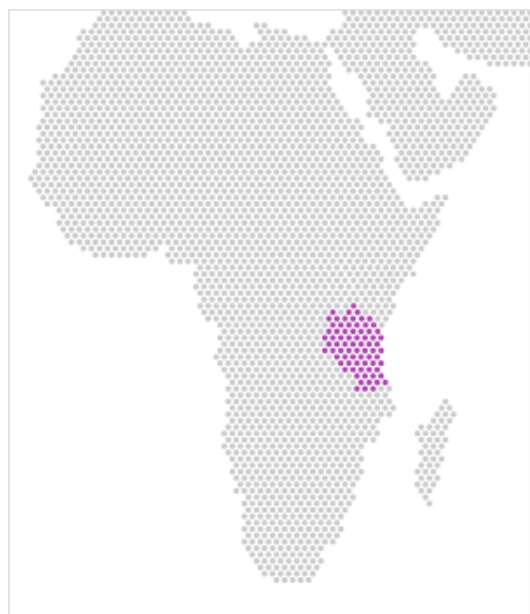


HIV and AIDS in Tanzania

Tanzania updated August2017.png



Tanzania (2016)

1.4 million people living with HIV

4.7% adult HIV prevalence

55,000 new HIV infections

33,000 AIDS-related deaths

63% adults on antiretroviral treatment

48% children on antiretroviral treatment

Source: UNAIDS Data 2017

KEY POINTS:

- Tanzania's extensive roll out of antiretroviral treatment medications has helped minimise the impact of the country's epidemic over the last decade.
- Cash transfer programmes and increased availability of condoms have been successful as prevention strategies in reducing the rate of new HIV infections in Tanzania.
- Tanzania has one of the largest needle-exchange programmes to help prevent the spread of HIV among people who inject drugs (PWID) in sub-Saharan Africa.
- Gender inequality and stigma against those living with HIV still act as major barriers to HIV prevention in Tanzania.

Explore this page to find out more about [populations most affected by HIV](#), [testing and counselling](#), [antiretroviral treatment](#), [prevention programmes](#), [barriers to prevention](#), and the [future of HIV and AIDS in Tanzania](#).

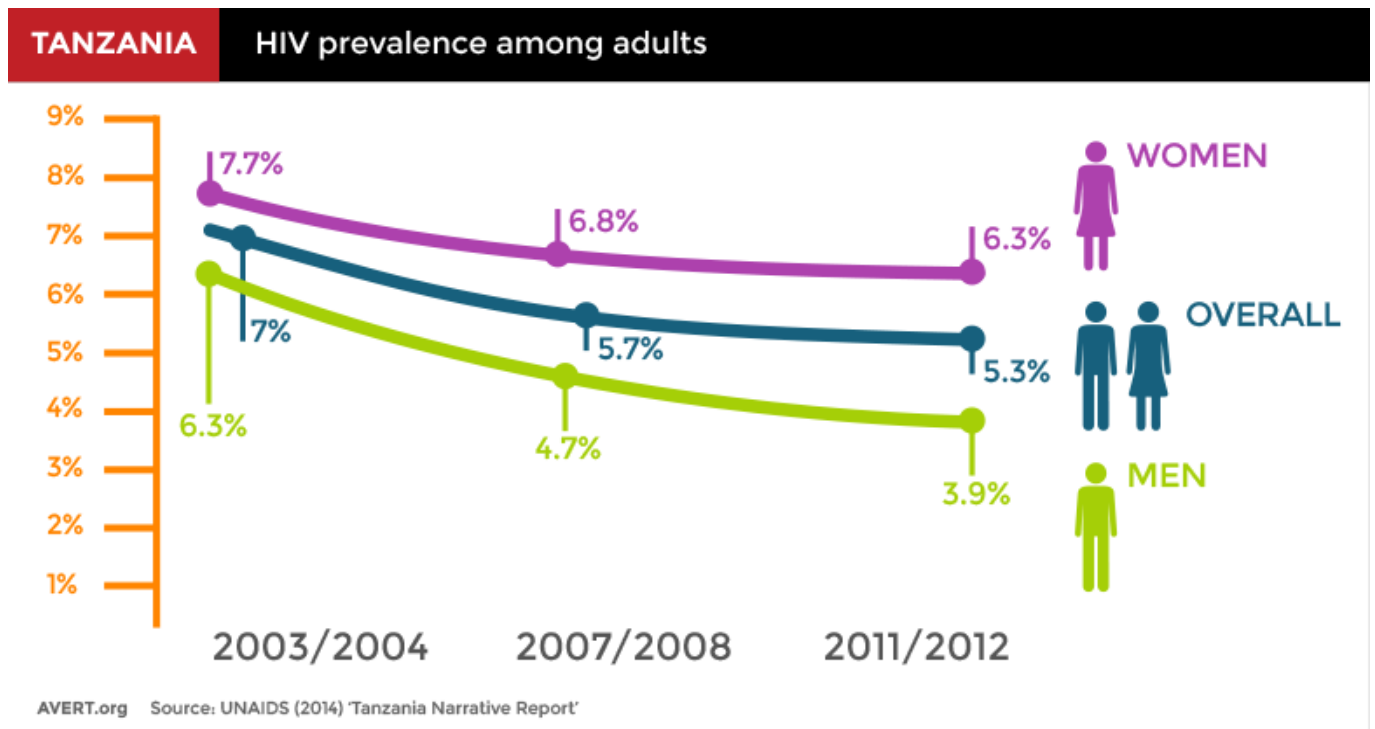
In 2016, 1.4 million people were living with HIV in Tanzania. This equates to an estimated HIV prevalence of 4.7%¹ In the same year, 55,000 people were newly infected with HIV, and 33,000 people died from an AIDS-related illness.²

