

**THE OPEN UNIVERSITY OF TANZANIA**

**&**

**SOUTHERN NEW HAMPSHIRE UNIVERSITY**

**MASTER OF SCIENCE IN COMMUNITY ECONOMIC DEVELOPMENT**

**(2007)**

**CAPACITY BUILDING OF LEMARA KATI WOMEN IN ACTION  
(LKWIA) ON HIV/AIDS INFECTION PREVENTION, TREATMENT AND  
STIGMA REDUCTION**

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**SOUTHERN NEW HAMPSHIRE UNIVERSITY AT THE OPEN  
UNIVERSITY OF TANZANIA**

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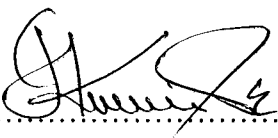
**A PROJECT SUBMITTED IN PARTIAL FULFILLMENT FOR THE  
REQUIREMENTS FOR THE DEGREE OF MASTER OF SCIENCE IN  
COMMUNITY ECONOMIC DEVELOPMENT IN SOUTHERN NEW  
HAMPSHIRE UNIVERSITY AT THE OPEN UNIVERSITY OF TANZANIA 2007**

**BY  
KASONKA, MARY PETER**

**APRIL 2007**

**SUPERVISOR'S CERTIFICATION**

I, **Joseph Mwerinde Kiangi** certify that I have thoroughly read this project report and found it to be in a form acceptable for review.

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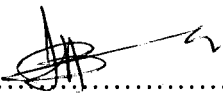
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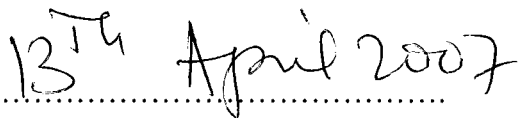
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**DECLARATION**

I, **Kasonka, Mary Peter** do hereby declare to the SENATE of the Southern New Hampshire University & the Open University of Tanzania that this project paper is the result of my original work, and to the best of my knowledge it has not been submitted for a similar degree award in any other University.

Signature: .....

Date: .....

**DEDICATION**

This work is dedicated to the Almighty God for giving me good health through out my studies in 2005 – 2006. Prophet GeorDavie Kasambale who prayed for me and gave me courage to undertake Community Economic Development course. My lovely husband Alfred Kasonka, My daughter Mwaka Marietha Kasonka, my son Nkana Luka Kasonka, my last baby Rhoda Atukelye Kasonka, My young sister Anna Nswilla, her daughters Sarah and Ritha and also son Paschal Vitalis Ntemi who were deprived of their motherly love during the period of study (18 Months). I dedicate also to Lemara Kati Women in Action (LKWIA) who were ready to volunteer in assisting people infected and affected with HIV/AIDS in an effort to restore human dignity from being stigmatized.

## **ABSTRACT**

This project addressed real needs and problems of the Community through proper participation right from the needs assessment, project designing, implementation, monitoring and evaluation. The project was carried out at Lemara Kati ward in Arusha Municipality, Northern Tanzania. The project aimed at building capacity of LKWIA on HIV/AIDS infection prevention, treatment and stigma reduction. Lemara Kati Women In Action (LKWIA) is a Community Based Organization formed by 20 women and was the target group. The project duration was eighteen months (September, 2005 to January 2007). Through authentic Community participation the researcher conducted Community Needs Assessment (CNA) on 27<sup>TH</sup> September 2005. Many needs and problems were identified, prioritized and ranked. In that exercise, “Inadequate capacity in handling people living with HIV/AIDs (PLWHAS) was scored first. The researcher conducted a scientific research to confirm the CNA after three months and findings revealed that LKWIA group had the same needs and problems. LKWIA desired training on the causes of HIV/AIDS infection, transmission, prevention, treatment of opportunist infections, referral of patients to Health Facilities for care and treatment. The project implementation involved manual preparation, training, monitoring and evaluation using agreed indicators and participatory methods. The monitoring and evaluation showed that LKWIA group had gained confidence dealing with HIV/AIDS and in preventing themselves from infections service provision. In addition, their confidence had warranted them to provide health education sessions in the community thus it was revealed that community awareness had raised, as well as stigma had been reduced and PLWHAS were able to live a healthier life that allowed them to produce their basic needs and contribute to their family and national income.

## ACKNOWLEDGEMENT

Many people have contributed their time, knowledge, and expertise to this report. I thank them all. First, the staff of WIA head office and LKWIA Community Based Organization (CBO) members who generously shared with me their frontline experiences in serving people with HIV/AIDs every day. Arusha Municipal Council HIV/AIDs Coordinator Dr. Solomon Ole-Logilunore and the Regional HIV/AIDs Coordinator Mr. Christopher Mremi who paved way in designing, choosing the CBO, implementing, training, monitoring and evaluation of this Project.. I thank Michel Adjibodou and Felician Mutasa who were my course instructors in Project design and Management because they laid a good foundation to this Project. I also received invaluable assistance in preparing this report from my project supervisor Mr. Joseph Mwerinde Kiangi. Without his continuous advice and guidance this report could not be visible, to him I am grateful. I thank Mwamini J. Nyakwela who facilitated LKWIA participants on Voluntary Counseling and techniques, Dr. Zuhura Sedute on care and treatment, drugs adherence and referral of patients for without them volunteering their valuable time the training could not have been successful. I thank my employer the Regional Administrative Secretary through the Regional Medical Officer Arusha who granted permission for me to undertake CED course and allowed the Regional Hospital staff to collaborate in implementing this project. I thank my family, all Mount Meru Regional Hospital staff through the Medical Officer in charge for supporting me both morally and materially through out my studies. Special thanks to Anna L. Nswilla who shared with me her experience in writing and formatting project papers to a presentable state. Last but not least I thank Mary Herman and Eva Ngalali who stayed with me in the office until late hours during project report writing. I really appreciate their cups of coffee. To them all I am indebted.

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**ABBREVIATIONS**

ACC	Arusha City Council
AIDS	Acquired Immuno Deficiency
CBO	Community Based Organization
CED	Community Economic Development
CHMT	Council Health Management Team
HBC	Home Based Care
HF	Health Facilities
HIV	Human Immuno Virus
HLM	Health Learning Materials
ICD	International Community Economic Development
LK	Lemara Kati
LKWIA	Lemara Kati Women In Action
MOH-SW	Ministry of Health and Social Welfare
NGO	Non Governmental Organization
OUT	Open University of Tanzania
PLWHAS	People Living With HIV/AIDS
RHMT	Regional Health Management Team
RMO	Regional Medical Officer
SNHU	Southern New Hampshire University
SPSS	Scientific Package of Social Statistics
WIA	Women In Action

## EXECUTIVE SUMMARY

This project involved training of 20 Lemara Kati Women In Action (LKWIA) so as to build capacity. Training needs assessment and survey conducted by the researcher revealed that LKWIA faced a challenge of inadequate knowledge and skills on the causes of HIV/AIDS infection, transmission, prevention, treatment of opportunist infections, use of antiretroviral drugs by the PLWHAS and referral of patients to health facilities for care and treatment. Due to this, the group lacked confidence during home visiting to people living with HIV/AIDS (PLWHAS) because they feared if they were asked any question they could not be able to answer properly. Moreover, they were afraid of being infected during the course of service provision. Such a situation made them not to be good advocates in the fight against the disease through education sessions in the community. Besides, the services that they provided to infected and affected people were inadequate. The group's desire was to be trained on the concept of HIV/AIDS so that they build their capabilities and confidence in handling HIV/AIDS patients in their homes. The researcher designed a training manual on infection prevention, treatment of opportunist infections, use of Antiretroviral drugs (ART) by the PLWHAS and referral of patients to Health Facilities for care and treatment. The manual was aimed at building confidence to 20 members of LKWIA group on providing Home Based Care (HBC) to people infected and affected with HIV/AIDS. The training included communication techniques in conducting advocacy sessions in the community to reduce stigma about the disease.

The goal of this project was, to have a group of LKWIA which is capable and confident in caring PLWHAS and Lemara Kati community with awareness on HIV/AIDS”.

The objectives of this project included:

- (i) To build capacity of 20 members of LKWIA in HIV/AIDS concept by January 2007.
- (ii) To improve Home Based Care skills by 80% by January 2007
- (iii) To raise community awareness by 80% by January 2007.

- (iv) To refer 50% of HIV/AIDS patients for care and treatment of opportunistic infections by December 2006.

Major activities included: Community needs assessment, problem statement, training of 20 LKWIA group on HIV/AIDS concept and HBC and community sensitization meetings in Lemara Kati to raise awareness on HIV/AIDS by December 2006.

Major achievements:

The project managed to train nineteen (19) out of twenty (20) LKWIA members which was 98% and made follow ups when the trained members were conducting community sensitization meetings in Lemara Kati to raise awareness on HIV/AIDS. Regional Hospital records on referral of patients showed that 50% of HIV/AIDS patients had been referred for care and treatment of opportunistic infections and use of Antiretroviral. The project showed achievements. As result LKWIA became capable and confident in caring PLWHAS and providing health education to Lemara Kati community. In general it created awareness on HIV/AIDS thus reducing stigma. Thus, this CED project had responded to communities' real needs and thus acted as a litmus test for community involvement in recognizing people's needs and problems. Moreover, this project had been very useful for LKWIA, Lemara Kati community, PLWHAS and the country as a whole. This was so because government's aim is to reduce stigma on HIV/AIDS so that the infected and affected live a normal life which will lead them to produce and increase national income and development. The researcher recommended that such a project should be copied to other wards of Arusha Municipality and the country as a whole through interested partners in the prevention and control of HIV/AIDS. With regard to sustainability, the researcher was convinced that it was viable because the international and government policies were in favor of HIV/AIDS prevention and control. Also LKWIA was dedicated to helping PLWHAS morally and materially thus ensuring sustainability.

## **CHAPTER I**

### **1.0 COMMUNITY NEEDS ASSESSMENT**

#### **1.1 Introduction**

This chapter intends to provide narration on how the project responded to the community's real needs. It outlines participation of community leaders and stake holders in recognizing their true needs and problems. It also highlights how leaders, LKWIA and Community accepted the project as their own. The Community needs assessment provides the Community profile and answers the following research questions: Who hosted the project? Why that community? What was the problem? and How the problem was addressed in the particular community?

#### **1.2 Community Profile**

This project was hosted by Lemara Kati Women In Action (LKWIA) which was based at Lemara Kati with a total population of 503 people that is 3% of the total population of Arusha Municipality projected from the national census conducted in 2002. This CBO was directly relevant to the project due to its Vision of improving the lives and conditions of people in Arusha. It focused particularly women, children and young people through their mission of empowering the group in social and legal rights. Their goal was to create a community dedicated to Health, Social, Economic and Legal change for sustainable development. Their specific objectives included:

- Assisting people living with HIV/AIDS (PLWHAS) through Home Based Care (HBC).

- Supporting orphans and vulnerable children living within Lemara Kati locality.
- Back stopping Youth Sexual Program by providing HIV/AIDS health education.
- Empowering women through income generating activities (gardening and Beads making).

Lemara Kati is a Swahili word meaning inner Lemara. This is an area within Lemara ward in Arusha Municipality, Northern Tanzania. The general social Economic status of this area is poor and is inhabited with people who live under one US \$ per day (Bureau of statistics, 2002). The area is slummy and surrounded with sewage dams in Kiswahili called Maji Machafu. Such an area cannot be occupied by well to do people. The ethnic groups are Arushan's. However, there are other smaller tribes from neighboring regions. Generally the area was over crowded. There was one government school which was also crowded. The average birth rate was five children per woman (Tanzania Census, 2002). Most people in this ward were doing small businesses due to lack of land to do farming.

### **1.3 Community Needs Assessment (CNA)**

LKWIA group provided Home Based Care (HBC) services to people living with HIV/AIDs (PLWHAS), widows, widowers and orphans. The CBO had a garden at Mianzini area where they grew vegetables and was making beads as their income generating activities. The income generated was used to support the needy. LKWIA had meetings every Tuesday at 3.00 pm at Lemara Kati ward government office. The

researcher met LKWIA group members on Tuesday 27<sup>th</sup> September 2005 at Lemara Kati ward office where they were holding their routine weekly meeting. The researcher explained her mission and lead the meeting using focus group discussions, structured questions and interviews and the group was able to come up with several needs and problems which were listed by members who were present (Please see List of names and needs assessment in appendix 2). After listing down needs and problems the researcher requested the group to rank the needs and problems in order of priority and capacity building ranked first. During that meeting the researcher used structured discussion mode and allowed group members to identify their needs and problems, prioritize and rank them in order of priority. They were further, asked to decide what needs could be addressed as advised by CEDPA, (1994). In ranking Inadequate knowledge and skills on HIV/AIDS scored first and the solution was Capacity building. The Researcher investigated further why LKWIA members thought inadequate capacity was a major problem? Most of them said they had no formal orientation or training, thus, they lacked confidence in handling HIV/AIDS patients, they feared to provide mass health education to relatives of the infected and to the entire community because they could not give proper explanations when challenged and also they feared to infect themselves in the cause of service provision. They were further asked which areas of training they needed. They chose to be trained on HIV/AIDS" concept that included, definition of the disease, means of transmission, prevention, care of the sick in their homes and referral of patients to health facilities. The researcher in collaboration with the CBO and WIA head office agreed to carry out the project as it was seen to be



beneficial not only to LKWIA group but to entire Lemara Kati community, Arusha Municipality and Tanzania as a whole.

#### **1.4 Research Methodology for CNA**

The research methodology used during CNA was qualitative which aimed at discovering the needs and problems of LKWIA group. The methodology was chosen on basis of phenomenon of gathering information on the thinking and feelings of LKWIA on HIV/AIDS infection transmission, transmission and home based care of the sick. The researcher in this case did not select population sample. The sample which was involved was dependent on the number of LKWIA members' attendance in that particular day meeting. Moreover, it was based on non probability based on convenience or accidental population. However, the researcher was not sure of "How many LKWIA members she was to meet" and thus she had no way of checking the element of bias in her inquiry. In addition the population involved in this research was very small.

#### **1.4 Tools**

The researcher chose to use mixed tools during CNA data collection as listed in 1.4.1 to 1.4.5 to compliment one tool to another in obtaining appropriate data from group members.

#### **1.4.1 Meeting**

During the meeting the researcher introduced herself to LKWIA and all members also did self introduction. Also the general introduction of the CED student's mission was provided, discussed and agreed.

#### **1.4.2 Interviews**

Structured interviews were conducted using questions prepared and administered by the researcher. The questions were answered by LKWIA members individually.

#### **1.4.3 Focus group discussions**

Focus group discussion was used to complement issues which were not captured in interviews and observations.

#### **1.4.4 Observation**

During the meeting, interviews and focus group discussions the researcher were observing the general conduct of group members, ability to respond to discussions, interests of the members and seriousness. In addition the Researcher was observing if the area had adequate posters which provide warnings on changing behaviors to fight HIV/AIDS.

#### **1.4.5 Records review**

The researcher was given documents from the Lemara Kati Ward leaders and was able to gather the population by age and gender, social – economical status, literacy rate, number of schools, toilet coverage, ethnic groups, occupations, number of people living with HIV/AIDS and the level community awareness in different diseases.

