THE SOUTHERN NEW HAMSPSHIRE UNIVERSITY

AND

THE OPEN UNIVERSITY OF TANZANIA

CAPACITY BUILDING FOR ADDRESSING VULVNERBILITY ISSUES IN HIV/AIDS IN INTERVENTION IN THE COMMUNITY: A CASE/STUDY OF ENGUSEROSAMBU AND ORGRSOROK VILLAGES.

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CAPACITY BUILDING FOR ADDRESSING VULNERBILITY ISSUES IN HIV/AIDS INTERVENTION IN THE COMMUNITY: A CASE OF ENGUSEROSAMBU AND ORGSOROK VILLAGES

A PROJECT SUBMITED IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE MASTER OF SCIENCE IN COMMUNITY ECONOMIC DEVELOPMENT IN THE SOUTHERN NEW HAMPSHIRE UNIVERSITY AT THE OPEN UNIVERSITY OF TANZANIA, 2007.

by Kaiza, Victor Baltazar.

SUPERVISOR CERTIFICATION

I, Joseph Kiangi Mwerinde certifies that I have read the project, and found it to be in a form acceptable for submission.

Signature.....

Date...18th August 2007

STATEMENT OF COPY RIGHT

DECLARATION BY THE CANDIDATE

I Kaiza Victor Baltazar do hereby declare to the SENATE of the Southern New Hampshire University at the Open University of Tanzania that this project paper is the original of my work, and it has not been submitted for the similar degree award in any other university.

Signature .....

Date 29 SEPTEMBER 2007

DEDICATION

This work is dedicated to all those who were ready and willing to live with the marginalized poor who are hard to reach, work with and are marginalized in an effort to restore human dignity for all people over the world.

ABSTRACT

The project is about capacity building for addressing vulnerability issues in HIV/AIDS intervention in Enguserosambu and Orgosorok villages. The project has highlighted the important role the community can play on HIV/AIDS along the continuum of community empowerment, awareness, knowledge and skills building. There was growing concern among community members on the rapid spread of HIV/AIDS and possible impact to the community. Methods and tools used in community needs assessment were story telling, observation and interviews using close-ended questionnaire, focus group and case studies. Generalizability of the study were limited because the sample was self selected, it was limited in size, behaviors were self reported, they led to biasness, time, and resource constraint. The project aimed at assisting all age groups in the community who were not infected with HIV/AIDS to avoid infection. The project objective was to improve awareness, knowledge and skills among groups and individuals in order to empower them to respond appropriately to HIV/AIDS, promote acceptability eventually, condom use. The positive outcome of the project was acceptance and increased communication with partners on safer sex through condom use. Many of the older and more influential people in this community still hold traditional views about sex and relation ships. The project frequently faced serious objections especially with campaigns on negative cultural practices that spread HIV. Pear educators had demonstrated that once well trained there was sense of sensitive

intervention in Maasai community. The study has shown that there was an element that would facilitate risk reduction.

It was thus recommended that future intervention should unique needs of this community into account aimed at reducing spread of the pandemic.

AKNOWLEDGEMENT

May I first of all express my appreciation to the leadership and community members of Pastoral Livelihood and Empowerment Program for accepting my participation in their organization. However I wish to mention some few individuals who offered recommendable support during the entire period of the project. They include: Mr. Yohana Turuni CBO chairman, Mr. Samueli Naingiria Coordinator and Mr. Anthony Perya Planning officer, without them this work would not have been completed to this level of quality. May I extend special appreciation to the course instructors firstly to Mr. Felician Mutasa and Mr. Michel Adjibodou for their valuable support, guidance and suggestions throughout the project period. I am heavily indebted to Mr. Joseph Kiangi Mwerinde, for his technical support, guidance and constructive criticism at various stage of my project. He is equally thanked for his tireless effort to read the report and make it the best as it is now. He deserves a special mention for his invaluable contribution to the success of this work. Finally I also wish to thank all my colleagues of CED program, fellow staff and members of my family especially my wife and children for their support and encouragement.

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EXECUTIVE SUMMARY

The project was on capacity building for addressing vulnerability issues in HIV/AIDS intervention in the community. The project's overall goals were to reduce the spread of HIV/AIDS through awareness, knowledge and skill improvement on the factors which contributes to the risk, and vulnerability of HIV among the groups and individual. The project aimed at assisting all age groups in the community who were not yet infected to avoid infection. The out put of the project was to strengthen the capacity of the community members to accept that HIV was within their community and that there were Maasai's who had been infected so there was a need of promoting acceptability and use of condom.

The community under the project were in Ngorongoro District Loliondo Division, Orgosorok ward, the project covered Loliondo and Engusero Sambu village. Total population to be served was about 5,200 with pastoralists Maasai making up of 90% of the population, 20 percent of the population were children under 5, 52 percent were children under 15 years. The literacy rate according to 2002 census was only 27 percent (National bureau of statistic 2003).

Information gathering and transmission to the community were through story telling and group meetings; majority of adult did not speak Swahili.

There had been growing concern by community members on the rapid spread of HIV/AIDS and the possible impact on the community, although prevalence in the community was relatively low compared to national estimates the infection could potentially spread very rapidly due to sexual mixing patterns and low use of condoms.

The available data from (Wasso hospital in 2003), showed that 2.2% of women attending antenatal clinics were infected. The awareness that HIV had started to affect Maasai

population was still low and misconceptions were rampant. The survey conducted during community needs assessment indicated that 78% of respondents agreed that they could not get HIV infection while 66% of respondents said that it was embarrassing to discuss sexual issues with their partners. Young men were increasingly migrating to urban areas in search of employment. Condom use in the community was very low because of low knowledge and limited availability. Sexually transmitted infection (STIs), social cultural and sexual practices allowed Maasai to engage in sex with a large number of partners. Most deliveries took place at home without gloves and aprons so local nurses participants carry risk of contaminating HIV.

The objectives of the project was to impart the awareness knowledge and skill building to the community so as to empower them to respond appropriately to HIV/AIDS and make the community accept that HIV is within their community. The second objective was to promote acceptance of condom use and improve its accessibility. Many Maasai's do not like condoms and some find it difficult to put on male condoms. The project sought to promote the use of condoms through demonstration by use of peer educators. Awareness, knowledge and skills building were done through traditional gathering and carrying out mobilization campaign of concerned age groups during traditional dancing as a place for education. Up to December 2006 all planned activities had been implemented, except in one hamlet

The major outcome of the project was the general acceptance and increased communication with partners on condom use. Another major out put was the general that HIV is spreading within the Maasai community. Culturally sensitive interventions

in Maasai community facilitated risk reduction and interventions. It was recommended that future interventions should take the unique needs of this community into accounts.

LIST OF TABLES

LIST OF ABBREVIATIONS

AIDS	- Acquired Immune Deficiency Syndrome
CBO	- Community Based Organization
RFA	-Regional Facilitating Agency
NOG	-Non Governmental Organization
STD	-Sexually Transmitted Disease
TACAIDS	- Tanzania Commission for AIDS
IEC	-Information Education and Communication
STI	- Sexually Transmitted Infections
LGAs	- Local Government Authroties
WHO	- World Health Organization
UN	-United Nations
PALSEP	- Pastoral lively hood and Empowerment Program
TBAs	- Traditional Birth Attendants
ACORD	-Agency for Cooperation and Research development

LIST OF MAASAI WORLDS

ESOTO	- An evening gathering warriors and girls
ILLAIGUANAK	- Age group leader
ORBO	- Aday time recreation place for worriors and girls
SAJAT	- Fertility rituals
MURRAN	- Maasai worriors

CHAPTER 1

1.0 Community profile

1.1Background about the District

Ngorongoro District is one of the six districts in Arusha Region. The district headquarters is Loliondo town, which is situated 424 Kilometres from Arusha (the region's headquarters) . The district borders Monduli District in the east, Mara and Shinyanga regions in the West and in the North, It borders the Republic of Kenya (Narok District). The district occupies a total surface area of 15,431 sq km and an estimated population of 129,000 people (2002 census) of mainly Maasai and Sonjo (Batemi) communities. Administratively, the District is divided in to 3 divisions namely Liliondo , sale and Ngorongoro. It has a total of 37 villages spread in 14 wards. About 51% of land area fall under Ngorongoro conservation Area Authority (NCAA) and 49% under the Liliondo game controlled area. The main economic activities are livestock keeping and agriculture. The infrastructure of the District includes 525 km of roads of which 325 km is gravel and 200 km is earth roads. Wireless telephones were installed in administrative and tourist centres. There are 17 dispensaries. Population served per dispensary is 7,058 people covering an area of 826 sq km. Primary School distribution is very scattered with about one primary school per 436 sq km.

Enguserosambu and Loliondo villages are about 400 km from Arusha town both village borders Kenya in the east. They hape population of about 5200, 20% of population are children under five, 52% of total population is under 15 years which is dependent population. The literacy rate of the population is 27% community per capita income is estimated to be about us$ 112 per year (National bureau of static's 2003)

The community live together practicing clan sharing, Land is owned by the community. Traditional leaders called 'Laigwanak' and age group leaders have great influence to the community that Government or political leaders. A husband is expected to share wives with age mates, the community practice polygamy where a man can marry as many women as he can.

Information gathering and transmission to the community was through, group meetings 'Engigwana' and through story telling 'lomon'. There is no public transport, no access to TV reception, national radio reception is very poor and majority of the adults can not speak Swahili.

1.2 Socio-Cultural HIV/AIDS context in Ngorongoro

The predominantly pastoral nature of the Ngorongoro Community with strong cultural beliefs and existence within the world heritage- Ngorongoro conservation Area with a congregate of foreigners from all over the world make the area a potentially HIV/AIDS high risk. Concerns on the spread of HIV in Ngorongoro have been expressed and documented by various development workers and researchers, raising for the need for systematic HIV and AIDS respondents taking into account the unique social cultural setting among the Maasai community and other smaller tribes (Asingwire 2004)

i. Misconception about HIV /AIDS is common even among those who have heard about HIV/AIDS. The understanding of what infection is indicated by different meaning which is used as bitia, engeeya naado (a long terminal illness) enamuratus (a disease that can be cured by circumcision) emiraka/ormitta (a disease causing wasting) . The belief that HIV /AIDS is

an ordinary disease and that is curable with traditional herbs is also wide spread.

ii. Social – cultural practices increase the risk of sexual transmission of HIV sexual mixing among Maasai extensive both before and during marriage. The social structure among Maasai, based on the age set system determnes the acceptable sexual partners for a member of an age set.

iii. Most deliveries take place as home and assisted by (Traditional Board Attendants) TBAs.. Home deliveries by TBA''s carry risk of infection they are likely to be infected if the mother is HIV- positive since delivery is generally carried out without the use of gloves and aprons.

iv. Sharing of potentially contaminated sharp instruments, male circumcision is universally practiced among Maasai. Often using one knefe for several boys to symbolize the bondage within age set.

As mentioned earlier Ngorongoro tribes have unique diverse cultures and traditions some of which contribute to the spread of HIV/AIDS. Taking into account the differences, application of different strategic approaches was imperative in addressing issues of HIV/AIDS in these communities such responses was to be coherent within the National Multi sect oral Frame work (NMSF). Although HIV/AIDS prevalence was still considered low in the district there was clear signs that the trend was changing in view of the risky practices and behaviors that still cherished by Ngorongoro community.

The National response has been sprearheaded by the health sector since the beginning of the epidemic in 1983 and has mainly focused on prevention of HIV transmission through awareness creation and control of other sexually transmitted infections. The

establishment of the Tanzania AIDS commission (TACAIDS) in 2001 has seen an acceleration of the responses with involvement of other key sectors and other partners. A national policy on HIV/AIDS and a National multisectoral strategic frame work (2003-2007) have been developed. HIV/AIDS has been recognized as a development issue and has been integrated into national instrument such as Poverty Reduction Strategy (PRS). The health sector has started to shift its emphasis from prevention to Voluntary counseling and Testing (VCT) and care, including provision of anti retroviral treatment. At district and community level capacity to respond has been very limited and intervention have been fragmented. Largely dependency on the support by externally funded project initiated by development partners, NGO's and CBO'S Council Multi Sectoral AIDS committees (CMAC) has been done in early 2004. Their role was to coordinate all the HIV /AIDS plan jointly formulated by all stake holders and enclosed by the council

1.3 Community Needs Assessment (CNA)

1.3.1 Research Methodology used in CNA

1.3.2 Research Design

This study intends to find out the level of understanding of the basic knowledge on HIV/AIDS and to identify factors that contribute to risk and vulnerability to HIV/AIDS. Behavior trend design methodology using questionnaires, interview and discussion with key informants, group discussion with youth, elders, and women, were used to determine HIV/AIDs related knowledge and behaviors on vulnerable group in the community. Group discussion has enabled the understanding of HIV/AIDS among pastorals content aimed at developing training capacity and skills that were capable of facilitating awareness rising and education on HIV within Maasai cultural context.

A cross sectional design which employs a survey method that is data at single point in time through informal data collection were also obtained by interviewing the sampled respondents.

1.3.3 Survey methods.

The questionnaires were trend designed using closed ended items. The close ended item is the question that requires the respondents to put a tick in a box on the respective answer.

Equivalency reliability was determined by giving different forms of the survey to two or more groups that have been randomly selected, then the equivalence reliability was determined by comparing the mean score and standard deviation results were highly correlated this ensured researchers reliability.

For internal validity the questionnaire was very short so that don not confuse the respondents and questioned were clear to allow easy understanding.

