TANZANIA ASSISTANCE STRATEGY

HIV/AIDS

TAS WORKING PAPER

February, 2000

"AIDS is no longer just a health crisis, it has become a full development crisis"

Peter Piot (UNAIDS)

"Posters and Seminars themselves cannot solve this problem"

John Malechela (MP)
and former Prime Minister, Tanzania.

HIV/AIDS CURRENT SITUATION IN TANZANIA

Distribution of AIDS Cases

Between 1st January and 31st December 1998, a total of 8,675 AIDS cases were reported to the NACP from the 20 regions of mainland Tanzania. Of these 8221 (95%) were AIDS cases diagnosed during the year of this report. The remaining 454 (5%) were diagnosed before the year of this report but were not reported to the NACP in time due to variety of reasons. Adding to the number of AIDS cases diagnosed and reported to the NACP since 1983, it brings the cumulative total to 109,863.

Age and sex differences of AIDS cases reported during the period January through December 1998 is presented in Table 1 and Figure 1. Age was not recorded in almost half of the cases (4242.49%), testifying incomplete recording at health facility level. Fifty percent of 4,433 cases whose age was recorded are below the age of 32 years, and 88.6% of them are 15 to 49 years. Overall, male and female are equally affected but women are affected in early age than men, Figure 1. The peak number of AIDS cases for women is in the 27-32 year age group while that of men is 33-38 years. Note on the figure that, between the age 15 to 22 women are four times more affected than men are. Note also that 24 cases were of the age group 65 and above.

Many factors could be responsible for age-sex differences in HIV infection. Among them are early sexual maturity among females and the tendency for older men to seek sexual relations with young girls in attempts to avoid infection. It is also possible that economic considerations are attracting young girls into sexual relations with older and well to do men.

Table 1: Age and Sex of Reported AIDS Cases: January to December 1998

Age	Female	Percent	Male	Percent	Unknown	Percent	Total	% Total
0 – 5	82	48	87	50.9	2	1.2	171	2
6 – 11	31	55.4	25	44.6	-	-	56	0.6
12 – 14	3	60	2	40	-	-	5	0.1
15 – 18	44	77.2	13	22.8	-	-	57	0.6
19 – 22	209	80.4	50	19.2	1	0.4	260	3
23 – 26	411	71.9	157	27.4	4	0.7	572	6.6
27 – 32	744	59.4	497	39.7	11	0.9	1252	14.4
33 – 38	459	46.3	527	53.2	5	0.5	991	11.4
39 – 44	234	41.7	32.4	7.8	3	0.5	561	6.4
45 – 49	83	31.7	177	67.6	2	0.8	262	3
50 – 54	48	36.9	82	63.1	-	-	130	1.5
55 – 59	19	30.2	43	68.3	1	1.6	63	0.7
60 – 64	8	27.6	20	69	1	3.4	29	0.3
65 and over	8	33.3	16	66.7	-	-	24	0.3
Unknown	1993	45.3	2244	54.5	5	0.2	4242	48.9
Total	**4376**	**50.44**	**4264**	**4915**	**35**	**0.40**	**8675**	**100**

The cumulative number of AIDS cases by region and year and the cumulative case rate (Number of cases per 100,000 population) are shown in Table 3. The total

population for 1988 by regions has been projected from the 1988 population census using exponential growth model with an annual population growth rate of 2.8%. The NACP estimates that only 1 out of 5 AIDS cases are reported due to under-utilization of health services, under-diagnosis, under-reporting and delays in reporting. However, the data is believed to reflect the trend of AIDS cases in the country. In face of under-reporting differences among regions, care is needed in the interpretation of region specific cumulative case rates. Indeed, regions with high case rates are those with fairly complete and regular recording and reporting. Mbeya can be cited here as an example of a region, which reports AIDS cases to the NACP fairly regularly and consistently. It appears on table 3 to have the highest case rate compared to other regions. Although it is one of the hard hit regions in the country, perhaps it wouldn't have ranked highest if reporting were regular and consistent in all regions. Thus, it is wise that case rates be used to judge disease burden (map 1) as well as worthiness of AIDS reporting system in the regions.

Figure 1: Age and Sex Differences of Reported AIDS Cases January – December 1998

HIV/AIDS Mortality

Results from a population based Adult Morbidity and Mortality Project (AMMP) August 1997 are that, HIV/AIDS is the commonest cause of deaths in adult males and females aged 15 – 59 years in Dar es Salaam city and Hai district. It was also the commonest cause of deaths in adult female, and second to acute febrile illness including Malaria in men in Morogoro rural district. AMMP is implemented in three areas namely Dar es Salaam city, Hai and Morogoro rural districts (Figure 2).

Figure 2: Top 15 Causes of Death in Males and Female Aged 15-59 Years in Dar es Salaam, Hai District and Morogoro Rural District.

Table 2: Cumulative AIDS cases by Region and Year (1992-1998)

Region	1992	1993	1994	1995	1996	1997	1998	Pop.	Case* Rate
Arusha	1,637	2,185	2,368	2,615	2,787	3,244	3,567	1,942,558	184
Coast	2,215	2,740	3,023	3,268	3,559	3,796	4,266	786,049	543
Dares Salaam	9,295	10,406	11,050	11,302	12,983	13,899	14,517	2,154,648	674
Dodoma	762	1,028	1,294	1,608	1,938	2,517	2,641	1,580,263	167
Iringa	3,334	4,462	4,674	4,785	4,883	5,008	5,031	1,573,726	320
Kagera	5,813	6,646	7,064	7,223	7,426	7,671	7,881	1,773,239	444
Kigoma	1,556	1,920	2,070	2,257	2,280	2,426	2,481	1,116,625	222
Kilimanjaro	3,707	4,699	5,119	5,513	5,991	6,618	7,375	1,374,734	536
Lindi	1,211	1,691	1,966	2,173	2,480	2,712	3,074	778,735	395
Mara	980	1,304	1,393	1,486	1,486,	1,486	1,515	1,274,893	119
Mbeya	9,890	11,439	12,214	12,371	14,685	16,835	19,949	2,016,408	989
Morogoro	3,598	4,328	4,575	4,903	5,189	5,438	5,534	1,558,884	355
Mtwara	1,968	2,090	2,201	2,267	2,444	2,569	2,843	1,014,563	280
Mwanza	4,207	5,349	5,731	5,974	6,365	7,006	7,384	2,462,018	300
Rukwa	496	715	777	801	882	1,227	1,359	1,083,173	125
Ruvuma	1,807	2,480	2,847	3,087	3,345	3,752	4,260	1,068,007	399
Shinyanga	1,874	2,624	3,062	3,361	3,824	4,217	4,515	2,424,494	186
Singida	1,107	1,472	1,688	1,908	2,135	2,167	2,262	1,160,907	295
Tabora	1,972	2,786	3,075	3,428	3,805	4,278	4,733	1,329,534	356
Tanga	2,636	3,207	3,475	3,793	4,062	4,278	4,632	1,606,328	288
Unspecified	1	1	2	44	44	44	44		
All	**62,058**	**75,565**	**79,668**	**84,167**	**92,593**	**101,188**	**109,863**	**30,079,785**	**365**

Note: Dar es Salaam Cases included in this report were reported from Aga Khan and wananyamala Hospitals only.

* Case rates per 100,000 population.

HIV Sentinel Surveillance Using Antenatal Clinics

HIV Serology in Sentinel Sites

During this reporting year, only 10 out of 24 sentinel sites located in 2 (Mbeya and Kilimanjaro) out of 11 regions were active. The prevalence of HIV among women attending various antenatal clinics in Mbeya and Kilimanjaro is shown in Table 4. The prevalence of HIV infection in Mbeya region ranged between 23% in Isoko and 24% in Kyela. In Moshi rural district Kilimanjaro region the prevalence was 20%. Proportions for 1992 through 1997 are also presented for comparison. The overall HIV sero-prevalence in Mbeya region during this reporting year is 15.4%, the same as that of 1992 and 3% lower than that of 1997. In contrast, HIV sero-prevalence in Moshi rural district in 1998 is 3 and 2 times higher than that of 1992 and 1997 respectively.

Table 3: HIV Sero-Prevalence Among Pregnant Women in Rural and Urban Sentinel Sites, 1992 – 1998

	1992	1993	1994	1995	1996	1997	1998
Mbeya Region	**15.4**	**15.9**	**20.3**	**18.6**	**17.4**	**18.2**	**15.4**
Mbeya rural	11.1	12.1	20.4	14.2	14.5	15.6	12.3
Mbeya urban	19.3	17.7	19.8	20.7	18.5	19.6	17.3
Kyela(border)	26.2	27.5	21.6	33.3	25.9	25	24
Rukwa			**26.5**	**17.4**			
Namanyere(Rural)	11.3	8.33	19	11.2		11.2	
Sumbawanga(Rural)	12	23.3	31.3	22.2		21.0	
Ruvuma							
Songea (Urban)	9.7	16.1	15.7	14.2		11	
Namtumbo (Rural)	3.5	6.7	3.2	5.6		4	
Kilimanjaro							
Moshi Rural	6.4				9.1	10	20

Seven-year HIV sero-prevalence trend for Mbeya, Rukwa, Ruvuma and Kilimanjaro is presented in Figure 3. The trendline for Moshi District is different from all in that it has doubled between 1997 and 1998.

Figure 3: Seven-Year Prevalence Trend of HIV Infection in Selected Areas of Tanzania

The observed prevalence of HIV infection in blood donors in Mbeya and Kilimanjaro is that of increase over time.

Table 4: Prevalence of HIV in pregnant women age 24 and below in Moshi Rural District in 1998

Age	All tested	HIV positive	%HIV Positive
17.24	132	27	20.5
25-48	169	33	19.5
Total	**301**	**60**	**19.9**

In Umbwe sentinel site (Moshi rural district), HIV prevalence rate among pregnant women aged 17-24 in 1998 is 20.5%. This rate is statistically not different from 19.5% in women aged 25 and above (p=0.841), Table 4.

HIV Sero-Prevalence from Population Based Studies

Population based studies are essential for validation of sentinel surveillance data. Results from a randomised trial of effects of Vitamin supplementation on pregnancy outcome, which was carried out in Dar es Salaam between 1995 and 1997, established HIV sero-prevalence rate of 13.5% in 1995, 12.4% in 1996 and 14.8% in 1997. Another study, which was carried out in Moshi rural district between March and June 1995, enrolling youth (15 – 24) came up with an overall prevalence rate of 7.5%. Prevalence in female was 9.7% and that of male was 5%.

HIV Sentinel Surveillance Using Blood Donors

Reporting of HIV serostatus of potential blood donors in the country has been taking place since 1987. Initially, screening was done in regional and referral hospitals only, but since 1990 all hospitals which provide blood transfusion to ensure safe transfusion. Sets of forms entitled blood donor HIV registers are distributed through RMOs to all hospitals carrying out blood donation and transfusion services. Copies of dully-filled forms are returned to the epidemiology unit for processing and reporting.

Regional Differences in HIV infection using blood donor data

During this reporting year, over 124,251 persons donated blood. Eighteen percent (22,299) of them were women. Ninety-four (94) percent were patients' relatives, 2.7% were institutional donors and relationship of the remaining 3.3% donors was not specified. The overall prevalence of HIV infection among blood donors was 9%. HIV prevalence rate in male blood donors was 8.5% and in female blood donors the rate was 11.8%. The prevalence of 11.8% in women is significantly higher than 8.5% in men. Extrapolating these rates to the adult population aged 15 years and above, 1,633,599 persons were infected with the AIDS virus as of December 1998.

