# 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.


**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

# TANZANIA AND HIV/AIDS

## Country Profile

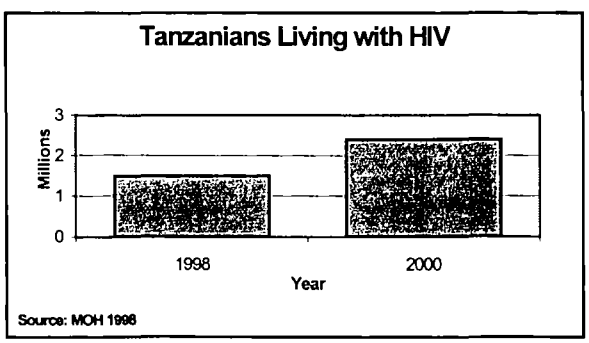
Tanzania is one of the few politically stable countries in East Africa; however, continued regional ethnic tensions and potential expansion of the conflict in the Great Lakes states threaten this stability. Tanzania is noted for accepting refugees displaced by the conflicts in neighboring Rwanda, Burundi, 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.

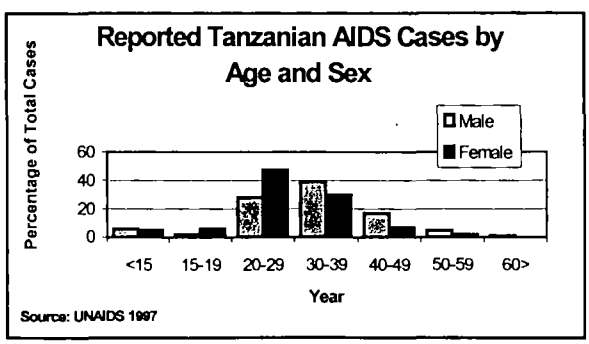
High rates of fertility (5.7) and sexually transmitted infections (STIs), including HIV/AIDS, contribute to elevated adult and infant morbidity and mortality rates in Tanzania. According to a 1996 Demographic and Health Survey (DHS), more than 43 percent of Tanzanian children under age 5 suffer from 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*

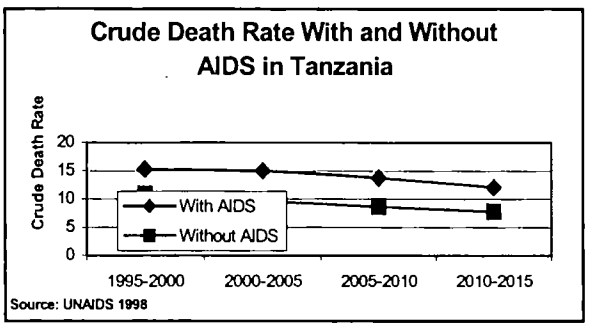
The first three AIDS cases were reported in Tanzania in 1983. Since then the HIV/AIDS epidemic in Tanzania has increased alarmingly each year. The epidemic is being driven by high-risk heterosexual sexual behavior characterized by high levels of STIs.

- 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.

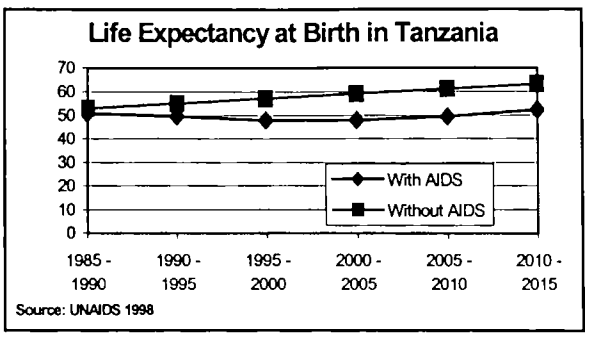


- From 1990 to 2010, AIDS will increase the crude death rate in Tanzania by more than 50 percent.




- 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*

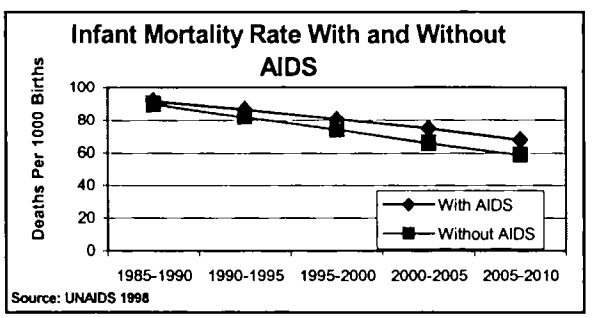
The number of women living with HIV/AIDS is growing. Women's low social and economic status, combined with greater biological susceptibility to HIV, put them at increased risk of infection. Deteriorating economic conditions, which make it difficult for women to access health and social services, compound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

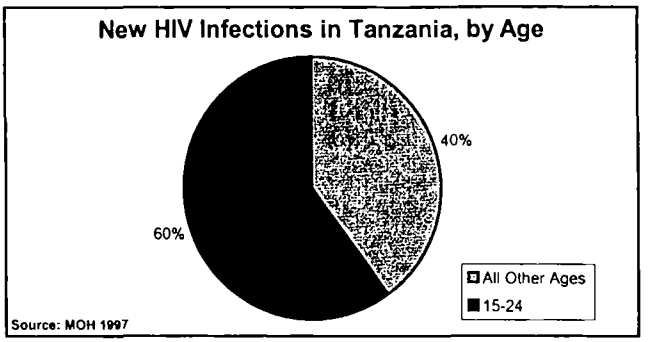



- An estimated 15 percent of all Tanzanian children under age 15 are missing one or both parents, many of them because of AIDS.
- To date, an estimated 730,000 children have been orphaned because of AIDS.

### *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:

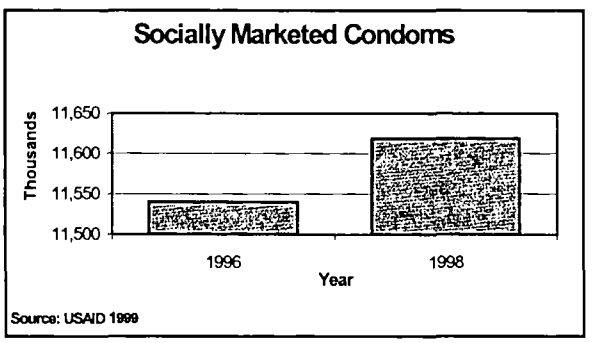
- Reviving under-resourced district AIDS coordination committees.
- Expanding district-level HIV/AIDS initiatives.
- Combating the recognized HIV-related stigma and denial of PLWHA in the clinic setting.

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*

# Tanzania

| | FY 1998 Actual | FY 1999 Estimate | FY 2000 Request |
|---|---|---|---|
| **Development Assistance** | $12,300,000 | $14,750,000 | --- |
| **Development Fund for Africa** | --- | --- | $16,150,000 |
| **Child Survival and Disease** | $7,400,000 | $6,900,000 | $7,300,000 |
| **Economic Support Fund** | --- | $9,231,000 | --- |
| **P.L. 480 Title II** | $10,623,000 | --- | --- |

**Introduction.**

The United States' national interests in Tanzania include stabilizing population growth, preventing the spread of HIV/AIDS, arresting environmental degradation, and promoting democracy, human rights, and broad-based national and regional economic growth. The United States also supports Tanzania's active role in resolving the multiple (and costly) crises afflicting the Great Lakes region. Since the launch of economic and political reforms in 1995, Tanzania has become a stronger development partner. It is a key East Africa country which, despite its limited financial resources, actively champions regional cooperation: 1) has set aside one-fourth of the world's most biologically diverse ecosystems in protected areas, 2) promotes private sector-led development, 3) is committed to democratic governance and a market driven economy, and 4) has a growing potential for attracting U.S. investment in its rich mineral and tourist sectors.

**The Development Challenge.**

Tanzania's challenges to development are formidable. Based on the severity of the problems faced by Tanzania, USAID expects to be involved in this country's economic development for at least the next decade. Over 50% of its 30 million people live in extreme poverty which is exacerbated by rapid population growth; high rates of transmitted diseases, including HIV/AIDS; unsustainable use of natural resources; and weak human and physical infrastructure. In addressing these problems, USAID is assisting the Government of Tanzania (GOT) to establish a foundation for sustainable growth and improved human welfare.

New policies, protocols, and planning tools have been developed and put in place by the Ministry of Health (MOH) with USAID assistance. Also, contraceptives, equipment and supplies have been provided to clinics. Over 5,200 public and private health providers have been trained in the areas of family planning (FP) and maternal and child health. Results to date include a doubling of modern contraceptive use in five years; availability of at least three FP methods at more than 90% of service delivery sites currently offering FP services; and an increase in the proportion of infants exclusively breast-fed.

USAID has assisted the GOT to develop a major new HIV/AIDS awareness and

prevention program involving over 180 NGOs. A program to promote social marketing of condoms has proved highly successful, with about 10 million units distributed in FY 1998.

USAID's environment program has assisted the GOT in strengthening the strategic planning capacity of the country's wildlife institutions which are addressing degradation issues in and around game reserves where population pressures are serious. USAID has improved GOT and donor coordination on key environmental issues; and facilitated the completion of an assessment, both internally and externally, of the economic opportunities available within the wildlife sector.

In the governance area, USAID has facilitated an increase in the transparency and professionalism of the judiciary through the introduction of Alternative Dispute Resolution (ADR) practices and a computerized court case flow management system. This system prevents tampering with records and increases transparency in the record keeping system. USAID has provided support to magistrates and judges through training and the provision of copies of the laws and for the Controller Auditor General's office where the GOT Auditing Act has been redrafted to introduce performance auditing.

USAID is working to improve the regulatory and tax environment for private sector-led growth and is providing business management skills through training and technical assistance to micro and small enterprises and business associations. Achievements to date include a restructuring of the financial sector which has resulted in an increase in the number of private financial institutions and in a more market driven economy. USAID has also contributed to the establishment of the Tanzania Revenue Authority, which has increased revenue collection by 45%; and has assisted in identifying and resolving procedural bottlenecks stifling the establishment of new firms.

USAID's successful infrastructure program has rehabilitated nearly 200 kilometers of district roads in the Iringa Region generating over 45,000 workdays of employment and contributing significantly to food security.

In FY 1998, USAID donated 20,000 MT of P.L. 480 Title II emergency food to defray suffering and hunger for over 1.4 million Tanzanians in regions facing food shortages due to drought. The El Nino rains which began in November 1997, resulted in only about 7,000 MT of the food being distributed through April 1998. However, another 7,000 MT was used later in 1998 to assist 150 villages in two regions where crops were destroyed by El Nino flooding and pests. The remaining 6,000 MT was transferred to the refugee food program in Tanzania. Also in response to the El Nino floods, USAID obligated $1 million in OFDA funds to repair rural roads destroyed by the heavy rains in five regions. As a result of the August 7, 1998 terrorist attack which killed 11 individuals and injured about 100 people in Tanzania, USAID will provide humanitarian assistance for bombing victims for rehabilitation and reconstruction of damaged infrastructure, and for building capacity within the GOT to better manage future disasters.

Tanzania's external debt is $8.2 billion of which less than $30 million (including $15 million of commercial debt) is owed to the United States. Almost all Tanzania bilateral debt owed to the United States (nearly $300 million) was cancelled between 1990 and 1993.

