

Tanzania

HIV/AIDS and Malaria Indicator Survey 2011-12

Policy Briefs

This 2011-12 Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS) was implemented by the National Bureau of Statistics (NBS) in collaboration with the Office of the Chief Government Statistician (OCGS-Zanzibar) from December 16, 2011, to May 24, 2012. The Tanzania Commission for AIDS (TACAIDS) and the Zanzibar AIDS Commission (ZAC) authorised the survey. Funding for the survey was provided by the United States Agency for International Development (USAID), the Tanzania Commission for AIDS (TACAIDS), and the Ministry of Health and Social Welfare (MoHSW). ICF International supported the survey through the MEASURE DHS project, a USAID-funded programme providing support, technical assistance, and funding for population and health surveys in countries worldwide.

Additional information about the survey may be obtained from the Tanzania Commission for AIDS (TACAIDS), P.O. Box 76987, Dar es Salaam, Tanzania (Telephone: 255-22-212-2651; Fax: 255-22-212-2427; Internet: www.tacaids.go.tz) and the National Bureau of Statistics, General Office, P.O. Box 796, Dar es Salaam, Tanzania (Telephone: 255-22-212-2722/3; Fax 255-22-213-0852; Internet: www.nbs.go.tz).

Information about the DHS programme may be obtained from MEASURE DHS, ICF International, 11785 Beltsville Drive, Suite 300, Calverton, MD 20705, USA. Telephone: 301-572-0200; Fax: 301-572-0999; E-mail: reports@measuredhs.com; Internet: <http://www.measuredhs.com>.

Recommended citation:

Tanzania Commission for AIDS (TACAIDS), Zanzibar AIDS Commission (ZAC), National Bureau of Statistics (NBS), Office of the Chief Government Statistician (OCGS), and ICF International. 2013. *Tanzania HIV/AIDS and Malaria Indicator Survey 2011-12: Policy Briefs*. Dar es Salaam, Tanzania: TACAIDS, ZAC, NBS, OCGS, and ICF International.



Introduction

On March 28, 2013, President Jakaya Kikwete formally released the findings for the 2011-12 Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS). The 2011-12 THMIS is the twelfth survey carried out in Tanzania by the National Bureau of Statistics with assistance from the MEASURE Demographic and Health Survey (DHS) project. All of these surveys offer a wealth of information about the health status of Tanzanians along with their knowledge, attitudes, and practices about a wide range of issues.

The 2011-12 THMIS focused mainly on HIV and malaria. The survey results provide insights into on-going programmes and policies in Tanzania. This report looks at current status of household water and sanitation, gender, malaria prevention and prevalence, HIV prevention and prevalence, and HIV and youth in Tanzania. Each of the six briefs attached considers regional patterns, trends over time, and their policy and programme implications.

The six policy briefs rely largely on the findings of five national surveys carried out in the last decade.

2011-12 Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS)

Sample: 10,040 households nationwide, 10,967 women and 8,352 men age 15-49

Implementing Agencies: National Bureau of Statistics (NBS) in collaboration with the Office of the Chief Government Statistician (OCGS-Zanzibar)

Funding: United States Agency for International Development (USAID), the Tanzania Commission for AIDS (TACAIDS), and the Ministry of Health and Social Welfare (MoHSW)

2010 Tanzania Demographic and Health Survey (DHS)

Sample: 9,623 households, 10,967 women and 8,352 men age 15-49

Implementing Agencies: NBS

Funding: USAID, MoHSW, Tanzania Food and Nutrition Centre (TFNC), Department of International Development (DFID), World Health Organization (WHO/Zanzibar), United National Fund for Population Activities (UNFPA), United National Children's Fund (UNICEF), World Food Programme (WFP), United Nations Development Programme (UNDP), and Irish Aid

2007-08 Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS)

Sample: 8,497 households, 9,343 women and 6,975 men age 15-49

Implementing Agencies: NBS in collaboration with OCGS-Zanzibar

Funding: USAID

2004-05 Tanzania Demographic and Health Survey (DHS)

Sample: 9,735 households nationwide, 10,329 women and 2,635 men age 15-49

Implementing Agencies: NBS in collaboration with OCGS-Zanzibar

Funding: USAID and the Government of Tanzania

2003-04 Tanzania HIV/AIDS Indicator Survey (THIS)

Sample: 6,901 households in Mainland Tanzania, 6,863 women age and 5,659 men age 15-49

Implementing Agencies: NBS under the authorization of TACAIDS

Funding: USAID

Household Environment

Executive Summary

Good health begins with clean drinking water, sanitary and safe latrine facilities, and good hygiene. Fewer than six in ten households in Tanzania have access to improved water sources, and far fewer, only 13%, have access to improved sanitation facilities. While the Government of Tanzania (GOT) has agreed to make clean water and sanitation facilities more widely available, it has not yet backed up this promise with concrete actions or funding. Comprehensive and sustained interventions by the government and its development partners are needed to improve Tanzanian household, community, and public environments and to bring living standards in Tanzania closer to those of other countries in East Africa.

Introduction

Access to improved water, improved sanitation facilities, and basic hygiene practices are essential to good health. Contaminated water, inadequate sanitation and poor hygiene standards lead to transmission of waterborne diseases, including cholera, diarrhoea, and dysentery. Time spent collecting water, work usually completed by women and girls, is time lost to education and productive work.

The Government of Tanzania has acknowledged the need to improve household water and sanitation. Access to water and sanitation is addressed under Millennium Development Goal (MDG) number 7, which requires member countries to halve, by 2015, the proportion of people without sustainable access to safe drinking water and sanitation facilities. The government has further committed through the National Sanitation Campaign to ensure that 27 million people have access to improved sanitation facilities and practice basic hygiene at the household level by 2015. Furthermore, the National Strategy for Growth and Reduction of Poverty (MKUKUTA II, 2010 under Goal 4 of cluster II) advocates for increased access to sanitation, hygiene, and affordable safe water, as do the National Water Policy (2002) and Health Policy (2007).

2011-12 Tanzania HIV/AIDS and Malaria Indicator Survey Findings

Inadequate access to an improved water source

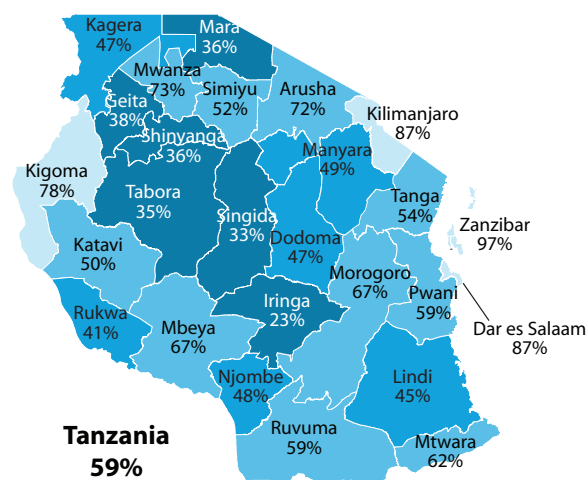
In Tanzania, four in ten households do not have access to improved drinking water. In rural areas, half of all households do not have improved drinking water on the premises compared with only 10% of urban households. Nationwide, family members in 44% of households spend 30 minutes or more for each trip to fetch water.

Access to clean drinking water varies substantially by region. Iringa, Singida, and Tabora report the lowest access to clean drinking water—23%, 33%, and 35% of households, respectively. In contrast, more than 75% of households in Kigoma, Kilimanjaro, Dar es Salaam, and Zanzibar have improved water sources.

Many health care facilities also lack improved water sources. According to the 2006 Tanzania Service Provision Assessment (SPA) survey, only 34% of health care facilities had regular supply of water from a tap.

Safe Drinking Water by Region

Percent of households with improved sources of water



Access to improved water has not changed much in the last five years. In 2007-08, 56% of households had access to improved water sources compared with 57% in 2010 and 59% in 2011-12.

Tanzania is far behind other countries in the East African Community. Just under 60% of Tanzanian households have access to improved water compared with more than 70% of households in Uganda, Rwanda, and Burundi.

Poor access to improved sanitation facilities

Most Tanzanians do not have access to clean and safe sanitation facilities. Nationwide, only 13% of households have improved sanitation facilities. Access to sanitation is better in urban areas, where one in four households have improved sanitation facilities compared with less than one in ten rural households.