For external validity a stratified random sampling was carried out in all eight hamlets of Enguserosambu and Loliondo village. The base of sampling were based on size of population (eg elders 50,youth 50 and women 50)

1.3.4 Survey Instruments

The survey instruments used were questionnaires this was distributed to different social groups i.e. elders, youth, and women. Focus groups discussion with different social groups i.e. elders, youths and women. Discussion were held with community key informants i.e. age set leaders and laigwanaks . Informal discussions through story telling by individuals, record review was also used as the tool to compare results from interview. Focus group discussion was chosen to add data that could have not captured by questionnaires.

1.3.5 Contents

The questionnaire contained five question all questioners tested the knowledge attitude and behavior of respondents toward HIV/AIDS

question contents were based on the following questions.

- To test perceived susceptibility of HIV Infections.
- To test level of acceptance of the fact that HIV is within the Maasai community.
- Attitude toward use of condoms as intervention measures by youth, elders and women.
- Test if the couples talks about AIDS issues and sexual behavior.
- To test the community if they do discuss general issue on safer sex such as the need to use condoms.

The content of questions during groups Discussion was based on the following question to test level of knowledge on the basic scientific facts on HIV/AIDS

- How is HIV/AIDS transmitted from one person to another?
- How can a person who is HIV positive are detected.
- What is STD (Sexually transmitted disease
- How is spread of HIV/AIDS related to STD.?
- What are sign of a person who has full blown Aids

1.3.6Administration of Survey

The study took place in Enguserosambu and Loliondo village, during implementation a number of approaches and strategies were employed as follows

Letters of Introduction were prepared and submitted to the local authority elders of the community and age set leaders. Appointment was planned by PALISEP management to meet village leaders and elders to discuss the study details and how to operationalise its implementation. The surveys question was distributed to the respondents by researcher assisted by PALISEP staff.

The researcher, PALISEP staff, and selected staff who participated in the National census of 2002, attended one day training on how to conduct a survey. Those selected have to speak fluently Maasai language because most of respondents could not speak swahili.

questionnaire distributed by January 2006 and were supposed to be collected in 30th – March. After the end of the survey the researcher started to organize focus group discussion.

1.3.7 Sampling techniques and sample size.

Due to nature of the study purposeful sampling was used as a tool, this is sometimes referred to as convenient sampling which involves systematic identification and picking subject from the sampling frame or population. Three different age groups and gender that is youths, women, men and elders were selected. According to National (2002) census Enguserosambu village has a population of 3500 and Loliondo has a population of 4300 of which 50% are under five not covered by the study. Two villages have 8 hamlets, subjects were selected from each hamlet, 400 subjects was considered acceptable proportion of the total population.

Characteristic of respondents in Loliondo Village.

No of subject	Village	No of hamlet	Sex	Age
50	Liliondo	1	Male	18-25
50	Liliondo	1	Female	25-45
50	Liliondo	1	Male	50-60
50	Liliondo	1	Female	50-60

Characteristic of respondents in Enguserosambu village.

No of subject	Village	No of Hamlet	Sex	Age
50	Loliondo	1	Male	18-25
50	Liliondo	1	Female	25-45
50	Liliondo	1	Male	50-60
50	Liliondo	1	Female	50-60

1.3.8 Data collection tools

During data collection several tools were employed such as questionnaire, survey, Interview, Story telling (informal discussion), focus group discussion, literature review and discussion with key informant's. Open ended and closed questioners were designed and used to guide exercise during data collection. These data collection techniques were employed due to the fact that most people in the community don't know how to read and write and most don't speak Swahili

1.3.8.1 Interviews

In carrying out interview a set of prepared key questions was used to guide discussion between the respondents and researcher. The Interviews were conducted inform of question and answer sessions. During Interview a conducive environment were created to enable respondents to express themselves openly and freely,

1.3.8.2 Key informant Interview

I interviewed key informants in eight hamlets of the two villages, those interviewed. Included government official in the villages age set leaders, and elders (laigwanaq) this method was used to obtain in depth qualitative information and identified epistemological inadequacies.

1.3.8.3 Informal discussion

Informal discussion with community members took place after interview and group meetings. The objective was to supplement collected information during survey and to obtain a broader view from many people relating to level of knowledge on HIV/AIDS in the community.

1.4 Presentation of Survey results.

Analysis was done using statistical package for social science (SPSS) processor software and qualitative methods data were analyzed using themes and categories from my questions. I then used descriptive analysis in presenting and discussing my findings. Also descriptive statistics such as means percentages tables and figures were used.

1.4.1 Descriptive analysis

Status of the participant respondents.

Respondents were in categories the first category were youth males whose age range 18-45 were 50% youth females whose age range from 18-45 were 50%. The second category were elders male whose age range were from 50-60 years 50% and elder female whose age range from 50-60 years were 50%. Education status ranged from informal education 80%, standard seven leavers 15% and form four leaver 0.01%

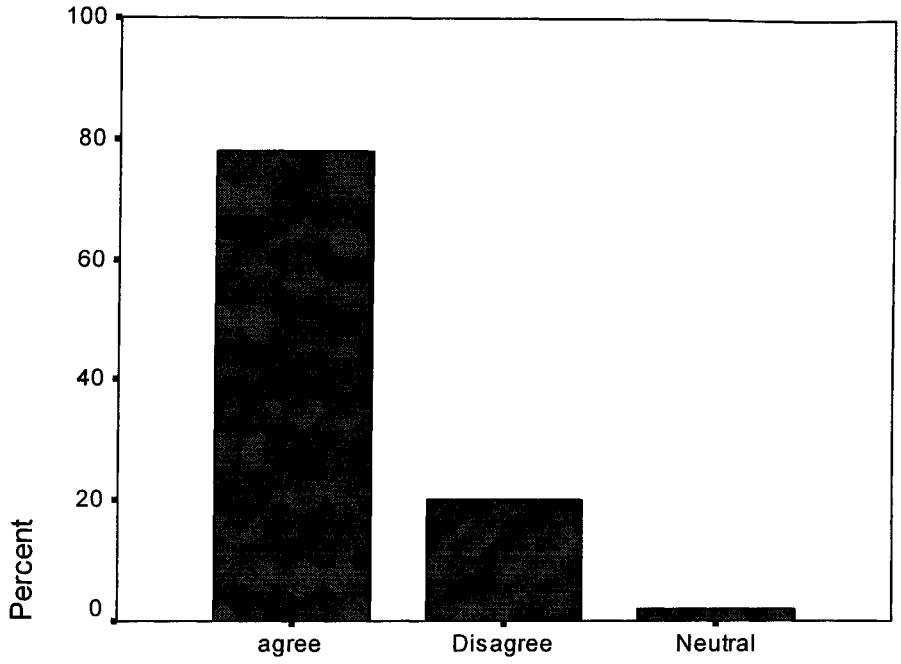
1.4.2 Presentation of survey results

Analysis was done by statistical package for social sciences (SPSS) data processor the results were as follows

People like me do not get HIV infection (male) age 25-45

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	agree	39	78.0	78.0	78.0
	Disagree	10	20.0	20.0	98.0
	Neutral	1	2.0	2.0	100.0
	Total	50	100.0	100.0	

Source: CNA survey data



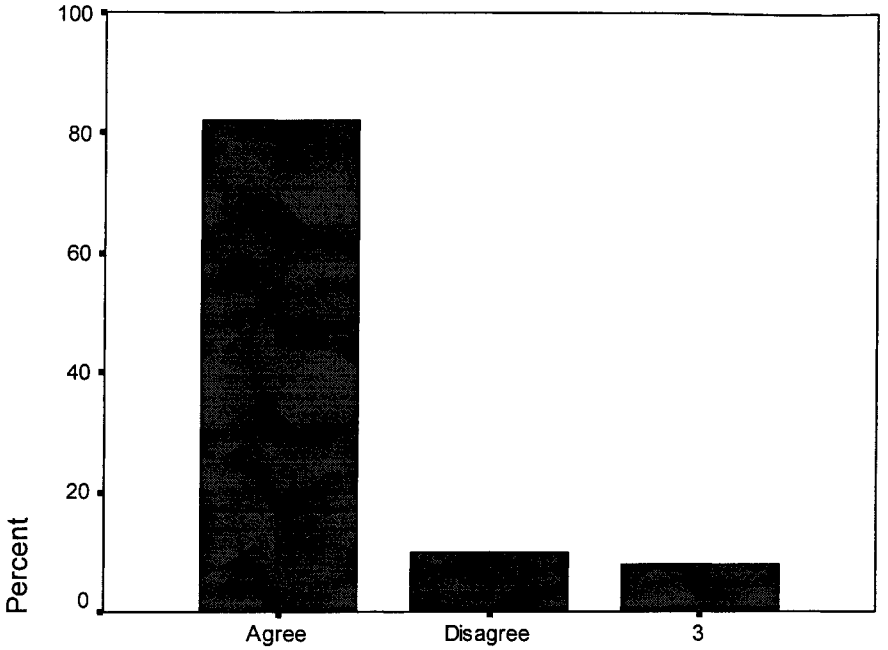
People like me do not get HIV infection (male) age 25-45

Respondents for these questions were youth male with the age range of 25-45 total number of respondents were 50. 78% of respondents said that they can not get infection of HIV while 20% said that they can get infection, 2% were neutral.

I am too young to get HIV infection (female) age 18-25

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	41	82.0	82.0	82.0
	Disagree	5	10.0	10.0	92.0
	3	4	8.0	8.0	100.0
	Total	50	100.0	100.0	

Source: CNA survey data(2006)



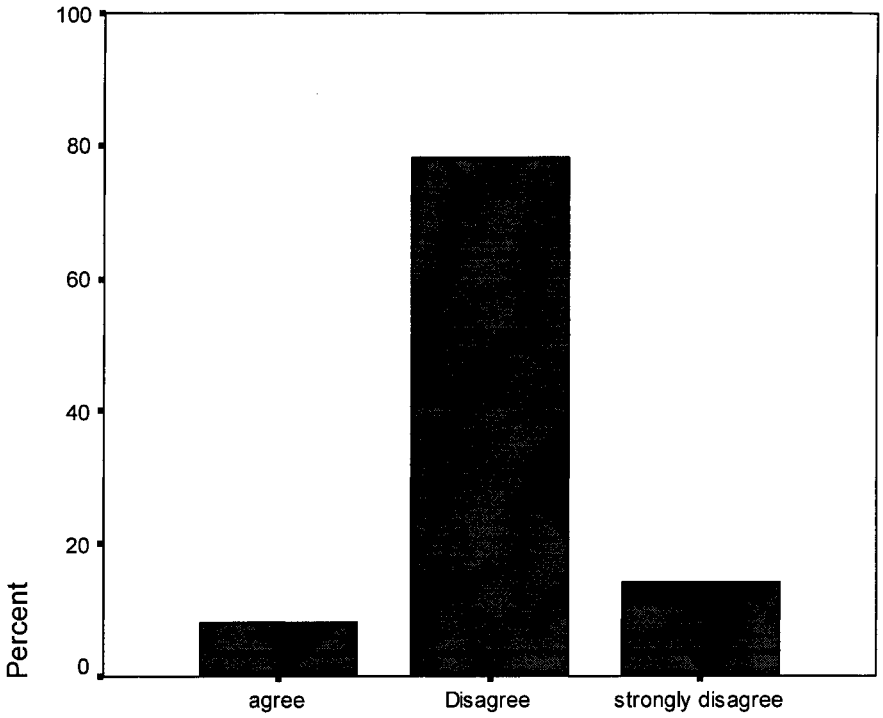
I am too young to get HIV infection (female) age 18-25

Respondents for this Question were female youth whose age ranges from 18-25 numbers of respondents were 50. 82% of respondents said yes that they are too young to get infection 10% said no they can get infection while 8% were neutral that means did not know if they can get infection or not.

Do you accept the fact that HIV is spreading within your community (elder male) age 45-60

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	agree	4	7.8	8.0	8.0
	Disagree	39	76.5	78.0	86.0
	strongly disagree	7	13.7	14.0	100.0
	Total	50	98.0	100.0	
Missing	System	1	2.0		
Total		51	100.0		

Source: CNA survey data (2006)



Do you accept the fact that HIV is spreading within your community (elder male) age 45-60

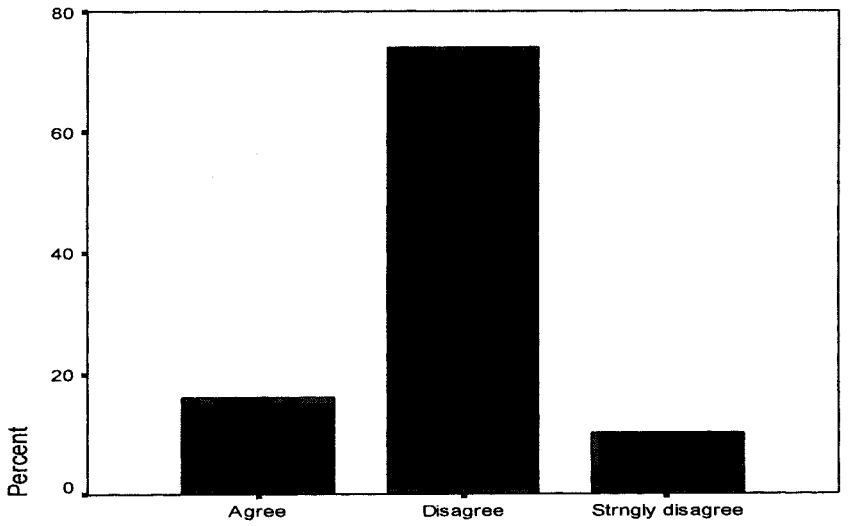
Respondents for this question were elder male whose age range from 45-60 numbers of respondents was 50.78% of respondents disagreed that HIV is not spreading in the community, 10% strongly disagreed, while 8% agreed. This shows the fact that HIV is

spreading within the community was very low and taking the fact that elder had a big say over youth in the community this was the big challenge.