**Other Donors.**

In FY 1998, the United States ranked tenth among donors. Other donors include the World Bank ($180 million), the Netherlands (the largest bilateral donor providing about $100 million), European Union ($80 million), Japan ($60 million), Denmark ($54

million), Norway ($51 million), Sweden ($49 million), Germany ($43 million), and United Kingdom ($33 million). USAID and other donor programs are complementary with broad donor coordination achieved through monthly meetings held among the donors and regular consultations with GOT officials to discuss achievements, issues and results within each sector.

**FY 2000 Program.**

USAID will continue working with the GOT to improve family health through family planning, HIV/AIDS prevention and child survival interventions; arrest environmental degradation; as well as establish a more responsive legal and policy environment. These interventions encourage Tanzanian citizens and businesses to take private initiative, which increases their productivity and incomes. Also, USAID will continue to work with civil society to enhance public participation, accountability and the rule of law. USAID's program will emphasize broad based national and regional growth. It will build on the lessons learned and results achieved during the previous years, while effectively coordinating its efforts with those of other donors and the GOT to achieve measurable results.

# TANZANIA

## FY 2000 PROGRAM SUMMARY
## (in Thousands of Dollars)

| USAID Strategic and Special Objectives | Economic Growth & Agriculture | Population & Health | Environment | Democracy | Human Capacity Development | Humanitarian Assistance | TOTALS |
|---|---|---|---|---|---|---|---|
| S.O. 1 Increased Use of Family Plan/ Maternal and Child Health and HIV/AIDS Preventive Measures | | | | | | | |
| - DFA | --- | 3,900 | --- | --- | --- | --- | 3,900 |
| - CS | --- | 7,300 | --- | --- | --- | --- | 7,300 |
| S.O. 2 Foundation Established for Adoption of Environmentally Sustainable NRM Practices | | | | | | | |
| - DFA | --- | --- | 3,800 | --- | --- | --- | 3,800 |
| S.O. 3 Civil Society and Government: More Effective Partners | | | | | | | |
| - DFA | --- | --- | --- | 2,500 | --- | --- | 2,500 |
| S.O. 4 Increased Micro and Small Enterprise Participation | | | | | | | |
| - DFA | 3,000 | --- | --- | --- | --- | --- | 3,000 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| S.O. 5 Rural Roads Improved - DFA | 2,800 | --- | --- | --- | --- | --- | 2,800 |
| S.P.O. 1 Tanzania Bomb Victims - DFA | 150 | --- | --- | --- | --- | --- | 150 |
| **Totals:** | | | | | | | |
| - DFA | 5,950 | 3,900 | 3,800 | 2,500 | --- | --- | 16,150 |
| - CS | --- | 7,300 | --- | --- | --- | --- | 7,300 |

USAID Mission Director, Lucretia Taylor

---

## ACTIVITY DATA SHEET

**PROGRAM:** TANZANIA
**TITLE AND NUMBER:** Increased Use of Family Planning/Maternal and Child Health (FP/MCH) and HIV/AIDS Preventive Measures, 621-SO01
**STATUS:** Continuing
**PROPOSED OBLIGATION AND FUNDING SOURCE:** FY 2000 $3,900,000 DFA, $7,300,000 CS
**INITIAL OBLIGATION:** FY 1995 **ESTIMATED COMPLETION DATE:** FY 2003

**Summary:** This strategic objective was redesigned in FY 1999 with the object of promoting changes in health-seeking behavior and a reduction in harmful health practices in order to reduce high fertility rates, high risk births, infant mortality, and rising rates of HIV transmission. The program made excellent progress over its first five years resulting in an increase in contraceptive prevalence from approximately 6% to 12% of all women. However, after this initial dramatic rise it appeared that contraceptive use began to level off in 1996 mainly due to periodic shortages of contraceptives. In 1997, this problem was rectified when a major donor, the United Kingdom, agreed to increase its donation of contraceptives. In 1997, the amount of contraceptives distributed increased by 14% over the previous year indicating that use of family planning was once again on the rise. Use of various media to provide information on AIDS prevention and an innovative condom social marketing program have resulted in annual sales of over 10 million condoms. Knowledge of how to prevent the spread of HIV is improving, but reduction in high risk behavior is still not adequate to reduce HIV transmission. The direct beneficiaries of the USAID program are adults of reproductive age (15-49) with a special target group of low income families living in both urban and rural areas.

**Key Results:** Three key intermediate results are necessary to achieve this strategic objective: 1) The formulation of policies and laws addressing key issues in HIV/AIDS, reproductive health, malaria and other key infectious diseases must occur to improve access to quality reproductive and child health services. Voluntary organizations and community based groups are being trained in advocacy to mobilize political and civil service leaders for better reproductive and child health services; 2) Increased provision of quality reproductive and child health services through training of health providers, equipping selected private, voluntary and government facilities, provision of contraceptives; and improvements in management and cost recovery; 3) Improved customer knowledge and practices to mitigate against disease as well as the health services' ability to respond to customer needs which affect demand for services. Health education programs through radio, posters and special events and social marketing programs have increased both demand for reproductive health products and customer knowledge. Customer feedback surveys will be utilized to shape service delivery and

quality assurance programs focused on clients' rights to ensure that customer-focus is part of health service delivery.

**Performance and Prospects:** Performance over the past year has met expectations. The GOT is undertaking major reforms in the health sector, including decentralizing authority and responsibility to district government authorities in administering health services. This presents both a major challenge as well as opportunity to enhance the achievement of USAID program objectives over the coming years.

As centrally-managed programs are phased-out and districts assume responsibility for programs in family planning and HIV/AIDs, there may be a decline in services because districts may not allocate sufficient resources to these key health interventions or have the technical and managerial capability to administer them effectively. The district staff will require much technical support and training to assume new roles in resource allocation, planning, budgeting and management. USAID is targeting its public sector assistance to support capacity building of district health teams to facilitate effective decentralization of health support systems. An important area of focus is improving the ability of district authorities to manage drug and contraceptive supply systems and to monitor supply levels at health facilities. USAID will also work with voluntary agencies to improve their capacity to work with district authorities in the delivery of reproductive and child health activities. There may be opportunities for voluntary agencies to assume responsibilities that government cannot or to provide services on behalf of government such as supervision, quality assurance, training, advocacy or other managerial support. USAID's efforts will promote a public-private partnership in health care delivery with a significant amount of assistance going to the voluntary sector.

Short-term progress over the next two to three years may be impeded during the transition to a decentralized health service delivery system. However, the long term outlook is very promising, particularly the potential larger role for the private, voluntary sector in the delivery of reproductive and child health services.

**Possible Adjustments to Plans:** USAID has been in dialogue with the GOT to develop a cohesive and comprehensive program of support to the voluntary health sector. The result will be an increased role of the voluntary sector in the provision of quality reproductive and child health services in addition to an increased awareness and demand for these services. Given the goals of health sector reform, including the need to rationalize service delivery in Tanzania, the objective of the new program will be to encourage and support partnerships between government and a range of voluntary agencies for improved reproductive and child health services. Public sector support will be reviewed and restructured in the coming year, particularly given the achievement of results in reproductive health over the past five years. This will ensure that USAID support to the public sector continues to be strategically placed and supportive of health sector reforms which focus on promoting policy and regulatory roles at the national level and enhanced ability of district level officials to plan, administer and deliver health services through public/voluntary partnerships.

**Other Donor Programs:** The top five donors in rank order are: Denmark, the United Kingdom, the United States, the World Bank and Switzerland. USAID and the United Nations Fund for Population Activities (UNFPA) are the main donors supporting family planning. The United Kingdom and Germany also support family planning commodities and related supplies. The Netherlands is the main donor of condoms to the private sector social marketing program. The European Union provides drugs to treat sexually transmitted diseases, and training through the National AIDS Control Program. The total health sector donor support per annum is approximately $100 million.

**Principal Contractors, Grantees or Agencies:** Host government; U.S. universities such as: Johns Hopkins University, University of North Carolina, and University of Michigan; U.S. non-government organizations (NGOs): such as CARE, AFRICARE, Pathfinder, Access to Voluntary and Safe Contraception International (AVSC International), Population Services International (PSI), Family Health International (FHI), MACRO International; and a diverse array of Tanzanian NGOs and voluntary agencies.

**Selected Performance Measures:**

| | Baseline (1996) | FY 2000 | Target (2003) |
|---|---|---|---|
| Modern method contraceptive use rate among all women age 15 - 49 | 11.7% | 16.2% | 20% |
| Proportion of men who know condom use is a way to avoid AIDS | 55% | 68% | 75% |
| Percent of service delivery sites with a practitioner trained in reproductive health | 59% | 69% | 80% |
| Percent of infants less than 6 months exclusively breast-fed | 29% | 35% | 42% |

---

## ACTIVITY DATA SHEET

**PROGRAM:** TANZANIA
**TITLE AND NUMBER**: Foundation Established For Adoption of Environmentally Sustainable Natural Resource Management Practices, 621-SO02
**STATUS:** Continuing
**PROPOSED OBLIGATION AND FUNDING SOURCE:** FY 2000 $3,800,000 DFA
**INITIAL OBLIGATION**: FY 1995 **ESTIMATED COMPLETION DATE:** FY 2003

**Summary**: The purpose of this strategic objective is to stem the loss of biodiversity by advancing environmental policies, legislation and improved natural resource management practices in selected areas. Within the context of Tanzania's evolving policy environment in the natural resources sector, four management systems have been identified for assistance: 1) the network of national parks; 2) the national system of game reserves as a second and more widespread network of protected areas; 3) community-based approaches in areas adjacent to protected areas on lands owned by communities and supported by local districts; and 4) coastal resources at both the national and local levels. USAID is implementing the following activities in these four areas. A consortium of the U.S. Department of Interior, Peace Corps, and USAID Partnership for Biodiversity is providing valuable assistance in anti-poaching, tourism promotion, and protected areas management. The World Resources Institute is designing new and innovative wildlife governance systems that will establish economic incentives for community and local government to sustainably manage wildlife resources. Peace Corps volunteers are working directly with communities to identify simple and low-cost conservation measures. The Tanzania Coastal Management Partnership comprised of the GOT, USAID, and University of Rhode Island's Coastal Resources Center is facilitating a participatory and transparent process to unite government and civil society to wisely conserve and develop coastal ecosystems and resources.

USAID's environmental education and communication outreach activities are designed to raise public awareness of targeted issues. An important principle guiding all USAID work is to ensure that a balance is achieved between conservation and production goals

and that resource owners and users are able to recoup a fair share of the benefits from resource use. Funding for these USAID-supported activities is channeled mainly through U.S. environmental non-governmental organizations (NGOs) and universities with efforts made to raise the capacity of local NGOs to participate fully in the future. The direct beneficiaries of achievement of this objective include government environmental management institutions and NGOs. The indirect beneficiaries are the people of Tanzania who will benefit from the improved natural resource management practices.

**Key Results:** Three key intermediate results were considered to be necessary to achieve this objective: 1) a policy framework established for sustainable Natural Resources Management (NRM) resulting in a wildlife conservation and utilization policy, environmental policy, and coastal resources management policy; 2) institutional strengthening and technical capacity for analysis built, particularly those of NGOs, local authorities and Government departments directly involved in the management of natural resources; and 3) practical applications appropriate for NRM identified, tested and implemented in pilot areas.