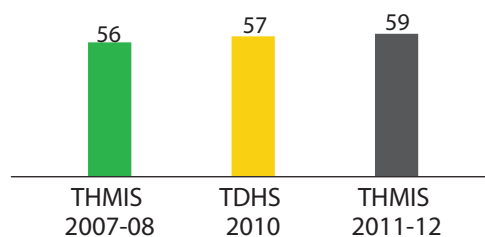
Twelve percent of Mainland Tanzania households do not have any sanitation facilities at all. This means that approximately six million Tanzanians are forced to defecate in the bush or in the open, putting themselves and their neighbours at risk of disease.

According to the 2011-12 THMIS, there is no region in Mainland Tanzania where at least half of the households have access to improved sanitation facilities. About one in four households in Dar es Salaam and one in three households in Kilimanjaro have improved sanitation facilities compared with less than 20% of households in the rest of the country. Regions with the lowest percentage of improved sanitation facilities include Geita and Katavi at 3% of households. In Zanzibar, by contrast, more than half of all households have improved sanitation facilities.

Tanzania lags behind other East African Community countries with respect to sanitation. Only 13% of Tanzanian households have access to improved sanitation facilities compared to almost one-fourth of Kenyan households and more than half of Rwandan households.

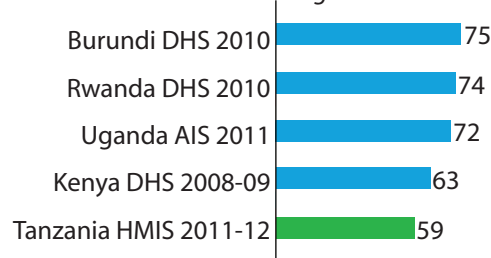
Trends in Access to Safe Drinking Water

Percent of households with improved source of drinking water



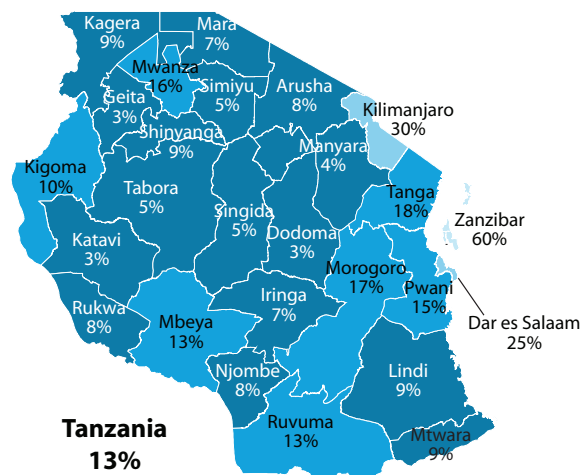
How Does Tanzania Compare? Safe Drinking Water among Eastern African Countries

Percent of households with an improved, source of drinking water



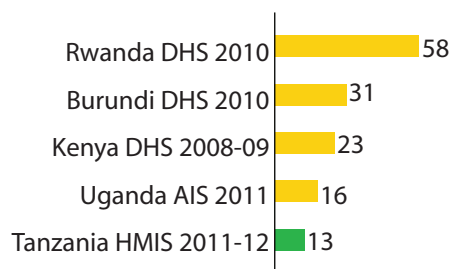
Household Sanitation by Region

Percent of households with improved, not shared toilet/latrine facilities



How Does Tanzania Compare? Sanitation among Eastern African Countries

Percent of households with an improved, non-shared sanitation facility



Conclusions and Implications for Programmes and Policies

In 2010, the United Nations General Assembly recognized access to sanitation and clean water as a basic human right. Yet, most Tanzanian households lack even the most basic facilities. Improving the household, community, and public sanitary environment should be a national priority for Tanzania.

- To meet the Millennium Development Goals, Tanzania will need to provide safe drinking water to eight in ten households and improve sanitation facilities to more than half of the households. This cannot happen without major comprehensive and sustained efforts by the GOT, its development partners, and the communities themselves. The first step is to place improved household water and hygiene on an equal footing with other health and development interventions such as HIV, malaria, and child survival.
- To get a complete picture of the current situation, the GOT should work with district planning and health teams to map water and sanitation services in households, schools, and health care facilities.
- At present, the GOT is reviewing guidelines for household water treatment and safe storage as part of the National Sanitation Campaign. Once these guidelines are enacted, the GOT should make them available to all actors at the national and local level who are involved in environment and hygiene services. These guidelines will be the basis for enforcing regulations governing sanitation facilities in local government authorities (LGAs). They will also direct the integration of water, sanitation and hygiene (WASH) issues into health, education, gender, and livelihood programmes.
- Safe water and improved sanitation need to be integrated into on-going programmes in health, education, gender, and livelihood, just as HIV prevention programmes have been.
- The GOT should take immediate steps to fund and implement WASH projects in rural areas, beginning with the regions with least access to clean water and improved sanitation facilities.
- The government and international donors should fund advocacy and awareness campaigns, programmes on hygiene and sanitation at households and service delivery sites, and allocate more resources to facilitate these programmes.
- Increasing community participation in establishing water committees at village and street levels for maintenance and expansion of water schemes is essential to ensure sustainability.



Many Tanzanians use non-improved sanitation facilities such as pit latrines.
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Gender

Executive Summary

Gender equality is critical to Tanzania's development. Changing societal norms to promote gender equality is essential, as are programmes that engage both women and men as change agents. Gender-sensitive policies and programmes can encourage equity in decision making from the household to the national level, which will in turn ensure stronger future leadership on gender issues. However, achieving gender equality requires concerted efforts at all levels of society.

Empowering women helps them protect their own and their families' health and participate fully in the nation's cultural, social, and economic development. Women are less likely to be educated in Tanzania than men; they are at higher risk of HIV than men, but are less likely to be well informed about how to protect themselves from infection. Women are also at risk of malaria during pregnancy, but many do not receive appropriate preventive treatment. Tanzania has a high burden of cervical cancer; women above age 15 years should be screened, and HPV vaccination should be scaled up among girls below age 13 years.

Gender sensitivity is not limited to women's concerns. Men are far more likely than women to have multiple sexual partners but get tested for HIV less, putting them at higher risk for HIV, so it is critical to initiate programmes that will encourage men to reduce risky behaviours and to know their HIV status.

Gender-based violence is prevalent in Tanzania with intimate partner violence being the most common practice. This violates the victim's rights and increases the cost of healthcare.



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Introduction

The promotion of gender equality and empowerment of women is one of the eight Millennium Development Goals, which underscores the importance of gender sensitivity and women's empowerment to development efforts. Lasting progress cannot be made in improving the health and well-being of individuals and the economic development of the nation as a whole while gender inequality persists.

Gender inequality increases women's vulnerability to a host of health problems. Women are biologically more vulnerable to HIV, and this is compounded by sociocultural norms about masculinity and femininity and the unequal power balance between men and women, which can lead to sexual exploitation, early marriage, and gender-based violence. Women often have less power within families and communities, a situation that is worsened by lack of access to economic opportunities, leaving women vulnerable to transactional sex and other risky sexual behaviours. In addition to supporting women and girls through improved education and economic empowerment, specific policy efforts can be made in the areas of HIV/AIDS, malaria, cervical cancer, and gender-based violence, to the benefit of all members of Tanzanian society.

2011-12 Tanzania HIV/AIDS and Malaria Indicator Survey Findings

Education

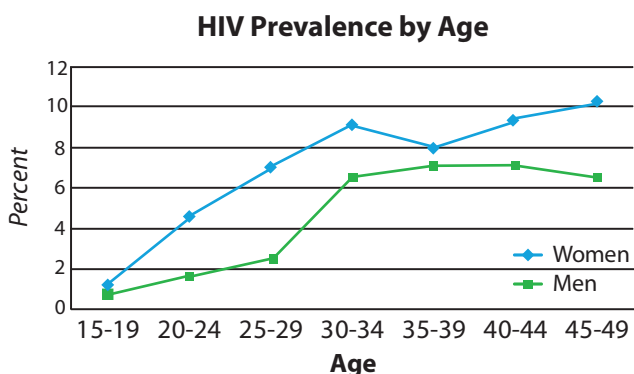
Education of women and girls is a key driver of family health and wealth. Tanzanian women are more likely than men to have little or no education. Women also have less exposure to mass media and are generally less informed about HIV and AIDS, malaria and other health issues.

Eighteen percent of women age 15-49 have had no formal education, compared to just 9% of men. At the higher level of education, 18% of women and 24% of men have attended secondary school or more, though only a fraction of those completed the secondary level.

Education levels vary markedly by region. In Katavi and Tabora about one in three women have no education compared to about one in eight men. In Dar es Salaam, however, the proportion of women and men with no education is the same, at 3%.