Despite the numbers, Tanzania has done well to control the HIV epidemic over the last decade. Scaling-up access to antiretroviral treatment has helped Tanzania minimise the impact of the epidemic. As a result, between 2010 and 2015, the number of new infections declined by more than 20% and the number of people dying from an AIDS-related illness halved.³

Between 2010 and 2015, the number of new infections declined by

The severity of the epidemic varies across the country.

Some regions report an HIV prevalence of around 1.5% (Manyara) while other regions have prevalence as high as 14.8% (Njombe).⁴ Overall, the epidemic has remained steady because of on-going new infections, population growth and increased access to treatment. **more than 20%.**



Key affected populations in Tanzania

Tanzania's HIV epidemic is generalised, with pockets of concentrated epidemics among **key populations** such as **people who inject drugs**, **men who have sex with men**, mobile populations and **sex workers**. Heterosexual sex accounts for the vast majority (80%) of all HIV infections in Tanzania and women are particularly affected.⁵

Women and HIV in Tanzania

Women are heavily burdened by HIV in Tanzania where 780,000 women aged 15 and over are living with HIV.⁶ In 2016 UNAIDS reported, HIV prevalence for women as 5.8%, compared to 3.6% for men.⁷ In 2012, women aged 23-24 were also twice as likely to be living with HIV than men of the same age. HIV prevalence among women ranged from 1% among those aged 15-19 to 10% among women aged 45-49.⁸

In 2016, more than 25,000 women aged 15-24 became infected with HIV, compared to around 20,000 men of the same age,⁹ Women tend to become infected earlier, because they have older partners and get married earlier.¹⁰ They also experience great difficulty in negotiating safer sex because of gender inequality.

The 'sugar daddy' culture is widespread in Tanzania. Women will often accept the sexual advances of older men for a variety of reasons including money, affection and social advancement. Intimate partner violence is also an issue with more than 30% of married or partnered women aged 15-24 experiencing physical or sexual violence from a male partner in the previous 12 months.¹¹

I have a child and when I go with a man like him, he can give me something to buy milk for the child.