Table 6: Prevalence (%) of HIV infection among male blood donors by region, 1992-1998

	1992	1993	1994	1995	1996	1997	1998
Arusha	2.6	2.6	2.7	6.1	3.0	2.8	4.2
Coast	4.1	5.9	6.6	5.5	9.4	8.2	7.7
Dodoma	2.8	1.7	0.0	0.0	4.9	7.9	4.9
DSM	8.5	-	-	4.9	17.2	19.8	12.5
Iringa	11.1	13.2	7.7	13.0	14.2	14.2	14.8
Kagera	10.9	5.8	7.9	10.8	8.0	8.6	14.8
Kigoma	1.9	7.0	3.4	4.9	5.6	2.8	3.8
Kilimanjaro	2.4	3.4	1.5	10.7	4.1	4.1	4.8
Lindi	3.7	2.5	-	3.0	3.7	3.0	3.3
Mara	6.9	5.0	3.7	5.8	7.6	9.5	6.9
Mbeya	15.1	0.0	-	9.0	11.1	12.6	13
Morogoro	4.6	5.7	-	-	4.1	5.5	7.4
Mtwara	5.2	9.5	15.2	10.1	9.7	4.5	8
Mwanza	5.1	4.0	2.9	12.5	7.6	9.5	6.9
Rukwa	6.7	-	-	-	8.0	7.9	-
Ruvuma	6.2	7.3	2.0	3.3	8.1	7.7	7.4
Shinyanga	6.1	6.4	14.7	11.7	8.5	8.5	8
Singida	2.7	2.8	0.0	-	5.6	3.6	6.2
Tabora	2.8	4.4	2.5	6.2	3.2	6.1	5.9
Tanga	7.1	4.4	-	10.4	5.5	8.0	7.3
All	**5.3**	**5.9**	**6.9**	**7.8**	**6.8**	**7.6**	**8.5**

Table 7: Prevalence (%) of HIV infection among female blood donors by region, 1992-1998

	1992	1993	1994	1995	1996	1997	1998
Arusha	2.2	3.9	-	15.6	4.4	6.0	7.6
Coast	5.0	10.2	11.8	9.2	-	8.0	13.1
Dodoma	4.8	-	-	0.0	-	9.2	6.2
DSM	7.7	-	-	6.7	-	40.6	32.1
Iringa	8.1	17.6	20.0	7.8	12.4	16.4	15.1
Kagera	11.0	8.6	8.3	14.3	7.4	11.3	14.3
Kigoma	4.1	5.8	5.1	0.0	6.1	2.6	2.6
Kilimanjaro	2.2	1.8	2.9	0.0	5.9	8.1	8.1
Lindi	.3	1.9	-	1.6	3.6	4.9	5.2
Mara	8.2	2.9	10.0	9.4	10.1	13.1	7.7
Mbeya	20.3	-	-	11.4	13.8	14.4	15.1
Morogoro	5.7	10.8	-	-	6.0	9.1	8.8
Mtwara	10.5	5.7	0.0	5.6	10.5	-	23
Mwanza	5.7	8.0	5.0	0.0	8.5	-	-
Rukwa	0.0	-	-	-	8.8	-	-
Ruvuma	6.4	6.7	2.1	6.1	10.5	12.7	12.2
Shinyanga	10.0	21.6	33.3	0.0	14.9	14.9	14.6
Singida	4.5	4.6	0.0	-	5.8	5.2	7
Tabora	2.7	5.8	0.0	12.9	3.2	7.7	9.5
Tanga	7.0	5.9	-	20.8	7.0	13.6	11.9
All	**5.9**	**6.2**	**4.8**	**9.4**	**8.2**	**11.6**	**11.8**

Figure 7: Seven Year prevalence Trend of HIV Among Men and Women Blood Donors

In general prevalence of HIV infection in both men and women has been continuously at increase for the past seven years.

Tables 9 and 10 show the prevalence of HIV infection among blood donors by region and gender for the period between 1992 and 1998.

Table 8: Age-Specific Prevalence (%) of HIV Infection Among Male Blood Donors (1991-1998)

Age	1991	1992	1993	1994	1995	1996	1997	1998
15 – 19	3.2	3.7	3.9	2.4	5.3	4.4	4.5	5.2
20 – 24	5.0	4.9	5.8	2.4	5.8	5.9	4.9	6.8
25 – 29	6.7	6.0	6.1	5.8	7.2	7.4	7.2	8.5
30 – 34	6.4	5.8	6.2	5.4	7.7	7.9	7.3	10.1
35 – 39	6.1	5.6	6.5	9.8	7.8	7.7	7.4	9.8
40 – 44	4.8	3.9	5.1	0.0	5.9	6.3	6.6	9.1
45 – 49	4.5	4.2	4.9	7.4	5.8	5.7	5.8	8.4
50 – 54	4.4	2.6	4.3	0.0	3.5	5.6	4.8	7.1
55+	4.0	2.3	5.2	12.5	2.5	4.4	5.9	8.2
All	**5.8**	**5.3**	**5.9**	**4.8**	**6.7**	**6.9**	**6.0**	**8.5**

Prevalence of HIV infection among blood donors shows some specific difference with regard to age and sex. Higher prevalence of HIV infection is seen among females than in males of the same age group. The prevalence across the age group for male ranges between 5.2% for the age group 15 – 19 and 10.1% for the age group 30 – 34. For female the range is 7.8% and 13.2% for the age groups 55 and above and 30 – 34 years respectively.

Figure 6: HIV Prevalence Rate Among Male Blood Donors for the Period 1996-1998

Prevalence of HIV infection among blood donors shows some specific difference with regard to age and sex. Higher prevalence of HIV infection is seen among females than in males of the same age group. The prevalence across the age group for male ranges between 5.2% for the age group 15 – 19 and 10.1% for the age group 30 – 34. For female the range is 7.8% and 13.2% for the age groups 55 and above and 30 – 34 years respectively.

Table 9: Age-Specific Prevalence (%) of HIV Infection Among Female Blood Donors (1991-1998)

Age	1991	1992	1993	1994	1995	1996	1997	1998
15 – 19	4.9	4.2	2.9	5.6	5.3	6.3	6.7	8.8
20 – 24	7.7	7.2	7.5	5.4	9.4	9.8	10.2	11.3
25 – 29	8.7	6.6	7.2	7.1	11.6	10.1	11.0	13
30 – 34	6.5	5.7	6.6	6.9	10.0	9.3	12.1	12.5
35 – 39	4.8	5.7	6.7	10.1	8.8	9.3	12.1	12.5
40 – 44	6.3	3.6	1.7	5.4	7.6	6.0	9.6	10.3
45 – 49	3.4	4.4	3.7	7.5	4.8	5.5	8.2	9.8
50 – 54	5.6	5.4	5.9	6.2	*6.3	5.6	11.2	8.8
55+	6.7	4.2	5.3	3.3	*16.7	7.1	7.6	7.8
Total	**7.2**	**5.9**	**6.3**	**6.9**	**9.2**	**8.7**	**9.7**	**11.8**

Figure 7: HIV Prevalence Rate Among Female Blood Donors for the Period 1996-1998

Considering individual age groups, HIV prevalence continued to rise over time during the period 1996 to 1998 for the age group 50 – 54.

Determinants of the Epidemic

From the situation analysis of HIV/AIDS in Tanzania, several determinants of the Epidemic were identified. The main groups are societal, behavioural and biological. These singly or in combination provide opportunities for HIV infection to occur to an individual.

Social determinants

1. Commercial sex workers form a group that potentially increases the sexual transmission rate of HIV infection. Studies by AMREF along the major truck stops and towns have shown this group to have a high HIV prevalence of up to 60%. A study conducted by MUTAN in the Moshi municipality showed that bar workers had HIV infection prevalence rate of 32%, while a study in Dar es Salaam showed that 50% of the bar workers were HIV positive.

2. Stigma and discrimination against people living with HIV/AIDS is quite common in Tanzania. Studies done in communities in Magu, Mwanza by TANESA showed the level of stigma and denial for AIDS and HIV to be very high. Many people would not admit that their sick relative could be suffering from HIV/AIDS but believe instead in witchcraft as the cause of their sickness. This situation makes it difficult to convince people with wife-inheritance traditions not to marry women whose husbands may have died from AIDS.

3. A large proportion of the population with very low and/or irregular income is an important social determinant. Over 50% of Tanzanians live below the

poverty line and females are worse than males. In addition, low and or irregular income creates an environment that encourages labour migration. Women in such situations may be easily tempted to exchange sex for money and this puts them and their spouses at risk for HIV. People with low income have less access to medical care including that for STDs and HIV/AIDS.

4. Social isolation for long periods and peer pressures for high-risk behaviour among the military form other social determinants. In Tanzania when one is enrolled in the army, one is confined in a camp and barred from getting married for six years. This makes one vulnerable to high-risk behaviour and hence to HIV infection especially when the army has no proper programs for HIV/AIDS prevention like the promotion of condom use and provision of IEC for HIV prevention.

5. Cultural norms, beliefs and practices that subjugate/subordinate women are important determinants These include cultural practices like wife inheritance, polygamy and female circumcision which are common among many tribes in Tanzania. Obligatory sex in marital situations is condoned even by religion, and women cannot divorce in some faiths. Furthermore, in some cultures multiple sex partners for men is tolerated and may even be encouraged.

6. Young people leave home and school environments to become independent without a source of income. In Tanzania every year about 300,000 pupils leave primary education quite early (age 13 - 17yrs) and a significant proportion migrates to large towns like Dar es Salaam in search of employment. These youth and especially the female, become very vulnerable because they end up getting employment, which is poorly paid and in turn have to supplement their meagre income through unsafe sexual practices. Although there have been attempts to introduce sex education in schools, these have not adequately prepared those leaving school to confront sexual issues.

7. Illiteracy and lack of formal education is on the rise in Tanzania. In the eighties the level of literacy in the country was around 80%. At that time many people could read and understand messages meant for their well being. Today, the literacy rate has gone down to less than 60%, this means less people can understand written messages. This has been contributed by the fact that many young people are not being enrolled into schools and these are unfortunate because it has been shown that the prevalence of HIV infection in educated women is lower than in those who were not educated. The other contributing factor to the declining literacy rate is that the post-independence adult education campaigns are currently so poorly managed for lack of resources that there is little or no output.

Behavioural determinants:

8. Unprotected sexual behaviour among mobile population groups with multiple partners makes them vulnerable to HIV infection. The groups include long distance truck drivers who have been found to have unprotected sexual intercourse with HIV sero-positivity of up to 50%. This is because they have

multiple sexual partners available in all major truck stops. Migrant or seasonal workers are also vulnerable. It has been found that farm and plantation workers in Iringa and Morogoro for example, have HIV prevalence of about 30%, which is very high compared to the general population.

9. Reduced Social discipline for making good decisions about social and sexual behaviour. Long before the eighties when the AIDS epidemic became apparent Tanzanians were a disciplined society where traditional values and norms were cherished. But recently, social discipline has been eroded. This is so because of several factors such as failure of parents to institute traditional values and discipline to their children for lack of time. Sudden mushrooming of television programmes and other mass media have also contributed negatively to social discipline.

Biological determinants

10. STDs Infections (especially gonorrhoea and other genital discharges) are among the top-ten causes of disease in mainland Tanzania. Studies have found that patients with STDs are 2 to 9 times more likely to be infected with HIV. However because HIV and other STDs are both highly associated with high-risk sexual behaviour it is difficult to show the extent to which STD alone enhance infection of HIV. Nevertheless, studies in Mwanza have shown that STD management within the existing PHC system can reduce the incidence of HIV infection by about 40%.

11. Unsafe blood transfusion is a major determinant of HIV transmission. The HIV transmission rate through transfusion of contaminated blood is almost 100%. For this reason, in Tanzania all centres rendering this service are equipped with facilities to ensure safe blood transfusion. However, due to lack of regular supplies of reagents and equipment as well as lack of reliable power supply in some centres there is some risk of transfusing contaminated blood. This situation therefore calls for improved blood transfusion services in the whole country.

Impact of the HIV/AIDS epidemic

Given that the HIV/AIDS epidemic has progressed with different rates in various population groups in Tanzania, the impact has varied from being minor to being profound depending on the time the infection was introduced in the area, rate of spread and the proportion of the population affected.

Experiences from several parts of the country indicate that HIV infected persons, on average, die about 4 to 12 months after falling ill with one or more of the major manifestations of AIDS. During this period a member of the family often has to stay at home or hospital with the patient to provide care especially during the terminal stages of the disease. The medical, emotional and social costs on the patient and indeed the family are frequently high. More socio-economic difficulties arise when the patient is the main bread earner. When death finally comes the traditional family structures, already stressed by poor health, increased burden of care and poverty, are in many cases at breaking points. Funeral costs have been estimated to exceed US $100 for every adult death in Kagera. Available data from severely affected communities show that AIDS often leads to social and economic disruption of affected individuals, families and communities. The poorest households are least able to cope with the impact of adult deaths due to AIDS and are frequently unable to obtain even the most basic needs in the short term. Child nutrition, education, health and living standards for the survivors may be severely affected.