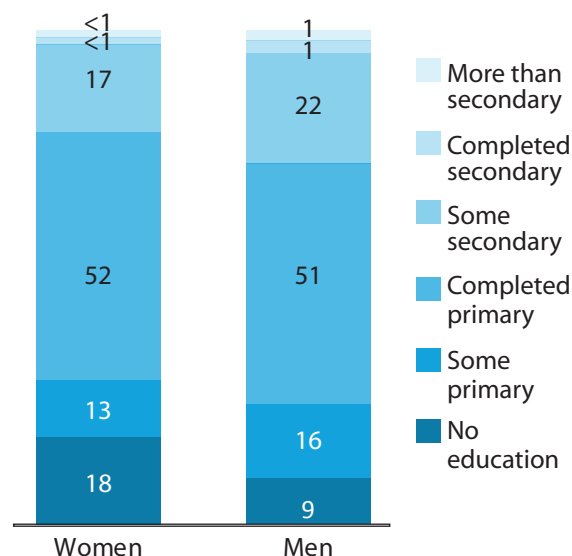
Women also have less exposure to radio, television and newspapers, which are important sources of health-related information. Only 49% of women listen to the radio at least once a week, compared to 74% of men. More than 40% of women do not regularly access any mass media compared to just 23% of men.

Not surprisingly, women are also less likely to be exposed to mass media educational messages about health issues such as malaria and HIV/AIDS. For example, only 48% of women said they had seen or heard an HIV education programme on TV or radio or in a magazine in the previous 12 months compared to 62% of men.



Education

Percent distribution of women and men age 15-49 by highest level of education completed or attended



HIV/AIDS

Nearly all Tanzanians have heard of AIDS, and nine in ten know where to get an HIV test. But women are more likely to be HIV-positive and less likely to know how to protect themselves from infection. The knowledge disparities between women and men are especially striking among rural residents and those in the poorest households.

HIV prevalence among all Tanzanian women age 15-49 is 6.2%, compared to 3.8% for men. Among young women, prevalence generally increases with age after they turn 20. The prevalence among women age 15-19 is relatively low, at 1.3%, but prevalence more than triples to 4.4% among women age 20-24. More women than men are infected with HIV at every age level. Although HIV prevalence overall has declined since 2003-04, prevalence is declining faster among men. From 2003-04 to 2011-12, prevalence among men in Mainland Tanzania dropped from 6.3% to 3.9%. During the same period, women's prevalence declined from 7.7% to 6.3%.

Women are somewhat less informed about HIV/AIDS than men in all categories except mother-to-child transmission of HIV. Women know less about how to protect themselves from HIV; 69% of women and 77% of men know that using condoms reduces HIV risk, and 84% of women and 87% of men know that limiting sexual intercourse to one uninfected partner reduces risk. Only 63% of women and 71% of men know about both methods.

Women are more likely than men to have had sex by age 18 (50% vs. 36%), increasing their exposure to both early pregnancy and HIV infection. Women are also much more likely to marry before age 20 than men, reducing their education and economic opportunities.

Cervical Cancer

Tanzania has one of the highest cervical cancer burdens in the world, and the highest in eastern Africa, according to a 2011 report from the Ocean Road Cancer Institute. Screening and early detection and treatment of cervical cancer can reduce rates of sickness and death. In addition, a vaccine against Human Papilloma Virus (HPV) can help protect women from cervical cancer if they are vaccinated before they become sexually active. Two-thirds of women in Tanzania have heard of cervical cancer. Awareness is higher in urban areas, and in Mainland Tanzania as compared to Zanzibar. However, among the women who have heard of cervical cancer, only 16% had spoken to someone about it during a visit to any health facility in the previous six months.

75% of pregnant women slept under an ITN the night before the survey.



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Malaria

Malaria is a major public health problem in Tanzania. Women are more susceptible to malaria during pregnancy, which can increase the risk of low birth weight, maternal anaemia, infant mortality, miscarriage, and stillbirth.

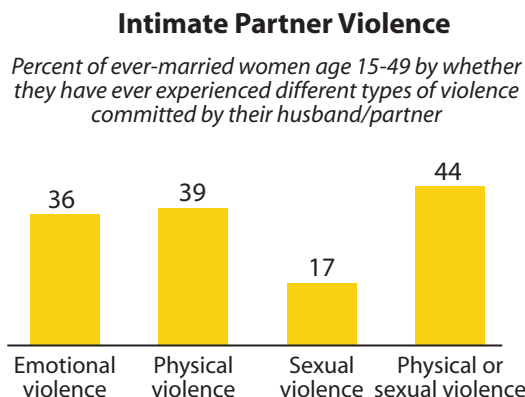
Nine out of ten women know that pregnant women are at high risk of getting malaria. Intermittent preventive treatment of malaria during pregnancy (IPTp) can reduce risk, but only 4% of women mentioned IPTp when asked about ways to avoid malaria. Among women who had a live birth in the two years before the survey, only 33% took the recommended two or more doses of SP/Fansidar.

Use of insecticide-treated nets (ITNs) has increased dramatically in recent years. Three-quarters of pregnant women surveyed in 2011-12 had slept under an ITN the previous night, up from 27% in 2007-08. Also, among children younger than five, girls are just as likely to sleep under ITNs as boys.

Gender-Based Violence

Violence against women is common in Tanzania. Gender-based violence violates the victim’s human rights and dignity and like all violence increases health care costs and reduces productivity, which can have a major impact on the economy. Results of the 2010 Tanzania Demographic and Health Survey (TDHS) showed that almost half of Tanzanian women have experienced physical or sexual violence by a husband or partner.

Four in ten ever-married women have experienced physical violence since age 15; 33% experienced violence often or sometimes in the 12 months before the survey. Almost 20% of ever-married women have ever experienced sexual violence, and 44% of ever-married women have experienced physical or sexual violence committed by a husband or partner. Intimate partner physical or sexual violence is most common in Dodoma and Mara, with more than 70% of women experiencing physical or sexual violence committed by their husband or partner, and least common in Tanga (16%) and in Zanzibar (9%).



Conclusions and Implications for Programmes and Policies

- Decision makers should consider the effects of gender dynamics on health and development, and ensure that all laws and programmes are gender sensitive. Programmes to empower women and girls through education and economic activities should be supported and funded.
- To help reduce rates of cervical cancer, GOT should promote and support cervical cancer screening for women above age 15, and scale up HPV vaccination among girls below 13 years of age. This includes providing appropriate equipment in health facilities and ensuring that providers are adequately trained.
- HIV prevalence is consistently higher among women than among men, suggesting that more needs to be done to help women protect themselves from infection. Prevention programmes should be designed to meet women’s prevention needs at different stages of their lives, and take into account the gender dynamics that can have a considerable effect on men’s and women’s health behaviour.
- GOT should scale up evidence-informed educational HIV/AIDS programmes focused on men, who have higher percentages of risky sexual behaviour but lower testing percentages as compared to women. Effective educational programmes for men will help protect men as well as their partners and children.
- All behaviour change communications should take into account gender roles and norms that increase women’s vulnerability to HIV, affecting the health of men, women, and children. Traditional methods of communication should be emphasized for those with lower literacy and less access to mass media.
- The GOT has put into place policies against gender-based violence and amended the penal code to address sexual violence. Now, efforts are needed to implement policies and enforce laws to protect women. Unless men are held accountable and experience consequences, violence against women will continue. In addition, the recent Law of the Child Act should be enforced to protect girls as well as boys from exploitation and violence.

Malaria Prevention



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Executive Summary

Malaria is a public health crisis in Tanzania. Treatment of the disease and lost days at work are costly for families and for the government. The Ministry of Health and Social Welfare (MoHSW) Health Management Information System estimates that 40% of the national disease burden is due to malaria. Minimizing this burden will improve public health and bring solid economic gains for individuals, families, and the public.

The Government of Tanzania (GOT) and partner organizations have made significant strides in scaling up malaria control interventions and reducing malaria prevalence among children to under 10% nationwide. Still, gaps in prevention exist. Too few women receive preventive care during pregnancy, and while nine out of ten Tanzanian households own at least one insecticide treated net (ITN), almost half of households do not have enough nets to cover all residents. Malaria interventions need to be supported and funded to ensure that recent gains are sustained and to reach those who still lack the knowledge or means to protect themselves and their families from malaria. Malaria prevention rests on sustained community action backed by national support for interventions that have shown success in reducing sickness and death from malaria in Tanzania.

Introduction

The GOT and international organizations are leading the fight against malaria. Roll Back Malaria (RBM) provides policy and technical advice to support efforts to reduce malaria morbidity and mortality by increasing net coverage and strengthening health systems through the Global Malaria Action Plan. Malaria control is part of two UN Millennium Development Goals (MDGs): MDG 4—Reducing Child Mortality, and MDG 6—Combating HIV/AIDS, malaria, and other diseases. The MoHSW aims to achieve RBM and MDG goals by scaling up and ensuring that 80% of the population has universal coverage of ITNs by 2015. Universal coverage is defined as one ITN per sleeping space or one net for every two people. Tanzania is close to achieving these goals.

