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VIEW IN FRAME


# Tanzania-US-AIDS: US donates 2.5 million dollars for Tanzanian HIV programmes

*Agence France-Presse - Tuesday, January 19, 2000*

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DAR ES SALAAM, Jan 19 (AFP) - The United States has donated 2.5 million dollars to finance programmes aimed at reducing the spread of HIV in Tanzania, according to a US statement released here Wednesday.

Sandra Thurman, director of the White House Office of National AIDS Policy, said in the statement that the funds would be directed to special programmes throughout Tanzania.

"The money, from the Leadership and Investment in Fighting an Epidemic (LIFE) initiative, will be used in four areas: primary prevention, including mother-to-child transmission; home- and community-based care and treatment, care for children affected by AIDS, and capacity and infrastructure development," the statement said.

According to official estimates, two million Tanzanians are infected with the HIV virus that leads to AIDS.

Thurman heads a six-member delegation currently in Tanzania to discuss the LIFE initiative.

She said her country was optimistic that Tanzania could stop the spread of HIV/AIDS on the basis of several successful pilot projects.

"The success stories include programmes to treat sexually transmitted diseases, marketing of condoms and campaigns for behavioural change," Thurman said.

"We are also impressed on how the country has recently demonstrated a high-level political commitment, along with the launch of a new five-year multi-sectoral strategy, to address HIV/AIDS," Thurman said.

Thurman, who has been in Tanzania since Sunday, is due to leave for Nairobi, the capital of neighbouring Kenya, late on Wednesday.
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# TANZANIA AND HIV/AIDS

## Country Profile

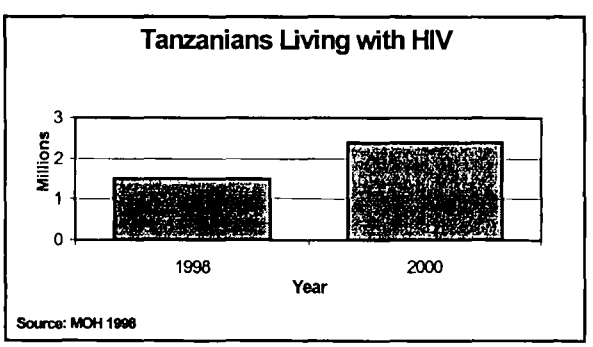
Tanzania is one of the few politically stable countries in East Africa; however, continued regional ethnic tensions and potential expansion of the conflict in the Great Lakes states threaten this stability. Tanzania is noted for accepting refugees displaced by the conflicts in neighboring Rwanda, Burundi, and the Democratic Republic of the Congo, at great political and economic cost. The country is rich in natural resources and contains some of the world's most biologically diverse ecosystems. Although Tanzania's gross domestic product (GDP) is increasing annually at a rate of 3.6 percent, it is not sufficient to sustain the country's annual 3 percent population growth. Tanzania's external debt stands at $8.2 billion and the country today remains one of the fifth poorest countries in the world.

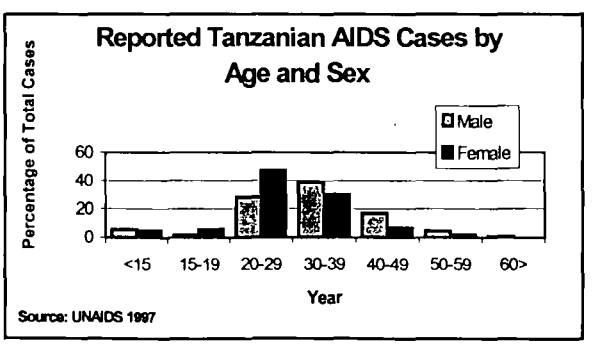
High rates of fertility (5.7) and sexually transmitted infections (STIs), including HIV/AIDS, contribute to elevated adult and infant morbidity and mortality rates in Tanzania. According to a 1996 Demographic and Health Survey (DHS), more than 43 percent of Tanzanian children under age 5 suffer from malnutrition: 30 percent are underweight; approximately 30 percent suffer from fever; and 14 percent suffer from diarrhoeal diseases. The overall infant mortality rate is 100 per 1,000 births and the child (under age 5) mortality rate is 145. Roughly 60 percent of the population still lack access to health services. The Tanzanian government currently allocates 6 percent of its central budget—3 percent of the GDP—to the health sector. In July 1996 the government initiated a plan for health sector reform.

### *HIV/AIDS in Tanzania*

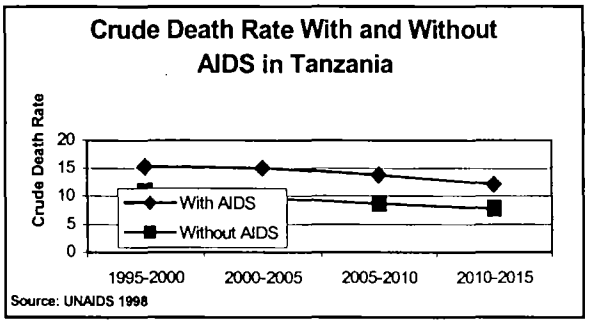
The first three AIDS cases were reported in Tanzania in 1983. Since then the HIV/AIDS epidemic in Tanzania has increased alarmingly each year. The epidemic is being driven by high-risk heterosexual sexual behavior characterized by high levels of STIs.

- Ten to 12 percent of adults (age 15 and over) are HIV-positive.
- An estimated 1.5 million Tanzanians are living with HIV—520,000 of them with AIDS. Following current trends, this figure is expected to rise to 2.4 million by the year 2000.
- In 1997, HIV prevalence rates among selected populations in urban areas ranged from 14 percent in low-risk groups to 50 percent in high-risk groups. Rural rates ranged from 17 percent in low-risk groups to 34 percent in high-risk groups.
- The highest HIV-prevalence rate is among 30- to 44-year-olds.
- In 1996, only 16 percent of men reported using a condom during their last sexual encounter.
- More than 150,000 people died of AIDS-related illnesses in 1997.

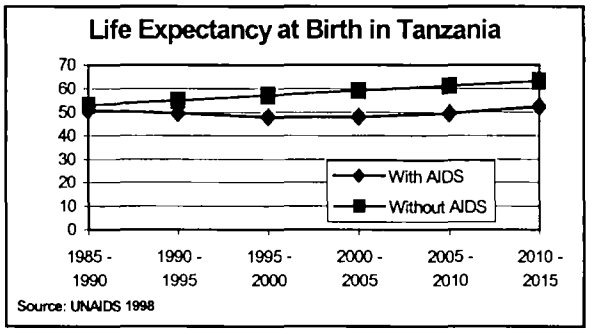


- From 1990 to 2010, AIDS will increase the crude death rate in Tanzania by more than 50 percent.




- Life expectancy will drop by 20 percent during the 1990s as a result of HIV/AIDS. By 2010 the average life expectancy will be 46 years.




## *Women and HIV/AIDS*

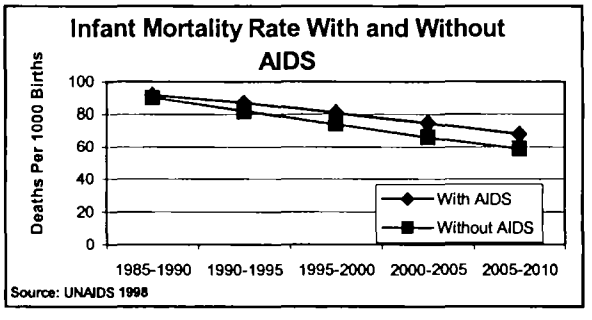
The number of women living with HIV/AIDS is growing. Women's low social and economic status, combined with greater biological susceptibility to HIV, put them at increased risk of infection. Deteriorating economic conditions, which make it difficult for women to access health and social services, compound their vulnerability.

- Data derived from ten antenatal sentinel surveillance sites show countrywide HIV-prevalence rates ranging from 10 to 33 percent among pregnant women.
- According to the 1996 DHS, 97 percent of women have heard of AIDS yet only 38 percent can name at least two correct ways to avoid HIV.
- According to the same study, 29 percent of Tanzanian women reported having only one sex partner and only 10 percent reported ever using a condom to avoid STIs.
- Eighteen percent of women 15 to 49 years old have been circumcised. Circumcision increases a woman's risk of contracting HIV.

## *Children and HIV/AIDS*

Forty-six percent of the Tanzanian population is under age 15. The HIV epidemic has a disproportionate impact on children, causing high morbidity and mortality rates among infected children and orphaning many others. Approximately 30 to 40 percent of infants born to HIV-positive mothers will also become infected with HIV.

- More than 68,000 children under age 15 are living with HIV/AIDS.
- Each year approximately 50,000 to 60,000 children are born HIV-positive.
- By 2015 the infant mortality rate is expected to be at least 16 percent higher than it would have been in the absence of AIDS.

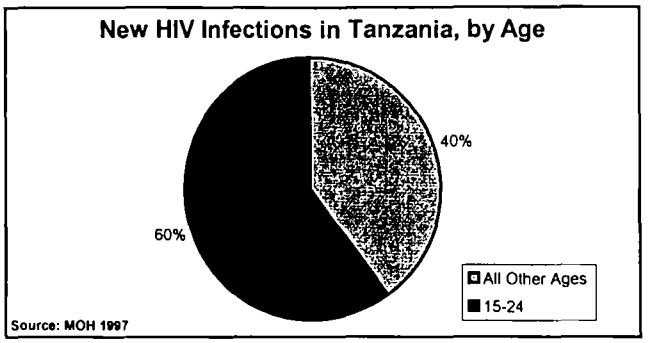



- An estimated 15 percent of all Tanzanian children under age 15 are missing one or both parents, many of them because of AIDS.
- To date, an estimated 730,000 children have been orphaned because of AIDS.

### *Youth and HIV/AIDS*

Youth and young adults account for a large percentage of all HIV/AIDS cases in Tanzania.

- Tanzanians 15 to 24 years old, while comprising only 20 percent of the population, account for 60 percent of new HIV infections.
- In 1996, 26 percent of teenagers had given birth or were pregnant for the first time.




## Socioeconomic Effects of AIDS

More than 80 percent of reported AIDS cases are 20 to 49 years old. Since this age group constitutes the most economically productive segment of the population, an important economic burden is created. Productivity falls and business costs rise—even in low-wage, labor-intensive industries—as a result of absenteeism, the loss of employees to illness and death, and the need to train new employees. The diminished labor pool affects economic prosperity, foreign investment, and sustainable development. The agricultural sector likewise feels the effects of HIV/AIDS; a loss of agricultural labor is likely to cause farmers to switch to less-labor-intensive crops. In many cases this implies switching from export crops to food crops—thus affecting the production of cash and food crops.

In 1996, the cost of AIDS care as a percentage of national health expenditure was 3.5 percent or $5.8 million. There are also many private costs associated with AIDS, including expenditures for medical care, drugs, funeral expenses, etc. The death of a family member leads to a reduction in savings and investment, and increased depression among remaining family members. Women are most affected by these costs and experience a reduced ability to provide for the family when forced to care for sick family members. And AIDS adversely affects children, who lose proper care and supervision when parents die. Some children will lose their father or mother to AIDS, but many more will lose both parents, causing a tremendous strain on social systems. At the family level there will be increased pressure and stress on the extended family to care for these orphans; grandparents will be left to care for young children and 10- to 12-year-olds become heads of households.

(For country-specific information on the socioeconomic impact of HIV/AIDS, refer to the *analysis* presented by the Policy Project.)

## Interventions

### *National Response*

Since 1983 various national efforts to control the spread of HIV have been launched. Currently there are two independent National AIDS Control Programmes (NACPs), one on the mainland and one in Zanzibar. A short term plan was prepared and implemented by the Ministry of Health and the NACP between 1985 to 1986. This was followed by the First Medium Term Plan (MTP1), for the period 1987 to 1991, and the Second Medium Term Plan (MTP2), for the period 1992 to 1996. In September 1995 the NACP developed a draft National Policy on HIV/AIDS/STIs. The specific objectives of this policy were to increase the community's awareness of HIV/AIDS; provide people living with HIV/AIDS (PLWHA) and their caregivers with social, medical, physical, and spiritual support; and safeguard and protect the

human rights of all PLWHA. To date, however, the policy has not been enacted.

After the MTP2 ended in 1996, the government finalized and launched a National Strategic Plan for HIV/AIDS for the period 1998 to 2002. The strategic plan, multisectoral in its approach, was developed by more than 20 government sectors, nongovernmental and religious organizations, PLWHA, and the private sector. It was launched by the Tanzania's prime minister and other high-ranking governmental officials. The U.S. , Swedish, and Norwegian ambassadors and the head of the European delegation also gave statements renewing their commitment to support the national response in the fight against HIV/AIDS in Tanzania.

The NACP strategy outlines 11 priority areas focusing on the prevention of HIV/AIDS and other STIs; protection of PLWHA; mitigation of the socioeconomic impact of HIV/AIDS; and the strengthening of NGOs, communities and individuals affected by the epidemic. Operational plans are being developed, primarily at the district level, to address these priorities.

With the launch of the National Strategic Plan, the government also made a commitment to reactivate the existing National AIDS Committee and form a new National Advisory Board on HIV/AIDS headed by the former president of the country.

### *Donors*

Multilateral and bilateral donors are actively engaged in HIV/AIDS in Tanzania. According to a UNAIDS/Harvard study, bilateral organizations contributed the following amounts in 1996-1997:

| Organization | Amount US$ 1996-97 |
|---|---|
| Norway | 1,207,337 |
| DANIDA | 643,362 |
| EU | 573,936 |
| TAP (USAID-funded) | 20,648 |
| **Total** | **2,700,255** |

*Bilateral organizations' contributions 1996-1997*

**USAID**'s HIV/AIDS funding for FY 1998 was $3,600,000. Working with Tanzania's NACP, USAID/Tanzania has supported the development of networks of indigenous NGOs and other private entities that are undertaking HIV/AIDS activities , the dissemination of AIDS information in various media, and social marketing of condoms. Areas of NGO activity also have included training for syndromic diagnosis and treatment for STIs and support for PLWHA. The mission also supports capacity building within the NACP and advocates for appropriate responses to HIV/AIDS at the national level. In 1998 USAID was a key donor and contributed to the development of the National Strategic Plan and the First National Scientific Conference on HIV/AIDS in Tanzania.

*The First National Scientific Conference on HIV/AIDS in Tanzania in 1998 provided a platform from which to disseminate the Tanzanian government's HIV/AIDS strategy to over 700 individuals, including media representatives. It also provided a forum for critical debate on pertinent issues and highlighted the lack of political support within the government. Subsequently, both the president and prime minister gave their first public remarks about HIV/AIDS in Parliament.*

In 1999 USAID/Tanzania will continue to support both public and voluntary sector activities, the latter through a voluntary sector umbrella grants program. Through these sectors, USAID/Tanzania intends to support the following types of activities:

- Address the weak policy and legal environments and strengthen national leadership.
- Develop information, education and communication (IEC) messages to increase client use of HIV/AIDS/STI clinics coordinated by NGO partners.
- Promote male and female condom social marketing campaigns.
- Launch advocacy campaigns to increase HIV/AIDS awareness among the general public.
- Train NGOs to provide indigenous, community-based approaches to AIDS prevention, education, counseling, and testing.
- Build district-level public/private partnerships to address HIV/AIDS, as well as reproductive and child health concerns.

**UNAIDS'** coordinating Theme Group in Tanzania includes representatives from UNDP, WHO, UNICEF, UNESCO, UNFPA, and The World Bank, and is chaired by UNFPA. UNAIDS receives multilateral funds from Norway, Ireland, ODA and GII. UNAIDS also receives core support from its cosponsors. UNAIDS is involved in several activities, including several independent contracts to conduct research, workshops and surveys on topics such as HIV subtypes, household sexual networks and HIV infection, and collection of HIV isolates in Tanzania. UNAIDS is also involved in health reform projects focusing on:

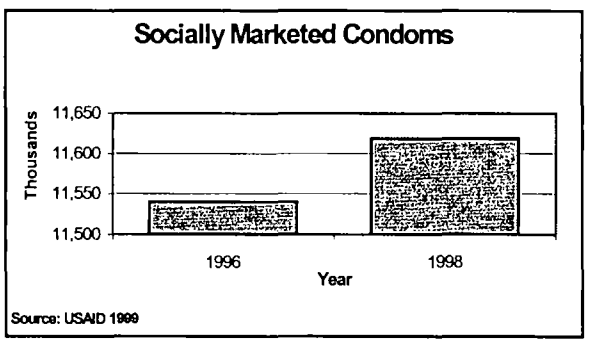
- Reviving under-resourced district AIDS coordination committees.
- Expanding district-level HIV/AIDS initiatives.
- Combating the recognized HIV-related stigma and denial of PLWHA in the clinic setting.

UNAIDS has also supported private sector mobilization projects for the expanded response to HIV/AIDS, and research projects including the PETRA study site on mother-to-child transmission, based in the Muhimbili Hospital in Dar es Salaam.

**The World Bank** supports HIV prevention through a $47.6 million health and nutrition project. By providing support to critical and strategic elements of the PHN sectors, the project reinforces the government's efforts to raise the quality, coverage and effectiveness of family planning, nutrition and basic health services in urban and rural areas.

**The European Union** provides STI drugs and training through the National AIDS Control Program.

**The World Food Programme (WFP)** provided




home-based care in collaboration with the NACP from 1992 to 1997. WFP assisted the Ministry of Health in its efforts to develop a model for home-based care in Kagera region, where there is a high HIV-prevalence rate among the most productive age group. The total budget for this program was $1.7 million.

**The Australian Agency for International Development (AusAID)** provided assistance from 1994 to 1997 to a high HIV-transmission area.

**The Finnish Ministry for Foreign Affairs, Department of International Development Cooperation** had a project in Tanzania from 1995 to 1998. This project, implemented by the Association for Developing Countries in Vasa, provided FIM 700,000 for dissemination of AIDS prevention information, and direct support for hospitals, education of health care staff, hospital equipment, and delivery. The Finnish government also supported an IEC program implemented by the Finnish Free Foreign Mission from 1995 to 1997, for FIM 2.2 million.

**The German Federal Ministry for Economic Cooperation and Development (GTZ)** supported a DM 1.5 million HIV/AIDS control program in 1997. This program helped to expand the AIDS control programs in the diocese of Moshi and in Arusha.

**The United Kingdom Department for International Development (DFID)** supported various NACP prevention projects by providing £2.48 million from 1994 to 1997.

**The Ford Foundation** is currently providing the Africa Medical and Research Foundation (AMREF) with a grant of $160,500. This grant supports the implementation of an HIV-transmission areas intervention project. The Ford Foundation is also supporting the Faraja Trust Fund, with a grant for $74,000. This grant is assisting with the second phase of a public education and community mobilization program to reduce HIV transmission in Morogoro.

### *Private Voluntary Organizations (PVOs) and Nongovernmental Organizations (NGOs)*

A number of PVOs implement activities funded by multilateral and bilateral donors. Some of the major USAID cooperating agencies include Family Health International (FHI)/IMPACT, Pathfinder International, Population Services International, John Hopkins University, CARE and MACRO International. *See attached preliminary chart for PVO and USAID cooperating agencies HIV/AIDS activities target areas. This list is evolving and changes periodically.*

Tanzania currently does not have an NGO coalition. The Tanzania AIDS Project (TAP) was initiated in June 1993 as a five-year project (1993 to 1998). TAP's principle goal was to build the capacity of indigenous NGOs to implement HIV/AIDS preventive education activities and to provide a source of support to people with HIV/AIDS. Funded by USAID and implemented by the FHI/Tanzania country office, TAP established the NGO cluster approach in 1993. This approach facilitated the creation of clusters or networks of NGOs working in HIV/AIDS prevention or care to help improve their capacity to challenge the epidemic. Peer education has been one of the primary strategies used by these NGO clusters and their members. According to USAID, NGO clusters or networks provide services within selected districts for 9 out of 20 regions in mainland Tanzania..

The African Medical and Research Foundation, based in Tanzania, is one of the larger research institutions in Africa. Traditional healers have an important role in Tanzania, and efforts are being made to bring them into an adjunct, cooperative relationship with biomedical workers to treat STIs and some infections caused by AIDS.

## Challenges

Major constraints to HIV/AIDS control in Tanzania include the following:

- Lack of political support within the government and from high-ranking officials.
- Shortages of trained health workers as well as financial resources in the biomedical sector.

The following gaps in programming must be filled in order to mount an effective response to HIV/AIDS in Tanzania:

- High-level political support and enforcement of a National AIDS Policy and National Strategic Plan.
- Legislation and enforcement to protect the human rights of PLWHA.
- Expanded funding sources for NGOs and community-based initiatives.
- Integration of HIV/AIDS/STI programs with reproductive health services.
- Focus on youth efforts and activities, including family life education and HIV/AIDS education programs in schools.
- Behavior change interventions are needed to complement all IEC activities. Although basic knowledge of HIV/AIDS is high among

Tanzanians, knowledge of self protection measures and behavior change is much lower.

## The Future

Although the Tanzanian government recently passed a National Strategic Plan, there continues to be limited overt political commitment to the fight against HIV/AIDS. This is demonstrated by a continued lack of decision making on the appropriate organizational home for the NACP, and the inactivity of the National AIDS Committee. Implementation of the National Strategic Plan is still in the early stages and will need continued commitment from the president and other high-ranking officials in order to be effective and sustainable. The challenge ahead is to make use of the favorable environment and act expeditiously, so as not to lose the high momentum of political support and leadership. Only with such leadership will it be possible to slow the spread of HIV in Tanzania.

## Important Links

1. Tanzania National AIDS Control Program: Ministry of Health, P.O. Box 9083, Dar-es-Salaam.
2. UNAIDS Country Program Adviser: Mulunesh Tennagashaw, UNAIDS, c/o WHO, Luthuli Road, P.O. Box 9292 Dar-es-Salaam; Tel: (255) 51 13 03 50, Tel mobile: (255) 812 781 987; Fax: (255) 13 96 54; email: mulu.unaids@twiga.com

**U.S. Agency for International Development**
**Population, Health and Nutrition Programs**
**HIV/AIDS Division**
1300 Pennsylvania Ave., N.W.
Ronald Reagan Building, 3rd Floor
Washington DC 20523-3600
Tel: (202) 712-4120
Fax: (202) 216-3046
URL: www.info.usaid.gov/pop_health

**Implementing AIDS Prevention and Care (IMPACT) Project**
Family Health International
2101 Wilson Boulevard, Suite 700
Arlington VA 22201 USA
Telephone: (703) 516 9779
Fax: (703) 516 9781
URL: www.fhi.org

*June 1999*

Country Brief

# UNITED REPUBLIC OF TANZANIA
# 06.01.00

## Socio-Economic Data

| | | |
|---|---|---|
| Total population (thousands), 1997 | 31,507 | UNPOP |
| % of population urbanized, 1996 | 25 | UNPOP |
| Annual population growth rate | 2.8 % | Census report 1998 |
| Infant mortality rate (per 1,000 live births), 1996 | 93 | UNICEF/UNPOP |
| Maternal mortality rate (per 100,000 births), 1990 | 770 | WHO/UNICEF |
| Life expectancy, 1996 | 51 | UNPOP |
| Adult literacy rate | 60 % | |
| Per capita GNP (US$), 1995 | 120 | World Bank |
| Human Poverty Index Value (HPI) | 39.7 | UNDP |

## Status of the Epidemic

| Prevalence – Year | Trend |
|---|---|
| 9.42 – 1997 | There is evidence of falling prevalence in some areas, but rising prevalence in others. Good surveillance system. |

## Impact of the Epidemic

- **Orphans:** 300 000 orphans estimated at the end of 1998;
- **Bed occupancy:** 50% of hospital beds are occupied by patients with HIV/AIDS related illnesses;
- **Decline in life expectancy:** According to World Bank estimates, by 2010 life expectancy will be 47 years instead of the projected 56 years in the absence of AIDS;
- **Decline in the age of the labour force:** Age of the working population will decline from 31 to 29 years between 1992 and 2010;
- **Funeral costs** are estimated at US$ 100 for every adult;
- **Lifetime nursing care** for HIV/AIDS patients is estimated at US$ 290 for adults and US$ 195 for children;
- **Production of food and cash crops:** As epidemic spreads into rural communities, the production of food and cash crops is to suffer.

