THE UNITED REPUBLIC OF TANZANIA

NATIONAL AIDS CONTROL PROGRAMME

SEMINAR PROGRAMME FOR HEADS OF UN AGENCIES AND SENIOR PROGRAMME OFFICERS ON HIV/AIDS
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HIV STATUS GLOBALLY AND IN TANZANIA: NATIONAL REPONSES TO THE EPIDEMIC

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1.0 HIV/AIDS STATUS GLOBALLY

In mid-July 1996, an estimated 21.8 million adults and children worldwide living with HIV/AIDS of whom 20.4 million (94%) were in the developing world. Of the adults 12. million (58%) were males and 8.8 million (42%) were females. Close to 19 million adults and children (86% of the world total) were living with HIV/AIDS in the sub-Saharan Africa and in South and South-east Asia. (See attached Fig. 1).

The HIV//AIDS pandemic is on the increase across continents. From the beginning of the pandemic until mid-1996, an estimated 27.9 million people worldwide have been infected with HIV. The largest numbeers of individuals ever infected with HIV were in sub-Saharan Africa, totalling 19 million (68% of the global total), and in South and South-east Asia, totalling 5 million (19% of the global total).

Since the beginning of the pandemic, the majority of HIV infections - 26 million (93%), have occurred in the developing world. The number of HIV infected people in the South and South-east Asia is now more than twice the total number of infected people in the entire industrialized world.

The global cumulative number of HIV infections among adults has more than doubled since the beginning of the decade, from about 10 million in 1990 to almost 25.5 million by mid-1996. Of these, 14.9 million were men (58%) and 10.5 million were women (42%).

More than 6 million adults have developed AIDS from the beginning of the pandemic to July 1996, and of these 4.5 million (close to 75%) were in sub-Saharan Africa; 0.4 million were in Latin America and Carribean (7%) and0.75 million were in North America, Europe and North and South Pacific combined (12%). In South and South-east Asia, where the epidemic gained

intensity more recently, it is estimated that 330,000 adults have developed AIDS. Of the 1.6 million children with AIDS, the majority, 1.4 million (85%) were in sub-Saharan Africa.

By July 1996, 5.8 million people (4.5 million adults and 1.3 million children) 75% of all people with AIDS are estimated to have died from AIDS worldwide.

2.0 HIV/AIDS STATUS IN TANZANIA AND NATIONAL RESPONSE

The first AIDS cases were suspected in Tanzania in 1983 in Kagera region and by the end of December 1991, a total of 33,699 AIDS cases had been reported to the Ministry of Health (Mainland) from all regions and another 356 AIDS cases reported to the Ministry of Health (Zanzibar), making a total of 34,055.

This figure is the number of cases reported from various hospitals in the country. I must say that this is just a small portion of the whole problem, as most patients are cared for at home or by traditional healers and hence are not reported. It is estimated that only one out of 4 - 8 cases are actually reported to the health care system.

This shows that AIDS has spread rapidly in all parts of our country, despite all concerted efforts taken by our Health Ministries and other organizations and sectors to limit the spread of the disease. It is estimated that the number of AIDS patients is more than 400,000 and those who have been infected by the Human Immunodeficiency Virus (HIV) is more than 1,200,000.

Blood donor data indicate that 6 - 7% of male adults and 7 - 9% of female adults are currently HIV infected. Alarming increases of HIV infection have been noted among youth. In the age group of 15-19 years, HIV prevalence has gone up from 0% in 1987 to 5.4% in 1990, while during the same period HIV prevalence in the 20-24 year age group increased from 3.4% - 5.8% in males and 0.0% - 9.4% in females.

AIDS has surpassed other communicable diseases including malaria as the most common cause of adult mortality in Tanzania and it is increasing as a major problem in paediatric wards. Successes made in other health programmes like Maternal and Child Health/Family Planning (MCH/FP) and Child Survival and Development initiative in this country are being threatened by the AIDS epidemic, which has reversed the downward trend of infant mortality rate of the 1970s and early 1980s.

It has been clearly shown that between 30% and 50% of the hospital beds in this country are occupied by HIV/AIDS patients. These patients are admitted with conditions related to AIDS and weakening immunity including: Tuberculosis, respiratory complications, diarrhoea and skin diseases. The burden on the Ministry of Health and other health providers including Non-governmental organizations (NGOs), the community and individual families in caring for the growing number of AIDS patients has already become enormous with the limited resources the nation has.