Do you accept the fact that HIV is spreading within your community (female) age 45-60

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	8	15.7	16.0	16.0
	Disagree	37	72.5	74.0	90.0
	Strngly disagree	5	9.8	10.0	100.0
	Total	50	98.0	100.0	
Missing	System	1	2.0		
Total		51	100.0		

Source: CNA survey data (2006)



Do you accept the fact that HIV is spreading within your community (female) age 45-60

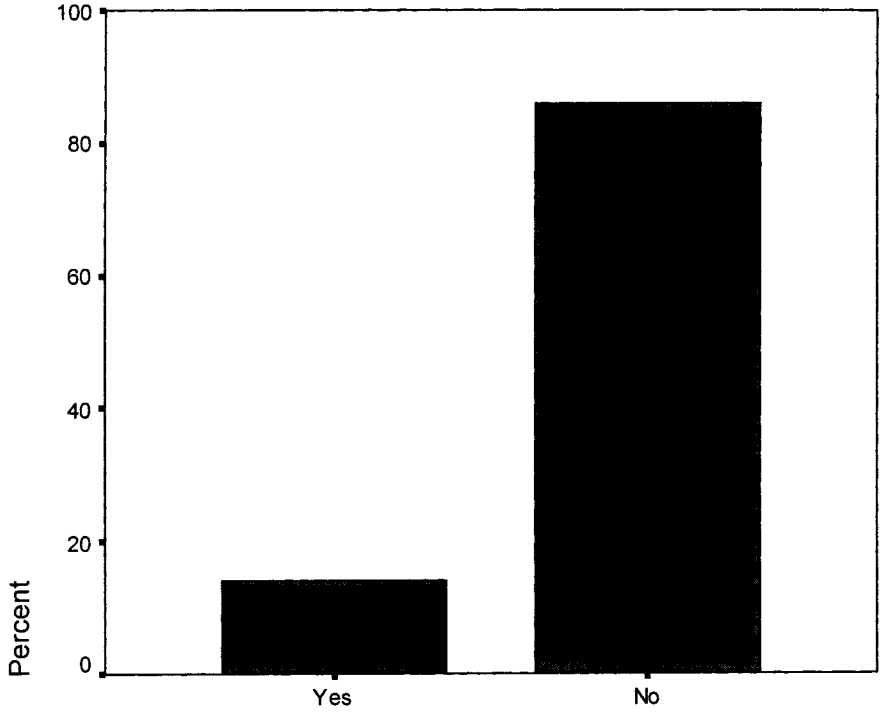
Same question were asked to female whose age range from 45-60 year, 74% of respondent said no HIV is not spreading within their community while 16% said yes HIV is

spreading to the community 4% agreed that can not either accept or reject. Again this shows the fact that HIV is spreading within the community was very low.

I feel comfortable talking about HIV/Aids issues and sexual behavior with my partner male age 18-45

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	7	13.7	14.0	14.0
	No	43	84.3	86.0	100.0
	Total	50	98.0	100.0	
Missing	System	1	2.0		
Total		51	100.0		

Source: CNA survey data (2006)



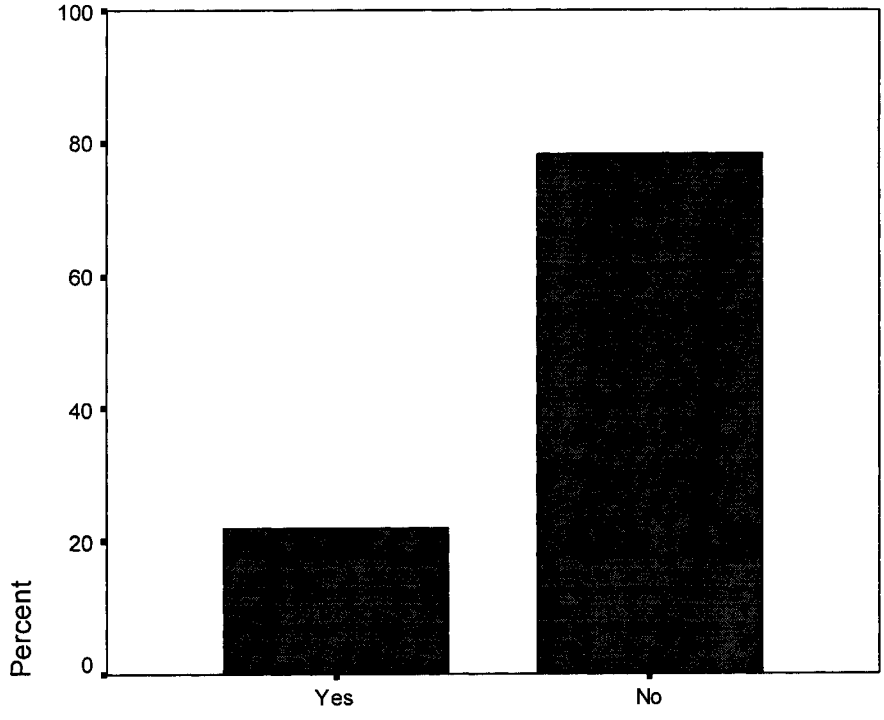
I feel comfortable talking about HIV/Aids issues and sexual behavior with my partner male age 18-45

Respondent of this question were male whose age range from 18-45 total number of respondents were 50. 86% of respondents said that they are not comfortable to talk about AIDS issues while 14% said that they are comfortable to talk about AIDS issues

I feel comfortable talking about HIV/Aids issues and sexual behavior with my partner female age 18-35

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	11	21.6	22.0	22.0
	No	39	76.5	78.0	100.0
	Total	50	98.0	100.0	
Missing	System	1	2.0		
Total		51	100.0		

Source: CNA survey data (2006)



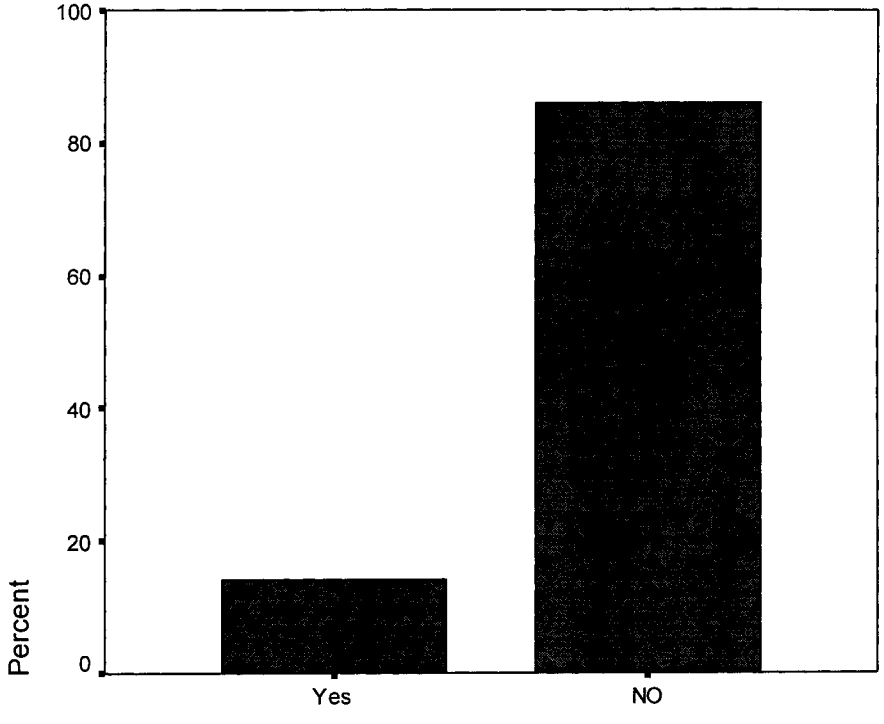
I feel comfortable talking about HIV/Aids issues and sexual behavior with my partner female age 18-35

Respondent of this question were female whose age range from 18-45 total number of respondents were 50 78% of respondents said not they are not comfortable to talk about HIV/AIDS issues while 22% said that they are comfortable to talk about HIV/AIDS issues

Would you recommend using condom as one of intervention measures male age 45 - 60

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	7	13.7	14.0	14.0
	NO	43	84.3	86.0	100.0
	Total	50	98.0	100.0	
Missing	System	1	2.0		
Total		51	100.0		

Source: CNA survey data (2006)



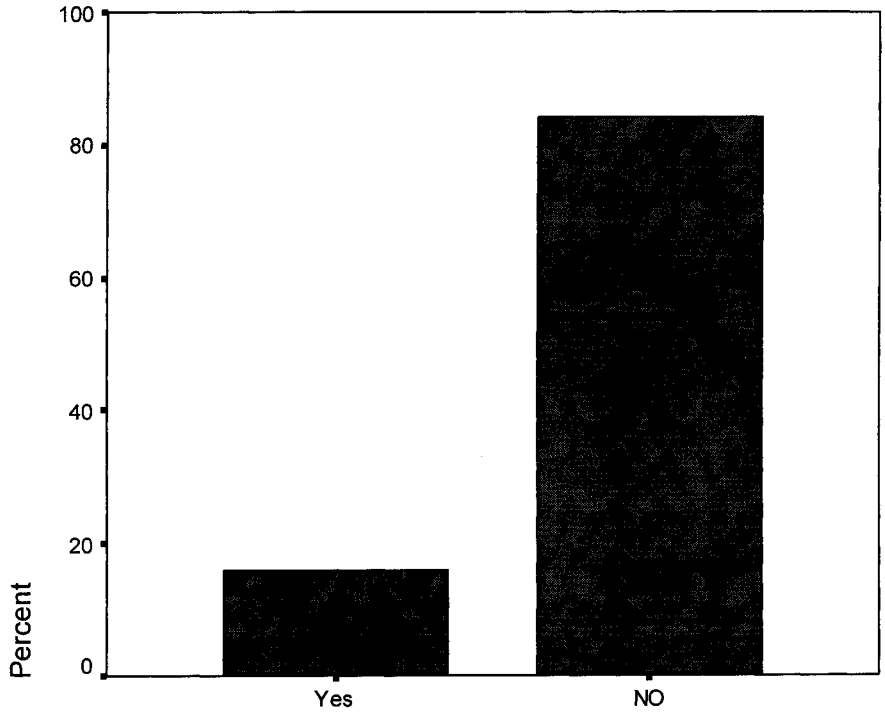
Would you recommend using condom as one of intervention measures male age 45 - 60

Respondent of this question were male whose age range from 45-60, number of respondents were 50. 86% of respondents said they do not accept use of condom as one of intervention measure against HIV while 16% said yes they accept use of condom as one of Intervention measure against HIV.

Would you recommend using condom as one of intervention measures female age 45-60

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	8	15.7	16.0	16.0
	NO	42	82.4	84.0	100.0
	Total	50	98.0	100.0	
Missing	System	1	2.0		
Total		51	100.0		

Source: CNA survey data (2006)



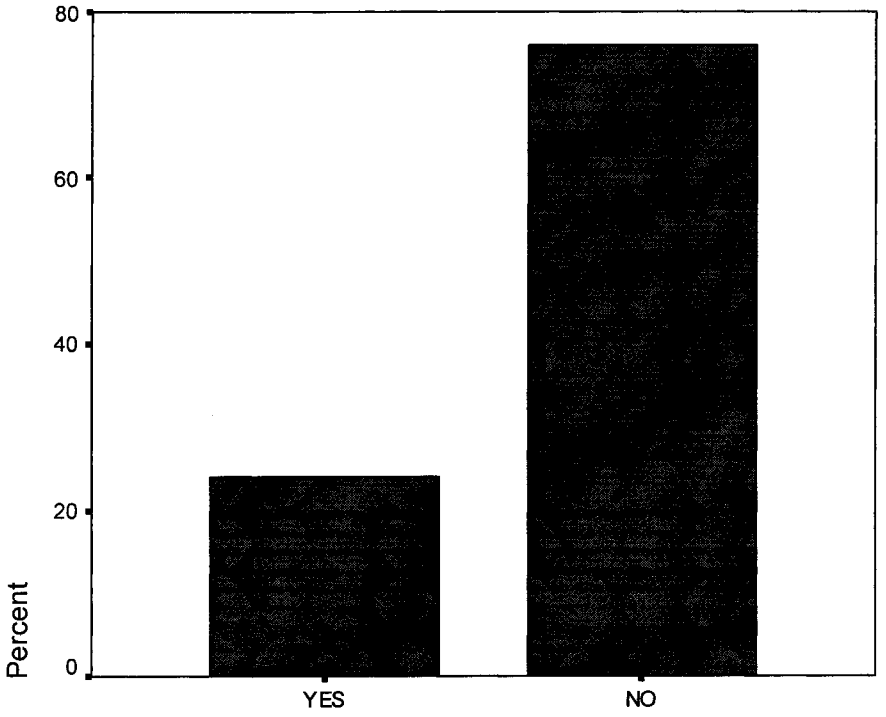
Would you recommend using condom as one of intervention measures female age 45-60

Respondent of this question were female whose age range from 45-60, number of respondents were 50. 84% of respondents said they do not accept use of condom as one of intervention measure against HIV while 16% said yes they accept use of condom as one of Intervention measure against HIV, this shows that the community had negative view on the use of condom in the fight against HIV/AIDS.

