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PRESIDENT'S OFFICE REGIONAL ADMINSTRATION AND LOCAL GOVERNMENT AUTHORITIES

KITETO DISTRICT COUNCIL

ANNUAL HIV PROFILE 2022

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TABLE OF CONTENTS

FOREWORD

The District HIV profile (DHP) report has been prepared focusing on twenty six indicators reflecting HIV service provision. The report gives a room the Council and Implementing Partners (IPs) a base to data driven decision-making during health care resource planning.

Additionally, during implementation of HIV care services in the year 2022, we have faced a notable increase in low retention among PLHIV. This has led to negative gain of the current on care, low suppression and possibly presence of new infection. Low retention has been attributed due to some mentioned reason and one of them is Lack of HIV knowledge, socio-cultural barrier for the nomadic society, stigma, presence of few numbers of CTC by 34% (13/38) and low trained human resource for health by 29%. These factors are contributing to a back pull on attaining quality provision of HIV care services across the district.

The preparation and completion of this profile will timely address these challenges by knowing the current status of HIV in the council, identification of the challenges and to suggest interventions that will be implemented. It will also provide a framework for the actions and formulating programs and projects to attain the vision of the district.

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CPA. Hawa Abdul Hassan

DISTRICT EXECUTIVE DIRECTOR

KITETO.

MKURUGENZI MTENDAJI (W)
HALMASHAURI YA WILAYA
KITETO

ACKNOWLEDGEMENTS

The development of the District HIV Profile (DHP) is a result of highly collaborative efforts from a number of people in Kiteto District Council. Special appreciation goes to CPA. Hawa Abdul Hassan (DED) for the irreplaceable support.

Moreover, we would like to acknowledge the individual tireless contributions, Dr. Vicent Gyunda (DMO), Erasmo T. Ndelwa (DPLO), Dr. Ramadhani Maingu (DACC), Lazaro Martin (DHS), Beatrice S. Lutanjuka (DHMISCo), Fatuma M. Kawia (DRCHCo) and Elizabeth Pius (DTHO).

However, we would like to recognize Global fund for disbursement of fund to fulfill the activity and the Regional Health Management Team, for support and guidance leading to the development of this profile.

Finally, we hope this report will be useful to the Council Health Management Team (CHMT) and other stakeholders in the district for program-planning aiming at improving access and quality of HIV services in the Council.

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Erasmo T. Ndelwa.
DISTRICT PLANNING OFFICER
KITETO.

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Dr. Vicent Gyunda
DISTRICT MEDICAL OFFICER
KITETO

EXCUTIVE SUMMARY

Kiteto District Council HIV Profile echoes the health status of the population, health system and service delivery. The report shows progress, challenges and successes the Council arose across in 2022.The data sources used to prepare the report were from Dhis2, ETL, Council Profile, HFR, HRH and CCHP. The Council has made a good progress in 95-95-95 goal, where the 1st 95 is 90.6%, second 95 is 98.8%, and third 95 is 92.5%. Still the council is striving to achieve the goal by end of the year 2025. Despite good coverage in ART initiation among newly diagnosed HIV pregnant women by 98% the council still observing mother to child transmission by registering 24 children under 15 years in CTC. By literature all HIV infection of <15 years is from mother to child transmission by 90%. However, the council has made a progress in TB case notification by 104% (840/804) in 2022.

HIV related death was observed to be in the top three cause of death in IPD client in 2022. This could be attributed by some observed factors including late diagnosis and low retention in care due to negative socio-cultural believes towards HIV.

Despite the progress made, the council still facing challenges in the following areas; low ART retention rate, this has been a remarkable challenge throughout , due to following reason; Low knowledge about HIV disease in conjunction to socio-cultural believes (*for the pastoralist community*), and their nomadic nature seeking for pastures and water for their livestock, temporary farming (influx of people during farming season and out-flux when the season goes), few number of care and treatment centers by 34% (13/38) versus a huge district square kilometers and many marginalized hard to reach areas.

However, the presence of many PMTCT-standalone provides major setback in smooth HIV care provision especially the case of adherence and male involvement.

The findings will alert the CHMT and other stakeholders in the council to take appropriate interventions. For more information about the Council please visit us at (http://www.kitetodc.go.tz)

ACRONYMS

ACRONYM	LONGFORM
ACF	Active Case Finding
CBCC	Community Behavioral Change Communication
ANC	Antenatal Clinic
ART	Anti-retroviral Therapy
ARVs	Anti-retroviral
BEmONC	Basic Emergency Obstetric and Newborn Care
CBHS	Community Based Health Services
CeMONC	Comprehensive Emergency Obstetric and Newborn Care
CHMT	Council Health Management Team
CHF	Community Health Fund
CCHP	Comprehensive Council Health Plan
CNR	Case Notification Rate
CTC	Care and Treatment Centre
DACC	District AIDS Control Coordinator
DBS	Dried Blood Spot
DHMIS	District Health Management Information System
DHMISCo	District Health Management Information System Coordinator
DHS	District Health Secretary
DHP	District HIV Profile
HsPs	Health Service providers
DHIS	District Health Information System
DMO	District Medical Officer
DC	District Council
DPLO	District Planning Officer
DRCHCO	District Reproductive and Child Health Coordinator
DTHO	District TB and HIV Officer
DED	District Executive Director
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
ETL	Electronic TB and Leprosy software

FP	Family Planning
GBV	Gender Based Violence
HB	Hemoglobin
HFR	Health Facility Registry
HRH	Human Resource for Health
HTC	HIV Testing and Counseling
HPV	Human Papilloma Virus
HVL	HIV Viral Load
Km	Kilometers
OIs	Opportunistic infections
IPD	In-patent Department
LTF	Lost To Follow up
MoHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
OPD	Outpatient Department
RMNCAH	Reproductive Maternal Newborn Child and Adolescents Health
RPR	Rapid Plasma Reagin
SDM	Service Delivery Model
TB	Tuberculosis
PORALG	President's Office Regional Administration And Local Government
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
VL	Viral Load
VNRD	Voluntary None Real Blood Donors