For example, it is estimated that the lifetime cost for medical treatment alone for one adult AIDS case is around $290 (84,100/= T.Shs.). Assuming that all current cases would be treated, the cost would amount to $116 million which is more than half of the Government recurrent health expenditure.

Yet, what we have witnessed so far is just a preamble to the explosion of the epidemic expected in the next few years.

The high HIV/AIDS associated morbidity and mortality rates have far reaching socio-political, cultural and economical implications. AIDS has such a big negative impact upon the society because it attacks the young people aged between 15 and 45 years who are most socially and economically active, persons having a lot of energy in nation building. Society is losing many of its educated persons in whom much money has been invested for years in training them. Such people dying of AIDS are leaving behind a gap which cannot be bridged in a short time.

Professionals in industry, agriculture, high learning institutions, health care, government and parastatal executives are being lost with serious implications to the entire nation.

Resulting from the increasing AIDS related adult mortality another social problem has cropped up and is growing fast like AIDS itself. This is the problem of orphans.

From a census carried out in Kagera region alone, their number is over 100,000. It is estimated that there are 200,000 orphans nation-wide, and even the most conservative estimate predicts that there will be about 1,000,000 orphans by the year 2000. Children are increasingly bearing the burden of caring for their sick parents, bearing the psychological trauma of seeing loved parent die and then being left orphans. These orphans need shelter, food, clothing, school uniforms and fees, social and psychological support as well as legal protection against exploitation and physical abuse.

This is a big problem facing our nation to such an extent that the traditional coping and support mechanisms, through out extended families are becoming strained beyond limits, as the elderly left behind are themselves weak and in need of support.

The first Medium Term Plan (MTP-I) which was implemented from 1987 and came to an end in December 1991 was a Health sector plan. The HIV/AIDS epidemic was then seen as a disease and therefore a health issue. Much as this is true, the Government has long realized that the HIV/AIDS epidemic is a "disaster" whose impact on the nation extends beyond HEALTH sector alone. It is a multi-sectoral problem and it requires multi-sectoral input from public and private sectors, NGOs, communities and individuals for effective control.

During MTP-I we decentralized AIDS control activities to the regions and districts. At present we have AIDS control coordinators in every region and district. Furthermore, the District and Regional multi-sectoral Primary Health Care Committees have been empowered to plan, implement, monitor and evaluate their AIDS control activities.

The first and foremost achievement during MTP-I was creating awareness of HIV/AIDS in the population. Surveys have shown that about 90% of adults Tanzanians know about HIV/AIDS and ways to protect themselves.

Most of the Health care staff nation-wide have been trained in the clinical management of sexually transmitted diseases and AIDS. Laboratory staff have been trained and equipped with means to secure screening of blood for transfusion.

Condom usage has been promoted among risk groups. Condoms and other medical supplies are regularly being distributed from central to regional level.

To cope with the growing number of persons with AIDS and affected dependencies, a counselling and social support unit has been established and is coordinating training of counsellors and facilitating development of home based and support of affected individuals and families.

The epidemiology unit has established systems for data collection on the number of AIDS cases, surveillance of HIV prevalence in blood donors and other groups and regularly prepares reports and feedback to the regions and districts.

Priority areas for research in HIV/AIDS and other STDs have been defined and mechanisms to facilitate research have been established.

The Ministry of Health undertakes quarterly supervisory visits to monitor the decentralized implementation, of activities reviews quarterly reports and compiles the information and provides a feedback to the implementors.

The recommendations of the 1991 review of the National AIDS Control Programme emphasized the issues of multisectoral collaboration, community mobilisation and participation, focus on sexually transmitted diseases and targeted IEC activities to bring about behaviour

change. These recommendations wee in line with the strategies indentified by the Government for MTP-II.

MTP-II is a framework for a multisectoral AIDS Control Programme in the United Republic of Tanzania. The National AIDS Committee is the highest organ which oversees all AIDS control activities in the country. NACP is the secretariat of the National AIDS Committee, and will have more of a coordinating than implementing role in MTP-II. All sectors collaborating in MTP-II have formed Technical Committees which will plan and implement AIDS control measures in their sectors as well as advise their Principal Secretaries on best interventions to be undertaken and resources to be used for AIDS prevention and care of affected individuals and their families. These committees will be answerable to the National AIDS Committee and will be required to submit mid-year plans and implementation reports.