**Performance and Prospects:** USAID supports institutional strengthening, policy dialogue, legislative reform, and discrete grass roots activities designed to test approaches to community-based natural resource management. There are several achievements to date: 1) strengthened strategic planning capacity of the country's wildlife institutions which will result in decentralized environmental management and improved resource use; 2) improved donor coordination on key environmental issues which has meant more focused interventions in the sector and avoided duplication of effort; 3) the completion of a comprehensive assessment of the opportunities for linking tourism and the wise and sustainable use of resources which will result in better wildlife conservation and greater income generating opportunities; 4) District and village level organizations are engaged in NRM activities such as restoration of water catchment areas and reforestation; and 5) The development of a General Management Plan for Tarangire has improved wildlife management. USAID works in partnership with the Peace Corps and local communities to introduce soil conservation techniques and identify and increase community benefits resulting from coexistence with wildlife. The Tanzania Coastal Management Partnership has started developing an integrated coastal management policy to address environmental degradation and sustainable use of coastal resources. USAID also supports a linkage project between Sokoine University of Agriculture (SUA) and Tuskegee University (TU). This project has strengthened the capacity of SUA to teach, promote and extend integrated natural resources management practices in 17 villages, improving incomes of about 75,000 low income people.

**Possible Adjustments to Plans:** While it is recognized that USAID will continue to support the GOT to preserve its unique biodiversity and natural resources, plans are underway to revise the assistance strategy. The purpose of this revision is to improve program management, link more fully conservation of biological diversity with economic opportunities in the wildlife sector, and establish a functional community-based natural resources management strategy that allows participation of Community Based Organizations (CBOs) and other NGOs. The outcome of these revisions should be known by the second quarter of FY 1999.

**Other Donor Programs:** There are at least 15 donors providing complementary assistance of over $50 million annually in broadly defined areas of environment and natural resources. The top five donors in rank order are: European Union, Germany (GTZ), Netherlands, Denmark (DANIDA) and the United States. The Mission co-chairs a monthly donor focus group on the environment which fosters coordination of activities to avoid duplication and to enhance attainment of results. Donor coordination is good and key government agencies are committed to protecting the country's rich natural resources and the environment.

**Principal Contractors, Grantees or Agencies:** USAID has built an excellent partnership between U.S. based organizations and host country NGOs to implement its program. Specifically, USAID implements activities with the U.S. Peace Corps, U.S. Fish and Wildlife Service, CARE, Tuskegee University, Sokoine Agriculture University, Colorado State University, University of Rhode Island, African Wildlife Foundation, World Wildlife Fund, World Resources Institute, Management Systems International, International Resources Group, Academy for Educational Development, Environmental Policy and Institutional Strengthening (EPIQ), and a number of host country NGOs and private voluntary organizations.

**Selected Performance Measures:**

| | Baseline | FY 2000 | Target |
|---|---|---|---|
| Areas under improved conservation practices adopted in selected zones as a % of total farmed area | 0 (1998) | 5% | 35% (2003) |
| Percent of Government revenue collection in pilot areas that is shared with local communities | 0 (1998) | 3% | 10% (2003) |
| Percent of selected communities effectively managing natural resources | 0 (1998) | 5% | 40% (2003) |

---

## ACTIVITY DATA SHEET

**PROGRAM:** TANZANIA
**TITLE AND NUMBER**: Civil Society and Government are More Effective Partners in Governance, 621-S003
**STATUS:** Continuing
**PROPOSED OBLIGATION AND FUNDING SOURCE:** FY 2000: $2,500,000 DFA
**INITIAL OBLIGATION**: FY 1995 **ESTIMATED COMPLETION DATE:** FY 2003

**Summary:** A study conducted in early 1998 to reassess the status of democratic governance concluded that the transition to a democratic system of governance in Tanzania had slowed compared to the pace in the early part of the 1990s. At the heart of this issue is the finding that the Executive Branch of the Government of Tanzania (GOT) dominates Tanzanian political life and is not balanced with, or checked by, any other countervailing political forces. The net result has been an ineffective form of governance which has been manifested by pervasive corruption, limited provision and poor quality of public services. Citizens and their voluntary organizations have had limited participation in the processes and institutions that define Tanzanian political life. While civil society provides the principal hope for improving the state of democracy and good governance in Tanzania through its demand for political reform, it is also recognized that there are institutions within central and local government that would like to reform. The problem, however, is the lack of interaction between these reformist elements in the government and those in civil society. The purpose of this strategic objective (SO) is to target and support those reformist elements in government units and civil society organizations (CSOs) that will broaden their participation in governance and public policy in order to rekindle the transition process. Direct beneficiaries include targeted government institutions and CSOs. The indirect beneficiaries are the men and women of Tanzania who will benefit from a more responsive government as well as more effective and active representation from CSOs on their behalf.

**Key Results:** Pursuant to the redesign of the activities in FY 1998, three key intermediate results have been identified as necessary to achieve this objective: (1) Targeted CSOs effectively represent public interests to government on selected issues. CSO capacity will be built in the areas of internal democratic practice, development management and policy advocacy; (2) Targeted government institutions are more responsive to public concerns on selected issues. GOT agencies will be targeted for capacity building assistance which aims at reinforcing a customer service orientation; and (3) The enabling environment supports CSO-government partnership in governance. The mission will closely monitor the legal and regulatory environment reforms in the political system.

**Performance and Prospects:** Progress has been most notable in implementing Alternative Dispute Resolution (ADR) in the court system, and strengthening the outreach capacity of selected non-governmental Organizations (NGOs) specifically those working on women's legal rights. The focus of the ADR activities remained in Kisutu court, which is one of the largest primary courts in Tanzania. There, the use of ADR became routine with one day set aside each week for ADR settlements, reducing the backlog of cases in the system. It had been planned that 50 cases would be settled by ADR last year but 102 were settled, exceeding our target by 100%. In conjunction with ADR, the use of the case-flow tracking system has improved the service provided by this court. The Chief Justice has noted that not only can he assure better management of cases through this computerized system, but he has a method to curb corruption in the system.

By supporting several workshops, through the distribution of literature and brochures, and with well-organized lobbying campaigns, one of Tanzania's leading women's organizations in conjunction with other groups has raised the level of awareness on the issue of violence against women. Participants in the workshops included ordinary citizens, government officials, police officers, health workers, lawyers, and university professors. As a result of the increased awareness, the issue of sexual violence was discussed more openly than in the past, and newspaper and television reports focused more on the problem. The citizens of Tanzania subsequently left the government with no option but to address this serious problem. On July 1, 1998, the Tanzanian Parliament passed the Sexual Offenses Special Provision Act. Under this act all persons convicted of rape or the sexual defilement of children will be sentenced for life. Such persons will not be entitled to having his/her sentence pardoned. With the passing of this act, it is envisaged that the rate of sexual crimes will fall considerably. To date, press reports confirm that the judicial system is actively implementing this law as several individuals have already been convicted and sentenced.

During an evaluation, it was found that even greater impact could be made if assistance were directed at further strengthening the capacity of targeted government units to provide better service, and to support mechanisms which promoted public dialogue between the government and civil society.

**Possible Adjustments to Plans:** To address these issues, additional support will be provided to the Judiciary and other GOT units, as well as providing technical assistance to CSOs for institutional capacity building and the strengthening of their advocacy and networking skills. Other donors with larger budgets are working more intensely in the area of civic education and USAID will continue to coordinate with these donors. The design of these assistance programs is ongoing at the present time. The Mission is working with its partners in the GOT and civil society, and with other donors to create activities that will be complementary and have the greatest impact.

**Other Donor Programs:** The following five donors in rank order are active in the democracy and governance sector: Norway, Sweden, Denmark, Netherlands and Germany. The United States is the smallest donor. The Danish International Aid Agency (DANIDA) is working on improving the legal system through support to the new commercial court; the Netherlands has been involved in improving the capacity of the media and trade unions, and providing civic education awareness training; Germany is also providing support to the media; and Sweden is providing capacity building assistance to the Tanzanian Parliament. Resources directed toward this objective from the GOT and donors is approximately $14 million per annum.

**Principal Contractors, Grantees or Agencies:** USAID implements activities with host country NGOs but will be soliciting competitively for the involvement of U.S. private voluntary organizations that are interested in implementing some of the new activities.

**Selected Performance Measures:**

| | Baseline | FY 2000 | Target (2003) |
|---|---|---|---|
| Number of cases resolved by ADR (per annum) | 0 (1995) | 200 | 325 |
| Number of CSO-initiated public policies presented to government that are acted-on | 0 (1998)* | 3 | 5 |
| Number of public hearings initiated by government units | 0 (1998)* | 2 | 4 |
| Percent of total court cases that go to ADR (per annum) | 0 (1998)* | 40% | 60% |

* a survey will be undertaken in the summer of FY 99 to provide baseline data

---

## ACTIVITY DATA SHEET

**PROGRAM**: TANZANIA
**TITLE AND NUMBER:** Increased Micro and Small Enterprise Participation in the Economy, 621-SOO4
**STATUS:** Continuing
**PROPOSED OBLIGATION AND FUNDING SOURCE:** FY 2000: $3,000,000 DFA
**INITIAL OBLIGATION:** FY 1995 **ESTIMATED COMPLETION DATE:** FY 2003

**Summary:** In 1995, Tanzania was only beginning to emerge from a centrally planned economy to a modern free market. With no private banks to stimulate investment, scarce opportunities for current and prospective private business owners to obtain business training and advice, and a government bureaucracy still unfriendly to private business, the vast majority of Tanzanians were stifled in their attempts to improve their livelihoods. The purpose of this strategic objective is to increase access by micro and small businesses to financing, business services and management skills within an improved business environment in order to stimulate employment and reduce poverty. The principal beneficiaries will be the 100,000 Tanzanian entrepreneurs who will receive both direct and indirect assistance to improve their management capacity and their access to credit including the Bank of Tanzania, Ministry of Finance, and senior and line civil servants of other arms of government; and business associations. The indirect beneficiaries are the more than 40% of Tanzanians who are unemployed or seasonally underemployed who derive jobs and incomes as a result of an expanding private

economy.

**Key Results**: USAID is addressing a wide range of constraints to private sector development. In order to achieve its objective, four intermediate results are required: 1) Legal and regulatory reforms support new and existing businesses as measured by the average number of months it takes to commence business operations; 2) Provision of sustainable financing to micro and small enterprises; 3) Enhanced micro and small enterprise (MSE) management through the provision of training to a broad audience in each of Tanzania's 20 regions; and 4) Strengthened business associations by at least quadrupling dues-paying membership in assisted associations within 5 years.

**Performance and Prospects**: Performance has been as expected in 1998. Tax collection and transparency in the tax process have improved with USAID assistance to help establish a new tax collection agency, the Tanzanian Revenue Authority. The "Investor Roadmap" has identified and continues to successfully implement a series of reforms in customs, immigration and business permits to make commercial and industrial operating procedures more business-friendly. USAID training and technical assistance to the Bank of Tanzania (BOT) has helped make the bank a leader in the reform process. USAID assistance in the financial sector is helping to free the banking sector of state domination and controls while improving oversight of the industry; set out a successful model for venture capital investment; and establish innovative programs for MSE lending. The USAID-financed Business Center (TBC) has trained over 5,000 micro-entrepreneurs and assisted directly over 800 small businesses. The combined result of increased access to finance and to technical know-how has resulted in over 4,000 new jobs and substantial increases in business incomes.