Hospital based data indicate that up to 50% of beds are occupied by patients with HIV/AIDS related illness. Consequently the demand for care and hospital supplies is enormous and by-and-large government health facilities are at a breaking point if not broken already due to inadequate funding and manpower. It is estimated that in Tanzania the ideal life-time and nursing-care costs for HIV/AIDS is US $ 290 for adults and US$ 195 for children. Gains made during 1980's in TB control have been lost due to HIV/AIDS. TB case rates had been declining steadily up to 1982 but since then there has been a sharp increase the number of reported TB cases and in most urban areas these have more than doubled.

Since agriculture is the backbone of the Tanzanian economy, and most agricultural workers are in the age group 15-45 who are mostly affected by the epidemic, the impact of HIV/AIDS is gradually becoming noticeable as the epidemic spreads to rural communities. Production of food and cash crops is bound to suffer as the labour force gets sick and dies from AIDS.

The World Bank estimates that because of the AIDS epidemic, life expectancy by 2010 will revert to 47 years instead of the projected 56 years in the absence of AIDS. The Bank further predicts that the mean age of the working population (labour force) will decline from 31.5 to 29 years between 1992 and 2010. The overall younger work force will have less education, less training and less experience. In addition the number of children orphaned by AIDS was estimated to be increasing from between 260,000 to 360,000 in 1995 to between 490,000 and 680,000 by the year 2000. Families, communities and the government will be required to generate resources to cater for the needs of these children. The Bank further estimates that, AIDS will

reduce average real GDP growth rate in the period 1985-2010 from 3.9% without AIDS to between 2.8 and 3.3% with AIDS. These factors will certainly have a negative impact on the overall economic performance of the country and its living standards.

Advocacy and Policies for HIV/AIDS

Government involvement and leadership are crucial for HIV/AIDS prevention and control activities. Governments have the mandate and means to finance public services necessary for the monitoring and control of diseases. Furthermore governments have the responsibility to create political and social environments that reduce high-risk behaviour in general. For example, government policies on provision of social services, maintaining law and order, poverty reduction, protection of the poor and weak are important in preventing HIV transmission and coping with its impact.

The situation analysis of the HIV/AIDS in Tanzania has shown lack of strong political will and commitment on the part of the government. As a consequence, policy and sensitization on HIV/AIDS issues at all levels of the political structure have been inadequate. Funding and other resources for HIV/AIDS activities in Tanzania have largely depended on external resources. Consequently efforts to curb the HIV/AIDS will stop if and when such funding stops forthcoming.

In spite of available data, including that from the World Bank, HIV/AIDS issues are yet to be adequately integrated into the macroeconomics and sectoral policies. To date most people including policy makers consider HIV/AIDS to be a health issue. Hence multi-sectoral response has been minimal. Legal and human rights issues related to community protection, protection of people living with AIDS and their families, widows and orphans have not been adequately addressed by the various sectors of the population. A draft HIV/AIDS policy document produced in 1995 that attempts to give guidance to some of these issues is yet to receive approval from appropriate government authorities.

The lack of a firm advocacy in the government machinery creates an environment that does not promote appropriate individual, community or national response to the HIV/AIDS epidemic. It is of interest to note that whenever there is strong advocacy from the government for a cause (e.g. cholera outbreaks) the communities are readily mobilized and effective measures put in place at all levels. However, when the AIDS problem continues to devastate our economy the response has not been serious. For example, the NAC which is the highest government body in AIDS control activities, has met only twice (instead of quarterly) during a period of 2 years indicating the low level of priority given to HIV/AIDS issues in the government system.

Key Outcomes to National Targets in the Past Five Years

In the past five years, on the basis of the nature of HIV epidemic in Tanzania 11 priority areas were addressed. Below outcomes are summarized.

Priority area 1: Provide Appropriate STD Case Management Services

The prevalence of STDs is high in Tanzania. Discharge syndromes are the most common STDs with gonorrhoea prevalence ranging from 2% to 10% among antenatal women. The patterns of genital discharge and genital ulcer diseases vary over the country with a higher prevalence of genital ulcers in the Mbeya/Iringa area and the Lake region than elsewhere. Syphilis prevalence in the same group varies between 5 and 15%. Of the genital ulcer diseases, syphilis is the most common causative agent, but there is a relatively high prevalence of chancroid, particularly in the Mbeya area. There are no reliable data for STD incidence in the country but if extrapolation from a small study area in Mwanza is made, it can be estimated that between 1 and 1.5 million symptomatic STD cases occur each year.

What was done in MPT-II

During the MTP-II some STD treatment centres were initiated in the Mbeya, Mwanza, Iringa, Shinyanga and Dar es Salaam regions. About 20 health facilities in 11 regions providing STD treatment in the country received drugs and other supplies from NACP. Some health staff were also trained by NGOs like TAP, AMREF and GTZ on STD control activities. Sex partner notification showed some success in most of the clinics. Also, the syndromic treatment guidelines were in place in most clinics. However, health seeking behaviour to STD clinics was inadequate because of the perceived stigma resulting to reluctance of some patients not directing their sex partners to health facilities for treatment. Condom use was still hindered by some religious beliefs.

Priority Area 2: Reduce Unsafe Sexual Behaviour among Highly Mobile Population Groups

Unprotected multiple sexual behaviour has been identified as a major determinant fuelling the epidemic in Tanzania. In particular, mobile population groups are well known for their frequent risk behaviour of acquiring multiple sex partners while they are away from home. Most sexual activity among them is unprotected. For this reason, reduction of sexual risk behaviour among these groups will be a major activity during MTP-III. Mobile populations include long distance truck drivers, seasonal farm workers, petty traders and small-scale miners.

What was done in MTP-II:

During MTP-II, NACP co-ordinated different research and instructional activities that were mostly carried out by NGOs like AMREF. Of the main mobile population groups in Tanzania (Truck drivers, petty traders, minors and seasonal workers), only truck drivers were provided with some service involving promotion of sexual behaviour change among them. Truck drivers were a special group that was mainly

accessed using the major truck stops in the country. In some areas, counsellors were trained, condoms distributed among truck drivers and STDs treated. However, the MTP-II did not spell out specific objective and strategies that were designed to approach this group and achieve the set objectives.

Priority Area 3: Reduce HIV Transmission among Commercial Sex Workers

The area of Commercial Sex Work (CSW) ranks very high among priority areas in HIV/AIDS prevention because commercial sex work is not only an important determinant driving the epidemic, but also has relatively effective interventions to reduce unprotected sexual behaviour among its clients

What was done in MTP-II:

Commercial sex workers are not a group officially recognised by the government of Tanzania. However, because the group is crucial in HIV/AIDS transmission, different NGOs in Dar es Salaam and Morogoro have been implementing different activities with the groups ranging from condom distribution to income generating activities. In Tanga region GTZ has been working with prostitutes using peer educators. Other organisations have worked with CSWs in truck stops. They have been recruited as peer educators, condom distributors and to some extent, counsellors. However, there are no accurate data on the dynamics of this group and hence success in HIV/AIDS control activities involving them has been difficult to measure.

Priority Area 4: Prevent Unprotected Sexual Activity Among the Military.

Studies show that military recruits are at a higher risk of HIV infection and STDs than the general population. This is partly due to the fact that they are highly sexually active and mobile and yet they are subjected to military regulations which bar them from getting married while in service for at least six years. Being socially isolated for long periods they develop high-risk behaviour that is fuelled by peer pressure to engage in unprotected sexual activity.

What was done in MTP-II:

During MTP-II, a civil military alliance, bringing together the police force, the armed forces and the civilian security forces, was formulated as a joint effort to fight HIV/AIDS among them. Screening for HIV and treatment of STDs were done in most places within the alliance. However, a proper research to establish the HIV prevalence among numbers of the alliance as a group has not taken place.

Priority Area 5: Reduce Vulnerability of Youth to HIV/AIDS/STD

In Tanzania, about 65% of the total population are below the age of 25 years. This group constitutes youths and children, the former being the majority. The in-school youth are potentially vulnerable to many risks including STD and HIV infection through early sexual intercourse combined with lack of knowledge on inherent risks and preventive measures. This situation gets worse when many of them drop out of school at relatively early age, and loose the school's protective environment.

The out-of-school youth are the most vital and economically active group. Yet, they are increasingly being acknowledged as a serious development issue following rapid rural urban migration, youth unemployment, drug addiction and the relationship between youth sexuality and HIV/AIDS/STD. Government as well as NGOs and CBOs are already running a range of youth development programmes. Some of these programmes incorporate HIV/AIDS activities. The youth programmes under the Ministry of Labour and Youth Development, which incorporate HIV/AIDS action and which UNDP will support are:

(a) Youth economic groups (YEGs),
(b) Young mothers economic groups (YMEGs) and
(c) The youth guidance and counselling programme.

YEGs are being created through the initiative of the youth themselves at the village level. They address youth unemployment as the root problem that gives rise to other youth problems, including susceptibility to HIV infection. This priority area will therefore have two components in its objective: one for the out-of-school, and the other for the in-school youth.

What was done in MTP-II

In some districts, there are NGOs that focus on out of school youth group. In MTP-II, this group was also accessed indirectly in STD management, counselling and condom distribution activities. This group was also reached by educational messages, which were disseminated to the general public. Also reached this group. Concerts aimed at behaviour change were conducted in four out of twenty regions of mainland Tanzania and also, some videocassettes were shown to this group. However, funds for production of IEC materials and for implementation of the planned activities at district level were not enough. Furthermore, there was no evaluation done on the content and impact of the materials used.

MTP-II did not have a direct focus on youths in school and as a consequence, the MTP-II Review Document does not mention any activity done in this group. However, some teachers in primary schools were sensitised on HIV/AIDS/STDs knowledge. Some learning materials were also prepared and incorporated in the primary school syllabus. However, there has been a lot of friction as to whether HIV/AIDS/STDs should be taught in primary schools.

Priority Area 6: Maintain Safe Blood Transfusion Services

By maintaining safe blood transfusion services throughout all transfusion centres in the country all HIV transmission due to blood transfusion or its products can be eliminated. This is a key responsibility of the health care delivery system of the MOH. Among the 182 blood transfusion sites throughout the country, the four national and seventeen regional sites are operating well. The remaining 161 transfusion sites are not working well due to various logistic problems. Problems associated with these sites include inadequate provision of basic supplies and equipment, lack of assurance

that supplies are being used properly, lack of cold chain facilities, and lack of standardized quality control for blood transfusion.

What was done in MTP-II

During MTP-II, most donated blood was screened for HIV anti-bodies using the simple rapid tests (HIV CHECK or CAPPILLUS) in all centres providing blood transfusion services. In addition, relevant data on screened blood donors were kept and maintained at these centres. However, due to interrupted power supply in some regional hospitals they were forced to use HIV CHECK instead of the recommended ELISA test. Furthermore, no quality assurance arrangements were made by NACP, and there were no adequate supervisory visits conducted by NACP to these centres due to shortage of transport and funds.

Priority Area 7: Reduce Poverty Leading to Sexual Survival Strategies

It is a well-known fact that poverty reduces access to basic needs such as food and shelter as well as social services such as health education and employment. These circumstances by themselves increase the vulnerability of the poor to diseases like STD and HIV/AIDS, and often create the vicious circle of poverty, ill health and poor economic status. In addition, the temptation is high for poor people to get out of this vicious circle through all kinds of more or less marginalized activities including sex for money or other favours.

While poverty alleviation is far beyond the scope of health planning in general, and of a national HIV/AIDS plan in particular, it remains that sex for money or other goods, especially by young women and girls, is a major determinant fuelling the HIV epidemic, and hence it is justifiable to address it during MTP-III.

What was done in MTP-II

During MTP-II, a poverty alleviation programme financed by UNDP was started. However, the programme does not focus on poverty as a factor that may lead to sexual survival strategies thereby increasing HIV transmission. Although there are other community based programmes in different areas of the country that mobilise women and provide them with soft loans, there is no active integration with activities aimed at reduction of sex for money.

Priority Area 8: Promote Acceptance of Persons Living with HIV/AIDS

Stigma, discrimination and non-respect of the basic rights of persons living with HIV or AIDS (PLHAs) not only are determinants for driving the epidemic - through having PLHAs conceal their HIV status to their partners if they know it, or discouraging them from testing, and hence contributing to the invisibility of the epidemic - but also constitute unacceptable breaches of these persons' human rights on the basis of their mere health status. An important role of PLHAs is not to be passive but to be responsible and to participate fully in HIV/AIDS control activities.