To create a clear and favourable environment for all aspects of HIV/AIDS/STDs control and prevention, a National Policy on HIV/AIDS/STDs has been prepared. Each sector will prepare policy guidelines for the implementation of AIDS prevention and control activities prevailing to its sector, for endorsement by the NACP. For example, policies and guidelines on AIDS education in schools need to be finalised urgently. Legal rights of orphans and other dependants, as well as rights of workers with HIV infection need statutory affirmation.

Another important issue is involvement of NGOs and other organizations in AIDS control activities. NGOs have played an important role in implementing targeted interventions aimed at specific groups. Some NGOs like AMREF, Tanzania Red Cross Society, Christian Medical Board of Tanzania (CMBT), Society for Women and AIDS in Africa (SWAA) Tanzania, Tanzania Council for Social Development (TACOSODE), Walio Katika Mapambano na UKIMWI (WAMATA), etc. have a national character in that they have activities in more than one region. There are also numerous organizations working in the districts and in the community providing care and support to patients with AIDS as well as AIDS prevention activities.

The Government recognizes the increasing role of NGOs and other organizations in AIDS control activities. An NGO Liaison Office has been established in the Ministry of Health to coordinate collaboration with NGOs. It is hoped that other sectors will follow this initiative.

The process of MTP-II development covering the period 1992-1996 started with a workshop Defining Areas of Emphasis for AIDS control in which several sectors participated, committing themselves to implement various AIDS control activities. This workshop resulted in the formulation of front-line intervention packages intended to facilitate planning at the district level. These have been summarized in the Strategic Plan of MTP-II Volume I. This document serves as an umbrella for the sectoral plans, outlining the policies, strategies and interventions which form the basis for AIDS control activities in Tanzania.

Subsequently, the various sectors drafted sectoral plans, with the primary purpose of supporting district-based activities during MTP-II. Some sectors, like Chama cha Mapinduzi (CCM) have been included because of their extensive network from national to village level as well as their experience in mass mobilisation which is being utilised in AIDS control activities.

The sectoral plans are contained in the documents about MTP-II. Volume II is the Zanzibar MTP-II Plan which incorporates all sectors, Volume III is the Health Sector Plan for Mainland and Volume IV is the Non-Health Sector Plans for Mainland.

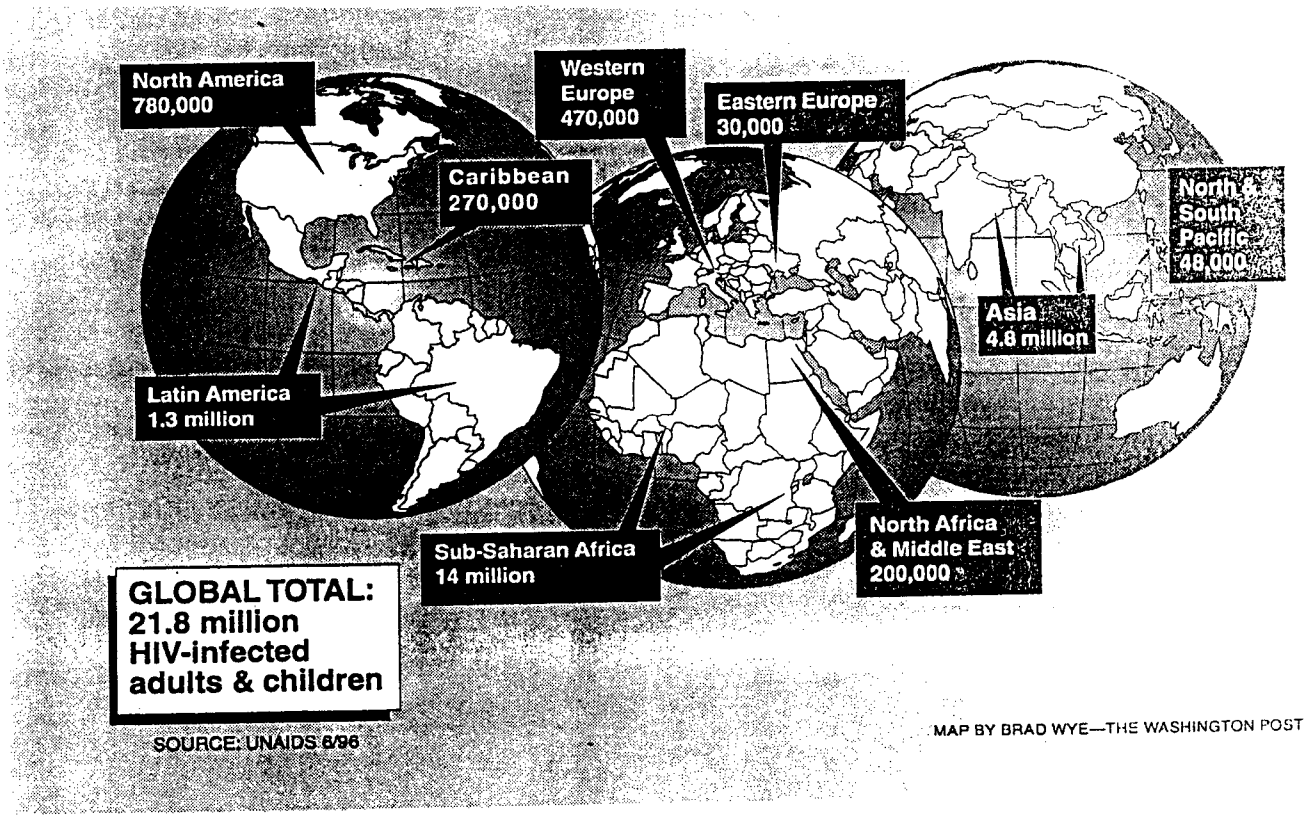
The Government recognizes and appreciates the presence of all parties and dignitaries who are attending this seminar. I do take this opportunity to request you all to take a considered view of our plan in fighting this common enemy - AIDS, and contribute towards its successful implementation.