- Aisha, a young women at a party in the Mkinga district [12](#)

People who inject drugs (PWID) and HIV in Tanzania

Tanzania is home to a significant population of people who inject drugs (sometimes referred to as PWID).[13](#)

In 2014, Tanzania National AIDS Control Programme (NACP) estimates there were 30,000 people who inject drugs in the country, 35% of whom were living with HIV.[14](#) However, data on people who inject drugs varies widely between studies, due to the hidden nature of this population.[15](#)

The HIV prevalence among women who inject drugs is thought to be twice that of their male peers. The reasons for this are not fully known although possible factors include women who inject drugs being involved in sex work or being last in line when syringes are shared.[16](#)

The majority of data on people who inject drugs in Tanzania has been collected in Dar es Salaam and Zanzibar. Zanzibar is a gateway to the African continent and is also situated along a major corridor for drug trafficking. Around one in six people who live in Zanzibar and inject drugs is infected with HIV according to 2010 estimates, but some believe this figure may be higher.[17](#) [18](#)

A 2015 study of 480 people who use drugs in the northwestern city of Mwanza found 13.5% of respondents injected drugs, 67% of whom shared needles. This study suggests that injecting drug use, particularly heroin, is now a significant issue in a major city outside Dar es Salaam and Zanzibar.[19](#)

Mobile populations and HIV in Tanzania

Migration is common in Tanzania. In particular, the expansion of the mining sector has led to greater urbanisation and mobility between rural and urban areas. This means that young and sexually active men come into close contact with 'high risk sexual networks' made up of sex workers, women at truck stops and miners: all of whom have high levels of HIV prevalence.[20](#) Long-distance truck drivers, agricultural plantation workers and fisherman working along coastal trading towns are also at an increased risk of HIV.

For example, a 2015 study by the International Organisation for Migration (IOM) on truck drivers in Dar es Salaam found all those surveyed had established sexual relationships with partners at truck stops whom they considered permanent or second wives (described as 'Mapoza').[21](#)

It is not only mobile men who are at increased risk of HIV infection. Women who travel away from home five or more times in a year have been found to be twice as likely to be infected with HIV than women who do not travel.[22](#)

Young people and HIV in Tanzania

Like most other sub-Saharan African countries, Tanzania has a very young population. A third of the country's population are aged 10-24, the age most become sexually active.[23](#)

In 2014, an estimated 6%

In 2016, an estimated 4.7% of adolescents (aged 10-19) were living with HIV in Tanzania.²⁴ Young people engaging in risky sexual behaviour (such as not using condoms), having multiple sexual partners, and first having sex before the age of 15 remain significant challenges in the country's HIV response. Comprehensive knowledge about HIV is also low – less than half of young people have adequate knowledge.

of adolescents were living with HIV.

However, improvements have been made in recent years. In 2014, the percentage of young girls having sex before 15 decreased from 11% to 9%.²⁵ Condom use has also increased, but is still inadequate, with only 34.1% of young men, and 41.5% of young women using a condom in the same year.

Men who have sex with men (MSM) and HIV in Tanzania

The proportion of HIV infections that arise from sex between men in Tanzania is very low, however men who have sex with men (sometimes referred to as MSM) are still disproportionately affected by the epidemic, with 25% estimated to be living with HIV.²⁶

Although HIV prevalence has declined significantly from previous estimates of 42% more has to be done. In 2014, less than half (45%) of all men who have sex with men reported using a condom during their last sexual contact, and only quarter were reached with some sort of HIV prevention programme.²⁷

HIV testing and counselling (HTC) in Tanzania

Over the last decade, Tanzania has increased its efforts to get more people testing for HIV. The number of voluntary counselling and testing (VCT) sites in the country has rapidly expanded to 2,137. According to the 2010-2011 Malaria and AIDS Indicator Survey, more than 90% of people knew where to get an HIV test.²⁸

In 2013, Tanzania introduced new HIV testing approaches such as home-based testing and community testing. Provider initiated testing, when a health care provider specifically recommends an HIV test to someone attending a health facility and performs the test unless the patient declines, has also been introduced.²⁹

Data from the THMIS 2010-2011 indicates that 67% of women and 50% of men had been tested for HIV at least once. However, Tanzania's UNAIDS 2014 progress report found in 2013 only 28.4% of people aged 15-49 had taken an HIV test in the past 12 months and knew their results. Furthermore, testing rates are declining, as this figure stood at 35.4% in 2012.³⁰

Antiretroviral treatment (ART) in Tanzania

Tanzania has made significant gains in the scale-up of its antiretroviral (ART) programmes, with the number of people on ART steadily increasing since 2010.