### **1.5 CNA Findings**

The findings were as follows:

- Most LKWIA members had partial knowledge on HIV/AIDS thus, they feared to expand their services to attend more patients in the outer part of Lemara ward because if they were challenged or asked technical questions on the disease they were not able to explain.
- Almost all LKWIA members did not know about treatment, of opportunistic diseases and where PLWHAS could get the Antiretroviral (ART) and drugs to treat opportunistic infections.
- Most LKWIA members and community did not know the causes of most diseases including HIV/AIDS and also the prevention measures.
- The social – economic situation was not conducive due to the fact that the area was congested (Slum), had only one primary school, low literacy rate and the housing were poor and congested. Also rented houses were occupied with more than five families sharing only one pit latrine and one bath room.

- The average family members were seven people with birth rate of five children per woman.
- The area was surrounded by sewage water known in Swahili as Maji Machafu full of bad smell at all times.
- There were inadequate posters that provide warning to the community on HIV/AIDS

Thus the CNA concluded that LKWIA had inadequate knowledge on HIV/AIDS concept.

## **1.6 Scientific research**

After CNA the researcher conducted a scientific research. The aim of this research was to detect if there were changes in knowledge and skills since the CNA as argued by Kothari, (1992) that the researcher should establish chances of the sample group changing their mind since the previous research. The research design involved the task of defining the research problem which was done by the researcher in collaboration with LKWIA group. They made decisions regarding where, when, how much and by what means. In fact they arranged all conditions for collecting and analyzing data in the manner that aimed to combine relevance to the research purpose with economy in procedure. They also, established goal, objectives, population, methodology, created questionnaire as shown in appendix four (4), pre-tested the questionnaires, conducted interviews, collected data, analyzed and produced the report and presented in plenary at Arusha centre CED class on 19<sup>th</sup> June 2006.

The findings were further used for justifying whether there was a need for the project to be carried out in Lemara Kati.

### **1.6.1 Research Goal**

The goal of the Research was: To assess the level of knowledge and skills of LKWIA on the concept of Home Based Care (HBC) of HIV/AIDS patients based in Lemara ward in Arusha Municipality, Northern Tanzania.

### **1.6.2 Research Objectives**

- Determine the level of LKWIA understanding about HIV/AIDS and HBC.
- Establish areas of strengths and weakness in the provision of HBC to patients.
- Find out the level of understanding of LKWIA on their needs and problems

### **1.6.3 Tools and methodology for Data Collection**

Tools which were used in this research include:

Questionnaire both Quantitative and Qualitative using focus group discussions.  
observation and interviews

#### **1.6.3.1 Questionnaire**

#### **1.6.3.2 Quantitative**

Quantitative questionnaire attached in Appendix 10 were administered by the Researcher and data collected from the answers provided by respondents.

### 1.6.3.3 Qualitative

Qualitative data collection was done to supplement quantitative method. This was done using focus group discussions of ten members each and personal interviews. The reason for conducting personal interviews was to allow flexibility in the questioning process because at most times the researcher had to clarify terms that were unclear. Also this helped the researcher in controlling the interview situation, privacy of respondents and it provided high response rate since all questions were answered.

### 1.6.3.4. Observation

Observations were continuous right from the needs assessment to the scientific study so that the researcher could get information which could not be captured through questionnaire and focus group discussion.

### 1.6.4 Methodology for data analysis

The questions were grouped into five (5) categories as shown below aiming at capturing information that is useful to know from the CBO and the community at large.

**Table 1: Grouping of Questions**

S/N	Question	Purpose
1	How old are you?	Understand the age of population
2	Are you Married?	Understand characteristics of

S/N	Question	Purpose
		respondents
3	What is your education level?	Understand learning ability of LKWIA
4	What is your Occupation?	Capture LKWIA workload
5	What do you know about HIV/AIDS?	Check understanding/Knowledge
6	What is the difference between HIV and AIDS?	Check understanding/Knowledge
7	What are the modes of HIV/AIDS transmission?	Check understanding/Knowledge
8	Is there any relation ship between HIV/AIDS and TB?	Check understanding/Knowledge
9	What do you advice pregnant HIV/AIDS infected mothers About HIV/AIDS ?	Check understanding/Knowledge
10	What are the kinds of food do you advice a HIV/ AIDS to eat?	Check understanding/Knowledge
11	What are the main responsibilities of HBC	Check understanding/Knowledge
12	Which donor partners are assisting your CBO?	Weakness in participating to CBO
13	How do you refer Patients if the condition worsens	System for structures of Referral?
14	Do you know any thing about HIV/AIDS treatment?	Understanding/Knowledge
15	What are the opportunistic Infections?	Understanding/Knowledge
16	What mostly do your patients complain of?	Complaints from the affected

### **1.6.5 Tools for data analysis**

Data were analyzed using Microsoft Office Excel 2003 software which is easy to use and compatible with SPSS.

### **1.6.6 Data Processing**

The processing of data involved:

- Data entering
- Data cleaning (editing errors and omissions so as to make corrections).
- Data analysis

The program for data entering was prepared using Microsoft Office Excel 2003. This was so because the software is easy to use and compatible with SPSS. The variables were constructed according to the questions used in the research without diverging the meaning.

When all data were successfully entered, the cleaning process was done in two stages, first within the excel spreadsheet and secondly the data was exported to the SPSS program for further cleaning. In this stage all necessary editing was done and correction was done accordingly, then the variables were labeled and grouping was done wherever necessary for example age groups.

Data analysis was done by running:

- Frequencies tables: The researcher generated frequency tables which showed percentages (%) which were easy to interpret in each questionnaire and compare



one questionnaire response to another as shown in tables 3 – 13 in page 13 to 24 below.

- **Crosstabs:** Generally this indicated the exiting relationship among variables. It was used as a combination of all variables to compute index variables for example knowledge of HIV/AIDS with age, marital status, education level and occupation to reveal significance. However, all the results were statistically insignificant to small sample size used in this study.
- **Chi-square test:** This was an important test amongst the several tests of significance done by the researcher for comparing a variance to a theoretical variance captured during CNA. As a non-parametric test it was used to determine if categorical data showed dependency or two classifications were dependent for example marital status and knowledge on HIV/AIDS.
- **Cramer's V:** This basically was used to prove the null hypothesis using the asymptotic standard error assuming the null hypothesis. In this study it was 0.901 which was not significant due to small sample size.
- **Constructing index variable (composite variable) using recodes and computes statements.**

#### **1.6.7 SPSS outputs**

The data were processed in Excel and outputs from SPSS. Some Frequencies tables and Bar charts which measure the level of knowledge are shown below in table's number 2 to percentage of distribution and frequency of each case. On the other hand crosstab

tables were ran. The crosstab indicated the exiting relationship among the variables while the chi-square test provided the level of statistical significance. Nevertheless, Cramer's V was observed whenever necessary. For exact out puts please see appendix 6. Since this survey had eight (8) variables aimed at measuring the level of HIV/AIDs knowledge among the community interviewed, the construction of index variable was inevitable. The eight variables were combined using recode and compute statements so as to produce a unique variable to measure the level of knowledge please see table 14.

### 1.6.8 Quantitative Research Findings

#### General information about LKWIA members

Table 2 below was summarized to show general information about LKWIA members on: age, education, marital status and occupation. Such information was useful to the Researcher to understand the qualities of the Research population. However, only the age and education are discussed below because marital status and occupation are not directly related to key issues which the researcher aimed at finding.

**Table 2: General information about LKWIA members**

How old are you? (n=20)		What is your education level?	
<b>Age groups</b>	<b>%</b>	<b>Education level</b>	<b>%</b>
18 – 27	35	Informal	10
28 – 37	20	Primary	45
38 – 47	20	Secondary	30
48 – 57	15	College	15
58 – and above	10		
Are you married?		What is your occupation?	
<b>Marital status</b>	<b>%</b>	<b>Occupation</b>	<b>%</b>
Single	20	House wife	40
Married	60	Farmer	15
Divorced	5	Hawkers	15
Widowed	10	Business	20
Separated	5	Employed	10

**Source: SPSS output ran by the researcher**

### Knowledge and skills level of LKWIA

Another important finding was about the knowledge and skills level of LKWIA since if, they had knowledge then, there were no need for training. Tables were all geared to determine LKWIA knowledge and skills level so that the Researcher could decide whether to conduct training or not. Frequency tables' number 3 to 12 and Bar charts number 1 to 11 below show the findings which assisted the researcher in making decisions.

**Table 3: Knowledge on HIV/AIDS**

**What do you know about HIV/AIDs?**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Caused by Viral Infection	13	65.0	65.0	65.0
	I don't know	1	5.0	5.0	70.0
	Caused by shaking hands, eating together	1	5.0	5.0	75.0
	Caused by cultural abuse	3	15.0	15.0	90.0
	Caused by osquito bite	2	10.0	10.0	100.0
	Total	20	100.0	100.0	

Table 3 above shows that 65% of LKWIA members were knowledgeable that HIV/AIDS is caused by viral infection while 35% had no knowledge. Besides, all provided home based care to patients. Figure 1 below shows the percentages in Bar charts.

Figure 1: Bar chart on knowledge on HIV/AIDS

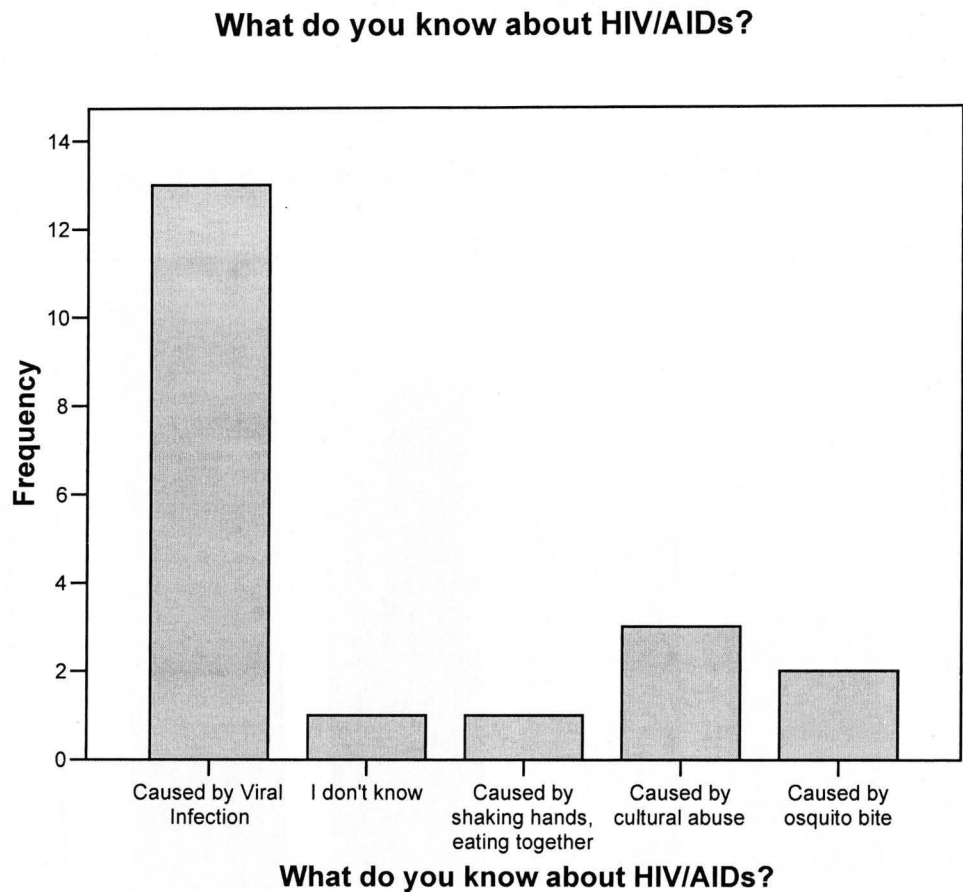
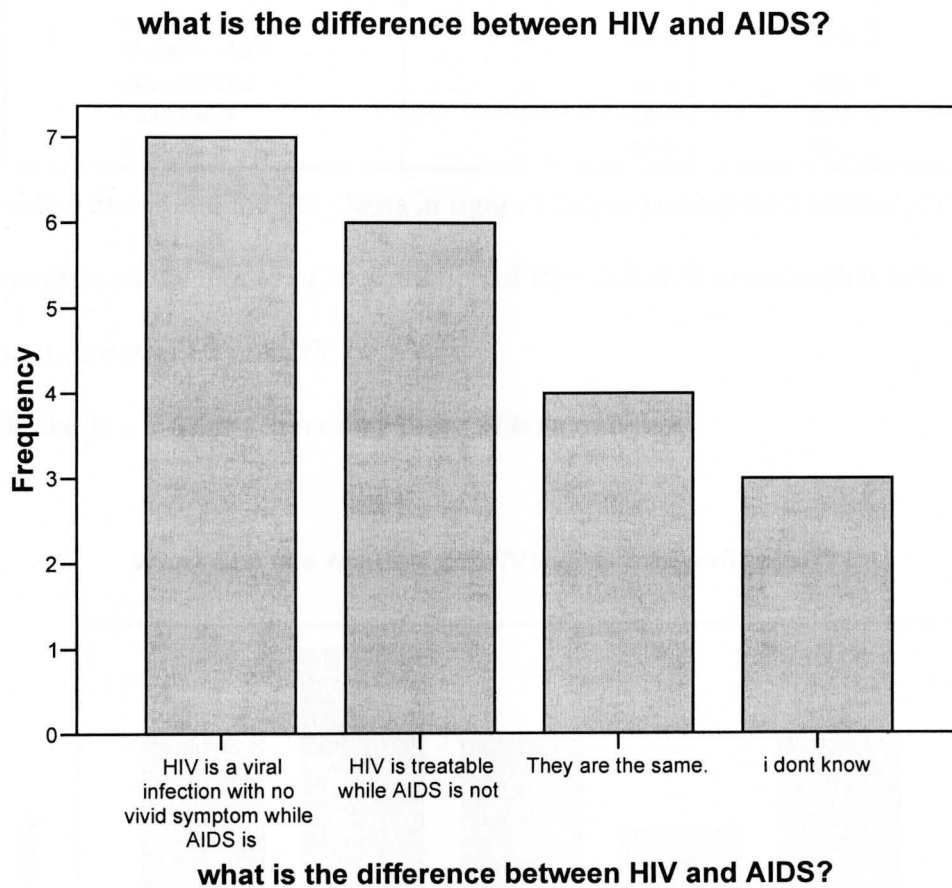


Table 4: Differences between HIV and AIDS

what is the difference between HIV and AIDS?		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	HIV is a viral infection with no vivid symptom while AIDS is	7	35.0	35.0	35.0
	HIV is treatable while AIDS is not	6	30.0	30.0	65.0
	They are the same.	4	20.0	20.0	85.0
	i dont know	3	15.0	15.0	100.0
	Total	20	100.0	100.0	

Table 4 above and the Bar charts in figure 2 indicate that only 35% had knowledge that HIV is a viral infection with no vivid symptom.