## National Response

### National AIDS Control Programme (NACP)

- Two independent NACPs, one on Mainland and one in Zanzibar. NACPs are under the related Ministries of Health.

### National Strategic Planning

- Tanzania (Main land) and Zanzibar have each completed their national strategic plan that was launched officially by the Prime Ministers.
- The two national strategic plans recognise AIDS as a socio-economic and development problem and are intended to promote a multisectoral approach against the HIV/AIDS

epidemic. In this perspective development sectors have been requested to establish their own technical AIDS committees. Local Government sectors plays a key role at district level.

- Local governments and district authorities are requested to play a key role in the implementation of the strategic plan. Districts are formulating their implementation plans.

**Political Commitment**

- In Tanzania and Zanzibar, there is a growing and visible political commitment for the fight against the HIV/AIDS epidemic. In his New Year presidential address the President called on the population to declare a war against the HIV/AIDS epidemic. The Prime Minister with the former President Mwinyi as Chair created a National Advisory Board.

**Multisectoral Involvement**

- In Zanzibar, the National AIDS Council is hosted by the office of the Primer Minister .
- All sectors were involved in the strategic planning process including the civil society and people living with HIV/AIDS.
- As a result several Ministries have established a focal point.
- A well co-ordinated and effective multisectoral mobilisation will be one priority area to be addressed by the international partnership.

**UN Theme Group on HIV/AIDS**

**Chair:** UNFPA Representative

**Members:** UNDP, WHO, UNICEF, UNESCO, UNFPA, World Bank

**UNAIDS Personnel:** Country Programme Adviser: Mulunesh Tennagashaw

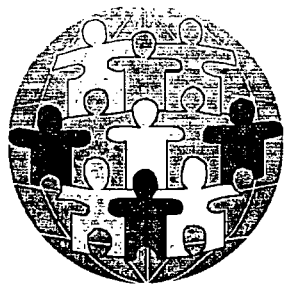
**Support from UN System Agencies for HIV/AIDS activities in 1996-97**

| *Organisation* | *Amount US$* |
|---|---|
| WHO | Not available |
| UNDP | 120,967 |
| UNFPA | 1,095,859 |
| UNICEF | 6,046 |
| ILO | Not available |
| UNESCO | Not vailable |
| UNAIDS | 2,030,761 |
| Total | 3,253,633 |

**Support from bilateral organisations for HIV/AIDS activities in 1996-97**

| *Organisation* | *Amount US$* |
|---|---|
| USAID | 254,972 |
| EU | 573,936 |
| DANIDA | 643,362 |
| DFID | Nil |
| NORWAY | 1,207,337 |
| TAP | 20,648 |

| | |
|---|---|
| Total | **2,700,255** |



The POLICY Project

# The Economic Impact of AIDS in Tanzania

by
John Stover
Lori Bollinger
Peter Riwa

September 1999

The Futures Group International
*in collaboration with:*
Research Triangle Institute (RTI)
The Centre for Development and Population Activities (CEDPA)

*POLICY is a five-year project funded by the U.S. Agency for International Development under Contract No. CCP-C-00-95-00023-04, beginning September 1, 1995. The project is implemented by The Futures Group International in collaboration with Research Triangle Institute (RTI) and The Centre for Development and Population Activities (CEDPA).*

AIDS has the potential to create severe economic impacts in many African countries. It is different from most other diseases because it strikes people in the most productive age groups and is essentially 100 percent fatal. The effects will vary according to the severity of the AIDS epidemic and the structure of the national economies. The two major economic effects are a reduction in the labor supply and increased costs:

Labor Supply

- The loss of young adults in their most productive years will affect overall economic output
- If AIDS is more prevalent among the economic elite, then the impact may be much larger than the absolute number of AIDS deaths indicates

Costs

- The direct costs of AIDS include expenditures for medical care, drugs, and funeral expenses
- Indirect costs include lost time due to illness, recruitment and training costs to replace workers, and care of orphans
- If costs are financed out of savings, then the reduction in investment could lead to a significant reduction in economic growth

| LABOR FORCE STATISTICS | | |
|---|---|---|
| | Economically Active Labor Force: 1967 | |
| **Sector** | **'000s** | **%** |
| **AGRICULTURE** | | |
| Agriculture, hunting, forestry and fishing | 5,216 | 90.8 |
| **INDUSTRY** | | |
| Mining and quarrying industries | 5.0 | 0.08 |
| Manufacturing industries | 98.9 | 1.7 |
| **SERVICES** | | |
| Electricity, gas and water | 5.7 | 0.1 |
| Construction | 33.1 | 0.6 |
| Transport, storage and communications | 46.8 | 0.8 |
| Commerce | 78.8 | 1.4 |
| Other services | 208.5 | 3.6 |
| Activities not adequately defined | 53.7 | 0.9 |
| **TOTAL EMPLOYED** | **5,747** | **100.0** |

Source: Europa World Year Book 1998

The economy of Tanzania is heavily based on agriculture, particularly subsistence farming. By 1996, 83% of the labor force was still employed in agriculture, with the sector contributing 52% of GDP. The main cash crops are coffee, cotton, cashew nuts, and cloves. Food crops include cassava and maize, along with cattle rearing. Very little mining activity exists, while the small amount of manufacturing activity consists mostly of food processing and textiles. The services sector was the second largest US$170 in 1996.[1]

[1] Europa World Year Book 1998, Volume 2 (1998) Europa Publications Limited (London).

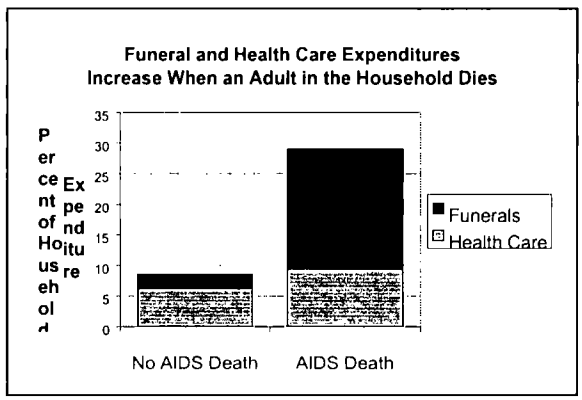
The economic effects of AIDS will be felt first by individuals and their families, then ripple outwards to firms and businesses and the macro-economy. This paper will consider each of these levels in turn and provide examples from Tanzania to illustrate these impacts.

## Economic Impact of AIDS on Households

The household impacts begin as soon as a member of the household starts to suffer from HIV-related illnesses:

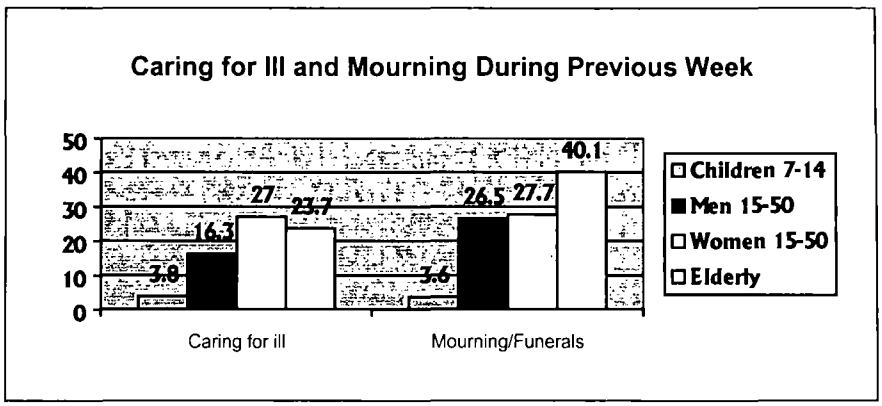
- Loss of income of the patient (who is frequently the main breadwinner)
- Household expenditures for medical expenses may increase substantially
- Other members of the household, usually daughters and wives, may miss school or work less in order to care for the sick person
- Death results in: a permanent loss of income, from less labor on the farm or from lower remittances; funeral and mourning costs; and the removal of children from school in order to save on educational expenses and increase household labor, resulting in a severe loss of future earning potential.

- In Tanzania, a study of adult mortality found that 8 percent of total household expenditure went to medical care and funerals in households that had an adult death in the preceding 12 months. In households with no adult death the figure was only 0.8 percent. On average, households with an AIDS death spent nearly 50 percent more on funerals than they did on medical care. In addition to increased expenditures, many households experienced a reduction in remittances if the adult member worked outside the home. In partial compensation for these financial setbacks, many households were forced to remove children from school in order to reduce education-related expenditures and have the children help with household chores.[2]




- When husbands die from AIDS, their widows suffer from a lack of cash, since men are the main cash income earners in Tanzania. Thus one study found that the most pressing need for widows was for credit to begin new cash-generating projects that could supplement farm work.[3]

[2] Mead Over, Martha Ainsworth, et al. 1996. Coping with AIDS: The Economic Impact of Adult Mortality from AIDS and Other Causes on Households in Kagera, Tanzania.
[3] Toupouzis, D (1998) "The Implications of HIV/AIDS for Rural Development Policy and Programming: Focus on Sub-Saharan Africa." HIV and Development Programme, UNDP, June 1998.




- In Tanzania, an adult death is mourned for about seven days, and a child's death up to three days. During this time, no one in the village does any agricultural work. The recent Kagera Demographic and Health Survey (KDHS) found that, in the week prior to the survey, over one quarter of both men and women spent some time either caring for an ill person or attending funerals. The average amount households reported spending on deaths was US$104, of which US$40 was spent on medical costs, and US$64 on the funeral itself. This expenditure was unequally distributed, with some households reporting zero expenditure, while in other households, expenditures were more than US$1000.[4]

- Data from the Kagera region of Tanzania show that new methods of coping with the financial demands of caring for AIDS patients are being developed. New savings, credit, and mutual aid societies have been created to meet the needs of households that are insuring against future death. Interestingly, the associations are mostly set up and run by women.[5]

- A World Bank study estimated that someone infected with HIV has an increase in morbidity of 170-340%. On average, clinicians in Tanzania estimate that an adult experiences 17 different episodes of illness prior to dying from AIDS, while a child experiences 6.5 episodes.[6]

- A recent study found that households in Tanzania were using a variety of mechanisms to cope with HIV/AIDS. Some households cut back on meals, some sold agricultural produce to raise money to pay health costs, some sold off assets such as cattle, some used child labor extensively to perform domestic and agricultural activities, which was associated with reduced school attendance.[7]

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[4] Lwihula, GK (1998) "Coping with AIDS Pandemic: The Experience of Peasant Communities of Kagera Region, Tanzania," Paper presented at the Technology Development Needs of African Smallholder Agriculture, Harare, June 8-10, 1998

[5] Lwihula, GK (1998) "Coping with AIDS Pandemic: The Experience of Peasant Communities of Kagera Region, Tanzania," Paper presented at the Technology Development Needs of African Smallholder Agriculture, Harare, June 8-10, 1998.

[6] The World Bank (1992) "Tanzania AIDS assessment and planning study", World Bank, Washington DC.

[7] Rugalema, G (1998) "It is not only the loss of labour: HIV/AIDS, loss of household assets and household livelihood in Bukoba district, Tanzania," Paper presented at the East and Southern Africa Regional Conference on Responding to HIV/AIDS: Development Needs of African Smallholder Agriculture, Harare (June 8-10).

## Economic Impact of AIDS on Agriculture

Agriculture is the largest sector in most African economies accounting for a large portion of production and a majority of employment. Studies done in Tanzania and other countries have shown that AIDS will have adverse effects on agriculture, including loss of labor supply and remittance income. The loss of a few workers at the crucial periods of planting and harvesting can significantly reduce the size of the harvest. In countries where food security has been a continuous issue because of drought, any declines in household production can have serious consequences. Additionally, a loss of agricultural labor is likely to cause farmers to switch to less-labor-intensive crops. In many cases this may mean switching from export crops to food crops. Thus, AIDS could affect the production of cash crops as well as food crops.

- In the Kagera region of Tanzania, although short-term impacts on agricultural production have not been felt yet, medium- and long-term impacts will occur. Soil fertility is being affected because labor is not available to mulch bananas or clear new areas, resulting in decreasing yields and overcropping. This can only increase pressure on the subsistence agriculture system that exists.[8]

- An earlier study of three communities in different districts in Tanzania found that there had been little effect of HIV/AIDS on agricultural output. The authors hypothesized that this was because prevalence was highest in those agricultural systems that are least vulnerable to labor supply interruptions. In addition to this, oxen are used extensively in Tanzania, so that they can be used as substitutes for labor during an interruption, thus cushioning the shock. The final results of this, however, may be a widening in the disparity between ox-owning and non-ox-owning households.[9]

- **In Kagabiro village, Tanzania, when a household contained an AIDS patient, the household labor supply was severely affected: on average, 29% of household labor was spent on AIDS-related matters, including care of the patient and funeral duties. If two people were devoted to nursing duties, as occurred in 66% of the cases, the total labor loss was 43%, on average.[10]**

- The orphan population continues to grow in rural Tanzania, where over one-third of children have at least one parent who is dead, and over one-tenth of children have both parents who have died. The study states that at least 40 percent of these deaths are due to AIDS.[11]

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[8] Toupouzis, D (1998) "The Implications of HIV/AIDS for Rural Development Policy and Programming: Focus on Sub-Saharan Africa." HIV and Development Programme, UNDP, June 1998.
[9] Barnett, T (1994) The Effect of HIV/AIDS on Farming Systems and Rural Livelihoods in Uganda, Tanzania and Zambia. Rome: AGSP, FAO.
[10] Tibaijuka, AK. 1997. AIDS and Economic Welfare in Peasant Agriculture: Case Studies from Kagabiro Village, Kagera Region, Tanzania. World Development; 25(6):963-975.
[11] AIDS Analysis Africa; 7(2): 5, April 1997.

## Economic Impact of AIDS on Firms

AIDS may have a significant impact on some firms. AIDS-related illnesses and deaths to employees affect a firm by both increasing expenditures and reducing revenues. Expenditures are increased for health care costs, burial fees and training and recruitment of replacement employees. Revenues may decrease because of absenteeism due to illness or attendance at funerals and time spent on training. Labor turnover can lead to a less experienced labor force that is less productive.

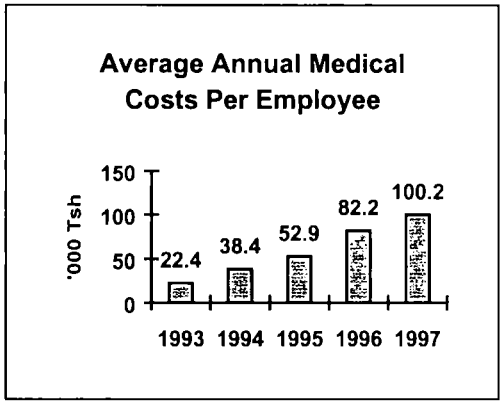
| Factors Leading to Increased Expenditure | Factors Leading to Decreased Revenue |
|---|---|
| Health care costs | Absenteeism due to illness |
| Burial fees | Time off to attend funerals |
| Training and recruitment | Time spent on training |
| | Labor turnover |

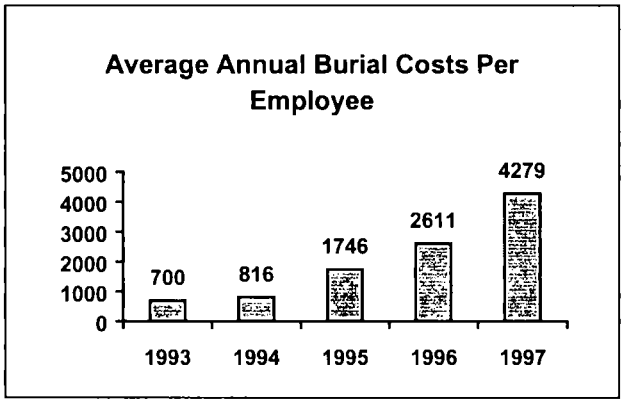
- A study completed by the ILO in 1995 examined the economic impact of HIV/AIDS by interviewing the leadership of eight organizations in Tanzania. Some of the findings from this study were:
  - Medical costs for the Tanzania-Zambia Railway Authority workers associated with AID-related diseases increased over a one-year timeframe from Tsh2.8 million in January to Tsh4.6 million in December, a 63% increase.
  - Overall, the study estimated that the organizations were losing employees at the rate of 0.5-1.5 percent per year due to AIDS-related deaths.
  - The age at death for the employees ranged between 31 and 38.7 years old. If the retirement age is assumed to be 55 years, then years of lost productivity per worker per AIDS death ranges between 16.3 to 24 years.
  - At the University of Dar es Salaam, funeral costs increased from Tshs 1,323 in 1988/89 to Tshs5.8 million in 1992/93, implying that costs in 1988/89 were only two percent of what the costs were in 1992/93. The study assumes that at least 50 percent of the deaths were due to AIDS.[12]

- Another more recent study collected information on the economic impact of AIDS for a variety of businesses in Dar es Salaam, including annual medical costs per employee per year, and annual burial costs per employee per year. The unweighted average across six companies over five years for these two variables are shown below. The trend for both variables is increasing substantially from year to year, particularly for burial costs. Firms in Tanzania usually pay for burial costs for the employee, spouse, children, and sometimes employee's parents, if they live with the employee. Note that the burial costs do not vary much between companies; medical costs, however, range from Tsh11,470 to Tsh287,500 in 1997. One company in particular experienced very large increases over time: from Tsh58,900 annual costs

[12] ILO/EAMAT (1995) "The Impact of HIV/AIDS on the Productive Labour Force in Tanzania, Eastern Africa Multidisciplinary Advisory Team Working Paper No. 3. Addis Ababa.

per employee in 1993 to Tsh287,500 in 1997. This firm has since instituted a cap on annual medical costs per employee of Tsh240,000.[13]




For some smaller firms the loss of one or more key employees could be catastrophic, leading to the collapse of the firm. In others, the impact may be small. Firms in some key sectors, such as transportation and mining, are likely to suffer larger impacts than firms in other sectors. In poorly managed situations the HIV-related costs to companies can be high. However, with proactive management these costs can be mitigated through effective prevention and management strategies.

## Impacts on Other Economic Sectors

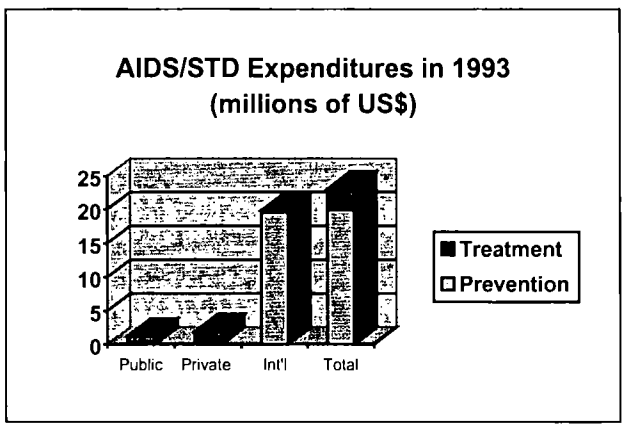
AIDS will also have significant effects in other key sectors. Among them are health, transport, mining, education and water.

- **Health.** AIDS will affect the health sector for two reasons: (1) it will increase the number of people seeking services and (2) health care for AIDS patients is more expensive than for most other conditions. Governments will face trade-offs along at least three dimensions: treating AIDS versus preventing HIV infection; treating AIDS versus treating other illnesses; and spending for health versus spending for other objectives. Maintaining a healthy population is an important goal in its own right and is crucial to the development of a productive workforce essential for economic development.

    - An early study using 1987-88 US dollars as a numeraire found that the direct cost of treating an adult in Tanzania varied between US$104 and US$631. The lower cost was relevant if the person was using village or relative care, while the higher cost was calculated based on utilization of the higher-priced private health care system. These costs are total costs, that is, they include costs paid by households,

[13] Clancy, P (1998) "The Economic Impact of AIDS at Firm Level in Tanzania," Dissertation, University of East Anglia.

government, and charitable health systems. The annual GNP per capita figure at that time was US$290.[14]




- A total of US$23.1 million was estimated to have been spent in Tanzania on AIDS/STDs in 1993. Of this money, 86 percent, or US$19.9 million, was spent on treatment. Note that no monies were spent on mitigation, although that was one of the expenditure categories. The total expenditure on AIDS/STDs was about 13.5% of total health expenditures in the country. The per capita expenditure on AIDS was approximately US$0.82.[15]

  - A 1996 study found that at the major referral hospital in the country, Muhimbili Medical Center in Dar es Salaam, the hospital could no longer afford to provide medicines and food freely to AIDS patients, who occupied half of the hospital beds at that time. Instead, women began to bring food to the hospital for their family members, and to pay for medicines separately.[16]

- **Transport.** The transport sector is especially vulnerable to AIDS and important to AIDS prevention. Building and maintaining transport infrastructure often involves sending teams of men away from their families for extended periods of time, increasing the likelihood of multiple sexual partners. The people who operate transport services (truck drivers, train crews, sailors) spend many days and nights away from their families. Most transport managers are highly trained professionals who are hard to replace if they die. Governments face the dilemma of improving transport as an essential element of national development while protecting the health of the workers and their families.

  - One of the main conduits of HIV transmission in Tanzania was determined to be along major highway routes. In 1993, a national intervention program was implemented to use peer educators to address the behavior patterns of long-distance truck drivers. Elements included condom promotion and distribution, distribution of educational materials, and small group discussions. Attempts were made to integrate the interventions in other areas such as village health

[14] Over, M S Bertozzi, J Chin, B N'Galy, K Nyamuryekung'e (1988) "The Direct and Indirect Cost of HIV Infection in Developing Countries: The Cases of Zaire and Tanzania." In Fleming, AF, M Carballo, DW FitzSimons, MR Bailey, and J Mann, ed. (1988) The Global Impact of AIDS. Alan R Liss, New York: NY.
[15] Shepard, DS (1996) "Impact of AIDS on health expenditures: Overview," Institute for Health Policy, Heller School, Brandeis University, Waltham, MA, June 1996.
[16] Outwater, A (1996) "The Socioeconomic Impact of AIDS on Women in Tanzania," in Women's Experiences with HIV/AIDS: An International Perspective, ed. by Lynellen D. Long and E. Maxine Ankrah, Columbia University Press, New York, NY: 1996.

committees, women's health groups, and AIDS advisory committees, so that activities could continue even after external funding ceased.[17]

- **Mining.** The mining sector is a key source of foreign exchange for many countries. Most mining is conducted at sites far from population centers forcing workers to live apart from their families for extended periods of time. They often resort to commercial sex. Many become infected with HIV and spread that infection to their spouses and communities when they return home. Highly trained mining engineers can be very difficult to replace. As a result, a severe AIDS epidemic can seriously threaten mine production.