The national alliance in the fight against AIDS is a part of the global effort. The government of the United Republic of Tanzania, takes this opportunity to thank all international agencies and collaborators who have helped us in the First and Second Medium Term Plans. The

government will continue to liaise and collaborate with the international community in the continued efforts in eradicating the HIV/AIDS epidemic.

Figure 1

The Scourge of AIDS Marches On
Estimated Number of Persons Living with HIV/AIDS
July 1996



The Status and Trends of the Global HIV/AIDS Pandemic

Table 2 (a) Cumulative aids cases by region and year (1983-1990)

Region	YEAR							
	1983	1984	1985	1986	1987	1988	1989	1990
Arusha	0	0	0	10	47	217	433	647
Coast	0	0	1	4	79	224	465	938
Dar es Salaam	0	0	51	471	1,470	3,093	5,209	7,246
Dodoma	0	0	0	7	47	105	262	310
Iringa	0	0	1	3	68	305	374	728
Kagera	3	106	322	847	1,666	2,143	2,576	3,472
Kigoma	0	0	0	3	50	109	244	607
Kilimanjaro	0	1	8	36	207	455	571	966
Lindi	0	0	0	1	10	46	113	484
Mara	0	0	0	3	30	99	141	280
Mbeya	0	0	0	16	208	751	1,077	3,890
Morogoro	0	0	0	11	88	254	364	637
Mtwara	0	0	1	5	26	90	141	280
Mwanza	0	0	15	54	171	448	667	1,308
Rukwa	0	0	0	1	5	98	94	140
Ruvuma	0	0	0	20	46	81	210	571
Shinyanga	0	0	0	8	31	144	238	583
Singida	0	0	0	6	74	197	284	456
Tabora	0	2	5	6	59	232	525	927
Tanga	0	0	0	13	80	210	351	838
Unspecified	-	-	-	-	-	-	-	1
TANZANIA	3	109	404	1,525	4,462	9,301	14,397	25,503
Doubling time (in months)		2	6	6	8	11		19

Table 2(b) Cumulative AIDS cases by region and year (1991-1995)