Malaria prevalence among children in Tanzania has declined to 9% in 2011 (2011-12 THMIS)*. This achievement is mainly attributable to low cost and effective interventions in malaria prevention and control, particularly ownership and use of ITNs, as well as strong behaviour change communication programmes and indoor residual spraying (IRS). The majority of Tanzanians—66% of women and 73% of men—cite malaria as the most serious health problem in their community. Almost all Tanzanians know some ways to prevent malaria, and 98% of survey respondents mentioned sleeping under a net. Other effective prevention methods, such as IRS and preventive treatment during pregnancy, are much less well known. Not surprisingly, more educated women and men cite multiple prevention methods than less educated men and women.

**In Tanzania, 9% of children age
6-59 months tested positive
for malaria.***

*Malaria testing done with the SD Bioline Malaria Ag Pf/Pan (Standard Diagnostics) rapid diagnostic test (RDT)

2011-12 Tanzania HIV/AIDS and Malaria Indicator Survey Findings

Insecticide Treated Nets (ITNs)

According to the 2011-12 THMIS, 75% of the population has access to an ITN, indicating that Tanzania is close to achieving its goal of 80% access. Access is highest in southern Tanzania and lowest in Geita, Rukwa, Mjini Magharibi, and Kusini Pemba where less than 65% of the population has access to ITNs.

Use of ITNs has increased markedly in the last decade among all household members, among children under five, and among pregnant women. Use of ITNs among children under five, the group most vulnerable to malaria, has risen steeply from only 16% in the 2004-05 Demographic and Health Survey (DHS) to 72% in 2011-12.

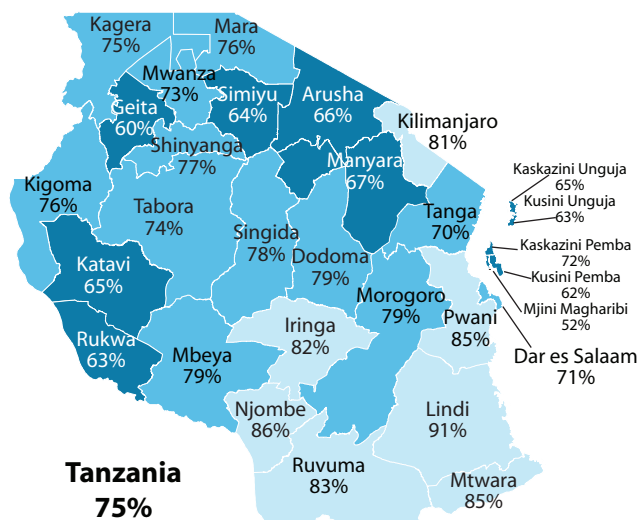
Increased availability of ITNs through government programmes accounts for much of this improvement. The majority of household nets were obtained from publicly subsidized programmes and from free net campaigns.

Still, ownership of nets does not always translate into use; more than 25% of household members in homes owning an ITN did not sleep under an ITN the night before the survey. Respondents cited a number of reasons for not using the ITNs: there were no mosquitos; the net was old or torn; or they were saving the net for later use.

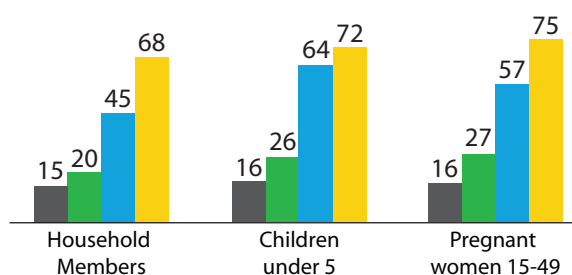
Indoor Residual Spraying (IRS)

Indoor residual spraying kills mosquitos living on household walls. IRS has been implemented in Zanzibar and in three regions of the Lake Zone (Kagera, Mwanza, and Mara). According to the 2011-12 THMIS, 87% of households in Zanzibar had received IRS in the 12 months preceding the survey. On Mainland Tanzania, in Kagera, the first area on the Mainland targeted by the government, 92% of households had been sprayed in the previous 12 months, and coverage in Mwanza and Mara was 41% and 61%, respectively.

ITN Access by Region
Percent of the population with access to an ITN within their household, assuming one ITN covers 2 people



Trends in Use of ITNs
Percent who slept under an ITN the night before the survey



Prevention of Malaria in Pregnancy

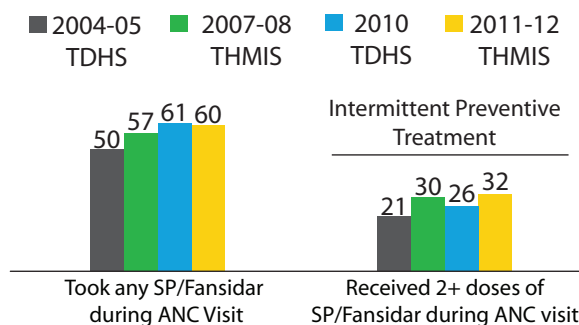
Malaria poses special risks during pregnancy. When women get pregnant they can lose some of their acquired immunity against the disease. Malaria can also lead to low birth weight among infants, a risk factor for neonatal illness and death. Intermittent preventive treatment (IPTp) is one of the key MoHSW and RBM interventions for preventing malaria among pregnant women. At the time of the survey, IPTp was defined as at least two doses of SP/Fansidar given to pregnant women during at least one antenatal care (ANC) visit. Just one-third of women pregnant in the two years before the 2011-12 THMIS received IPTp. Use of any SP/Fansidar during an antenatal care visit and the full dose of IPTp have improved only slightly since the 2007-08 THMIS.

When compared to other countries in East Africa, Tanzania is behind Zambia and Malawi in IPTp uptake. However, Tanzania is doing better than Uganda, Kenya, Mozambique and Rwanda.

Only one-third of pregnant women received 2+ doses of SP/Fansidar during an antenatal care visit.

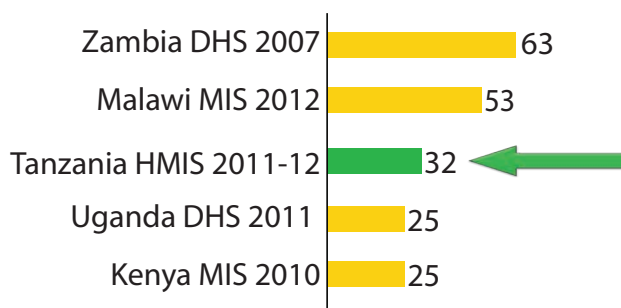
Trends in Intermittent Preventive Treatment of Pregnant Women

Percent of women pregnant in the two years before the survey, based on their last birth who:



How Does Tanzania Compare? IPTp among Eastern African Countries

Percent of women age 15-49 with a live birth in the two years before the survey, who took 2+ doses of SP/Fansidar and received at least one during ANC



Malaria Knowledge

Malaria control requires individual and community action. Behaviour change communication (BCC) is key to improving knowledge of malaria prevention and for increasing demand for malaria control interventions. The MoHSW strategy focuses on increasing community awareness of integrated malaria prevention and control interventions such as access to and use of ITNs, putting screens in windows to reduce human-vector contact, IRS, maintaining a clean environment to remove breeding sites, improving acceptability of IRS and IPTp, and testing and diagnosis before malaria treatment. The 2011-12 THMIS shows, however,

that knowledge of these interventions, with the exception of ITNs, is far from universal.

Almost all women and men in Tanzania know that sleeping under a mosquito net prevents malaria. Far fewer adults cite other prevention methods, particularly related to reducing mosquito infestation. For example, only 21% of women and 33% of men cite keeping household surroundings clean as a prevention method, and only 12% of women and 20% of men cite removing standing water. Of great concern is that only 4% of women mentioned IPTp as a way to avoid malaria even though 9 in 10 women know pregnancy increases a woman's risk of getting the disease.

Conclusions and Implications for Programmes and Policies

Malaria is a complex disease that requires comprehensive and consistent interventions. Tanzania is making good progress in some areas, especially increasing ITN ownership and use. Sustaining these interventions is essential to eliminating the disease, which claims thousands of lives every year.

