6. Social Protection and Social Services excluding Orphans and Vulnerable Children (sub-total)	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**				
6.1 Monetary benefits	**0.0**															
6.2 In-kind benefits	**0.0**															
6.3 Social services	**0.0**															
6.4 Income generation	**0.0**															
6.9 Others / Not elsewhere classified	**0.0**															
7. Enabling Environment and Community Development (sub-total)	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**				
7.1 Advocacy and strategic communication	**0.0**															
7.2 Human rights	**0.0**															
7.3 AIDS-specific institutional development	**0.0**															

7.4 AIDS-specific programs involving women	**0.0**															
7.9 Others / Not elsewhere classified	**0.0**															
8. Research excluding operations research which is included under (sub-total)	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**1,700,000,000.0**	**0.0**	**0.0**	**0.0**				
8.1 Biomedical research	**0.0**															
8.2 Clinical research	**0.0**															
8.3 Epidemiological research	**0.0**															
8.4 Social science research	**0.0**															
8.5 Behavioural research	**0.0**								1,700,000,000.0							
8.6 Research in economics	**0.0**															
8.7 Research capacity strengthening	**0.0**															
8.8 Vaccine-related research	**0.0**															
8.9 Others / Not elsewhere classified	**0.0**															

* The term vulnerable children in this context refers to children whose parent is too ill to take care of them but do not qualify for social support as orphan.