    - In Tanzania, mining is a very small part of the economy, so the impact of HIV/AIDS will not be pronounced.

- **Education.** AIDS affects the education sector in at least three ways: the supply of experienced teachers will be reduced by AIDS-related illness and death; children may be kept out of school if they are needed at home to care for sick family members or to work in the fields; and children may drop out of school if their families can not afford school fees due to reduced household income as a result of an AIDS death. Another problem is that teenage children are especially susceptible to HIV infection. Therefore, the education system also faces a special challenge to educate students about AIDS and equip them to protect themselves.

    - One study estimates that it will cost the country US$40 million to replace the 15,000 teachers who will have died from AIDS through the year 2010. Furthermore, if the household of a student has lost an adult female member in the previous year, school attendance of those aged 15-20 is cut in half[18]

- **Water.** Developing water resources in arid areas and controlling excess water during rainy periods requires highly skilled water engineers and constant maintenance of wells, dams, embankments, etc. The loss of even a small number of highly trained engineers can place entire water systems and significant investment at risk. These engineers may be especially susceptible to HIV because of the need to spend many nights away from their families.

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[17] Mwizarubi, B, C Hamelmann, K Nyamuryekung'e. (1997) "Working in high-transmission areas: truck routes." In HIV prevention and AIDS care in Africa: A district level approach, ed by J Ng'weshemi, T Boerma, J Bennett and D Schapink. Amsterdam, Netherlands, Royal Tropical Institute, 1997, p. 137-49.

[18] PHNFlash Issue 58, Feb 22, 1995, "The Economic Impact of AIDS," found at website http://www.worldbank.org/html/extdr/hnp/hddflash/issues/00075.html

## Macroeconomic Impact of AIDS

The macroeconomic impact of AIDS is difficult to assess. Most studies have found that estimates of the macroeconomic impacts are sensitive to assumptions about how AIDS affects savings and investment rates and whether AIDS affects the best-educated employees more than others. Few studies have been able to incorporate the impacts at the household and firm level in macroeconomic projections. Some studies have found that the impacts may be small, especially if there is a plentiful supply of excess labor and worker benefits are small.

There are several mechanisms by which AIDS affects macroeconomic performance.

- AIDS deaths lead directly to a reduction in the number of workers available. These deaths occur to workers in their most productive years. As younger, less experienced workers replace these experienced workers, worker productivity is reduced.

- A shortage of workers leads to higher wages, which leads to higher domestic production costs. Higher production costs lead to a loss of international competitiveness which can cause foreign exchange shortages.

- Lower government revenues and reduced private savings (because of greater health care expenditures and a loss of worker income) can cause a significant drop in savings and capital accumulation. This leads to slower employment creation in the formal sector, which is particularly capital intensive.

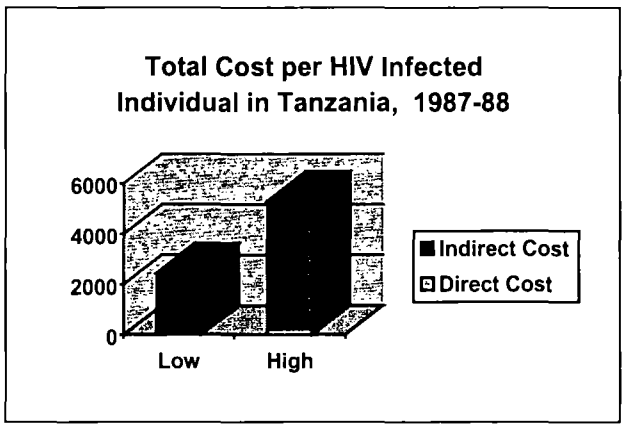
- Reduced worker productivity and investment leads to fewer jobs in the formal sector. As a result some workers will be pushed from high paying jobs in the formal sector to lower paying jobs in the informal sector.

- The overall impact of AIDS on the macro-economy is small at first but increases significantly over time.

    - A macroeconomic simulation model estimated that the impact of AIDS on the growth path of the Tanzanian economy would be to reduce GDP by between 15-25% by the year 2010, and to reduce per capita income by between 0-10%. The levels of per capita income are not affected as much as GDP because the population will be less due to deaths from AIDS. The model includes consideration of increasing morbidity and mortality from AIDS, which in turn affect labor productivity, higher health care spending, and lower savings rates leading to lower investment levels.[19]
    - One study by the ILO suggests that the size of the labor force will decrease by 20% by 2010 due to the impact of HIV/AIDS, and there will be a decrease in

[19] Cuddington, JT (1993) "Modeling the Macroeconomic Effects of AIDS, with an Application to Tanzania," World Bank Economic Review 7 (May 1993):173-89.

production as younger, less experienced workers replace those who have died.[20]




- The total cost to care for an HIV-infected adult in 1987-88 in Tanzania when both direct and indirect costs are included for low-cost sources was estimated to be US$2462, while the cost for using private sources was US$5316. Indirect costs include appropriately discounted years of healthy life lost, based on wage rates available at the time.[21]

- Providing triple combination antiretroviral therapy to HIV-positive adults in Tanzania would cost 51% of the GDP, according to one recent estimate.[22]

## What Can Be Done?

AIDS has the potential to cause severe deterioration in the economic conditions of many countries. However, this is not inevitable. There is much that can be done now to keep the epidemic from getting worse and to mitigate the negative effects. Among the responses that are necessary are:

- **Prevent new infections.** The most effective response will be to support programs to reduce the number of new infections in the future. After more than a decade of research and pilot programs, we now know how to prevent most new infections. An effective national response should include information, education and communications; voluntary counseling and testing; condom promotion and availability; expanded and improved services to prevent and treat sexually transmitted diseases; and efforts to protect human rights and reduce stigma and discrimination. Governments, NGOs and the commercial sector, working together in a multi-sectoral effort can make a difference. Workplace-based programs can prevent new infections among experienced workers.

    - An intervention in the Mwanza district of Tanzania found that establishing an STD clinic resulted in a reduction of 42% in newly acquired HIV infections. This

[20] ILO EAMAT (1995) "The Impact of HIV/AIDS on the Productive Labour Force in Africa," EAMAT Working Paper no. 1 (Addis Ababa).
[21] Over, M S Bertozzi, J Chin, B N'Galy, K Nyamuryekung'e (1988) "The Direct and Indirect Cost of HIV Infection in Developing Countries: The Cases of Zaire and Tanzania." In Fleming, AF, M Carballo, DW FitzSimons, MR Bailey, and J Mann, ed. (1988) The Global Impact of AIDS. Alan R Liss, New York: NY.
[22] Hogg, R, KJ Craib, A Weber, A Anis, MT Schechter, JS Montaner, MV O'Shaughnessy (1998) "One world, one hope: the cost of making antiretroviral therapy available to all nations," Int Conf AIDS. 1998; 12:830 (abstract no. 444/42283).

is a promising area to pursue in order to prevent new infections, although new research from Uganda shows no effect of STD clinics on new HIV infections.[23]

- HIV/AIDS education programs were incorporated into agricultural and rural development projects by GTZ. The cooperative efforts of GTZ and the nine projects involved made this effort possible; individually, the projects could not have each developed and carried out their own education programs.[24]

- The risk of HIV transmission is very high in refugee camps; in some of the camps in Tanzania, the prevalence rate is 33% for sexually active adults.[25] Programs to address this issue are vital.

- **Design major development projects appropriately.** Some major development activities may inadvertently facilitate the spread of HIV. Major construction projects often require large numbers of male workers to live apart from their families for extended periods of time, leading to increased opportunities for commercial sex. A World Bank-funded pipeline construction project in Cameroon was redesigned to avoid this problem by creating special villages where workers could live with their families. Special prevention programs can be put in place from the very beginning in projects such as mines or new ports where commercial sex might be expected to flourish.

- **Programs to address specific problems.** Special programs can mitigate the impact of AIDS by addressing some of the most severe problems. Reduced school fees can help children from poor families and AIDS orphans stay in school longer and avoid deterioration in the education level of the workforce. Tax benefits or other incentives for training can encourage firms to maintain worker productivity in spite of the loss of experienced workers.

  - Some communities have set up programs on their own to cope with the impact of HIV/AIDS on families. Women in some villages have set up associations specifically to help families who have experienced an AIDS death.[26]

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[23] Grosskurth H, F Mosha, J Todd, et al., "Impact of improved treatment of sexually transmitted diseases on HIV infection in rural Tanzania: randomised controlled trial." Lancet 1995; 346:530-536; Mayaud P, F Mosha, J Todd et al. (1999) Control of sexually transmitted diseases for AIDS prevention in Uganda: a randomised community trial." Lancet 1999; 353:525-35.

[24] Hemrich, G and B Schneider (1997) "HIV/AIDS as a cross-sectoral issue for Technical Cooperation," GTZ, Eschborn, Germany, May 1997, p. 32.

[25] Cooperative for Assistance and Relief Everywhere (CARE) estimates, cited in AIDS Prevention and Mitigation in sub-Saharan Africa: An Updated World Bank Strategy, 1996, p. 1.

[26] The World Bank (1997) "Confronting AIDS: Public Priorities in a Global Epidemic," Oxford University Press, p. 219.

- **Mitigate the effects of AIDS on poverty.** The impacts of AIDS on households can be reduced to some extent by publicly funded programs to address the most severe problems. Such programs have included home care for people with HIV/AIDS, support for the basic needs of the households coping with AIDS, foster care for AIDS orphans, food programs for children and support for educational expenses. Such programs can help families and particularly children survive some of the consequences of an adult AIDS death that occur when families are poor or become poor as a result of the costs of AIDS. The costs of these programs can vary widely.[27]

**Annual Costs of Programmes to Mitigate the Household Impacts of AIDS, Kagera, Tanzania, 1992**

| Type of Programme | Annual Cost (US$) |
|---|---|
| Home care for people with AIDS | $227 per patient |
| Orphanage care | $1,063 per child |
| Foster care | $185 per child |
| Feeding post | $69 per child |
| Basic needs support | $47 per household |
| Educational support | $13 per child |

*A strong political commitment to the fight against AIDS is crucial. Countries that have shown the most success, such as Uganda, Thailand and Senegal, all have strong support from the top political leaders. This support is critical for several reasons. First, it sets the stage for an open approach to AIDS that helps to reduce the stigma and discrimination that often hamper prevention efforts. Second, it facilitates a multi-sectoral approach by making it clear that the fight against AIDS is a national priority. Third, it signals to individuals and community organizations involved in the AIDS programs that their efforts are appreciated and valued. Finally, it ensures that the program will receive an appropriate share of national and international donor resources to fund important programs.*

*Perhaps the most important role for the government in the fight against AIDS is to ensure an open and supportive environment for effective programs. Governments need to make AIDS a national priority, not a problem to be avoided. By stimulating and supporting a broad multi-sectoral approach that includes all segments of society, governments can create the conditions in which prevention, care and mitigation programs can succeed and protect the country's future development prospects.*

[27] World Bank, 1997. *Confronting AIDS: Public Priorities in a Global Epidemic.* New York: Oxford University Press.

# TANZANIA AND HIV/AIDS

## Key Talking Points

Tanzania's HIV/AIDS epidemic has increased alarmingly each year. The epidemic is being driven by high-risk heterosexual sexual behavior, characterized by high incidence of sexually transmitted infections.

- Ten to 12 percent of adults (age 15 and over) are HIV-positive.
- An estimated 1.5 million Tanzanians are living with HIV—520,000 of them with AIDS. Following current trends this figure is expected to rise to 2.4 million by the year 2000.

***AIDS Deaths*** From 1990 to 2010, AIDS will increase the crude death rate in Tanzania by more than 50 percent. Life expectancy will drop by 20 percent during the 1990s as a result of HIV/AIDS, and by 2010 will average 46 years.

***Women and HIV/AIDS*** Data derived from ten antenatal sentinel surveillance sites show countrywide HIV-prevalence rates ranging from 10 to 33 percent among pregnant women.

***Youth and HIV/AIDS*** Tanzanians 15 to 24 years old, while comprising only 20 percent of the population, account for 60 percent of new HIV infections.

***Children and HIV/AIDS*** Forty-six percent of the Tanzanian population is under age 15. More than 68,000 children under age 15 are living with HIV/AIDS. Each year approximately 50,000 to 60,000 children are born HIV-positive. By 2015 the infant mortality rate is expected to be at least 16 percent higher than it would have been in the absence of AIDS.

An estimated 15 percent of all Tanzanian children under age 15 are missing one or both parents; an estimated 730,000 children have been orphaned because of HIV/AIDS.

***Health Care Costs*** The Tanzanian government currently allocates 6 percent of its central budget—3 percent of the GDP—to the health sector. In July 1996 the government initiated a plan for health sector reform.

***USAID*** supports a variety of HIV/AIDS prevention activities in Tanzania, contributing $3.6 million for FY 1998. In 1998 USAID was a key donor and contributed to organizing the National Strategic Plan and the First National Scientific Conference on HIV/AIDS in Tanzania.

***National Response*** Currently there are two independent National AIDS Control Programmes; one on the mainland and one in Zanzibar. Although the Tanzanian government recently launched a National Strategic Plan, there continues to be limited overt political commitment to the fight against HIV/AIDS. Implementation of the National Strategic Plan is still in the early stages and will need continued commitment from the president and other high-ranking officials in order to be effective and sustainable.


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**Population, Health and Nutrition Programs**
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Fax: (202) 216-3046
URL: www.info.usaid.gov/pop_health

**Impact** Implementing AIDS Prevention and Care Project
**Implementing AIDS Prevention and Care (IMPACT) Project**
Family Health International
2101 Wilson Boulevard, Suite 700
Arlington VA 22201 USA
Telephone: (703) 516-9779
Fax: (703) 516-9781
URL: www.fhi.org

USAID

*The Director of the USAID Mission to Tanzania*

*Ms. Lucretia D. Taylor*

*requests the pleasure of the company of*

Sandra L. Thurman

for Lunch

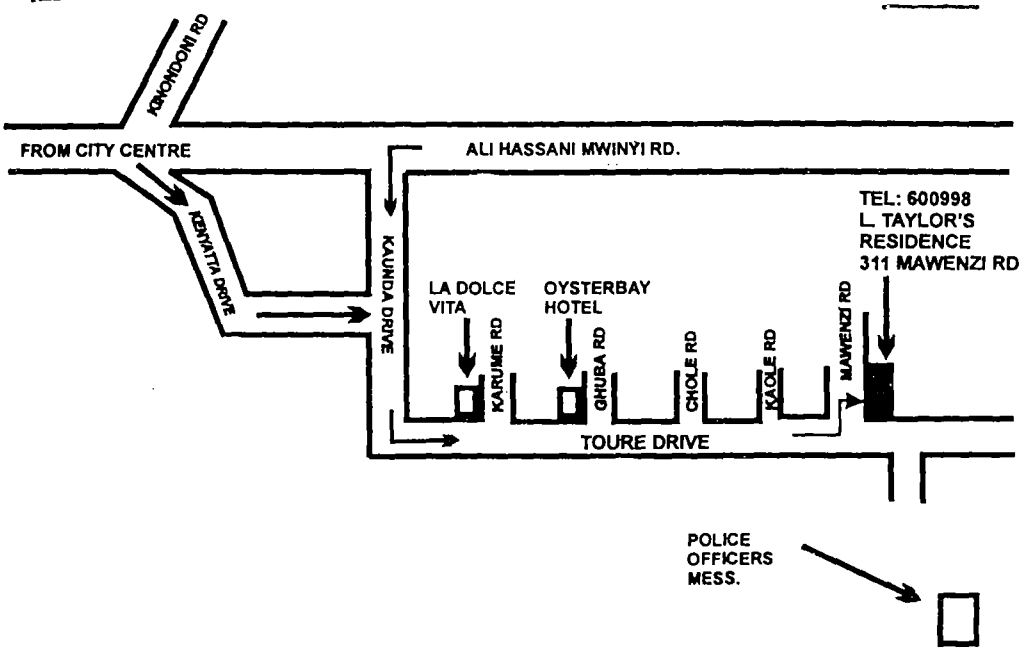
on Wednesday, January 19, 2000

at 1:00 p.m. - Dhow Restaurant, Sea Cliff Hotel

Tel: 117537-43/115374
R.S.V.P.

311 Mawenzi Road
(~~map~~ on back)
Dress: Business

To meet the Delegation from the Office of the National AIDS Policy, The White House



Ms. Sandra L. Thurman

# HIV/AIDS in Tanzania
# Talking Points for Sandy Thurman
# Office of National AIDS Policy, The White House
# January 2000

## I. The HIV/AIDS Epidemic in Tanzania

HIV/AIDS is the single most significant and growing health problem. It is also potentially the greatest constraint to economic growth. The USG is the largest donor for HIV/AIDS prevention and control with an annual budget of US$ 4.5 million. Under the new LIFE initiative of the Clinton Administration, Tanzania will receive US$ 2.5 million additional resources to support HIV/AIDS activities this year.

## II. National Tanzanian Leadership

National leadership is critical to fight the epidemic effectively. Current GOT efforts to strengthen national leadership require continued high level political support and commitment. To channel political commitment effectively, institutions with national leadership roles require clear mandates and the authority to exercise them.

National and local leaders – political, religious and commercial – play a key and important role in reducing the stigma associated with HIV/AIDS by speaking openly about HIV/AIDS and its reality in their own professional and personal lives. Initiatives taken by the President and Prime Minister are commendable and need to be continued. Their leadership in this area needs to be followed by other influential national and local leaders.

A *National Policy on HIV/AIDS* provides an important framework for a national response. Participatory processes involving a wide-range of stakeholders have provided a sound proposal for a Tanzanian policy. Its adoption and implementation requires high level political support and commitment.

## III. Behavior Change to Prevent and Control HIV/AIDS

There is an urgent need for a large-scale behavior change communication campaign, using both modern media (including radio, television, newspapers and journals) and traditional media (including dance, song and theatre. National and local leadership is required to coordinate this through the public, voluntary and private sectors.

## IV. Islands of Excellence in Tanzania

The non-governmental sector, especially non-profit and voluntary organizations, has played an important role in HIV/AIDS interventions, including a number of advocacy initiatives, information services, voluntary counseling and testing, condom social marketing and distribution, clinical care, care of orphans, monitoring and HIV/AIDS research efforts. These isolated activities, many of which are recognized nationally and internationally as examples of best practices, need to be coordinated and expanded to meet growing needs for prevention and care.

## V. HIV/AIDS and Women and Children in Tanzania

Women's vulnerability to HIV/AIDS reflects gender inequalities, poverty and limited access to education and employment. There is a need for expanded advocacy initiatives, with leaders at national and local levels as well as within communities and families, to ensure that women's rights are recognized and protected through formal and customary laws.

The use of anti-retroviral treatment and avoidance or reduction in breastfeeding to prevent transmission from mothers to their children poses difficult and often unrealistic choices for individual women, their families and the Government. Instead, strategies could focus immediately on expanding counseling and testing services, reducing viral load through repeated exposure, treating STIs, preventing malaria, supplementing vitamin and micronutrients, and avoiding invasive medical interventions during pregnancy and birth.

Traditional cultural practices in which families and communities take responsibility for the care of orphans are no longer adequate. There is an urgent need to organize a greatly expanded social response to provide for the care of orphans. This will require political support to ensure that resources are made available and that the quality of their care is protected.

**Background Notes on HIV/AIDS in Tanzania for Sandy Thurman**
**Office of National AIDS Policy, The White House**
**January 2000**

## I. The HIV/AIDS Epidemic in Tanzania

The first cases of AIDS in Tanzania were reported in 1983 and by 1986 AIDS cases had been reported in all regions of the country. The HIV epidemic has continued to spread, and AIDS is now the leading cause of death among male and female adults in Tanzania. Data from three years ago estimate an overall prevalence rate for HIV infection of 8% for males and 12% for females, with the major mode of transmission through heterosexual relations. Tanzania is now listed as one of the countries experiencing a reversal in human development due to the HIV/AIDS pandemic. Despite alarming statistics, the epidemic in Tanzania may not yet have reached the 'generalized' stage.

- *The life expectancy at birth in Tanzania is expected to drop 15 years, from 61 years to 46 years by 2010 due to the AIDS epidemic. Similarly, population growth rate is expected to drop from 2.6% to 1.8%.*
- *By 2015 the Infant Mortality Rate is expected to be at least 16% higher than it would have been in the absence of AIDS, and by 2010 the Child Mortality Rate is expected to be at least 37% higher than it would have been without AIDS.*
- *It is estimated that the future GDP in Tanzania will be 20% lower in 2010 than it would have been without the AIDS epidemic.*

## II. National Tanzanian Leadership

Since 1985, three national plans have been formulated to guide the Tanzanian National AIDS Control Program, a national policy on HIV/AIDS has been drafted, and a number of structures have been proposed to manage their implementation. The current strategy was formulated with the participation of a wide-range of stakeholders, including government, voluntary sector, commercial sector and people living with AIDS. As a result, recommended priorities, strategies and activities within these documents are quite sound. However, there is poor implementation of these strategies, due mainly to limited political commitment and associated leadership for a national response. Recent steps have been taken by the President and Prime Minister to generate a greater national response to stem the epidemic. There is a need to continue and build on their efforts.

- *Key organizational and financial constraints limit national leadership.*
  - *The two governmental bodies charged with national HIV/AIDS leadership, the National AIDS Council composed of ministerial permanent secretaries (NAC) and the Secretariat to the national program, have unclear mandates and limited authority. Moreover, the National AIDS Council has met infrequently to*

*discuss AIDS.*

- *The newly established National Advisory Board for HIV/AIDS is comprised of prominent leaders from the private sector and is chaired by the former President, Ali Hassan Mwinyi. While a significant step in giving voice to AIDS advocates, it too has an unclear mandate and authority base.*
- *Limited political commitment is compoundeds by the lack of a line item for HIV/AIDS in the development and individual ministry budgets of the GOT.*

- *The Ministry of Health is conducting an assessment of the organizational, managerial and technical needs of the National AIDS Control Program to address issues of mandates, authority and structure among national HIV/AIDS bodies.*

- *The Policy Framework for HIV/AIDS intervention has yet to be fully implemented.*
  - *The first two plans were only minimally implemented, and resources to implement the current plan are greatly underestimated at only US$20 million for five years.*
  - *The national policy for HIV/AIDS has been in draft since 1995 with no indications of it being adopted in the near future. The Ministry of Health has recently suggested that instead of a national policy, the document should be processed as a guideline under the National Health Policy. This is contrary to a multi-sectoral approach and would maintain the lack of a legal binding framework for program implementation.*

## III. Behavior Change to Prevent and Control HIV/AIDS

Data from the Tanzanian Demographic and Health Survey four years ago (TDHS 1996) indicates that HIV/AIDS was almost universally known in Tanzania with over 97% of women and men having heard of the disease. Unfortunately awareness is not matched by an understanding of ways to prevent its spread, especially in rural areas. With this lack in knowledge comes limited behavior change in sexual practices to prevent further spread of the infection. Limited behavior change is underscored by considerable stigma surrounding the disease. Many local government officials and frontline health providers continue to deny the epidemic, and information on HIV/AIDS is not included in routine information systems at present. National leaders don't often speak on the importance of this issue.