- The public programmes for distributing ITNs throughout Tanzania have been very successful, with more than 90% of households owning at least one net. The MoHSW has developed an ITN keep-up strategy to achieve universal coverage with ITNs (defined in Tanzania as one ITN per sleeping space or one net for every two people), which is currently being piloted. National scale-up, which is planned, must be adequately funded. Particular focus should be given to those regions such as Geita that have high malaria parasitemia and are below targets for ITN access.
- In addition, the MoHSW should scale up strategies for ensuring access to ITNs and improving consistent net use in households that own ITNs, particularly among young children and pregnant women.
- Much of the funding for malaria control has come from international programmes and donors such as the Global Fund to Fight AIDS, Tuberculosis, and Malaria and the U.S. President's Malaria Initiative, as well as several bilateral development partners. Now, the MoHSW must develop a financial sustainability plan and advocate increasing GOT funding for procuring, distributing, and promoting use of ITNs, IRS, and other prevention interventions.
- The MoHSW should continue to provide IRS services, and implement efforts in regions where this intervention is indicated. IRS can be effectively implemented to cut off well-identified peaks of seasonal transmission. IRS is also indicated in areas of special economic interest where a high protection level is required, for example, areas with mining, agricultural schemes, dams, and tourist resort areas, and in areas with highly seasonal malaria transmission.
- To sustain and scale up IRS where it is indicated, the MoHSW needs to develop a financing strategy that attracts more IRS partners overall and also includes public-private partnerships.
- IPTp reaches only one-third of pregnant women. The MoHSW must explore what barriers are limiting both the demand for IPTp among women and their families and also the supply of IPTp through health care facilities. In addition, the MoHSW must review best practices from other countries that have successful IPTp programmes such as Zambia and Malawi, and use their lessons learned to develop an effective national implementation plan for Tanzania.
- Tanzania Parliamentarians Against Malaria (TAPAMA) is being reactivated. TAPAMA and the Parliamentary Social Committee should raise the agenda of malaria among parliamentarians and government ministries and should regularly invite the MoHSW, NMCP, and key malaria partners to discuss progress in malaria control indicators, and identify priority actions to communicate to their constituents. Parliamentarians must participate actively in advocating for government support for strong malaria prevention, as well as mobilizing their communities to demand and use malaria control interventions.
- More than 50% of women and 60% of men have seen or heard messages about malaria prevention and treatment in the past year. Still information gaps and misconceptions persist. The MoHSW's NMCP meets regularly with behaviour change communication (BCC) partners; malaria messages are developed by the BCC working group and reviewed by the MoHSW's Health Education Unit. The efforts should be sustained, and recommended BCC interventions should be adequately funded and supported.

Malaria Prevalence, Diagnostics, and Treatment

Executive Summary

Malaria continues to affect many families in Tanzania. Almost one in ten children age 6-59 months tested positive for malaria, according to the 2011-12 Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS). Timely detection and appropriate treatment of malaria are critical steps for reducing severe illness and malaria transmission. Encouraging caretakers of sick children to seek treatment within 24 hours of symptoms, and preventing stock-outs of artemisinin-based combination therapy (ACT), are essential to combating the disease.

Introduction

The 2011-12 THMIS marks a major milestone in malaria control in Tanzania. The survey shows that malaria prevalence in children age 6 to 59 months has declined to 9% nationwide. Thus, Tanzania has changed from a hyper- to a hypo-endemic country, that is, national prevalence below 10%. Prevalence ranges widely throughout Tanzania, from less than 1% in Zanzibar to 25% or more in Geita, Mara, Kigoma, and Lindi. Rural children are three times as likely to test positive for malaria as urban children. Malaria infection decreases as household wealth and mother’s education increases.

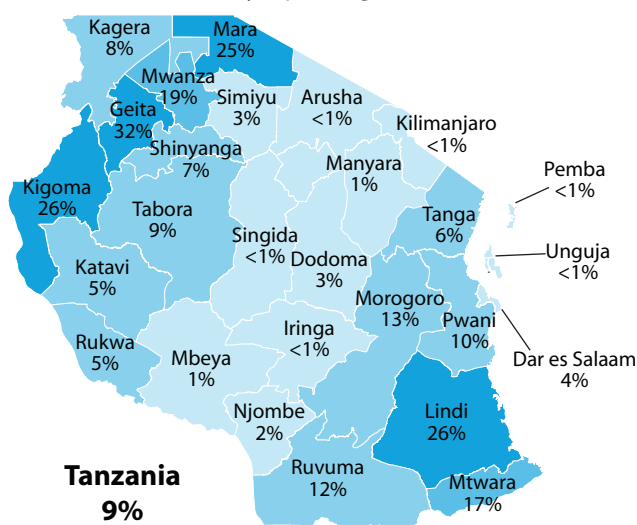
To improve malaria detection and treatment, the Tanzania Mainland and Zanzibar Ministries of Health and Social Welfare (hereafter MoHSW) changed the national treatment guidelines in 2012. Previously, MoHSW recommended presumptive treatment for children under five years of age—that is, treating every fever case with antimalarial drugs. Following the WHO recommendations, MoHSW now endorses testing every suspected malaria case, regardless of age, with a rapid diagnostic test (RDT) and providing treatment only to those who test positive for malaria. The recommended first-line treatment, ACT, and malaria rapid diagnostic tests have been scaled up nationally and should be available in all health facilities.



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Malaria Prevalence in Children by Region

Percent of children 6-59 months testing positive for malaria by rapid diagnostic test (RDT)



2011-12 Tanzania HIV/AIDS and Malaria Indicator Survey Findings

Malaria Diagnostics and Treatment

Fever is common in young children. In the two weeks preceding the 2011-12 THMIS, 20% of children under age five had a fever. Among these children, 77% sought treatment from a health care facility, health care provider, or pharmacy. Treatment seeking is slightly higher in urban than rural areas and higher among wealthier and more educated families. Despite the new MoHSW policy on malaria testing, only one-fourth of children for whom treatment was sought had blood taken from a finger or heel for testing. Diagnostic testing is much higher in urban areas (61%) than in rural areas (17%), largely because the scale-up of RDTs had yet to happen.

The recommended first line drug for malaria is ACT. In Mainland Tanzania, the recommended ACT is artermether-lumefantrine (ALu) and in Zanzibar it is artesunate-amodiaquine (ASAQ). The World Health Organization and MoHSW recommend that ACTs be taken within 24 hours of malaria diagnosis. Among the children with fever in the two weeks preceding the 2011-12 THMIS, just over half (54%) took any type of antimalarial drug; only 33% took ACT, and only 34% took an antimalarial drug within 24 hours of fever. However, of those who did not take antimalarial drugs, some might have had a negative malaria test and so the medication was not indicated. About 20% of children with fever took mono-therapies—chloroquine, quinine, or amodiaquine—instead of the recommended combination therapy. The mono-therapy drugs are not recommended for treatment of malaria and have been banned, but they continue to be available from many private drug sellers.



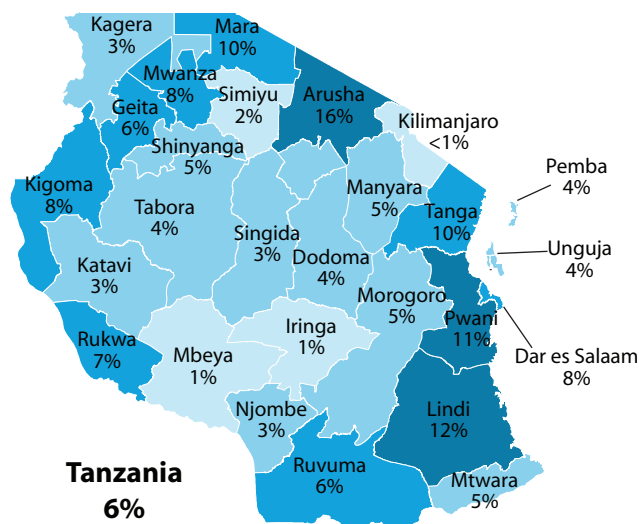
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Anaemia Prevalence

Although there is an association between malaria and anaemia, the prevalence of severe anaemia has changed very little since 2007-08 compared to the decline in malaria parasitemia. In the 2007-2008 THMIS, 8% of children under five had severe anaemia; this dropped slightly to 6% in 2011-12. The regions showing higher anaemia prevalence are Arusha (16%), Lindi (12%), and Pwani (11%). The regions with the highest malaria prevalence are Geita, Kigoma, Lindi, and Mara.

