



1. Demographic and socioeconomic data

	Date	Estimate	Source
Total population (millions)	2004	37.7	United Nations
Population in urban areas (%)	2003	34.9	United Nations
Life expectancy at birth (years)	2002	46.5	WHO
Gross domestic product per capita (US\$)	2001	263	IMF
Government budget spent on health care (%)	2001	12.1	WHO
Per capita expenditure on health (US\$)	2001	12	WHO
Human Development Index	2001	0.400	UNDP

3. Situation analysis

- Epidemic level and trend and gender data.** The United Republic of Tanzania is a high-burden, low-income country facing one of the largest HIV pandemics on the globe. The country is experiencing a mature, generalized HIV epidemic, which is still growing. The first cases of HIV/AIDS were reported in 1983. By 1985, the United Republic of Tanzania had an estimated 140 000 people living with HIV/AIDS (1.3% prevalence) and by 1990, about 900 000 (7.2% prevalence). Since the National AIDS Control Programme was established in 1985, the progression of the epidemic has been monitored through unlinked, anonymous testing of blood from pregnant women attending antenatal clinics for the first time in selected sentinel sites. Best estimates of prevalence suggest that the rural prevalence is about 2% lower than the national average and roughly half the urban prevalence. The overall prevalence of HIV infection among blood donors during 2002 was 9.7%, with women having a higher prevalence (12.3%) than men (9.1%). Based on the prevalence among blood donors and the 2002 census data, an estimated 1 894 160 people aged 15 years and above were living with HIV/AIDS in the United Republic of Tanzania in 2002.
- Major vulnerable and affected groups.** The major groups include: 1) women 15–24 years old; 2) orphans and vulnerable children 0–18 years old; 3) men 25–34 years old; 4) sex workers; 5) people in the transport sector, mines, police force, military, prisons and prisoners; 6) refugees; and 7) elderly people forced into new roles as caregivers without support themselves.
- Policy on HIV testing and treatment.** The national policy on HIV/AIDS specifies that all linked HIV testing must be voluntary, with pre- and post-test counselling, and all

2. HIV indicators

	Date	Estimate	Source
Adult prevalence of HIV/AIDS (15–49 years)	2003	6.4–11.9%	WHO/UNAIDS
Estimated number of people living with HIV/AIDS (0–49 years)	2003	1 200 000–2 300 000	WHO/UNAIDS
Cumulative number of reported AIDS cases	2001	132 606	WHO/UNAIDS
Reported number of people receiving antiretroviral therapy (15–49 years)	June 2004	1 650	WHO
Estimated total number needing antiretroviral therapy in 2005	2003	260 000	WHO/UNAIDS
HIV testing and counselling sites: number of sites		not available	
HIV testing and counselling sites: number of people tested at all sites		not available	
Prevalence of HIV among adults with tuberculosis (15–49 years)	2002	33.8%	WHO

testing for other health conditions must conform to ethical principles, that is, informed consent. In March 2003, the Ministry of Health developed the Health Sector HIV/AIDS Strategy for 2003–2008, on which the National Care and Treatment Plan for HIV/AIDS for 2003–2008 was developed, in collaboration with country partners. The Cabinet has approved the National Care and Treatment Plan for HIV/AIDS, and all care and treatment projects and programmes in the country will be incorporated into the Plan.

- Antiretroviral therapy: first-line drug regimen, cost per person per year.** First-line antiretroviral therapy regimens for adults are: a) stavudine + lamivudine + nevirapine; b) stavudine + lamivudine + efavirenz; c) zidovudine + lamivudine + efavirenz; and d) zidovudine + lamivudine + nevirapine. First-line antiretroviral therapy regimens for children are: zidovudine + lamivudine + nevirapine and zidovudine + lamivudine + efavirenz. The cost of basic highly active antiretroviral therapy dropped to US\$ 360 per person per year in February 2003 (Dar es Salaam) and is expected to continue to fall rapidly.
- Assessment of overall health sector response and capacity.** The overall health sector response capacity is rated as high compared with other countries in Africa with a similar level of development. By 1999 there were 4961 health facilities, of which the government owned 3035 and nongovernmental organizations, parastatal organizations, voluntary agencies and the private sector owned 1926. Community- and home-based care initiatives are being introduced in some areas. There are an estimated 250 voluntary counselling and testing sites nationwide, of which the government runs 180. Less than 5% of the population has accessed voluntary counselling and testing services because of stigma and costs, although the Ministry of Health has committed to testing health



workers, youth and poor people free of charge in the Health Sector HIV/AIDS Strategy for 2003–2008. The government is strongly committed to the fight against HIV/AIDS and that commitment continues to expand. The Tanzania Commission for HIV/AIDS (TACAIDS), created in 2000, leads the national response to HIV/AIDS.

- *Critical issues and major challenges.* The constraints in the existing public health sector infrastructure are recognized as a major bottleneck to the implementation of the National Care and Treatment Plan for HIV/AIDS for 2003–2008. No legal instrument is in place to overrule the requirements of intellectual property rights regulations and allow the import of generic drugs and the local manufacture of drugs covered by patents. Access to voluntary counselling and testing varies greatly, and the price of voluntary counselling and testing has constituted a financial access barrier. The human resource shortage in the health sector is a major constraint to scaling up antiretroviral therapy.