*Four years ago, data suggested that among individuals who had heard of AIDS,*

- *35% of women and 34% of men believe that there is no way to avoid AIDS or they do not know of any way.*

- *39% of women and 55% of men cite the use of condoms as a way to avoid AIDS. A quarter of women and men say that having only one partner can help prevent the spread of AIDS, and 20% of women and 17% of men report that limiting the number of sexual partners can prevent AIDS.*

- *Only 1/3 of men and 13% of women who had had sex in the past 12 months had used a condom for either contraceptive or STD prevention purposes.*

- *Only 4% of women and 11% of men had already been tested for AIDS.*

## IV. Islands of Excellence in Tanzania

Despite the lack of a nation-wide response, there are a number of impressive local initiatives. This is true even through the private for- and non-profit sectors have only flourished since the early 1990s. The non-profit or voluntary sector has played an especially important role in HIV/AIDS interventions, including a number advocacy initiatives, information services, voluntary counseling and testing, condom social marketing and distribution, clinical care, care of orphans, monitoring and HIV/AIDS research efforts. What is now needed is coordination and expansion of these efforts under a national program.

- The *National Social Marketing* program sold a record number of condoms in 1999, totalling over 18 million.

- Net earnings from the *Social Action Trust Fund*, a non-governmental multi-million Tanzanian Trust support children orphaned by AIDS.

- Advocacy through the *NGO Cluster for Iringa Region* has yielded strong political commitment within regional and district governments. This has resulted in the mobilization of public sector resources for HIV/AIDS activities, such as the provision of an office and vehicle for management of the regional NGO cluster and funds through district budgets.

- The *Tanga AIDS Working Group*, formed by hospital workers, has integrated the use of traditional medicines in their home-based care program. By incorporating traditional therapies for symptoms associated with selected opportunistic infections , such as thrush, herpes and diarrhea, more cost-effective home-based care is provided to a large population of people coping with AIDS.

- The *Infectious Disease Clinic* in Dar es Salaam has effectively integrated STI treatment and voluntary counseling and testing into their regular services. In addition, they have targeted youth as a high-risk and under-served group. With an emphasis on counseling, they have earned the confidence of many and several clients come from outside their catchment area.

- Tanzania hosted the well-known study in Mwanza on the reduction of transmission through the treatment of STIs.

- Tanzania currently hosts the *Adult Mortality and Morbidity Study* that has documented HIV/AIDS as the leading cause of death in adults in its three study districts. It also hosts a surveillance and intervention project in Mbeya Region has shown that prevalence can be stabilized through interventions to prevent the spread of HIV.

## V. HIV/AIDS and Women and Children in Tanzania

Women and children are especially vulnerable to HIV/AIDS in Tanzania. This is compounded by a prominence of the C strain in Tanzania – a strain associated with greater transmission from mother-to-child and under inflammatory conditions.

### HIV/AIDS and Tanzanian Women

AIDS is the leading cause of death among adult women. Rates of HIV infection among pregnant women are particularly high, contributing to high rates of maternal mortality. Women tend to become infected at a younger age than men indicating their biological and social-cultural vulnerability. Gender relationships in Tanzania continue to limit a woman's ability to negotiate sexual practices, including refusing sex or the use of condoms by both non-regular partners and their spouses. Poverty, limited access to education and a lack of employment opportunities combine with gender inequalities to force many women into sexual relations in order to survive.

- *Rates of HIV infection among pregnant women range from 7% - 44% in rural areas and 22% - 36% among urban women.*
- *Data from 1996 TDHS found that:*
  - *by age 15, 19% of women had had sexual intercourse.*
  - *by age 18, 62% of women had had sexual intercourse.*
  - *among women aged 20-24 years of age, only 7% had never had sexual intercourse.*

### HIV/AIDS and Tanzanian Children

HIV positive mothers most likely infect young children living with AIDS, and yet consideration of anti-retroviral treatment and limited breastfeeding to prevent this transmission raises complex ethical issues. Children are also greatly affected by HIV infection in their parents. Some 1 million children are thought to have been orphaned by HIV/AIDS. The ability of families and communities, as well as of local social and political organizations, to cope with the care of orphans no longer meets existing and growing demands.

- *Data from TDHS four years ago found that of children under 15 years of age, 6% had lost their fathers, 3% had lost their mothers and less that 1% had lost both parents. In a population of 30 million, this would mean that over 1.4 million children had lost one or both parents.*

# MINISTRY OF HEALTH

*NATIONAL AIDS CONTROL PROGRAMME*

## BRIEFING NOTES ON THE
## NATIONAL RESPONSE TO HIV/AIDS/STDS
## JANUARY, 2000

*Prepared by:*
*National AIDS Control Programme*
*13 January, 2000*
*DAR ES SALAAM*

## 1.0. INTRODUCTION:

Tanzania belongs to a group of twenty-five countries in world where the most severe HIV/AIDS epidemic has been documented[1]. Twenty-four of the 25 countries are found in Africa South of Sahara. In Tanzania, as in the rest of African countries, the presence of HIV/AIDS was recognized quite early on, but the response to HIV/AIDS was underestimated. HIV/AIDS was perceived and grouped as one among many problems that the African continent is dealing with. Initially AIDS was addressed primarily as a health issue and this masked the full impact of HIV/AIDS as a developmental issue. Currently a multisectoral response is being instituted but the scale of the existing national response is still limited. Many islands of best practice are scattered in a few parts of the country. The main challenge facing the country today is to scale up in a systematic manner the few interventions that have been shown to be effective to the HIV epidemic. The Third Medium Term Strategic Plan on HIV/AIDS is the national framework for establishing an expanded multisectoral response to HIV/AIDS involving all the partners under a strong and clear government leadership.

## 2.0. HIV/AIDS EPIDEMIC IN TANZANIA

Tanzania has a generalized and mature HIV epidemic – well established all over the country.

As of Dec. 1998 the main features of the epidemic were:

- First 3 AIDS Cases reported in 1983
- Cumulative number of reported AIDS Cases 109,863
- Estimated cumulative AIDS cases 520,000

[1] The twenty five worst affected countries in the World are in order: Zimbabwe, Botswana, Namibia, Zambia, Swaziland, Malawi, Mozambique, South Africa, Kenya, Rwanda, CAR, Djibouti, Cote d' Ivoire, Uganda, Tanzania, Ethiopia, Togo , Lesotho, Burundi, Congo, Burkina Faso, Cameroon, DRC, Gabon, Haiti and Nigeria. Source – UNAIDS.

- 86% of reported cases are between the year 20 – 49 years.
- Male – female ratio - 1:0.99 with male patients being older than female patients.
- In 1998 – Tanzania was home to some 1.63 million people living with HIV.
- Blood donors in 1998: 8.5% of males blood donors and 11.8% or female blood donor were HIV positive.
- Among pregnant women attending ANC Services, prevalence have varied between 0.9% - 36% between 1992 – 1998.
  Most sites are now stabilizing around 10 – 12%
- AIDS is the leading cause of adult mortality in Dar es Salaam Region, Hai and Morogoro districts.

## 3.0. THE NATIONAL RESPONSE TO HIV/AIDS PRIOR TO MTP-III

Institutional efforts to control the spread of HIV in Tanzania date back to 1985 when a Short Term Plan was prepared and implemented by Ministry of Health between 1985 and 1986. The Short Term Plan was followed by the First Medium Term Plan (MTP-I) which was implemented from 1987 – 1991 and Second Medium Term Plan (MTP-II) which was implemented from 1992 – 1996. The initial efforts were mainly implemented by the Ministry of Health, but overtime there has been a gradual involvement of other public sectors – non-governmental organization (NGOs) and Community Based Organizations (CBOs). Responses under MTP-I and II focused on the following areas.

- Behaviour change communication.
- Blood safety.
- Patient care including counselling and social support.
- Condom programming
- Surveillance and fore-casting
- Research

- Advocacy and multisectoral involvement.
- Control of sexually transmitted disease.

The impact of all the interventions has been reflected in the following areas:

- HIV/AIDS/STD awareness is universal in Tanzania. Some 97% of women 15 – 49 years and 99% of men 15-59 years are aware of AIDS.

- As a result of this awareness, 73% of women (15 – 49) and 87% per cent of men 15-59 reported changes in their sexual behaviours. The most cited changes among those who have changed their behaviour are:

- Restricting sex to one partner: 77% women and 61% men.
- Reducing number of partners: 23% women and 31% men.
- Use of condoms: 3% women and 12% men.

## 4.0. MEDIUM TERM PLAN III

This is a strategic framework for establishing an expanded multisectoral response to HIV/AIDS. MTP-III has a broad ownership, which is a result of wide consultation of all stakeholders through 3 stages of; Situation Analysis, Response Analysis and Strategic Formulation. MTP-III treat people as agents of change and not objects for intervention. The focus of MTP-III is district level with public, private, NGOs and working together to help communities to act for themselves. MTP-III draws on the best experiences of MTP-I and MTP-II focuses on the following priorities.

1. Provide appropriate STD Case Management Services
2. Reduce Unsafe Sexual Behaviour among Highly Mobile Population Groups.
3. Reduce HIV Transmission among Commercial Sex Workers
4. Prevent Unprotected Sexual Activity among the Military.

5. Reduce Vulnerability of Youth to HIV/AIDS/STDs
6. Maintain Safe Blood Transfusion Services.
7. Reduce Poverty Leading to Sexual Survival Strategies.
8. Promote acceptance of Persons Living with HIV/AIDS
9. Reduce Widespread Unprotected Sexual Intercourse among men with multiple sex partners.
10. Improve education opportunities especially for girls
11. Reduce vulnerability of women in adverse cultural environments.

## 5.0. EFFORTS TO MAKE MTP-III FULLY OPERATIONAL

Following the launching of MTP-III in March 1998, a number of actions have been taken to create effective mechanisms and supportive environment for the successful implementation of an expanded multisectoral response to HIV/AIDS. The following are the key actions:

(1) Formation of a National Advisory Board on AIDS (NABA) chaired by the former President HE. Ali Hassan Mwinyi.

(2) Reconstitution of the National AIDS Committee to involve Public Sector, Private Sector, NGOs and People Living with AIDS (PLWA).

(3) Formation of Technical AIDS Committees in all sectors.

(4) Formulation of National Multisectoral Policy Guidelines on HIV/AIDS

(5) Consultation among all partners on how to step up the national response within the Framework of International Partnership Against AIDS in Africa (IPAA).

(6) A review of the NACP Secretariat to determine its optimal role mandate, and location to coordinate a multisectoral National response.

(7) A consultancy to determine Advocacy needs for an expanded Multisectoral Response.

(8) Preparation of Sectoral Action Plans and Implementation strategy for MTP-III.

## 6.0. ACHIEVEMENTS SO FAR

Some progress has been made on the following areas:

- About 98 per cent of women between the age of 15 – 49 years and 99 per cent men of age 15 – 59 are aware of the AIDS epidemic (Target was 80%).
- Sexual behaviour has changed: according to the TDHS (1996) about 87% of men and 73% of women reported to have changed sexual behaviour. Areas of behaviour change:
  1. Restricting to one sexual partner.
  2. Reducing the number of partner.
  3. Condom use.
- Condom availability and use has increased: about 39% of women and 55% men reported use of condoms and 60% of Tanzania women and men are ready to be tested for HIV.
- Blood safety activities have increased: HIV screening is available in all 182 hospitals where blood is transfused and health workers have been trained on safety measures to reduce risk of transmission of HIV infection in the delivery of health services.
- The number of health facilities with STDs treatment services have increased; and screening of syphilis has been reinforced in Iringa, Mwanza, Dar es Salaam, Shinyanga and Mbeya.

## 7.0 CONSTRAINTS:

The national response has faced the following constraints:

- A weak multi-sectoral response, some sectors are yet to get involved.
- Low acceptance of protected and non-penetrative sex.
- Lack of visible symptoms associated with the long incubation period of HIV/AIDS.
- Weak institutional capacity.
- Gender inequalities in society, in particular, the prevalence of discriminatory customary practices against women.
- Lack of legal and regulatory environment in which to conduct AIDS activities.
- Poor co-ordination of AIDS activities at all levels.
- Lack of resources to cover all the programme areas.

## 8.0 FUTURE PLANS.

Tanzania is now implementing MTP-III. The following challenges need to be addressed:

- Establishment of a well co-ordinated multi-sectoral response at all levels.
- Integration of AIDS activities into sectoral reforms especially the Health Sector Reforms, the Civil Service Reforms and Decentralisation.
- To sustain the reached level of public awareness on HIV/AIDS/STDs and find innovative ways to make people use the knowledge they have gained to protect themselves.

- Identification of resources to make accessible to all in need, those strategies, which are now available to prevent transmission of HIV.
- Find ways to strengthen and make health facilities bear the big burden occasioned by HIV/AIDS.
- Increase funding and other resources for AIDS activities.
- Strengthen capacity of communities to evolve coping strategies.
- Establish a strong institutional framework to co-ordinate AIDS activities,
- Motivate the past donors and new ones to continue funding AIDS Control and prevention.
- Established health care seeking behaviour for STDs services among sexually active groups.
- Advocacy for stronger political commitment for AIDS Control.
- To fight stigma and discrimination around HIV/AIDS

Of the areas mentioned above, the following are the priorities:

- Nationwide programme for sexually transmitted diseases STD
- Blood Safety for all hospitals public and private.
- Establishment of voluntary counselling and Testing Services
- AIDS Education for all schools primary, secondary and tertiary
- Drugs for opportunistic infections including anti-retro virals

## 9.0 CONCLUSION

A solid foundation for a multisectoral response to HIV/AIDS is in place. However, the response in place is still decimal compared to the magnitude of the epidemic that we are facing. The future looks bright for one reason. We know that HIV/AIDS prevention works and we have a lot of experience. We now know where to invest our resources. Experience has shown that the following interventions are effective for HIV prevention and control.

- Behaviour change communication – using mass media, peer educators, theatre arts and counselling.
- Early and affordable services for sexually transmitted infections (STI).
- Access to good quality condoms to all those in need.
- Blood safety.
- Treatment for opportunistic infections including tuberculosis.
- Accessible and affordable voluntary testing services (VTC).
- Preventing mother to child transmission of HIV.
- Advocacy and openness on HIV/AIDS.

Our challenge is to find resources to scale up all the known successful interventions.

DRAFT PRESS RELEASE

# U.S. TO BOOST FUNDING FOR HIV/AIDS IN TANZANIA

A six-person delegation is in Tanzania from the U.S. Office of National AIDS Policy, The White House, led by its dynamic director, Ms. Sandra Thurman. The Office of National AIDS Policy has been the driving force behind the unprecedented U.S. funding increases to fight AIDS in Africa and India. Sub-Saharan Africa and India have been the hardest hit regions by the deadly disease.

President Clinton has launched a new U.S. program called the "Life Initiative" to stop the spread of HIV/AIDS in countries where the disease continues to increase at a high rate. Tanzania will receive approximately $6.0 million dollars (4.8 Billion Tsh) from the U.S. Government in the year 2000, nearly double previous amounts, for HIV/AIDS programs. This would include support for HIV/AIDS prevention programs such as counselling and testing, and behaviour change communication activities; home and community based care for people with AIDS; caring for children affected by AIDS; and capacity and infrastructure development.

The U.S. is optimistic that Tanzania can stop the spread of this deadly disease. There are "islands of excellence" in which a number of local initiatives have been effective in reducing the spread of the disease such as programs to treat sexually transmitted diseases in Mwanza and Mbeya regions, condom social marketing and a number of NGO activities to motivate behaviour change. Recently demonstrated high level political commitment along with the launch of a new five-year multi-sectoral strategy to address HIV/AIDS (Medium Term Plan III), may garner the necessary national leadership to turn these "islands of excellence" into a coordinated national response to AIDS.

The U.S. delegation includes Ms. Sandra Thurman, Director of the Office of National AIDS Policy at The White House; Michael Iskowitz, Chief Counsel on poverty, disability and family policy to Senator Ted Kennedy; Thomas Niblock, Deputy Director of the Economic Policy, Bureau for African Affairs, State Department; Mary Fisher, Founder of the Family AIDS Network; Kate Carr, Chief Executive Officer of the Elizabeth Glaser Pediatric AIDS Foundation; Ronald Johnson, Associate Executive Director, Gay Men's Health Crisis, New York City.

# Dying of Aids or 'after long illness?'

By Simon Kivamwo

TANZANIA Home Economics Association yesterday said the open attitude towards the killer disease Aids displayed by the Government in recent months should have started 10 years back.

"It was common to hear that so and so has died 'after a long illness' instead of mentioning the actual cause," Tahea Chairman Ms Freda Chale told *Daily Mail* yesterday.

However, she applauded the attitude "despite the fact that it had taken so much time for the Government to speak out" and "something was better than nothing".

"It's impressing to note that the Government has now joined the world-wide campaign and decided to call a spade a spade," she said.

"So long as the Government has started to vigourously embark on openness regarding the scourge, society can expect some changes in the near future."

Ms Chale said for quite a long time, the Government failed to speak out on deaths caused by the epidemic.

"This has contributed to the rise of the disease in our country," she said

She called on the joint efforts to combat the scourge which has taken away many lives especially youths.

Ms Chale said this has resulted in the increase in number of both widows and orphans.

In his New Year message to the nation, President Benjamin Mkapa called for joint efforts in demolishing the wall of silence surrounding the incurable disease, saying people should now desist from whispering about it and be more open.

The President described the situation as 'very serious', promising that the Government will this year step up sensitization campaigns on preventive measures and change in sexual behaviour.

He said the Government could not fight the deadly disease single-handedly. He called for support from religious and social leaders, public institutions, donors and the private sector.

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INSIDE



# Mkapa urges openness on AIDS

By JAPHET SANGA

**PRESIDENT Benjamin Mkapa has exhorted Tanzanians to intensify efforts in fighting against HIV/AIDS this year through being more open and sincere about the scourge.**

In his New Year greetings to the nation yesterday, the president called for joint efforts in demolishing the wall of silence surrounding the incurable disease, saying people should now desist from whispering about it but be more open.

President Mkapa decried the dishonest in Tanzanians when it comes to explaining the cause of death of their relatives whereby, if it was AIDS, relatives of the deceased will mention another disease as the cause.

He described the AIDS situation in the country as "very serious," promising that the government, will this year, step up sensitisation campaigns on preventive measures and change in sexual behaviour.

Mr Mkapa, who addressed the nation from State House in Dar es Salaam, asked religious leaders in the country to address the HIV/AIDS problem accordingly during their sermons and preachings.

The president said the government could not fight the deadly disease single-handedly but also needed support from religious and social leaders, public institutions, donors and the private sector.

"This is an epidemic which calls for emergency measures to contain it. We should, therefore, strive to achieve the United Nations goal which needs a 25-per cent reduction of the HIV/AIDS spread by the year 2005," said the president.

Mr Mkapa urged the public to accommodate HIV/AIDS infected people, saying it was highly inconsiderate to ostracize or deriding them because anybody could be infected.

On the economic front, President Mkapa said the government remains committed to fighting poverty, ignorance and diseases, a task which it will uphold this year.

He said the government has already started talks with the International Monetary Fund (IMF) and the World Bank on a programme aimed at reducing poverty – Poverty Reduction and Growth Facility (PRGF).

Mr Mkapa commended Tanzanians for rekindling the self-help spirit whereby construction of schools, dispensaries, police posts in most parts of the country have been realised through communal initiatives.

He said the government will sustain its concerted efforts to licking the economy into shape this year through strict monetary and fiscal policies which have now reduced the inflation rate to seven per cent.

It was good news that Tanzania will be given priority this year in debt cancellation for the High Indebted Poor Countries (HIPC), the president said.

However, the president told Tanzanians to double their efforts in agriculture production and drop the aid dependence syndrome, saying the country had vast arable land and ample rainfall.

Touching on the general elections slated for later this year, Mr Mkapa said the government will strive to ensure t the elections were wholly funded by the government.

"It's improper if we depend on donors to fund our elections," said the president, adding that the government is now readying itself for the elections to ensure they were free and fair.

## LAST SUNSET OF SECOND MILLENNIUM SETS IN DAR

## ☞ Health

EOTF participates in SAMOTA - Safe Motherhood Initiative in Tanzania which is a project proposed to be implemented in five districts of Tanzania.

*EOTF Chairperson, Mama Anna Mkapa appreciates the quality of products our women produce.*

## ☞ Welfare

A special programe has been designed to assist street children and orphans.

## ☞ Networking

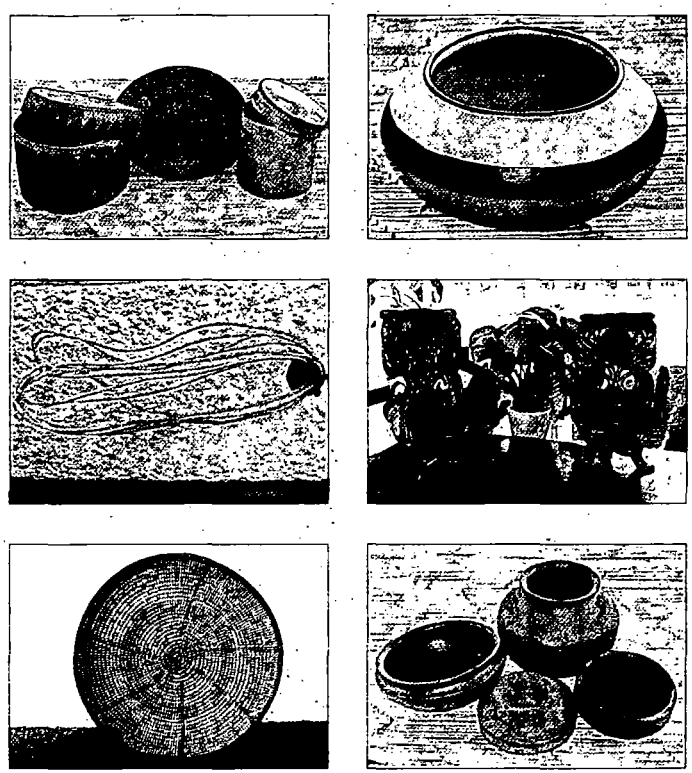
Considering EOTF capacity, EOTF shall as much as possible collaborate with any organisation which will assist in achieving its objectives.