**Figure 2: Bar Chart on the differences between HIV/AIDS**

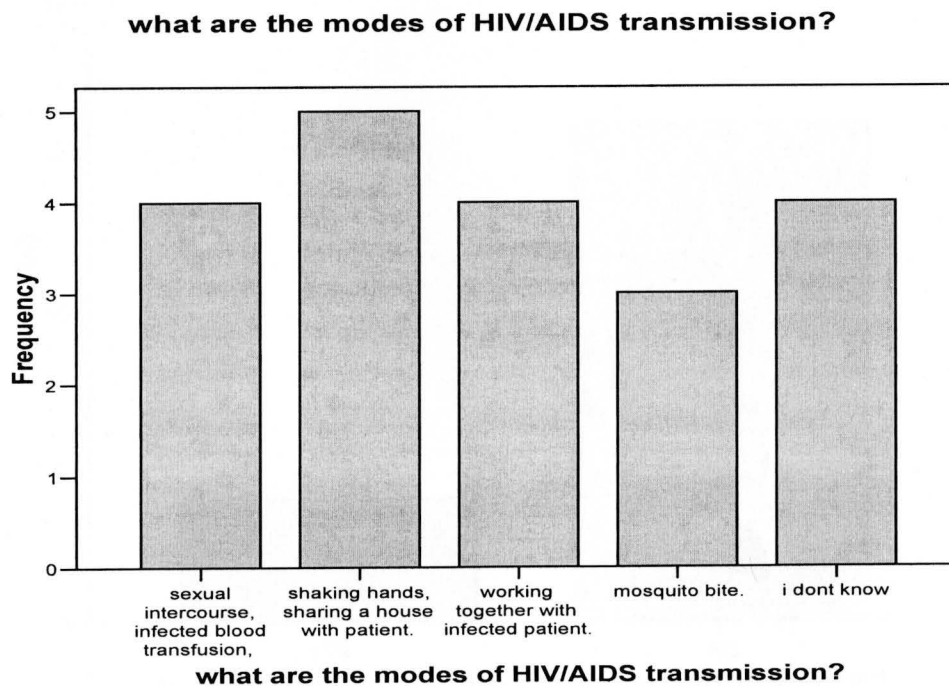


**Table 5: HIV/AIDS modes of transmission**

what are the modes of HIV/AIDS transmission?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	sexual intercourse, infected blood transfusion,	4	20.0	20.0	20.0
	shaking hands, sharing a house with patient.	5	25.0	25.0	45.0
	working together with infected patient.	4	20.0	20.0	65.0
	mosquito bite.	3	15.0	15.0	80.0
	i dont know	4	20.0	20.0	100.0
	Total	20	100.0	100.0	

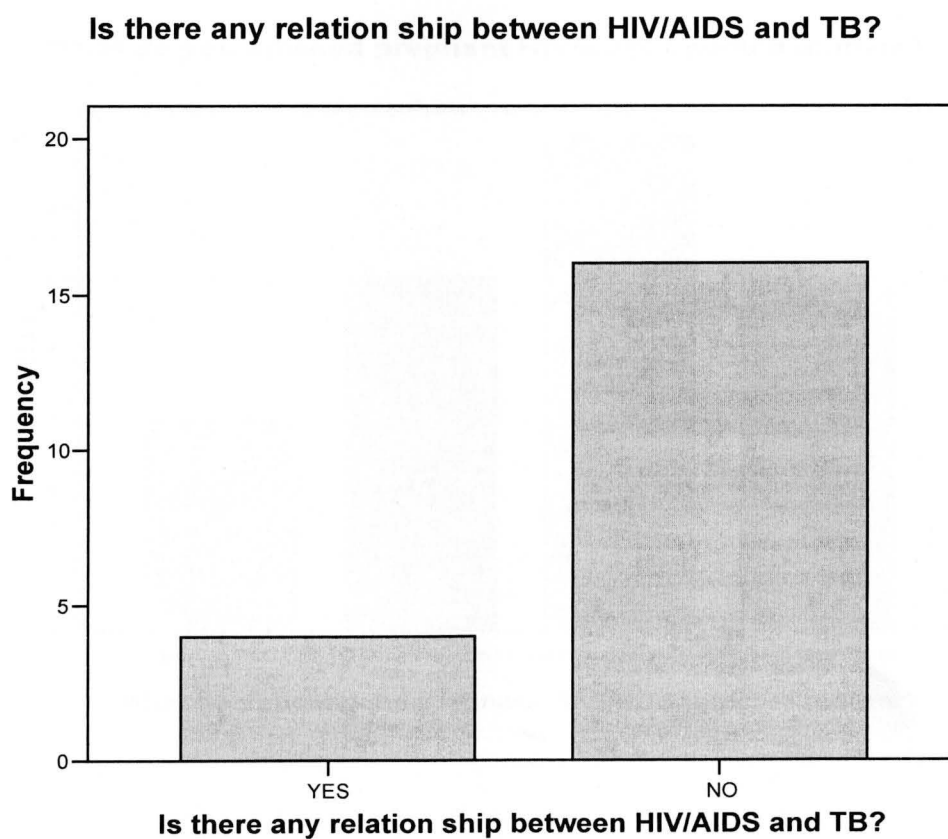
Table 5 above and the Bar charts in figure 3 below portray the knowledge of LKWIA members on the modes of transmission of HIV/AIDS. It revealed that only 20% knew exact causes of HIV/AIDS.

**Figure 3: Bar Chart on Modes of transmission**

**Table 6: Relationship between HIV/AIDS and TB**

Is there any relation ship between HIV/AIDS and TB?					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	YES	4	20.0	20.0	20.0
	NO	16	80.0	80.0	100.0
	Total	20	100.0	100.0	

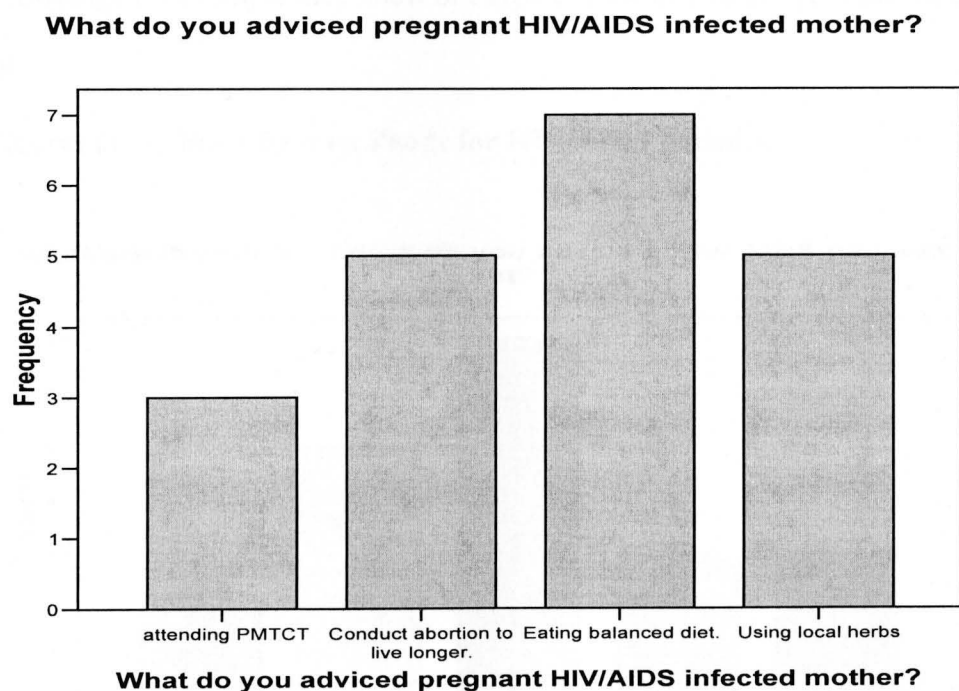
Table 6 above and figure 4 below shows that only 20% had knowledge that there is relationship between HIV/AIDS and TB whereas 80% did not know.

**Figure 4: Bar Chart on relation ship between HIV/AIDS and TB**

**Table: 7: Advice to pregnant HIV/AIDS infected mothers****What do you adviced pregnant HIV/AIDS infected mother?**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid attending PMTCT	3	15.0	15.0	15.0
Conduct abortion to live longer.	5	25.0	25.0	40.0
Eating balanced diet.	7	35.0	35.0	75.0
Using local herbs	5	25.0	25.0	100.0
Total	20	100.0	100.0	

Table 7 above and figure 5 below shows that only 15% of LKWIA members had knowledge on HIV/AIDS prevention from mother to child (PMTCT) but 85% had no knowledge.

**Figure: 5: Bar Chart on advice to Pregnant infected mothers?**



**Table 8: Foods for HIV/AIDS patients**

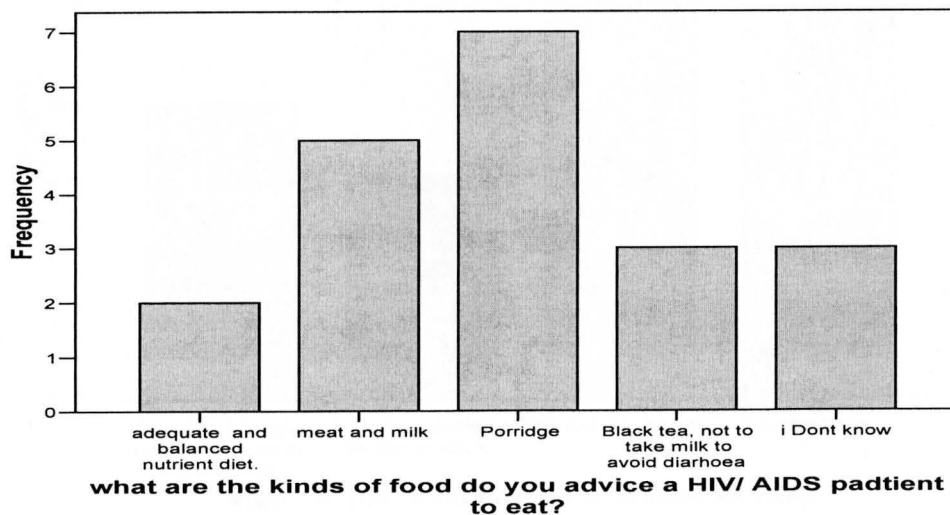
**what are the kinds of food do you advice a HIV/ AIDS padtient to eat?**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid adequate and balanced nutrient diet	2	10.0	10.0	10.0
meat and milk	5	25.0	25.0	35.0
Porridge	7	35.0	35.0	70.0
Black tea, not to take milk to avoid diarhoea	3	15.0	15.0	85.0
i Dont know	3	15.0	15.0	100.0
Total	20	100.0	100.0	

Table 8 above and figure 6 below shows that only 10% had adequate knowledge on the type of diet which were recommended to HIV/AIDS patients and 90% had scanty knowledge for example they knew one type of food or two but 15% had no knowledge at all.

**Figure: 6: Bar Chart on Foods for HIV/AIDS patients**

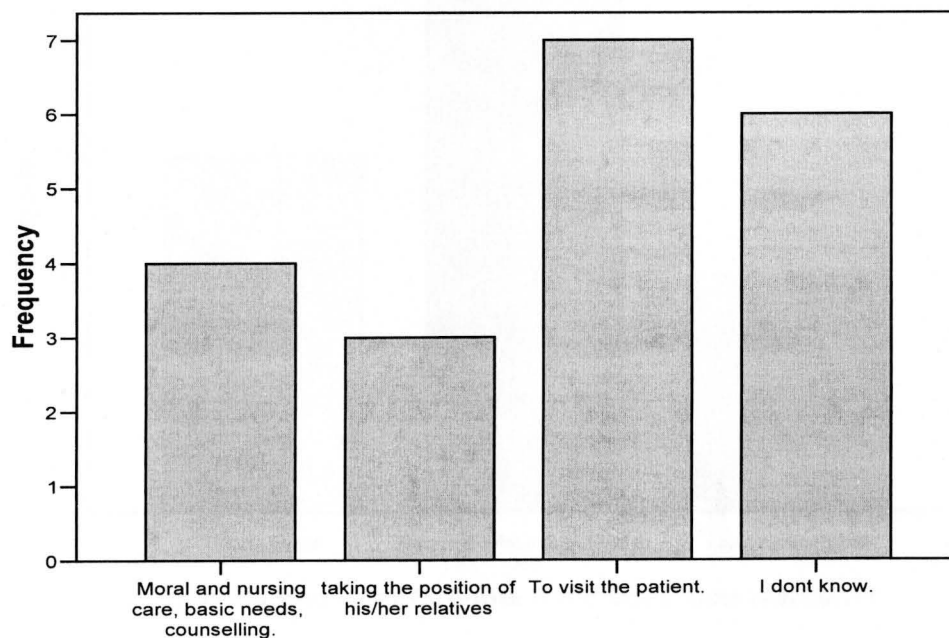
**what are the kinds of food do you advice a HIV/ AIDS padtient to eat?**



**Table 9: Responsibilities of HBC****what are the main responsibilities of HBC**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Moral and nursing care, basic needs, counselling.	4	20.0	20.0	20.0
	taking the position of his/her relatives	3	15.0	15.0	35.0
	To visit the patient.	7	35.0	35.0	70.0
	I dont know.	6	30.0	30.0	100.0
	Total	20	100.0	100.0	

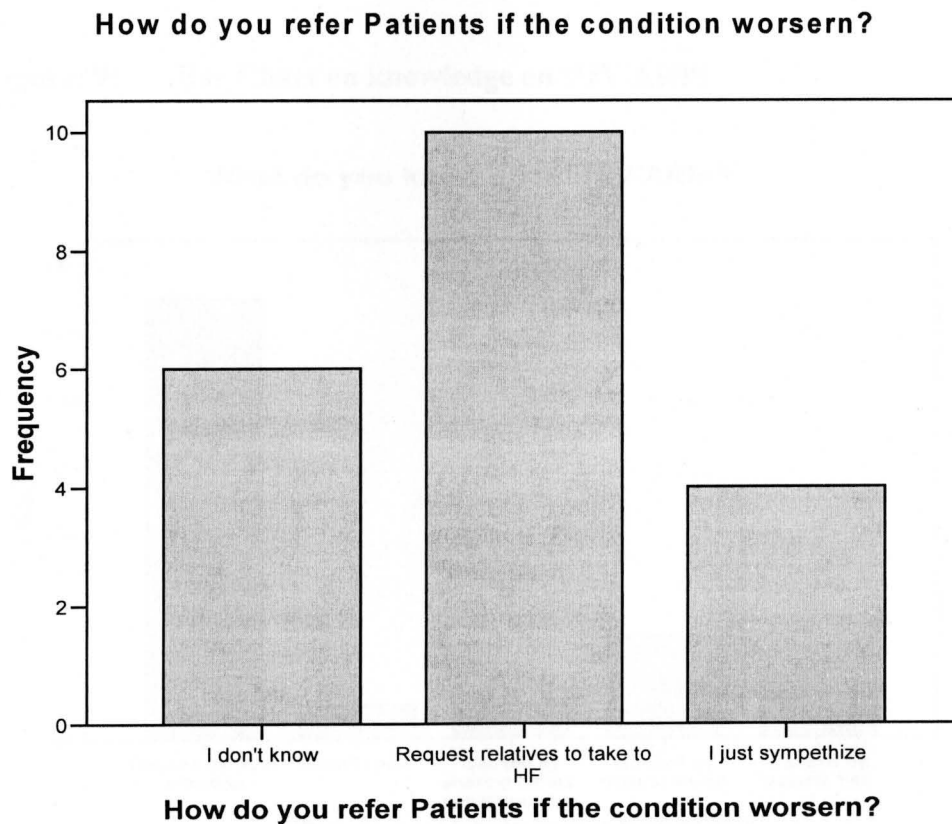
Table 9 above and figure 7 below shows that 20% had adequate knowledge on the responsibilities of a home based care giver while 80% had partial knowledge.