A pilot technical assistance scheme with Tanzania's largest business association, in cooperation with Sweden's SIDA, was launched in 1998. It has resulted in increased demand by business associations for specific help in such areas as strategic planning; software for tracking membership data bases; and maximizing income sources for sustainability. Numerous and growing private business associations have broadly acknowledged, for the first time, that this support must enable them, and the private sector as a whole, to operate independently over time to meet the needs of their growing membership, including advocating for public sector reform. With the active support of USAID Tanzania, The Tanzania Private Sector Foundation, was formed in 1998 to carry on this function of supporting the development of sustainable, effective, business associations. USAID is recognized as the leader in private sector development in Tanzania by the government and donors alike.

**Possible Adjustments to plans**: Many of the activities are winding down after several years of successful implementation. In order to determine the best strategy to continue to move the objective forward, USAID is undertaking several sectoral analyses. Preliminary results indicate that this objective will likely focus more on both urban and rural (agriculture-based) enterprise development as the most effective way to create employment and generate economic growth. USAID's approach to enterprise development must be flexible and responsive to the human, technological (including infrastructure) and capital capacities of the average Tanzanian while simultaneously increasing these capacities. In addition, we anticipate that we will target the agribusiness and mining sectors. USAID is also investigating appropriate interventions to dramatically increase access to micro credit and finance, building upon experience establishing lending programs for MSEs.

**Other Donor Programs:** Donor coordination in assistance to the private sector is strong. USAID chairs the donor working group on private sector development and its sub-committee on micro-finance. The top five donors in rank order are: The United States, United Kingdom, Netherlands, Denmark and Sweden. Approximately $20 million

is provided on annual basis to this sector.

**Principal Contractors, Grantees, or Agencies:** The program is implemented with the strong participation and leadership of the government as well as local non-governmental organizations. Private companies are important partners as well as beneficiaries. Current U.S. private company partners include Development Alternatives, Inc., as the prime contractor for The Business Center component that terminates in January 31, 1999, and the 8(a) firm of Gardiner, Kamya Associates which is conducting BOT in-country training. The Investor Roadmap was completed under contract to The Services Group.

**Selected Performance Measures:**

| | Baseline (1992) | FY 2000 | Target (2003) |
|---|---|---|---|
| Bureau of Statistics estimate of the private sector's contribution to GDP (%) | 64% | 75% | 80% |
| No. of private financial institutions | 0 | 19 | 20 |
| Small Business Finance Provided ($US millions) | 2.9 | 26.25 | 35 |
| New Jobs Created (Formal Sector) | 0 | 4,200 | 8,000 |
| No. of paid-up members-- Tanzania Chamber of Commerce Industries and Agriculture Targeted Branches | 1,014 | 4,325 | 9,000 |

---

## ACTIVITY DATA SHEET

**PROGRAM**: TANZANIA
**TITLE AND NUMBER:** Rural Roads Improved In a Sustainable Manner, 621-SO05
**STATUS:** Continuing
**PROPOSED OBLIGATION AND FUNDING SOURCE:** FY 2000: $2,800,000 DFA
**INITIAL OBLIGATION:** FY 1997 **ESTIMATED COMPLETION DATE:** FY 2003

**Summary:** In 1997, USAID focused its successful regional road program down to the district level, where the responsibility of supporting road maintenance on 60% of the country's road network lies. Rural districts in Tanzania are the hub of agricultural production and home to 80% of the country's population. The selected 20 out of 100 districts have the highest potential for surplus food crop production in the country. Planned road activities in these particular districts are expected to lower transport costs and improve year-round access to markets, thereby enhancing incentives for agricultural production and increasing food security. In 1997, when USAID began work on this focussed objective, none of the 20 districts had a sustainable system of road rehabilitation and maintenance, only 5% of all district road work was contracted out to the private sector and the cost of transport was rising due to the dismal conditions of the roads. One million dollars was disbursed to the GOT for emergency road repair for damages resulting from the El Nino rains. The money was used to repair 25 bridges thus restoring accessibility to the area affected.

The purpose of this activity is to: 1) increase the number of districts where decentralized road rehabilitation and maintenance work is operating in a sustainable manner from none in 1997 to 20 districts in 2003; 2) increase the percentage of district roads

rehabilitated/maintained by the private sector from 5% of all district road works in 1997 to 80% in 2003; and 3) reduce the average cost of transport by up to 60% on each road section rehabilitated/maintained under the program through FY 2003. The principal beneficiaries will be the residents in the 20 districts where roads will be improved. Their transport costs will decrease for goods and services. Additionally, over 1,000 Tanzanian contractors and consultants will receive both direct and indirect assistance in the management and execution of road rehabilitation and road maintenance contracts. More broadly, the Tanzanian people will benefit from easier access to markets, schools and health service centers.

Due to the prolonged El-Nino rains and floods throughout Tanzania for a major part of the last year, a substantial number of bridges, culverts and sections of roads were either destroyed or damaged resulting in the disruption of vital transportation on major portions of the country's road network, including roads that were rehabilitated under USAID's rural roads program. As a humanitarian response to this disaster, USAID assisted the GOT in repairing some of the damaged bridges, culverts and road section utilizing $1 million of OFDA funds as well as another $1 million equivalent in local currency from USAID's existing portfolio. Many other donors also responded.

**Key Results:** The four key intermediate results necessary to achieve the program's strategic objective are: 1) decentralization of road rehabilitation and maintenance systems and activities to the district level; 2) private contractors rehabilitating/maintaining district roads; 3) community involvement in road maintenance increased; and 4) Roads Fund used for district road maintenance. Specific activities to be undertaken include: revising GOT procedures to decentralize road operations to the district level; providing technical assistance, training and limited equipment to build the capacity of the local technical staff to plan, budget, and supervise road contracts; assisting the district offices to establish and follow transparent allocation criteria and procedures in the use of road maintenance funds including transparent tendering and contract award systems; funding actual road maintenance contracts with local private contractors and involving local communities in the maintenance of district roads.

**Performance and Prospects**: For FY 1998, it was anticipated that: 1) sustainable systems of road maintenance would operate in eight districts; 2) district road works contracted out to the private sector would be 30% of all district road contracts executed; and 3) reduction in the average transport cost of goods on district roads would be 30% to 60%. By the end of FY 1998, sustainable systems have been introduced in five districts, over 60% of all district roads executed were contracted out to the private sector and 40% reduction in the average transport cost of goods was realized. For FY 1999, sustainable systems of road maintenance will operate in nine districts compared to eight as targeted. The 30% of district road network to be contracted out to the private sector as targeted for FY 1999 has been surpassed already and is anticipated to reach 70% - 80% by the end of the FY 1999. Reduction in the average transport cost of goods that was targeted at 30% to 60% for FY 1999 will be measured after the road rehabilitation is completed and an impact survey is undertaken. Based on USAID's eight year experience in this sector, it is believed that this level of transport cost reduction will be attained in FY 1999 and all targets for FY 2000 as shown in the table below will also be attained if not surpassed.

The maintenance and construction of bridges and culverts has also commenced in the five districts with both community and local government participation. Contributions from USAID, communities and local government are in the range of 50%, 25% and 25%, respectively.

Unified donor pressure, led to passage of a Roads Fund Bill by Parliament in November, 1998 which protects the funds for road maintenance and establishes a Roads Fund Board and Road Agency that are both fully accountable and that are expected to operate freely,

effectively and efficiently, following commercial principles.

**Possible Adjustments to plans:** No adjustments are anticipated at this stage.

**Other Donor Programs**: The top five donors in rank order providing funds for district roads are: The United States, Denmark, Switzerland, United Nations Development Program (UNDP), and World Bank. UNDP, Denmark and Switzerland are assisting the GOT in the rehabilitation and maintenance of roads in 15 of the 100 districts of the country at a combined funding level of $2 million per year. The GOT is providing $3 million per year from the Roads Fund for the maintenance of roads in the 100 districts of the country. All donor road assistance is coordinated through the Integrated Roads Program (IRP), which has proven to be a good forum for donor coordination. Sixteen donors are providing approximately $100 million per year for the government's overall roads program.

**Principal Contractors, Grantees, or Agencies:** Local private road construction firms, the Ministry of Works (MOW), the Prime Minister's Office (PMO) and various local community groups at the regional and district levels.

**Selected Performance Measures:**

| | Baseline (1997) | FY 2000 | Target (2003) |
|---|---|---|---|
| Sustainable system operating in districts | 0 | 12 | 20 districts |
| District road works contracted out to private sector as percent of all district roads contracts executed | 5% | 50% | 80% |
| Reduction in the average transport cost of goods on district roads. | 0% | 30% - 60% | 30% - 60% |

---

## ACTIVITY DATA SHEET

**PROGRAM:** TANZANIA
**TITLE AND NUMBER:** Suffering of Tanzania Bomb Victims Reduced and Local Disaster Response Capacity Enhanced, 621-SPO1
**STATUS:** Continuing
**PROPOSED OBLIGATION AND FUNDING SOURCE:** FY 2000: $ 150,000 DFA
**INITIAL OBLIGATION:** FY 1999 **ESTIMATED COMPLETION DATE:** FY 2001

**Summary:** This is a program that was created in response to the August 7, 1998 terrorist bombing attack on the U.S. Embassy in Dar es Salaam, Tanzania. As a result of the bombing, $100,000 worth of equipment and supplies were provided to the main government hospital to replenish their stock. This enabled the hospital to continue with their normal operation smoothly. USAID is designing a program to provide humanitarian assistance for bombing victims, to reconstruct damaged infrastructure and to assist Tanzanian institutions and personnel to manage future disasters. Victims of the bombing will be assisted through a grant to Plan International which is undertaking family assessments to determine actual needs. USAID is also reviewing the Ministry of Works (MOW) assessments of damage to infrastructure to establish a basis for reimbursements directly to property owners. In conjunction with the Department of Health and Human

Services and USAID's Office of Foreign Disaster Assistance, USAID is designing a program to upgrade the capacity of Tanzanian institutions to cope with disasters.

**Key Results:** Two key intermediate results that were considered necessary to achieve the program's special objective are: 1) Psycho-social, economic and health impact of bomb blast reduced as indicated by the restoration of damaged properties and settlement of eligible claims. Additionally, hospitals in greater Dar es Salaam are reimbursed for medical expenses incurred because of the bombing; and bomb blast victims receive follow up medical care, counseling and other types of economic assistance; and 2) Preparedness for future disasters enhanced through increasing disaster preparedness and management capability of hospitals and other organizations as well as establishment of a safe and adequate blood transfusion system at selected sites.

**Performance and Prospects:** It is expected that the first funds will be disbursed to victims early in 1999. Reimbursements for infrastructure repairs will begin as soon as possible after an independent contractor reviews the MOW damage assessments and a firm can be contracted to manage the reimbursements based on property owner receipts and police reports (and reimbursed insurance claims). Finally, USAID will provide equipment, technical assistance and training to the GOT to improve their capacity to respond to future disasters. An initial needs assessment will be performed early in 1999.