Would you recommend using condom as one of intervention measures male age 18-45

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	YES	12	23.5	24.0	24.0
	NO	38	74.5	76.0	100.0
	Total	50	98.0	100.0	
Missing	System	1	2.0		
Total		51	100.0		

Source: CNA survey data (2006)



Would you recommend using condom as one of intervention measures male age 18-45

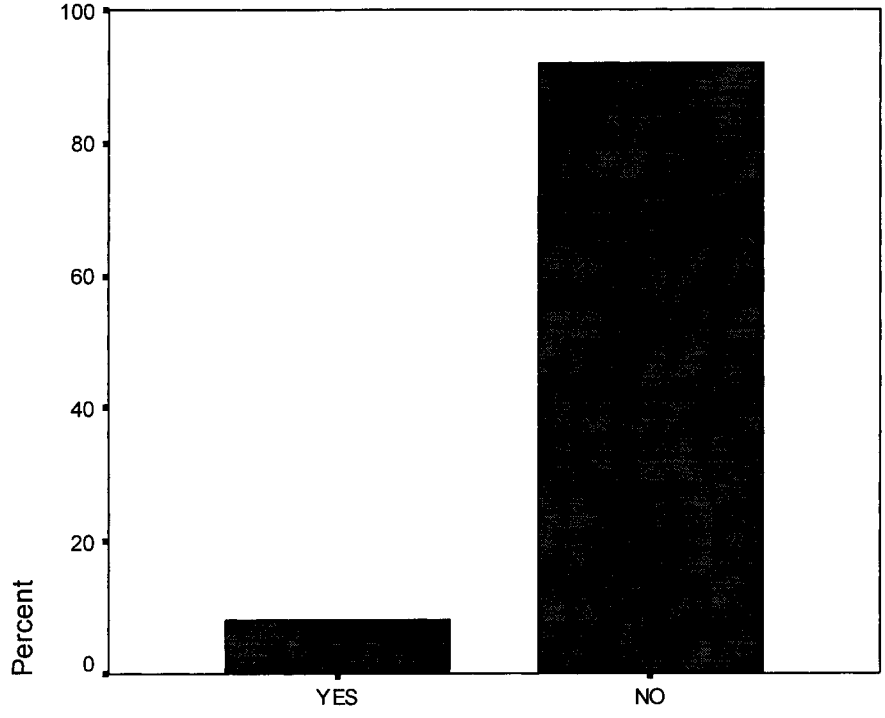
Respondent of this question were male whose age range from18-45, number of respondents were 50. 76% of respondents said they do not accept use of condom as one of intervention measure against HIV while 24% said yes they accept use of condom as

one of intervention measure against HIV, this shows that the high risk group in the community had negative view on the use of condom in the fight against HIV/AIDS.

Would you recommend using condom as one of intervention measures female age 18-45

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	YES	4	7.8	8.0	8.0
	NO	46	90.2	92.0	100.0
	Total	50	98.0	100.0	
Missing	System	1	2.0		
Total		51	100.0		

Source: CNA survey data (2006)



Would you recommend using condom as one of intervention measures female age 18-45

Respondent of this question were female whose age range from18-45, number of respondents were 50. 92% of respondents said they do not accept use of condom as one of intervention measure against HIV while 8% said yes they accept use of condom, this

Poses a biggest challenging the fight against HIV because women were at high risk

1.4.3 Focus groups

Focus groups were organized in each of the 8 hamlets in two villages Loliondo and Enguserusambu. Discussion were also held with traditional leader, age set elders and village HIV/AIDS committees, this was done to capture more information that could have not captured in survey and questionnaire. From focus group discussion the following were revealed.

- Most members of the community could describe HIV/AIDS correctly but they were weak on many scientific facts of HIV/AIDS
- Most members of the community could describe correctly the mode of transmission of HIV but they had weak knowledge of the relation ship between HIV/AIDS and sexually transmitted Diseases STDs.
- Condom use is low it was revealed from discussion with village HIV/AIDS committee that promotion and demonstration of condom use has not widely done. It was revealed from (Ngorongoro District health annual report 2003) that about 10,000 condoms were distributed in 2003 through health sector which is

less than one condom per sexually active person per year the reason given was the high stigma attached to there use.

It was found from age set elders that commercialization of sex has found its way into very traditional cultural system where hitherto social taboos and value guided

1.4.4 Results

In summary the following were features that were observed from community needs Assessment.

- The acceptance that HIV is spreading within the Maasai community is still low.
- There is weak knowledge on possible strategies to reduce the increasing HIV prevalence this is aggravated by the resistance to use condoms as one of intervention measures and stigma to discuss HIV/AIDS issues between partners.
- Many Maasai don't like condoms and most find it difficult to talk about safer sex with their partners.

CHAPTER II

2.0 PROBLEM INDENTIFICATION.

The identified need through community needs assessment was that there was weak knowledge on the rapid spread of HIV/AIDS in the community and weak preventive strategies that could lead to possible impact in the community and the projected devastating impact. Although prevalence in the community was still relatively low compared to the national estimates, the infection could potentially spread very rapid due to prevailing sexual active was at risk and could potentially be infected was not easy to be understood.

Available data showed that HIV epidemic in Ngorongoro District was at a relatively early stage, with 2.2% of the surveyed women attending antenatal clinics being infected. Prevalence in Loliondo ward was 2.3% when extrapolating these data, it was estimated that there were 1500 HIV positive people in the district of whom about 150 might have developed AIDS in 2003. The study carried out by (Dr. Moke Magoma et. Al, 2001) in Ngorongoro district showed that morbidity and mortality data from Wasso hospital (the hospital attended by people from Orgosorok ward) showed that 6 out of 602 (1%) adult admission in the second half of 2003 were diagnosed carrying AIDS related complication and one out of 6 hospital death was attributed to AIDS out of 38 patient tested for HIV in the some period, 19 patient were found to be HIV positive (based on only one rapid test, Wasso hospital 2001). Population at risk are men and women ages 12-55

Many social, cultural and economic factors contributed to the risk and vulnerability of HIV transmission in the district. The people definition of HIV/AIDS and its association with gender and life cycle revealed a lot about their understanding of the disease and transmission myth. Lack of information coupled with the stigma associated with HIV/AIDS; prevented people from knowing or disclosing the status of the disease at the community and household level.

The awareness that HIV has started to affect the Maasai population was still low as AIDS was no yet visible and misconception were rampant among young men who increasingly migrate to urban areas in search of employment. Possibly these men were exposing themselves to HIV through sexual intercourse with city women. Condom use in the district was very low because of low knowledge and limited availability.

Other sexually transmitted infections (STIs) were reported to be common and medical treatment was not readily available or accessed; the presence of STI facilitates the transmission of HIV. Social cultural and sexual practices allow Maasai to engage in sex with large number of partners of both sexes before and during marriage. Girls become sexually active at a very tender age (as early as 9 or 10 years). Male circumcisions using one knife for several boys are still carried out. Most deliveries take place at home assisted by traditional birth attendant, (TBAs) without the use of gloves and aprons, and carry some risk of HIV transmission. HIV is also transmitted from in infected mother to her child during delivery and breast feeding. The estimated result was about 46 HIV infected babies per year in the district. The non – indigenous population on the ward was at high risk because it often come on temporary assignments leaving their families behind and they were highly mobile, they were likely to engage in sex with bars girls and commercial sex workers, especially the tour drivers, guides and hotel workers.

2.1 Factors which contributes to risk and vulnerability of HIV transmission.

Although limited surveys showed that most people have heard about HIV/AIDS, the perception that was a Swahili disease were wide spread, Maasai men believed that they were only vulnerable when they engage in sexual intercourse with non-Maasai women in urbarness. The fact that most posters and videos used in education sessions were in Swahil8i depicts no – Maasai reinforces on this belief. Visibility of the disease was low since few Maasai had actually developed full- blown AIDS or have dies of AIDS. To date there was no known person living openly with HIV among the Maasai in the district.

2.1.1 Misconceptions about HIV and IADS are common.

Even among those who have heard about HIV and AIDS. The understanding of what the infection might differ as indicated by a variety of Maasai names with different meanings that were used i.e a long terminal illness, a diseases that can be cured by circumcisions, a disease causing wasting. The belief that HIV/AIDS was on ordinary known diseases and that it was curable with traditional herbs were widespread.

2.1.2 Migration by young men to cities might lead to high risk during sexual interaction.

Migration out of Ngorongoro to seek employment (mainly as watchmen) in Arusha, Mererani and Kenya were reported to be increasingly high among young Maasai youngsters.

2.1.2 High prevalence of STI facilitates transmission of HIV

Data from Wasso hospital (for the period of July to December 2003) showed that among 4139 adult out patients diagnoses, 181 (4.4%) were infected with STIs. The presence of

another STI, especially genital ulcer, increases the risk of HIV transmission during unprotected sexual intercourse.

2.1.3 Socio – Cultural practices increase the risk of sexual transmission of HIV.

The family structure relevant to the situation was that a husband was expected to share wives with the age mates polygamy. Men could marry as many women as they could afford, older men can even marry young girls. Sexual missing among Maasai is extensive both during and after marriage. The social structure among Maasai is based on age set system which determines the acceptable sexual partners for a member of age set. "illegal sexual relations" for example between warriors (murrain) and married women also take place. Young uncircumcised girls (entity) from age 9-10 up ward are expected to engage in sex with murran and extensive sexual mixing takes place at youth gathering these circumstances, naturally existing social networks still can be targeted by prevention programs. HIV prevention interventions undertaken with social networks can establish new groups norms, reduce risk behaviors of networks members and can reach hidden members of population known personally to leaders of the social networks.

lovers" for sexual satisfaction. Husbands are expected to share their wives with their age mates, Guests commonly sleep in the house of an age mate.

2.1.4 Sharing of potentially sharp instruments.

Male circumcision is universally practiced among Maasai, often using one knife for several boys to symbolize the bonding within the age set. Other possible transmission routes include scararifications, tattooing, piercing and sharing of razor blades for shaving.

2.1.5 Low use of Condom

Promotion and demonstration of condom use has not been widely done. Many Maasai do not like condoms and some find it difficult to put on the male condom because in the Maasai circumcision, the foreskin is partially excised but remains attached and forms a potential hindrance when unrolling condom over the penis. (Kelly et al, 2005), observed that population segment at highest risk of HIV is often hidden, marginalized, and hard to reach by conventional prevention. This pattern is true especially in Ngorongoro District where there was little precedence's for strong community based organization services programs. In the overall strategy. PLALISEP believes that approapriate skills, information and organisation go beyond implementation of the project. The community believes that HIV/AIDS was the cross cutting issue because income generating activities could expose both men and women to HIV especially when they moved away from their homes in search of markets. The community believed that the mainstreaming

2.2 Consequences of the problem

- HIV/AIDS if not controlled could lead to impoverishing of the Maasai pastoralist because of the physical impact of the well being as both economical and social effect.
- The epidemic has the potential to create massive economic problem arising from losses of productivity and diversion of funds from development to crisis health and care.
- The epidemic has the potential of leading to massive deaths and eventually wiping of the Maasai pastoralists community due to uncontrolled sexual mixing between girls, young boys and warriors.

2.2.1 Target Community

The community covered by the project were in Loliondo Division Orgosorok Ward,the project covered Loliondo and Enguserosambu village. PALISEP organisation objective was support pastoral and agro pastoral community lively hood by mobilizing the available resource and help to explore the possible opportunities to sustain their livelihood. The community capacity building was (Esoto, Orbo/Olip, Manyatas) It is believed that semen helps a girls to mature physically. It is reported that a murran can have 10 or more partners in one week.

An "elder" is expected to marry and can accumulated as many wives as he can afford. When old men marry young girls it is common practice for these girls to have other lover.

2.2.3 Stake Holder Analysis

Table 1. Stake holder analysis

Stakeholders	**Roles**	**Concern**	**Expectations**
Community member under the project	- Target group - Recipient of project	Rapid spread spread of HIV with the community	i) Reduce transmission of HIV ii) Reduce impact of AIDS
District Council	i) Collaborate with	HIV spread rapidly	Strengthened

	the CBO and community through ward multsectoral Aids committee WMAC ii) Technical assistance iii) Financial assistance iv) Coordination	among the poor and it increase poverty on already poor	capacity and individuals to arrest the spread of HIV/AIDS and mitigate the impacts.
RFA	i) Capacity building to the CBO ii) Technical assistance iii) Coordination iv) Funding of the project	Rapit spread of HIV within the community	Strengthened capacity of the community and individuals to arrest the spread of HIV/AIDS and mitigate the impact.
TACAIDS	Collaborate with	i) Financial	Strengthened

	community based organization through RFA and CMAC	assistance ii) Technical iii) Coordinators	capacity of the community and individuals to arrest the spread of HIV/AIDS and mitigate the impact.
OXFARM	i) Technical assistance	i) Financial assistance ii) Technical iii) Coordinators	Strengthened capacity of the community and individuals to arrest the spread of HIV/AIDS and mitigate the impact.
ACCORD	i) Technical assistance	i) Financial assistance ii) Technical iii) Coordinators	Strengthened capacity of the community and individuals to arrest the spread of

			HIV/AIDS and mitigate the impact.

Source: Author from survey during community needs assessment (2006)

2.2.4 Project goals

The overall goal of the project was to reduce the spread of HIV/AIDS through awareness, knowledge and skill improvement, on the factors that contributes to the risk and vulnerability of HIV among the community members. The community based awareness campaigns were organized to make the community accept that the Maasai have become infected and the infection was no longer confined to those who have migrated to town, but also spreading within the villages. The project aimed at assisting all age groups in the community who were not yet infected with HIV to avoid infection. This was done through;

- Support of traditional courts to discuss and eradicate tradition that contributed to the spread of HIV/Aids.
- Use traditional gathering to educate community to fight against/protect against HIV/Aids.
- Mobilize the concerned age groups to be traditional dancing Esoto/orbo as a place for education.
- Many Maasai do not like condoms and some find it difficult to put on male condoms. The project promoted the use of condoms through demonstration using peer educators.