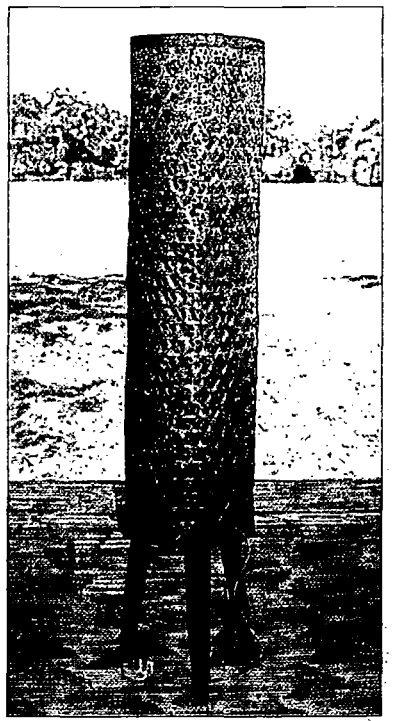
## ☞ Monitoring and Evaluation

This is participatory. Together with stakeholders EOTF looks at whether activities implemented were directed at objectives and measure progress and use of resources.

## ☞ Sustainability

EOTF finances its activities through donations from friends and donor partners. To be sustainable, EOTF supplements these resources thrugh management fees, projects, research and consultancy, EOTF shall ensure that whatever intervention, it promotes, sponsors or facilitates has a built-in potential of sustaining itself after such interventions.





# QUAL OPPORTUNITIES FOR ALL TRUST FUND

EQUAL OPPORTUNITIES FOR ALL TRUST FUND

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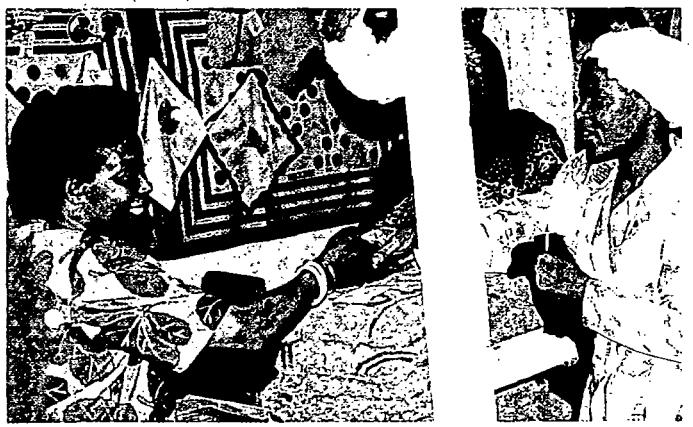
**Fax: 255-51-114793**
**-mail: eotf raha.com**

# THE EQUAL OPPORTUNITIES FOR ALL TRUST FUND (EOTF)

## BACKGROUND

The Equal Opportunities For All Trust Fund (EOTF) is a registered, non-profit, non-governmental charitable organization whose mission is to empower women through increased economic and educational opportunities. Founded by Tanzania's First Lady Mama Anna Mkapa, EOTF is dedicated to fighting and eradicating poverty focusing on rural women and other dissadvantaged groups with special needs. Specifically, EOTF aims to champion the economic empowerment of women through various channels, including access to information, credit, market education, health, training programmes and training facilities. In addition, EOTF provides a forum for women to exchange ideas, channel their views and concerns, as well as link to a network of various national and international organisations. Against this background a multidisciplinary programme on Women in Poverty Eradication (WIPE) has been initiated.



***Mama Anna Mkapa greets WIPE exhibitors at the 1998 Saba Saba WIPE pavilion.***

## EOTF GOAL

To contribute to national goals aimed at poverty eradication through the empowerment of women.

## EOTF OBJECTIVES

- To initiate, promote, facilitate and support the empowerment of rural women, youths, children and other disadvantaged members of the Tanzanian society through connecting them to the existing opportunities in training, credit and other means of funding, acquisition of appropriate technology and marketing skills;
- To create a mechanism that enables development agencies to channel resources directly to the intended beneficiaries into business associations or groups;
- To facilitate investors, both local and international (hereinafter referred to as "collaborators") to establish collaboration arrangements with business associations or oganisations of rural women and youths or which aim at enhancing their skills and creating job opportunities for them;
- To prepare and solicit funds for, or otherwise support programmes that will ensure:
- That girls and boys have access to education from primary, secondary, to technical education levels as well as higher education, by granting scholarships to orphans, and girls and boys who are academically capable but whose parents were victims of calamities, such as war and AIDS and those who are economically incapable to pay for their education;
- That economically active youths who have completed professional training at Diploma to degree levels get access to job-creation opportunities which will ensure that full participation in their individual economic development;
- Rural women are reached through adult education programmes not only by teaching them reading and writing skills but also educating them on issues of concern like health, nutrition, family planning, child care, environmental conservation and income generating activities;
- That women and youths participate efficiently in business undertakings, including enhancing their marketing skills, both at national and international level;
- To advocate for inclusion and integration of women and youths development issues at all policy planning levels - from local government to the international level;
- To provide legal literacy progremmes which will raise women's awareness of their rights;
- To raise funds to facilitate the achievement of the above mentioned objectives.

## EOTF ACTIVITIES

### ☞ Micro Enterprise Programme

The Dar es Salaam International Trade Fair (DITF) is one of the many activities sponsored by the EOTF. The Objective of the trade fair is to promote marketing of the products and facilitate networking among women entrepreneurs. EOTF facilitate mobilisation of financial resources to enable women from remote areas in Tanzania to participate in the DITF each year.

ARUMERU ARUSHA

***WIPE participants speaking to potential clients at the 1998 WIPE pavilion.***

- EOTF facilitates the participation of women entrepreneurs in market promotion activities including exhibitions, exhange visits and study tours within and outside the country.
- EOTF support programmes on enterpreneurship and managerial skills training programmes through inter alia workshops, seminars and symposiums

### ☞ Women Access to Credit - WAC

The Equal Opportunity for All Trust Fund is mobilising resources to initiate a 5-year programme to assist women especially rural women and poor women in urban areas to effectively access credit, accumulate savings and develop the necessary capacities required for them to access credit loans and guarantees.

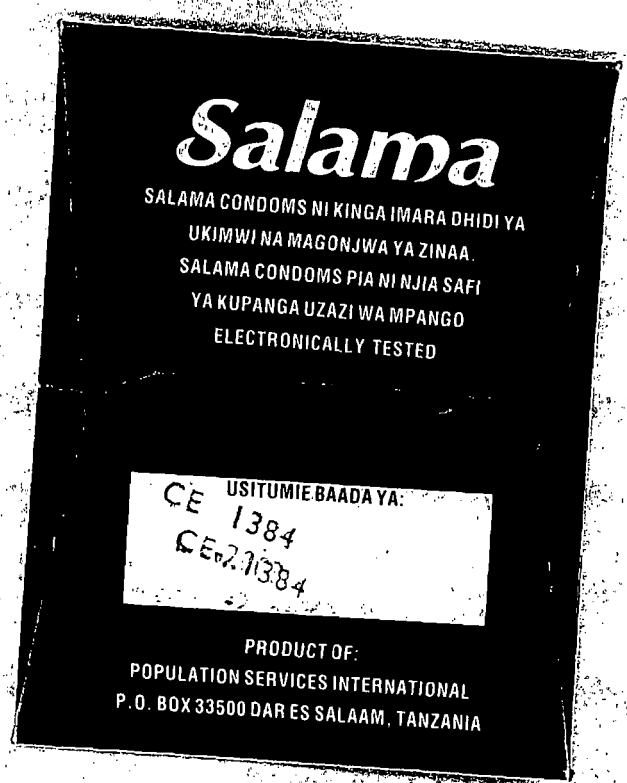
### ☞ Education

EOTF has initiated an Education support programme, which is aimed at providing school fees to the disadvantaged youth in the community. Also participate in activities aimed at mobilising resurces to support provision of educational facilities, including construction of schools, school desks, etc.

The Equal Opportunities for All Trust Fund initiated the Education Support Programme (ESP) with objectives of meeting educational challenges facing the poor, neglected, orphans, and homeless children by providing them with scholarships and educational supplies to enable them attend secondary and technical school within Tanzania.

Through the Education Support Programme, EOTF also seeks to network with local and international donor agencies to solicit, acquire and distribute educational supplies such as books, school building materials, school supplies and financial resources needed to assist in rehabilitation, construction, and equipping schools with educational facilities and supplies.

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# SHDEPHA+

## CONSTRAINTS AFFECTING WOMEN LIVING WITH HIV/AIDS VIRUS IN OUR COMMUNITY

Constraints facing women living with HIV/AIDS in Tanzania are mainly caused by our traditional beliefs and culture also poverty.

**Problems or Constraints are such as:-**

I. **DEATH:** (Mainly caused by AIDS)

Death of a husband who is the bread earner of the family leave women and children in serious economic problems.

In most cases it is believed that the woman has bewitched the late husband therefore it is used as an excuse to kick them out of the matrimonial homes and completely disinheriting them.

Furthermore, widows are left in great fear of being inherited by the deceased male relatives. This is one way of spreading HIV/AIDS, if one is already infected by HIV/AIDS.

If either husbands or wives die they leave behind single parents and children with disrupted life styles and standard of living.

**II. DISCRIMINATION/STIGMA:**

- Discrimination in workplaces; (after death of husband due to HIV/AIDS).
- Lack of proper medical and health facilities in hospitals.
- Termination of employees at workplaces after testing positive in medical examination.

**III. TRADITION AND BELIEFS:**

In our community women are rejected and not heard, for instance:-

- a woman has **'no say upon her body'**, for example, a woman knowingly that her husband has several other relationships still she cannot ask her husband to use a condom when they mate. Because, it is a great shame to decide for her husband.
- A woman is not involved in decision- making both in the family or society.
- Wives are not members of the husband family for **'LAND HOLDING'** purposes. Therefore, she has no share of the inheritance.

## IV. LACK OF FUNDS FOR SELF-PROJECTS:

In most cases women living with HIV/AIDS are either terminated or not employed in workplaces therefore making them fail to conduct their lives and family. Therefore, because of survival SHDEPHA+ Women's group is prepared to initiate activities which can enable them be active and productive.

For example: We have organized a women's group with the aim of creating employment to women living with HIV/AIDS but, still lack funds for conducting many of our activities.
Our group has written several proposals to different donors and the government but have received no response. Either donors are more willing to give funds for Programme Activities for the Community and give little or no priorities to women groups. Luckily, a few years back DANIDA funded our group with funds for Batik Project.

## V. CONCLUSION:

Plans for SHDEPHA+'s Women's Group is to run an Orphans and Widows Centre inorder to create an environment where widows and orphans will be able to ventilate their feelings and utilize their abilities in the best possible manner.

The objective being provision of Care, Education and Recreation for Orphans so as to minimise trauma on children and enhance hope and independence on widows.

Beneficieries being Orphans, Widows, Widowers due to HIV/AIDS, and the community.

Therefore, we ask well wishers and donors to sympathize with us and join hands in the fight against poverty and discrimination facing women and children who are both infected and affected with HIV/AIDS.

Thank-you!

**SHDEPHA+ WOMEN'S GROUP**

Iringa Pres Mkapa

# TANZANIA AND HIV/AIDS

## Key Talking Points

Hamza

Tanzania's HIV/AIDS epidemic has increased alarmingly each year. The epidemic is being driven by high-risk heterosexual sexual behavior, characterized by high incidence of sexually transmitted infections.

- Ten to 12 percent of adults (age 15 and over) are HIV-positive.
- An estimated 1.5 million Tanzanians are living with HIV—520,000 of them with AIDS. Following current trends this figure is expected to rise to 2.4 million by the year 2000.

***AIDS Deaths*** From 1990 to 2010, AIDS will increase the crude death rate in Tanzania by more than 50 percent. Life expectancy will drop by 20 percent during the 1990s as a result of HIV/AIDS, and by 2010 will average 46 years.

***Women and HIV/AIDS*** Data derived from ten antenatal sentinel surveillance sites show countrywide HIV-prevalence rates ranging from 10 to 33 percent among pregnant women.

***Youth and HIV/AIDS*** Tanzanians 15 to 24 years old, while comprising only 20 percent of the population, account for 60 percent of new HIV infections.

70,000 a

***Children and HIV/AIDS*** Forty-six percent of the Tanzanian population is under age 15. More than 68,000 children under age 15 are living with HIV/AIDS. Each year approximately 50,000 to 60,000 children are born HIV-positive. By 2015 the infant mortality rate is expected to be at least 16 percent higher than it would have been in the absence of AIDS.

An estimated 15 percent of all Tanzanian children under age 15 are missing one or both parents; an estimated 730,000 children have been orphaned because of HIV/AIDS.

700,000 orphans

***Health Care Costs*** The Tanzanian government currently allocates 6 percent of its central budget—3 percent of the GDP—to the health sector. In July 1996 the government initiated a plan for health sector reform.

***USAID*** supports a variety of HIV/AIDS prevention activities in Tanzania, contributing $3.6 million for FY 1998. In 1998 USAID was a key donor and contributed to organizing the National Strategic Plan and the First National Scientific Conference on HIV/AIDS in Tanzania.

***National Response*** Currently there are two independent National AIDS Control Programmes; one on the mainland and one in Zanzibar. Although the Tanzanian government recently launched a National Strategic Plan, there continues to be limited overt political commitment to the fight against HIV/AIDS. Implementation of the National Strategic Plan is still in the early stages and will need continued commitment from the president and other high-ranking officials in order to be effective and sustainable.


**U.S. Agency for International Development**

**Population, Health and Nutrition Programs**
**HIV/AIDS Division**

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**Impact** Implementing AIDS Prevention and Care Project

**Implementing AIDS Prevention and Care (IMPACT) Project**

Family Health International
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# TANZANIA AND HIV/AIDS

## Country Profile

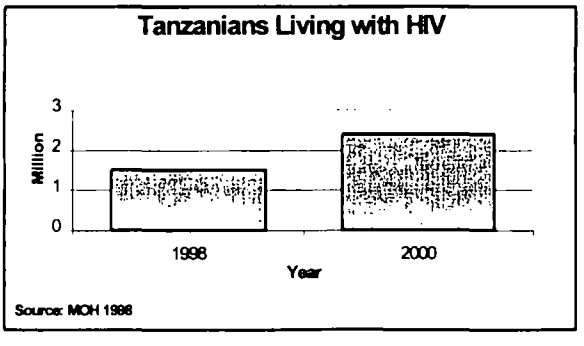
Tanzania is one of the few politically stable countries in East Africa; however, continued regional ethnic tensions and potential expansion of the conflict in the Great Lakes states threaten this stability. Tanzania is noted for accepting refugees displaced by the conflicts in neighboring Rwanda, Burundi, and the Democratic Republic of the Congo, at great political and economic cost. The country is rich in natural resources and contains some of the world's most biologically diverse ecosystems. Although Tanzania's gross domestic product (GDP) is increasing annually at a rate of 3.6 percent, it is not sufficient to sustain the country's annual 3 percent population growth. Tanzania's external debt stands at $8.2 billion and the country today remains one of the fifth poorest countries in the world.

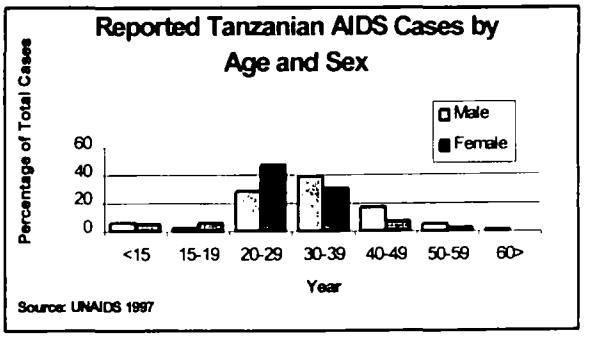
High rates of fertility (5.7) and sexually transmitted infections (STIs), including HIV/AIDS, contribute to elevated adult and infant morbidity and mortality rates in Tanzania. According to a 1996 Demographic and Health Survey (DHS), more than 43 percent of Tanzanian children under age 5 suffer from malnutrition: 30 percent are underweight; approximately 30 percent suffer from fever; and 14 percent suffer from diarrhoeal diseases. The overall infant mortality rate is 100 per 1,000 births and the child (under age 5) mortality rate is 145. Roughly 60 percent of the population still lack access to health services. The Tanzanian government currently allocates 6 percent of its central budget—3 percent of the GDP—to the health sector. In July 1996 the government initiated a plan for health sector reform.

## *HIV/AIDS in Tanzania*

The first three AIDS cases were reported in Tanzania in 1983. Since then the HIV/AIDS epidemic in Tanzania has increased alarmingly each year. The epidemic is being driven by high-risk heterosexual sexual behavior characterized by high levels of STIs.

- Ten to 12 percent of adults (age 15 and over) are HIV-positive.
- An estimated 1.5 million Tanzanians are living with HIV—520,000 of them with AIDS. Following current trends, this figure is expected to rise to 2.4 million by the year 2000.
- In 1997, HIV prevalence rates among selected populations in urban areas ranged from 14 percent in low-risk groups to 50 percent in high-risk groups. Rural rates ranged from 17 percent in low-risk groups to 34 percent in high-risk groups.
- The highest HIV-prevalence rate is among 30- to 44-year-olds.
- In 1996, only 16 percent of men reported using a condom during their last sexual encounter.
- More than 150,000 people died of AIDS-related illnesses in 1997.



**U.S.-Tanzanian Relations Moving Closer:**

Both President Mkapa and Foreign Minister Kikwete have worked to shift Tanzania's worldview away from that of a Marxist, Non-Aligned state to one more open to closer relations with the United States. The good cooperation between Tanzanian and the U.S. in the wake of the August 7 bombings greatly accelerated the pace of high-level exchanges and changed the nature of the bilateral relationship. For example, the U.S. and Tanzania concluded a Status of Forces Agreement this year, a security relationship the Tanzanians would never have considered as recently as two years ago. There are frequent discussions between U.S. and Tanzanian officials on regional crises, such as those affecting Congo and Burundi. The U.S. and Tanzania are allies in the fight against terrorism, as evidenced by Tanzania's assistance in rounding up the Embassy bombers and their good participation in U.S. Anti Terrorism Assistance training (ATA).

The U.S. Embassy built upon this new spirit of goodwill by facilitating a September 1999 Tanzanian reverse trade mission to the U.S. led by President Mkapa. Mkapa, accompanied by over 50 Tanzanian businessmen, met with President Clinton, Treasury Secretary Summers, and business leaders in Boston, New York, Washington, D.C. and Atlanta. As a result of this visit, American companies gained high level access to Tanzania's business leaders. The visit also led to the first-ever U.S. Open Skies agreement with an African country. There are few divisive issues between the U.S. and Tanzania and relations can be expected to continue growing closer over the next several years.

# TANZANIA

U.S. Agency for International Development (USAID)
Population, Health, and Nutrition Briefing Sheet

## Country Profile

Tanzania, with the fifth largest population in sub-Saharan Africa, is among the poorest countries in the world. Decades of central control have left the nation with an inadequate and crumbling infrastructure and an over staffed and poorly paid civil service. Despite its limited financial resources, however, Tanzania stands at the forefront of multiethnic balance in a region racked with turmoil and instability. It may yet serve as an African model of democratic governance and a market-driven economy.

## USAID Strategy

USAID's family planning and health program in Tanzania is a nationwide initiative conducted in partnership with the Ministry of Health and emphasizes increasing private sector participation and improving conditions in rural areas. USAID support is designed to increase demand for and access to services for family planning, maternal and child health (MCH), and prevention of HIV/AIDS and other sexually transmitted infections (STIs). USAID addresses sustainability by promoting cost recovery to support clinical services under the Ministry of Health and nongovernmental organizations (NGOs).

## Major Program Areas

*Family Planning/Maternal and Child Health Services Support.* USAID supports improved reproductive health and child survival through information, education, and communications (IEC) activities; distribution of equipment, contraceptives,and other supplies; and extensive training to improve service quality in the public and private sectors. Contraceptive social marketing efforts are complemented by additional support from the British Department for International Development (DFID). Additional efforts focus on strengthening management; institution building in the Ministry of Health; and integrating services for family planning, child survival, women's health, and HIV/AIDS prevention at the service delivery level.

*HIV/AIDS Prevention and Support.* Working with Tanzania's National AIDS Control Program (NACP), USAID supports the development of networks of NGOs and other private entities undertaking HIV/AIDS activities (particularly those based at the workplace), dissemination of AIDS information, and condom social marketing. NGO activities include training for syndromic diagnosis and treatment of STIs, and support for people impacted by HIV/AIDS, especially orphans. The mission supports capacity building within the NACP and advocates for appropriate national level responses to HIV/AIDS.

## Results

- The use of modern contraceptives by married women in Tanzania doubled from 6 percent in 1991 to 12 percent in 1996, surpassing program expectations.
- There were 735 nurses trained in reproductive health clinical skills in 1996-97. In 1996, 69 percent of health facilities had at least one health provider trained in family planning and reproductive health skills in 1996, up from 24 percent in 1994.
- Availability of contraceptives increased in 90 percent of family planning facilities, with most having at least three methods in 1996, after nearly constant stockouts a few years earlier.
- Exclusive breastfeeding rates for infants younger than six months old tripled to 25 percent in 1996, up from less than 8 percent in 1991-92.
- More than 10 million condoms were sold annually in 1996-97, through an innovative marketing program using various media to promote HIV/AIDS prevention.
- More than 750 clinical officers were trained in syndromic management of STIs in 1996–97.

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- The NGO sector was recognized as a full partner in strategic planning efforts by the National AIDS Control Program, a direct result of the strong role NGOs have played, with USAID support, in community mobilization nationwide.

## Success Stories

USAID has played a critical leadership role in developing the family planning and health sector in Tanzania. USAID encouragement and coordination with other donors has led to additional support from DFID and German KFW to help meet the increasing demand for contraceptive commodities. Quality assurance guidelines and various integrated training curricula developed with USAID support are now fully used by other donors, NGOs, and government programs nationwide. USAID support for research and surveys produces a wide range of data that are used for family planning and health sector programming throughout Tanzania, as evidenced by the 1996 Demographic and Health Survey. USAID also serves on the steering committee for Tanzania's National Immunization Days, which have played an integral role in successful efforts to increase coverage against polio.

With USAID assistance, the curriculum and training materials for community-based contraceptive distribution agents were revised and expanded to include integrated reproductive health and child survival messages. To date, more than 2,000 educational flipcharts have been distributed to agents; these flipcharts contain exclusive breastfeeding, immunizations, growth monitoring, and nutrition messages. Other USAID-supported integrated IEC activities include expanding the radio program "Zinduka" (a Kiswahili term meaning "wake up") to include child survival and family planning messages, and developing an IEC "toolkit" for MCH nurses designed to improve counseling for mothers on immunizations, antenatal care, maternal and child nutrition, breastfeeding, family planning, and HIV/AIDS.

## Continuing Challenges

Rapid population growth, high infant and child mortality rates, and the heavy impact of HIV/AIDS on Tanzania's most productive age group continue to have grave social and economic consequences. On the positive side, however, the Government of Tanzania is undertaking major reforms in the civil service, health, and local government sectors. Tanzania's health sector reform activities aim to change the Ministry of Health's role from implementation to policy and regulation; develop a sectorwide program; and enhance district-level service delivery. USAID support for effective public health policy and improved health systems organization will be particularly important during Tanzania's transition to a new health system.