**Possible Adjustments to Plans:** Not anticipated.

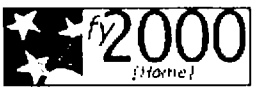
**Other Donor Programs:** The United States ranks first followed by UNDP. Other donors provided symbolic assistance at the time of the bombing. To date, the GOT, Canada, Saudi Arabia, Egypt, Japan, the African Medical and Research Foundation, Algeria, and Nigeria have provided funding and supplies worth approximately $1.7 million to hospitals and for bombing victims. The United Nations Development program is the only other donor currently providing limited disaster preparedness training and technical assistance.

**Principal Contractors, Grantees or Agencies:** A grant has been signed with Plan International to manage the assistance to victims. A contractor will be hired to manage the funds for reimbursing property owners. Grants or contracts will be signed with contractors or Private Voluntary Organizations to manage the disaster preparedness assistance as well as funds being transferred to the Department of Health and Human Services.

**Selected Performance Measures:**

| | Baseline | FY 2000 | Target (2001) |
|---|---|---|---|
| Percent of bomb blast victims with emergency needs met | 50% (1998) | 95% (1999) | 95% |
| Number of people trained in disaster preparedness skills | 50 (1998) | 150 (2000) | 250 |
| Percent of damaged properties eligible for USG assistance restored | 0 (1998) | 95% (2000) | 95% |
| Number of hospitals reimbursed and eligible individual claims settled | 20% (1998) | 100% (2000) | 100% |
| Percent of bomb blast victims with medical and consulting needs met | 50% (1999) | 95% (2000) | 95% |

| | | | |
|---|---|---|---|
| Percent of victims economically disadvantaged by bomb blast assisted | 50% (1999) | 95% (2000) | 95% |
| Number of personnel who complete training in disaster management | 50 (1999) | 100 (2000) | 200 |
| Percent of hospitals with emergency response in place | 0 (1998) | 60% (2000) | 80% |
| Safe and adequate blood transfusion systems exist in selected sites | 25% (1998) | 40% (2000) | 60% |




---

# HIV/AIDS Profile: Tanzania

| | with AIDS | without AIDS | | with AIDS | without AIDS |
|---|---|---|---|---|---|
| Population (1000s) | 35,306 | 36,902 | Growth Rate (%) | 2.6% | 3.1% |
| Crude Birth Rate | 40 | 40 | Crude Death Rate | 13 | 8 |
| Infant Mortality Rate | | | Life Expectancy | | |
| Both Sexes | 81 | 72 | Both Sexes | 52 | 64 |
| Male | 86 | 77 | Male | 51 | 62 |
| Female | 76 | 66 | Female | 53 | 66 |
| | | ********** | | | |
| Percent Urban | 20 | | Total Fertility Rate | 5.5 | |

**Note:** Above indicators are for 2000

**********

| | |
|---|---|
| Estimated % of adults living with HIV/AIDS, end 1999 | 8.1% |
| Cumulative AIDS rate (per 1,000) as of 12/31/98 | 3.23 |
| Cumulative AIDS cases as of 12/31/98 | 109,863 |

Sources: U.S. Census Bureau, UNAIDS, Population Reference Bureau, World Health Organization.

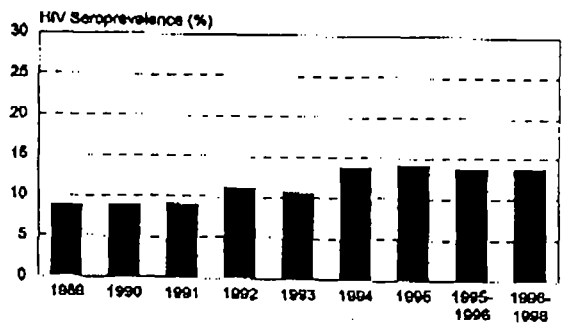
## Epidemiological Data

Epidemic State: Generalized

In Tanzania, like much of East Africa, the HIV epidemic began in the early 1980s. A steady increase in infection levels among pregnant women in many areas of the country occurred up through the mid 1990s; there is some evidence of a decline in recent years, although the epidemic remains a serious problem. Females are infected at younger ages and rural areas are less affected than urban areas.

- Since the mid 1990s, HIV seroprevalence among pregnant women in Dar es Salaam, the capital of Tanzania, has remained stable at around 14 percent. This data are from antenatal clinic sites of the HIV sentinel surveillance system.

HIV Seroprevalence for Pregnant Women
Dar es Salaam, Tanzania: 1989-1998

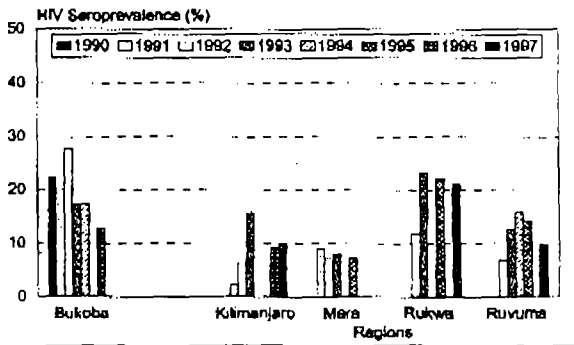



Source: International Programs Center, Population Division, U.S. Census Bureau, HIV/AIDS Surveillance Data Base, June 2000.

## Tanzania

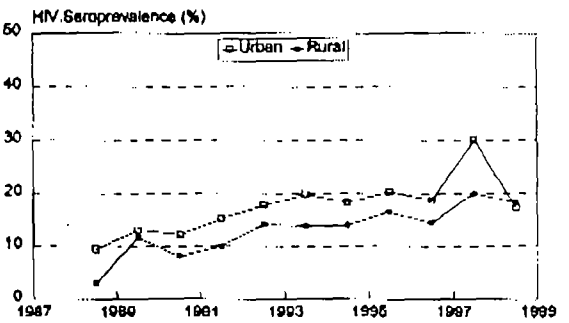
- Based on sentinel surveillance results between 1990 to 1997 in various areas of Tanzania, HIV seroprevalence among pregnant women in the lakeside town of Bukoba (Kagera Region) has fallen from 28 percent in 1992 to 13 percent by1996; in Rukwa Region, prevalence remained relatively unchanged over the time period and was 21 percent in 1997.

HIV Seroprevalence for Pregnant Women
Bukoba and Various Regions
Tanzania: 1990-1997



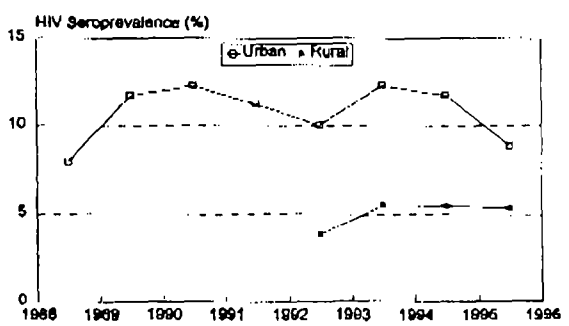

- HIV seroprevalence in both urban and rural areas of Mbeya Region, on the Zambian border, has increased among pregnant women since 1988. By 1997, prevalence was 30 percent in urban areas, 20 percent in rural areas. Prevalence in rural areas has been lower than that measured in urban areas.

HIV Seroprevalence for Pregnant Women
Mbeya Region, Tanzania: 1988-1998




- Mwanza Region is in northwest Tanzania on Lake Victoria. During 1988-1995, prevalence among pregnant women in urban areas of the region has averaged 11 percent. Prevalence among pregnant women in rural areas has averaged 5 percent.

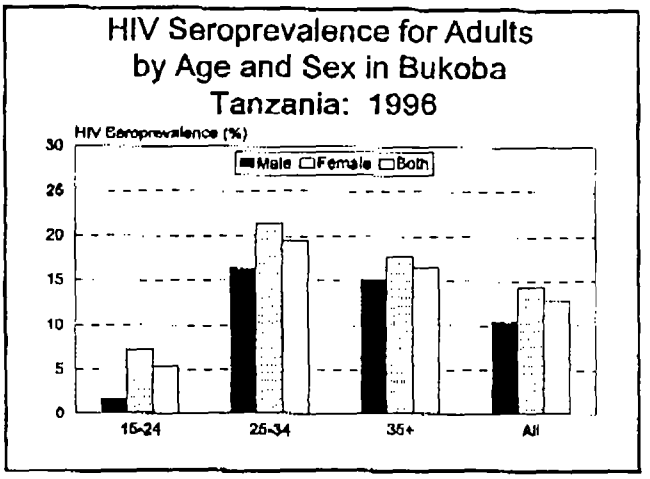
HIV Seroprevalence for Pregnant Women
Mwanza Region, Tanzania: 1988-1995



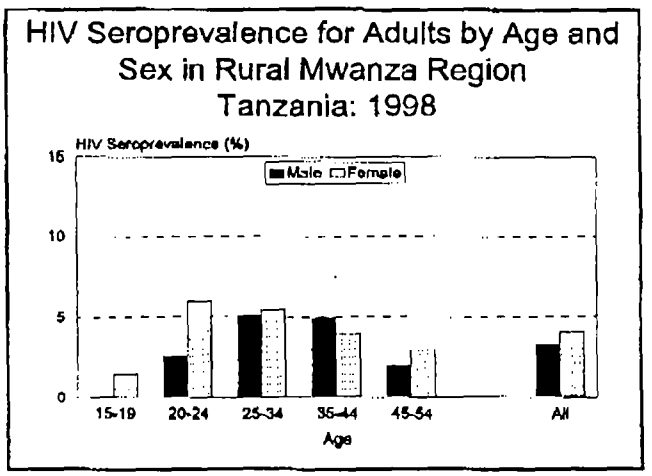

Source: International Programs Center, Population Division, U.S. Census Bureau, HIV/AIDS Surveillance Data Base, June 2000.

## Tanzania

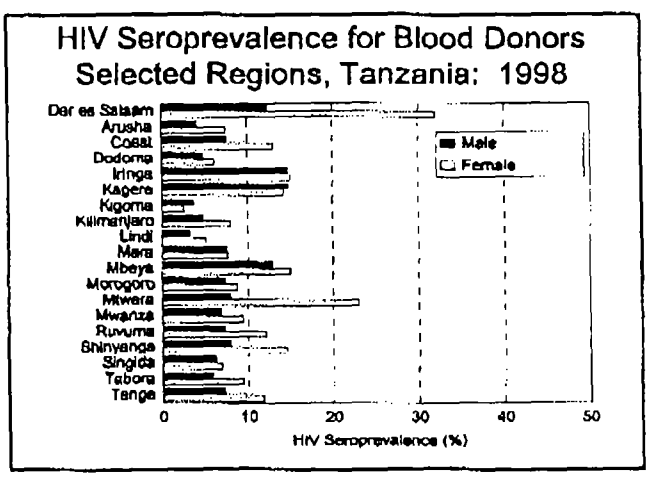
- In Bukoba, a special population-based study indicated that 13 percent of all adults were HIV positive in 1996. HIV seroprevalence among females was higher than that among males for every age group. The greatest disparity between the sexes was found in those 15-24, where HIV prevalence among females, 7 percent, was over three times higher than males, 2 percent.