The percentage of adults (aged 15 and over) living with HIV in Tanzania and receiving antiretroviral treatment (ART) stood at 63% in 2016.³¹ When split by gender, this equates to 62% of women and 40% of men living with HIV receiving ART.³² In total, 688,600 adults were receiving ART in 2015, compared to 500,000 in 2013.³³

In 2016, 48% of children (aged 0-14) living with HIV were receiving ART. This equates to around

51,400 children.³⁴

In 2013, 1209 health facilities were providing HIV treatment - equating to three facilities per 100,000 people.³⁵

The Tanzanian government has begun to simplify drug regimens and move to fixed-dose combinations (FDC) and phase out toxic drugs such as Stavudine. In addition, new guidelines are being issued to increase eligibility and access to ART to sero-discordant couples, all pregnant women living with HIV and key affected populations.

Despite this progress fundamental challenges remain. The Tanzanian Commission for AIDS (TACAIDS) has identified a number of challenges relating to the scale-up of ART - including limited financial resource base for ART and for testing; weak supply chain management systems; and poor drug management and drug stock-outs.³⁶

HIV prevention programmes in Tanzania

Prevention of mother-to-child transmission of HIV (PMTCT)

Nearly a fifth of all new HIV infections in Tanzania are due to mother-to-child transmission (MTCT).³⁷ Tanzania aims to virtually eliminate MTCT and reach 90% of all pregnant women with treatment, reduce the MTCT rate to less than 5%, and maternal and child mortality by 90% by 2017.³⁸ In 2015, 86% of pregnant women living with HIV were receiving effective ART.³⁹ This figure stood at 77% in 2013, showing progress is being made.⁴⁰

Nearly a fifth of all new HIV infections in Tanzania are due to mother-to-child transmission.

To reach as many women as possible, 97% of PMTCT services are now integrated with reproductive and child health services. Around 90% of all women are now tested for HIV during antenatal care visits.⁴¹ This has contributed to a 48% reduction in MTCT between 2009 and 2012.⁴²

However MTCT rates remain high. This can be attributed to a lack of access to PMTCT services during pregnancy, inefficient antiretroviral drug regimens, drug stock-outs and poor adherence to treatment. Plans are now currently under way to address these issues and to roll out option B+.⁴³

Furthermore, only 37% of PMTCT centres provide HIV early infant diagnosis and only 30% of infants exposed to HIV have access to early infant diagnosis services.⁴⁴ However, rates of new infections among children (0-14 years) are declining, falling from 14,000 in 2010 to 10,000 in 2016.⁴⁵

Condom promotion

The Tanzanian government recognises condom promotion as an integral part of its fight against the epidemic.

In 2013, the most current annual data available, over 109 million condoms and 1.7 million female condoms were distributed.⁴⁶

In 2016, Tanzania's Ministry of Health, in collaboration with Population Services International (PSI) and TACAIDS, announced plans to distribute more than 21 million free, branded condoms across the country. The initiative was introduced to counter perceptions that unbranded, government

condoms were of lesser quality than commercial alternatives in order to encourage use.⁴⁷

Condom use during last sexual intercourse has increased significantly from 46.3% to 58% for women, and from 49% to 59% for men between 2008 and 2012.⁴⁸ In comparison, the Demographic and Health Survey and Malaria

Indicator Survey 2015 - 16, reports only 54% of sexually active unmarried women are using any contraceptive method during sex, of which only 15% were using male condoms.⁴⁹

Voluntary Medical Male Circumcision (VMMC) in Tanzania

Circumcision is an effective HIV prevention strategy, reducing a man's risk of acquiring HIV by approximately 60%. When used in combination with other prevention measures, circumcision is an important addition to HIV-prevention options for men.