What was done in MTP-II

During MTP-II, the NACP supported some NGOs to implement community based counselling. Pre-and Post-test - counselling was implemented for those seeking voluntary HIV testing such as pre-marital couples and the worried well. A similar service was also provided for population-based surveys requiring HIV testing. Home-Based Care activities were carried out by different organisations like WAMATA, PASADA, UPENDO, TANESA and other several organisations dealing directly with PLHAs. Also, NACP conducted a baseline survey on Home-Based Care (HBC) and conducted training for home caregivers in two pilot regions, Rukwa and Coast. During MTP-II NACP trained 73 hospital-based counsellors in 59 hospitals to implement the counselling service.

However, there was little documentation on the counselling process, hence it is difficult to assess the quality of the services given. It was also noted that the existing guidelines for counselling are mostly hospital-based. It was also noted that privacy of counselling seemed to be lacking in most institutions. Also, family and couple counselling were not addressed in the MTP II. The MTP-II review also noted that HBC service providers are not well motivated. Furthermore, the NGOs dealing with HBC were not evaluated to measure the impact of HBCs on the welfare of PHLAs.

Priority Area 9: Reduce Unprotected Sex among Men with Multiple Sex Partners.

This priority area focuses on the reduction of widespread unprotected sexual intercourse among men with multiple sex partners. Although men and women are equally involved in unprotected multiple sexual intercourse, men have generally been responsible for initiating such risk behaviour. As such intervention among men should result in a significant reduction in HIV transmission.

What was done in MTP-II

The only men's group that was specifically targeted during MTP-II was the highly mobile population group of truck drivers. IEC activities were conducted by different NGOs in the major truck routes and condoms distributed in these areas. For the other male population groups, owners of guesthouses and hotels were encouraged to make condoms available in their guesthouses and hotel rooms. TV and radio programmes (messages) targeting high-risk behaviour were designed and produced. A set of IEC materials (newsletters and calendars) were produced and distributed by different communication channels. Different NGOs were also used to reach the general public in trying to advocate for safer sex. However, the limited community involvement in planning, implementing and producing IEC materials acted as an obstacle against more achievements. Furthermore, the impact of these materials was not evaluated.

Priority Area 10: Improve Educational Opportunities Especially for Girls.

Many studies have shown that women in many African cultures are subjugated and are powerless economically and socially. Hence their power to negotiate for safer sex

is limited. Women marry earlier than men and acquisition of knowledge about factors affecting their health is delayed. School attendance is poor among women while dropout rates among those in school are higher than among boys. For these reasons, education for girls is a priority area that should be addressed during MTP-III. Education will equip them with the necessary tools to negotiate for safer sex and will further delay early marriage, which puts most of them at risk.

What was done in MTP-II
During MTP-II, secondary and higher education girls were not prioritized as a vulnerable group. The group was being reached by the information targeted to the general population using IEC materials, listening to radio, meetings, drama etc. School enrolment in favour of girls was not discussed during MTP-II because it was a matter to be taken up by the MOEC and the private school system.

Priority area 11: Reduce vulnerability of women in adverse cultural environments

The situation analysis done in 1997 for MTP-II already mentioned the erosion of cultural norms and beliefs, and the general decline in morality in the Tanzanian society as a factor that could adversely affect the HIV/AIDS situation.

It is well known that individual behaviour can ultimately influence a person's susceptibility to become infected with HIV. However, individuals belong to a society and undergo cultural influences from that society, even in their most intimate behaviour such as sex.

What was done in MTP-II

During the MTP-II, members of parliament were sensitised on the issue of the rights of women, and it ended up with enacting a law that safeguards the interests of women in sexual matters. Different NGOs dealing with human rights have passed messages to the community on the rights of persons to make decisions on sexual matters. Televisions, newspapers, meetings and radios were used during MTP-II to pass messages on sexual rights to different population groups.

As it were previous activities of priority areas lack adequate quantification. This should be taken as a lesson for future activities. Actually it has been rectified in MTP-III.

THE NATIONAL HIV/AIDS POLICY AND STRATEGIES

The National HIV/AIDS Policy

The AIDS policy is intended to create a clear and favourable environment for all aspects of AIDS control and prevention. The policy is essential for successful implementation and coordination of AIDS control and prevention activities. The AIDS policy has drawn from past experience gained from AIDS activities in Tanzania and other parts of the world as well as other health programmes. The policy is broad enough and it includes the diverse and varied aspects of multisectoral response to

HIV/AIDS which include, among others, care for AIDS patients, family life education, government budgetary allocations, condoms and basic rights of people with AIDS. It is also flexible and subject to periodic revisions to accommodate new developments that may emerge.

The National AIDS policy has been prepared when the HIV epidemic is still spreading fast and there is no cure or vaccine for AIDS. If there were a vaccine or cure for AIDS, National AIDS Policy might have required a different strategy and response.

HIV is transmitted from one person to another through body fluids. Epidemiological studies have documented three modes of HIV transmission:

(a) through sexual intercourse with an infected person, most particularly vaginal and anal intercourse;
(b) through contact with infected blood products or donated organs or bone grafts tissue;
(c) from an infected woman to her child in the womb, possibly during birth or from breast-feeding.

In view of this, the following principles will guide the National AIDS Policy:

1. Transmission of HIV is preventable through changes in individual behaviour; education and prevention programmes are necessary to bring about such changes.
2. Each person must accept responsibility for preventing him/herself becoming infected through sexual intercourse or the sharing of needles and for preventing further transmission of the virus
3. The community as a whole has the right to appropriate protection against infection.
4. The law should complement and assist education and other public health measures.
5. Public health objectives will be most effectively realized if the co-operation of people with HIV infection and those most at risk is maintained.
6. Specific informed consent should be obtained before any test is performed to diagnose a person's HIV infection status. The result should remain confidential, as regard third parties and appropriate pre- and post-test counselling should be provided.
7. People infected with HIV have the right to participate in the community without discrimination, and have the same rights to comprehensive and appropriate health care, income support and community services as other members of the community.
8. Professional and community care-providers have a duty to care for infected individuals; governments, employers and unions have a responsibility to provide working conditions and training programmes which minimize the risk of occupational transmission.

9. Research on the AIDS epidemic is essential to the management of the disease.
10. General principles of public health service provision and the legal system will be applicable to the HIV epidemic where special measures or services require justification.

Overall Goal of the Policy

To mobilize and sensitize the community to get actively involved in preventing further transmission of HIV and to cope with the social and economic consequences of AIDS.

Specific Objectives for the Policy

1. To increase the community's awareness of HIV/AIDS and its consequences through IEC.
2. To prevent further transmission of HIV/AIDS through use of preventive measures such as safer sex, testing and counselling.
3. To provide infected persons and their carers with appropriate social, medical, physical, and spiritual support through the existing health care system and through home based care.
4. To safeguard the rights and interests of infected persons by preventing discrimination in relation to employment, housing, treatment, travel, education and other social services.
5. To safeguard the rights of the community as a whole against infection with HIV/AIDS/STDs.
6. To support and promote research activities geared to strengthening the national efforts towards control and prevention of HIV/AIDS/STDs.
7. To define and coordinate the roles of different players involved in AIDS control and prevention.
8. To create a national institutional framework that will coordinate the mobilization of financial, human and material resources for AIDS prevention and control.

Management and Organization

In 1988, the Ministry of Health established the National AIDS Control Programme which is the institution responsible for the control and prevention of HIV/AIDS/STDs, epidemic in the country.

Mission Statement for NACP

To reduce the rate of infections with the AIDS virus, associated diseases and socio-economic effects on individuals and the society.

The Goal of NACP

The major goal of the National AIDS Control Programme is twofold:

(a) To reduce further transmission of HIV and
(b) To minimize or mitigate the personal and social impact of HIV infection.

Accordingly, the implementation of the National AIDS Policy will be coordinated by NACP located in the Ministry of Health. However, due to the multisectoral nature of the issues involved, there will be created, at various levels, multisectoral committees to coordinate the different sectors.

Strategies for AIDS Control and Prevention

The components which comprise the National Strategy focus the following areas:

Education/Information

Promote awareness of the community about HIV/AIDS/STDs problems to a level where:

(a) All are familiar, as a responsibility/duty, with the facts about HIV transmission.
(b) Individuals are able to assess their own risk and make decisions which protect them from transmission and about testing and counselling.
(c) Protective behaviour is sustained in the long run.
(d) It is appreciated and accepted that HIV infected persons do not pose a risk in every day situations.
(e) Myths, prejudices and unnecessary fears are reduced to insignificant levels.
(f)

Prevention

To eliminate transmission through the use of preventive facilities such as safer sex, and drug using practices, testing with counselling, removal of legal impediments and education to prevent the infection of people who care for infected individuals.

Promote and establish appropriate and up-to-date guidelines, rules, regulations and laws, where none exist, to safeguard individual and the community against the risk of exposure to HIV/AIDS/STDs infection.

Treatment, Care and Counselling

To provide infected persons and their carers with appropriate and adequate treatment and services, physical, emotional, spiritual and psychological support, whenever possible within the existing health care system and through home based care.

Access and Participation

To maintain quality of life for infected persons by pregenting discrimination in relation to access to employment, financial support, housing, treatment, education and other social services.

Research

To support a research programme consistent with the overall goal of the National Strategic plan.

NB: The National HIV/AIDS Policy is in the process of enrichment. Parliament is yet to ratify the enriched version.

Objectives and Strategies in MTP-III

Guided by this policy, objectives and strategies have been formulated. The section below addresses these.

Objective: To reduce STD cases by 25% by the year 2002 with emphasis on hard-hit districts

In order to address the above objective, the following strategies, their corresponding steps, key actors and inputs were identified:

Strategy 1. Establish appropriate environments for management of STD cases in hard-hit districts.

The steps to accomplish this strategy are to modify the existing syndromic approach to STD management and care for use by district level health care workers. This would involve the hiring of experts from STD management and district staff to define needs and gaps in the current STD management. Next, identify training needs, determine the need to revive prophylaxis and treatment for neonatal conjunctivitis, determine whether partner notification and counselling services need to be re-established, draft training materials, design a training of trainers course and implement STD management activities at the district level. The next step is to conduct a thorough analysis of the required facilities and supplies needed at the district level to maintain quality health care delivery, identify storage needs and current capacity, obtain materials including STD drugs and condoms and distribute through the Medical Stores Department. The District Health Management Team should be involved in overseeing programme implementation Another important step to accomplish this strategy is to incorporate STD drugs and supplies into the Essential Drug Programme kits, and to integrate STD services into the PHC structure. The key actor for this strategy is the Ministry of Health with support from the DHMTs. The major inputs are resource persons including those from NGOs, supply of STD drugs, condoms, training materials, storage facilities, test kits for syphilis and transport for distribution and supervision.

Strategy 2. Strengthen and expand sentinel surveillance sites.

The first step is to establish a comprehensive surveillance system for STDs. This would involve designating the responsibility of formulating such a system to a national expert. Once a system is in place, sentinel sites should be formed in areas where essential information will be needed and can be provided regularly. The next step is to identify training needs of health workers, procure essential test kits and carry out necessary training, monitoring, distribution and evaluation. The key actor is the Ministry of Health. The major inputs are syphilis test-kits, reagents, and relevant, well-trained human resources.

Strategy 3. Strengthen management and co-ordination capacity at all levels.

The major steps involved include an analysis of management needs, identifying terms of reference for addressing training needs, identify a national training facilitator, providing training for District Health Management Teams, and establishing key documentation centres for personnel to update their knowledge and skills in the care and management of STDs. The key actor is the Ministry of Health. The major inputs needed are training materials, transport, venue for training and staff for the documentation centres.

Strategy 4 *Promote reproductive health education in hard-hit districts.*
The steps for accomplishing this strategy are to promote reproductive health education in selected districts by identifying a national expert to develop IEC materials on STDs and reproductive health for women at the district level, and to conduct awareness seminars to district leaders and the communities including schools. The expert should also recommend appropriate methods for reaching the target population. The key actors are the Ministry of Health and the District Health Management Teams. The major inputs are human resources, materials for developing IEC messages and transport.

Strategy 5 *Promote health-care seeking behaviour.*
Steps for promoting health care seeking behaviour are to conduct a RAP to determine patterns of health care seeking behaviour, Assessment study, develop and distribute IEC materials for promotion of health care seeking behaviour, to sensitize health care workers to the needs of STD patients and to prevent stigmatization through appropriate counselling. The key actors are the Ministry of Health and the District Health Management Team. The major inputs are human resources, to conduct RAP and develop appropriate IEC materials. Trainers of health care workers and transport.

Objective: To obtain sexual behaviour change among 30-50% of mobile population groups in Tanzania by 2002.