2.2.5 Project objectives:

Objectives of the project were:

1. To improve awareness, knowledge and skill among groups, and individual in order to empower them to respond appropriately to HIV/AIDS. The aim of the awareness, knowledge and skill building to the community would be to strengthen the capacity of members of the community to accept that HIV is within their community and that there are Maasai who have become infected. The fact that infection no longer confined to those who have migrated to town but also to any other members of the community.
2. To promote condoms use and improve access to condoms.

2.6.6 Host Organization.

The pastoral Livelihood support and empowerment Program (PALISEP) is a community based organization. Registered under the Law of the United Republic of Tanzania in November 2002. it is located in ngorongoro District Orgosorok ward. The vision of PALISEP envisages society where information, empowerment, and solidarity from the basis for strategic lively hood improvement. The Mission of PALISEP was to prepare unite and provide appropriate information of the marginalized community and especially to those most in need to be in a position to maximize the available opportunities and take a rightful place in Tanzania society. PALISEP is governed by the boards of governance from the local community that comprise traditional leaders, expert from other organization which comprise a gender balanced team. Annual general assembly was convened each year. The CBO had originally two objectives; one was community empowerment through micro enterprise Second was sustainable natural resource use management through conservation of Loliondo forest. On 6th April 2004

stake holder's workshop for HIV/AIDS situational analysis in the district commissioned by ERETO conducted at SOPA lodge PALISEP representative attended it was learned that awareness that HIV/Aids had started to affect maasai pastoralists was low. Also limited effort to create awareness so far has been done to the community. After the workshop the CBO conducted general meeting on October 2005 that comprised of women, youth and aged who deliberated tat HIV/Aids should be mainstreamed into big components of the CBOs objectives. It was observed that in mainstreaming this sub theme pastoral community was still faced by male centered social-cultural factors that accept men as decision makers in the household. However this being the case, it was decided that sensitive campaign on these interventions require joiner join effort and PALISEP within its coverage was to collaborate with Ox farm GB Loliondo, ACCORD, District Council and TACAIDS through Regional facilitating Agencies (FRA).

PALISEP was initially farmed to face the problem relating to livestock in Orgosorok ward. It is believed that information, solidarity and relevant empowerment would facilitate the ushering of pastoral of self-reliance and fruitful participation in development issue. In 2002 the CBO was registered as an entity to foster livestock improvement, economic empowerment and environmental management under the philosophy of community based of natural resource management with the special emphasis to Loliondo natural forest.

2.6.7 Project inception

The idea and importance of systematically addressing issue of HIV/AIDS within Ngorongoro communities was conceived by Ereto NPP during its phase II planning. This was between 2002 and 2003, where different stakeholders held various meeting concerning pastoralist and HIV/AIDS. The prevalence rate of HIV infection in the

district was estimated at 2.1%. However within the generalized rate of prevalence of STI, syphilis was said to stand at 4.5% (Hilde Basstanie and Rafael Ole Moon 2004).

The high prevalence among blood donors serves to highlight how big a threat of HIV/AIDS was in the district as of 2003 the HIV/prevalence among blood donors was 5.2% (Basstanie, Ole Moono 2004). According study made by (Dr. Mole Magoma et. al 2003) in the context of his study, blood samples were taken from nearly 2500 antenatal clinic 2500 antenatal clinic attendees in 70 clinic sites (two hospital sites and 68 reach sites). Preliminary finding showed that the overall HIV prevalence in the district was 2.1% and the syphilis prevalence was 4.5% Data are presented in the table below

Table 2: HIV and syphilis Infection among pregnant women, Ngorongoro District

Division	Number tested	HIV Infection		Syphilis Infection		HIV and syphilis Infection	
		Nr	%	Nr	%	Nr	%
Loliondo	861	20	2.3	42	4.9	5	0.6
Ngorongoro	889	10	1.1	54	6.1	1	0.1
Salei	747	22	2.9	16	2.1	5	0.7
Total Ngorongoro District	2497	52	2.1	112	4.5	11	0.4

Source: (Wasso hospital, 2003)

From the data above it was estimated that there were about 1500 HIV positive adults in the district. Every year about 46 infants would acquire HIV from their mother at birth or through breast- feeding.

Morbidity and mortality data from Wasson district a designated hospital showed that out of 602 (1%) of adult admission in the second half of 2003 were diagnosed as AIDS related complication and one out of hospital death was attributed to AIDS

Table 3: HIV Infection among pregnant women according to partner's mobility status.

Division	Number tested	Women with migrating partner		HIV infection among women with migrating partner		HIV Infection among women without migrating partner	
		Nr	%	Nr	%	Nr	%
Liliondo	861	30	3.5	2	6.7	18	2.2
Ngorongoro	889	58	6.5	1	1.7	9	1.1
Salei	747	153	20.5	10	6.5	12	2.0
Total Ngorongoro District	2497	241	9.7	13	5.4	39	1.7

Source: (Wasso Hospital 2003)

CHAPTER III.

LITERATURE REVIEW

1.3 Theoretical literature review:

3.1.2. Conceptual framework of CBO.s.

In order to be able to understand and learn how development functions and operates the following definition are provided.

"Community Based Organization (CBO) this is a term referred to grass root people and community centered organization formed in a particular locality in pursuit of common goal, agenda, or issues."(Colin Ball & Leith Dunn, 1995).

However CBO may transform itself by expanding its operation and thus become NGO.

CBO has the following features;

- They are formed to improve the livelihood of the poor and other disadvantaged people who are unable to realize their potential or achieve the full right in the society through direct or indirect forms of action.
- They act on issue of community and public concern.

The CBO are essentially social organization, that they enjoy a varying degree of autonomy and independency from the government, but also they are bound to be self regulating and voluntary nature consequently CBO embody diverse interest which in turn influence their relationship with the government. CBO's underpin vision, mission goals, and objectives based on their desire to advance and improve human condition in various ways.

- Taking into account and consideration of the problem and needs of the people.
- Devoting maximum recourses to address those problem and needs.

- Ensuring that organization remain aligned and true to their mission objectives and integrity.
- Ensuring maximum involvement of beneficiaries and other stakeholders.
- Maintain high ethical standard at both organizational and community level.
- Ability to undertake planning effective management of activities projects

and program including regular and rigorous evaluations of those activities, project and programs the above is argued by (Colin & Leith Dunn, 1995).

Legal and Institute Framework of CBO's in Tanzania operate under specific defined legal and Institutional frame work. The legal frame work has been a fundamental frame work prerequisite for legal existence and operations of these organizations. The legal frame work contains law and regulatory process which operate. To this effect in Tanzania up to 2001 there were three law government operations of CSO's or NGO's.

- Societies ordinance administered by the Registrar of societies in the Ministry of Home Affair.
- Companies ordinance in the Ministry of Trade and Industries.

Trustee Incorporate ordinance administer by Administrator General in the Ministry in 2002 a new law, the NGO Act 1 2002 was enacted. Under the new law among other things registrations has been streamlined and decentralized. The new law requires national organization to registered in Dar es Salaam met the NGO Registered in the division of NGO's officer of the Vice – President while District Based NGO's/CBO's are now to be registered at the region (if they operate in more than one District) or a district level (for though operating only one district) in the office of the District Commissioner (DC)

"When AIDS emerged from the shadows two decades ago, few people could not predict how the epidemic would evolve, and fewer still could describe it with any certainty the best ways of combating it. Now at the start of a new millennium, we are past the stage of conjectured. We know from experience that AIDS can devastate whole regions, knock decades off natural development, widen the gap between rich and poor nations and push already stigmatized groups closer to the margins of society. Just as clearly, experience shows that the right approaches, applied quickly enough with courage and resolve, can and do result in lower HIV infections rates and less suffering for those affected by the epidemic".(UNAIDS 2000:) this shows the importance of mainstreaming HIV in daily activities to reduce the impact.

AIDS(Acquired Immune Deficiency Syndrome) emerged in the 1980 as the most terrifying epidemic of modern times with AIDS the body's immune system can not fight the virus for a long time. Diseases and death may not occur until years after first infection. Hence HIV, or Human Immunodeficiency virus, that leads to AIDS, spread unduly throughout the world before the epidemic was even apparent(AIDS), seen as a rare condition affecting homosexual men in the US around 1980, was only recognized as a global health problem of paramount importance six years later (Malhler, 1986).

After a period of time this virus damages the Immune system. HIV/AIDS is a complicated and hugely important world issue. (UNAIDS September, 2003) . Home and Community for people with HIV and AIDS, the richest resource a country has is without question, the Compassion of its people (UNAIDS) 2000b:60).

As the HIV/AIDS epidemic expands caring for patients HIV related disease is increasingly taking place in the home and Community, people cannot afford long hospital stays and in any case, hospital beds are in limited supply. Patients are often

discharged to die at home(UNAIDS 2000b:60). Home and Community care offers the only feasible option for the majority of patients at most stages of their disease , not just dying. Sufficient resources must be mobilized to make the services work, and crucially, the services need to be "owned" and as far as possible run by the communities they set out to serve.

The Continuum of care might be the development of Community residential centres, perhaps linked with health clinics, where families could bring patient for temporary treatment and learn better nursing nutritional and support skills and information. This concept might be a highly cost effective (Jackson and Kerkhoven,1995). This can be very effective in Tanzanian Community setting were the resource are very limited.

Aids and Women.

In many parts of sub-Saharan Africa inequality between men and women, and economic deprivation helps to drive the epidemic. Women and girls are commonly discriminated against access to education, employment, credit, health care, land and in heritance.

The vulnerability of African women and girls to HIV infection & Integrally lindke to underlying gender inequalities societal norms and discrimination. Sustained changes in this vulnerability will require fundamental shift in the relation ship between men an women. The United Nations Goals.

Most HIV + Women have been infected with HIV through heterosexual sex. Physically, women are more susceptible than men to HIV infection through heterosexual sex, information drawn from different studies shows that during heterosexual sex women are about twice as likely to become infected with HIV from men as men are from women.

(Delgado et. Al; (1998) in his report on collaboration project undertaken by a University which observed that innovative approaches are needed to reach puerto Rican,

Dominican, and other Latino communities in the fight against epidemic. To be effective approaches must involve all sectors and must reach out to individuals uwilling or unable to access conventional programs it was found that project was successful in involving a culture-based institution, increasing referrals for HIV testing and distributing information about HIV and AIDS.

In Uganda (Knsman et al, 2002), in description of the implementation of a large Community base HIV/AIDS behavioural Interventions in rural Uganda; Intervention included drama and video show, community educators, as well as condom and leaflets distribution annual attention rate was found to be 11% with stable workers more likely to be older, married or opinion leaders in their community than those who dropped out (Kinsman et al,2002), in spite of initial resistance to the intervention, particularly in relation to condom it has been demonstrated that people in rural Africa can accept and actually participate in the dissemination of HIV/AIDS prevention messages throughout their own communities.

A number of factors contribute to the hetero sexual transmission of HIV in sub- Saharan Africa. They included those who works at the level of Individual those related to societal norms, those connected to health care Infrastructure and those that out of Laws, policies, and developmental issues (Lamptey et al. 1997). Clearly no single preventive strategy can hope to tackle all these factors but behavioural Interventions- which seek specifically to reduce risk behaviours;- offer one of the most promisngi kapproaches (Oakley at al; 1995), with the potential to work on both Individuals and society as a whole.

3.2.2. Use of behovioural theory in the AIDS Community Demonstration Project.

(Feshbein, Rhodes, (1997) using behavioural theory in HIV prevention asserts that the AIDS Community. Project Intervention is based in Health belief model, the Theory of Reasoned

Action and Social Cognitive theory. They identified a core set of factors in the intervention in order to encourage behaviour change some of the factors identified are attitude, perceived norms, perceived risk and self efficacy. The Theory of Reasoned Action suggetsts that one should focus intervention messages on specific behaviours e.g. condom use for sex with a main or steady partner. In addition, social Cognitive Theory it highlights the importance of peer modeling and social reinforcement of behaviour in human learning and behaviour change. The theory suggest that peers could be particularly effective in delivering the intervention, this is due to the fact that behaviours are guided by attitudes, beliefs, experiences and expectation of other persons reactions, this suggest that persons from the targeted at – risk communities are recruited and trained to be Community advocated and to distribute role model and risk reduction supplies on the streets of their communities.

The key to building community level responses is inspring local ownership of the initiative. Communities must be able to say "we accomplished something and are proud of it. Long term financial support looking community to outside sources of information and facilitating horizontal communication among groups are essential for sustainability of the project.

3.2.3 mportance of Community involvement.

Most people in sub Saharan African with HIV or AIDS will rely on care form their families, friends and Communities and also need to know how best to help themselves. Most people with HIV will rarely if ever see a professional counselor except at point of HIV testing.

Stories abound of individuals being rejected and whole families affected by AIDS, usually out of fear, confusion shame anger or blame. The quality of care, given by family and community members is likely to improve greatly with some basic training in counseling and nursing.

Male Circumcision and AIDS

(Halperin et.al 2000) found that male circumcisions, the removal of the fore skin from the penis confers some protection against HIV infection in men; Apparently this reduces the risk by about half or more. The foreskin being more vulnerable to various STD infections, virologists believe that HIV spreads more easily concentrated in fore skin but largely absent from circumcised penis

3.3 Empirical literature review.

Sub- Saharan African is the region of the world that most affected by HIV/AIDS an estimated 25.8 million people were living with HIV at the end of 2005 and approximately 3.1 million new infections occurred during that year. In one year the epidemic has claimed lives of an estimated 24 million people in this region in the absence of massively expanded prevention, treatment and care effort, the AIDS death toll expected to continue rising before peaking around impact is already being felt widely not only in healthy but in education, industry agriculture, transport, human resource and the economy in general.Before 1983 medical professional in Tanzania took Acquire Immune Deficiency Syndrome (AIDS) as the disease occurring in Europe, very little attention was focused on this disease. The epidemiological data in 2003 indicated that a total of 18,929 AIDS cases were reported to the NACP from 21 regions during the year 2003. This resulted into a cumulative total of 176,102 reported cases since 1983. In 2003 Tanzania mainland was estimated to have about 1,810,000 people living with HIV(840,000) males and (940,000) females (NACP 2003 report no.18).