**Figure: 7: Bar Chart on responsibilities of HBC provider****what are the main responsibilities of HBC****what are the main responsibilities of HBC**

**Table 10: Referral of patients****How do you refer Patients if the condition worsen?**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid I don't know	6	30.0	30.0	30.0
Request relatives to take to HF	10	50.0	50.0	80.0
I just sympathize	4	20.0	20.0	100.0
Total	20	100.0	100.0	

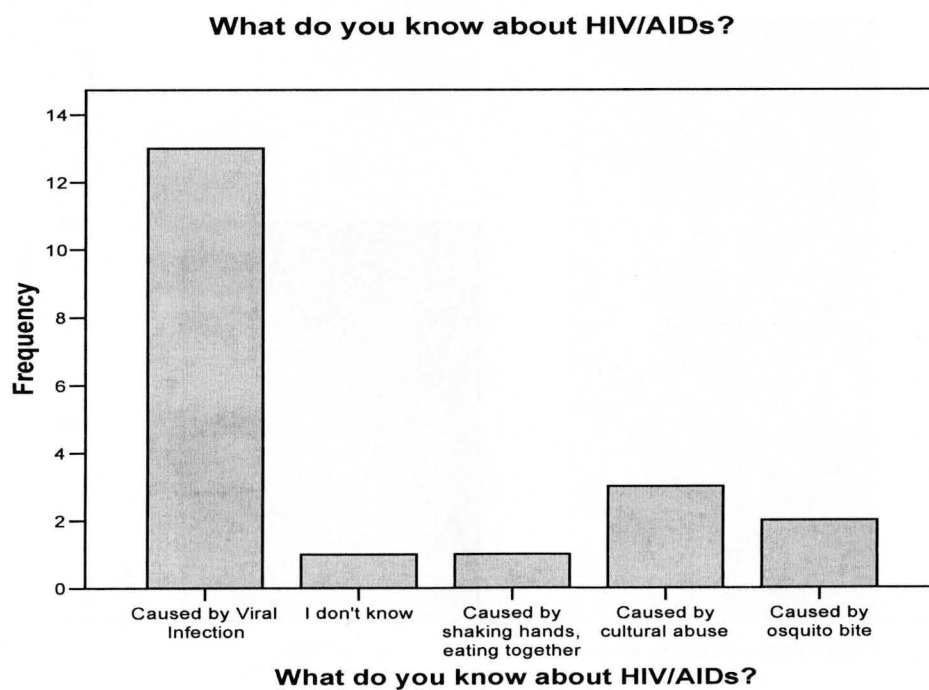
Table 10 above and figure 8 below shows that 50% had knowledge to advise relatives if the condition of patients worsened.

**Figure: 8: Bar Chart on Referral of Patients**

**Table: 11: Knowledge about HIV/AIDS treatment****Do you know any thing about HIV/AIDS treatment?**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid NO	12	60.0	60.0	60.0
Yes	8	40.0	40.0	100.0
Total	20	100.0	100.0	

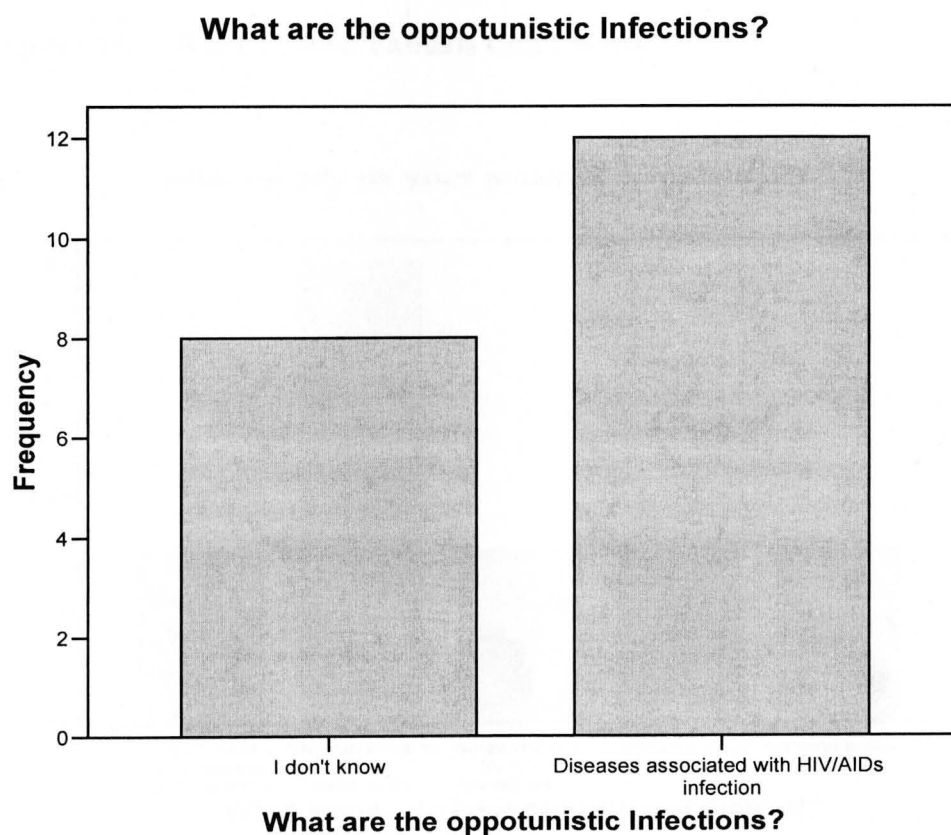
Table 11 above and figure 9 below indicate that only 40% of LKWIA members had adequate knowledge on the treatment of HIV/AIDS patients 60% did not .

**Figure: 9: Bar Chart on knowledge on HIV/AIDS**

**Table: 12: Opportunistic infections****What are the oppotunistic Infections?**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid I don't know	8	40.0	40.0	40.0
Diseases associated with HIV/AIDs infection	12	60.0	60.0	100.0
Total	20	100.0	100.0	

Table 12 above and figure 10 below shows that 60% of LKWIA members had knowledge on opportunistic infections and only 40% had no knowledge.

**Figure: 10: Bar Chart: Knowledge on opportunistic infections**

**Table 13: Patients complaints**

What mostly do your patients complain of?		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	They do not know where to get treatment	3	15.0	15.0	15.0
	Stigmatization by the LK community	8	40.0	40.0	55.0
	No assistance from the government	3	15.0	15.0	70.0
	Health services inadequate	3	15.0	15.0	85.0
	Referral system not known	3	15.0	15.0	100.0
	Total	20	100.0	100.0	

Table 13 above and figure 11 below shows the complaints of Lemara Kati ward HIV/AIDS patients. The table revealed that 40% of patients complained on stigmatization.

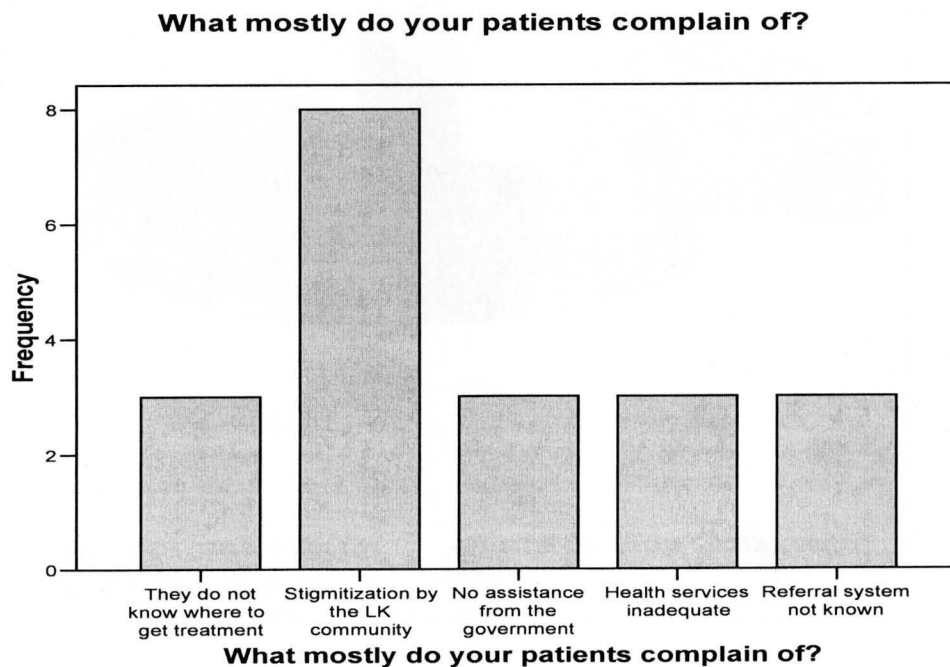
**Figure: 11: Bar Chart on Patients Complaints**

Table number 14 and pie chart in figure 12 below summarize the above frequency tables number 2- 13 and Bar charts figure 1 – 11.

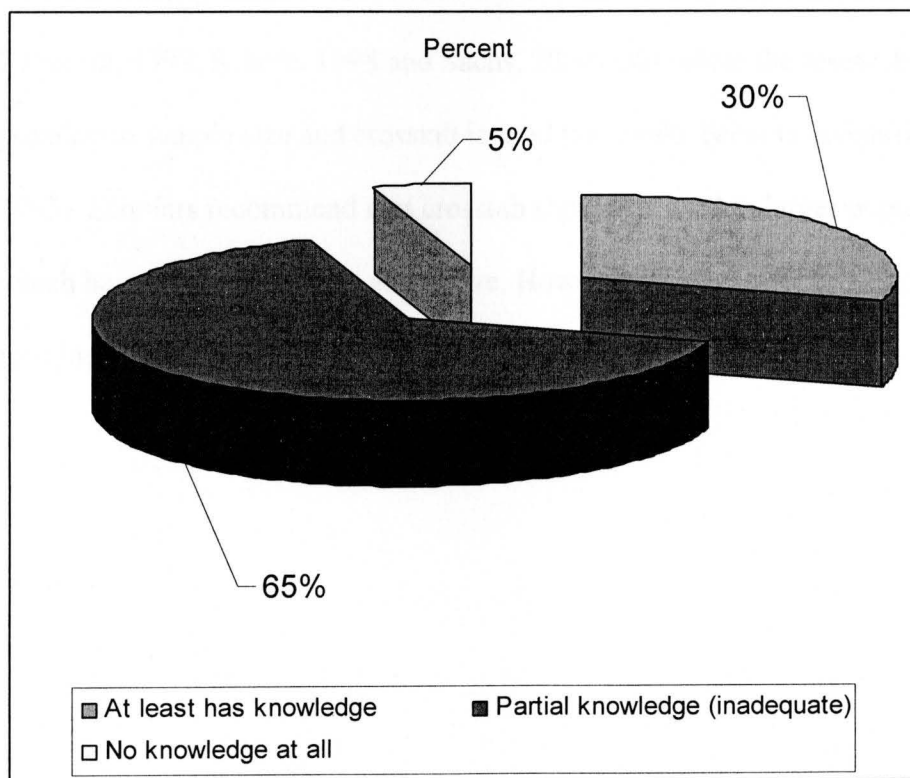
### Index variable (Composite) analysis

**Table 14: Frequencies**

Combination of all variable to compute index variable for knowledge

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	At least has knowledge	6	30.0	30.0	30.0
	Partial knowledge (inadequate)	13	65.0	65.0	95.0
	No knowledge at all	1	5.0	5.0	100.0
	Total	20	100.0	100.0	

**Figure 12: Pie Chart: Knowledge on HIV/AIDS of LKWIA members**



The research outcome explained in the pie chart diagram above indicates that LKWIA members were at risk of infecting themselves on the course of their service provision. This was dangerous to them, PLWHAS and Lemara Kati Community at large. Both the CNA and the scientific research met the objectives of the researcher as she was able to determine the level of understanding of LKWIA members on HIV/AIDS in totality.

### **3.8. Findings from the Crosstab**

Generally findings revealed that there were no relationship between knowledge on HIV/AIDS and Occupation, Education, age and Marital status. However all the results were statistically insignificant because it is evidenced by many scholars (Ursano, 1994, Solomon, 1992, Schore, 1998 and Sachs, 2000) that where the researcher has a small population sample size and crosstab is used the results become insignificant (Hobfoll, 1995). Scholars recommend that crosstab should be used to larger population samples which have 100 respondents and above. However, the Researcher gathered adequate insights which led her in making decisions.



## Qualitative Data Analysis

In table 15 below are the results from votes of members during qualitative research. Members' expressed their feelings and scoring method was used to determine the results.

**Table 15: Qualitative Data**

Need/problem	Number of votes
Inadequate knowledge and skills	7 Members out of 16
Lack of transport to refer patients	2 Members out of 16
Inadequate basic needs (Food, shelter and clothing	2 Members out of 16
Inadequate income of PLWHAS	1 Member out of 16
Stigmatization of PLWHAS by the community	1 Member out of 16
Gender inequalities to PLWHAS	1 Member out of 16
Bad Cultures, Customs, beliefs, Norms and Values	1 Member out of 16
Slum location	1 Member out of 16

**Source: LKWIA Focus group discussion held on 27<sup>TH</sup> September 2005.**

## Discussion

From the literature review the researcher gained theoretical, empirical and policy capabilities which were used to build a foundation on Lemara Kati Women in Action (LKWIA) capacity building project. The theoretical, empirical and policy literature review gave a lot of lessons and experiences to the researcher who was also a volunteer in this project on areas of strengths and weaknesses of such projects which paved way to improvement of LKWIA capacity building project.

However, as argued by many scholars in theoretical literature review; involvement of stake holders right from project designing which starts at needs assessment is very important as it helps in overcoming bottlenecks of improper designing that contribute to failure of many community based projects. Moreover, such involvement enhances community empowerment and ownership of the project that is also vital to sustainability of the project. In addition HIV/AIDS projects according to the literature requires involvement to capture cultures, beliefs, habits etc that contribute to stigma and segregation of PLWHAS that also trigger HIV/AIDS infections spread because the affected hide so that they cannot be abused. The empirical literature revealed that projects on the war against HIV/AIDS which were designed and implemented by Health Workers or policy makers without real involvement of the community were not successful while those which had authentic community participation were successful.

The policy review at all levels (International, National, Regional, District and local level) were in favor of CBO involvement in combating HIV/AIDS (Multisectoral efforts). From the qualitative data which was collected right from the CNA and during scientific research revealed that most of LKWIA members feared to attend more people to cover the outer part of Lemara ward because if they were challenged or asked technical questions on the disease they were not able to explain. Also sometimes they said during home visiting when PLWHAS asked them about treatment, of opportunistic diseases and where they could get the Antiretroviral (ART) but they did not know where they could be attended. The researcher tried to guide them so that they could explain if

they knew Health Facilities that provided opportunistic infection and ART drugs free of charge but they did not know.

### **Research Conclusion**

The Researcher achieved the goal of assessing the level of knowledge and skills of LKWIA on the concept of Home Based Care (HBC) of HIV/AIDS patients based in Lemara ward in Arusha Municipality, Northern Tanzania through the findings which were obtained. In addition, the research objectives were achieved especially from the findings shown in the pie chart in page twenty eight (28) where by the level of LKWIA understanding about HIV/AIDS and HBC shows weaknesses in the provision of HBC to HIV/AIDS patients. Thus, the CNA, the qualitative and quantitative Research concluded that LKWIA had inadequate knowledge on HIV/AIDS concept which was very dangerous in providing care to HIV/AIDS patients.