Anaemia Prevalence in Children by Region

Percent of children 6-59 months with moderate to severe anaemia



Conclusions and Implications for Programmes and Policies

Malaria imposes a huge social, health, and economic burden on Tanzania. The GOT, MoHSW, and Tanzania's development partners have succeeded in reducing this burden in the last five years. Still, the MoHSW must sustain the gains and reduce malaria prevalence further by:

- Continuing the implementation of a package of low-cost and effective malaria control interventions—ITNs, indoor residual spraying (IRS), intermittent preventive treatment during pregnancy (IPTp), malaria diagnosis and treatment—and intensifying behaviour change communication. Behaviour change communication must focus on promoting the interventions noted above as well as environmental prevention by reducing mosquito breeding sites and installing screens in houses. (See Policy Brief on Malaria Prevention)
- Targeting additional interventions to areas showing high or increasing malaria transmission, particularly in the Lake Zone, in southern Tanzania, and in Kigoma.
- Ensuring appropriate malaria surveillance and putting in place epidemic early warning and preparedness systems to detect any sudden increase in malaria transmission and respond appropriately to contain the outbreak and prevent death.
- Increasing the government contribution for malaria control. At present, the National Malaria Control Programme (NMCP) interventions (ITNs, IRS, IPTp, malaria case management) are funded from external sources. The GOT should include a budget line for malaria control in the 2014 fiscal year.
- Improving diagnosis of malaria. Misuse of ACT is poor care for patients and can lead to drug resistance; thus ACT should be prescribed only for confirmed cases of malaria. However, the 2011-12 THMIS shows that only one-fourth of children with fever had blood drawn for testing. The Ministry of Health Management Information System needs to capture tested and confirmed cases to guide forecasting and quantification of malaria diagnostic commodities. Periodic routine health facility surveys indicate frequent stock outs of malaria RDT kits. Efforts must be taken immediately to ensure that RDTs are widely and consistently available, that health care providers are informed about routine testing for malaria, and that clinic records of testing and treatment are rigorously maintained and reviewed to ensure compliance.
- Improving treatment of malaria with ACT. Several approaches are required:
 - Drug supply chains should be improved to reduce stock outs of ACTs in health care facilities and ensure that ACT is widely available.
 - The Tanzania Food and Drug Agency should enforce the ban on mono-therapies such as amodiaquine and chloroquine and institute penalties for non-compliance. Such mono-therapies were banned in 2008 but are still used, mainly in the private sector.
 - The Parliament must earmark funds for procurement of ACTs and malaria rapid diagnostic tests.
 - The MoHSW should develop an advocacy programme for malaria testing for service providers and the community.
- The MoHSW should conduct secondary analysis to find the causes of anaemia and constitute a multi-sectoral team to address the problem.

HIV Prevention and Prevalence

Executive Summary

In the 30 years since AIDS was first identified in Tanzania, the epidemic’s impact continues to be felt in all spheres of life. Since the disease usually affects people in their most active and productive years, it can have a devastating effect on the well-being of individuals, families, and communities.

If the Government of Tanzania (GOT) is to realize its vision of an AIDS-free generation, all sectors of society need to work together to reduce the spread of HIV. The GOT should scale up education programmes to ensure that all Tanzanians are reached, especially those with persistently lower levels of awareness, such as people living in rural areas and those with less education. In addition to promoting full knowledge and healthy behaviour, the government should strengthen and expand HIV testing, which is a key entry point to services such as: prevention of mother-to-child transmission; male circumcision; and care and treatment for people who test positive.

Introduction

Tanzania is at a critical point in its campaign against HIV. Prevalence has declined in the last decade, and most people have some information about the disease, but knowledge gaps remain, and many people still engage in behaviours that put them and their families at risk. In Mainland Tanzania, current HIV prevalence among men and women is 5.3%, significantly lower than 7.0% reported in the Tanzania AIDS Indicator Survey in 2003-04 (THIS). Although the decline is encouraging, the decrease in the past five years is slight, signalling that support for prevention must be increased to accelerate gains and protect against backsliding.

In addition to support for prevention of mother-to-child transmission of HIV, promotion of voluntary medical male circumcision, and expansion of HIV testing, the government must continue to promote condom use and encourage people to limit sex to one partner.

2011-12 Tanzania HIV/AIDS and Malaria Indicator Survey Findings

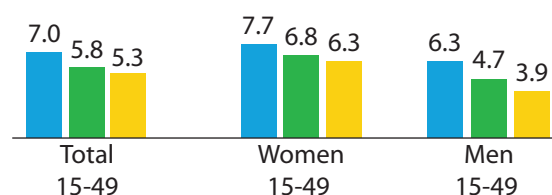
HIV Prevalence

HIV prevalence in Tanzania has declined from 5.7% in the 2007-08 survey to 5.1% in 2011-12. The decline is not statistically significant, but it is not surprising to see such a small change, since national prevalence tends to change slowly. As in past surveys, the prevalence in Zanzibar is low—only 1.0%. Prevalence for Mainland Tanzania shows considerable demographic and geographic disparities.

Prevalence remains higher among women (6.3%) as compared to men (3.9%). Percentages are declining faster among men. From 2003-04 to 2011-12, prevalence among men in Mainland Tanzania dropped from 6.3% to 3.9%. During the same period, women’s prevalence declined from 7.7% to 6.3%.

Trends in HIV Prevalence in Mainland Tanzania (Zanzibar Excluded)

■ 2003-04 THIS ■ 2007-08 THMIS ■ 2011-12 THMIS
Percent HIV-positive



Overall HIV prevalence is higher in urban areas (7.2%) than in rural areas (4.3%). On the Mainland, prevalence is highest in Njombe region (14.8%), Mbeya (9.0%), Iringa (9.1%), and Ruvuma (7.0%) and lowest in Manyara (1.5%).

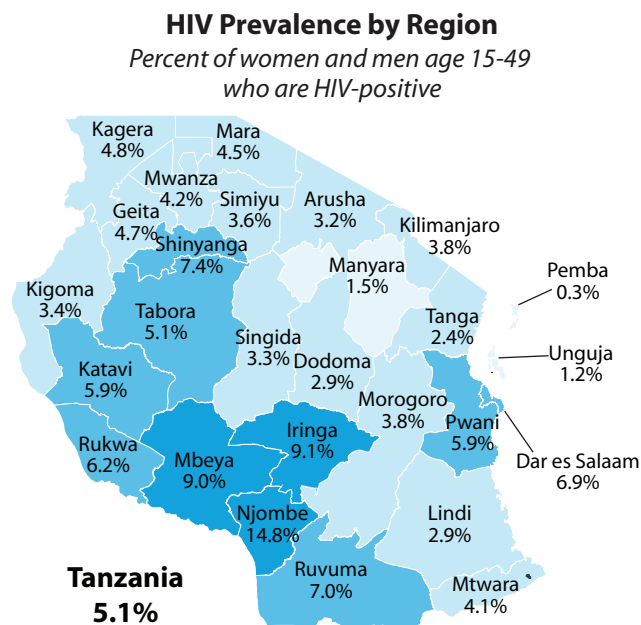
There is no clear pattern of HIV infection and educational attainment, though people with secondary education and beyond are less likely to be infected. Prevalence increases with wealth. Among women in the richest quintile, the prevalence is 8.0% compared to 4.8% among women in the poorest quintile.

Knowledge Related to HIV/AIDS

Nearly all Tanzanians have heard of AIDS, and many know how it is transmitted and how to protect themselves from infection. While knowledge alone does not often prompt people to reduce risky behaviour, it is an essential first step.

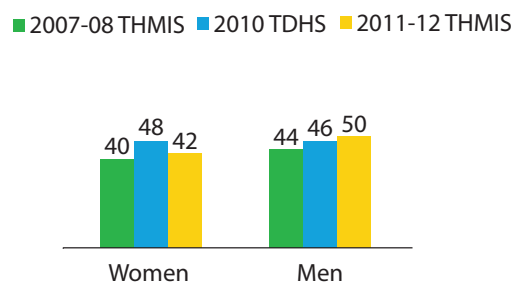
A majority of those surveyed—69% of women and 77% of men—know that using condoms reduces the risk of HIV infection. In addition, 84% of women and 87% of men are aware that limiting sexual intercourse to one uninfected partner reduces the risk of HIV, and 63% of women and 71% of men know about both methods. These levels have changed very little since the 2007-08 THMIS.

Misconceptions about HIV/AIDS are decreasing over time, and well over 75% of men and women are well informed. Still, one in five women do not know that healthy-looking people can be HIV positive and that mosquitos do not transmit HIV. Although knowledge has increased, the percentage of Tanzanians who are fully informed remains disturbingly low and has not changed much over time. Only 42% of women and 50% of men have comprehensive knowledge of HIV/AIDS.