3.3.1Behavioral Factor.

Multiple sexual contact, prostitution, obligatory sex (marital situation), coercive sex (rape and defilement) recreational sex, and early initiation of sex.

3.3.2 Biological factor:

Presence of other STDs, biological and anatomical structure of women immature sexual anatomy of young girls, infected blood and blood product, infected skin piercing instrument, prenatal transmission.

Situation increasing risk of transmission includes,

- Multiple sexual partners
- Commercial sex work
- Single sex quarter or separation from family
- Other sexually transmitted disease (STDs)

3.2.3 Condom uses

As personal strategy HIV Infection, Condom use is not a perfect solution it is requiring people to be highly motivated, always be able to access good quality condoms in sufficient numbers and to have them available when needed. Also succeed in negotiating condom use with partners. At population level, important strategic targeting of condoms at those who are most likely to transmit Infections. (Moses at al, 1991) Cited in (World Bank 1997:83) through a study conducted in 500 sex workers in Nairobi.

A study in men's attitudes to condoms and to female- controlled method of protection, such as female condoms, (pool et al,2000) found that male attitude to the male condom, the female condom and female- controlled methods of protection generally were characterized by ambiguity and amity. The liked male condoms because they protect against unwanted pregnancy and infection, but were worried about the rumours that it was unreliable. The authors conclude that the development of female controlled methods will need to include education and social marketing to reassure men of the benefits to them as well as to women.

(Mitchell K et al,2002) exploring the community response to a randomized controlled HIV/AIDS Intervention trial in rural Uganda. Explored the response to a Community based randomized controlled trial (RCT) of an HIV/AIDS behavioural change Intervening in rural Uganda, the views of field workers, trial community non-governmental organization representation and religions leaders were explored via focus groups(13) and interview (45). The result suggest that the component of the intervention valued by the community are not necessarily those prioritized by trial Implementers specifically, prevention activities appear to be valued less than material assistance for the reasons sensitive mobilization ,respect for community members and their appointed leaders and outgoing communication is essential.

A Case study conducted in Senegal by "UN AIDS/03.44E September, 2003 Reveled that strong community participation has been a major factor in Senegal success in maintaining a low rate of prevalence in the general population has been achieved. Peer education has been an effective tool in mobilization of Senegalese communities. Schools, Churches the work place and other forms that brings people together are effective tools in the armoury of HIV- prevention measures. The Leaders of these groups are respected and influential within community, and they provide opportunities for addressing risky behavior and for expanding medical services and counseling.

Reports on impact of Aids in Africa reveals that Community on the study done in South Africa based – care programs, often organized by people living

with HIV/AIDS, had become one of the outstanding features of the epidemic. The are playing a key role in easing the impact. Although many of these programs are operated by religious groups or non governmental organization the effectiveness of the care does depend on support from normal health, welfare and other social sectors.

The study further reveal that while home – based care is not cheap it is an option for the care though not cheap it still become an affordable option for the care of people living with HIV/ADIS.

A study done in Uganda by (Kinsman et, al,2000) asserts that Implementation of large scale behavioural intervention faced difficulties ranging from practical low to recruit train and supervise and motivate more 550 field workers from 12 different communities. To the political field many of the older and more influential people in rural Masaka hold traditional view about sex and relationshipo projects occasionally faced serious objections to what is being done. However with sensitivity tenacity and the support of key local leader's project were ultimately able to define or at least ameliorate thsese situations the lesson learned tells us that providing rural African communities with HIV/AIDS prevention messages and skills is practicable and that members of the target communities can themselves play central role in the process.

In their study of HIV/AIDS Interventions(Tim Allen and Suze Heald 2002), argue that a comparison of HIV/AIDS policies in Botswana and Uganda helps to

Highlight the kinds of polices that are necessary to come to terms with pandemic in Africa. They argued that the promotion of Condoms at an early stage proved to be counter- production in Botswana, whereas the lack of condom promotion during strategies in Uganda. Other important factors included national and local- level leadership, the engaging of religions group and local leaders and most controversially procedures of social compliance.

(Giles et. Al, 2003) in their study of condom use in African a dole scents the role of individual and group factors reveals that the study was set out to assets tae ability of the Theory of planned behaviour to predict and explain condom use in a traditional African

context and in particular to asses the relative contributions of individual and normative constructs the result showed that sexual behavior in a rural location governed by family social influence subjective norms provide to be most significant elements with many family emerged as the most significant other.

On the other hand (Kathleen et, al,2005) revealed that. A community – level intervention program aimed at young adolescents' delays early intercourse, increases condom use and reduces the type of risky sexual behavior. The intervention consisted of AIDS education, skills training, peer influence and both family and neighborhoods support to avoid and reduce high risk behavior among adolescents. Community level interventions have proven to be successful with gay men drug users and inner-city women. (Helen et, al, 1990). A case of TASO the AIDS support organization in Uganda. TASO was started in the 1980s by Noerine Kaleeba, occupational therapist whose husband was dying of AIDS. A that time they experienced such hostility and lack of understanding among the hospital staff and community. That Noerine formed a small group of people with HIV/AIDS and asked family members to provide mutual support and understanding. TASO has developed from this fledgling, informal group into a major NGO offering professional counseling, home care, orphans support and other services in many people living with HIV. TASO has retained a strong community focus and emphasis on openness and care. Counsellors have been trained from among the community to provide home based services. Uganda is one of the few countries in Africa where the rate of new infections is declining (Helen et,al, 1995). AIDS AFRICA continent in crisis.

Evaluation report ya (Kwateng & Shangnessing 1997) Wolrd vision Tanzania in Arumeru Districts Government implementing HIV/AIDS revealed that strong

community ownership and the tackling of underlying causes and an almost seamless Inter- sectional collaboration were among the success of the project.

(Kathleen et, al ,2005) reveals that adolescents HIV Risk Reduce with community Interventions. A community – level Intervention program aimed at young adolescents delays early Intercourse. Increases condom use and reduces the type of risky sexual behaviours that can result in sexual transmitted diseases and HIV/AIDS (New Haven, Conn. Yale researcher). The Intervention consisted of AIDS education. skills training, peer influence and both family and neighborhood support to avoid and reduce high –risk behavior among adolescents. The author asserts that community level interventions have proven to be successful with gay men, drug use's inner city women. The program successfully delays sexual debut and increases use of condoms.

3.2.4 Involvement of traditional leaders.

The involvement of traditional sources of community support such as traditional leaders, chiefs, Kraal heads and others is also valuable traditional communitiesk have support mechanisms for dealing with death and crises, and cultural traditions in major life events. This structure is crucial in local social scene as it can influence attitude and behavior change. Conversely if they ignored or threatened, a confusing and conflictual atmosphere can develop between external support agencies and local structure.

Senegalese delegated to SANASO conference (SAFIDS, 1995: 13) asserts that to change our cultural norms we used to say needed two generation.

That is not true. HIV has moved our cultural norms in a very short space of time. But it depends how it is approached. Take sexual cleansing in Zambia (where by a widow has sex with her diseases husbands brother). Community leaders were aware of a new

situations and integrated new aspects into ritual cleansing. They can change these norms where as outsiders can not.

The AIDS Community Demonstrated Project was a 5 years study (1989- 1994) that HIV prevention interventions. The goal of the intervention was to

Promote constant condom among injection drug users, female sex partners, female commercial sex workers. The study was conducted in California, New York and Washington. The study was based on the stage of change model which recognizes that behaviour change is a process and takes time. Community members were mobilized verbally reinforced on prevention materials among their peers. Small media materials were also developed for distribution. Condoms were made available for community members at the end of intervention, 54% of larger population members had received role model stories. Overall, individuals in the intervention communities showed more movement toward consistent use of condoms. Individuals who were directly exposed to the intervention were more likely to carry condoms(American Journal of Public Heath 1999).

The Maasai pastoralists are a distinctive segment of the national population and have maintained fabric of their culture which is very different from those of main stream Tanzania communities in dress, language , Swahili, and therefore" cut off" from existing global HIV/AIDS Campaign in the communication media. This has contributed greatly to the ignorance on the side of the Maasai pastoralists on the HIV/AIDS pandemic, it also puts them in a different class group that requires special attention to get through walls of their lives are fortified by strong cultural adherence population increase which has occurred in the face of diminishing resource has forced the pastoralist youth to seek employment in cities and mining areas and are currently contracting HIV virus.

3.3 Policy Review:

3.4.1. Global Policy

The UN Declaration of Commitment on HIV/AIDS, and the millennium Development Grab have set ambitions and measurable targets to be reached by Africa and the rest of the world in the coming years of halting and beginning to reverse the spread of the epidemic by b2015. Governments, donors, and other stakeholders will have to move beyond advocacy, funding commitments and plans for action. Major intensification of the disbursement of funds and implementation of stronger programs are put in place.

The UN declaration of commitments on HIV/AIDS requiring that by 2005, 90% of young people (aged 15-24) should have access to prevention including services to develop the life skills needed to reduce vulnerability to HIV infections. (UNAIDS)(1999/2000) developed a series of booklets to help guide the strategic planning process for a national HIV/ADS response. It includes focus on:

1) The strategic frame work, principles, broad strategies and institutional frame work.
2) Factors promoting HIV spread or impending the quality of life of those living with and affected by HIV/AIDS.
3) Examining the official program and all the other main contributions from NGO'S communities, the private sector and so forth.
4) On of UNAIDS core recommendations for HIV prevention and care in sub-Saharan Africa are, recognitions and facilitation of community activities that mitigate the impact of HIV/AIDS- COLL SECK (20001).

WHO and UNAIDS(2000) suggested a focus on nascent concentrated and generalized pandemic through analysis high risk environments within a country or reign and

therefore for targeting interventions strategically though understanding the environmental risk factors for different population groups, factor pointed out as the main risk factors for high HIV- transmission rates in South Africa includes:-

- Population movements.
- Developed Trades and Transport Routs,
- Poverty and unequal distribution of Wealth,
- Broad sexual mixing pattern and multiple partnership
- Various cultural factors, e.g. male circumcision
- High level of Untreated sexually transmitted infections
- Relatively low condom use

3.4.2. The National Multisectoral Strategic Frame work HIV/AIDS.

It is the policy guideline that in fighting HIVV/AIDS strong emphasis will be on community based response, that communities are fully empowered and involved in formulating and implementing own responses. Each sector, public, private, non-governmental organization, faith based organizations and communities in

Rural and urban areas are required to plan and implement cost effective HIV/AIDS interventions according to their comparative advantage.

3.2.5 Policy Statement on district and community response.

The policy states that effective response to the epidemic is based on the capacities of people living in communities to asses their own vulnerability and plan their own responses. Community mobilizations, empowerment and support to communities to respond effectively are the key elements of the Nation response. It is in the communities and at local level where the fight against AIDS will be decided. NGO's,CBO's and faith

based organization can make important contributions towards mobilization of communities and need to be supported.

3.4.3. Roles and Functions at the District and Village levels.

Local government council will bring together and coordinate all actors working on HIV/AID in the respective district. Attached to one of their subcommittees a special multi-sect oral HIV/AIDS committee will be established consisting of representatives of all major government, civil society and private partners of the district. It is this committee which will do the actual technical work.

- At village/Ward a similar HIV/AIDS committee comprising of the important actors will be created and responsible for the planning and implementation of HIV/AIDS responses.
- NGO'sCBO's and faith based organizations will play an important role in supporting districts and villages in the elaboration and implementation of

Their plans and activities. New partnerships between public and private/civil sectors will have to be creates.

Facilitating Agencies will be used to support Local Government Authorities (LGAS) and communities to build up the necessary organization and technical capacity related to the effective development and implementation of HIV/AIDS activities.

CHAPTER IV

PROJECT IMPLEMENTATION

Findings from community needs assessments showed that the perception of vulnerability to HIV/AIDS were very low at 12%. Discussion of safer sex among partners and use of condoms was low this was due to the stigma attached to condom use in the community. Large number of sexually active population did hold the view that HIV affect only prostitute who frequent township. These shows that the level of awareness was very low in the community. Results of the community needs assessments was the base for project implementation.

4.1.2 Product and out puts of the project

The expected achievements was Awareness creation, knowledge and skills building within the community to accept the fact that Maasai are vulnerable to HIV/AIDS, infection and remove the notion that infection is only confined to those who have migrated to town. The aim was to reduce unsafe sexual behavior among the communities. Second expected out put was to promote acceptance of condom use by increasing the knowledge on condoms and increase the distribution channels. The last expected out put was reducing transmission of HIV/AIDS and other sexually transmitted infection (STI) among community members.

4.1.3 Planned Activities

Planned activities that was done from April 2006 were, identification of project staff this was carried out by researcher, PALISEP coordinator in collaboration with OXFARN GB staff. After staff identification then it follows vetting of project staff by community members, this was done to ensure that staff are committed to the project and to ensure

project sustainability. Identification of peer educators, volunteers, elders, and youth and women leaders was done by researcher , PALISEP coordinator with assistance of ERETO staff. Training needs assessment for project staff was done to ascertain training needs suitable to project staff. Other activities done was to produce posters and identify distribution channels to the community, Use traditional gathering to educate the community to fight against HIV/AIDS, training of important people of both genders from every settlement, to conduct mobilization campaign, to avail and train on proper use of condoms, identify distribution channels of male and female condoms to organize discussion on traditional preventive measures , identify and train traditional birth attendants and circumcisers on safe delivery.