### **Research Recommendations**

- Training of LKWIA members on HIV/AIDS and HBC awareness
- Sensitization of Lemara Kati community to reduce stigma was required.
- Further research using adequate sample size of more than 100 respondents.
- Close supervision to LKWIA members is required to ensure quality continuum HBC services.

## **CHAPTER II**

### **2.0 PROBLEM IDENTIFICATION**

#### **2.1 Introduction**

The objective of this chapter is to define specific areas which were targeted and focused to effect change in the project. The section provides direction of the project on how it responded to community's real needs. It gives a direct documentation of the community's involvement in recognizing their needs and problem identification. The section is divided into, problem statement, target community, stake holders, project goals, objectives and host Organization.

#### **2.2 Problem Statement**

##### **The situation that needed to be changed**

LKWIA by then had a problem of lack of knowledge and skills on the causes of HIV/AIDS infection, transmission, prevention, treatment of opportunist infections, use of Antiretroviral drugs by the PLWHIAS and referral of patients to health facilities for care and treatment. Due to the problem they lacked confidence during home visiting to PLWHAS because when they were asked any question they were not able to answer properly.

Moreover, they were afraid of being infected on the course of service provision. In addition they were not in a position to help to fight against the disease through education session in the community. Solution to this problem as discussed and agreed with stake holders was formal training of all 20 LKWIA group members who were the HBC providers so that they could be able to provide quality services to PLWHS in Lemara Kati. Besides, the above challenge, they had a desire to solve the problem of HIV/AIDs and assisted PLWHAS.

### **Affected Groups**

The problem cited above had affected all Lemara population as they lacked knowledge of the deadly disease thus the stigma in their area persisted. The CBO also was affected by their partial knowledge on the disease because they did not meet their goal of having adequate coverage in their service provision. In addition, the government had wasted resources that were used to sensitize the community through the Radio and television, workshops, seminars and meetings conducted at various levels.

## **2.3 Causes and Consequences of the Problem**

The causes and consequences of this problem include:

- Inadequate communication and advocacy sessions on the causes of HIV/AIDS infection, transmission, prevention, treatment of opportunist infections, use of Antiretroviral drugs by the PLWHIAS and referral of patients to health facilities for care and treatment do not reach this community.

- Stigmatization and discrimination towards HIV/AIDS patients is still very strong among community members and even within the families thus PLWHAS lack comfort and support which cause them to hide the disease and continue transmitting the disease.
- Absolute poverty among Lemara population to meet basic needs due to: Unemployment, inadequate income generating activities, slum location that cause inadequate transport, illiteracy that results to bad cultures, customs, beliefs, norms, values for example polygamy and fleeing with several partners and contribute to persistent Gender inequalities which in turn contribute to spread of HIV/AIDS.

#### **2.4 Extent of the Problem**

Lemara Kati has a total population of five hundred and three (503) and among them there were eighty six (86) PLWHAS amounting to 17% of the total population. The Arusha prevalence rate among blood donors and voluntary counseling and testing (VCT) clinics was 24%.

#### **2.5 Relation of the Problem to the Purpose of LKWIA**

The purpose of LKWIA was to help PLWHAS, orphans, widows, widower and the community at large in giving comfort, basic needs, counseling services and referral to health facilities through home based care (HBC). It was the researcher's view that if these Community Based Health Workers (CBHWS) were knowledgeable on the causes of HIV/AIDS infection, transmission, prevention, treatment of opportunist infections,

use of Antiretroviral drugs (ART) by the PLWHAS and referral of patients to health facilities for care and treatment the stigma about the disease could be reduced as they could work confidently and perhaps reach more PLWHAS. Moreover, if PLWHAS could use the ART and be treated with opportunistic infections they could lead a healthy life which could let them produce their basic needs and contribute to the family and national income. In addition, deaths could be reduced, thus the number of widows, widower and orphans reduced.

## **2.6 Outcome of the Problem if not addressed**

- Morbidity and Mortality due to HIV/AIDS would increase
- There would be more Orphans, Widows and Widowers in the community who require assistance.
- Stigma would increase
- Development would increase
- There would be adverse effects on social, economic, cultural and development.

## **2.7 Target Community**

To arrest the spread of HIV/AIDS and reverse the trend of increase in the number of infected people the government through its 2001 HIV/AIDS policy had designed many strategies. Among them was to work with the community directly or through CBOS. The researcher aimed at dealing with LKWIA group of twenty women who in turn would Save PLWHAS, widows, widower, and orphans and provide mass HIV/AIDS sessions

in the community of Lemara Kati to raise awareness and reduce stigma and infection transmission. It was envisaged that LKWIA will be the key actors or project owners. The researcher had to become a volunteer to provide expertise in collaboration with the Health Management Committees at council and Regional levels (CHMT and RHMT). It was expected that all would yield high degree of participation.

## 2.8 Stake Holders

The project stake holders included LKWIA group of twenty women whom their capacity was to be built, the whole community of Lemara Kati through awareness creation sessions, PLWHAS who would receive services from LKWIA group, WIA head office who were the care taker of LKWIA group who would collaborate with the author to carry out the project, RHMT and CHMT who were collaborating with the researcher in implementing the project. HIV/AIDS issues needed multidiscipline professions which were within these two teams. SNHU and OUT who supervised the researcher to ensure the project was real CED project and would use the project as a reference in future trainings.

**Table16: Stakeholders participation**

Stakeholder	Participation	Impact of Participation	Researcher's Plan
WIA Head Office	Involved fully in care taking LKWIA and assisted the Researcher in project designing, implementation,	Allowed the researcher to work with the CBO and the project succeeded as a result of their good	Fully involvement right from the project designing to evaluation and report writing



Stakeholder	Participation	Impact of Participation	Researcher's Plan
	Monitoring and evaluation	collaboration	
RHMT/CHMT	Collaborated with the researcher in implementing the project by providing trainers and in monitoring and evaluating the project	Project implemented according to HIV/AIDS standards as provided in the guidelines	Involved fully to ensure quality training
LKWIA	Core participators and owners of the project. Therefore, from day one to the last date of the compilation of the project report they were fully involved.	Smooth carry out of the project	Involved them from the CNA, Problem identification, implementation, Monitoring and evaluation
PLWHAS	Received services from LKWIA group	The researcher and trainers were able to follow up practical skills gained by LKWIA	Involved them in identifying areas of weaknesses of their service providers through talks during Monitoring and evaluation
Lemara Kati Community	Attended awareness creation sessions	Stigma reduction in the Community	Involved them fully from project introduction through their leaders

**Source: CEDPA, (1994)**

## **2.9 Project Goal in CED terms**

### **2.9.1 The Project Goal was to:-**

Have LKWIA group that is capable and confident in caring PLWHAS and Lemara Kati community with awareness on HIV/AIDS by January 2007.

### **2.9.2 Conditions of the target Community at the start of the project**

At that time their current condition was inadequate knowledge and skills in caring PLWHAS thus lead LKWIA members to lack confidence in the provision of services which in turn caused less coverage.

### **2.9.3 Preferred conditions the project promoted**

LKWIA preferred to be trained so that they acquire proper knowledge and skills on HIV/AIDS and HBC concepts and the project promoted their preference by capacity building through training.

### **2.9.4 Goal outline**

LKWIA was providing HBC to PLWHAS in Lemara Kati ward but had inadequate knowledge and skills. This was dangerous to them, the PLWHAS and the Community at large. Thus, the solution to this problem was to build LKWIA members capacity through training so that they become conversant on HIV/AIDS and HBC concepts and improved confidence.

### **2.9.5 How the goal was defined**

The goal was defined by LKWIA in collaboration with WIA head office, RHMT and CHMT while the CED student was a facilitator as directed by CEDPA, (1994) that the targeted community should be authentically involved in designing, implementing, monitoring and evaluation of the project.

### **2.9.6 Feasibility of the project**

The project was feasible because LKWIA understood the reality of their environment, reflected on factors which were important in shaping their environment, the steps to effect changes and aimed at improving the situation. The project was feasible because all stake holders were positive to empowering LKWIA with knowledge and skills. In addition, the multisectoral policy is also positive.

### **2.9.7 Project progress in achieving the goal**

The monitoring and evaluation showed that LKWIA group had gained confidence dealing with HIV/AIDS and in preventing themselves from infections arising on the course of service provision. In addition, their confidence had warranted them to provide health education sessions in the community and thus the community awareness had raised whereas stigma had been reduced and PLWHAS are able to live a healthier life that allowed them to produce their basic needs and contribute to the family and national income. In this case the Researcher is convinced that the goal has been achieved fully.

## **2.10 Project Objectives**

To accomplish the goal above the following objectives were set:

- Build capacity of 20 members of LKWIA on what entails care taking to PLWHAS. by December 2006
- Establish socio-economic characteristics through stigma reduction using mass sensitization meetings by December 2006.
- Ensure 50% of HIV/AIDS patients' were referred to health facilities for treatment by December 2006.
- Raise voluntary counseling and testing (VCT) acceptance by 20% by December 2006.
- Establish treatment supporters to ensure adherence to drugs by all PLWHAS by December 2006.

## **2.11 Project Major Activities**

- Conduct community needs assessment of LKWIA group by December 2005.
- Conduct survey to confirm Needs assessment/Problem identification by December 2005.
- Conduct discussions to come up with project problem statement by December 2005.
- Train 20 LKWIA group on HIV/AIDs by December 2006.

- Conduct three community sensitization meetings in Lemara Kati to raise awareness on HIV/AIDS by December 2006.
- Refer 50% of HIV/AIDS patients for care and treatment of opportunistic infections by December 2006.

## **2.12 Objective Prerequisites and Necessary Resources**

The Objectives of the project required were specific for LKWIA members and resulted from their CNA. The services which they provide to PLWHAS are significantly different from other social services. The prerequisite here was to ensure that the project design suit the particular context. To come up with the objectives the researcher had to conduct supportive conversation or focused problem-solving sessions with LKWIA and the community. Thus, the target group was guided to determine range of issues encountered in communities during their care and treatment provision to PLWHAS. The researcher capitalized on their strengths, experiences and weaknesses in developing training framework and specific interventions appropriate to Lemara Kati context. The resources included: LKWIA members, the researcher, stationery, transport, venue, trainers, training manuals and time. The resources which required monetary terms were funded by the researcher. However, the RHMT, CHMT and WIA head office were very helpful in carrying out the implementation of that project. Further more, SNHU/OUT instructors provided adequate guidelines to the researcher.

### 2-13 Host Organization

The organizations which hosted and acted as affiliates to facilitate specific components of the project were: LKWIA, WIA head office which was care taker of the CBO, Arusha council health department and the Regional Medical Officer (RMO) who was the overseer of all Health Services in the Region. The RMO allowed RHMT members and other Regional Hospital staff to facilitate sessions during implementation of this project. The Researcher had a role of facilitating the project to ensure that it accomplished the objectives as planned. The responsibilities included: CNA, Carrying out survey, Project planning, Training manual preparation, Pre-testing, Soliciting trainers and other resources, Post test, Monitoring and evaluation, Report write up and presentation. Table eight below shows: What these organizations did, their participation, and the role of the Researcher.

**Table 17: Host Organizations' Roles, Responsibilities and participation**

<b>Organization</b>	<b>Specific areas they facilitated</b>	<b>What does the organization do?</b>	<b>Participation</b>	<b>Role of the Researcher</b>
LKWIA	CNA, Project designing, implementation, Monitoring and Evaluation	Caring PLWHAs in Lemara Kati ward, Arusha Municipality Thus, they are the direct beneficiaries.	They were positively active at all project stages	Facilitate the CBO in Needs assessment, Problem identification, conducted the survey, analyzed data, pre-tested the training manual, solicited resources, implemented the project, monitored and evaluated and wrote the report.
WIA head office	They allowed the Researcher to carry	They care take different CBO	Positive involvement	Collaborated with WIA to get the CBO that

<b>Organization</b>	<b>Specific areas they facilitated</b>	<b>What does the organization do?</b>	<b>Participation</b>	<b>Role of the Researcher</b>
	out the project	under them and LKWIA were among them.		suited her interested project area. Also the Researcher would submit one copy of her final report.
Arusha Council Health Department	Identified WIA who is the care taker of LKWIA thus assisted the Researcher in obtaining a CBO to conduct her research	They are the supervisors of all Health services in Arusha Municipality	They were very positive and willing to assist the Researcher	Went to their office to seek permit of carrying out the project and involved them at each stage. Also the Researcher would submit one copy of her final report.
Regional Medical Officer (RMO)	As a Regional Health services supervisor assisted the Researcher in allowing Trainers from the Regional Hospital to participate in training LKWIA group	He is the over all supervisor of Health services in the Region	He was very positive and he provided a lot of learning materials	The Researcher had to seek permission to attend the course and she was providing him progress report at each step from CNA to M & E. Also the Researcher would submit one copy of her final report.
Lemara Kati Community	They were the beneficiaries of the project because PLWHAS are their relatives/come from their Community	They host LKWIA by allowing them to use Lemara Kati ward office to carry out their meetings	They were positive and they attended the sensitization meetings	Ensure they were involved in carrying out the project from the start to the end.
PLWHAS	They were the beneficiaries of the services provided by LKWIA	They are the Recipients of the services.	They had words to say (Comments) about the quality of services	Involved them to identify areas of weaknesses from the services they received from LKWIA.

**Source: Designed by the Researcher, 2006.**

## **CHAPTER III**

### **3.0 LITERATURE REVIEW**

#### **3.1 Introduction**

This section is linking community needs assessment with literature review to account for what has been published on a topic by accredited scholars and researchers. The main purpose is to convey to readers knowledge and idea that had been established on capacity building to people volunteering to provide HBC to PLWHAS basing on the strengths and weaknesses. In other words, the chapter is providing research back up to the project problem or issue linking with objectives so that discussions and arguments portray and demonstrate skills in qualitative research. The chapter is divided into three parts namely: Theoretical, empirical and policy.

#### **3.2 Theoretical Literature Review**

This part is capturing different scholars' theoretical thinking through systematic literature review. Various definitions of terms and concepts on HIV/AIDS, community based care and its impact on poverty alleviation strategy and community economic development in general, have been advocated. It is worthwhile to quote few.

##### **3.2.1 Definitions and Concepts**

###### **3.2.1.1 What is HIV?**

HIV stands for human immunodeficiency virus. It is the virus that causes AIDS. A member of a group of viruses called retroviruses; HIV infects human cells and uses the energy and nutrients provided by those cells to grow and reproduce (WHO, 1980).



### **3.2.1.2 What is AIDS?**

AIDS stands for acquired immunodeficiency syndrome. It is a disease in which the body's immune system breaks down and is unable to fight off infections, known as "opportunistic infections," and other illnesses that take advantage of a weakened immune system. When a person is infected with HIV, the virus enters the body and lives and multiplies primarily in the white blood cells (WHO, 1982). These are immune cells that normally protect us from disease. The hallmark of HIV infection is the progressive loss of a specific type of immune cell called T-helper, or CD4, cells. As the virus grows, it damages or kills them and other cells. It also weakens the immune system and leaves the person vulnerable to various opportunistic infections and other illnesses ranging from pneumonia to cancer. A person can receive a clinical diagnosis of AIDS, as defined by the U.S. centers for disease control and prevention (CDC), if he or she has tested positive for HIV and meets one or both of these conditions:

- The presence of one or more AIDS-related infections or illnesses;
- A CD4 count that has reached or fallen below 200 cells per cubic millimeter of blood. Also called the T-cell count, the CD4 count ranges from 450 to 1200 in healthy individuals (McFarlane, 2004).