DEFINITION OF KEY TERMS

TERM	DEFINITION
Case Notification Rate (CNR)	Is calculated as the number of new and re-treated TB cases reported in the past year divided by the total population in the specified area
District HIV Profile (DHP)	It is a report that provides an overview of HIV status in the district as assessed using priority HIV indicators. The report also includes the status of health systems and health service delivery.
Data	Facts or figures or information to be processed from which conclusions can be inferred
Indicator	A measurement that is used for monitoring.
Number of neonatal deaths	The number of newborn deaths that occur within the first 28 days of life in a given period.
Number of Infant deaths	The number of infants who die within the first year of life in a given period.
Number of under five deaths	The number of under five deaths that occur within 5 years of life in a given period.
Number of maternal deaths	The number of women who die of causes related to pregnancy, delivery, and postpartum in a given year or other period.
Antenatal care coverage: first visit before12 weeks gestational age	Percentage of pregnant women who start ANC before 12 weeks of gestational age
Antenatal care coverage: 4 visits	Percentage of pregnant women who attended antenatal care four or more times in a given time period
HIV testing coverage: PLHIV aware of their status	Proportion of PLHIV who are aware of their HIV status
Miss Appointment	Not seen for 3 days or more since the last scheduled appointment
Lost to follow up (LTF)	Not seen for 3 month or more since last scheduled appointment.
ART coverage	Proportional of adults and children currently receiving antiretroviral therapy (ART)
Virally suppressed	Percentage of ART patients with a suppressed viral load (VL) result (<1000 copies/ml) within the past 12 months
Tx Curr	Refers to number of clients receiving/received service at a particular period. *(It measures the ongoing scale-up and uptake of ART and retention).*
1st 95	95% of all people living with HIV know their status by year 2025

2nd 95	95% of those diagnosed with HIV receive Antiretroviral treatment by year 2025
3rd 95	95% of those on treatment achieve viral suppression by year 2025

CHAPTER 1.0: INTRODUCTION

Kiteto District is one of the seven administrative blocks of Manyara Region; it covers an area of 16,685 square kilometers, which is 34.1% of the whole Manyara Region. The District borders are Simanjiro district to the North, Kilindi district to the East, Kilosa and Kongwa districts to the South &Chamwino and Chemba districts to West. Kibaya is the council Headquarter. Most of the people are engaged in Agriculture and Livestock keeping. Availability of large land for agriculture and livestock keeping contributes to temporary settlement and movementfrom one place to another especially during rainy season for farming and livestock keeping activities. The most grown crops are maize and sunflower. The tribes mainly found are Maasai, Rangi, Nguu, Gogo, Kamba and Bena. Kiteto Council has 7 divisions, 23 Wards and 63 Villages.

Fig1: Manyara Region Administrative Blocks

1.1: District Vision and Mission

1.1.1: Vision

Kiteto District Council vision is to be "A council that provide quality services and create conducive investment environment for sustainable development".

1.1.2: Mission

Kiteto District council mission is to "provide quality services and create conducive investment environment through available resource for sustainable development".

1.2. POPULATION PROFILE.

Kiteto Council is estimated to have a population of 340,301 in year 2022 of whom 167,068 were males and 173,233 were females. The population distribution by age and sex categories is described in the table 1 below:-

Table1: Distribution of the population by sex and age group, 2022.

AGE GROUP	MALE	FEMALE	TOTAL
<1 year	6919	6924	13843
1-4	25371	25217	50588
5-9	27322	27859	55181
10-14	19062	19290	38352
15-19	17386	18244	35630
20-24	14198	16314	30512
25-49	41466	45960	87426
50-60	10272	8733	19005
60+	5072	4692	9764
TOTAL	**167,068 (49%)**	**173,233 (51%)**	**340,301**

Data source: Dhis2.

1.3. HEALTH INFRASTRUCTURE DISTRUBUTION:

Kiteto District Council is currently served by 38 health facilities of which are; 1 Hospital, 2 Health Centers, 35 Dispensaries (see table 2).

Table 2: Distribution of Health Facilities by type and ownership.

TYPE OF FACILITY	OWNERSHIP				Total
	Government	FBO	Parastatal	Private	
Hospital	1	0	0	0	1
Health centers	2	0	0	0	2
Dispensaries	29	3	1	2	35
Total	**32**	**3**	**1**	**2**	**38**

Data source: Dhis2.

Table 3: Distribution of Health Facilities providing CTC services.

TYPE OF FACILITY	CTC	PMTCT STAND ALONE	TOTAL
Hospital	1	0	1
Health centers	2	0	2
Dispensaries	10	21	31
TOTAL	**13 (34%)**	**21 (55%)**	**34 (89%)**

Data source: Dhis2

CTC and PMTCT standalone Health facilities covers 34% and 55% contributing to a total of 89% HIV service accessibility in the council. The other 11% are the hard to reach remote locations which are often need constant resource supply to maintain outreach.

Table 2: Distance from headquarters to health facilities by kilometres.

SN	HF NAME	FACILITY CATEGORY	KM
1	Bwagamoyo	Dispensary	4
2	Kijungu	Dispensary	80
3	Loolera	Dispensary	87
4	Lesoit	Dispensary	86
5	Olkitikiti	Dispensary	104
6	Engong'ngare	Dispensary	116
7	Asamatwa	Dispensary	116
8	Sunya	Health Centre	126
9	Loltepesi	Dispensary	90
10	Laiseri	Dispensary	104
11	Dongo	Dispensary	98
12	Emarti	Dispensary	62
13	Magungu	Dispensary	51
14	Ngipa	Dispensary	46
15	Orkine	Dispensary	53
16	Songambele	Dispensary	46
17	Dosidosi	Dispensary	41
18	Nchinila	Dispensary	47
19	Osteti	Dispensary	53
20	Matui	Dispensary	34
21	Engusero	Health Centre	35
22	Njiapanda	Dispensary	18
23	Kiperesa	Dispensary	21
24	Njoro	Dispensary	14
25	Kibaya	Dispensary	0
26	Ndaleta	Dispensary	15
27	Ngabolo	Dispensary	22
28	Ndedo	Dispensary	80
29	Makame	Dispensary	110
30	Irikiushbor	Dispensary	90
31	Katikati	Dispensary	66
32	Ilera	Dispensary	14
33	Lengatei	Dispensary	98
34	Mwanya	Dispensary	19
35	ACDK	Dispensary	2
36	Kipok	Dispensary	4

CHAPTER 2.0: MORBIDITY AND MORTALITY STATISTICS.

This chapter provides the top 10 causes of morbidity and mortality of the Council for the year 2022. It also highlights challenges that were encountered and provide recommendations for improvement.

Table 4: Top 10 OPD diagnoses 2022.