In order to address the above objective, the following strategies, their corresponding steps, key actors and inputs were identified:

Strategy 1. *Create opportunities and environments for decision about sexual issues.*
The major steps were identified as follows: to identify peer educators for highly mobile populations using the AMREF experience; to produce peer educative materials in collaboration with AMREF and PSI; to train additional peer educators using other peer educators; and to produce a one page summary quarterly report on activities undertaken. AMREF will be the key actor for this strategy. Other actors can also join hands to address this strategy. Major inputs will be resource persons to train peer educators, materials for peer education and management support to NGOs.

Strategy 2. *Reach highly mobile groups in their respective areas*

Major steps identified were: to conduct a needs assessment for condom use among highly mobile groups outside AMREF's target groups; to develop IEC materials in a united effort among selected partners who are already working with some target groups; to procure and distribute condoms; to distribute relevant IEC materials in strategic areas; and to sensitise/orient health workers to the needs of relevant highly mobile populations in selected areas. The key actors are NGOs with assistance from AMREF. Key inputs include experts to conduct needs assessment for condoms, development of IEC materials, transport for distribution of materials and for supervision.

Strategy 3. *Make use of available entertainment areas and facilities.*

Major steps identified were: to identify and sensitise owners of entertainment facilities in HIV/AIDS/STD prevention among vulnerable and highly mobile populations; and to identify and orient contact persons in entertainment facilities on HIV/AIDS/STD prevention. The key actors are NGOs e.g. AMREF. Key inputs are resource persons to sensitise owners of entertainment facilities and to orient contact persons in these facilities. Resources will also be needed to develop IEC material and condoms. Also transport for distribution of relevant materials is essential.

Strategy 4. Use existing religious institutions.

Religious leaders and institutions already working with highly mobile population groups for dissemination of information on HIV/AIDS/STD prevention will be identified and supported. For example; Father Joinet's "Fleet of Hope"/"Three-Boats" concept of abstinence, fidelity and use of technology (condoms) and the Ugandan experience. The key actors are religious organisations such as the Christian Council of Tanzania and the BAKWATA (Baraza Kuu la Waislamu Tanzania- The Muslim Council of Tanzania). Key inputs include IEC materials and transport for their distribution. Resource persons, educators, preachers etc. may also be required to disseminate the required information.

Objective: To reduce STD and HIV Transmission among CSWs By 25% By the Year 2002.

In order to address the above objective, the following strategies, their corresponding steps, key actors and inputs were identified:

Strategy 1. To Promote Health Care Seeking Behaviour among CSWs

Important steps to implement this strategy are:
to collate and analyze available information on CSWs, identify different groups of CSWs and their focal points and develop and implement IEC interventions including peer education and counselling targeted towards CSWs. In view of the above-mentioned obstacle of the Government not recognising the existence of CSWs, NGOs are the key actors for this strategy. The Key inputs are resource persons and materials needed to

collect and to analyse available information on CSWs, to train peer educators and counsellors and to develop of IEC materials for CSWs.

Strategy 2. *To Improve and expand access to STD services for CSWs.*
This strategy will need 2 essential steps, namely: To ensure availability of STD services, including drugs for CSWs and to promote non-discriminating attitudes among health care provides. The limited Government capacity to ensure a regular drug supply may remain a constraint to this strategy. The ongoing EU support for STD control is a great opportunity for this strategy. The MOH is a key actor and key inputs will include human and other resources for running STD clinics either separately or integrated into routine services. Continuing educational materials and resource persons for sensitising health care providers will be needed.

Strategy 3. *To promote the use of condoms among CSWs*
Free condom distribution for all is already being implemented by the NACP, but there is no guarantee that they reach the CSWs as a group. Therefore, an important step for this strategy is to develop further the condom distribution system and to conduct social marketing for condoms, targeting CSWs. The total number of condoms distributed or sold will be a good indicator for monitoring this strategy. Respectively the MOH and the private sector will be key actors. Key inputs include resources to evaluate the existing condom distribution system and to recommend ways of improving it to include CSWs. Resources will be needed for conducting social marketing for condoms and for monitoring and evaluating condom distribution and use among CSWs.

Strategy 4. *To promote income generating activities among CSWs*
Promoting income-generating activities amongst CSWs empowers them to negotiate for safer sex. A better economic status of CSWs may not only encourage some of them to withdraw from CSW all together, but also empowers them to adopt the attitude of "No condom, no sex!" An obstacle to consistent condom use by CSWs' is the lack of acceptance of condoms by their clients. Many CSWs clients prefer to have sex without condoms and therefore they do not hesitate to offer higher prices if the CSWs so demand.

Steps for the implementation of this strategy are: to identify partners interested in running and supporting income generating programmes for women and to create awareness among CSWs of existing credit schemes and negotiate with the schemes to give preferential treatment to CSWs in approving credits. The key actor will be the MCDWAC. The key inputs will include resource persons to identify partners interested in supporting income generating activities and resource persons and materials for creating awareness about credit schemes and for negotiating with them.

Objective: *To reduce unprotected sexual behaviour among the armed and security forces (Civil Military Alliance) by 75% before the end of 2002*

In order to address the above objective, the following strategies, their corresponding steps, key actors and inputs were identified:

Strategy 1 *To establish base-line data on condom use among the armed and security forces*

The important steps to implement this strategy are: to prepare terms of reference for a base-line study to establish the level of condom use among the military; to assign a military consultant to conduct the study; report the results of such a study to the relevant forum. These steps will provide the needed information on condom use. The main actor is the Civil Military Alliance. The main inputs will be the cost of the base-line study.

Strategy 2 *To promote and provide condoms*

Steps to address this strategy are: to prepare, pre-test, print and distribute IEC materials on condom use; identify proper storage facilities and transport for condoms; identify appropriate sources and procure condoms. The key actor is the Civil Military Alliance. The main inputs are IEC personnel and materials, condom storage facilities and transport

Strategy 3 *To establish regular voluntary HIV screening and counselling services*

Steps for achieving this strategy include identification and establishment of centres for voluntary HIV screening and counselling; identify and procure appropriate HIV test kits; identify appropriate storage facilities and transport for distribution of the test kits; train and re-train laboratory technicians for HIV testing; for the services. The key actors are the Civil Military Alliance and the MOH. The main inputs will be training and re-training of laboratory technicians and counsellors, regular supply of HIV testing kits, training materials, transport and resource persons with supervision skills.

Strategy 4 *To provide STD case management services*

Steps towards achieving this strategy include training of trainers on STD management; preparation of training materials; procurement of laboratory equipment and reagents; procurement of STD drugs and treatment algorithms. The key actors will be the Civil Military Alliance and the main inputs will be trainers, training and service materials and cost of STD drugs, laboratory equipment and reagents.

Strategy 5 *To promote positive sexual behavioural change*

Steps include identification and training of peer educators on positive sexual behavioural change among the armed forces. The peer educators should then train their peers on positive sexual behaviour change with regular supervision by informed resource persons. The number of educative sessions and the number attending will measure achievement.

The key actors will be the Civil Military Alliance and the main inputs will be training of peer educators, training materials and transport.

Objective (a): To reduce vulnerability to HIV/AIDS/STD among in-school and out-of-school youth by at least 50% before the year 2002.

In order to address the above objective, the following strategy, its corresponding steps, key actors and inputs were identified:

The strategy: to take advantage of existing youth meeting points in the communities in order to reach the out-of-school youth.

The corresponding steps are:
To conduct needs assessment research at youth meeting points/centres, to identify peer educators among the cultural and economic groups, to train these peer educators on HIV/AIDS/STD prevention, to strengthen existing youth economic generating groups for maintaining health status, e.g. HIV prevention, improving vocational skills for securing employment, etc. and to encourage young people to start new youth social and economic groups.

The key actor in this area is the Ministry of Labour and Youth Development (MLYD) which should seek the collaboration of various NGOs with working skills among youth. Key inputs include resource persons for conducting needs assessment research in youth centres and for identifying and training peer educators. Other inputs include resources for strengthening existing youth economic groups.

Objective (b): To provide HIV/AIDS education for in-school youth at primary, secondary and post secondary levels.

Achieving behaviour change, especially among young people is not just a matter of providing them with the appropriate information. It requires various strategies to influence them through different channels that convey messages leading to the same objective. Hence, in order to address the above objective, the following strategies, their corresponding steps, key actors and inputs were identified:

Strategy 1: To incorporate HIV/AIDS/STD education in school curriculum.

The following steps will lead to the accomplishment of this strategy:
Conducting a needs assessment concerning the teaching of HIV/AIDS/STD in schools, preparing training manuals and education materials for teachers and students respectively and identifying and training teachers to provide HIV/AIDS/STD education in schools. The key actor here as in the other strategies to follow will be the MOEC.

Strategy 2: To involve parents in HIV/AIDS/STD prevention efforts in schools.

The strategy comprises the following steps:
To establish school committees where they do not exist, to arrange meetings of chairpersons of school committees to sensitize them on HIV/AIDS/STD education, to convene school committee meetings to discuss HIV/AIDS/STD related issues and to sensitize parents through parents' meetings.

Strategy 3: To promote HIV/AIDS/STD education in school extra curricular activities. such extra-curricular activities could include:

The strategy comprises the following steps:
Participatory theatre groups and debating clubs, developing and conducting plays to promote prevention of HIV/AIDS/STD, identifying and training of

peer educators and establishing or strengthening counselling services in schools.

Strategy 4: To Strengthen and promote the use of school libraries.

In existing school libraries, relevant educational materials on HIV/AIDS/STD will be identified, or otherwise provided to them from other sources such as UNICEF or NGOs working in this area.

Strategy 5: To use peer educators in influencing behaviour change at post-secondary school level.

The steps to implement this strategy include:

The establishment of committees in the various institutions, identifying and recruiting a consultant with appropriate terms of reference for the development of guidelines for peer educators training, conducting the training of selected peer educators and supporting and supervising peer educators on a regular basis. The key actor is this area is the MOEC, which should utilize school committees, boards, parents, teachers and the students. Key inputs include development of guidelines for peer educators, training of peer educators, development of self-sufficient educational materials for the students and encouragement and training of teachers to participate fully in HIV prevention work

Objective: To ensure that safe blood is available in all blood transfusion sites at all times by 2002

In order to address the above objective, the following strategies, their corresponding steps, key actors and inputs were identified:

Strategy 1. *Update status of blood transfusion in all health units where blood transfusion is performed.*

The steps identified to accomplish this strategy include the undertaking of a research project to identify the needs and actions that must be taken to upgrade the existing transfusion sites. The first step is to prepare terms of reference, identify a consultant who is familiar with the blood safety issues in Tanzania and conduct the research. The key actor will be the MOH. The major inputs are human resources and funds for conducting the research.

Strategy 2. Develop a National Blood Transfusion Service.

The standardization and quality control of the district blood transfusion services need to be established, understood, and practised by all managers. This will require an investigation of whether the quality and standards already in place are adequate to meet demand and whether these standards are practised in the districts. A blood safety consultant is proposed to investigate the situation and make recommendations in collaboration with a national blood safety team. The recommendations should result into formulation of a National Blood Transfusion Service whose main

responsibility will be to monitor the standards and quality of district blood transfusion.

The key actor will be the MOH while the main inputs will be human resources and funds for the consultancy tasks and the required investigations..

Strategy 3. Provision of materials.

The action required to provide materials on a sustaining basis is to establish a responsive monitoring system that will anticipate the need for materials, storage, and transport logistics.

The key actor will be the MOH and the main inputs will be the cost of supplying on a regular basis, the needed basic supplies and equipment for safe blood transfusion services and the monitoring and quality control aspects of the programme.

Strategy 4. Training

The first step is to identify the training needs among the staff responsible for blood safety in the respective transfusion sites. This should also establish the manpower needs in each of these sites, their job description-responsibilities for managing a unit and any employment factors that may impede their management responsibilities. The next step is to identify a resource person who can carry out a training programme based on the needs identified among staff. The terms of reference of the training manager and the number of facilitators required will depend on the extent of training needs identified and the number of staff to receive training. Human resource opportunities probably exist among the National and Regional transfusion sites that are in good working order.

The key actor will be the MOH and the main inputs will be a resource person to identify manpower and training needs, facilitators to train existing staff and funds for regular retraining workshops.

Objective: To reduce the number of persons in poverty who earn money for sex, by 25% before the end of 2002.

In order to address the above objective, the following strategies, their corresponding steps, key actors and inputs were identified:

Strategy 1: To initiate income-generating activities for low-income women who earn money from sex.