### **3.2.2 How quick do people get infected with HIV and subsequently develop AIDS?**

In some people, the T- cell decline and opportunistic infections that signal AIDS develop soon after infection with HIV. But most people do not develop symptoms for 10 to 12

years, and a few remain symptom-free for much longer. As with most diseases, early medical care can help prolong a person's life (WHO, 2004).

### **3.2.3 How is HIV transmitted?**

A person who has HIV carries the virus in certain body fluids, including blood, semen, vaginal secretions, and breast milk. The virus can be transmitted only if such HIV-infected fluids enter the bloodstream of another person. This kind of direct entry can occur (1) through the linings of the vagina, rectum, mouth, and the opening at the tip of the penis; (2) through intravenous injection with a syringe; or (3) through a break in the skin, such as a cut or sore. Usually, this is how HIV is transmitted:

- **Unprotected sexual intercourse (either vaginal or anal) with someone who has HIV:**

Women are at greater risk of HIV infection through vaginal sex than men, although the virus can also be transmitted from women to men. Anal sex (whether male-male or male-female) poses a high risk mainly to the receptive partner, because the lining of the anus and rectum is extremely thin and is filled with small blood vessels that can be easily injured during intercourse.

- **Unprotected oral sex with someone who has HIV:** There are far fewer cases of HIV transmission attributed to oral sex than to either vaginal or anal intercourse, but oral-genital contact poses a clear risk of HIV infection, particularly when ejaculation occurs in the mouth. This risk goes up when either partner has cuts or

sores, such as those caused by sexually transmitted infections (STI), recent tooth-brushing, or canker sores, which can allow the virus to enter the bloodstream.

- **Sharing needles or syringes with someone who is HIV infected:** Laboratory studies show that infectious HIV can survive in used syringes for a month or more. That's why people who inject drugs should never reuse or share syringes, water, or drug preparation equipment. This includes needles or syringes used to inject illegal drugs such as heroin, as well as steroids. Other types of needles, such as those used for body piercing and tattoos, can also carry HIV.
- **Infection during pregnancy:** childbirth, or breast-feeding (mother-to-infant transmission). Any woman who is pregnant or considering becoming pregnant and thinks she may have been exposed to HIV-even if the exposure occurred years ago-should seek testing and counseling. In the U.S., mother-to-infant transmission has dropped to just a few cases each year because pregnant women are routinely tested for HIV. Those who test positive can get drugs to prevent HIV from being passed on to a fetus or infant, and they are counseled not to breast-feed.

### **3.2.3 Ways in which HIV cannot be transmitted**

HIV is not an easy virus to pass from one person to another. It is not transmitted through food or air (for instance, by coughing or sneezing). There has never been a case where a person was infected by a household member, relative, co-worker, or friend through casual or everyday contact such as sharing eating utensils or bathroom facilities, or

through hugging or kissing. (Most scientists agree that while HIV transmission through deep or prolonged "French" kissing may be possible, it would be extremely unlikely.) Here in the U.S., screening the blood supply for HIV has virtually eliminated the risk of infection through blood transfusions (and one cannot get HIV from giving blood at a blood bank or other established blood collection center). Sweat, tears, vomit, feces, and urine do contain HIV, but have not been reported to transmit the disease (apart from two cases involving transmission from fecal matter via cut skin). Mosquitoes, fleas, and other insects do not transmit HIV (MOH, 2002).

### **3.2.4 Reduction of risks of becoming infected with HIV through sexual contacts**

The World Health Organization, (2003) advice that “If you are sexually active, protect yourself against HIV by practicing safer sex” Whenever you have sex, use a condom or "dental dam" (a square of latex recommended for use during oral-genital and oral-anal sex). When used properly and consistently, condoms are extremely effective. But; one should remember to:

- Use only latex condoms during sexual intercourse or dental dams for oral sex.  
Lambskin products provide little protection against HIV.
- Use only water-based lubricants. Latex condoms are virtually useless when combined with oil- or petroleum-based lubricants such as Vaseline or hand lotion. (People with latex allergies can use polyethylene condoms with oil-based lubricants).
- Use protection each and every time you have sex.

- If necessary, consult a nurse, doctor, or health educator for guidance on the proper use of latex barriers.

### **3.2.5 Other ways of avoiding HIV through sex**

The male condom is the only widely available barrier against sexual transmission of HIV. Female condoms are fairly unpopular in the U.S. and still relatively expensive, but they are gaining acceptance in some developing countries. Efforts are also under way to develop topical creams or gels called "microbicides," which could be applied prior to sexual intercourse to kill HIV and prevent other STIs that facilitate HIV infection.

### **3.2.6 Linkage between HIV and other sexually transmitted infections**

Having a sexually transmitted infection (STI) can increase risk of acquiring and transmitting HIV. This is true whether one has open sores or breaks in the skin (as with syphilis, herpes, and chancroid) or not (as with chlamydia and gonorrhea) as cited by WHO, (1998). Where there are breaks in the skin, HIV can enter and exit the bloodstream more easily. But even when there are no breaks in the skin, STIs can cause biological changes, such as swelling of tissue that may make HIV transmission more likely. Studies show that HIV-positive individuals who are infected with another STI are three to five times more likely to contract or transmit the virus through sexual contact (WHO, 1998).

### **3.2.8 How can one avoid acquiring HIV from a contaminated syringe?**

If a person is injecting drugs of any type, including steroids, should not share syringes or other injection equipment with anyone else. (Disinfecting previously used needles and syringes with bleach can reduce the risk of HIV transmission). If some one is planning to have any part of the body pierced or to get a tattoo, should be sure to see a qualified professional who uses sterile equipment.

### **3.2.9 HIV/AIDS infection world wide**

The Joint United Nations Programme on HIV/AIDS (UNAIDS, 2006) estimates that there are now 40 million people living with HIV or AIDS worldwide. Most of them do not know that they carry HIV and may be spreading the virus to others. In the U.S., approximately one million people have HIV or AIDS, and 40,000 Americans become newly infected with HIV each year. According to the CDC, (2002) it is estimated that a Quarter of all people with HIV in the U.S. do not know they are carrying the virus. Since the beginning of the epidemic, AIDS has killed more than 25 million people worldwide, including more than 500,000 Americans. AIDS has replaced malaria and tuberculosis as the world's deadliest infectious disease among adults and is the fourth leading cause of death worldwide. Fifteen million children have been orphaned by the epidemic.

### **3.2.10 Population groups which are most vulnerable**

Women are at least twice more likely to contract HIV through vaginal sex with infected males than vice versa. This biological vulnerability is worsened by social and cultural factors that often undermine women's ability to avoid sex with partners who are HIV-infected or to insist on condom use. In the U.S., the proportion of HIV/AIDS cases among women more than tripled from 8 percent in 1985 to 27% in 2004. African American and Hispanic women, who represent less than one-quarter of U.S. women, account for 80% of new HIV infections among American women each year.

### **3.2.11 Treatments for HIV/AIDS**

For many years, there were no effective treatments for AIDS. Today, a number of drugs are available to treat HIV infection and AIDS. Some of these are designed to treat the opportunistic infections and illnesses that affect people with HIV/AIDS. In addition, several types of drugs seek to prevent HIV itself from reproducing and destroying the body's immune system:

- Reverse transcriptase inhibitors attack an HIV enzyme called reverse transcriptase. They include abacavir, delavirdine, didanosine (ddl), efavirenz, emtricitabine (FTC), lamivudine (3TC), nevirapine, stavudine (d4T), tenofovir, zalcitabine (ddC), and zidovudine (AZT);
- Protease inhibitors attack the HIV enzyme protease and include amprenavir, atazanavir, fosamprenavir, indinavir, lopinavir, nelfinavir, ritonavir, saquinavir, tipranavir, and darunavir.

- Fusion inhibitors stop virus from entering cells. To date, only one fusion inhibitor, enfuvirtide, has been approved by the Food and Drug Administration.

### **3.2.12 Drug adherence**

Many HIV patients take these drugs in combination-a regimen known as highly active antiretroviral therapy (HAART). When taken as directed, anti-HIV treatment can reduce the amount of HIV in the bloodstream to very low levels and sometimes enables the body's immune cells to rebound to normal levels. Several drugs can be taken to help prevent a number of opportunistic infections including *Pneumocystis carinii* pneumonia, toxoplasmosis, *Cryptococcus* and cytomegalovirus infection. Once opportunistic infections occur, the same drugs can be used at higher doses to treat these infections, and chemotherapy drugs are available to treat the cancers that commonly occur in AIDS.

### **3.2.13 Research**

Researchers are continuing to develop new drugs that act at critical steps in the virus's life cycle. Efforts are under way to identify new targets for anti-HIV medications and to discover ways of restoring the ability of damaged immune systems to defend against HIV and the many illnesses that affect people with HIV. Ultimately, advances in rebuilding the immune systems of HIV patients will benefit people with a number of serious illnesses, including cancer, Alzheimer's disease, multiple sclerosis, and immune deficiencies associated with aging and premature birth.



### **3.2.14 Is there cure for AIDS?**

There is still no cure for AIDS. And while new drugs are helping some people who have HIV live longer, healthier lives, there are many problems associated with them:

- Anti-HIV drugs are highly toxic and can cause serious side effects, including heart damage, kidney failure, and osteoporosis. Many (perhaps even most) patients cannot tolerate long-term treatment with highly active antiretroviral therapy (HAART).
- HIV mutates quickly. Even among those who do well on HAART, roughly half of patients experience treatment failure within a year or two, often because the virus develops resistance to existing drugs. In fact, as many as 10 to 20 percent of newly infected Americans are acquiring viral strains that may already be resistant to current drugs.
- Because treatment regimens are unpleasant and complex, many patients miss doses of their medication. Failure to take anti-HIV drugs on schedule and in the prescribed dosage encourages the development of new drug-resistant viral strains.
- Even when patients respond well to treatment, HAART does not eradicate HIV. The virus continues to replicate at low levels and often remains hidden in "reservoirs" in the body, such as in the lymph nodes and brain.

In the U.S., the number of AIDS-related deaths has decreased dramatically because of widely available, potent treatments. But more than 95 percent of all people with HIV/AIDS live in the developing world, and many have little or no access to treatment.

### **3.2.15            Is there a vaccine to prevent HIV infection?**

Despite continued intensive research, experts believe it will be at least a decade before we have a safe, effective, and affordable AIDS vaccine. And even after a vaccine is developed, it will take many years before the millions of people at risk of HIV infection worldwide can be immunized. Until then, other HIV prevention methods, such as practicing safer sex and using sterile syringes, will remain critical.

### **3.2.16            Can one tell whether someone has HIV/AIDS?**

You cannot tell by looking at someone whether he or she is infected with HIV or has AIDS. An infected person can appear completely healthy. But anyone infected with HIV can infect other people, even if they have no symptoms.

### **3.2.17            How can one know of being infected?**

Immediately after infection, some people may develop mild, temporary flu-like symptoms or persistently swollen glands. Even if somebody look and feel healthy, may be infected. The only way to know of ones HIV status for sure is to be tested for HIV antibodies-proteins the body produces in an effort to fight off infection. This usually requires a blood sample. If a person's blood has HIV antibodies, that means the person is infected.

### **3.2.18 Should one be tested?**

If a person thinks of being exposed to HIV, the person should get tested as soon as possible. This is so because:

- Even in the early stages of infection, some one can take concrete steps to protect individual long-term health. Regular check-ups with a doctor who has experience with HIV/AIDS will enable the infected person (and entire family members or loved ones) to make the best decisions about whether and when to begin anti-HIV treatment, without waiting until they get sick.
- Taking an active approach to managing HIV may give a person many more years of healthy life than would otherwise have.
- If one is HIV positive, will be able to take the precautions necessary to protect others from becoming infected.
- If a woman is HIV positive and pregnant, can take medications and other precautions to significantly reduce the risk of infecting the infant, including not breast-feeding.

### **3.2.19 How can some one get tested?**

Most people are tested by private physicians, at local health department facilities, or in hospitals. In addition, many states offer anonymous HIV testing. It is important to seek testing at a place which also provides counseling about HIV and AIDS. Counselors can answer questions about high-risk behavior and suggest ways some one can protect ones self and others in the future. They can also help that person to understand the meaning of

the test results and refer the infected person to local AIDS-related resources. Though less readily available, there is also a viral load test that can reveal the presence of HIV in the blood within three to five days of initial exposure, as well as highly accurate saliva tests that are nearly equivalent to blood tests in determining HIV antibody status. In some clinics a person can get a test called Oral Quick that gives a preliminary result in 20 minutes. You can also purchase a kit that allows some one to collect the suspected person's blood sample, send it to a lab for testing, and receive the results anonymously. Only the Home Access brand kit is approved by the Food and Drug Administration. It can be found at most drugstores. Keep in mind that while most blood tests are able to detect HIV infection within four weeks of initial exposure, it can sometimes take as long as three to six months for HIV antibodies to reach detectable levels. The CDC currently recommends testing six months after the last possible exposure to HIV. This part of literature review has tried to give an overview on HIV/AIDs definition and concept in general so as to pave way to the essence of community based care to PLWHAs.

### **3.2.20 Community based care (CBC) to PLWHAS**

The community is the key factor in curbing the HIV/AIDs epidemic as argued by (Blinkhoff, 2001). The community should be fully informed about HIV/AIDs and the real life challenges in its prevention and care for PLWHAs in their localities (TACAIDS, 2001). For CBC to be successful there is a need to train Home Based Care (HBC) helpers who can volunteer from within the community (WHO, 2001). The HBC is a solution to most Sub Saharan African countries that are severely faced with the problem of limited resources to provide a basic level care and support to every one affected by

the dual epidemic of HIV/AIDs. Blinkhoff, (2001) explains that, this is one of the most daunting challenges facing governments' through out Sub Saharan Africa. The strategy according to Uys and Cameron, (2005) does not confine simply to care and treatment of the sick but, it is a more comprehensive approach that address the needs of the PLWHAs, their families and the community at large through; counseling, moral and material support that plays major role in stigma reduction against PLWHAs. However, (Cohen, 1992:16; Seghal, 1999:6) argues that, HBC had generally achieved only limited coverage and often relatively expensive to operate. Besides, HBC some scholars (Bonnel, 2000, Blinkhoff, 2001, Cohen, 1992:16; Seghal, 1999:6 ) argue that, if the HBC program is carried out by volunteers who understand the problems caused by HIV/AIDs, come from within the community and they had encountered such problems in their own families and their neighbors and friends in their every day lives they become very effective.

Uys and Cameron, (2005) wrote a textbook aimed at nurses family and friends of a persons with AIDS. The book shows the importance of people working with and in the homes of people with HIV/AIDs to be knowledgeable with HIV/AIDs issues in general. Such issues include:

- Model for home-based care (HBC)
- Implementing integrated community-based home care
- Training community caregivers for a home-based care program
- Counseling in the context of HIV/AIDs
- Running support groups for people with HIV/AIDs

- Dealing with the symptoms of AIDS
- Doing a home visit
- Infection prevention and control aspects in home-based health care
- Dealing with poverty
- Planning for orphans and HIV/AIDS affected.

It is from this basis that LKWIA capacity building project based, since they come from within the Lemara Kati community and they volunteered willfully.