In 2010 the government prioritised 11 regions for scaling VMMC and set a target of 2.8 million circumcisions by 2016. By the end of 2015, more than 1.3 million VMMCs were conducted.⁵⁰

Two traditionally non-circumcising regions, Iringa and Njombe, made substantial progress toward their regional targets and reached complete VMMC saturation among adolescents. However other regions continue to lag behind. ⁵¹

Creating demand for VMMC

When a VMMC project was first established in the Kaliua District, Tabora, many men were put off by rumours that the removed foreskins would be used for conducting rituals. To dispel these rumours and create demand for the service, peer educators from the project held meetings with community leaders to answer specific questions and address any concerns about the safety of VMMC and the disposal of foreskins.

Targeting influential people within the community paid off. The number of people presenting for voluntary circumcision, which had previously been visited predominantly by boys from a nearby primary school, subsequently increased to an average of between 20 to 28 adult men each day. The local outreach site and dispensary conducted more than 1,000 VMMCs in 2015. ⁵²

Cash transfer programmes

Cash transfer programmes form part of a new arm of HIV prevention that focuses on integrated programmes for social protection schemes and sexual health. Across sub-Saharan Africa these types of programmes have been shown to have a positive effect on preventing HIV and other sexually transmitted diseases (STIs).

In one Tanzanian pilot, cash incentives of US\$10 or US\$20 were given to young adults aged between 18 and 30, as long as they were free from STIs. One year into the study, there was a 25% risk reduction in STIs. These programmes show that economic benefit can positively influence people to use condoms more frequently.⁵³

As of 2016, the Tanzanian government, in collaboration with UNICEF, began exploring a 'cash plus' transfer scheme (where money is provided alongside other forms of support) for adolescents. If implemented, the scheme will focus on the wellbeing of adolescents as they become young adults,

in particular to reduce their risk of exposure to HIV.⁵⁴

Harm reduction

In 2011, with assistance from PEPFAR, Tanzania became the first country in sub-Saharan Africa to implement a [harm reduction](#) programme for people who inject drugs.⁵⁵ A methadone treatment clinic opened up in Tanzania's largest health facility, based in Dar es Salaam, then extended to a second hospital in the city.⁵⁶ Needle and syringe exchanges are also being implemented. The number of syringes distributed per person is the highest in sub-Saharan Africa and among the highest in the world.⁵⁷

We are among the first and the most successful methadone programmes on the continent. We have had other countries, like Kenya, Mozambique and Zambia come over to learn from our experience.

- Dr Pilly Sahid Mutoka, Mwananyamala District Hospital⁵⁸

HIV and TB co-infection in Tanzania

The World Health Organization (WHO) classifies Tanzania within the top 20 high burden countries for Tuberculosis (TB) and for TB/HIV.⁵⁹ In 2015, just under 61,000 cases of TB were presented and 93% had a known HIV status. Of this group, 36% were co-infected with HIV, of whom 86% were on antiretroviral treatment.⁶⁰

The government have prioritised the integration of TB services with HIV services to minimise the burden of these two co-morbidities. Ensuring that people living with HIV are on antiretroviral treatment means that they are in a better place to fight off TB infection. Integrating these two services will also ensure greater access to TB treatment.