Trends in Comprehensive Knowledge of HIV

Percentage of women and men age 15-49 who have comprehensive knowledge of HIV*



*Comprehensive knowledge of HIV knowledge means knowing that consistent use of condom during sexual intercourse and having just one uninfected faithful partner can reduce the chance of getting HIV, knowing that a healthy-looking person can have HIV, and rejecting the two most common local misconceptions about HIV transmission or prevention.

Women are somewhat less informed than men in most categories, with the notable exception of mother-to-child transmission (MTCT); 64% of women and 55% of men know that HIV can be transmitted through breastfeeding, and that the risk of MTCT can be reduced if the mother takes special drugs during pregnancy. MTCT knowledge has declined among men and women since the 2007-08 THMIS.

Knowledge is consistently lower among people living in rural areas, those who have never had sex, and those ranked lowest in wealth and education. The disparities are especially striking in education. For example, men and women who completed primary school are twice as likely to have comprehensive knowledge of HIV/AIDS as those with no education.

Behaviour

In Tanzania, sexual contact accounts for the majority of new HIV infections. As a result, understanding sexual behaviour is critical to developing effective means to prevent HIV transmission. Prevention programs focus on several key behaviours: delaying sexual debut among young people (see Policy Brief on HIV and Youth, page 21), using condoms, and limiting the number of sexual partners or remaining faithful to one partner.

The THMIS asked respondents how many sexual partners they had in the previous 12 months. The differences between men and women are striking; 21% of men report two or more partners, compared with just 4% of women. On average, men report more than six lifetime sexual partners, whereas women report about two.

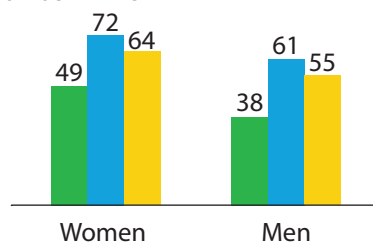
Multiple partners are more common on the Mainland than in Zanzibar; 21% of men in Mainland Tanzania report multiple partners in the previous year, compared with 9% in Zanzibar.

Among women and men reporting multiple partners, only 27% say they used a condom the most recent time they had sexual intercourse.

Trends in Knowledge of Prevention of Mother-to-Child Transmission

Percentage of women and men age 15-49 who know that HIV can be transmitted by breastfeeding and that the risk of MTCT can be reduced by the mother taking drugs during pregnancy.

■ 2007-08 THMIS ■ 2010 TDHS ■ 2011-12 THMIS



Prevention of Mother-to-Child Transmission

The second most common cause of HIV infection in Tanzania is transmission of the virus from mothers to babies during pregnancy, delivery, or breastfeeding. Since antiretroviral drugs can greatly reduce the risk of mother-to-child transmission, all pregnant women should be tested for HIV.

Among all women who gave birth in the two years before the survey, 52% had been counselled and tested for HIV during antenatal care and received their test results. This represents a sharp rise from 30% in 2007-08. However, since well over 90% of pregnant women get antenatal care (2010 Tanzania DHS), this represents a lost opportunity to reach at-risk women and babies.

HIV testing during pregnancy varies widely by region, from a low of 29% in Mara to a high of 81% in Iringa. The overall percentage for Zanzibar was 70%, compared to 51% in Mainland Tanzania. A considerable number of women who were not tested for HIV during antenatal care received a test during labour and delivery. However, waiting until labour to test for HIV is not ideal because antiretroviral drugs are more effective when started early in pregnancy. In all, 77% of women were tested for HIV during antenatal care or labour.

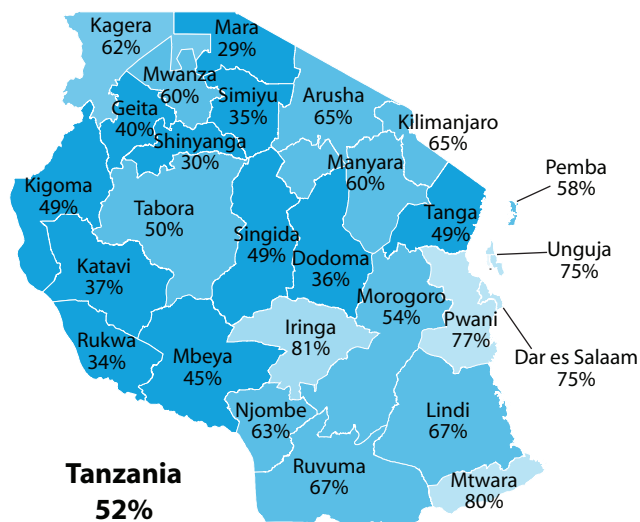
Testing is more common among women who live in urban areas and among women with more wealth and education. For example, only 38% of women in the lowest wealth quintile were counselled and tested for HIV during antenatal care and received results, compared to 56% in the middle quintile and 70% in the wealthiest group.

HIV Testing

Knowledge of HIV status helps people care for themselves and their partners. Testing for HIV has been increasing steadily in Tanzania, and nine in ten Tanzanians know where to get an HIV test. One in three women and 27% of men had been tested in the 12 months preceding the survey and received the results compared to only 19% of both women and men in 2007-08. Overall, 62% of women and 47% of men report that they have been tested for HIV at some point and received the results. Urban dwellers and people from wealthier households are somewhat more likely to have been tested and received results than other people. The differences between Mainland Tanzania and Zanzibar are slight.

HIV Testing During Pregnancy by Region

Percent of women age 15-49 who gave birth in the last 2 years who received HIV counselling, an HIV test, and test results during ANC



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About 30% of women and men age 15-49 have been tested for HIV in the 12 months before the survey.

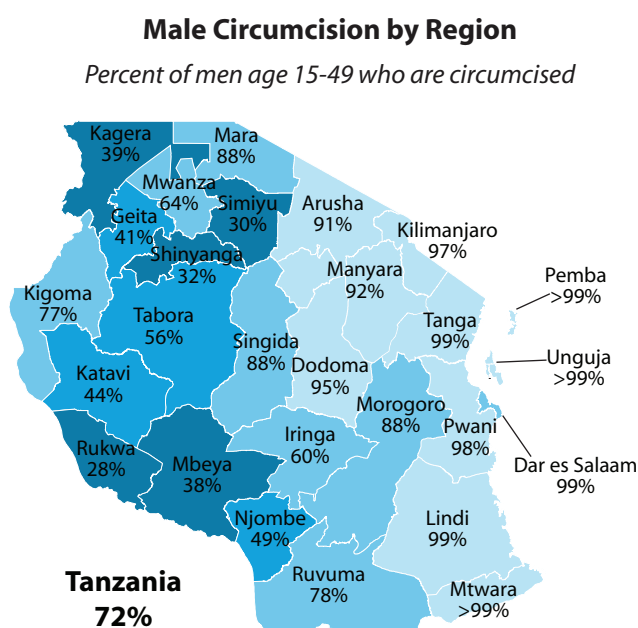
Male Circumcision

In some parts of Tanzania, male circumcision is a common practice. Since male circumcision is associated with lower risk of HIV transmission, the GOT has been encouraging voluntary medical circumcision for adult men.

The THMIS found that 72% of men report being circumcised, an increase from the 67% reported in 2007-08. The practice is more common in urban areas (94%) than in rural areas (64%), but does not vary by age, except that the percentages are somewhat lower (66%) among men ages 15-19.

Male circumcision is nearly universal in Zanzibar. In Mainland Tanzania, male circumcision prevalence is 96% or more in Eastern, Southern and Northern zones, and lowest in Southwest Highlands (37%) and Lake (49%) zones.

About 3% of circumcised men are HIV-positive compared to 5% of uncircumcised men.



Conclusions and Implications for Programmes and Policies

- Even though many Tanzanians know something about HIV transmission and prevention, significant knowledge gaps remain, and many people still engage in risky behaviours. Some levels of knowledge have even declined in the past five years. Thus, programmes are still needed to increase knowledge about HIV infection and prevention.
- In late 2012, with the release of its Zero VVU Kwa Watoto strategy, the GOT committed to working towards the elimination of mother-to-child transmission of HIV by 2015 and substantially reducing AIDS-related maternal deaths. This initiative should be fully supported and funded.
- Funds for male circumcision should be included in council budgets and plans, with special emphasis in the regions with low prevalence of male circumcision.
- Although great strides have been made in HIV testing, more progress is needed. Expansion and improvement of HIV testing and counselling should include a special emphasis on pregnant women and on men through couple counselling and male participation in antenatal clinics.

HIV and Youth



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Executive Summary

Although HIV prevalence among young people in Tanzania remains markedly lower than those among people over age 24, prevalence among youth has changed very little since 2007-08. At the same time, some measures of young people's knowledge and behaviour show a disturbing increase in risk-taking. Young people in Tanzania urgently need comprehensive information and skills to help them avoid infection.