4. Resource requirements and funds committed for scaling up antiretroviral therapy in 2004–2005

- WHO estimates that the total funding required to support scaling up antiretroviral therapy to reach the WHO “3 by 5” treatment target of 130 000 people in 2005 is between US\$ 185 million and US\$ 314 million.
- Of this, the government has committed about US\$ 8.9 million to support scaling up antiretroviral therapy for 2004 – 2005, and the United States President’s Emergency Plan for AIDS Relief is expected to commit substantial support of US\$ 89.6 million over the same period. Other bilateral partners are expected to provide additional support of about US\$ 13.9 million.
- The Global Fund to Fight AIDS, Tuberculosis and Malaria provided a grant of US\$ 87 million in Round 3 for tuberculosis and HIV collaborative activities, including care and treatment. The Global Fund Round 4 proposal requested US\$ 288 million, of which US\$ 207 million is allocated for care and treatment for two years. The Global Fund Round 3 grant is anticipated to provide an estimated US\$ 4.2 million for scaling up antiretroviral therapy during 2004–2005.
- Other funding to support scaling up antiretroviral therapy will be available starting in 2004 through the World Bank Multi-Country HIV/AIDS Program for Africa.
- Taking into account the funds committed to date to support scaling up antiretroviral therapy, WHO estimates that the total funding gap to reach 130 000 people by the end of 2005 will be between US\$ 68 million and US\$ 197 million.

5. Antiretroviral therapy coverage

The total treatment need for 2005 is estimated to be 260 000 people, and the WHO “3 by 5” treatment target for 2005 is 130 000 people (based on 50% of estimated need). The government has declared a national antiretroviral therapy target for 2005 of 220 000 people, and the current estimate of antiretroviral therapy coverage is 1650 people.

6. Implementation partners involved in scaling up antiretroviral therapy

- *Management and leadership.* In 2000, the government established TACAIDS under the auspices of the Prime Minister’s Office to lead the multisectoral response to the epidemic. The role of TACAIDS is to intensify the national response through strategic leadership, policy guidance and coordinating public, voluntary, private and community efforts. The Ministry of Health provides leadership in policy and programming within the public sector, with the TACAIDS supporting the national planning process, fundraising and programme evaluation. National human resources planning provides the greatest challenge, and studies to inform the planning process are ongoing with support from the President’s Office for Regional Administration and Local Government and the Ministry of Finance.
- *Antiretroviral therapy service delivery.* The Ministry of Health leads and manages most delivery of antiretroviral therapy services. WHO provides normative support for developing tools and guidelines along with the United States Centers for Disease Control and Prevention and nongovernmental organizations. The Medical Stores Department provides leadership in procurement and supply chain management, with the United States Agency for International Development, WHO, the United States Centers for Disease Control and Prevention and a range of nongovernmental organizations providing support, also in capacity-building, site-level training, strengthening laboratories and accelerating prevention.
- *Community mobilization.* The Ministry of Health provides leadership in programme communication, capacity-building among people living with HIV/AIDS and adherence and psychosocial support. WHO, the President’s Office for Regional Administration and Local Government and a range of nongovernmental organizations work alongside the government in mobilizing communities.

- *Strategic information.* The Ministry of Health leads and manages surveillance, monitoring and evaluation, information management and operational research activities. WHO plays an important role in providing technical guidance. The United States Centers for Disease Control and Prevention, UNAIDS and TACAIDS provide support for surveillance activities. Monitoring antiretroviral drug resistance, tracking patients and information management activities require additional strengthening and support. The government and its international partners signed a memorandum of understanding recently, articulating the desire by all partners to coordinate their efforts in planning, implementing monitoring and evaluation and mobilizing resources for the National Multi-sectoral Framework on HIV/AIDS. In this context, implementing partners have different roles, which TACAIDS is monitoring and coordinating.

7. WHO support for scaling up antiretroviral therapy

WHO’s response so far

- Supporting the development of the Round 4 proposal for the Global Fund to Fight AIDS, Tuberculosis and Malaria
- Conducting a “3 by 5” scoping mission in December 2003 to identify opportunities and challenges for scaling up antiretroviral therapy
- Under the WHO/OPEC Fund Multi-country Initiative on HIV/AIDS, supporting the strengthening of voluntary counselling and testing services and improved access to home-based care in Iringa, Dodoma and Zanzibar; promoting institutional capacity-building in each of the districts; improving the capacity of the WHO Country Office by financially supporting one national project officer; and supporting a project coordinator at the Ministry of Health, National AIDS Control Programme.

Key areas for WHO support in the future

- Establishing a “3 by 5” country team to support the government and all partners in scaling up antiretroviral therapy
- Supporting the health sector review
- Providing technical assistance in human resource planning and capacity-building
- Providing technical assistance in developing a plan for voluntary testing and counselling
- Providing technical assistance in facilitating the disbursement of Round 3 funds from the Global Fund to Fight AIDS, Tuberculosis and Malaria
- Providing technical assistance on procurement issues
- Supporting the strengthening of the human resources capacity of the National AIDS Control Programme in laboratory services, organization of HIV/AIDS clinical services, monitoring and evaluation and community mobilization.

Staffing input for scaling up antiretroviral therapy and accelerating prevention

- Current WHO Country Office staff responsible for HIV/AIDS and sexually transmitted infections include one National Programme Officer, and recruitment of an international “3 by 5” Country Officer is currently underway.
- Under the WHO/OPEC Fund Multi-country Initiative on HIV/AIDS, an additional National Programme Officer is in place and two additional WHO National Programme Officers are scheduled for immediate deployment.

For further information, please contact:

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This country profile was developed in collaboration with national authorities, the WHO Country Office for the United Republic of Tanzania and the WHO Regional Office for Africa.