Region	YEAR 1991	1992	1993	1994	1995	Population	Rate	Rank
Arusha	1,117	1,637	2,185	2,368	2,490	1,730,838	143.9	17
Coast	1,676	2,215	2,740	3,023	3,116	749,578	415.7	4
Dar es Salaam	8,834	9,295	10,406	11,050	11,241	1,477,962	760.6	1
Dodoma	536	762	1,028	1,071	1,077	1,839,206	58.6	20
Iringa	2,281	3,334	4,462	4,674	4,748	1,464,255	324.3	6
Kagera	4,742	5,813	6,646	7,064	7,163	1,602,514	447.0	3
Kigoma	930	1,556	1,920	2,070	2,084	1,040,803	200.2	14
Kilimanjaro	2,060	3,707	4,699	5,119	5,339	1,298,636	411.1	5
Lindi	842	1,211	1,691	1,966	2,064	757,727	272.4	9
Mara	639	980	1,304	1,393	1,419	1,176,320	120.6	18
Mbeya	6,924	9,890	11,439	12,214	12,312	1,829,892	672.89	2
Morogoro	2,398	3,598	4,328	4,575	4,605	1,476,698	311.8	7
Mtwara	1,361	1,968	2,090	2,201	2,254	1,010,408	223.1	13
Mwanza	3,041	4,207	5,349	5,731	5,858	2,268,991	258.2	11
Rukwa	261	496	715	777	783	915,939	85.5	19
Ruvuma	1,197	1,807	2,480	2,847	2,988	978,939	305.2	8
Shinyanga	1,278	1,874	2,624	3,062	3,215	2,168,600	148.3	16
Singida	763	1,107	1,472	1,688	1,718	952,924	180.3	15
Tabora	1,400	1,972	2,786	3,075	3,221	1,235,305	260.7	10
Tanga	1,914	2,636	3,207	3,475	3,759	1,509,507	249.0	12
Unspecified	1	1	1	2	44	-	-	-
TANZANIA	44,195	60,066	73,572	79,445	81,498	27,484,889	296.4	
Doubling time (months)	15	27	41	108	333			

Table 3: AIDS cases reported during 1995 by the year should have been reported

Year	No of AIDS cases	Percent of Total
1987	6	0.0
1988	15	0.1
1989	269	1.0
1990	3,124	11.1
1991	6,573	23.3
1992	7,195	25.5
1993	5,907	20.9
1994	3,109	11.0
1995	2,053	7.3
Total	28,251	100.0

Table 5
Distribution of cumulative AIDS cases by age and sex, 1987 - 1995 (Age-specific population is also provided)

	Male				Female				Total			
Age	Cases	%	Population	Rate	Cases	%	Population	Rate	Cases	%	Population	Rate
0 -4	1,488	5.1	2,264,530	65.7	1,280	4.4	2,297,615	55.7	2,768	4.8	4562145	60.7
5-9	160	0.5	2,124,460	7.5	213	0.7	2,120,643	10.0	373	0.6	4245103	8.8
10-14	103	0.4	1,810,466	5.7	144	0.5	1,803,074	8.0	247	0.4	3613540	6.8
15-19	487	1.7	1,448,737	33.6	1,791	6.2	1,532,082	116.9	2,278	3.9	2980819	76.4
20-24	2,480	8.5	973,457	254.8	6,281	21.7	1,237,709	507.5	8,761	15.1	2211168	396.2
25-29	6,159	21.1	943,743	652.6	7,904	27.3	1,123,638	703.4	14,063	24.2	2067381	680.2
30-34	6,798	23.3	686,344	990.5	5,650	19.5	772,041	731.8	12,448	21.4	1458385	853.5
35-39	4,785	16.4	612,787	780.9	3,094	10.7	665,422	465.0	7,879	13.5	1278209	616.4
40-44	3,129	10.7	435,562	718.4	1,396	4.8	497,047	280.9	4,525	7.8	932609	485.2
45-49	1,815	6.2	419,806	432.3	689	2.4	433,908	158.8	2,504	4.3	853714	293.3
50-54	945	3.2	338,427	279.2	320	1.1	387,883	82.5	1,265	2.2	726310	174.2
55-59	438	1.5	283,122	154.7	123	0.4	267,906	45.9	561	1.0	551028	101.8
60-64	249	0.9	239,904	103.8	79	0.3	274,300	28.8	328	0.6	514204	63.8
65+	140	0.5	602,359	23.2	29	0.1	558,516	5.2	169	0.3	1160875	14.6
Total	29,176	100.0	13,183,700	221.3	28,993	100.0	13,971,780	207.5	58,169	100.0	27,155,490	214.2
Unknown	901	3.0 % of the total			907	3.0 % of total			1,808	3.0 % of total		
Overall Total	30,077			228.1	29,900			214.0	59,977			220.9

M:F case ratio	30,077/29,900	1.01
M:F rate ratio	228.1/214.0	1.07