No.	Less than 5 years			5 years and above		
	OPD Diagnoses	No. of Diagnoses	(%)	OPD Diagnoses	No. of Diagnoses	(%)
1.	Upper Respiratory infections	26175	41.92	Upper Respiratory Infections	10142	18.89
2.	Pneumonia-Severe& Non severe	8592	13.76	Urinary Tract Infections	7709	14.35
3.	Diarrhea With No Dehydration	8419	13.48	Pneumonia-Severe &Non Severe	3565	6.64
4.	Urinary Tract Infections	2883	4.62	Intestinal worms	1850	3.44
5.	Diarrhea With Some Dehydration	2613	4.18	STI Pelvic Inflammatory Diseases	1825	3.4
6.	Skin Infection, Non Fungal	2255	3.61	Hypertension	1756	3.27
7.	Intestinal Worms	2232	3.57	Peptic Ulcers	1631	3.04
8.	Other Non-Infectious GIT diseases	1697	2.72	Diarrhea With No Dehydration	1562	2.91
9.	Skin Infection-Fungal	1499	2.4	Typhoid	1397	2.6
10.	Eye Diseases, Non Infectious	823	1.32	Other Non-Infectious GIT Diseases	1393	2.59
	TOTAL	**57188**	**91.58**	**TOTAL**	**32830**	**61.13**

Data source: Dhis2

The table above shows respiratory infection took top three to both age category accounting 42% (< 5 years) and 19% to 5years and above). This could be attributed by weather condition and cultural behavior (poor housing, clothing habit).

Table 5: Top 10 causes of admission, 2022.

No.	Less than 5 years			5 years and above		
	IPD Diagnoses	No. of Diagnoses	(%)	IPD Diagnoses	No. of Diagnoses	(%)
1.	Pneumonia-Severe & Non severe	507	40.72	Pneumonia –Severe & Non severe	217	30.86
2.	Acute Diarrhoea(<14Day days	259	20.8	Anaemia-Mild &Severe	171	15.76
3.	Diarrhea Chronic(>=14 Days)	63	5.06	Hypertension	160	3.83
4.	Anaemia-Mild & Severe	54	4.34	Road Traffic Accidents	118	3.29
5.	Birth Asphyxia	51	4.1	Typhoid	116	3.1
6.	Upper Respiratory infections	38	3.05	Urinary Tract Infections	103	2.31
7.	Urinary Tract Infection	30	2.41	Gynecological diseases	77	1.83
8.	Burn	29	2.33	Peptic Ulcers	76	1.77
9.	Peptic Ulcers	26	2.09	Acute Diarrhoea(< 14 days)	76	1.58
10.	Low Birth Weight and prematurity complications	22	1.77	Diabetes Mellitus	73	1.34
Total		**1079**	**86.67**		**1187**	**65.67**

Data source: Dhis2

The top 10 IPD causes of admission were respiratory infection and diarrheal diseases to children aged below five years while pneumonia, Anemia and Hypertension were top three among IPD diagnoses to individuals aged five years and above. Inadequate of universal safe and clean water availability might have contributed. Knowledge gap on utilization of iron-sourced food should be given priority to the community.

Table 6: Top 10 causes of deaths 2022

No	Less than 5 years			5 years and above		
	Cause of Death	No. of Death	(%)	Cause of Death	No. of death	(%)
1.	Neonatal Asphyxia	14	29.17	Respiratory tuberculosis-confirmed	12	12.9
2.	Pneumonia	8	16.67	Heart failure	6	6.45
3.	Marasmic-kwashiorkor	5	10.42	HIV diseases	6	6.45
4.	Shock(cardiogenic, hypovolemic)	2	4.17	HIV disease with tuberculosis	6	6.45
5.	Stillbirth(fresh)	2	4.17	Other and unspecified diarrheal diseases	4	4.3
6.	Stillbirth	2	4.17	Motorcycle rider injured	3	3.23
7.	Respiratory distress	2	4.17	Sepsis	3	3.23
8.	Unspecified protein-energy malnutrition	2	4.17	Postpartum hemorrhage	3	3.23
9.	Iron deficiency	2	4.17	Pneumonia	3	3.23
10.	Down syndrome	1	2.08	Secondary hypertension	3	3.23
	Total	**40**	**83.36**		**49**	**52.7**

Data source: Dhis2

The top 10 causes of deaths in children aged below five years accounted for 83% and 53% for individuals aged five years and above.

Tuberculosis was the number one cause of death among those >5 years IPD client by 12%. HIV related death ranges third (6%) among all IPD deaths to those 5 years and above. This probably tells us something, either late diagnosis or diagnosed but not using ART correctly. (*I.e. reflected by many Miss Appointments and LTF see retention table 12*).

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CHAPTER 3.0: HEALTH SERVICE PROVISION

3.1: MATERNAL, NEONATAL AND CHILD HEALTH

Summarized statistics of maternal, neonatal and child mortality for the period 2020-2022.

Table 7: Maternal and Neonatal Deaths, 2020 – 2022.

Performance indicators	Number of deaths			Major causes of death
	2020	2021	2022	
Number of neonatal deaths	16	5	12	Intrauterine Hypoxia, Birth Asphyxia, prematurity complications, congenital malformations.
Number of Infant deaths	14	10	6	Prematurity, Sepsis, pneumonia
Number of under five deaths	41	18	35	Pneumonia, malnutrition, Burn,
Number of maternal deaths	5 (77/100000)	8 (121/100000)	3 (48/100000)	Obstetric Hemorrhages (PPH, APH), Eclampsia

Data source: Dhis2

Intrauterine hypoxia, birth asphyxia, prematurity complications, pneumonia, Sepsis, eclampsia and obstetric hemorrhages are the major causes of deaths in the described groups above. Strategies to prevent/reduce maternal and perinatal deaths includes ensuring availability of medicines, medical equipments, laboratory and other medical supplies are available for routine care and during emergencies. Distribution of S.O.Ps and guidelines to Health care Facilities, to facilitate Health Centers to provide CEmONC services. However continual knowledge-update to Health service provider should be routinely emphasized.

Summarized statistics of maternal, neonatal and child health for the period. 2020 to 2022.

Table 8: Status of Reproductive Health Services, 2020-2022.