### **3.2.21 HIV/AIDS linkage with poverty alleviation and Community Economic Development**

Bonnel, (2000) in his article General Macroeconomic affects has argued that, the extraordinary impact of HIV/AIDS on development is attributable to its ability to undermine three main determinants of economic growth, namely physical, human and social capital. He continues by saying, current estimates suggest that HIV/AIDS has reduced the rate of growth of Africa's per capita income by 0.7 percentage points a year and that for those African countries affected by malaria, growth was further lowered by 0.3 percentage points per year. He clarifies that, not only is HIV/AIDS having a detrimental effect on the growth of African economies but also it is reversing the modest gains made in recent times. He says the effects on growth at the macro-economic level are gradual and drawn out over time, partly due to the long incubation period of the virus. Broadly speaking he says that, poverty, income inequality, labor migration, gender inequality, low levels of education, and a range of context-specific socio-cultural variables and

initial health conditions facilitate the spread of HIV/AIDS and are associated with higher prevalence rates which need to be combated by all the people. He further argues that the education is yet to reach the majority thus mixed techniques be used to ensure massive education, which could improve the situation. HIV/AIDS affects all sectors of the economy (Ainsworth & Over, 1994) and the costs that are incurred as a consequence of the disease are not just financial in nature but fundamentally social and psychological (Cohen, 1992;). There is no conceivable way of measuring all these costs; however it is possible to explore the ways in which the disease affects different economic sectors. In all sectors HIV increases the rates of absenteeism, reduces productivity, and imposes additional costs in training and hiring new recruits and increases spending on health care, retirement and death benefits (Bollinger et al, 1999 and UNAIDS, 2000). HIV/AIDS also has an impact on human capital accumulation. As previously noted HIV/AIDS affects the most economically active age-groups, thereby reducing both the quantity and quality of available labor (Cohen, (1992):16; Seghal, (1999):6). Entire generations of teachers, health workers, civil servants and other skilled and professional people are being lost. Shorter life expectancies are raising the costs of schooling and training, thereby reducing the short-term returns (AMREF, 2003) since a significant amount of human capital accumulation takes place within the household, the death or sickness of a parent, particularly a mother, can have a disruptive impact on the inter-generational transmission of knowledge. Moreover, children may be forced to leave school to

help replace lost income or production caused by the loss of a parent, as family finances come under increasing strain. Thus the human capital of African nations is being eroded and incentives to invest in the education training of replacement labor are being reduced (Bonnell, 2000, Annex 5: 4).

### **3.3 Empirical Literature**

LKWIA capacity building project was a CED project that was couched in CED practice, tradition and informed with similar work successfully carried out by others else where. It is followed practical steps emphasized by CEDPA, (1994) training manual volume II that is an experienced organization in project design for program managers. The projects discussed in this manual were aimed at empowering community through capacity building to be full partners in development, make them innovative and capable of identifying their needs and problems. In the course of designing this project the researcher ventured on several similar projects which were successful and others which were not as follows:

#### **3.3.1 Maharashtra HBC for HIV/AIDS Patient care**

Dutta, (2005) conducted a capacity building project on HIV/AIDs at Mumbai in a suburb known as Maharashtra that dealt with standardizing Home-Based Care for HIV/AIDS patients. Maharashtra is high-risk state caught in the dragnet of HIV/AIDs virus. It took the lead in standardizing Home-Based patient care for HIV/AIDs patients. Within a few months, the Mumbai District AIDs Control



Society (MDACS) released protocols to be followed by Home-based HIV/AIDS patients, families and caregivers, which included Doctors, Nurses, Para-medical staff, Counselors and Lab-technicians. A panel of 14 doctors was trained and became trainer of trainers who in turn trained 40 caregivers each time (Gill, 2005). The outcome was 125,000 trained caregivers in Maharashtra and awareness creation reached a total of 300, 000 populations. This project shows that the project was successful in capacity building, increasing coverage on HIV/AIDS knowledge and reducing infections.

### **3.3.2 HBC Project for HIV/AIDS in Rwanda**

Chandler, Decker, and Nziyige, (2004) who were Partners for Health Reform plus worked on HBC project for HIV/AIDS in Rwanda. The project was based on a comparison of facility- and Community-based programs offering care in early 2004. They came up with findings that HBC for HIV/AIDS is increasingly viewed as a more accessible and affordable alternative to inpatient care, both for patients who are unable to travel to or pay for inpatient care as well as for governments that must fund inpatient facilities. Moreover, they found out that HBC also offers a holistic approach including psychosocial support, not only to people living with HIV/AIDS, but to entire households and community provided that the caregivers have adequate capacity. Moreover, the study found that facility-based care had higher estimated costs per client than community-based care, with monthly costs per client ranging from approximately \$31.20 to \$36.01

per month, while the cost of CBC ranged from \$ 12.75 to \$ 24.53 per month. HBC is cost effective for many households that are faced by poverty.

### **3.3.3 HBC in Zimbabwe**

UNAIDS, (2005) conducted a study on HBC in Zimbabwe, and found out that the number of new infections was actually falling down where CBO members were taught how to prevent the disease transmission and HBC provision techniques through formal training and issuance of learning materials. The training had a heading of “You know the risks - but do you know what AIDS actually is?”

### **3.3.4 HBC to PLWHAs in Dipaleseng area in Mpumalanga**

Dr. Teusink, (2005) from SIM HOPE focuses on programs which offer services to PLWHAs in their own homes. The emphasis is on medical and social care. HBC conduct outreach activities, which are offered to a monthly average of 6,000 people from the greater Dipaleseng area in Mpumalanga Province Malawi, as well as communities on the borders of the Gauteng and Free State Provinces. Dipaleseng residents have been trained to be field workers for the HBC Project. The field workers are in daily contact with families affected and infected by HIV/AIDs. They offer basic medical care, including wound dressings, bed baths, bed turning and training of the patient's family in these tasks. They develop strong relationships with the patients and their families, give guidance, support, and provide a 'listening ear'. When not calling on specific patients, the field

workers go from house to house to offer the services of the Program. They also document information about each household, such as the number of family members, who is employed, how many children live there, levels of wellness amongst family members, and so on. This crucial information helps the staff of the HBC and Community Outreach Program prepare for future needs within the area. The doctor and social worker make weekly visits, and are also called upon to do so by the field staff when this is needed. The doctor administers care and medication free of charge, and/or the social worker provides counseling and social assistance. This project has been very effective in HIV/AIDs care and treatment and also as awareness creator.

### **3.3.5. HIV/AIDs in Krobo District**

Mensah, (1994) conducted a study from 1987 to January 1988 with a team of medical personnel from the Korle-Bu teaching hospital. The study was an epidemiological study in the Krobo district to study the efficiency and potency of a Korean and Zairean herbal preparation. Findings showed that: more people with HIV/AIDs remained undetected in their homes than the number who reported in the hospitals; the disease was recognized as one for those who traveled outside the country. Some related HIV infection to evil spirits; and certain hospitals were afraid of being labeled as having AIDS patients in their hospitals. Community, church and NGO involvement in case-identification, mobilization, education, treatment and support was stressed. St. Martin's clinic at Agomanya took in many of the HIV/AIDs sufferers in the area. The clinic tried

to involve the community in the education and support of sufferers, to provide home-based nursing care, counseling services, social and pastoral support and provide income-generating activities for young people in the area. The services provided were: outpatient care; home care; pastoral care and social services. The program was evaluated to judge whether the needs of the community and patients were met by the services provided and to draw lessons for the future. Between 1988 and 1991, there was an increase in the number of people living with HIV/AIDS and receiving Home-Based Care. Some recommendations were put forward, including: the importance of political involvement to support in the areas of personnel, finance and material from the national, regional and district levels; employment opportunities for young people in rural areas; and educational programs on HIV/AIDS in existing activities. It was also suggested that churches and Christian families should play a leading role in promoting sex education and moral values. This project was not successful because it did not involve stakeholders during project designing.

### **3.3.6. HIV/AIDS, HBC and Counseling Project**

Sagnia, (1999) was one of the many dedicated staff who worked with world wide Evangelization for Christ International on the Catholic Relief Services' supported HIV/AIDS, HBC and Counseling Project. This project had trained Peer Health Educators in order to train PLWHAS in Brikama in Gambia. They helped individuals and local communities provide assistance to PLWHAS and to

Gambian communities that had been affected by the AIDS pandemic. Their support included free voluntary counseling and testing services, training of community leaders, sensitization of communities about HIV/AIDS, provision of support and care for PLWHAS and other chronic illnesses. With support from Catholic relief services, World wide Evangelization for Christ was able to:

- Trained 30 community leaders and 60 other key players at the community level.
- Trained traditional communicators involved in sensitizing communities on HIV/AIDS and on how to respond to people who are infected or affected by the illness.
- Trained male and female peer health educators in the villages. They are taught how to offer counseling and other preventive services. Some of these young people also provide support to chronically ill patients at home.
- Registered over 200 chronically ill patients since the beginning of the project, all of which have received a continuum of care from the community to the hospital level. This project was effective in reducing the strong stigmatization of HIV/AIDS in Gambia and it increased privacy to clients.

### **3.3.7. HIV/AIDS home-based care and counseling in Ibis Namibia**

Amatheus and Naris, (2003) worked at Ibis' Regional Office and Central Support Office in Windhoek, Namibia. They completed six weeks of intensive training on HIV/AIDS Home-Based Care and Counseling. Ibis' Namibia has

taken an inside out approach to HIV/AIDS training and mainstreaming, offering a continuum of learning and opportunities for reflection and action, starting with each individual in the organization as a potential change agent due to the high prevalence rate of HIV/AIDS of 22.5% in the adult population of ages between 15 and 49. Amatheus and Naris became trainer of trainers and Counselors who now run training courses with the support of Ibis' Regional HIV/AIDS Program. Ibis' is now proud to have a supportive and motivated team who can assist other colleagues to understand that being HIV positive is not a death sentence any more. In addition PLWHAS have been able to continue with their work within their families and communities. HIV/AIDS education has been transmitted among colleagues whereby families now are able to support each other to break down stigma and discrimination and encourage each other to test and live positively. HIV/AIDS in Songwe Division in Mbeya Rural District.

The District Medical Officer (DMO) Mbeya Rural District in Mbeya Region had similar project in Songwe division in 2001 where 509 community members, 23 commercial sex workers (CSW) and 160 school pupils participated in the workshop (DMO, 2001). The project aimed at increasing knowledge, skills and practices to curtail the rate of HIV/AIDS infections in the project area. Evaluation was conducted in 2003 and results revealed that the project was not effective in reducing infections because the project was designed by Health workers after they learnt that HIV/AIDS knowledge and skills was extremely low (AMREF, 2003). They did not conduct any needs assessment to design educational programme.

### **3.4. Policy Review**

#### **3.4.1 Policy described**

A policy is a standing plan which specifies the organizations or countries general response to known problems or designed situation. A health policy takes cognizance of three basic elements: the context, the content and the process (Green, 2004).

The context according to Green, (2004) is concerned with the community that the policy targets. Community context therefore considers the social political, economic and environmental factors which define the community during the specific time period and also considers policy implications.

The policy content according to Green, (2004) is the substance that makes up the policy. It is the relevance of the policy content in the defined context that determines the relevance and applicability of the policy.

The process is concerned with the formulation of policy. The process is influenced by suitability of the policy formulation with respect to their knowledge, attitude and practice. The process is also concerned with determination of context, the content and the acceptance and adoption of the policy. Consultations with those to be affected by the policy before its formulation are an essential step in the process. Other steps in the process include communication, advocacy, translation, resource mobilization, mobilization, monitoring and evaluation (Green, 2004). The needs assessment exercise took

the above factors into consideration with respect to global agreements that HIV/AIDS is a disaster to be fought by all nations in the world (UNAIDS, 2003).

### **3.4.2 HIV/AIDS Policies at International level:**

The global fight against HIV/AIDS is a renewed effort to member countries' commitment to turning the tide against the deadly disease. Several strategies are laid down in the content of world wide policy. Moreover, working with global partners, is emphasized to be a better way to overcome HIV/AIDS through compassion, commitment, and decisive action (UNAIDS, 2001). The awareness meeting of member states conducted in Copenhagen in 1995 resulted into policy resolutions on HIV/AIDS (UNAIDS, 2000). Also the Cairo and Beijing conferences highlighted more issues to the extent of dramatizing them and all countries agreed on battling HIV/AIDS with emphasis on raising awareness, stigma reduction, voluntary counseling and testing (VCT), home based care (HBC) of the sick, improved nutrition and care and treatment (CTC) of the sick. The global policy further urge multisectorism, integration, working closely with NGOs and strengthening of Health Management Information System (HMIS). However, latest estimates on HIV/AIDS infections, clearly demonstrate that the world still has a major and deadly epidemic on its hands, one that demands and deserves urgent attention and action. In addition, the United Nations (UN) is committed on the disease through its Millennium development goals where there are set goals, objectives and measurable targets to be achieved by 2015 by all



nations. Also the UN Millennium goals lay out a comprehensive strategy for combating global poverty, hunger and disease (UNAIDS, 2005). In combating HIV/AIDS the UN has developed a series of book lets which guide nations on the interventions. Among the interventions HBC, community awareness and stigma reduction are recommended (UNAIDS, 2005).

### **3.4.3 Africa Region Policy on HIV/AIDS**

Member countries had defined and formulated HIV/AIDS policies trough collective deliberations. All issues on combating HIV/AIDS were clarified especially with regards to targeting groups in the prevention and treatment of people living with HIV/AIDS (PLWHAS). The countries had a meeting in Lesotho in 1993 and they came out with Health policy and resolutions (CRHCS, 1997). Interventions for Africa region member countries are in line with the international policies and guidelines as issued by UNAIDS. It is universally accepted fact that HIV/AIDS is a disease of public health importance globally (ESCA, 1997). The disease causes the greatest suffering and impoverishment among poor people, particularly in Africa South of Sahara. This is because social behavior change to most people is very low and majority acquires infections.

### **3.4.4 Tanzania's Health Policy**

The Tanzania national policy on HIV/AIDS (MOH, 2001) has announced HIV/AIDS to be a national disaster that require collaborative efforts to overcome. The policy has recognized that HIV/AIDS is a threat to national life,

survival and development. Moreover, the policy is recognizing that most community is not yet aware on the causes of HIV/AIDS infections, transmission and prevention thus encouraging partners in the fight. However, it is difficult to reach the community without having agents. The policy urge that, HIV/AIDS should be fought using every thing we have got. The policy further, urge to begin by preventing new HIV/AIDS infections, targeting about 85% of sexually active population that is still free from HIV/AIDS infections as well as taking care of the already affected so as to contain the spread because if they are neglected they will continue spreading. In addition, the policy urges that, people must be informed, empowered and helped to ensure they remain HIV-negative. They have to be encouraged to undergo voluntary counseling and testing (VCT) to confirm that they are free from the disease and are further counseled on the necessary precautions in order to maintain that status. The policy also states clearly that, those who are found positive should benefit from getting prophylactic treatment against opportunistic infections and continue to lead normal and productive lives. Moreover the government, with the support of development partners' aim at building capacity at all levels to provide the services. LKWIA is an agent to transmit such information, knowledge and skills to Lemara Kati ward. If these 20 women are empowered with knowledge and skills on HIV/AIDS issues in totality, they shall be able to halt HIV/AIDS spread in their ward.

#### **3.4.5 Health Policy at Regional level**

The Region has a role of receiving, interpreting, disseminating, and enforcing government policies to the lower levels. At regional level there is the Regional AIDS Control Program Coordinators (RACC) who is charged with functions of conducting follow ups at local levels to oversee that, there is adherence (MOH, 2001).