- In general, HIV seroprevalence among adults in rural Mwanza Region in 1998 was higher for females than males, according to results from a population-based intervention study. As seen in other areas, in the younger age groups, females had much higher HIV infection levels. In the age group with the largest disparity, 20-24, prevalence among females was more than double that found in males.



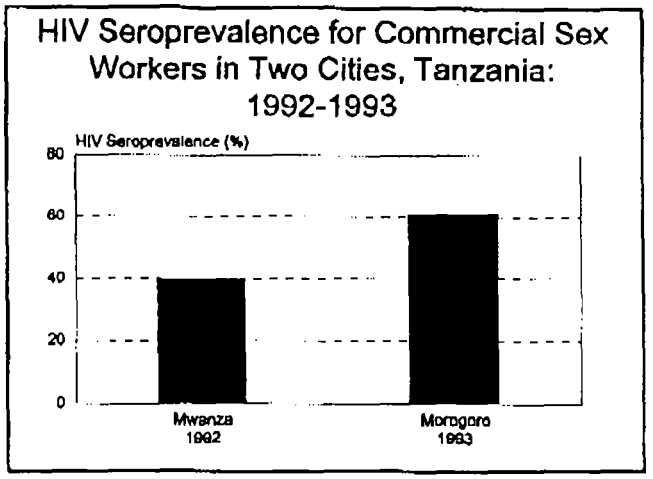

- Since 1990, all hospitals in Tanzania have screened the blood of potential donors. In 1998, HIV seroprevalence among blood donors varied greatly between regions and sexes. Prevalence levels among female donors in Dar es Salaam and Mtwara Region were 32.1 percent and 23 percent, respectively. Female prevalence was more variable than male prevalence.



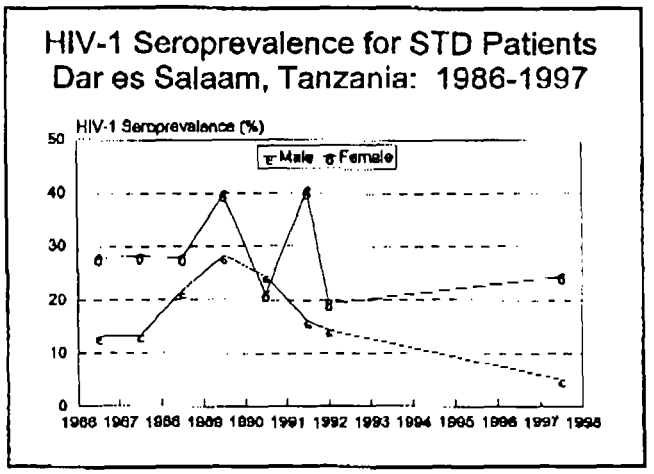

Source: International Programs Center, Population Division, U.S. Census Bureau, HIV/AIDS Surveillance Data Base, June 2000.

**Tanzania**

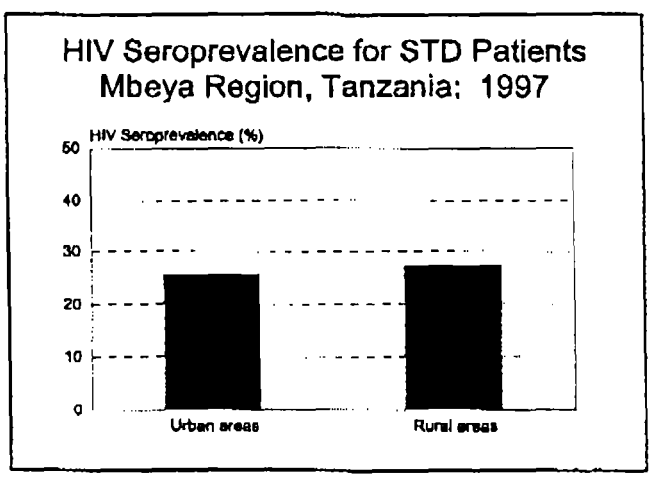
- HIV infection levels among commercial sex workers in Mwanza and Morogoro show very high prevalence in the early 1990s.



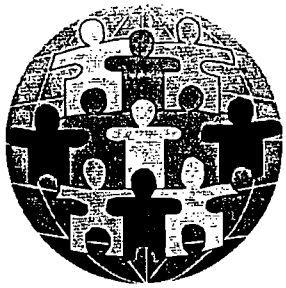

- Female STD clinic patients in Dar es Salaam generally had higher HIV seroprevalence levels than male patients. Data from several reports showed rates for females fluctuating between 20 and 40 percent since 1988.




- In Mbeya Region, there was little difference between prevalence levels in urban and rural areas among STD clinic patients in 1997.




Source: International Programs Center, Population Division, U.S. Census Bureau, HIV/AIDS Surveillance Data Base, June 2000.



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).

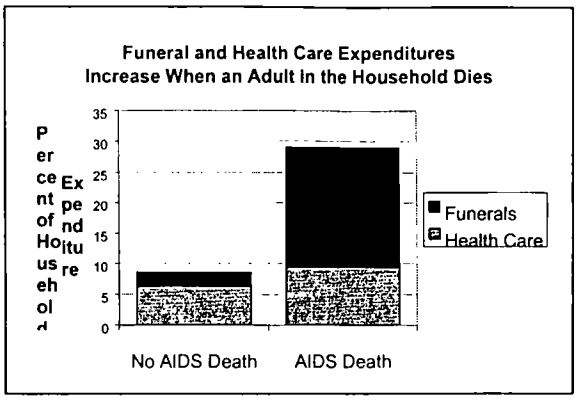
The economic effects of AIDS will be felt first by individuals and their families, then ripple outwards to firms and businesses and the macro-economy. This paper will consider each of these levels in turn and provide examples from Tanzania to illustrate these impacts.

## 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.

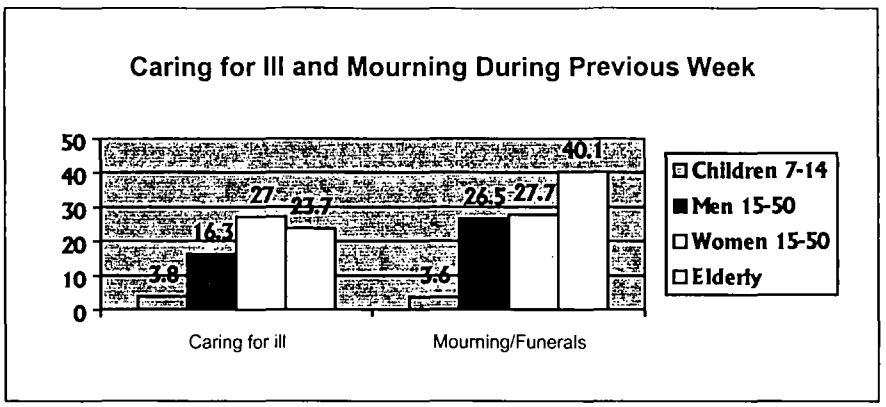
- In Tanzania, a study of adult mortality found that 8 percent of total household expenditure went to medical care and funerals in households that had an adult death in the preceding 12 months. In households with no adult death the figure was only 0.8 percent. On average, households with an AIDS death 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]

---

[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]

---

[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.

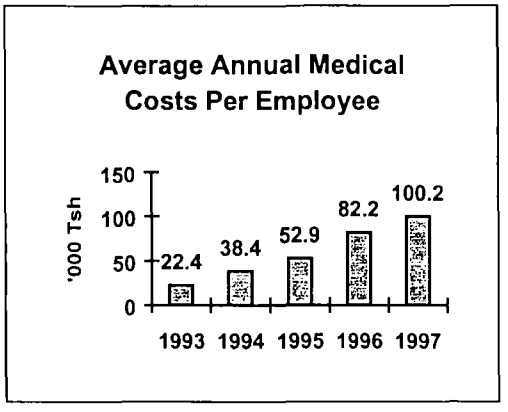
| Factors Leading to Increased Expenditure | Factors Leading to Decreased Revenue |
|---|---|
| Health care costs | Absenteeism due to illness |
| Burial fees | Time off to attend funerals |
| Training and recruitment | Time spent on training |
| | Labor turnover |

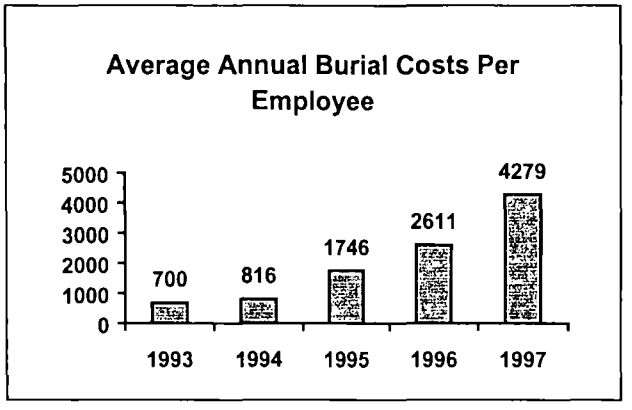
- A study completed by the ILO in 1995 examined the economic impact of HIV/AIDS by interviewing the leadership of eight organizations in Tanzania. Some of the findings from this study were:
  - Medical costs for the Tanzania-Zambia Railway Authority workers associated with AID-related diseases increased 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

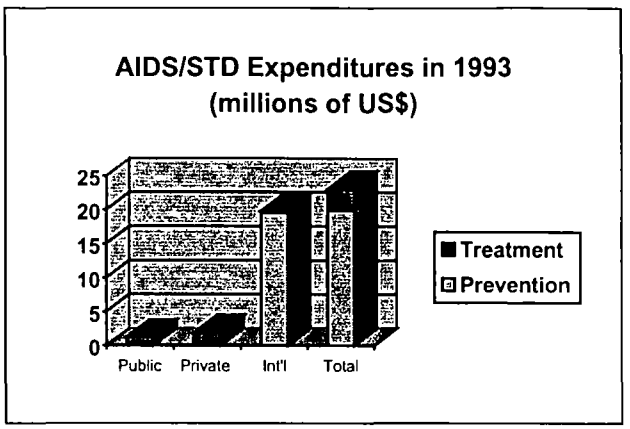
AIDS will also have significant effects in other key sectors. Among them are health, transport, mining, education and water.

- **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.

---

[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.

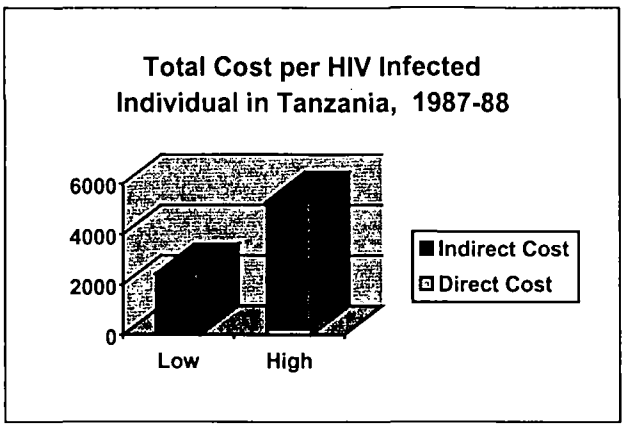
- Reduced worker productivity and investment leads to fewer jobs in the formal sector. As a result some workers will be pushed from high paying jobs in the formal sector to lower paying jobs in the informal sector.