Performance indicators	National Target		District Target	Achievement		
	by 2025		by 2025	2020	2021	2022
Percentage of ANC first visit before12 weeks of gestation	60%		60%	36.9%	40.8%	40%
Percentage of ANC 4 plus visits coverage	80%		80%	82.1%	88.2%	83.1%
% of Pregnant women who receive iron and folic acid tablets supplementation during ANC visits	80%		80%	71.5%	72%	82.2%
Percentage of institutional deliveries	90%		90%	46%	48%	49%
Percent of mothers who received Postnatal care within 7 days after delivery	90%		90%	98.9%	107%	105%
Percent of women of Reproductive age using Modern Family planning methods	42%		42%	37%	50.4%	58%
Percentage of Health centers and hospitals providing CeMONC services	HC	100%	100%	1 /2 (50%)	1 /2 (50%)	1 /2 (50%)
	HSP	100%	100%	1/1 (100%)	1/1 (100%)	1/1 (100%)

Data source: Dhis2

Inadequate stock of basic laboratory test kits for basic investigations to ANC clients like HB cuvettes, RPR, urinalysis and Hepatitis B	-Forecasting -Timely ordering -Procurement to prime vendors -Improvement in revenues collection -Construction/rehabilitation of health facilities infrastructures to provide laboratory services
Inadequate stock of basic prophylactic drugs to ANC clients like FeFo and mebendazole to cover all clients in needs	-Forecasting -Timely ordering -Procurement to prime vendors -Improvement in revenues collection
Negative socio-cultural beliefs and practices among community members	-Continuous health education -Meeting with influential community leaders
Shortage of Skilled health care workers	PORALG to employ enough skilled staff to cover the shortage

3.1.1: Key Activities in 2022/23 (RMNCAH)

- Maternal retesting mentorship to service providers
- Community score card meetings done to 7 villages
- BEmONC post training follow up (Makame and Ndaleta dispensaries)
- Introduction of CECAP new tools
- Training of HEI early registration
- Provision of Health education to adolescents and youths at schools and community conducted by girls mentors and Youth Health champions
- Monthly mother psychosocial support group meetings conducted at Kibaya RCH
- Mentorship on EmONC services at Kibaya DH and Sunya HC
- Quarterly CECAP outreach services conducted to 7 Health Facilities

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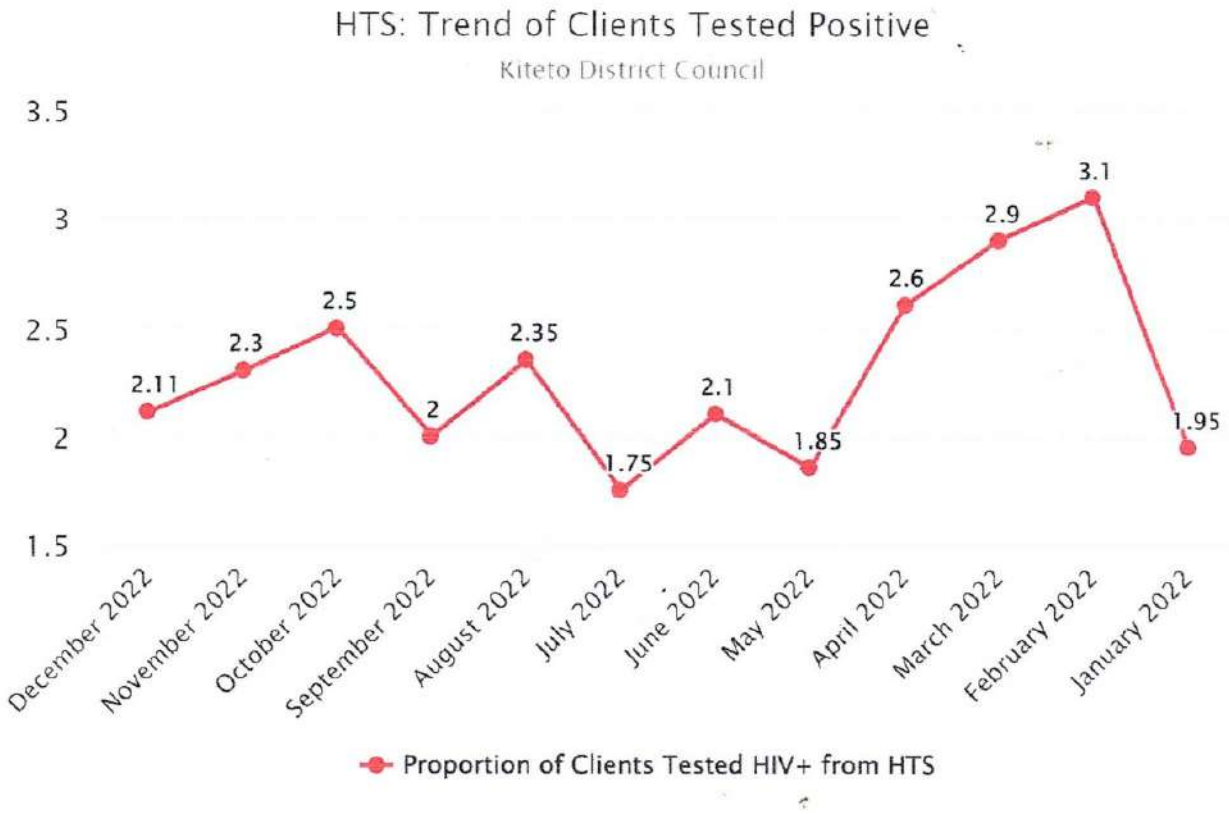
- DQA + mentorship of RMNCAH indicators to 10 Health Facilities
- Training of M-MAMA program and registration of community drivers
- School symposium on reproductive health issues done to 2 secondary schools (Kibaya and Bwakalo)
- Orientation meeting with community influential leaders/peoples to promote women, youth and children access to integrated GBV, HIV, FP and TB and other RCH services was conducted.
- Monthly family planning service days to one Hospital and one health Centre was conducted.
- Integrated family planning, cervical cancer screening, TB screening, PITC and GBV outreach services was conducted on quarterly basis.
- Postpartum Family planning training to service providers from lower level health facilities was conducted.
- Integration /provision of family planning services during immunization were conducted on monthly basis.
- Quarterly data collection, verification and uploading into DHIS2 were conducted on monthly basis.
- Quarterly HPV vaccination to primary and secondary schools was conducted by health providers from lower level health facilities.
- Procurement of gas cylinders for gas cooker refilling was conducted by lower level health facilities.
- Procurement of medical equipment's (delivery kits, MVA kits) conducted by lower level health facilities.
- Procurement of medicines and laboratory supplies to be used at health facilities.
- To procure 3LP gas Cylinder (15kgs) for vaccines refrigerators was conducted by lower level health facilities.
- Recruitment, mobilization and collection of blood units from voluntary none real blood donors (VNRD) was conducted on quarterly basis by laboratory staffs.
- Referrals from primary health facilities to district, regional and consultant hospitals of pregnant and under-five children needing tertiary level of care were conducted.