Table: 5 Implementation calendar

OUT PUT	ACTIVITY	INPUT REQUIRED	RESPONSIBLE PERSON	TIME FRAME							
				2005				2006			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Improved awareness knowledge and skills among.	1. Carry out training need assessment group and other actors	- Facilitation fee - Field allowances - Transport - TV sets	- Peer educators - Project staff - Facilitator								
Target group	2. Training of community groups 3. Community mobile campaigns 4. Production and distribution of IEC material	Appropriate tapes									
Minimize eradicate harmful practices and reinforce good practices	1. Organize analytical educational session on cultural practices that after its HIV/AIDS Interventions 2. 2. Encourage the use of Tradition gathering as	- Facilitation fee - Field allowed - Transport - TV sets appropriate tapes	-Peer educators - Project staff - Facilitator								

	educational forums on HIV/AIDS										
	1. Organize open discussion on traditional preventive measures 2. Avail and train on proper use of male and condoms.	- Facilitation fee - Field allowed - Transport - TV sets appropriate tapes	- Peer educators - Project staff - Facilitator								
	1. Identify and train TBAS, THS and circumcisers on safe delivery and other productive.	- Facilitation fee - Field allowed - Transport - TV sets appropriate tapes									

	2. Provide protective gear such as gloves, aprons knives ect.										

Source: compiled by author during implementation

Table: 6 Project implementation Plan

Out put 1.1 Project implementation getting started	1.1.1 Identification of key staff to be involved in project implantation from the community - youth - volunteer - retirees - peer educators	1.1.1 Key staff for the project have been identified and recruited by the project from the community	Jan-March 2006	- Transport - Stationeries - Meal	300,000 500,000 150,000
Output 1.2 Awareness knowledge and skill improved among Communities	Act. 1.1.2 Asses training needs of tradition leaders, youth leaders when leaders and traditional midwives and circumcise	1.1.2 training needs traditional leaders, youth, women leaders and traditional midwives has been identifies.	April – May 2006	- Transport - - Stationeries - Meal - Fail - Fee	- 250,000 40,000 - 200,000 - 400,000
	Act. 1.1.3 Organize community mobilization campaign production	1.1.3 The process of obtaining			

	distribution IEC materials	IEC material is still going on after receiving funds from RFA'S			

Source: compiled by author during implementation

4.1.4 Getting started

The project started after completion of community needs assessment to test implementation strategies. The first step of project implementation was identification of project staff; this was done by the project coordinator, consultant from ACCORD and OXFARM GB staff based in Loliondo. The selection criteria for staff were;

- Deep understanding of maasai culture and language
- Ability to learn new ideas and pass the knowledge to others
- Willingness to attend training without demanding perdiems except lunch
- Committed to work with the project for project life
- Ability to speak in front of group of varying gender, size and
- Ability to promote various HIV prevention approaches.

4.1.5 Vetting of the project staff

After selection, the proposed project staffs was vetted by community members to ensure that project staff are ones with good behaviors, self respect and willingness to work with project with minimum allowances.

4.1.6 Identification of peer Education

Peer educators were selected by project staff, after undergoing two weeks training.

Important point that peer educators needed to know includes.

- The role of peer educators
- How to communicate effectively with peers
- How to promote positive behaviors with regards to HIV/AIDS
- HIV transmission prevention
- The relationship between HIV and untreated sexually transmitted diseases
- Confidentiality of a person's HIV status

Table: 7 Summary of topic covered for project staff and peer educators.

1. Basic facts and knowledge and skills on HIV/AIDS	
Target; to provide participants with basic facts on HIV/AIDS/STLS and elaborate issues tied to them discussion cantered on. • Dentitions of HIV/AIDS • Symptoms of HIV/AIDS • Modes of transmission of HIV • Myths on HIV/AID • HIV/AIDS prevention • STI's and their relationship with HIV/AIDS • Cultural practices that facilitate transmission of HIV transmission	Total number of days 10 total number per day 8 Total number of hours for the training 50 hours.
2. HIV/AIDS situation	
Target; To provide participants with the overall picture of HIV infection in Ngorongoro District. Discussion centered on; • History of the epidemic in Tanzania • Epidemiology and prevalence	

• Contributing behaviors to the HIV transmission.	
3. HIV/AIDS and women	
Target; To enable participants understand the reproductive organs and Discussion centered on; • Impact of HIV/AIDS on women • Factors that render women vulnerable to HIV/AIDS infection • Strategies for remedies and empowerment	
4. Communication barriers of HIV/AIDS	
Target; To discuss effective communication mechanisms for HIV/AIDS messages and education to facilitate positive cultural behavior change. • Commonly used communication methods for conveying HIV/AIDS information • Strength and weakness underlying each of them • Women friendly communication method	
The role of the peer educator	
Target; To provide participants with monitoring and follow-up skills so as to monitor behaviour patterns of the community members with regards to HIV/AIDS/STI's prevention.	

Source: compiled by author during community needs assessment (2006)

4.1.7 The Training methodology

In trying to make use of the participant experience and knowledge on the subject, Training was participatory in nature. Various training methods were adopted, this included plenary sessions where by participant discuss and agree on particular topic to be covered. Second method were lectures, this method helps to provoke discussions between participants. Third method used were video shows, this method when used enable communication with others, insiders and outsiders work together to clearly determine what information they need to convey. Other methods were group discussion and plenary sessions this helped to identify knowledge gap between participants. Also used were role plays and brain storming.

4.1.8 Actual implementation

Actual implementation started 1st may 2006 after securing of fund. Implementation started by organizing mobilization campaign this covered eight hamlets in two villages under the project this activity took two moths up to July 1st. On 2nd July distribution of IEC material started followed by identification of distribution channels for condoms. Improved awareness, knowledge and skills among target groups was done by project staff, peer educators, volunteers, elders through community mobilization campaigns, method used were production and distribution of IEC materials, group meetings, and the use of traditional gathering as educational forum.

CHAPTER V

5.0 MONITORING, EVALUATION AND SUSTAINABILITY:

The monitoring and evaluation system for HIV/Aids intervention at council and village level and selected indicators of this project were largely taken from multisectoral strategic frame work.

Table: 8 monitoring plan

Objectives	Activities	Indicator	Data source	Methods/ tools	Person responsible	Time frame
1. Improved awareness knowledge and skills among target groups	1. Carry out training need assessment group and other actors 2. Training of community groups 3. Community mobile campaigns 4. Production and distribution of IEC material	1. Needs assessment report available 2. Number of community group trained 3. Number of community members reached 4. Number and type of IEC material produced and distributed	1. Field reports 2. Records from Wasso hospital and Loliondo health centers.	1. Group meeting 2. Open ended stories 3. Community case study 4. Semi structured interview		
2. Minimize/eradicate harmful practices and reinforce good practices.	1. Organize analytical educational session on cultural practices that after its HIV/AIDS Intervention s 2. Encourage the use of Tradition gathering as educational forums on HIV/AIDS	a) Reports of community based discussion available b) Reports of traditional gathering discussed. c) Number of traditional gathering Held and education session on HIV/AIDS discussed d) Number of people attended traditional gathering		1. Group meeting 2. Open ended stories 3. Community case study 4. Semi structured interview		

3. Promote preventive approaches against STI/HIV/AIDS	1. Organize open discussion on traditional preventive measures 2. Avail and train on proper use of male and female condoms	a) Reports of traditional gathering discussed. b) Number of traditional gathering Held where education session on HIV/AIDS discussed. c) Number of people attended traditional 2. Number of female and male condoms distributed		1. Group meeting 2. Open ended stories 3. Community case study 4. Semi structured interview		
4. Reduce transmission HIV/AIDS through delivery and invasive practice	4.Produce posters leaflets in the local language and make dances/songs on the HIV/AIDS theme	1. Number of posters produced 2. Number of posters distributed 3. Number of people got and read posters		1. Group meeting 2. Open ended stories 3. Community case study 4. Semi structured interviews		

Source compiled by author during implementation (2006)

5.1.1 Research methods

Structured interview were used as the data collection tool using close ended questionnaires, one type of questionnaire were used with the aim of testing knowledge attitude and practices on sexual behavior, STIs and HIV/AIDS during project implementation.

(a) Sampling techniques and sample size.

Subjects were selected from each hamlets, 50 male youth aged (18-45), 50 from each from four hamlets Making total of 200 subjects.

(b) Data collection

The close-ended questionnaire was administered to the subject through one-one interviews for ethical issues all individuals were conducted in privacy. A total of 200 respondents were interviewed 50 male youth aged (18-45).

(c) Data analysis

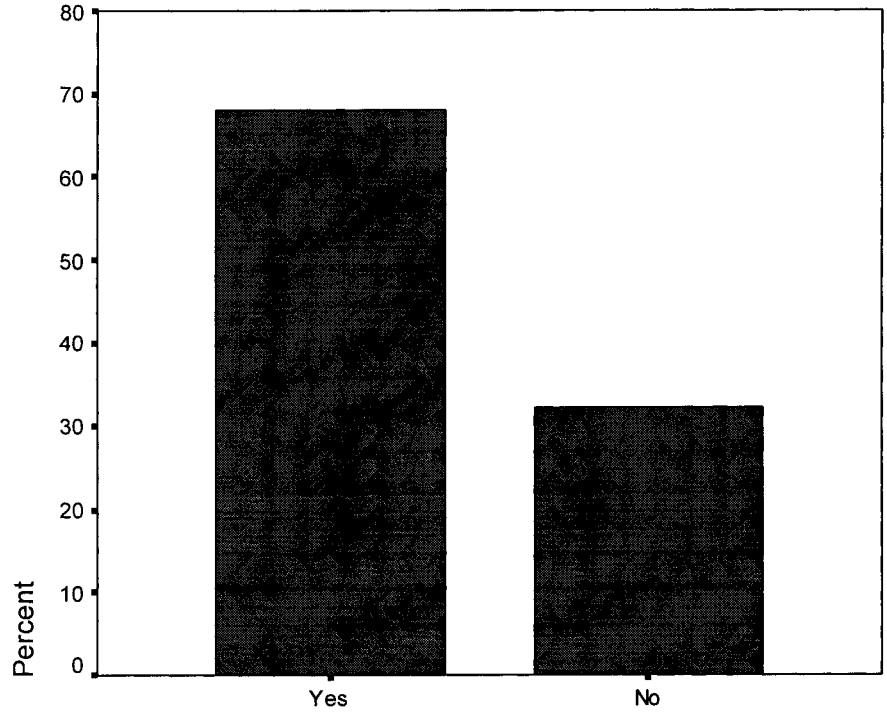
After data collection, the responses in questionnaires were reviewed in order to generate qualitative data. A coding frame was developed to code the responses according to categories required. The data analyses were processed by computer using SPSS soft ware for simple tabulation and graphical representation.

(d) Survey results

I feel comfortable talking about HIV/AIDs issues and sexual behavior with my partner male age 18-45

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	34	66.7	68.0	68.0
	No	16	31.4	32.0	100.0
	Total	50	98.0	100.0	
Missing	System	1	2.0		
Total		51	100.0		

Source: Monitoring survey data (2006)



I feel comfortable talking about HIV/AIDs issues and sexual behavior with my partner male age 18-45

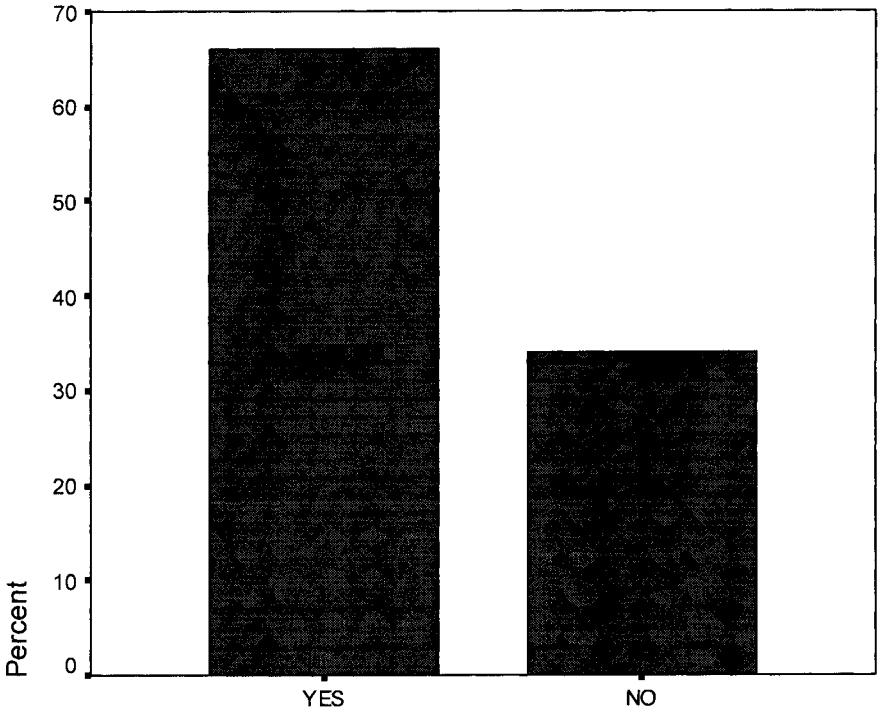
Respondent of this question were male whose age range from 18-45 total number of respondents were 50, 68% of respondents said that they are comfortable to talk about HIV/AIDS issues while 32% said that they are not comfortable to talk about HIV/AIDS

issues, this shows that project had had some impact in charging behavior of the members of the community compared to the results before the project implementation.