USAID

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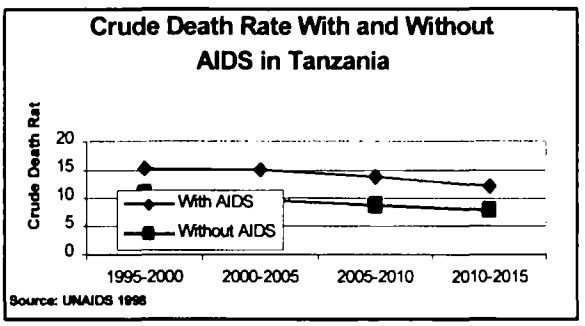
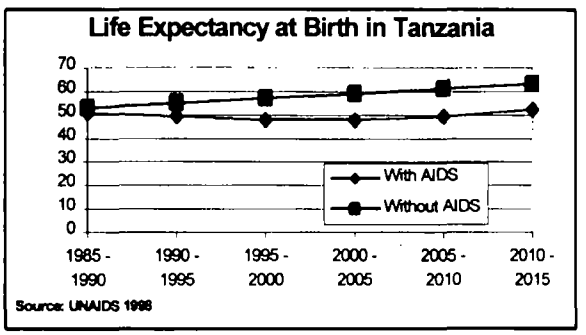
Prepared by Center for International Health Information, Arlington, Virginia 22209, October 1998

- From 1990 to 2010, AIDS will increase the crude death rate in Tanzania by more than 50 percent.




- Life expectancy will drop by 20 percent during the 1990s as a result of HIV/AIDS. By 2010 the average life expectancy will be 46 years.




## *Women and HIV/AIDS*

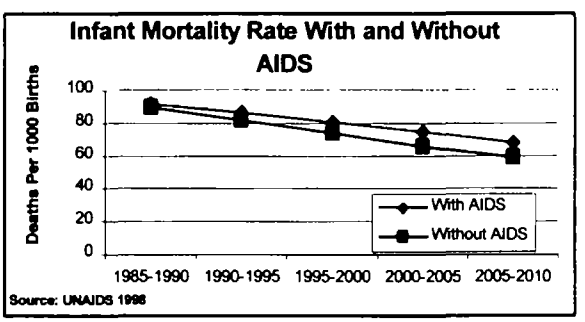
The number of women living with HIV/AIDS is growing. Women's low social and economic status, combined with greater biological susceptibility to HIV, put them at increased risk of infection. Deteriorating economic conditions, which make it difficult for women to access health and social services, compound their vulnerability.

- Data derived from ten antenatal sentinel surveillance sites show countrywide HIV-prevalence rates ranging from 10 to 33 percent among pregnant women.
- According to the 1996 DHS, 97 percent of women have heard of AIDS yet only 38 percent can name at least two correct ways to avoid HIV.
- According to the same study, 29 percent of Tanzanian women reported having only one sex partner and only 10 percent reported ever using a condom to avoid STIs.
- Eighteen percent of women 15 to 49 years old have been circumcised. Circumcision increases a woman's risk of contracting HIV.

## *Children and HIV/AIDS*

Forty-six percent of the Tanzanian population is under age 15. The HIV epidemic has a disproportionate impact on children, causing high morbidity and mortality rates among infected children and orphaning many others. Approximately 30 to 40 percent of infants born to HIV-positive mothers will also become infected with HIV.

- More than 68,000 children under age 15 are living with HIV/AIDS.
- Each year approximately 50,000 to 60,000 children are born HIV-positive.
- By 2015 the infant mortality rate is expected to be at least 16 percent higher than it would have been in the absence of AIDS.

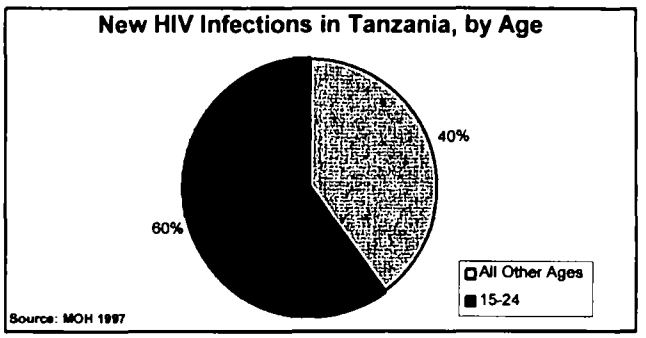



- An estimated 15 percent of all Tanzanian children under age 15 are missing one or both parents, many of them because of AIDS.
- To date, an estimated 730,000 children have been orphaned because of AIDS.

### *Youth and HIV/AIDS*

Youth and young adults account for a large percentage of all HIV/AIDS cases in Tanzania.

- Tanzanians 15 to 24 years old, while comprising only 20 percent of the population, account for 60 percent of new HIV infections.
- In 1996, 26 percent of teenagers had given birth or were pregnant for the first time.




## Socioeconomic Effects of AIDS

More than 80 percent of reported AIDS cases are 20 to 49 years old. Since this age group constitutes the most economically productive segment of the population, an important economic burden is created. Productivity falls and business costs rise—even in low-wage, labor-intensive industries—as a result of absenteeism, the loss of employees to illness and death, and the need to train new employees. The diminished labor pool affects economic prosperity, foreign investment, and sustainable development. The agricultural sector likewise feels the effects of HIV/AIDS; a loss of agricultural labor is likely to cause farmers to switch to less-labor-intensive crops. In many cases this implies switching from export crops to food crops—thus affecting the production of cash and food crops.

In 1996, the cost of AIDS care as a percentage of national health expenditure was 3.5 percent or $5.8 million. There are also many private costs associated with AIDS, including expenditures for medical care, drugs, funeral expenses, etc. The death of a family member leads to a reduction in savings and investment, and increased depression among remaining family members. Women are most affected by these costs and experience a reduced ability to provide for the family when forced to care for sick family members. And AIDS adversely affects children, who lose proper care and supervision when parents die. Some children will lose their father or mother to AIDS, but many more will lose both parents, causing a tremendous strain on social systems. At the family level there will be increased pressure and stress on the extended family to care for these orphans; grandparents will be left to care for young children and 10- to 12-year-olds become heads of households.

(For country-specific information on the socioeconomic impact of HIV/AIDS, refer to the *analysis* presented by the Policy Project.)

## Interventions

### *National Response*

Since 1983 various national efforts to control the spread of HIV have been launched. Currently there are two independent National AIDS Control Programmes (NACPs), one on the mainland and one in Zanzibar. A short term plan was prepared and implemented by the Ministry of Health and the NACP between 1985 to 1986. This was followed by the First Medium Term Plan (MTP1), for the period 1987 to 1991, and the Second Medium Term Plan (MTP2), for the period 1992 to 1996. In September 1995 the NACP developed a draft National Policy on HIV/AIDS/STIs. The specific objectives of this policy were to increase the community's awareness of HIV/AIDS; provide people living with HIV/AIDS (PLWHA) and their caregivers with social, medical, physical, and spiritual support; and safeguard and protect the

human rights of all PLWHA. To date, however, the policy has not been enacted.

After the MTP2 ended in 1996, the government finalized and launched a National Strategic Plan for HIV/AIDS for the period 1998 to 2002. The strategic plan, multisectoral in its approach, was developed by more than 20 government sectors, nongovernmental and religious organizations, PLWHA, and the private sector. It was launched by the Tanzania's prime minister and other high-ranking governmental officials. The U.S., Swedish, and Norwegian ambassadors and the head of the European delegation also gave statements renewing their commitment to support the national response in the fight against HIV/AIDS in Tanzania.

The NACP strategy outlines 11 priority areas focusing on the prevention of HIV/AIDS and other STIs; protection of PLWHA; mitigation of the socioeconomic impact of HIV/AIDS; and the strengthening of NGOs, communities and individuals affected by the epidemic. Operational plans are being developed, primarily at the district level, to address these priorities.

With the launch of the National Strategic Plan, the government also made a commitment to reactivate the existing National AIDS Committee and form a new National Advisory Board on HIV/AIDS headed by the former president of the country.

## *Donors*

Multilateral and bilateral donors are actively engaged in HIV/AIDS in Tanzania. According to a UNAIDS/Harvard study, bilateral organizations contributed the following amounts in 1996-1997:

| Organization | Amount US$ 1996-97 |
|---|---|
| Norway | 1,207,337 |
| DANIDA | 643,362 |
| EU | 573,936 |
| TAP (USAID-funded) | 20,648 |
| **Total** | **2,700,255** |

*Bilateral organizations' contributions 1996-1997*

**USAID**'s HIV/AIDS funding for FY 1998 was $3,600,000. Working with Tanzania's NACP, USAID/Tanzania has supported the development of networks of indigenous NGOs and other private entities that are undertaking HIV/AIDS activities, the dissemination of AIDS information in various media, and social marketing of condoms. Areas of NGO activity also have included training for syndromic diagnosis and treatment for STIs and support for PLWHA. The mission also supports capacity building within the NACP and advocates for appropriate responses to HIV/AIDS at the national level. In 1998 USAID was a key donor and contributed to the development of the National Strategic Plan and the First National Scientific Conference on HIV/AIDS in Tanzania.

***The First National Scientific Conference on HIV/AIDS in Tanzania in 1998 provided a platform from which to disseminate the Tanzanian government's HIV/AIDS strategy to over 700 individuals, including media representatives. It also provided a forum for critical debate on pertinent issues, and highlighted the lack of political support within the government. Subsequently, both the president and prime minister gave their first public remarks about HIV/AIDS in Parliament.***

In 1999 USAID/Tanzania will continue to support both public and voluntary sector activities, the latter through a voluntary sector umbrella grants program. Through these sectors, USAID/Tanzania intends to support the following types of activities:

- Address the weak policy and legal environments and strengthen national leadership.
- Develop information, education and communication (IEC) messages to increase client use of HIV/AIDS/STI clinics coordinated by NGO partners.
- Promote male and female condom social marketing campaigns.
- Launch advocacy campaigns to increase HIV/AIDS awareness among the general public.
- Train NGOs to provide indigenous, community-based approaches to AIDS prevention, education, counseling, and testing.
- Build district-level public/private partnerships to address HIV/AIDS, as well as reproductive and child health concerns.

**UNAIDS'** coordinating Theme Group in Tanzania includes representatives from UNDP, WHO, UNICEF, UNESCO, UNFPA, and The World Bank, and is chaired by UNFPA. UNAIDS receives multilateral funds from Norway, Ireland, ODA and GII. UNAIDS also receives core support from its cosponsors. UNAIDS is involved in several activities, including several independent contracts to conduct research, workshops and surveys on topics such as HIV subtypes, household sexual networks and HIV infection, and collection of HIV isolates in Tanzania. UNAIDS is also involved in health reform projects focusing on:

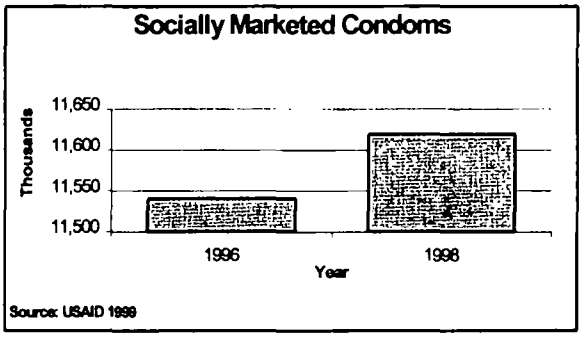
- Reviving under-resourced district AIDS coordination committees.
- Expanding district-level HIV/AIDS initiatives.
- Combating the recognized HIV-related stigma and denial of PLWHA in the clinic setting.

UNAIDS has also supported private sector mobilization projects for the expanded response to HIV/AIDS, and research projects including the PETRA study site on mother-to-child transmission, based in the Muhimbili Hospital in Dar es Salaam.

**The World Bank** supports HIV prevention through a $47.6 million health and nutrition project. By providing support to critical and strategic elements of the PHN sectors, the project reinforces the government's efforts to raise the quality, coverage and effectiveness of family planning, nutrition and basic health services in urban and rural areas.

**The European Union** provides STI drugs and training through the National AIDS Control Program.

**The World Food Programme (WFP)** provided




home-based care in collaboration with the NACP from 1992 to 1997. WFP assisted the Ministry of Health in its efforts to develop a model for home-based care in Kagera region, where there is a high HIV-prevalence rate among the most productive age group. The total budget for this program was $1.7 million.

**The Australian Agency for International Development (AusAID)** provided assistance from 1994 to 1997 to a high HIV-transmission area.

**The Finnish Ministry for Foreign Affairs, Department of International Development Cooperation** had a project in Tanzania from 1995 to 1998. This project, implemented by the Association for Developing Countries in Vasa, provided FIM 700,000 for dissemination of AIDS prevention information, and direct support for hospitals, education of health care staff, hospital equipment, and delivery. The Finnish government also supported an IEC program implemented by the Finnish Free Foreign Mission from 1995 to 1997, for FIM 2.2 million.

**The German Federal Ministry for Economic Cooperation and Development (GTZ)** supported a DM 1.5 million HIV/AIDS control program in 1997. This program helped to expand the AIDS control programs in the diocese of Moshi and in Arusha.

**The United Kingdom Department for International Development (DFID)** supported various NACP prevention projects by providing 2.48 million from 1994 to 1997.

**The Ford Foundation** is currently providing the Africa Medical and Research Foundation (AMREF) with a grant of $160,500. This grant supports the implementation of an HIV-transmission areas intervention project. The Ford Foundation is also supporting the Faraja Trust Fund, with a grant for $74,000. This grant is assisting with the second phase of a public education and community mobilization program to reduce HIV transmission in Morogoro.

### *Private Voluntary Organizations (PVOs) and Nongovernmental Organizations (NGOs)*

A number of PVOs implement activities funded by multilateral and bilateral donors. Some of the major USAID cooperating agencies include Family Health International (FHI)/IMPACT, Pathfinder International, Population Services International, John Hopkins University, CARE and MACRO International. *See attached preliminary chart for PVO and USAID cooperating agencies HIV/AIDS activities target areas. This list is evolving and changes periodically.*

Tanzania currently does not have an NGO coalition. The Tanzania AIDS Project (TAP) was initiated in June 1993 as a five-year project (1993 to 1998). TAP's principle goal was to build the capacity of indigenous NGOs to implement HIV/AIDS preventive education activities and to provide a source of support to people with HIV/AIDS. Funded by USAID and implemented by the FHI/Tanzania country office, TAP established the NGO cluster approach in 1993. This approach facilitated the creation of clusters or networks of NGOs working in HIV/AIDS prevention or care to help improve their capacity to challenge the epidemic. Peer education has been one of the primary strategies used by these NGO clusters and their members. According to USAID, NGO clusters or networks provide services within selected districts for 9 out of 20 regions in mainland Tanzania..

The African Medical and Research Foundation, based in Tanzania, is one of the larger research institutions in Africa. Traditional healers have an important role in Tanzania, and efforts are being made to bring them into an adjunct, cooperative relationship with biomedical workers to treat STIs and some infections caused by AIDS.

## Challenges

Major constraints to HIV/AIDS control in Tanzania include the following:

- Lack of political support within the government and from high-ranking officials.
- Shortages of trained health workers as well as financial resources in the biomedical sector.

The following gaps in programming must be filled in order to mount an effective response to HIV/AIDS in Tanzania:

- High-level political support and enforcement of a National AIDS Policy and National Strategic Plan.
- Legislation and enforcement to protect the human rights of PLWHA.
- Expanded funding sources for NGOs and community-based initiatives.
- Integration of HIV/AIDS/STI programs with reproductive health services.
- Focus on youth efforts and activities, including family life education and HIV/AIDS education programs in schools.
- Behavior change interventions are needed to complement all IEC activities. Although basic knowledge of HIV/AIDS is high among

Tanzanians, knowledge of self protection measures and behavior change is much lower.

## The Future

Although the Tanzanian government recently passed a National Strategic Plan, there continues to be limited overt political commitment to the fight against HIV/AIDS. This is demonstrated by a continued lack of decision making on the appropriate organizational home for the NACP, and the inactivity of the National AIDS Committee. Implementation of the National Strategic Plan is still in the early stages and will need continued commitment from the president and other high-ranking officials in order to be effective and sustainable. The challenge ahead is to make use of the favorable environment and act expeditiously, so as not to lose the high momentum of political support and leadership. Only with such leadership will it be possible to slow the spread of HIV in Tanzania.

## Important Links

1. Tanzania National AIDS Control Program: Ministry of Health, P.O. Box 9083, Dar-es-Salaam.
2. UNAIDS Country Program Adviser: Mulunesh Tennagashaw, UNAIDS, c/o WHO, Luthuli Road, P.O. Box 9292 Dar-es-Salaam; Tel: (255) 51 13 03 50, Tel mobile: (255) 812 781 987; Fax: (255) 13 96 54; email: mulu.unaids@twiga.com

**U.S. Agency for International Development**

**Population, Health and Nutrition Programs**
**HIV/AIDS Division**

1300 Pennsylvania Ave., N.W.
Ronald Reagan Building, 3rd Floor
Washington DC 20523-3600
Tel: (202) 712-4120
Fax: (202) 216-3046
URL: www.info.usaid.gov/pop_health

**Implementing AIDS Prevention and Care (IMPACT) Project**

Family Health International
2101 Wilson Boulevard, Suite 700
Arlington VA 22201 USA
Telephone: (703) 516 9779
Fax: (703) 516 9781
URL: www.fhi.org

*June 1999*

# Tanzania

| Organization | Intervention | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Advoc. | BCI | Care/S | Training | Cond. | SM | Eval. | HR | IEC | MTCT | Research | Policy | STD | VCT | Orphan | TB | Other |
| JSI/FPLM | | | | | | | | | | | | | | | | | |
| TFGI/Policy Project | X | | | | | | | | | | | X | | | | | strategic planning |
| Horizons | | | | | | | | | | | | | | X | | | |
| FHI/IMPACT | X | X | X | X | | | | | | | | X | X | X | X | | |
| JHUCCP | | X | | | | | | | X | | | | | | | | |
| Macro International | | | | | | | | | | | X | | | | | | |
| Pathfinder International | X | X | | X | | | | X | X | | | | X | | | | IP |
| PSI | | | | | | X | | | X | | | | | | | | |
| WorldVision | | | | | | | | | | | | | | | X | | |
| Media for Development International | | X | | | | | | | X | | | | | | | | |
| PATH | | X | | X | X | | X | | X | | | | | | | | |
| Catholic Relief Services | | | X | X | | | X | | X | | | | | | X | | |
| IPPF/WHR | | | | X | | | | | | | | | | | | | |
| Center for AIDS Prevention Studies | | | | | | | | | | | X | | | X | | | |
| CARE | | | | | | | | | | | | | | | | | Increasing access to and use of clinical services |
| Civil/Military Alliance to Combat HIV/AIDS | X | | | X | | | | X | | | | X | | X | | | |

**KEY:**

| | | | |
|---|---|---|---|
| **Advoc.** | Advocacy | **MTCT** | Mother to Child Transmission activities |
| **BCI** | Behavior Change Intervention | **Research** | HIV/AIDS research activities |
| **Care/S** | Care & Support Activities | **Policy** | Policy monitoring or development |
| **Training** | HIV/AIDS training programs | **STD** | STD services or drug distribution |
| **Cond.** | Condom Distribution | **VCT** | Voluntary counseling and testing |
| **SM** | Social Marketing | **Orphan** | AIDS orphan activities |
| **Eval.** | Evaluation of several projects | **TB** | TB control |
| **HR** | Human Rights activities | **Other** | (i.e. blood supply, etc ). |
| **IEC** | Information, education, communication activities | | |

*United Republic of Tanzania*

# Epidemiological Fact Sheet

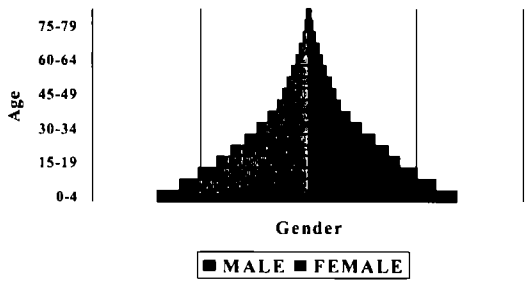
## on HIV/AIDS and sexually transmitted diseases

UNAIDS
UNICEF • UNDP • UNFPA
UNESCO • WHO • WORLD BANK

World Health Organization

# Country information

## Population pyramid, 1997




| Indicators | Year | Estimate | Source |
|---|---|---|---|
| Total Population (thousands) | *1997* | 31,507 | UNPOP |
| Population Aged 15-49 (thousands) | *1997* | 14,347 | UNPOP |
| Annual Population Growth | | | |
| % of Population Urbanized | *1996* | 25 | UNPOP |
| Average Annual Growth Rate of Urban Population | *1980-1996* | 7 | UNPOP |
| Net Migration Rate | | | |
| GNP Per Capita (US$) | *1995* | 120 | World Bank |
| GNP Per Capita Average Annual Growth Rate | *1985-1995* | 1 | World Bank |
| Human Development Index Rank (HDI) | | 149 | UNDP |
| Real GDP Per Capita Rank - HDI Rank | | 21 | UNDP |
| Gender Related Development Index Rank | | 123 | UNDP |
| Gender Empowerment Measure Rank | | | |
| Human Poverty Index Value (HPI) | | 39.7 | UNDP |
| % Population Economic Active | | | |
| Unemployment Rate | | | |
| Total Adult Literacy Rate | | | |
| Adult Male Literacy Rate | | | |
| Adult Female Literacy Rate | | | |
| Male Secondary School Enrollment Ratio | *1990-1995* | 6 | UNESCO |
| Female Secondary School Enrollment Ratio | *1990-1995* | 5 | UNESCO |
| Crude Birth Rate (births per 1,000 pop.) | *1996* | 42 | UNPOP |
| Crude Death Rate (deaths per 1,000 pop.) | *1996* | 14 | UNPOP |
| Maternal Mortality Rate (per 100,000 live births) | *1990* | 770 | WHO/UNICEF |
| Life Expectancy at Birth | *1996* | 51 | UNPOP |
| Total Fertility Rate | | | |
| Infant Mortality Rate (per 1,000 live births) | *1996* | 93 | UNICEF/UNPOP |
| Under Five Mortality Rate (per 1,000 live births) | *1996* | 144 | UNICEF/UNPOP |
| % Population Access to Safe Water | | | |
| % Population Access to Adequate Sanitation | | | |

Contact address:
UNAIDS/WHO Working Group on Global HIV/AIDS and STD Surveillance
20, Avenue Appia
CH - 1211 Geneva 27
Switzerland
Fax: +41-22-791-4878
e-mail: Surveillance@UNAIDS.org
http://www.who.ch/emc/diseases/hiv
http://www.unaids.org

## UNAIDS/WHO Working Group on Global HIV/AIDS and STD Surveillance

Global surveillance of HIV/AIDS and sexually transmitted diseases (STDs) is a joint effort of WHO and UNAIDS. The UNAIDS/WHO Working Group on Global HIV/AIDS and STD Surveillance, initiated in November 1996, guides respective activities. The primary objective of the working group is to strengthen national, regional and global structures and networks for improved monitoring and surveillance of HIV/AIDS and STDs. For this purpose, the working group collaborates closely with national AIDS programmes and a number of national and international experts and institutions. The goal of this collaboration is to compile the best information available and to improve the quality of data needed for informed decision-making and planning at national, regional and global levels. The Epidemiological Fact Sheets are a first output of this close and fruitful collaboration across the globe.