- Maternal and Perinatal deaths review meetings was conducted weekly at Facility level, monthly at council level and quarterly at regional.

3.2: STATUS OF HIV/AIDS SERVICES.

Fig 2: HTS trend of Clients tested HIV positive:



Data source: Dhis2 (NACP dashboard).

The figure above illustrate that the trend of clients tested positive from HIV testing services in the council in the year 2022. It is observed at an average of 2. (*2 can test HIV positive in 100 population*).

Table 11: HIV testing and uptake of ARVs 2022

Performance indicators	Region Target	District Target	Achievement		
	by 2022	by 2022	2020	2021	2022
Number of HIV tested (total tested)	381,336	56,979	66,457	43,726	40,709
Performance against Target (Testing)					**71%**
Performance (%) (1st 95)					91%
Number of HIV tested positive	3,984	840	911	611	505
Performance against target (tested positive)					**60%**
Number of Persons newly initiated on ART	2,335	499	916	590	490
Performance (%) (2nd 95)					98%
Total current on ART	25,373	5,337	3,215	3,512	3,383
Number of ART clients who received viral load test with viral load results documented			1,159	1,899	2,497
Number of ART clients with suppressed viral load test			1,052	1,714	2,314
Proportion suppressed virally (3rd 95)	**95%**	**95%**	**91%**	**90%**	**92.5%**

Data source: Dhis2

The council is making a progress toward attaining 95-95-95 goal by 2025. Testing versus target we attained 71%. Still much effort should be put on identifying those who are positive through big result testing by focusing on Optimized PITC and index testing. These testing modalities sometimes need support from IPs (transport, extra duty allowances) owing to little number of HRH, knowledge part of it and presence of hard to reach remote area. We real appreciate the support from the council stake holders (The council itself, USAID-Afya yangu, THPS, Kizazi hodari.

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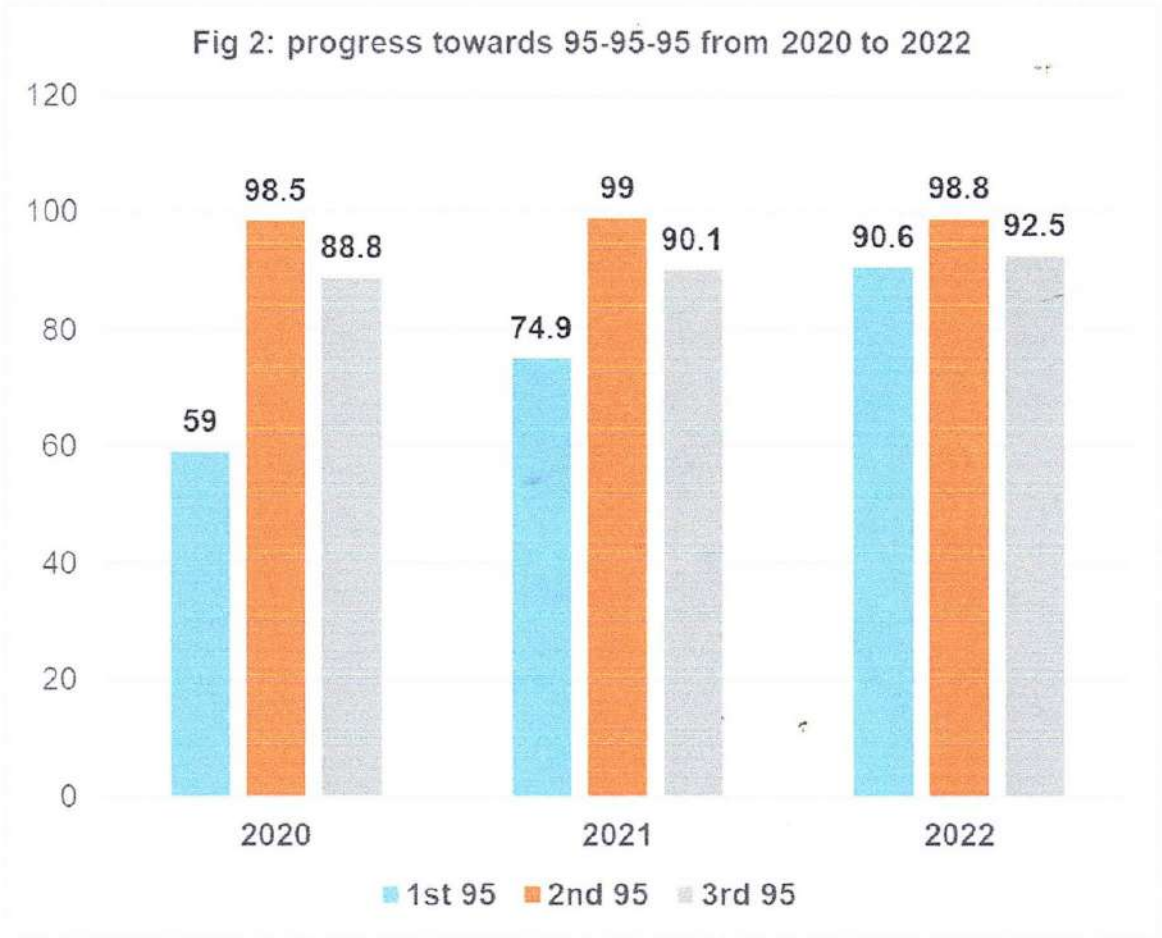
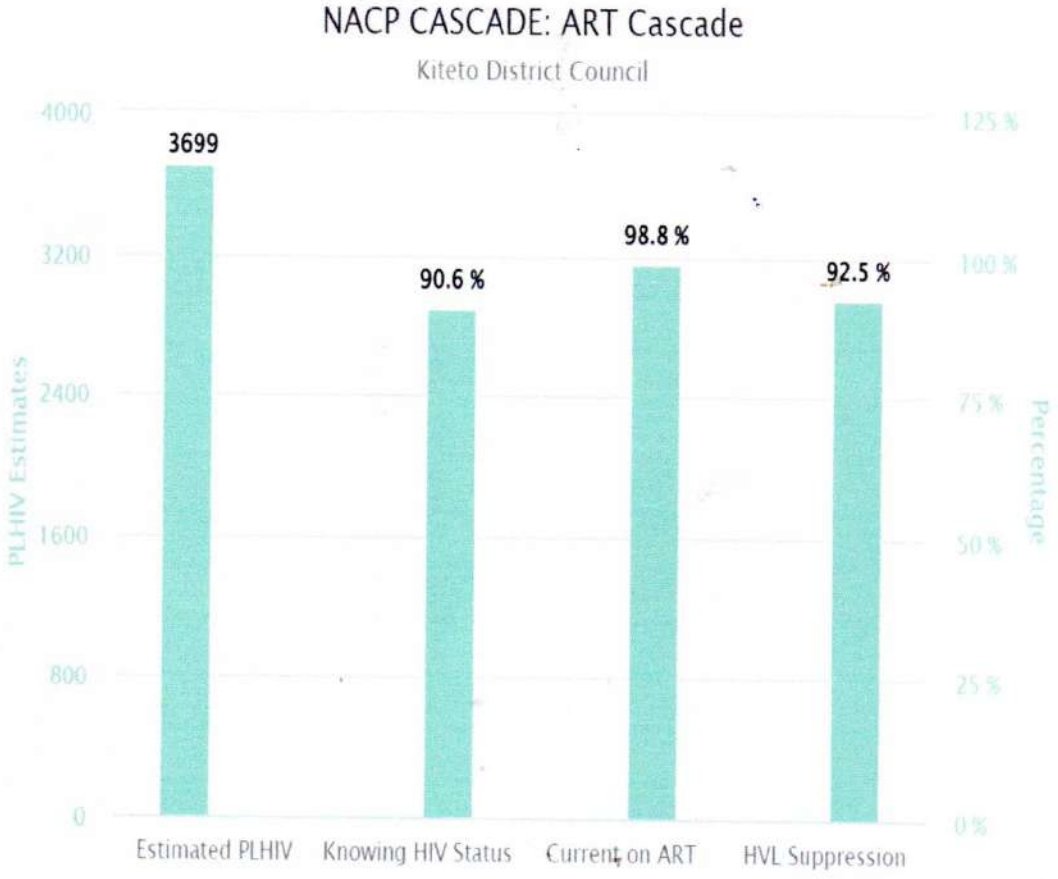
3.2.1: The Council 95-95-95 performance