Young women are at higher risk of HIV infection than young men, and prevalence among young women rises markedly once they leave their teen-age years. For young men, risk behaviours such as multiple sexual partners are showing a worrying increase. New interventions are needed to ensure that young Tanzanians can enter adulthood free of HIV.

**2% of young women and men
age 15-24 are HIV-positive.**

Introduction

The transition from adolescence to young adulthood is one of enormous change, opportunity, and potential risk. As they gradually assert their independence and begin to take on adult responsibilities and behaviours, young people remain particularly vulnerable to contracting HIV.

The 2011-12 Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS) found that 2% of Tanzanians age 15-24 are HIV positive. That means more than 180,000 young people in Tanzania are living with HIV.

Since the 2007-08 THMIS, changes in young people's knowledge and behaviour have been mixed. The good news is that more young people know where to obtain condoms, and in most cases condom use is gradually increasing. However, the percentage of youth having sex before age 15 has remained largely the same, and more young people, especially young men, report having premarital sex and multiple partners.

HIV prevalence in Tanzania varies by region. In general, urban youth are at higher risk for HIV compared to their rural counterparts. Among youth, the highest HIV prevalence is found in Njombe, Iringa, and Dar es Salaam. The lowest HIV prevalence is found throughout Zanzibar and in Arusha, Pwani, Manyara, and Tabora.

2011-12 Tanzania HIV/AIDS and Malaria Indicator Survey Findings

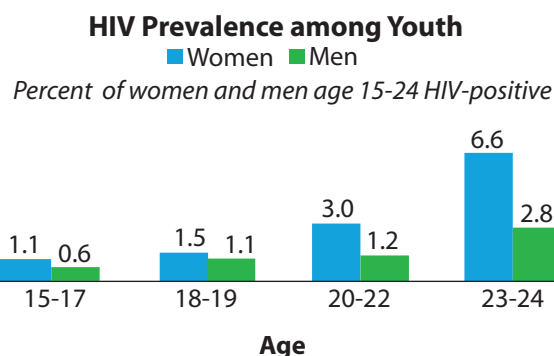
HIV Prevalence among Tanzanian Youth

The prevalence of HIV among young people age 15 to 24 is 2%, which is nearly the same as the prevalence measured in the 2007-08 THMIS. As in previous surveys, young women are at greater risk; 3% of women are HIV positive compared to 1% of young men.

Prevalence increases dramatically within short age intervals. Among women age 18-19, the prevalence is 1.5%, but the prevalence for women age 23-24 is 6.6%.

Urban youth are more likely to be HIV-positive than those living in rural areas (3.2% urban, 1.5% rural), and prevalence is higher in Mainland Tanzania than in Zanzibar (2% versus 0.5%).

Njombe region has the highest HIV prevalence among young people at 5.1%. Wealth appears to affect HIV status. HIV prevalence is higher among more affluent youth; 2.9% of the wealthiest quintile is HIV positive compared with 1.5% among the poorest.



Knowledge of HIV/AIDS

Knowing how HIV is transmitted—and how to reduce the risk of transmission—is critical for young people, as they choose when to become sexually active. But the percentage of Tanzanian youth with comprehensive knowledge of HIV/AIDS has barely changed since the 2003-04 Tanzania HIV/AIDS Indicator Survey (THIS). Comprehensive knowledge is defined as knowing that consistent use of a condom during sex and having just one uninfected faithful partner can reduce the chance of contracting HIV; knowing that a healthy-looking person can have HIV; and rejecting the two most common local misconceptions about transmission or prevention of HIV.

The current survey shows that only 40% of young women and 47% of young men have comprehensive knowledge of HIV/AIDS. In the 2007-08 THMIS, 39% of women and 42% of young men demonstrated comprehensive knowledge. Youth living in urban areas and older youth are better informed, but even in urban areas about half of young people lack comprehensive knowledge. Comprehensive knowledge varies considerably by education and region. Among those with no education, 20% of young women and 18% of young men had comprehensive knowledge of HIV/AIDS. For those who attended secondary school and beyond, 55% of young women and 60% of young men had comprehensive knowledge.

The number of young people who know of a source for condoms has increased steadily since 2003-04. While this is an encouraging trend, women continue to be less informed than men; 85% of young men know where to obtain condoms, compared to only 65% of young women.

Behaviour

Since unprotected sex is the primary mode of HIV transmission in Tanzania, understanding young people’s sexual behaviour is important for developing prevention interventions. In the 2011-12 THMIS, respondents age 15-24 were asked a variety of questions about their behaviour, including when they first had sex, how many partners they had, and whether they had used a condom the most recent time they had sex.

Among young people who have never been married, 60% of young women reported that they had never had sex, compared to 48% of young men. Thirty-two percent of never-married women reported having had sex in the previous 12 months, up very slightly from 30% in 2007-08. The increase in premarital sex among young men was more pronounced; 42% of never-married men reported having had sex in the previous 12 months, compared to 33% in the 2007-08 survey.

The percentage of young people who first had sexual intercourse before age 15—9% of women and 10% of men—has stayed largely the same since the 2003-04 THMIS.

Young men are much more likely than young women to report multiple sexual partners; 14% of men reported two or more partners in the previous 12 months, a notable increase from the 2007-08 THMIS figure of 9%. Only 4% of young women reported multiple partners.

Condom use at last sex has been steadily increasing among young people, and the percentages are almost the same for men and women. Among never-married youth who had had sex in the previous 12 months, 58% of women and 59% of men reported condom use at last sex, compared to 49% for men and women in 2007-08. More educated youth are notably more likely to have used a condom in this situation. Condom use is considerably lower among youth who reported having multiple partners and among young men who paid for sex, suggesting that some youth are likely to engage in multiple risk behaviours.



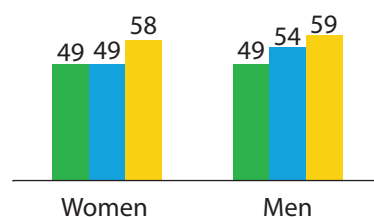
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14% of young men age 15-24 reported multiple sexual partners compared to only 4% of young women.

Trends in Condom Use at Last Sex Among Never-Married Youth

Among never-married women and men age 15-24 who had sexual intercourse in the last 12 months, percent who used a condom at last sex

■ 2007-08 THMIS ■ 2010 TDHS ■ 2011-12 THMIS



HIV Testing Among Youth

While HIV testing among all adults in Tanzania has increased since the 2007-08 survey, testing percentages among youth have stayed largely the same. Those who test HIV-negative can be counselled on how to stay negative. Young people who test positive can be referred to care and treatment programmes and counselled on how to protect their partners.

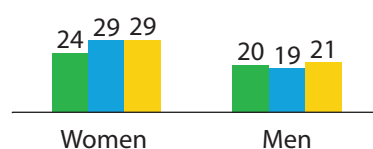
Fewer than one in three young women and only one in five young men had been tested in the previous 12 months and received their results.

HIV testing among young pregnant women is slightly lower than among their older counterparts; 47% of young women who gave birth in the two years preceding the 2011-12 THMIS were counselled and tested for HIV during antenatal care, and received the results, compared to 52% for all pregnant women

Trends in HIV Testing among Youth

Percentage of women and men age 15-24 who have been tested for HIV in last 12 months and received the results

■ 2007-08 THMIS ■ 2010 TDHS ■ 2011-12 THMIS



Conclusions and Implications for Programmes and Policies

- Less than half of young Tanzanians have comprehensive knowledge about HIV/AIDS, and this has not increased appreciably since 2003-04. Young people need more information about how to protect themselves from HIV, as well as skills and services to empower them to use that knowledge. Comprehensive sexuality and life skills education in schools should be promoted and interventions should be designed for out-of-school youth, who are hard to reach, underserved, and more vulnerable to infection.
- Young men are reporting more risky behaviours than young women. Condom use among young men who paid for sex has decreased (even though 85% of young men say they know where to get condoms), and more young men report multiple partners and premarital sex. The government should promote 100% condom use to all sexually active youth, provide behaviour change campaigns targeted at young men, and ensure that condoms are widely available and accessible to young people.
- Risky behaviours remain high for all youth. Targeted interventions are needed for young people and for their parents to encourage youth to adopt positive behaviours and protect themselves from HIV. In addition, more research is needed to identify key at-risk populations in need of targeted services.
- HIV testing should be promoted and supported for young people. Testing must be complemented by services, so that those who are positive can be referred for treatment and care. Those who are negative need comprehensive services as well, such as peer education and life skills to build and reinforce knowledge and behaviours that will help them to stay HIV-negative.

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July 2013