Following a series of consultations, the working group and its partners established a framework standardizing the collection of data deemed important for a thorough understanding of the current status and trends of the epidemic, as well as patterns of risk and vulnerability in the population. Within this framework, the Fact Sheets collate the most recent country-specific data on HIV/AIDS prevalence and incidence, together with information on behaviours (e.g. casual sex and condom use) which can spur or stem the transmission of HIV. The data include prevention indicators developed by WHO's Global Programme on AIDS, which aim to measure trends in knowledge of AIDS, relevant behaviours, and a host of other factors influencing the epidemic. Additional indicators – for example, on care and support -- will be included when available.

Not unexpectedly, information on all of the agreed-upon indicators was not available for many countries in 1997. However, the fact sheets do contain a wealth of information which allows identification of strengths in currently existing programmes and comparisons between countries and regions. The fact sheets may also be instrumental in identifying potential partners when planning and implementing improved systems.

The fact sheets can be only as good as information made available to the UNAIDS/WHO Working Group on Global HIV/AIDS and STD Surveillance. Therefore, the working group would like to encourage all programme managers as well as national and international experts to communicate additional information to the working group whenever such information becomes available. The working group also welcomes any suggestions for additional indicators or information proven to be useful in national or international decision making and planning.

# Estimated number of people living with HIV/AIDS

In 1997 and during the first quarter of 1998, UNAIDS and WHO worked closely with national governments and research institutions to recalculate current estimates on people living with HIV/AIDS. These calculations are based on the previously published estimates for 1994 (WER 1995; 70:353-360) and recent trends in HIV/AIDS surveillance in various populations. Epimodel 2, a microcomputer programme originally developed by the WHO Global Programme on AIDS, was used to calculate the new estimates on prevalence and incidence of AIDS and AIDS deaths, as well as the number of children infected through mother-to-child transmission of HIV, taking into account age-specific fertility rates. An additional spreadsheet model was used to calculate the number of children whose mothers had died of AIDS.

The current estimates do not claim to be an exact count of infections. Rather, they use a methodology that has thus far proved accurate in producing estimates which give a good indication of the magnitude of the epidemic in individual countries. However, these estimates are constantly being revised as countries improve their surveillance systems and collect more information. This includes information about infection levels in different populations, and behaviours which facilitate or impede infection.

Adults in this report are defined as women and men aged 15 to 49. This age range covers people in their most sexually active years. While the risk of HIV infection obviously continues beyond the age of 50, the vast majority of those who engage in substantial risk behaviours are likely to be infected by this age. Since population structures differ greatly from one country to another, especially for children and the upper adult ages, the restriction of the term adult to 15-to-49-year-olds has the advantage of making different populations more comparable. This age range was used as the denominator in calculating adult HIV prevalence.

## Estimated number of adults and children living with HIV/AIDS, end of 1997

These estimates include all people with HIV infection, whether or not they have developed symptoms of AIDS, alive at the end of 1997

| | | | |
|---|---|---|---|
| **Adults and children** | **1400000** | | |
| **Adults (15-49)** | **1400000** | **Adult rate (%)** | **9.42** |
| **Women (15-49)** | **680000** | | |
| **Children (0-15)** | **68000** | | |

## Estimated number of AIDS cases

Estimated number of AIDS cases in adults and children that have occured since the beginning of the epidemic:

| | |
|---|---|
| **Cumulative no. of AIDS cases** | **1000000** |

## Estimated number of deaths due to AIDS

Estimated number of adults and children who died of AIDS since the beginning of the epidemic:

| | |
|---|---|
| **Cumulative deaths** | **940000** |

Estimated number of adults and children who died of AIDS during 1997:

| | |
|---|---|
| **Deaths in 1997** | **150000** |

## Estimated number of orphans

Estimated number of children who have lost their mother or both parents to AIDS (while they were under age 15) since the beginning of the epidemic:

| | |
|---|---|
| **Cumulative orphans** | **730000** |

Estimated number of children who have lost their mother or both parents to AIDS and who were alive and under age 15 at the end of 1997:

| | |
|---|---|
| **Current living orphans** | **520000** |

# HIV Sentinel surveillance

This section contains information about HIV prevalence in different populations. The data reported in the tables below are mainly based on the HIV data base maintained by the United States Bureau of the Census and are a compilation of data from different sources, including national reports, scientific publications and abstracts. To provide for a simple overview of the current situation and trends over time, summary data are given by population group, geographical area (Major Urban Areas versus Outside Major Urban Areas), and year of survey. Studies conducted in the same year are aggregated and the median prevalence rates (in percentages) are given for each of the categories. The maximum and minimum prevalence rates observed, as well as the total number of surveys/sentinel sites, are provided with the median, to give the reader an overview of the diversity of HIV-prevalence results in a given population within the country.

The differentiation between the two geographical areas Major Urban Areas and Outside Major Urban Areas is not based on strict criteria, such as the number of inhabitants. For most countries, Major Urban Areas were considered to be the capital city and – where applicable – other metropolitan areas with similar socio-economic patterns. This distinction assumes that capital cities in many countries have specific characteristics related to the prevalence of higher risk behaviour and a concentration of HIV infections. The term Outside Major Urban Areas considers that most sentinel sites are not located in strictly rural areas, even if they are located in somewhat rural districts. Site/study-specific data on which the medians were calculated are printed in an annex at the end of this fact sheet.

## HIV prevalence in selected populations in percent

| Group | Area | | 1984 | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Pregnant women | Major Urban Areas | N_Sites | | | 1 | | 1 | 1 | 1 | 2 | 1 | 2 | 1 | 2 | 1 | |
| | | Minimum | | | 3.7 | | 7.8 | 8.9 | 8.9 | 9.1 | 11 | 10.6 | 13.8 | 7.3 | 13.7 | |
| | | Median | | | 3.7 | | 7.8 | 8.9 | 8 9 | 9.7 | 11 | 13.35 | 13.8 | 9.75 | 13.7 | |
| | | Maximum | | | 3.7 | | 7.8 | 8.9 | 8 9 | 10.3 | 11 | 16 1 | 13.8 | 12.2 | 13.7 | |
| Pregnant women | Outside Major Urban Areas | N_Sites | | | | 1 | 11 | 10 | 8 | 15 | 20 | 18 | 13 | 14 | | |
| | | Minimum | | | | 6 | 1.7 | 0.4 | 2 4 | 2.3 | 3.5 | 1 | 5.1 | 0 | | |
| | | Median | | | | 6 | 5.5 | 9.85 | 10.5 | 9 | 9.85 | 11.55 | 15 | 9 6 | | |
| | | Maximum | | | | 6 | 11 | 21.2 | 22.2 | 21 | 30 4 | 27.2 | 27 5 | 32 5 | | |

| Group | Area | | 1984 | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Sex workers | Major Urban Areas | N_Sites | | | 1 | | 1 | 1 | 1 | 1 | | 1 | | | | |
| | | Minimum | | | 29 | | 42.1 | 43.7 | 45 | 42.9 | | 49.5 | | | | |
| | | Median | | | 29 | | 42.1 | 43 7 | 45 | 42 9 | | 49.5 | | | | |
| | | Maximum | | | 29 | | 42.1 | 43.7 | 45 | 42.9 | | 49.5 | | | | |
| Sex workers | Outside Major Urban Areas | N_Sites | | | | | 6 | | | | 1 | 1 | | | | |
| | | Minimum | | | | | 7.5 | | | | 39.8 | 60.9 | | | | |
| | | Median | | | | | 19.05 | | | | 39.8 | 60.9 | | | | |
| | | Maximum | | | | | 31.9 | | | | 39.8 | 60.9 | | | | |

| Group | Area | | 1984 | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Injecting drug users | Major Urban Areas | N_Sites | | | | | | | | | | | | | | |
| | | Minimum | | | | | | | | | | | | | | |
| | | Median | | | | | | | | | | | | | | |
| | | Maximum | | | | | | | | | | | | | | |

| Group | Area | | 1984 | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Military | Major Urban Areas | N_Sites | | | | | | | | | | | 1 | | | |
| | | Minimum | | | | | | | | | | | 12.9 | | | |
| | | Median | | | | | | | | | | | 12.9 | | | |
| | | Maximum | | | | | | | | | | | 12.9 | | | |

| Group | Area | | 1984 | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| STD patients | Major Urban Areas | N_Sites | | | 2 | 1 | 1 | 1 | 1 | 2 | 1 | | | | | |
| | | Minimum | | | 9.3 | 13.4 | 21 8 | 28.3 | 24.5 | 16.1 | 14.4 | | | | | |
| | | Median | | | 11.25 | 13.4 | 21.8 | 28.3 | 24.5 | 17.3 | 14.4 | | | | | |
| | | Maximum | | | 13.2 | 13.4 | 21.8 | 28.3 | 24.5 | 18.5 | 14.4 | | | | | |
| STD patients | Outside Major Urban Areas | N_Sites | | | | 1 | | 1 | | | | | | | | |
| | | Minimum | | | | 20 | | 21.4 | | | | | | | | |
| | | Median | | | | 20 | | 21.4 | | | | | | | | |
| | | Maximum | | | | 20 | | 21.4 | | | | | | | | |

| Group | Area | | 1984 | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Truck drivers | Major Urban Areas | N_Sites | | | | | | | | 1 | 1 | 1 | | | | |
| | | Minimum | | | | | | | | 31 | 27.5 | 22 | | | | |
| | | Median | | | | | | | | 31 | 27.5 | 22 | | | | |
| | | Maximum | | | | | | | | 31 | 27.5 | 22 | | | | |

# Assessment of epidemiological situation

## Assessment of country epidemiological situation

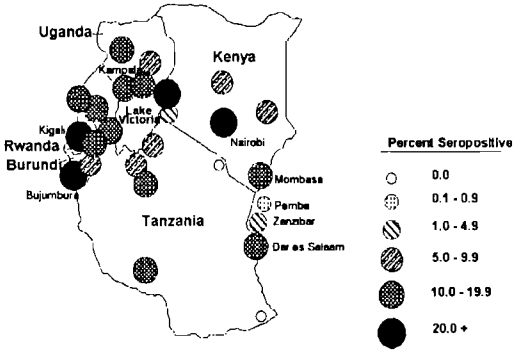
HIV information among antenatal clinic attendees has been available from Tanzania since the mid-1980s. In Dar es Salaam, the major urban area, HIV prevalence among antenatal clinic attendees tested increased from 4 percent in 1986 to 14 percent in 1995-96. Age detail is available for 1989 and 1995-96. In 1995-96, 7 percent of antenatal clinic attendees less than 20 years of age tested were HIV positive. Peak infection occurred among the 25-29 year old clinic attendees. Outside of Dar es Salaam, HIV information is available from sentinel surveillance reporting and from additional special studies. Median HIV prevalence increased from 6 percent in 1987 to 15 percent in 1994. In 1995, median HIV prevalence among antenatal clinic attendees tested in the 14 reporting sites was 10 percent ranging from no evidence of HIV infection to 33 percent. In Zanzibar and Pemba Island, HIV information on antenatal clinic attendees was available since the late-1980s. HIV prevalence among antenatal clinic attendees increased from less than one percent in 1987 to nearly two percent in 1993. In 1994, less than one percent of women tested on Pemba Island were HIV positive.

Information on HIV prevalence among sex workers in Dar es Salaam has been available since the mid-1980s. HIV prevalence among sex workers tested increased from 29 percent in 1986 to 50 percent in 1993. Outside of Dar es Salaam, HIV information on sex workers is available from Kilimanjaro, Arusha, Moshi, Tanga, Dodoma, and Singida in 1988. Median HIV prevalence among sex workers tested in these areas was 19 percent, ranging from 8 to 32 percent. In 1992, 40 percent of sex workers tested in Mwanza town were HIV positive and in 1993, 61 percent of sex workers in Morogoro were HIV positive.

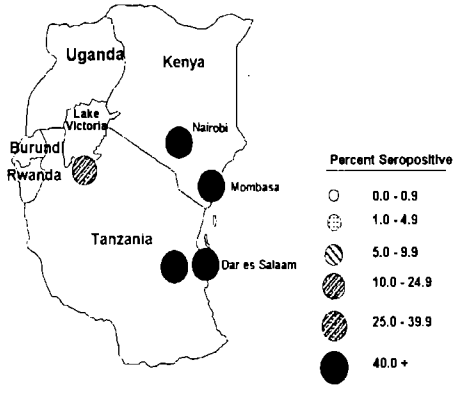
In Dar es Salaam, HIV prevalence among male STD clinic patients tested increased from 11 percent in 1986 to 28 percent in 1989. Outside of Dar es Salaam, 20 percent of male STD patients tested in Kagondo in 1986-87 were HIV positive. In 1988-89, 21 percent of male STD clinic patients tested in Mbeya were HIV positive.

## Regional maps

**Seroprevalence of HIV-1 for Pregnant Women East Africa**




**Seroprevalence of HIV-1 for Sex Workers East Africa**



# Reported AIDS cases

## AIDS cases by year of reporting

| 1979 | 1980 | 1981 | 1982 | 1983 | 1984 | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 | Total | Unknown |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0 | 0 | 0 | 0 | 3 | 106 | 295 | 1121 | 2937 | 4839 | 5096 | 11106 | 18692 | 15871 | 13506 | 5873 | 3909 | 5313 | | | 88667 | |

Date of last report: 31-Dec-1996

AIDS cases officially reported to WHO. Due to gaps in diagnosis, underreporting, and reporting delays, officially reported AIDS cases represent only a portion of all cases in a country. Completeness of reporting varies substantially from one country to another, from less than 10% in some countries with fewer resources to more than 80% in most industrialized countries (please also compare with the section on estimates). Therefore, distribution by age, sex and modes of transmission may not be representative for all people living with AIDS in a given country.

## AIDS cases by mode of transmission

Hetero: Heterosexual contacts.
Homo/Bi: Homosexual contacts between men.
IDU: Injecting drug use. This transmission category also includes cases in which other high-risk behaviours were reported, in addition to injection of drugs.
Blood: Blood and blood products.
Perinatal: Vertical transmission during pregnancy, birth or breastfeeding.
NS: Not specified/unknown.

| Sex | Trans. group | <94 | 94/<95 | 1995 | 1996 | 1997 | 1998 | Unkn. | Total | % |
|---|---|---|---|---|---|---|---|---|---|---|
| All | All | | | | 5313 | | | | | |
| | Hetero | | | | 4079 | | | | | |
| | Homo/Bi | | | | 0 | | | | | |
| | IDU | | | | 0 | | | | | |
| | Blood | | | | 63 | | | | | |
| | Perinatal | | | | 207 | | | | | |
| | Other known | | | | 0 | | | | | |
| | Unknown | | | | 964 | | | | | |
| Male | All | | | | | | | | | |
| | Hetero | | | | 1879 | | | | | |
| | IDU | | | | 0 | | | | | |
| | Blood | | | | 31 | | | | | |
| | Other known | | | | 0 | | | | | |
| | Unknown | | | | 0 | | | | | |
| Female | All | | | | | | | | | |
| | Hetero | | | | 2154 | | | | | |
| | IDU | | | | 0 | | | | | |
| | Blood | | | | 31 | | | | | |
| | Other known | | | | 0 | | | | | |
| | Unknown | | | | 0 | | | | | |
| NS | All | | | | | | | | | |
| | Hetero | | | | 46 | | | | | |
| | IDU | | | | 0 | | | | | |
| | Blood | | | | 1 | | | | | |
| | Perinatal | | | | 207 | | | | | |
| | Other known | | | | 0 | | | | | |
| | Unknown | | | | 964 | | | | | |

## AIDS cases by age and sex

| Sex | Age | <1994 | 94/<95 | 1995 | 1996 | 1997 | 1998 | Unkn. | Total | % |
|---|---|---|---|---|---|---|---|---|---|---|
| All | All | | | | | | | | 67146 | 100% |
| | 0-4 | | | | | | | | 2982 | 4% |
| | 5-14 | | | | | | | | 734 | 1% |
| | 15-19 | | | | | | | | 2419 | 4% |
| | 20-29 | | | | | | | | 24784 | 37% |
| | 30-39 | | | | | | | | 22441 | 33% |
| | 40-49 | | | | | | | | 7893 | 12% |
| | 50-59 | | | | | | | | 2025 | 3% |
| | 60+ | | | | | | | | 544 | 1% |
| | NS | | | | | | | | 3324 | 5% |
| Male | All | | | | | | | | 32681 | 100% |
| | 0-4 | | | | | | | | 1594 | 5% |
| | 5-14 | | | | | | | | 314 | 1% |
| | 15-19 | | | | | | | | 516 | 2% |
| | 20-29 | | | | | | | | 9259 | 28% |
| | 30-39 | | | | | | | | 12643 | 39% |
| | 40-49 | | | | | | | | 5489 | 17% |
| | 50-59 | | | | | | | | 1525 | 5% |
| | 60+ | | | | | | | | 423 | 1% |
| | NS | | | | | | | | 918 | 3% |
| Female | All | | | | | | | | 32907 | 100% |
| | 0-4 | | | | | | | | 1381 | 4% |
| | 5-14 | | | | | | | | 415 | 1% |
| | 15-19 | | | | | | | | 1899 | 6% |
| | 20-29 | | | | | | | | 15505 | 47% |
| | 30-39 | | | | | | | | 9762 | 30% |
| | 40-49 | | | | | | | | 2396 | 7% |
| | 50-59 | | | | | | | | 497 | 2% |
| | 60+ | | | | | | | | 117 | 0% |
| | NS | | | | | | | | 935 | 3% |
| NS | All | | | | | | | | 1558 | 100% |
| | 0-4 | | | | | | | | 7 | 0% |
| | 5-14 | | | | | | | | 5 | 0% |
| | 15-19 | | | | | | | | 4 | 0% |
| | 20-29 | | | | | | | | 20 | 1% |
| | 30-39 | | | | | | | | 36 | 2% |
| | 40-49 | | | | | | | | 8 | 1% |
| | 50-59 | | | | | | | | 3 | 0% |
| | 60+ | | | | | | | | 4 | 0% |
| | NS | | | | | | | | 1471 | 94% |

# Curable STDs

Control and prevention of sexually transmitted diseases (STD) have been recognized as a major strategy in the prevention of HIV infection and ultimately AIDS. Consequently, monitoring different components of STD control can also provide information on HIV prevention within a country. One of the cornerstones of STD control is adequate management of patients with symptomatic STDs. This includes diagnosis, treatment, and individual health education and counselling on disease prevention and partner notification.

## Estimated incidence and prevalence of curable STDs

| | Incidence | | | | Prevalence | | | |
|---|---|---|---|---|---|---|---|---|
| **STDs** | Year | Male | Female | All | Year | Male | Female | All |
| Chlamydia trach. | | | | | | | | |
| Gonorrhoea | | | | | | | | |
| Syphilis | | | | | | | | |
| Trichomonas | | | | | | | | |
| **Comments** | This data is not available, current data based on syndromatic mgmt. | | | | This data is not available Current data is based on Syndromatic case management. | | | |
| **Source** | | | | | | | | |

## STD Incidence, men

Prevention Indicator 9: Proportion of men aged 15-49 years who reported episodes of urethritis in the last 12 months.

| Year | Area | Age | Rate | N= |
|---|---|---|---|---|
| 1996 | All | 15-49 | 2 2 | |

Comments: 2.2% is for any STDs. For Syphilis it is 0.6% and for Gonorrhea it is 1.4%.

Sources: Tanzania Demographic Health Surveys TDHS

## STD Prevalence, women

Prevention Indicator 8: Proportion of pregnant women aged 15-24 years attending antenatal clinics whose blood has been screened with positive serology for syphilis.

| Year | Area | Age | Rate | N= |
|---|---|---|---|---|
| 1996 | All | 15-24 | 5.3 | 1615 |

Comments: The data are from one region where surveillance data for pregnant women has been collected from time to time. The data can be a representative of an actual situation within the country since they are collected both rural and urban areas.

Sources: National AIDS Control Programme HIV/AIDS/STD Surveillance report no. 11

## STD Case management (counselled)

Prevention Indicator 7: Proportion of people presenting with STD or for STD care in health facilities who received basic advice on condoms and on partner notification.

| Year | Area | Age | Rate | N= |
|---|---|---|---|---|
| 1994 | All | All | 82.2 | |

Comments: PPI7-Advise on Condoms: 86.3%; PPI7-Participation notification: 95.2%. Final PPI7 score 120/146=82.2%

Sources: PPI 6&7 Survey. National AIDS Control Programme/WHO 1994

## STD Case management (treatments)

Prevention Indicator 6: Proportion of people presenting with STD in health facilities assessed and treated in an appropriate way (according to national standards).

| Year | Area | Age | Rate | N= |
|---|---|---|---|---|
| 1994 | All | All | 5.5 | |

Comments: PPI-Correct History: 91.8%; Correct Examination: 51.4%; Correct Treatment: 6.2%

Sources: PPI 6&7 Survey. National AIDS Control Programme/WHO 1994

# Health service indicators

HIV-prevention strategies depend on the twin efforts of care and support for those living with HIV or AIDS, and targeted prevention for all people at risk or vulnerable to the infection. These efforts may range from reaching out to vulnerable communities through large-scale educational campaigns or interpersonal communication; provision of treatment for STDs; distribution of condoms and needles; creating an enabling environment to reduce risky behaviour; voluntary testing and counselling; home or institutional care for persons with symptomatic HIV infection; and preventing perinatal transmission and transmission through infected needles or blood in health care settings. It is difficult to capture such a large range of activities with one or just a few indicators. However, a set of well-established health care indicators -- such as the percentage of a population with access to health care services; the percentage of women covered by antenatal care; or the percentage of immunized children -- may help to identify general strengths and weaknesses of health systems. Specific indicators, such as access to testing and blood screening for HIV, help to measure the capacity of health services to respond to HIV/AIDS-related issues.

## Access to health care

| Indicators | Year | Estimate | Source |
|---|---|---|---|
| % of Pop. with access to health services - total: | | | |
| % of Pop. with access to health services - urban: | | | |
| % of Pop. with access to health services - rural: | | | |
| Contraceptive prevalence rate (%): | | | |
| % of births attended by trained health personnel: | | | |
| % of pregnant women immunized against tetanus: | *1995-1996* | 92 | UNICEF |
| % fully immunized - Tuberculosis. | *1995-1996* | 96 | UNICEF |
| % fully immunized - DPT: | *1995-1996* | 85 | UNICEF |
| % fully immunized - Polio: | *1995-1996* | 80 | UNICEF |
| % fully immunized - Measles: | *1995-1996* | 81 | UNICEF |
| Proportion of blood donations tested: | | | |
| % of ANC clinics where HIV testing is available: | | | |
| HIV/AIDS Hospital Occupancy Rate (Days): | | | |

Latex condoms are the only technology available that can prevent sexual transmission of HIV/STD. Persons needing protection in situations that carry risk should have consistent access to high quality condoms. National AIDS Programmes implement activities to increase both availability of and access to condoms. The two condom availability indicators below are intended to highlight areas of strength and weakness at the beginning and at the end of the distribution system so that programmatic resources can be directed appropriately to problem areas.