Data source: Dhis2

The figure above shows, for the past three years a progress of first 95 and third 95 is remarkably improving. Still some effort is needed to reach goal. Some effort is to be distributed to address stigma and negative social-cultural beliefs that hinder health seeking behavior towards HIV and use of ART among community in hard to reach remote areas.

Fig 3: 95-95-95 Cascade in 2022.

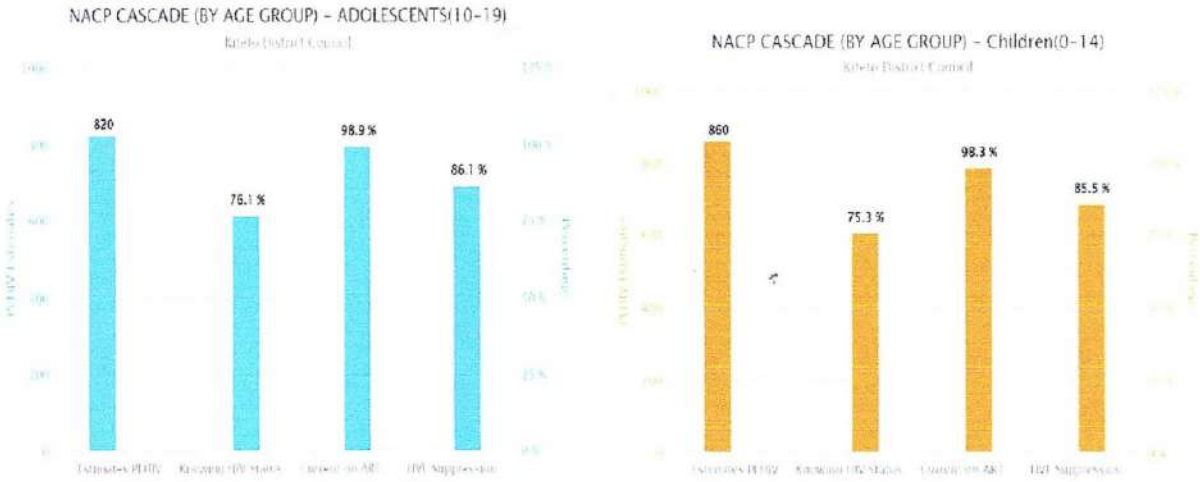


Data Source: Dhis2 NACP Dashboard.

3.2.2: Notable low 95-95-95 Performance among male, Children and Adolescent group.

Despite a notable progress in the 95-95-95 cascade, still are some pull back in the 1st and 3rd 95 among the Children (0-14) and adolescent group (10-19 years) where the 1st 95 and 3rd 95 are 76% & 86% respectively. (See table 4 below). Furthermore, when comparing male and female group, the male group seems to lags behind in 1st 95 and 3rd 95 as compared to the female counterpart (See table 5 below). This could be explained by low health seeking behavior, responsibility (no time to waste, seeking for daily family bread). However, for the adolescent group it could be endorsed by unavailability of youth friendly service, peer pressure, hormonal and emotional changes, self and community stigma. For children group this could be explained by some factor including, guardian-assistance dependency for drug intake (child need other person to supervise), pills with different frequency (ABC/3TC taken twice a day while DTG taken once a day), parental awareness gauge and sometime inconsistent supply of these commodities.

Fig 4: Adolescent group VS Children group (95-95-95 Cascade)



Data Source: Dhis2

.Fig 5:Male VS Female, 95-95-95 Cascade.

3.2.3: Retention in HIV care Status:

The council has experienced major challenge in net gain of the TxCurr (See table 11 below).