After identifying such women in the community and conducting a needs assessment, the next steps will be to train, encourage and assist them to obtain soft loans for initiating small businesses as income generating activities. The MCDWAC will be the key actor and NGOs already working in this area such as TGNP, TAMWA, TAHEA, etc. will be the key partners. The Key inputs will be resource persons for identifying low-income women groups in the community earning money for sex and conducting a needs assessment to determine their needs. Resource persons and materials will also be needed for their training in management of

small-scale income generating activities and assistance in obtaining soft loans.

Strategy 2: To promote the rights of women.

As a first step, any law that would implicitly infringe women's rights should be identified and every effort made to change it in the legal frameworks which are now under consideration, particularly those of HSR and decentralization.

A complementary step is to sensitize women about their rights, and support and empower them to stand up for these rights. The NGOs already mentioned here above will be critical partners in helping the MJCA, which will be the key actor, to materialize this important strategy. The key inputs will be resource persons to identify laws that infringe women's rights and to recommend their appropriate amendments. Resource persons and materials will also be needed to sensitize women about their rights.

Strategy 3: To provide girls with opportunities to have access to vocational training.

Several successive steps will be needed to build up this strategy, in which relatively little has been done so far.

* Needs assessment for the demand for vocational training among girls.
* Identify existing vocational training centres and assess training opportunities for girls.
* Encourage the local government and community to establish vocational training centres for girls with accommodation facilities.
* Promote educational opportunities for girls in vocational training centres to be the same as for boys, if not more.

Sensitize parents and the society in general regarding the importance of vocational training for girls. The key actors in this process will be the local government, the MLYD and the MCDWAC. Key inputs will be resource persons to conduct a needs assessment for the demand for vocational training among girls. Resource persons will also be needed to identify existing vocational training centres and assess training opportunities for girls. Resource persons and materials will in addition, be needed for sensitising parents and the society regarding the importance of vocational training for girls.

Objective: To improve the well being of persons living with HIV/AIDS (PLHAs).

In order to address the above objective, the following strategies, their corresponding steps, key actors and inputs were identified:

Strategy 1: To encourage and support counselling and voluntary HIV testing for communities and to improve access to care for PLHAs

This can be done in the following steps:

Training of 2 counsellors as trainers per region who should then train in their respective regions 25% of health staff in care and counselling services to be extended to district hospitals, developing a code of ethics for counsellors, incorporating counselling training into the curricula of doctors, clinical officers and nurses, updating on a regular basis the policies on care and counselling services for PLHAs and encouraging and supporting the formation and running of voluntary HIV counselling and testing centres at district level.

The percentage of health care staff trained in the care and counselling of PLHAs. the incorporation of a code of ethics into the AIDS policy document, and the number of health related curricula with counselling incorporated will be indicators for the effective implementation of this strategy. The MOH and the constituent medical institutions are key actors for this area.

Key inputs are as follows:

i. Resource persons, funds and materials for training 2 counsellors per region as trainers.
ii. Funds for training 25% of health care staff in the care and counselling skills for HIV/AIDS.
iii. Resources persons and materials for developing a code of ethics for counsellors.
iv. Resource persons, funds and materials to incorporate counselling aspects into the curricula of doctors, clinical officers and nurses.
v. Resource persons, funds and materials to review and update policies on care and counselling services for PLHAs.
vi. Resource persons, funds and materials to support the formation and running of voluntary HIV counselling and testing centres at district level.

Strategy 2: The Government to regulate and create a favourable environment to ensure availability of relevant and effective drugs at affordable cost.

Once the list of necessary essential/drugs has been established, the appropriate government sector will negotiate affordable prices for them, and review pharmaceutical laws accordingly. UNAIDS and WHO will be key partners to the MOH which is the key actor. The Pharmacy Board and the MSD will assist the MOH in addressing this issue. The key inputs are resource persons to develop a list of necessary/essential drugs for the management of HIV/AIDS. The Pharmacy Board to review pharmaceutical laws and MSD to negotiate for affordable prices.

Strategy 3: To expand and improve HBC services, focusing on districts with high HIV prevalence.

The steps leading to the accomplishment of this strategy are:

Identify training needs of HBC services in districts with high HIV prevalence, prepare and ensure availability of manuals and guidelines on HBC, recruit and train HBC providers and develop a clear discharge plan that links hospital based services to HBC.

While the different steps can be monitored through the respective outcome indicators, the final success of the strategy will be measured by the proportion of hospital-based AIDS patients referred to HBC and given effective and appropriate home-based care. The MOH will be the key actor for this strategy. The DHMT and interested NGOs will be partners to the MOH.

The key inputs are:

i) Resource persons to identify training needs of HBC services in districts with high HIV prevalence.

ii) Resource persons, funds and materials to prepare and ensure availability of manuals and guidelines on HBC.

iii) Resource persons, funds and materials to train HBC providers at district level in high HIV prevalence areas.

iv) Resource persons to develop a patient discharge plan that links hospital-based services to HBC.

Strategy 4: To address stigma within the community and health facilities.

The creation of public awareness on ethics and human rights in relation to HIV/AIDS will be achieved through the following policy and advocacy steps:

a) Conduct a study to find out why the level of stigma is still very high in the community and health facilities despite high levels of HIV/AIDS awareness.

b) Promoting mass media information programmes on misconceptions, cultural norms, beliefs, customs and taboos on HIV/AIDS.

c) Sensitise mass media journalists in HIV/AIDS related issues.

d) Enforcing laws on (basic) constitutional human rights and promoting legal aid groups.

e) Finalizing the National HIV/AIDS/STD policy document and submitting it for ratification.

f) Conduct advocacy activities on HIV/AIDS related issues by sensitising the community at grass-roots level.

Ratification and wide dissemination of the National HIV/AIDS Policy will be a good indicator for progress made in this area, and will greatly contribute to reducing stigma and discrimination against PLHAs and their relatives and immediate environment. The key actor will be the MOH and the MJCA will be a major partner.

The key inputs are:

i) consultant/resource persons and funds to conduct a study to find out why stigma persists in communities and health facilities despite high level of HIV/AIDS awareness.

ii) Resource persons, funds and materials to sensitise mass media journalists and to promote mass media information on misconceptions regarding HIV/AIDS.

iii) Resource persons and funds to finalize the National HIV/AIDS/STD policy document.

iv) Resource persons, funds and materials to conduct advocacy activities on HIV/AIDS by sensitising communities at grassroots level.

Objective: To reduce the percentage of men practising unsafe sex through multiple sex partnerships by 25% before the year 2002

In order to address the above objective, the following strategy, corresponding steps, key actors and inputs were identified:

The strategy identified is to promote safer sex through scaling up of the strategy of Father Joinet's "Three-Boats" concept of abstinence, fidelity and use of technology (condoms). Major steps identified are to provide awareness education on HIV/AIDS through IEC materials, public meetings, radio and TV programmes; to develop IEC materials, and to disseminate the IEC materials to the target population. The key actors are religious organizations, NGOs, PSI and MOH. The key inputs are: Resource persons, funds and materials to develop, test and disseminate IEC materials using appropriate means e.g. posters, leaflets, booklets, public meetings, TV and radio.

Objective: To promote secondary and higher education for girls to reach 50% of total enrolment by 2002

In order to address the above objective, the following four strategies, their corresponding steps, key actors and inputs were identified:

Strategy 1: *to expand secondary and higher education opportunities for girls to reach 50% of available total enrolment capacity in secondary and higher education facilities.*

The major steps were identified as follows: to negotiate with education providers (public, religious, private and NGOs) for them to purposely expand enrolment for girls in their facilities; allocate more places in favour of girls in all secondary schools and higher education facilities. Key actors were identified as the MOEC and the MSTHE.

The key inputs are:

Resource persons and funds to make contacts with the relevant authorities in the MOEC and MSTHE to negotiate for expansion of enrolment for girls and their facilities. Negotiations should lead into allocation of more places in secondary/higher educational institutions in favour of girls.

Strategy 2: *To incorporate life skill education in school carricula with emphasis on cultural norms and values that help to reduce HIV/AIDS.*

The major steps were identified as follows: to draw the terms of reference for identification of positive norms and values; to engage a consultant who will identify positive cultural norms and values; to review secondary and higher education curricula and incorporate life skills education with positive norms and values; to orient teachers on the newly incorporated features of the curriculum. Key actors were identified as the MOEC and the MSTHE. The key inputs are consultants/resource persons to identify positive cultural norms and values, to review secondary/higher education curricula and incorporate life skill education and to orient teachers on the newly incorporated features of the curricula.

Strategy 3: *To provide economic assistance to girls in need to have access to secondary and higher education*

The major steps identified were: to develop criteria for identification of girls in need for economic assistance; to employ the criteria to identify candidates and to solicit for assistance; to provide assistance to the needy girls. Key actors were identified as the Ministry of Education and Culture, the Ministry of Science, Technology and Higher Education, Ministry of Rural Development, Women Affairs and Children, NGOs dealing with women affairs and UNICEF.

Resource persons to develop criteria for identification of girls in need for economic assistance, to employ the criteria to identify candidates and to propose a means to solicit for economic assistance. Funds will also be needed from charitable organisations to provide assistance to needy girls.

Objective: To promote the cultural norms and values in the Tanzanian society that encourage positive attitudes and decision-making about sexual matters

In order to address the above objective, the following strategy, its corresponding steps, key actors and inputs were identified:

The strategy: to revive cultural norms and values in the Tanzanian society that encourage positive attitudes and decision-making about sexual matters.

Major steps identified were:

a) To develop terms of reference for a consultant to design a study on identification of cultural norms and values in the Tanzanian society that encourage positive attitudes and decision-making about sexual matters and to suggest ways of reviving them
b) To identify and recruit the consultant to conduct the study to identify positive cultural norms and values
c) To identify peer educators and mass communication media at all levels of the society
d) To train peer educators and use mass communication media to sensitise, educate and inform the society about the positive cultural norms and values
e) To sensitise, educate and inform the society to internalise positive cultural norms and values through various interventions and communication channels

Key actors are NGOs dealing with identification of positive norms and values such as TAMWA Mass Media, MOH, DHMT, MOEC, MSTHE, UNICEF, private sectors and religious organizations.

The key inputs are:
Resource persons, funds and materials to conduct a study to identify positive cultural norms and values and train peer educators on mass communication media at various levels of the society. The peer educators together with mass media should train, educate and inform the community and society at large about the positive cultural norms and values.

RESOURCES REQUIRED

In this section issues related to resources will be addressed. The human resource component has been addressed above in the priority area and strategies. Financial resources will therefore be dealt with below.

3.0 MTPIII Estimated Budget

The current MTPIII budget initiated in 1998 stands above twenty million US dollars (US$ 20,365.000). We expect the total budget expenditure for the 5-year period and when all sectors will be involved and districts become more active, to be far beyond this figure. Recognizing the country's limited budget, funding for the MTPIII will

therefore heavily rely on external funding as there is a significant gap as can be seen in table I below.

Resource mobilization therefore is another major activity during the life of the MTPIII in order to fill the budget deficit for AIDS control activities in the country.

Table I: Government Funds Allocation and Projections for AIDS Control Programme- Health Sector 1998/99 – 2001/2002:

YEAR	TOTAL ESTIMATED FUNDS FROM MTPIII	FUNDS ALLOCATED BY THE GOVERNMENT *			IDENTIFIED GAP
		RECURRENT	DEVELOPMENT	TOTAL	
1998/99	3,383.433,850	104,000,000	30,000,000	134,000,000	3,249,438,850
1999/2000	3,142,800,000	143,778,260	56,000,000	199,778,260	2,943,021,740
2000/2001	3.054,375,000	215,667,360	100,800,000	316,467,360	2,737,907,640
2001/2002	2,991,600,000	323,501,055	181,440,000	504,941,055	2,486,658,945
*NB. Increase in Government allocation for recurrent will be more than 50% and for Development will be more than 80% using 1998/99 figures as base.					

Source: NACP

3.1: Development Partners involvement and support to the MTPIII.

Already a number of development partners have continued to show interest to assist the Government of Tanzania in its efforts to fight the HIV/AIDS epidemic. Their assistance will be more required at the time when the sectoral and district plans will be completed. Many of these activities will be drawn from the MTPIII strategic plan. Although the MTPIII had a budget made at the time of its formulation, the budget is likely to be inadequate at the implementation level. This is because at the time of formulation not all the expected sectors and NGOs did make their individual budgets. At the same time there has been a lot of advocacy activities to mobilize all sectors including the private sector and NGOs to come on board and implement AIDS activities throughout the country. This is being done in the spirit of the 'Expanded Response Initiative' and multisectoral participation and involvement. Once this initiative is realized many more sectors will develop and implement realistic activity plans in accordance to their own comparative advantages. The expanded involvement

and participation will entail an increased requirement of resources and hence a bigger budget than what was envisaged before.