The Tanzanian government has done well to keep the country on track to reaching all of the TB targets set within the Millennium Development Goal (MDG) frameworks.⁶¹

The number of people living with HIV who presented with TB and received treatment for HIV and TB increased from 25.9% in 2012 to 54% in 2013. However, this still leaves a large portion of people with HIV/TB co-infected without comprehensive treatment.⁶²

Barriers to HIV prevention programmes in Tanzania

Structural barriers

According to WHO, Tanzania has one of the worst physician-to-patient ratios in the world, with just 0.031 physicians per 1,000 people in 2012.⁶³ The lack of doctors is a particular problem in rural areas, where there are often only nurses available to treat patients. Additionally, a recent study showed that 40% of all doctors in Tanzania work in the private sector.⁶⁴

Qualified doctors and nurses emigrating abroad because of better pay, conditions and training

opportunities means that health sector shortages remain a critical problem to the scale up of HIV treatment, counselling and prevention in Tanzania.

Legal barriers

The Tanzanian parliament passed the HIV and AIDS Act in 2008, protecting the rights of people living with HIV and AIDS. The Act makes it illegal to discriminate against someone because of their HIV status.

However, harmonisation with other legislation is needed to ensure that different laws do not contradict each other. The criminalisation of high-risk groups in Tanzania such as sex workers and men who have sex with men is at odds with the 2008 law as it makes it almost impossible for these groups, already marginalised and stigmatised, to access care and treatment. For example, in August 2016, Tanzania announced new plans to suspend the registration of any charity or non-governmental organisation that 'supports homosexuality' along with a partial ban on the import and sale of lubricants.⁶⁵

Social barriers

Gender inequalities and gender based violence (GBV) continue to hamper the HIV response in Tanzania.⁶⁶ The Tanzania Demographic and Health Survey 2010, the last large scale survey to record GBV, found around 10% of women between the ages of 15-49 reported their first sexual intercourse as forced and 48% of married women reported experiencing sexual violence.⁶⁷

Stigma and discrimination is also a major challenge. The Tanzania Stigma Index 2013 Report by the National Council of People Living with HIV shows clear infringements on the rights of people living with HIV in health, work and school settings. For example, 13% of people living with HIV reported being told not to have children by health care providers. Others reported being coerced into sterilisation and pregnancy termination due to their HIV positive status.⁶⁸

This type of stigma means that many people living with HIV practice self-censorship and have feelings of guilt that affect their quality of life. Indeed, around 44% of those surveyed for the Stigma Index had low self esteem, and 30% felt ashamed.⁶⁹

"At home my mother and myself have tested and been found positive. She has told me not even to tell my relatives; not even my own sister because she is afraid I will be stigmatised.

- A young girl from Tanzania ⁷⁰

Economic barriers

More financial resources are needed in order to scale-up Tanzania's HIV response, especially in line with new WHO treatment guidelines and with the adoption of option B+. More resource are also needed to ensure that proper monitoring and reporting systems are in place for transparency of funding.⁷¹

The Tanzanian HIV response is heavily reliant on foreign funding, with 97.5% coming from foreign donors. Moreover, the share of health sector spending by the government from its own resources has significantly declined from 13% in 2006/7 to approximately 6% in 2013/14.⁷²

In December 2014, a revision of Tanzania's national accounts brought the country closer to the World Bank threshold to qualify for lower middle income status. As of the end of 2016, this reclassification had not been made. If it were to happen it would have significant implications for the amount of domestic funding that some international donors would require the Tanzanian government to provide for its HIV response.⁷³

The future of HIV and AIDS in Tanzania

Although HIV prevalence has fallen in Tanzania over the past decade, tens of thousands of people become infected with HIV every year.⁷⁴ Stigma against HIV positive people and human resource shortages are among the obstacles to ensuring a sustained reduction of new HIV infections and to providing care and treatment to those already infected.

There is also a greater need for targeted HIV programming for key affected populations. As well as programmes that reach hard-hit pockets of communities along high traffic areas.

A 2015 analysis by PEPFAR cites health financing, supply chain, and performance and financial data collection as areas where Tanzania's national HIV response needs improvement. In response to this, the government presented a comprehensive health care financing strategy to the Cabinet, with a focus on scaling up health insurance coverage, strengthening value for money, and engaging the private sector.⁷⁵ These efforts will be necessary if Tanzania is to overcome the debilitating effects the HIV epidemic continues to have on its economy and society.

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