- 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]

---

[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.

# HAMZA KASSONGO HOUR

Ref : 786/DTV/312/00
Date : 13 June 2000

Miss Sandra L. Thurman,
Director,
Office of National AIDS Policy,
The White House,
WASHINGTON, D.C.

Dear *Sandra*,

I thank you very much indeed for your letter of appreciation which you wrote on March 27th, 2000. Unfortunately, I only received it on May the 3rd, 2000, but the delay not withstanding I was thrilled to bits to get it. First, out of the hundreds of people I have invited to my programme you are the first overseas visitor and a superb visitor to write about the programme.

Ever since I received your letter I meant to write back immediately, but this has been the most difficult thing in my life.

Whenever I want to write to you something related to HIV/AIDS that I want to share with you happens.

Ever since your visit and our meeting on January 17th, 2000, the country seems to have awaken up from the big slumber. Whether it was the aftermath of your visit and the discussions you had with our top leadership or my HAMZA KASSONGO HOUR Programme or it is a mere coincidence I cannot tell. But what is extremely important and rewarding especially for me is the fact that many people have opened up and broken the silence.

Please take a moment to look at but a very few examples of what has occurred and indeed is still happening as late as yesterday June 13th, 2000.

On May Day [Labour Day for you] President Benjamin Mkapa for the first time admitted at a public rally that people were dying of IHV/AIDS. Furthermore he gave statistics of the deaths in both the Government Service and Parastatal Organisation.



P.O. Box 2615 DAR ES SALAAM
TEL: 255 51-137595. FAX: 255-51-138340 MOBILE: 0812 780 565.

The Prime Minister Frederick Sumaye took the cue and spoke widely. He also began to readily agree to give interviews. Where before I got problems to get any of the leaders to speak on the pandemic now it is easy. For example, in my UNICEF Sponsored programme in Kiswahili, UKO TAYARI? [ARE YOU READY?]. I wanted him to come and speak. To my surprise as soon as he returned to Dar es salaam he wrote back to accept. A Kiswahili letter, without translation, is herewith attached: No.1.

Other leaders also started to speak about the deadly disease. Of interest to you whenever you issue a statement from your White House Office or wherever the local press picks it up. I have not collected all the cuttings but one such example is herewith attached from the Africa privately owned daily: No.2.

There is much more but suffice for me to move on to only yesterday when President Mkapa in a Nation wide broadcast on both Radio and TV spoke candidly about his worries for HIV/AIDS. The statistics he gave were, to put it mildly, agonizing.

The eight daily papers that I bought today June 13th carried the story. Mostly as lead story. The cutting enclosed is from the Daily news which is Government owned: No. 3

So you see Madam, your previous visit has had an immeasurable impact. Now that you are here again let us hope more openness will ensue.

In conclusion allow me to share with you my personal experience. First, let me admit as both a practising Moslem and a born and bred Tanzanian African before our interview on January 17th, I was not as open as I ought to have been.

Since then, oh my god, sometimes I even become shocked of what I say!

Please find enclosed my work assignment of the very successful series funded by UNICEF: No. 4. I shall quote only three episodes as being the most illuminating. On our visit to Chalinze, Prog no. 4, [recorded on Labour day] we hired five prostitutes. They did not want either their faces or identities to be concealed. What they said and we broadcast was unheard before. On our part we had to issue a warning about some of the language which we did not want children to hear about. Suffice for me to say and I hope you will understand, when I tell you, Sandra these girls were unbelievably BOLD.

In the second episode we had a team from WAMATA. Those youths, both girls and boys openly told the public about their sexual experience and what they do when they have the urge to do it! It was fantastic.

The resultant was too good to be true. Forodhani School a Roman Catholic run school called them to give the same lecture to the students. Sandra, I could not have asked for more satisfaction.

Last episode was when I had a phone in live programme. One of the participants was a lady who has lived with the virus for 11 years.

Subsequent to this programme, WAMATA has an increase of about 200 people who visited them. The center for councilling, nutrition and health care whose representative talked about diet is overwhelmed with enquiries.

As if that was not enough HIV/AIDS patients want me to have them on a live programme. Although the UNICEF funds are exhausted I have convinced the management of DTV/Channel TEN to give me one or ½ hours F.O.C.

This they have done, thank God. Therefore on Thursday June 15th, I shall have three ladies and one man who have been living with AIDS. For periods from 8 years to 14. I think this is great.

Let us hope your current visit will bring even more wonderful successes in the fight against AIDS. Welcome back to Tanzania and it is indeed wonderful to have you again.

With salaams,

HAMZA KASSONGO
PROGRAMMES CONSULTANT

**FOIA Number:** 2007-1550-F

# Clinton Presidential Records
# Foreign Language Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff to identify the location of a document written in a foreign language

---

**Foreign Language Marker**

---

**Collection:** Clinton Presidential Records

**Subgroup:** National AIDS Policy Office

**Series:**

**Subseries:**

**Document Title** Tanzanian media request

**Language:** Kiswahili

**Folder Title** Tanzania [2]

**OA/ID:** 21062

# US triples HIV budget resources in Africa

By STAFF REPORTER

**THE White House official responsible for overseeing US government policy on HIV/AIDS says 1999-2000 was a "breakthrough year" in the battle against the epidemic.**

Sandra Thurman, director of the White House office of national AIDS policy, said the past year has seen intensified action on AIDS both in the United States and world-wide, according to a statement issued by the US embassy in Dar es Salaam.

She cited a combination of increased political engagement, a dramatic rise in funding, engagement by the private sector, and a recognition that AIDS is a security, economic and political issue.

The expanded response to the epidemic "gives us renewed hope that we can make a difference," she told a May 26, press briefing in Geneva, Switzerland. "Millions of lives are in the balance."

Thurman said the world missed an important opportunity to control the epidemic in the late 1980s. "Yet today we have a rare second chance to respond correctly and appropriately. We have the momentum and should not lose sight of it. Anything less, and history will judge us harshly."

Thurman pointed out that the US has been an international leader in the fight of the global AIDS pandemic since the beginning. The policy director said the US is the largest contributor to AIDS efforts around the world and the largest contributor to UBAIDS, the body which co-ordinates the United Nation's AIDS/HIV efforts.

"Over the past year the United States has tripled its budget resources for AIDS in Africa," Thurman said. "In just a few short years, AIDS in Africa has wiped out decades of hard work and steady progress in development and will soon double infant mortality, triple child mortality and slash life expectancy by 20 years or more.

"AIDS is indeed a plague of biblical proportions. It is killing more people in Africa than all the wars on the continent combined."

Thurman, who acts as the president's special assistant on AIDS related issues, emphasised that President Clinton and Vice President Gore both have a deep, personal commitment to controlling the spread of AIDS and caring for those affected.

The initiative by Vice President Gore and US Ambassador to the UN Richard Holbrooke to hold a landmark UN Security council meeting on HIV/AIDS in Africa focused new international attention on the epidemic as a security issue.

That meeting helped spur a "vastly expanded response in the US government, as well as in other countries, the UN system and in donor agencies," Thurman said. "We really do see this pandemic as a fundamental threat to the health and security of people around the world."

She noted that many US government agencies are engaged in the battle against AIDS. The department of Commerce is working to encourage private corporations to become more involved in AIDS, and the Department of Defence is proposing a programme to work with African militaries to implement AIDS training and education among their troops.

In Geneva to attend the programme Co-ordinating Board of UNAIDS, Thurman said she was pleased to see how many other countries are also developing a multi-sectoral approach to fighting the epidemic. "This is not just a health issue, it is a development issue, a security issue and a political issue."

The African, Thursday June 1, 2000

DAILY NEWS TUESDAY, JUNE 13, 2000

# Customs fuel HIV scourge -Mkapa

**PRESIDENT Benjamin Mkapa has challenged Tanzanians to discard outdated traditions and customs that contribute to the spread of HIV/AIDS and cherish those which protect people from acquiring it.**

By *DAILY NEWS* Reporter

Mr. Mkapa threw the challenge in Dar es Salaam yesterday in his Uhuru Torch race message to the nation broadcast live over *Radio Tanzania Dar es Salaam* (RTD) last night. This year's theme for the race is: "Youth against HIV/AIDS."

"Formerly in our tribes, there were customs which worked as society codes which forbid sexual practices before or outside marriage. Let's revive them in the war against HIV/AIDS," he said.

He also called on the youths, who are the most affected group, to control their sexual urge to reduce the spread of the pandemic.

He asked them to desist from excessive drinking of alcohol and sexual provocation which are the temptation for early sexual practices.

He also cautioned the society against the belief that youths are HIV/AIDS free thus making adults — both male and female, solicit their favours.

These are shameful habits which need to be fought by all in society — and anyone with such habits should stop them immediately," he remarked.

He said although unemployment has forced many youths, especially girls, into commercial sex they must now look for decent sources of income. He promised government's support to NGOs in setting a conducive environment for employment in the informal sector.

In Tanzania it is estimated that in every two barmaids and every two commercial sex workers, one is HIV/AIDS positive, he said.

Mr. Mkapa said it is disgusting to note that the society does not fear the disease and it has been hard to accept behavioural change as a way to fight the scourge.

# SPECIAL SERVICE AGREEMENT (INSTITUTIONAL CONTRACTOR)

unicef

| AGREEMENT NO | FUNDING | OFFICE OF ISSUE |
|---|---|---|
| (SSA/TNZA/00/00000642 -0) | GC/96/6007-1 | Dar-es-Salaam Country Off |

| Agreement Entered Into Between UNICEF And: *(Hereinafter Referred To As "The Contractor")* | NAME | CONTACT PERSON |
|---|---|---|
| | DAR ES SALAAM TELEVISION-DTV | |

| ADDRESS | TELEPHONE NO | FAX NO |
|---|---|---|
| P.O.BOX 2615<br>DAR ES SALAAM. | 255-51-137595 | 255-51-138340 |

*This Agreement shall commence on 09 April 2000, and shall expire on the satisfactory completion of the services described below, but not later than 29 June 2000, unless sooner terminated under the terms of the agreement.*

**THIS AGREEMENT IS SUBJECT TO THE ATTACHED CONDITIONS OF SERVICE.**

## TERMS OF REFERENCE

### (a) Work Assignment

Introduction

Mr. Hamza Kassongo, the producer and presenter of The Hamza Kassongo Hour on Dar es Salaam Television (DTV), agrees to produce a series of 12 television programmes in Kiswahili highlighting the key programmatic areas of HIV/AIDS and Basic Education. These areas have been identified by UNICEF and GoT as pivotal for child survival, development, protection and participation. The content and format of the programmes are developed jointly by Mr. Kassongo and UNICEF (AMCA and BELSA teams).

The programmes will run 12 consecutive weeks on DTV Channel Ten commencing on April 13th, 2000 and will be repeated on DTV. Channel Ten (launched on 1st.April) is available to viewers in Dar es Salaam, Mwanza, Dodoma, Arusha and Tanga regions (with spinoff reception in other regions, depending on distance, weather etc.) while DTV programmes are received in Dar es Salaam region. There will also be other spinoffs including video replay by DTV's associates in Mbeya (Dhandho Cable Network), Morogoro (Bob's Recording Centre) and Mwanza (Mwanza Cable Satellite). Further distribution will be negotiated by DTV on Radio Tanzania, Dar es Salaam-Zanzibar ferry boats, upcountry video coaches, video parlours and other outlets. Also, UNICEF and its partners will be free to use the videos for training and discussion purposes (e.g. Uhuru Torch).
The content and timing of the programmes is given below.