Currently a number of development partners have been supporting the country in this struggle. Their contributions have been in the areas of financing specific activity plans, material supplies and technical support. The program has therefore enjoyed support from the following development partners: UNAIDS, UNDP, UNFPA, WHO, UNICEF, as well as country Agencies: - USAID, NORAD, EU, THE NETHERLANDS GOVERNMENT (supporting the TANESA project in Mwanza) and JAPAN (material support). Their specific areas of support are as shown in the table below

Table II: Donor and Government Contribution to the AIDS Programme (1996- 1998)

Name of Donor	Material support	Tech. support	Financial support in US $ (to the nearest figure).			
			1996	1997	1998	
UNAIDS	-	YES	715,531	345,571	693,800	
NORAD				1,207,337	1,070,000	
UNDP	YES	YES	50,941	70,025	453,702	
USAID	YES		80,706	174,266	631,027	
EU	YES	YES	343,791	230,140	221,782	
UNFPA	YES		620,640	475,219	UNAIDS	
UNICEF			6,045		UNAIDS	
DANIDA			473,885	160,477	839,634	
GOVT	YES	YES	33,333	33,333	50,000	
JAPAN	YES					
TAP			975	19,673	USAID	
TOTAL			**2,325,848**	**2,716,042**	**3,959,945**	

Source: NACP

4.0: The current strategy:

The current strategy is to enhance and expand the national response in implementation of HIV/AIDS activities through the District Response Initiatives on AIDS. This initiative seeks to ensure that each District has formulated its own AIDS prevention plan and implemented it. The plan should aim to draw its budget from the local

resources to a large extent. District authorities therefore are being encouraged therefore to look for resources within their own areas including resources from the private sector. In this way donor dependence may be reduced in the near future.

At the same time there has been quite a number of human resource development mainly at local level for the implementation of different development programmes. It is envisaged that this process will continue in order to ensure that there is sustainable human resource base for the implementation of these and similar programmes. As we move towards home based care for the majority of AIDS patients, the need for the training of care provides at local level becomes more crucial. The National level I expected to be more involved in the coordination, monitoring and surveillance activities apart from strategic and policy development. Through such approaches we expect to each District. As the focal point for the implementation of all plans will be able to sustain its plans in the long term.

5.0: Key players and target populations:

According to the MTPIII the key players or principle-targeted populations are vulnerable populations - the youth, children and women as indicated in the priority areas numerated under this strategy. Others are all those population groups involved engaged into risk activities such as sex workers or women engaged in sex for money, mobile populations and men with multiple sexual partners.

As regards the response to the epidemic leading to the provision of material and financial support. a number of strategic activities have been identified for a wider involvement at all levels. There is a major component within the MTPIII- for advocacy activities mainly targeting policy makers, political and government leaders at all levels in order to have a full commitment and support of the intended activities. The advocacy strategy will ensure both the public and private sectors are fully involved in HIV/AIDS activities. The involvement ranges from the funding levels to the implementation of the planned activities. Further to that it also goes beyond these levels to involve the donor community so as to ensure that all resource gaps are filled. Within the District response Initiative efforts are being made to encourage Local Authorities to allocate resources for HIV/AIDS activities in their areas. The process will involve the District and Town Councils as well as the Municipal and City Councils to mobilize resources at their level for AIDS activities. An Alliance of Mayors and Municipal Leaders has recently been launched which seeks to commit

and engage these leaders into planning for AIDS interventions in their areas using local resources. In addition there are advanced developments in regard to the involvement of the Private Sector. Already the private sector partnership is in the making, whereby the private sector will be expected to initiate plans AIDS intervention activities within their own capacities and comparative advantages.

XISTING AND POTENTIAL PROBLEMS RELATED TO GOVERNANCE AND THE INSTITUTIONAL SETUP AND CAPACITY

In this section operational problems which have been experienced will be documented. It is assumed that by solving or reducing them the chances of success in future in this area will be increased. These problems will be related to the priority areas identified above.

Priority area 1: Provide Appropriate STD Case Management Services

Obstacles for MTP-III as regards this priority area

The presence of a high prevalence of a symptomatic infections in the general population particularly among women, was a major obstacle. This was compounded by the poor partner notification rate seen in most clinics due to the accompanying stigma. Other major obstacles met during MTP-II were the irregularity in the supply and distribution of relevant equipment, STD drugs and the total lack of female condoms, which would probably be more acceptable than the male condom. Furthermore, general lack of trained personnel, inadequate STD management training manuals for health care workers and the unwillingness of the prevalence sector to create conducive environments for proper STD management were important obstacles for consideration during MTP-III.

Priority Area 2: Reduce Unsafe Sexual Behaviour among Highly Mobile Population Groups

Obstacles for MTP-III as regards this priority area

In order to implement successfully the strategies to promote sexual behaviour change among highly mobile groups, obstacles identified during situation and response analysis of MTP-II must be addressed. It is difficult to identify and access some of the highly mobile groups, which are not homogeneous, making it difficult to provide them with the necessary

Priority Area 3: Reduce HIV Transmission among Commercial Sex Workers

Obstacles for MTP-III as regards this priority area

In Tanzania the Government has difficulties in recognizing the reality of commercial sex work, and thereby making it difficult to approach this population group for education, condom promotion and distribution. This lack of recognition further leads to increased stigmatization, and hinders the provision of appropriate and adapted STD services. There has not been enough information on the dynamics of CSW's. For that reason, it becomes difficult to identify different group needs for intervention. Most of them do not have a permanent place for their sex work, making condom distribution a difficult endeavour. Because CSWs do their activities in "darkness", it could be difficult to identify the needs for the peer educators, and even to design proper messages targeted to them. The health seeking behaviour of CSWs especially with regard to STD treatment is not known, hence it will be necessary to find innovative ways to provide them with care without stigmatising them.

Priority Area 4: Prevent Unprotected Sexual Activity Among the Military.

Obstacles for MTP-III as regards this priority area

The military as a group is sparsely distributed in the country and so, if needs assessment to cover the whole country has to be done, then financial resources are likely to be an obstacle. It may be difficult for relevant civilian NGOs to operate within the military but this can be negotiated whenever it becomes necessary.

Priority Area 5: Reduce Vulnerability of Youth to HIV/AIDS/ST

Obstacles for MTP-III as regards this priority area

Youth out-of-school is a fragile group. It is difficult to reach them. Most of them are very mobile, hence not easily traced. Furthermore, they are in most cases not an organised group.

Parents and teachers are an important group to be incorporated in this struggle but, the willingness of some parents and teachers to participate in informing the children is also another obstacle. Drama and debate groups need to be used but there are not enough skilled teachers in those areas. Most of schools lack libraries making it difficult to make the necessary HIV/AIDS/STDs materials available.

Priority Area 6: Maintain Safe Blood Transfusion Services

Obstacles for MTP-III as regards this priority area

In MTP-III donated blood is more likely to be HIV sero-positive than previously and hence be discarded. For this reason, more blood donors will be needed to satisfy the demand for safe blood transfusion. Furthermore, the pool of blood donors is likely to decrease due to increasing fear of sero-positivity among potential donors. However with intensive intervention activities in other priority areas of MTP-III this problem is likely to be minimized.

Priority Area 7: Reduce Poverty Leading to Sexual Survival Strategies

Obstacles for MTP-III as regards this priority area

The difficulty of identifying low-income women who engage in sex for money is an obstacle. Lack of awareness among women on the availability of credit facilities and

the negative attitude of some men towards women enterpreneurship, are some of the hindrances that need to be addressed.

Priority Area 8: Promote Acceptance of Persons Living with HIV/AIDS

Obstacles for MTP-III as regards this priority area

Lack of a strong political commitment may be an important obstacle in this area. Shortage of drugs in most places where PHLAs go for treatment of their opportunistic infections is very frustrating. Lack of enough qualified counsellors could be a hindrance to PHLAs to come in public for necessary care and social support. Lack of awareness of legal rights hinder PHLAs to expose themselves to the public. Fear of HCWs to contract the disease from patients also makes the management of opportunistic infections of PLHAs difficult.

Priority Area9: Reduce Unprotected Sex among Men with Multiple Sex Partners.

Obstacles for MTP-III as regards this priority area

TV and radio as a means for communicating messages do not reach each and every targeted group. because not all of them have TVs or radios. Some cultures allow men to have more than one wife, but this relationship is not considered to be multiple sex partnership unless one or more of the partners engage in extra-marital sex relationship. Although multiple sex partnership in Tanzania is rampant, identifying situations of multiple-sex partnership is difficult and may constitute an obstacle for MTP-III. However, reducing the widespread unprotected sexual intercourse among men with multiple sex partners will be the best option for MTP-III to reduce HIV transmission.

Priority Area 10: Improve Educational Opportunities Especially for Girls.

Obstacles for MTP-III as regards this priority area

A major obstacle in this area is the lack of enough qualified girls to fill positions in secondary and higher learning institutions because of high dropouts and failure to pass the relevant examinations. A negative attitude towards girl's education by some cultures is likely to be an obstacle in getting more girls in higher education. Some parents would like to have their girls married early and hence never proceed to higher education. The inclusion of educational aspects of culture and life skills in secondary and higher education school curricula is a process that is likely to take some time before it happens. Private schools are likely not to allow girls of low pass marks to join their schools just as a favour.

Priority area 11: Reduce vulnerability of women in adverse cultural environments

Obstacles for MTP-III as regards this priority area

In a country as vast as Tanzania it is somehow difficult to reach consensus on what positive norms and values should be adopted. Furthermore, certain groups may be

reluctant to give information about positive norms and values. There are taboos and beliefs that could make people consider negative values and norms as positive. Different societies have issues that cannot be discussed with people of different age groups in a gathering. Ignorance of the law and illiteracy could deny some people information about their sexual rights.

MANAGEMENT AND INSTITUTIONAL PROBLEMS

Response analyses indicated that weak institutional capacity and poor coordination of programme activities have been responsible for poor performance of previous programmes.

The management mechanism of MTP-II consisted of the National AIDS Committee (NAC) and the secretariat of the National AIDS Control Programme. Activities in sectors, which participated in the implementation of MTP-II, were managed and co-ordinated by the respective sector Technical AIDS Committees (TACs). However, the major problem with the NAC was its inability to meet according to schedule. This problem made it difficult to play its leadership role in the programme. With regard to the NACP secretariat its effectiveness was constrained due to lack of leadership by the NAC and was therefore not effective in co-ordinating and mobilizing multi-sectoral initiatives. This outcome is a reflection of the general lack of political commitment towards the programme, making key actors in the Government, including its sectors, to give low priority and preference to the NACP activities as reflected in the passiveness of NAC and sectoral TACs.

The experience of MTP-II also shows that the problem of lack of political commitments was compounded by shortage of resources. This shortage manifested itself in the problems of inadequate management and low technical capacity to implement programme activities. Shortage of financial resources was another major obstacle to achieve the objectives of MTP-II. During this phase only 20 percent of the programme budgeted funds were mobilised. Thus, MTP-III will take cognisance of these obstacles.

- The future approach to HIV/AIDS control will involve many sectors. The immediate problem which is encountered is coordination. Efficiency in coordination declines when varied sectors are involved in planning making decisions and implementation. Care will have to be exercised to make sure that those who don't have resources, like local governments are not left behind. On the other hand those who bring in most resources must not dominate. When such a large variety of sectors are involved political will is critical.
- The institutional structure for HIV/AIDS control as envisaged, has several layers. One layer is an institution, i.e. the NACP. The others are not institutions as such but committees, which function through "meetings". Within this arrangement the National AIDS Committee (NAC) will be the highest programme management body with respect to implementing future HIV/AIDS programmes. NAC however has no offices. Under these

arrangements most of the day to day work is still left with NACP. Within the various ministries there will be technical AIDS committees to enable these to function the secretariat to NACP should report to permanent secretary Ministry of Health. This will also give access to NACP of the other permanent secretaries. Again here political will and support from the government is an overider.