Table 12: TX CURR NEGATIVE GAIN DUE TO ATTRITION

PERIOD	TxCurr	PERIOD	TX Curr	PERIOD	TxCurr	PERIOD	TxCurr
By end of December **2021**	3,512	By end of March 2022	3,314	By end of June 2022	3,356	By nd of September 2022	3,346
Jan-Mar 2022 New started ART	121	Apr-Jun2022 New started ART	128	July-Sept2022 New started ART	111	Oct-Dec 2022 New started ART	130
Expected TxCurr for Jan-Mar 2022	3,633	Expected TxCurr for Apr-Jun 2022	3,442	Expected TxCurr for July-Sept 2022	3,467	Expected TxCurr for Oct-Dec 2022	3,476
TxCurr as per Jan-Mar 2022	3,314	TxCurr as per Apr- Jun 2022	3,356	TxCurr as per Jul - Sept 2022	3,346	TxCurr as per Oct - Dec 2022	3,383
Loss	-319	Loss	-86	Loss	-121	Loss	-93

Data source: Dhis2 (Quarterly ART report):

Low immunity was one of the factors that precipitating COVID19 infection. The council has made priority to integrate COVID 19 vaccination into routine CTC services whereby 78% of clients were vaccinated by 2022.

3.2.5: HIV/AIDS challenges and recommendations 2022.

Table 14: HIV/AIDS challenges and recommendations.

Challenges	Identified reasons	Recommendation
High number of Miss App/LTF	-Low HIV knowledge among pastoralist *(Address hard to make them believe on presence of HIV on their society)* -Low number CTC (13/34) to maximize coverage in remote areas. -Few and less supported CBHS. -Low HRH -Few Implementing partners (IP) despite vast squared km-as compared to urban area with large number of IPs	-To involve the influential leaders/people ("Laigwainan/Laigwainak" political figure and religious leaders) in CBCC campaigns. -To promote PMTCT-standalone into full CTC (formal basic ART training) -To increase CHV Number – (1CHV per village/sub village) -Mobile ART refill outreaches. (Fuel, vehicle, extra-duty allowance).
Knowledge gap between PMTCT stand alone and the USAID –Afya yangu supported site. (HsPs Non supported site lack some update concerning HIV service)	-No funds to cover the trainings	- To continue with On job training during CHMT supportive supervision. -IPs need to support CHMT supportive supervision into the non-supported site.

3.2.6: Key Activities in 2022/23 (for HIV/AIDS services).

- To Conduct Index Testing and OPITC.
- To conduct integrated ART refill outreaches on hard to reach sites (*Amei, Kirimbogo, Engurumweusi, Kidongo, Kinua, Pori #1)*
- Tracing for MissAPP and LTF

- To conduct CHMT comprehensive supportive supervision.
- Monitoring and evaluation activities (Coordination, data management and analysis).

3.3: STATUS OF TUBERCULOSIS SERVICES

Table15: TB case notification, case notification rate and treatment success in 2020, 2021 and 2022.

Performance indicators	National Target	District Target	District Achievement		
	by 2022	by 2022	2020	2021	2022
Number of TB Notifications for all forms	**98,349**	**1,200**	**1086**	**953**	**840**
Case Notification rate (CNR) for all forms of Tuberculosis Patients per 100,000 *(CNR refers to cases notified per 100,000 population in a given year).*	**205**		**2.3**	**1.98**	***1.7***
Treatment success rate for all forms of Tuberculosis Patients (2022)	**90%**	**83.5**	**99.3**	**100**	**100**

Data source: ETL

The table shows a remarkable decrease in TB case notification due decrease in support (Phasing out of IP), particularly at the end of the year 2021. In 2022 there has been little activities carried out at the community level. These community-level activities need financial support (Vehicle, fuel and per diem). Activities conducted at the community level includes Active case finding (ACF), and Contact tracing.

- To conduct CHMT comprehensive supportive supervision.
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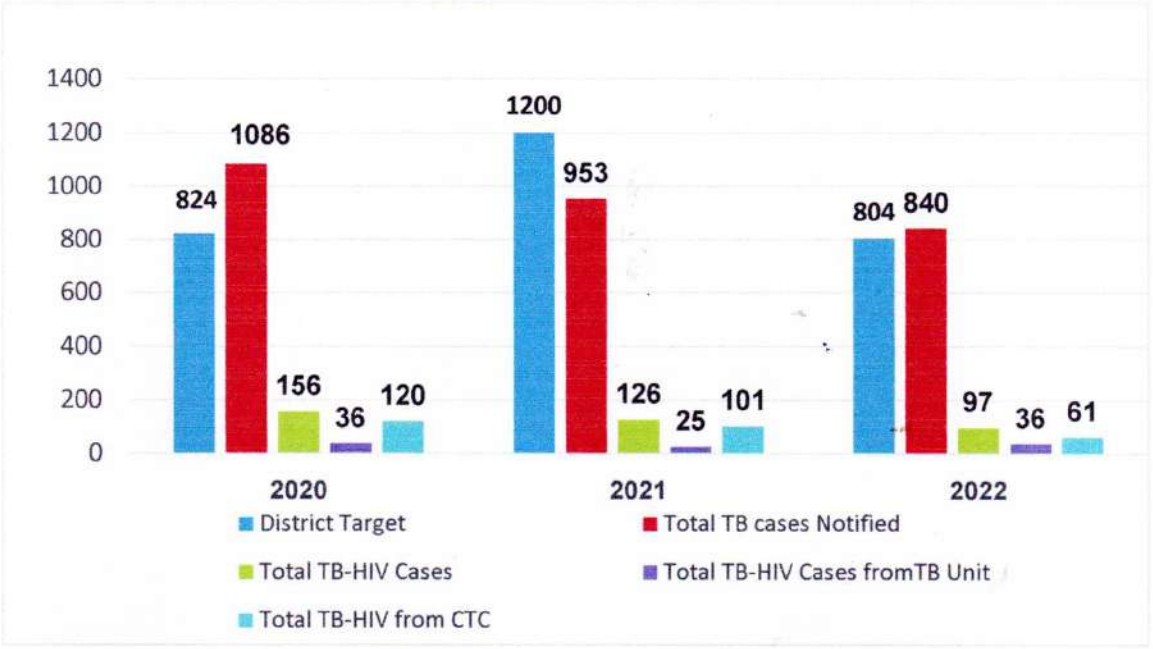
Fig 6: TB Case notification during the year 2020– 2022.



Data source: ETL

Table 16: Leprosy prevalence and proportion of grade two disabilities 2022.