PROGRAMME
SEGMENT I: HIV/AIDS -- UKO TAYARI!

~~1. INTRODUCTION TO HIV/AIDS. Play on HIV/AIDS (by Kisarawe youth), discussion and Prime Minister's reaction and~~

| AUTHORIZING OFFICER NAME AND SIGNATURE | SIGNATURE (CONTRACTOR) |
|---|---|
| NAME: Rieben, Heinz | *I acknowledge that I have read and accept the attached conditions.* |
| DATE: 14/04/00 PLACE: DSM | DATE: _____ PLACE: _____ |

# SPECIAL SERVICE AGREEMENT (INSTITUTIONAL CONTRACTOR)

unicef

| AGREEMENT NO | FUNDING | OFFICE OF ISSUE |
|---|---|---|
| (SSA/TNZA/00/00000642 -0) | GC/96/6007-1 | Dar-es-Salaam Country Off |

| Agreement Entered Into Between UNICEF And: *(Hereinafter Referred To As "The Contractor")* | NAME | CONTACT PERSON |
|---|---|---|
| | DAR ES SALAAM TELEVISION-DTV | |

| ADDRESS | TELEPHONE NO | FAX NO |
|---|---|---|
| P.O.BOX 2615<br>DAR ES SALAAM. | 255-51-137595 | 255-51-138340 |

1. INTRODUCTION TO HIV/AIDS. Play on HIV/AIDS (by Kisarawe youth), discussion and Prime Minister's reaction and statements. Broadcast date: 13 April 2000

2. BREAKING THE SILENCE Presentation and discussion of findings of Kisarawe/Musoma/ Makete life skills assessment etc. as a basis for the need to break the silence. Participants will include IFM and secondary school students. Broadcast date: 20 April 2000

3. CONTRIBUTING FACTORS TO HIV/AIDS -- TRADITIONAL AND MODERN: Traditions (widow cleansing, widow inheritance, FGM, ngoma etc.), video parlours, alcohol and drug abuse. Gender and AIDS. How should we deal with these issues? Broadcast date: 27 April 2000

4. CONTRIBUTING FACTORS TO HIV/AIDS -- BEHAVIOURS: Casual sex; commercial sex in Chalinze; ngoma in Kisarawe; role plays of big shots at evenings at workshops, official visits etc. Interviews with commercial sex workers, bar staff, lorry drivers, shoe shine boys (pimps). What should be done about this? (Kwetu Counselling, AMREF, KIWOHEDE, Kuleana) Broadcast date: 04 May 2000

5. SEX AND LOVE: Risk taking in sex and love. When can one give up condom use? Role plays between young men and women. Discussion on strategies on how to remain safe. Broadcast date: 11 May 2000

6. EFFECTS OF HIV/AIDS -- ORPHANS: Location: Makete. Orphans and child-headed households. Extent and severity of the problem nation-wide. Interviews with orphans, orphan-care NGO staff, National Orphan Fund officials, etc. Broadcast date: 18 May 2000

7. EFFECTS OF HIV/AIDS -- MOTHER-TO-CHILD TRANSMISSION: Extent and severity of the problem. Medical and community effects. Effects of not breastfeeding, alternatives to breastfeeding, economic impact, father's role. Broadcast date: 25 May 2000

8. HIV/AIDS -- EDUCATION AND COMMUNICATION: What do parents think about their growing children's behaviours? What do they know about their adolescent children? What are their chief fears? How much do parents know about HIV/AIDS?

What do they know about their adolescent children? What are their chief fears? How much do parents know about HIV/AIDS? How much do children know? What should parents tell their children? What can they do to improve communication? What should schools teach? Life skills and parenting skills Broadcast date: 01 June 2000

9. PEOPLE LIVING WITH AIDS -- BREAKING THE STIGMA: Breaking the silence. Personal testimonials, life stories. Interviews with SHDEPHA, WAMATA Broadcast date: 08 June 2000

10. WHAT IS BEING DONE ABOUT HIV/AIDS: Current and proposed programmes, eg. Saab Scania, Tanzania Cigarette Co., Coca Cola Kwanza and others, NACP, programmes for youth (AMREF, TANESA), UNAIDS/UNICEF. The programme should be linked to the forthcoming DAC commemorations in CSPD wards. Broadcast date: 14 June 2000

SEGMENT II: BASIC EDUCATION

11. BASIC EDUCATION -- CHALLENGES AND PROSPECTS: Assessment of the current state of basic education and trends -of policies on children, parents, community, nation. Age of access, equity, quality, economics. Current government policy Impact entry in primary school and the effects of late enrolment. Student nutrition. Broadcast date: 22 June 2000

12. BASIC EDUCATION -- CHILD FRIENDLY SCHOOLS: What is a classroom like today? Water supply and sanitation, corporal punishment, expulsion of pregnant school girls, student labour, child abuse. Classroom interaction. What are the ingredients of a child friendly classroom, school? What can the government, the community, and teachers do to make schools child friendly? What can parents do? What can children do? Examples of some schools where the child friendly concept is being applied. Broadcast date: 29 June 2000

**(b) Deliverables**

| | |
|---|---|
| 10-April-2000 | Signed Contract |
| 04-May-2000 | Betacam and VHS Copy of the 1st four Programmes |

SANDRA.

Assima, my wife runs her own Fitness Centre. She too has joined the Band wagon.

Attached is her latest project.

Thanks 13/06/2000


# Health and Fitness Extravaganza

## "Give your ♥ to Aids Orphanage"

Come join us and experience the
Power, Energy and Non-Stop Action
at the Slipway
on 16th June 2000
from 2.00 p.m. - 6.00 p.m.
**Help Raise Money for Aids Orphanage**

This year 2000's benefit powerful workout
will be led by 6 Fitness Centre Instructors.

Many surprise offers will be given.

**BLESS YOUR HEART**

Participation fee TSh. 1500/-

SPONSORS

**SLIPWAY**

mobitel "Now You're Talking"

COOL BLUE Pure Drinking Water

THE W STORE WOOLWORTHS

CocaCola KWANZA

884 CLOUDS FM The peoples' station

THE UNITED REPUBLIC OF TANZANIA

# MINISTRY OF FINANCE

Telegrams: "TREASURY", DAR ES SALAAM.
Tel.: 111174/6, Fax: 110326, Telex: 41329.
(All Official communications should be addressed to the Permanent Secretary to the Treasury and NOT to individuals).
In reply please quote:

P.O. BOX 9111,
DAR ES SALAAM.

Ref. No. TYC/C/240/27/01

8th June, 2000

The Ambassador,,
Embassy of the United States of America,
DAR ES SALAAM.

**Your Excellency,**

RE: BILATERAL RESCHEDULING AGREEMENT UNDER PARIS CLUB VI AGREED MINUTE OF 14TH APRIL 2000

Kindly refer to our letter Ref. TYC/C/240/27/01 of 5th June,2000. We wish to replace paragraph '2' of the letter to read as follows:-

***To implement the terms of the aforesaid Agreed Minute, the Government of the United Republic of Tanzania would like to request the Government of the United States of America, through you, to initiate the process of negotiation with a view to concluding bilateral agreement between our two Governments.***

We very much regret for any inconveniences that may have been caused by the error committed in the letter under reference.

Accept your Excellency, the assurances of our highest consideration .

Yours sincerely,

R. P. Mwasha
**For: PERMANENT SECRETARY**

c.c. Mr. Francois Perol,
General Secretary of Paris Club,
**Fax 33 1 53 36 04.**

The Governor,
Bank of Tanzania,
DAR ES SALAAM.

THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF FINANCE

Telegrams: "TREASURY", DAR ES SALAAM.
Tel.: 111174/6, Fax: 110326, Telex: 41329.
(All Official communications should be addressed to the Permanent Secretary to the Treasury and NOT to individuals).
In reply please quote:

P.O. BOX 9111,
DAR ES SALAAM.

Ref. No. ..... TYC/C/240/27/01

5th June, 2000

The Ambassador,
Embassy of The United States of America,
DAR ES SALAAM.

Your Excellency,

**RE: BILATERAL RESCHEDULING AGREEMENT UNDER PARIS CLUB VI AGREED MINUTE OF 14TH APRIL 2000**

I have the hour to refer to the Agreed Minute of Paris Club VI dated 14th April 2000, in which among other things, requires The Government of the United Replic of Tanzania to conduct bilateral negotiations and conclude bilateral agreements with Paris Club creditors.

To implement the terms of the aforesaid Agreed Minute, the Government of the United Republic of Tanzania would like to request the Government of Austria, through you, to initiate the process of negotiation with a view to concluding bilateral agreement between our two Governments.

You may note Your Excellency, the matter requires urgent attention so as meet the deadlines.

We look forward to receiving your kind response at your earliest convenience.

Accept, your excellency, the assurance of our highest consideration.

Yours sincerely,

Gray S. Mgonja
**For: PERMANENT SECRETARY**

c.c. Mr. Francois Perol,
General Secretary of Paris Club,
**Fax 33 1 53 36 04.**

The Governor,
Bank of Tanzania,
**DAR ES SALAAM.**

THE WHITE HOUSE

WASHINGTON

October 30, 2000

Ms. Margaret Mshana
Chairperson
Kiwakuki
PO Box 567
Moshi, Tanzania

Dear Margaret:

Please accept this *very* belated note of thanks for the wonderful visit I made to Kiwakuki during my visit to Tanzania with President Clinton in August. As you may know we are in the middle of our national elections in the United States and that always means life in our nation's capital is even busier than normal!

I cannot begin to tell you how impressed I was with all of the wonderful people at Kiwakuki. However, I was especially taken with the extraordinary group of young people. What an inspiration they are! It gives me great hope for the future when I see youth from all around the world taking responsibility for educating themselves and their peers about HIV and AIDS.

I hope you will express my heartfelt appreciation to everyone who made my visit so memorable. Keep up the great work and I hope I will have an opportunity to come back and visit you soon.

With warmest regards,

Sandy

Sandra L. Thurman
Presidential Envoy for AIDS Cooperation, and
Director, Office of National AIDS Policy

THE WHITE HOUSE

WASHINGTON

October 30, 2000

Ms. Veronica Shao
Project Manager
Kilimanjaro NGO Cluster
PO Box 7445
Moshi, Tanzania

Dear Veronica:

Please accept this *very* belated note of thanks for the wonderful visit I made to Kilimanjaro during my visit to Tanzania with President Clinton in August. The wonderful overview you presented of the NGO network in the region was very helpful.

I cannot begin to tell you how impressed I was with all of the wonderful people I met. However, I was especially glad to meet with the representatives of the community of people living with HIV and AIDS. What an inspiration they are! As in the United States, their willingness to openly disclose their HIV status and their personal stories provides great inspiration to others.

I hope you will express my heartfelt appreciation to everyone who made my visit so memorable. Keep up the great work and I hope I will have an opportunity to come back and visit you soon.

With warmest regards,

Sandy

Sandra L. Thurman
Presidential Envoy for AIDS Cooperation, and
Director Office of National AIDS Policy