- Given past experiences the question of *Human Resources Development is crucial.* An appropriate human resource must be developed to meet the new challenges of multisectorality. Capacity to involve all sectors and be able to locate the HIV/AIDS problem within the sectoral context is of critical importance to the success of future programmes. Technical capacity to generate relevant information within the sectoral context has been a problem in the past. The district level is a real challenge in this area. Who will provide the resources is an issue that needs to be solved. Most districts are resource constrained.
- Resource mobilization has been a problem in the past. Only about 25% of all needed resources have been made available in the past. This has left a large part of the programme unimplemented. The epidemic has continued to spread partly due to this. In future programmes adequate financial and material resources will be decisive in failure or success.
- Sources of financial resources have more often than not been foreign. This is a non-strater. At times these sources are not reliable. Plans, therefore, get frustrated. It is necessary that sources of financial resources are as local as possible. If HIV/AIDS is given the priority it deserves, its funding then should assume a higher position in budget allocation. Finances from outside should be seen as supplementary.
- Financial management has been a problem in many programmes. Either reports of financial expenditure are not submitted on time or not at all. For an infrastructure as wide as the one being suggested for HIV/AIDS control, the need for training cannot be overemphasized. Levels far away from the center will be activity centers. Training at these remote areas is necessary to avoid future withdrawal of support.
- Management information systems do form the backbone of implementable plans. Programme management is also entirely dependent on timely and appropriate information. For the time NACP is not at its best in this direction. It needs therefore to create a database on HIV/AIDS for better performance. At the district level this database should be integrated within MTUHA/HMIS.
- Disease surveillance has been an operational problem. Often health workers don't do on time the necessary paper work. They are not therefore sent for analysis and report writing. Incomplete reporting is also an issue. If surveys were carried out a better picture of the situation could be obtained.
- No management activity is complete without monitoring and evaluation. Do to scarce resources this has been a problem in the HIV/AIDS progamme. In future resources need to be allocated to this as a priority.
- Information flow between different levels justify generation of information. This has been found to be a real problem in the current nation wide MTUHA/HMIS. If the HIV/AIDS programme are going to be multisectoral it is necessary to put in place an information flow system which works.

- Research is a critical input in any programme. With the HIV/AIDS programme research has depended almost exclusively on finances from without. These often are commissioned researches agendas as far as HIV/AIDS are concerned. Prioritization of research in governants budget is therefore crucial.

STRENGTHS AND WEAKNESSES OF THE INSTITUTIONAL LAYOUT

For a long time HIV/AIDS prevention was approached like any other infectious disease. That is IEC will solve the problem. The fallacy of this approach is verified by the growth of the epidemic. Whereas for malaria or cholera creation of social memory is effective, for HIV/AIDS social memory is inadequate as a deterrent. This is so because there are no social controls where HIV/AIDS is contracted. This disease is contracted in a situation which is beyond social control. In the deepest of privacy where the individual is his/her own master. For cholera for example even if one does not wish to use a toilet, the fact that society is on contact watch pushes him/her to use it. But sex (that fatal sex) is done where no one is watching. It is only the individual memory which matters. The issue here therefore is to use an approach which batters the persons memory to such an extent that they become their own monitors or watchdogs.

One of the best ways of doing this is through a multisectoral approach. Involvement of all sectors is necessary. These will constantly and everywhere remind people of the scourge. Unlike the other health problems, HIV/AIDS cannot respond to a vertical approach. The current multisectoral approach therefore is a new strength in the fight against HIV/AIDS. The weakness of this arrangement lies in the size of the structure itself. Coordinating it may be quite problematic. The other weakness is getting enough resources to run it. The cost of every activity now will be several times larger than before. As it were, because the structure now has many ministries, and NAC will have advisory role to government, it will be easier to marshal political support.

Poverty Reduction, Gender and HIV/AIDS

HIV/AIDS is a poverty disease. Poverty makes AIDS education difficult due to high levels of illiteracy and little access to mass media, health, and educational services. Poverty directly exacerbate HIV transmission through prostitution and inferior health care. Poverty indirectly exacerbate HIV transmission by increasing migrant labour family dissolutions, landlessness, overcrowding and homelessness which lead to a greater risk of multiple partners. Poor people are less likely to take serious an infection fatal years to come. Incubation period is shortened due to poor standards of nutrition and repeated infections and less access to medical care. A loss of an adult in a poor household, drives the family into greater poverty. Poverty affects women most, their economic dependence on man in marriage or in less formal commercial sexual relations is thereby increased. Poorly educated women are not likely to be able to protect themselves from infected husbands, little health information and little power to control any aspect of sexual relations (G. Hemrich and B. Schneider, 1997).

Gender and the AIDS epidemic

AIDS has become a fast spreading epidemic in Tanzania for several major reasons, among them being the increasing economic crisis and gender inequality. The economic crisis has lead to a deterioration of living standards of the average Tanzanian family of both urban and rural areas. In order to achieve the same living standards of the average Tanzanian family of both urban and rural areas. In order to achieve the same living standards as before household members are working more hours, and more members of the household are working. This leads to a decrease in the quality of life of the household: fatigue; diseases; stress; and an increasing vulnerability to infections. The medical services and sanitation in the communities have declined substantially during this period.

Women are particularly vulnerable to the virus due to biological and socio-economic factors. Biologically, it is easier for a woman to get infected from each sexual encounter than it is for a man. In addition, since many women have untreated STDs, this increases their risk of HIV contraction. Also, as childbearers they are at higher risk when delivering their babies under hygienic conditions which are not completely safe and sanitary.

Gendered social roles also increase the vulnerability of women to HIV infection (Schoepf, 1988; Mbilinyi, 1993; TGNP, 1993). Gender inequality in culture, wealth, power, and politics tends to keep women oppressed. Women, culturally are not able to force their husbands to lovers to wear condoms, nor are they able to refuse to have conjugal relations with them even if they feel at risk due to their partner's promiscuity. Moreover, women most vulnerable to infection are of child-bearing age, and are expected to bear children. Therefore, the use of condoms is not encouraged for it will impede their fertility. Children are desired as labour for their households' economic activities, and as future security in old age.

Strategies to prevent the spread of HIV have focused on the promotion of condom use, reduction of number of sexual partners and treatment of STDs. Many of these responses, however, have failed to address social, economic, and power relations between women and men, among men, and among women. These relationships, together with physiological differences, determine to a great extent women's and men's risk of infection, their ability to protect themselves effectively and their respective share of the burdens of the epidemic.

Reducing women's and men's risk of infection demands gender-based responses that focus on how the different social expectations, roles, status and economic power of man and women affect and are affected by the epidemic.

AIDS shows clearly how vulnerable women are in this region. Women do not have control over either their production or reproduction activities. Unfortunately, at this time it could mean the death of many women. AIDS has made the issue of women's struggle for empowerment, for more economic power and decision making over their bodies more evident. There is a linkage between lower HIV transmission rates and the education and empowerment of women (Confr. AIDS?? Illiteracy vs HIV graph, check pg28).

It is evident that gender relations have to change in order to reduce the spread of the epidemic. Reducing the epidemic spread by prevention efforts is not enough if women cannot use their acquire information. Even if women are educated about the risks and are able to recognize them, unless they can make their own decisions and are not economically and socially dependent on men, they will not be able to practice what they have learned. A change in male behaviour towards HIV prevention will be facilitated by a change in gender relations, i.e., by an increase in women's socio-economic status. Thus there is a need along with other AIDS prevention efforts, to reduce poverty, and to increase women's economic and cultural empowerment, i.e., to eliminate gender inequality.

Furthermore, gender is an integral part of the impact of AIDS on development in rural agricultural communities because women are the major producers in this sector (Mbilinyi 1991, TGNP 1993). It is important to look at gender relations and the specific positions of women and men in agriculture. Gender-focussed research is crucial in guiding policies in health and economic areas. This already has been demonstrated by economists such as Diane Elson (1989), and Anne Whitehead (1991) among others. They have shown how the lack of gender sensitivity in macroeconomic policy formation results in worsening women's position even more, and undermining the achievement of policy goals (cite specific examples).

Structural adjustment policy is one example of a policy made without taking gender differences into consideration. These programmes tend to shift responsibility, physical and financial, from the public sector to the local community and households, and onto women in particular. They fail to consider the gendered division of labour; and the extent to which women are already overburdened, which is important in trying to model how the increased responsibilities will affect household production.

HIV/AIDS is facilitated by poverty and it turn exacerbates poverty. The section below on the macroeconomic impact of the AIDS epidemic amply presented by Mbilinyi conveys the message succinctly.

Macroeconomic Impact of the AIDS epidemic

Accurate assessment of the macroeconomic impact of the AIDS epidemic rests heavily on information on the impact of HIV infection on individual and household supply and investment behaviour. Studies of this type are rare (confronting aids: vol 2). According to Cuddington (1993), without decisive policy action, AIDS may reduce Tanzanian GDP in the year 2010 by 5-25% in relation to a no-AIDS scenario. Per capita income levels are expected to fall by 0-10%. Effects of AIDS can be grouped into those associated to rising morbidity and those associated with rising mortality rates. With morbidity there is negative labour productivity effect – loss of labour from the sick and their caretakers. Health care expenditures increase causing a negative savings effect. With savings decreasing and capital decreasing, there is an adverse effect on the per capita income in the labour force. The children in AIDS afflicted households experience a decline in schooling, there is no money for school fees and they are needed at home to take care of their sick parents, thus decreasing human capital investments.

With experienced workers dying, human capital stock declines and thus national output declines. Labour force composition changes to younger, less-experienced workers. Mortality reduces the population growth rate, thus reducing

the total population size in the future. Age structure of the population will be towards the younger-age cohorts. And size of working age population decreases, also labour force productivity declines due to lower average ages and experience of labour force declining. With a larger proportion of the young, the educational expenses increase, consumption rates will be higher, thus saving rates will be lower due to the shift in the age structure of the population (Cuddington, 1993).

By using the Solow growth model, which stresses the linkages between population growth and capital accumulation on one hand, and the resulting ratio of capital/labour and per capita income levels on the other, Cuddington demonstrates the effect of AIDS on potential GDP through the negative effect of AIDS on the workers' health, experience level, and size of labour force. In this model Cuddington (1993) uses Bulatao's (1990) projections (which has an assumption of only 15% of the population as annual AIDS related medical costs financed out of savings, and annual proportion of labour lost per AIDS stricken worker due to absence or reduced productivity on the job.

The results from the above model shows that the presence of AIDS reduces the average real GDP growth rate in 1985-2010 from 3.9% to a range of 2.8-3.3% depending on the (reduced) savings rate and (reduced) productivity rate parameters. Per capital GDP effect ranges from 0.2-0.7% with AIDS, versus 0.7% with no AIDS, here less change is more likely. Per capita GDP is affected only moderately because of the decrease in population growth rate. Bloom and Sachs (1998) study demonstrates the linage of Africa's economic performance to it's geography, and demography. Africa has the world's highest yough dependency ratios which impose a substantial drag on African economies by reducing their productive capacity per capita. Low life expectancies and extremely youth-heavy age distributions also tend to be associated with lower rates of saving and investment and therefore slower economic growth. The role of age structure and health conditions (life expectancy) have received less attention in the growth literature, yet these factors are – along with geography – are estimated to account for a sizable share of Africa's slow growth.
The youth dependency burden poses a significant impediment to the growth of income per capita, since labourforce participation, productivity, and savings are low among the dependent population, relative both to the working age population and to their own consumption and investment requirements. With HIV/AIDS epidemic, all the factors contributing to Africa's poor economic performance, as presented by the Bloom and Sachs (1998) study, are exacerbated. This implies that Tanzania is likely to experience a bigger impact on its economic growth in the future based on the impact of the epidemic reducing the life expectancy of its population and shifting the population structure towards younger-age.

As it were, therefore, reduction of poverty-particularly among women – is an effective way of controlling HIV/AIDS.

DOCUMENTS USED IN COMPILING THIS WORKING PAPER

National AIDS Control Programme HIV/AIDS/STD Surveillance, Report No. 13, December, 1998, Ministry of Health, Tanzania Mainland. Epidemiology Unit, NACP, Dar es Salaam. Issued in October, 1999.

Strategic Framework for the Third Medium Term Plan (MTP-III) for Prevention and Control of HIV/AIDS/STDs: 1998-2002. Ministry of Health, Tanzania (Mainland) Dar es Salaam. July 1998.

The National Policy on HIV/AIDS/STD, The National AIDS Control Programme Tanzania Mainland. Ministry of Health, United Republic of Tanzania. September 1995, Version 1.0.

A Document prepared by Nnali Mbilinyi (Provided by UNICEF).