Would you recommend using condom as one of intervention measures male age 18-45

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	YES	33	64.7	66.0	66.0
	NO	17	33.3	34.0	100.0
	Total	50	98.0	100.0	
Missing	System	1	2.0		
Total		51	100.0		

Source: Monitoring survey data (2006)



Would you recommend using condom as one of intervention measures male age 18-45

Respondent of this question were male whose age range from18-45, number of respondents were 50. 66% of respondents said they do accept use of condom as one of

intervention measure against HIV while 34% said that they do not accept use of condom as one of intervention measure against HIV, this shows change of attitude after project implementation when this results compared before the project.

Table: 9 Summary of monitoring indicator results.

Objectives	Activities	Indicator	Results
1. Improved awareness knowledge and skills among target group	1. Carry out training need assessment group and other actors 2. Training of community groups 3. Community mobile campaigns 4. Production and distribution of IEC material.	1. Needs assessment report available 2. 25 community group trained 3. 3500 community members reached 4. Number and type of IEC material produced and	1. Needs assessment report were produced which was the base for plan of operation. 2. Ten women group 15 youth group and 5 elders in Loliondo and Enguserosambu village were trained 3. 1,500 community members were reached by project staff. 45,000 posters, 2000 brochures in Maasai language were produced and distributed.
2. Minimize eradicate harmful cultural practices and reinforce good practices	1. Organize analytical educational session on cultural practices that after its HIV/AIDS	a) 5 Reports of traditional gathering discussed b) 5 traditional gathering Held where education	a) Three reports of community based discussion were produced

	Interventions 2. Encourage the use of Tradition gathering as educational forums on HIV/AIDS.	session on HIV/AIDS discussed. c) 1500 people attended traditional gathering.	b) Three reports of traditional gathering were produced. c) 800 people attended traditional gathering.

Source: Compiled by author during monitoring(2006)

5.2 Evaluation:

Evaluation was conducted twice in six month after project implementation and after one of project implementation. The method used was participatory evaluation this gave the opportunity for both community members under the project and outsiders to reflect on what has been done in the past in order to make decisions about the future. Evaluation was direct liked to the goals, objectives, targets, and indicators were related to the National Multisectoral Strategic Framework on HIV/AIDS of 2003-2007. In carrying out evaluation first a meeting was convened involving CBO members, members of the community and the stakeholders.

During that meeting long and short term objectives were reviewed and it wad decided what needed to be known from the evaluation, direct and indirect indicators for evaluations were chosen. Source of information for evaluation were through story telling, group discussion and structured interview using stratified random sampling.

5.2.1 Research methods

Structure interview were used as the data collection tool using close ended questionnaires, one type of questionnaire were used with the aim of testing knowledge attitude and practices on sexual behaviour, STSs and HIV/AIDS during evaluation.

(a) Sampling techniques and sample size

Subjects were selected from each hamlets, 50 male youth aged (18-45) from each four hamlet making total of 200 subject

Data collection

Close-ended questionnaire was administered to the focus group through one-on-one interviews for ethical issues all individuals were conducted in privacy. A total of 200 respondents were interviewed 50 male youth aged (18-45),.

(b) Data analysis

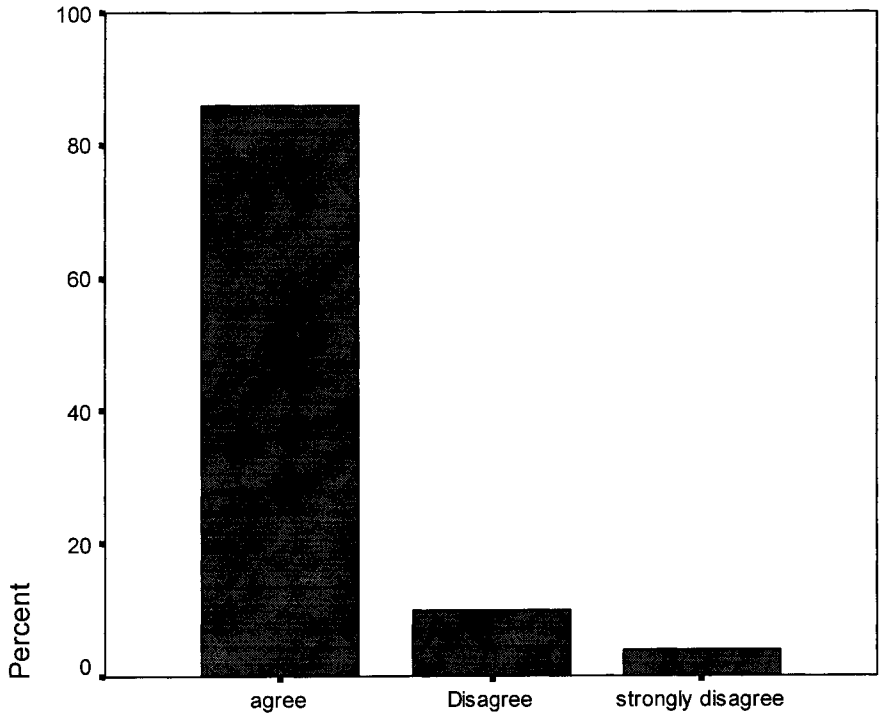
After data collection, the responses in questionnaires were reviewed in order to generate qualitative data. A coding frame was developed to code the responses

(c) Survey results

accept the fact that HIV is spreading within your community (male)age 45-60

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	agree	43	84.3	86.0	86.0
	Disagree	5	9.8	10.0	96.0
	strongly disagree	2	3.9	4.0	100.0
	Total	50	98.0	100.0	
Missing	System	1	2.0		
Total		51	100.0		

Source: Evaluation survey data (2006)

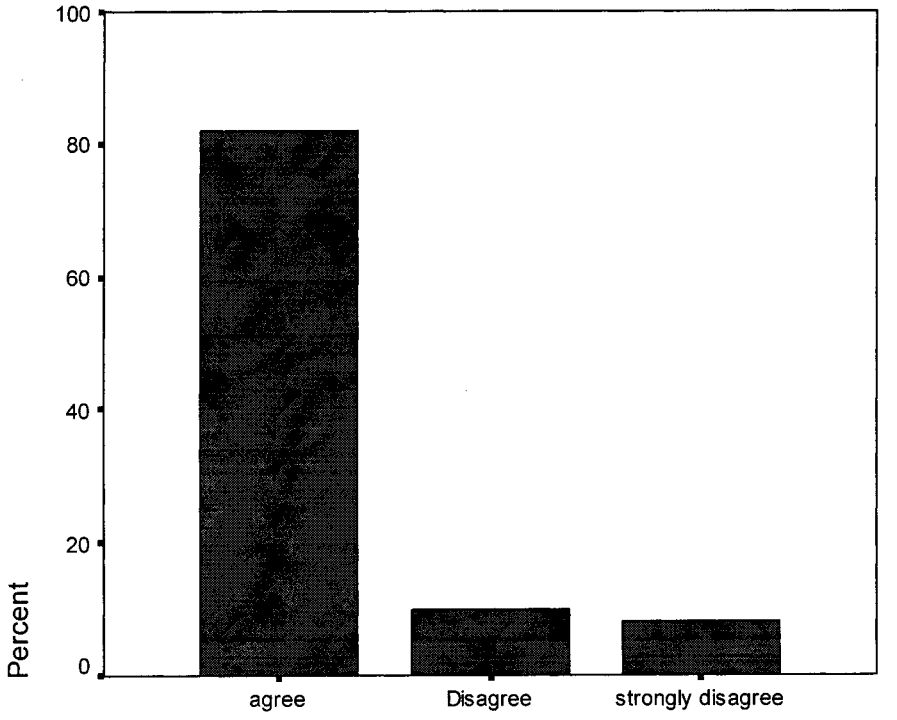


accept the fact that HIV is spreading within your community (male)age 45-60

Do you accept the fact that HIV is spreading within your community (female)age 45-60

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	agree	41	80.4	82.0	82.0
	Disagree	5	9.8	10.0	92.0
	strongly disagree	4	7.8	8.0	100.0
	Total	50	98.0	100.0	
Missing	System	1	2.0		
Total		51	100.0		

Source: Evaluation survey data(2006)



Do you accept the fact that HIV is spreading within your community (female)age 45-60

During evaluation elder male and female were asked whether they accept the fact that HIV is spreading within their community 82% agreed and 10% of female disagreed while 4% strongly disagreed. On the other hand when the same question were asked to elder aged 50-60 years 86 agreed while 12% disagreed, while 2% strongly disagreed,

this indicated that mobilization campaign conducted during implementation of the project had brought some positive impact whereby most Maasai accept the fact that HIV/AIDS is spreading within the Community and they do discuss issues on safer sex including use of condoms.

Table 10 Summary of evaluation indicator results.

Goal	Objective	Indicators	Results
To reduce spread of HIV/AIDS through awareness, knowledge and skill improvement.	1. To improved awareness knowledge and skills among target groups and individual in order to empower them to respond appropriately to HIV/AIDS 2. To promote condom use and improve access to condoms	i. 35 traditional leaders trained ii. 20 traditional birth attendants were trained iii. 8 hamlet that discussed HIV/AIDS and developed their own responses iv. 4 different type of IEC materials available v. Number of condoms distributed and used	i. 20 traditional leaders were trained ii. 12 traditional birth attendants were trained iii. 7 hamlet developed their own responses iv. 4 different types of IEC material were developed and distributed v. 150,000 condoms were distributed and used

Compiled by author during evaluation (2006)

5.3 Project Sustainability

The first strategy for sustainability was community participation in formulation of the project and availability of Human capacity from the community. Actors capable of facilitating the planning, implementation and monitoring of activities, another strategy were community involvement in the selection of field workers and minimal cash incentive to project staff. The project staff were dedicated volunteers who were working primarily for the benefit of the community, who were supported by getting nominal monthly allowances.

5.3.1 Financial sustainability.

The project strived to start by selection field workers vetted by community leaders who were enthusiastic and respected to solicit support and future funding. There is opportunity for continual supervision support and staff retraining provided by District Council. The project had the government support which released sum of TShs. 3,500,000 through Regional facilitating agencies PALISEP & collaborating with Oxfarm GB Loliondo, ACORD and District Council. The project has an activity operating centre provided by the community. The project has conducted advocacy meeting with stakeholder on the project activities.

5.3.2 Institutional sustainability

The CBO has Vision, mission and values that envisages society where information empowerment and solidarity are basis for strategic livelihood improved with HIV/AIDS as crosscutting issues in all CBO core functions. As the strategy for institutional sustainability the CBO has developed a

participatory institutional evaluation and monitoring system. The CBO would be conduction meeting involving community members, stakeholders and donors to review monitoring and evaluation question. Goals, target, objectives and activities would be reviewed during these meeting. Project staff would be regularly with the help of OXFARM GB, ACORD and District Council to develop staff competency.

5.3.3 Political sustainability

CBO and the project had the support of the District for the project goals, objective and activities are within the National Mult-sectoral Strategic Frame work on HIV/AIDS of 2003-2007. The frame work states that communities (villages) at the grass root level will be involved in conduct their own situation analysis and planning of key activities. NGO's, CBO's, faith based organization and other actors of civil society present at the District/Village plans will be consolidated into District plans keeping the ward level informed. The project goals, objectives, targets and activities are complement and supplement of long term National policies. The CBO is the member of the National CBO's and NGO's net work (NGONET). The CBO has conduced three advocacies meeting with stakeholders and donor to lobby for continued political support. The media has been contacted to publicize project activities as the sustainability strategy.

CHAPTER VI

6.0 CONCLUSION AND RECOMMENDATION

6.1 Conclusion

The project experience had highlighted the important role which the community level AIDS initiative can play along the continuum of community empowerment, awareness, knowledge and skill building. On conceptual level, the community response was seen as immediate direct and flexible, as they emerge from local condition are driven by community members responsive to local needs, reflect local forms of organizing, and acting, draw upon available resource beyond addressing specific needs, community activity also seems to foster empowerment and lead to social change.

Many older people and more influential in this community still held traditional view about sex and relationships. The project frequently faced serious objections to what we were doing, however with sensitivity, tenacity and support of some key local leaders the project was ultimately able to defuse or at least ameliorates these situations. What the project had demonstrated therefore was providing rural communities with HIV/AIDS preventive messages and skills which where practicable and that members of target community could play central role in fighting against HIV/AIDS.

Our condom promotion activities proved occasionally to be contentious, the same had been reported else were in Uganda (Kagimu et, al, 1998) especially at the start great care had to be taken to avoid alienating certain section of the

community partly as the result of the controversial they provoked. Project activities had facilitated community wide acceptance of this occasionally contentious product. The positive out come of the project was the acceptance and increased communication with partners on condom use especially to youths both males and females, but there was still resistance to aged males and women.

6.2 Recommendations

Based on findings of the research, it is hereby recommended that:

- Culturally sensitive interventions in Maasai community facilitate risk reduction and interventions, future interventions should take the unique needs of this community into account.
- Skills' training has demonstrated positive reduction in HIV risk behaviour especially for women and should be included in future interventions. This includes practical skills such us correct use of condoms, but also encompasses technique such us improving communication skills regarding negotiating safer sex practices.
- Peer educators once well trained have shown to have high degree of efficacy as trained thus using peer educators increase the likely hood of maintaining integrity and effectiveness of interventions delivered by the community based organizations this would also increase cost effectiveness of community based HIV interventions.
- Due to shorter period of the project it had not been able to achieve behavioural as this require long period to of time. Future study should attempt to measure

whether behaviour change were maintained over long period of time say five years.

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