## Condom availability (central level)

Prevention Indicator 2: Availability of condoms per capita in the country over the last 12 months (central level).

| Year | Area | N | Rate |
|---|---|---|---|
| 1996 | All | | 3 |

Comments:
Sources: Tanzania AIDS Project, Family Planning Unit and National AIDS Control Programme. 1996.

## Condom availability (peripheral level)

Prevention Indicator 3: Proportion of people who can acquire a condom (peripheral level).

| Year | Area | N | Rate |
|---|---|---|---|
| 1996 | All | | 3 |

Comments: The policy is that in every 50 m there should be a condom available.
Sources: Tanzania AIDS Project, Family Planning Unit and National AIDS Control Programme, 1996

# Knowledge and behaviour

Information on knowledge and behaviour related to HIV/AIDS is essential in identifying populations at risk for HIV infection. It is also critical in assessing changes over time as a result of prevention efforts. Guidelines and recommendations have been published in the publication: "Evaluation of a National AIDS Programme: A methods package. 1. Prevention of HIV infection. WHO/GPA/TCO/SEF/94.1 Geneva, 1994".

## Knowledge of HIV-related preventive practices

Prevention Indicator 1: Proportion of people citing at least two acceptable ways of protection from HIV infection.

| Year | Area | Age group | Male | Female | All |
|---|---|---|---|---|---|
| 1996 | All | 15-19 | 78.6 | 65.1 | 68.1 |
| 1996 | All | 20-24 | 76.6 | 81 | 80.1 |
| 1996 | All | 25-49 | 75.9 | 78.4 | 77.9 |
| 1996 | All | 15-49 | 76.1 | 76.4 | 76.3 |

Comments: Data are for those who can cite at least ONE way of avoiding AIDS.

Sources: Tanzania Demographic Health Surveys TDHS

## Reported non-regular sexual partnerships

Prevention Indicator 4: Proportion of sexually active people having at least one sex partner other than a regular partner in the last 12 months.

| Year | Area | Age group | Male | Female | All |
|---|---|---|---|---|---|
| 1990 | All | 15-19 | 80.5 | 39.1 | |
| 1990 | All | 20-24 | 67.9 | 20 | |
| 1990 | All | 25-39 | 31.5 | 15.1 | |
| 1990 | All | 40-49 | 23 | 10.3 | |
| 1990 | All | 15-49 | 45.4 | 19.3 | |
| 1996 | All | 15-19 | 25.7 | 11.6 | |
| 1996 | All | 20-24 | 49.4 | 18.3 | |
| 1996 | All | 25-49 | 24.6 | 12.1 | |
| 1996 | All | 15-49 | 29.1 | 12.9 | |

Comments: Over-representation of women.

Sources: KABP/Behavioural Studies - GPA, 1993, Demographic Health Survey, 1996.

## Reported condom use in risk sex (gen pop)

Prevention Indicator 5: Proportion of people reporting the use of a condom during the most recent intercourse of risk.

| Year | Area | Age group | Male | Female | All |
|---|---|---|---|---|---|
| 1996 | All | 15-19 | 25.4 | 18.7 | 15.9 |
| 1996 | All | 20-24 | 40.3 | 21.9 | 29.1 |
| 1996 | All | 25-49 | 33.8 | 14.4 | 22.1 |
| 1996 | All | 15-49 | 34.8 | 17.2 | 23.7 |

Comments:

Sources: Tanzania Demographic Health Surveys TDHS, 1996

# Knowledge and behaviour

## Ever use of condom

Percentage of people who ever used a condom.

| Year | Area | Age group | Male | Female | All |
|---|---|---|---|---|---|
| 1992 | All | 15-19 | | 1.8 | |
| 1992 | All | 20-24 | | 6.2 | |
| 1992 | All | 25-29 | | 3.7 | |
| 1992 | All | 30-34 | | 4.8 | |
| 1992 | All | 35-39 | | 3.7 | |
| 1992 | All | 40-44 | | 2.6 | |
| 1992 | All | 45-49 | | 0.8 | |
| 1992 | All | Total | | 3.6 | |
| 1996 | All | 15-19 | 10 | 3.5 | |
| 1996 | All | 20-24 | 26.8 | 10.7 | |
| 1996 | All | 25-29 | 26.6 | 8.9 | |
| 1996 | All | 30-34 | 25.7 | 8.3 | |
| 1996 | All | 35-39 | 20.5 | 6.7 | |
| 1996 | All | 40-44 | 14.3 | 5 | |
| 1996 | All | 45-49 | 8.1 | 1.9 | |
| 1996 | All | Total | 18.1 | 7 | |

Comments: All women

Sources: Demographic and Health Survey

## Median age at first sexual intercourse

Median age of people at which they first had sexual intercourse.

| Year | Area | Age group | Male | Female | All |
|---|---|---|---|---|---|
| 1996 | All | 20-24 | 17.8 | 17.4 | |
| 1996 | All | 25-49 | 18 | 16.7 | |
| 1996 | All | 45-49 | 18.1 | 16.6 | |

Comments:

Sources: Tanzania Demographic Health Surveys TDHS, 1996

## Adolescent pregnancy

Percentage of teenagers 15-19 who are mothers or pregnant with their first child.

| Year | Area | Age group | Rate | N |
|---|---|---|---|---|
| 1996 | All | 15 | 1.3 | 288 |
| 1996 | All | 15-17 | 10.3 | 1039 |
| 1996 | All | 16 | 11.2 | 408 |
| 1996 | All | 17 | 39.2 | 343 |

Comments:

Sources: Tanzania Demographic Health Surveys TDHS, 1996

## Reported condom use in risk sex (MSM)

| Year | Area | Age group | Male | All |
|---|---|---|---|---|
| n/a | | 15-49 | | |

Comments: Although sex between men and men at present is available in Tanzania; there is no statistical evidence which analysis its magnitude and no information with regard to the way it is practiced.

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# Annex: HIV Surveillance data by site

| Group | Area | | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Pregnant women | Outside Major Urban Areas | Arusha | | | | 5 5 | | | | | 1 | | | | |
| | | Bukoba | | | | | | 22.2 | 20 | 27.7 | | 17.3 | | | |
| | | Dodoma | | | | 3 | | | | | | | | | |
| | | Iringa | | | | | | | 21 | 25 | | | | | |
| | | Kilimanjaro | | | | | | | 2.3 | 6 4 | 15.8 | | 0 | | |
| | | Lindi | | | | | 0 4 | | | | | | | | |
| | | Mara (2) | | | | | | | 5.9 | 6 5 | 7.7 | | | | |
| | | Mara(1) | | | | | | | | | | | 7.2 | | |
| | | Mbeya(1) | | | | 10.3 | 16.9 | 12.2 | 15.3 | 25 | 23.3 | 19.6 | 10.5 | | |
| | | Mbeya(2) | | | | 11 | 7.3 | 8.5 | 9.5 | 17 | 13.7 | 16 | 10 3 | | |
| | | Mbeya(3) | | | | 7 | 10.6 | 14.6 | 17.5 | 11 | 22.3 | 19.5 | 14.8 | | |
| | | Mbeya(4) | | | | 2.9 | 21.2 | 2.4 | 3.9 | 5.3 | 10.7 | 16 | 17.5 | | |
| | | Mbeya(5) | | | | 1.7 | 6.3 | 8 8 | 6.6 | 30.4 | 10.8 | 15 | 32.5 | | |
| | | Mbeya(6) | | | | 4.2 | 9.1 | 6.4 | 12.9 | 18 | 27.2 | 5.1 | 13.9 | | |
| | | Mbeya(7) | | | | | 12 | | | 8 | 8 5 | 8 | 20 3 | | |
| | | Mbeya(8) | | | | | 2 | | | 8 | 15.5 | 27.5 | | | |
| | | Mbeya(9) | | | | | | | | | | 13 | | | |
| | | Mtwara | | | | | | | 4.4 | | | | 0 | | |
| | | Mwanza region | | | 6 | | | | | | | | | | |
| | | Mwanza(1) | | | | 8 | 11.7 | 12.3 | 11.2 | 10 | 12.3 | 11.7 | 8.9 | | |
| | | Mwanza(2) | | | | | | | 3.7 | 4.6 | 5 4 | 5 5 | 5.4 | | |
| | | Mwanza(3) | | | | | | | 3 7 | 3.9 | 5.5 | | 5.4 | | |
| | | Mwanza(4) | | | | | | | | | | | 8.7 | | |
| | | Rukwa(1) | | | | | | | | 12 | 23.2 | | | | |
| | | Rukwa(2) | | | | | | | | 11.3 | | | | | |
| | | Ruvuma(1) | | | | | | | | 9.7 | 16.1 | | | | |
| | | Ruvuma(2) | | | | | | | | 3.5 | 6.7 | | | | |
| | | Shinyanga | | | | | | | | | | 10.9 | | | |
| | | Singida | | | | 3.6 | | | | | | | | | |
| | | Tanga | | | | 7 | | | | | | | | | |
| | Major Urban Areas | Dar es Salaam(1) | | 3.7 | | 7.8 | 8.9 | 8.9 | 9 1 | 11 | 10 6 | 13 8 | 7.3 | 13.7 | |
| | | Dar es Salaam(2) | | | | | | | 10.3 | | 16.1 | | 12.2 | | |

| Group | Area | | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Sex workers | Outside Major Urban Areas | Arusha | | | | 18.6 | | | | | | | | | |
| | | Dodoma | | | | 19.5 | | | | | | | | | |
| | | Kilimanjaro | | | | 14.8 | | | | | | | | | |
| | | Morogoro | | | | | | | | | 60.9 | | | | |
| | | Moshi | | | | 31.9 | | | | | | | | | |
| | | Mwanza town | | | | | | | | 39.8 | | | | | |
| | | Singida | | | | 7.5 | | | | | | | | | |
| | | Tanga | | | | 25.7 | | | | | | | | | |
| | Major Urban Areas | | | | | | | | | | 49.5 | | | | |
| | | Dar es Salaam | | 29 | | 42.1 | 43.7 | 45 | 42.9 | | | | | | |

| Group | Area | | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Injecting drug users | Major Urban Areas | | | | | | | | | | | | | | |

| Group | Area | | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Military | Major Urban Areas | Dar es Salaam | | | | | | | | | | 12.9 | | | |

| Group | Area | | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| STD patients | Outside Major Urban Areas | Kagondo | | | 20 | | | | | | | | | | |
| | | Mbeya | | | | | 21 4 | | | | | | | | |
| | Major Urban Areas | Dar es Salaam(1) | | 13.2 | | | | | 18.5 | | | | | | |
| | | Dar es Salaam(1) | | 9.3 | 13.4 | 21.8 | 28.3 | 24.5 | 16.1 | 14.4 | | | | | |

| Group | Area | | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Truck drivers | Major Urban Areas | Not specified | | | | | | | 31 | 27.5 | 22 | | | | |

**Notes:**

# TANZANIA

U.S. Agency for International Development (USAID)
Population, Health, and Nutrition Briefing Sheet

## Country Profile

Tanzania, with the fifth largest population in sub-Saharan Africa, is among the poorest countries in the world. Decades of central control have left the nation with an inadequate and crumbling infrastructure and an over staffed and poorly paid civil service. Despite its limited financial resources, however, Tanzania stands at the forefront of multiethnic balance in a region racked with turmoil and instability. It may yet serve as an African model of democratic governance and a market-driven economy.

## USAID Strategy

USAID's family planning and health program in Tanzania is a nationwide initiative conducted in partnership with the Ministry of Health and emphasizes increasing private sector participation and improving conditions in rural areas. USAID support is designed to increase demand for and access to services for family planning, maternal and child health (MCH), and prevention of HIV/AIDS and other sexually transmitted infections (STIs). USAID addresses sustainability by promoting cost recovery to support clinical services under the Ministry of Health and nongovernmental organizations (NGOs).

## Major Program Areas

*Family Planning/Maternal and Child Health Services Support.* USAID supports improved reproductive health and child survival through information, education, and communications (IEC) activities; distribution of equipment, contraceptives,and other supplies; and extensive training to improve service quality in the public and private sectors. Contraceptive social marketing efforts are complemented by additional support from the British Department for International Development (DFID). Additional efforts focus on strengthening management; institution building in the Ministry of Health; and integrating services for family planning, child survival, women's health, and HIV/AIDS prevention at the service delivery level.

*HIV/AIDS Prevention and Support.* Working with Tanzania's National AIDS Control Program (NACP), USAID supports the development of networks of NGOs and other private entities undertaking HIV/AIDS activities (particularly those based at the workplace), dissemination of AIDS information, and condom social marketing. NGO activities include training for syndromic diagnosis and treatment of STIs, and support for people impacted by HIV/AIDS, especially orphans. The mission supports capacity building within the NACP and advocates for appropriate national level responses to HIV/AIDS.

## Results

- The use of modern contraceptives by married women in Tanzania doubled from 6 percent in 1991 to 12 percent in 1996, surpassing program expectations.
- There were 735 nurses trained in reproductive health clinical skills in 1996-97. In 1996, 69 percent of health facilities had at least one health provider trained in family planning and reproductive health skills in 1996, up from 24 percent in 1994.
- Availability of contraceptives increased in 90 percent of family planning facilities, with most having at least three methods in 1996, after nearly constant stockouts a few years earlier.
- Exclusive breastfeeding rates for infants younger than six months old tripled to 25 percent in 1996, up from less than 8 percent in 1991-92.
- More than 10 million condoms were sold annually in 1996-97, through an innovative marketing program using various media to promote HIV/AIDS prevention.
- More than 750 clinical officers were trained in syndromic management of STIs in 1996–97.

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Website:
www.info.usaid.gov/regions/afr/

- The NGO sector was recognized as a full partner in strategic planning efforts by the National AIDS Control Program, a direct result of the strong role NGOs have played, with USAID support, in community mobilization nationwide.

## Success Stories

USAID has played a critical leadership role in developing the family planning and health sector in Tanzania. USAID encouragement and coordination with other donors has led to additional support from DFID and German KFW to help meet the increasing demand for contraceptive commodities. Quality assurance guidelines and various integrated training curricula developed with USAID support are now fully used by other donors, NGOs, and government programs nationwide. USAID support for research and surveys produces a wide range of data that are used for family planning and health sector programming throughout Tanzania, as evidenced by the 1996 Demographic and Health Survey. USAID also serves on the steering committee for Tanzania's National Immunization Days, which have played an integral role in successful efforts to increase coverage against polio.

With USAID assistance, the curriculum and training materials for community-based contraceptive distribution agents were revised and expanded to include integrated reproductive health and child survival messages. To date, more than 2,000 educational flipcharts have been distributed to agents; these flipcharts contain exclusive breastfeeding, immunizations, growth monitoring, and nutrition messages. Other USAID-supported integrated IEC activities include expanding the radio program "Zinduka" (a Kiswahili term meaning "wake up") to include child survival and family planning messages, and developing an IEC "toolkit" for MCH nurses designed to improve counseling for mothers on immunizations, antenatal care, maternal and child nutrition, breastfeeding, family planning, and HIV/AIDS.

## Continuing Challenges

Rapid population growth, high infant and child mortality rates, and the heavy impact of HIV/AIDS on Tanzania's most productive age group continue to have grave social and economic consequences. On the positive side, however, the Government of Tanzania is undertaking major reforms in the civil service, health, and local government sectors. Tanzania's health sector reform activities aim to change the Ministry of Health's role from implementation to policy and regulation; develop a sectorwide program; and enhance district-level service delivery. USAID support for effective public health policy and improved health systems organization will be particularly important during Tanzania's transition to a new health system.

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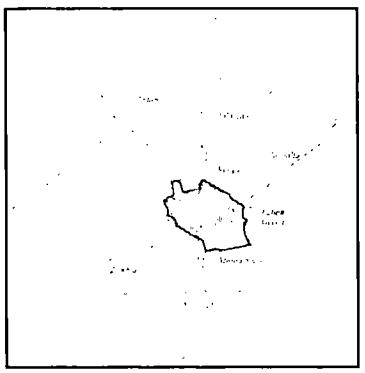
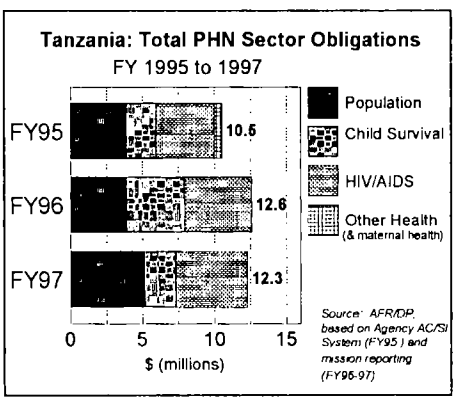
**USAID Country Program Brief, October 1998**
**Family Planning and Health Activities in**

# Tanzania



| | |
|---|---|
| Population: | 31.5 million (UN estimate for 1997) |
| Infant mortality rate: | 88 deaths per 1,000 births (1996 DHS) |
| Adequate nutrition (wt.-for-age): | 59% of children age 12–23 mos. (1996 DHS) |
| Total fertility rate: | 5.8 children per woman (1996 DHS) |
| Contraceptive prevalence rate: | 11.7% (all women/modern methods, 1996 DHS) |
| Demographic and Health Surveys: | 1991/92; 1994 (TKAPS); 1995 (in-depth); 1996 |
| Multi-indicator cluster survey: | 1996 (UNICEF) |

USAID/Tanzania is following a country strategic plan for 1997–2003 with the goal of promoting broad-based sustainable economic growth. The mission's family planning (FP) and health program is a nationwide initiative carried out in partnership with the Ministry of Health (MOH), but focuses on increasing private sector participation and improving conditions in rural areas in particular. Agencywide funding trends for FP and health activities in Tanzania for 1995–1997 are summarized in the figure to the right. The mission's results framework includes one strategic objective and two intermediate results (IRs) in family planning and health.




*Strategic Objective 1*: Increase use of FP and maternal and child health (MCH), and human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) preventive measures.

*IR 1.1:* Increase knowledge and availability of FP/MCH services.

*IR 1.2:* Increase knowledge and availability of HIV/AIDS information and services.

## Activities in Family Planning and Health

*Donor Coordination and Sector Leadership.* Quality assurance guidelines, a reproductive health and child survival skills curriculum, and a community-based distribution curriculum developed through USAID assistance are now fully utilized by other donors, nongovernmental organization (NGOs), and government programs. The mission has served on the steering committee for Tanzania's national immunization days (NIDs), playing an integral role in Tanzania's successful efforts to increase coverage against polio. Extensive USAID support for research and surveys have produced data for family planning and health sector programming.

*Family Planning/Maternal and Child Health Services Support.* USAID/Tanzania pursues improved reproductive health and child survival through information, education, and communication (IEC) activities; distribution of equipment, contraceptives, and other supplies; and training to improve service quality in the public and private sectors. Contraceptive social marketing efforts are complemented by support from DFID. Training in the MOH's Family Planning Unit (FPU) focuses on improving reproductive health and IEC capacity in the Lake Zone. The mission fully supports the integration of FP with MCH interventions, including integrated curricula for service providers and an IEC campaign that incorporates child survival and safe motherhood messages. National-level reproductive health training supported by the mission will now include a focus on child survival interventions, particularly in nutrition and the management of childhood illnesses.

*HIV/AIDS Prevention and Support.* Working with Tanzania's National AIDS Control Program (NACP), USAID/Tanzania supports the development of networks of indigenous NGOs and other private entities that are undertaking HIV/AIDS activities (particularly those based at the workplace), the dissemination of AIDS information in various media, and social marketing of condoms. Areas of NGO activity also include training for syndromic diagnosis and treatment for sexually transmitted infections (STIs) and support for those with HIV/AIDS, especially orphans. The mission supports capacity-

building within the NACP and advocates for appropriate responses to HIV/AIDS at the national level.

## Global Bureau and USAID/Tanzania Joint Programming Activities

**AIDS Control and Prevention Project** has sought to reduce the social and economic impact of HIV/AIDS on Tanzanian society through assistance to prevention and support activities. AIDSCAP promoted institutional development for more than 100 local NGOs providing IEC, community mobilization, and counseling services in high prevalence areas. Other activities include development of home care counseling manuals, STI education for pharmacists, and establishment of training sites for syndromic management and treatment of STIs.

**Population Services International** conducted social marketing of condoms as a subcontractor to the AIDSCAP Project. Future HIV/AIDS prevention activities will take place under the IMPACT Project.

**AVSC International** is working with the local family planning association, UMATI, to implement a nationwide service delivery system for long-term and permanent contraception. AVSC provides training to government surgeons, counselors, and clinicians.

**Center for the Development of Population Activities/Women's Empowerment** is promoting partnerships with local institutions to empower women in areas of reproductive health and economic policy. Demographic and Health Surveys, in conjunction with the Bureau of Statistics, has implemented and disseminated findings of the 1991/92 DHS; the 1994 Tanzania Knowledge, Attitudes, and Practices Survey; and the 1996 Tanzania DHS, which has been accepted as the official document of reference for family planning and health data.

**Family Planning Logistics Management Project** is assisting the National Family Planning Unit in commodity management and monitoring. FPLM is also developing and implementing a national strategy for regional and district-level training for national family planning program and National AIDS Control Program personnel.

**Johns Hopkins University** is helping the Ministry of Health to develop and disseminate FP/MCH messages.

**MEASURE 2/Evaluation Project**

**Pathfinder International** supports efforts of local NGOs and Dar es Salaam University to provide family planning, child survival, and HIV/AIDS services, initiating community-based distribution of FP/MCH services through the MOH as well as NGOs, and increasing access to contraceptive methods and family planning information through the Seventh Day Adventist Family Planning Services Project and the Organization of Tanzania Trade Unions.

**POLICY/RAPID IV Project** is providing assistance through the MOH, the Bureau of Statistics, and the Population Planning Unit of the Planning Commission to increase local capacity to manage integrated reproductive health programs.

**Population Council** is conducting research in support of the family planning program. Specific studies include a comparative assessment of various models of community-based distribution of services.

**Program for International Training in Health** (INTRAH/PRIME) has helped the government's Family Planning Unit to become capable of designing and implementing a nationwide training program. INTRAH has also adapted the family planning curriculum for clinic-based training to include modules on safe motherhood and child survival services.

**Program for Appropriate Technology in Health** seeks to decrease vaccine wastage through the use of vial monitors, which signal a color change when the vaccine has expired or been exposed to heat for too long.

## Bureau for Humanitarian Response, Office of Private & Voluntary Cooperation
### Child Survival Grantees in Tanzania as of 1998

**Africare** has a project through 2001 that includes a focus on micronutrients for improved child health.

**CARE** has a project through 2000 in Kwimba District focusing on prevention and control of HIV/AIDS as well as family planning and maternal and newborn care.

*This USAID Country Program Brief was prepared for the Human Resources Division, Office of Sustainable Development, USAID Africa Bureau (AFR/SD/HRD), by the Center for International Health Information (CIHI). Questions and comments can be directed to CIHI (info@cihi.com).*