Performance indicators	National Target	District Target	Achievement		
	by 2022	by 2022	2020	2021	2022
Leprosy prevalence rate (# of patient registered at the end of year x 10,000 per population)	< 1	< 1	0	0	0
Proportion of Grade two disability among new Leprosy patients	7%	7%	0	0	0

Data Source: ETL

No reported case for Leprosy in 2022. Monitoring should continue.

3.3.1: Key activities in 2022/23 (TB Services).

- Active TB case finding quarterly
- Contact tracing.
- Maximize TB Screening at all entry points (OPD, RCH).
- Sputum sample referral from spokes (peripheral HF) to Hub (District hospital) for Gene Xpert examination
- To conduct integrated ART and antiTB refill outreach

CHAPTER 4.0: FINANCE, HUMAN RESOURCE FOR HEALTH.

Table 17: Financing, Human resource for Health.

STATUS OF DISTRICT HEALTH SYSTEMS	District Target	ACHIEVEMENT		
	2022/2023	2019/2020	2020/2021	2021/2022
Total budget allocation to health in the district (all sources)	6,870,877,044.00	2,575,481,233.00	6,915,020,688.00	8,254,279,705.00
Total budget allocation to HIV AIDS services in the district (all sources)	85,242,500.00	293,285,000.00	51,600,000.00	27,818,000.00
Total funds received for health services (all sources)	2,712,133,843.66	1,360,425,786.16	1,108,483,969.78	1,117,293,766.42
Total fund received to HIV AIDS services in the district (all sources)	37,192,388.00	135,718,000.00	43,437,967.14	27,818,000.00
Total funds utilized in health services (all sources)	2,153,343,849.73	1,360,425,786.16	1,036,406,424.73	932,483,572.35
Total funds utilized to HIV AIDS services in the district (all sources)	37,190,000.00 (99.9%)	135,718,000.00	43,437,967.14	27,818,000.00
Proportion of households enrolled in any Health insurance schemes	30%	2%	4.1%	6.4%
Number of health facilities with no skilled personnel (Clinician and Midwifes)	0	0	0	0

Data source; CCHP, HRH and District profile

In financial year 2021-2022, the District had approved budget of Tshs. 8,254,279,705.00 for health, but only 14% (1,117,293,766.42) was disbursed. 43% (37,192,388/85,242,500) of HIV 2022/23 budget was disbursed. The proportion of households enrolled in ICHF scheme was 6.4% in 2021/22 far from target (30%).

Table 18: Availability of Human resource for Health by cadres in the year 2022.

SN	CADRE	REQUIRED	AVAILABLE	DEFICIENCY
1	Medical Doctors	29	13	16
2	AMO	43	3	40
3	CO	41	33	8
4	ACO	31	21	10
5	Dental Officer	1	0	1
6	Ass. Dental Officer	6	0	6
7	Dental Therapist	6	4	2
8	Nursing Officer	24	4	20
9	ANO	129	48	81
10	Nurse	209	83	126
11	Health Assistant	120	73	47
12	Anaesthetist	10	0	10
13	Lab Scientist	3	2	1
14	Lab. Technologist	8	4	4
15	Physiotherapist	2	2	0
16	Lab. Technologist Ass.	41	9	32
17	Pharmastist	3	3	
18	Pharmaceutical Tech	7	1	5
19	Ass. Pharmaceutical Tech	41	1	40
20	Enviromental Health Officer	4	0	4
21	Electrical technician(prosthetic)	3	0	3
22	Ass. Enviromental Health Officer	7	5	2
23	Ass. Accountant	33	0	32
24	Data Clerks	33	1	32
25	Cook	5	0	5
26	Security Guard	8	0	8
27	Head of Department	1	1	0
28	Personal Secretary	2	0	2
29	Radiographer	7	1	6
30	Social welfare Officer	11	4	7
31	Health secretary	2	2	2
32	Nutritionist	2	2	0
33	Dhobi	10	0	10
34	Mortuaty Attendant	7	0	7
35	Biomedical Engeering	4	1	3
	TOTAL	**893**	**321**	**572**
			36%	**64%**

Data source: Council HRH profile

On the path towards achieving the World Health Organization-recommended ratio of 1 doctor per 1000 population by 2024, the situation in Kiteto District Council is 1 doctor/nurse per 20,000 populations.

5.1: Challenges and recommendations in financing and human resources.

Table 19: Challenges and recommendations in financing and human resources.

Challenges	Recommendations
Low number of HRH by 36%	District to hire HRH for Key areas with scarcity.
Delay in Fund allocation	Government to deploy fund as per scheduled time
Low fund disbursed as per budget	Government and partners to disburse fund as per budget
Remote areas with limited social services especially houses	Community to be sensitized so that they can construct houses for HRH

CHAPTER 5.0: CONCLUSION

The report has tried as much as possible to provide a summary of Kiteto DC HIV Profile for the year 2022. The Council has made progression in 95-95-95 goal though still a work to attain target by 2025. Despite of the progress, still a remarkable effort is needed in addressing a challenge of low ART retention in the society, owing to socio-cultural barriers toward HIV among the nomadic society. Low health facility delivery by 49% and Low proportional of ANC first visit <12 weeks of gestation by *40% in 2022*) addresses a need of multi-sectorial participation in addressing it as it contributes to pull-back of effort to reduce new HIV infections.

Moreover, low proportional of CTC number (34%) with presence of marginalized remote-hard to reach areas adjuncted by a nomadic community has been a remarkable restriction in maintaining good ART adherence which consequently affect the 3rd 95 goal (viral suppression), leading to potential increase in new HIV infection and Mother to child transmission (MTCT).

HIV related death being number three among IPD admission, rings an alarm to late diagnosis and an observed low retention in care. Low retention in care has been embraced by negative believes (social-cultural). This need a total throttle effort to involve community influential leaders, political leader, and religious leader during community behavioral change communication campaigns.

6.0: ANNEXES

Annex 6.1: Implementing partners by Program area in 2022.

NAME OF THE PARTNER	PROGRAM AREA
EGPAF (*USAID Afya yangu*)	HIV/PMTCT,FP and TB
THPS (*Mlango II project*)	Key Vulnerable Population
Kizazi Hodari	Orphaned and Vulnerable Children and youth
Global Fund	Tb, HIV/AIDS and Malaria
Marie stop	FP
Pathfinder	FP/Environment conservation
M/MAMA	Mobile Mama

Annex 6.2: Picture:

Kiteto District HIV Profile 2022 preparation @Maktaba Hall.