#### **3.4.6 Health policy at Local Council level**

The local council level is the implementer of all policies. There is the Council AIDS Control Program Coordinators (CACC). However, working with CBO like LKWIA is ideal to ensure that information is reaching the community at grass root level as stipulated in the national policy (MOH, 2001).

## CHAPTER IV

### 4.0 IMPLEMENTATION OF LKWIA CAPACITY BUILDING PROJECT

#### 4.1 Introduction

This section puts into action the recommendations from the CNA, Literature Review and Scientific Research portrayed in chapter one above. It provides both original plan and the actual implementation of Lemara Kati women in action capacity building project. Also it reports what was accomplished at the end of the project.

#### 4.2 Products and Out puts

The researcher had planned to start community needs assessment in September 2005 and complete the project by December 2006 so that she could write the report and submit by January 15<sup>TH</sup> 2007. Summarized in table nine below are the products and outputs accomplished by the end of the project life as suggested by CEDPA, (1994) p. 62.

**Table 18: Products and Out puts**

Objectives	Indicators/Outputs
Conduct community needs assessment of LKWIA group by December 2005	a) Availability of needs and problems list b) Prioritized needs and Problems
Come up with project problem statement by December 2005,	Problem stated according to acceptable standards
Train 20 LKWIA group members on HIV/AIDS by December 2006	Number of LKWIA group members trained
Conduct three community sensitization meetings in Lemara Kati	Number of sensitization meetings conducted at Lemara Kati

to raise awareness on HIV/AIDS by December 2006	
5. Refer 50% of HIV/AIDS patients for care and treatment of opportunistic infections by December 2006.	Number of PLWHAS identified and referred to Care and treatment centers.

Source; CEDPA (1994) p. 68

### 4.3 Project Planning

The researcher had set out a plan for this project as shown in Gantt chart in appendix six.

Below is the action plan which was followed during actual implementation.

**Table 19: Original Project Plan**

ACTIVITIES	EXPECTED OUTPUT	TIME FRAME	RESPONSIBLE PERSON	RESOURCES & BUDGET	ASSUMPTIONS
CBO identification and enrollment	CBO identified	September to Oct. 05	Project volunteer/CED student and Municipal AIDS Control program coordinator	Transport and lunch allowance Tshs 55,000/=	Availability of transport & permission from employer
Meet CBO members and conduct needs assessment	List of needs and prioritized problems	Sept to Oct. 05	Project volunteer/ CED student WIA head office staff and LKWIA	Transport and lunch allowance Tshs 55,000/=	Availability of transport & permission from employer
Prepare and submit project proposal by January 2006	Proposal write up	Nov 05 to Jan 2006	Project volunteer/CED student	Stationery and internet costs Tshs 60,000/=	Availability of transport & permission from employer
Solicit training	Availability of	Jan-March	Project	Stationery, Fax,	Availability

ACTIVITIES	EXPECTED OUTPUT	TIME FRAME	RESPONSIBLE PERSON	RESOURCES & BUDGET	ASSUMPTIONS
facilitators, training materials and funds by April 2006	resources	2006	volunteer/CED student	transport and telephone cards Tshs 100,000/=	of transport & permission n from employer
Conduct training to 20 LKWIA Members by December 2006.	Number of sessions conducted and syllabus covered	June to December 2006	Project volunteer/CED student, LKWIA and invited facilitators	Transport, Lunch allowance, Refreshments, Training materials 1,200,000/=	Availability of transport & permission n from employer
Conduct community sensitization meetings	Number of meetings conducted	June-Dec 2006	Project volunteer/CED student, LKWIA and community	Transport with laud speaker, Allowances and refreshments 1,500,000/=	Availability of transport & permission n from employer
Identification and referral of PLWHAS to health facilities	Number of homes visited and number of patients identified	June-Dec 2006	Project volunteer/CED student, LKWIA and PLWHAS	Transport, Lunch allowance, Support materials to PLWHAS 1,200,000/=	Availability of transport & permission n from employer

**Source: Arusha Municipal Council CCHP 2005/06 and CDPA, (1994) p. 46**

#### **4.4 Inputs**

The inputs for this project as highlighted by CEDPA, (1994) included:

- Project Volunteer/CED student
- WIA head office staff
- University Instructors and supervisor (SNHU & OUT)
- Lemara Kati group members
- Project survey and approved proposal
- Trainers
- Transport
- Funds
- Training materials (Training manual, Books and brochures, Chalk board, Flip chart, Video and TV, Over head projector and Posters)

#### **4.5 Staffing Pattern**

The staffing pattern of this project involved LKWIA group members lead by their chair person, secretary and treasurer. The CED student was a volunteer and facilitator of the project. The WIA head office staffs who were involved as care takers and supervisors of the project to ensure that it is implemented as planned. The SNHU and OUT instructors who were providing instructions on how the project should be carried out. The summary of responsibilities is as in table eleven below.

**Table 20: Staffing Plan**

<b>Position to program</b>	<b>Responsibilities</b>	<b>Roles</b>	<b>Staff training needs</b>
LKWIA group members	Learning on HIV and HBC concepts, Practicing the skills trained, Ensure project success and sustainability	Collaborate in CNA, Problem identification, project designing, implementation, Monitoring and Evaluation	HIV/AIDS and HBC concepts, communication and advocacy skills, Monitoring and evaluation skills and Report writing.
The CED student/volunteer	Facilitator of the project	Conduct CNA and Survey, Write project proposal, Solicit resources, Ensure smooth project implementation, Monitoring and Evaluation and writing of final project report	Working with CBO in designing, implementing, monitoring and evaluation of Community projects
WIA head office staffs	Care takers of the CBO	Supervisors of the project to ensure that it is designed and implemented	None



Position to program	Responsibilities	Roles	Staff training needs
		according to Community needs and problems as planned	
SNHU and OUT instructors/Supervisor	Guide the CED student	Provide instructions and standards on how the project should be carried out (General supervisory role)	None

Source designed by Researcher, 2006.

Detailed job descriptions are attached in appendix seven (7).

#### 4.6 Budget

There were no budgets for salaries in this project because LKWIA is a voluntary CBO lead by the chair person, secretary and treasurer positions which are not salaried. Also the Researcher was a volunteer. However, budgets involved are as in table 12 below:

**Table 21: Budget Summary**

<b>Salaries</b>	<b>Equipment costs</b>	<b>Start up costs</b>	<b>Operating expenses</b>	<b>Professional or out sourced services</b>	<b>Contract needs</b>	<b>Remarks</b>
None	None	1,200,000	2,970,000	1,200,000	None	Professional/ out sourced services involve allowances to Trainers from the Regional Hospital Mount Meru, Arusha.

**Source designed by Researcher, 2006.**

#### **4.7 Actual Implementation**

Actual implementation of the project followed the implementation plan as show in the Gantt chart below.

Table 22: LKWIA Capacity Building Project Implementation (Gantt chart)

Activities	Project Months															Resources Needed	Person responsible	
	2005				2006													
	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11			12
Meet with WIA head office																	Transport and allowances	Project volunteer/ Researcher WIA head office staff and LKWIA
Meet LKWIA																	Transport and allowances	Project volunteer/ Researcher WIA head office staff and LKWIA
Conduct CNA and Survey																		volunteer/ Researcher, LKWIA and WIA head office
Develop training manual																	National policy, guidelines for HBC, TOT Class note	

Activities	Project Months																Resources Needed	Person responsible
	2005				2006													
	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12		
Solicit HLM and Facilitators																	Transport and allowances	Project volunteer/ Researcher
LKWIA training																	Facilitators, Venue Funds, HLM Transport, Stationery, Allowances and Refreshments	Project volunteer/ Researcher WIA head office staff, Facilitators and LKWIA
Community sensitization																	Facilitators Funds, HLM, Transport, Allowances and Refreshments	Project volunteer/ Researcher WIA head office staff and LKWIA
Identification of PLWHAs and referral																	Transport, allowance, needs to PLWHA	Project volunteer/ Researcher and LKWIA
Follow up to PLWHAs and referrals																	Transport, allowance, Basic needs to PLWHAs	Project volunteer/ Researcher and LKWIA

Activities	Project Months															Resources Needed	Person responsible	
	2005				2006													
	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11			12
Conduct Monitoring and evaluation																	Time, stationery, transport and allowances	Project volunteer/ Researcher WIA head office staff LKWIA and Supervisor
Project write up, presentation and submission																	Computer, stationery and binding costs	volunteer/ Researcher

Source: CEDPA, (1994) p.46.

## CHAPTER V

### 5. MONITORING, EVALUATION AND SUSTAINABILITY OF LKWIA PROJECT

#### 5.1. Introduction

This section portrays the monitoring and evaluation for LKWIA project as planned to routinely gather information needed to keep the project on schedule. The aim was to design signals to anticipated problems which could arise so that solutions could be formulated prior to happening. Also signals were used to measure project progress and evaluate program success. Monitoring and evaluation was a useful tool in reviewing the project with an eye to ensure that its capacity to function regardless of changes in external funding sources and staffing. Actually monitoring and evaluation was part of the project implementation as such it was done continuously from the CNA to the summative evaluation, January 2007. Table 14 below is original plan.

#### 5.2 Original monitoring Plan was as follows:

**Table 23: Information for Monitoring Project Operations**

<b>Categories of information</b>	<b>What was monitored</b>	<b>What records were Kept</b>	<b>Who collected data</b>	<b>Who used data</b>	<b>How information Was used</b>	<b>What decisions were made</b>
1. Work plan Activities	Timing of activities and availability of resources	Work plan and schedules	Project volunteer/Researcher and LKWIA Chair person	Project volunteer/ Researcher and LKWIA	To track implementation in order to ensure that time is managed properly	Change schedule or combine some activities

<b>Categories of information</b>	<b>What was monitored</b>	<b>What records were Kept</b>	<b>Who collected data</b>	<b>Who used data</b>	<b>How information Was used</b>	<b>What decisions were made</b>
2. Costs and expenditures	Budgeted amounts, funds at hand and expected funds and other resources	Cash at hand, Cash book and Bank A/C	Project volunteer/Author and LKWIA leadership	LKWIA, Financers and donors	Ensure that funds are used as intended	Re-budgeting, look for additional donors or revise project aims
3. Staff in supervision	Knowledge, attitudes, and skills of LKWIA, referral of patients, and awareness	Performance reviews, Feed back from capacity building sessions, Home visits conducted	Project volunteer/Author, LKWIA leadership, supervisors, CHMT and RHMT	Project volunteer/ Researcher, LKWIA leadership, supervisors, CHMT, RHMT, MOH and TACAIDS	Improve CBO management, HBC, awareness creation and referral system	Time table of facilitation sessions
4. Commodities	Learning materials for example Posters ordering and distribution	Ledgers and reports from LKWIA	Project volunteer/Author, LKWIA leadership, supervisors, CHMT and RHMT	Project volunteer/ Researcher LKWIA leadership, supervisors, CHMT and RHMT	Ensure availability of learning materials at all times	Quantity to order, order period and interval
5. Results	Number of LKWIA who	Attendance registers, Facilitators	LKWIA, author PLWHAS and Supervisors	Project volunteer/ Researcher	Ensure objectives are realistic, assess	Revise objectives, repeat

Categories of information	What was monitored	What records were Kept	Who collected data	Who used data	How information Was used	What decisions were made
	attended sessions no. of community meetings conducted, no. of PLWHAS referred to HF and quantity of HLM distributed	signed forms, referral of patients register, register of PLWHAS Ledger of HLM and ward office visitors book		r, LKWIA leadership, supervisors, CHMT and RHMT	quality of services provided to PLWHAS assess appropriateness of capacity built	sessions, revise HLM distributed, revise project strategies and redesign the project if need be

**Source: CEDPA, (1994) Page 59**

### **5.3 Actual Monitoring**

Actual monitoring was done to measures achievements that were aligned to planned objectives, strategies and activities to ensure that they were on track. In particular there were close monitoring of the following:

- Inputs ( Human, Finance, Materials, Logistics, Time and in-kind resources),
- Process where by activities were monitored to ensure that they were carried out as planned and completed.
- Outputs were monitored to ensure that they met the standards.
- Outcomes were measured through indicators.



Input indicators included the following:

- The amount of funds available according to the budget
- Number of training manuals produced and other training materials and equipment.
- Number of participants and Facilitators available for training
- Venue
- Time table

Output indicators:

- Training sessions conducted
- Number of members trained
- Number of Facilitators who turned up
- Number of Training proceedings available

#### **5.4 Research Methodology used for Monitoring**

The methodology employed to collect the data for monitoring was mainly through:-

- Participatory role of both the Researcher and LKWIA group members in open discussions using structured questionnaires and questions. This aimed at discovering the feelings of beneficiaries (LKWIA)
- Observation which involved, looking, listening and learning techniques. Using this tool the researcher was able to observe the dynamic behavior of LKWIA members as she new the initial values/conditions of LKWIA before training. This tool enabled the researcher to determine future conditions of the group which is discussed further in sustainability.

- Review of relevant documents which led to determine transparency, accountability and team spirit. This was used by the researcher to gain experience on first hand data kept at source (Lemara Kati ward office) in coming up with conclusions which were capable of being verified by observation.

**Table 24: Summary of actual Monitoring**

<b>Information</b>	<b>Monitoring Questions</b>	<b>Sources of information (how)</b>	<b>Type of report Frequency</b>	<b>Who Collected</b>
Overall Goal	To what extent the training improved quality of services provided by LKWIA	Council Supervision report prepared by HIV/AIDS section	Semi annual and annual	Researcher Community Development Officers
Project Objectives/ Project purpose	- What type of training required to LKWIA?	CNA and survey report	1 <sup>st</sup> Quarterly report	Researcher & LKWIA
Expected results/Outputs	- How many members had been trained? To what extent was trained LKWIA members correctly applied their skills? What % of patients referred to Health facilities	Training report Field report by HBC coordinator Care and Treatment report	Quarterly reports Monthly supervision reports	Researcher & LKWIA
Activities/Processes	- To what extent has the implementation covered the planned activities in the period of 18 months? - How effective were training	Training report prepared by Facilitators and trainees	Quarterly, semi annual and annual reports	Researcher and LKWIA

<b>Information</b>	<b>Monitoring Questions</b>	<b>Sources of information (how)</b>	<b>Type of report Frequency</b>	<b>Who Collected</b>
	materials and approach used in training?			
Resources/inputs	What was the total budget for the training? How much spent on materials over the last 18 months?	Quarterly financial reports	Quarterly reports	Researcher & LKWIA
Context/Assumptions	To what extent had other things affected/ influenced the implementation of activities in the last 18 months?	Filed reports	Quarterly reports	Researcher & LKWIA

**Source: Designed by the Researcher, 2006**

## **5.5 Evaluation**

This project evaluation was divided in three parts:

- Before implementation to ensure that inputs and timing of activities were in line with work schedules.
- Formative evaluation which was conducted while activities were on progress to discover whether there were deviations to planning and to see the extent to which the project was achieving its objectives through the activities. At the end summative evaluation was done using base line information gathered during needs assessment comparing with actual outputs and outcomes to determine whether the project was successful or not. The evaluation was looking at the systems for implementing planned activities in terms of

efficiency and effectiveness of the project and to see whether all objectives and goal or project purpose was met. This was where information gathered was useful for improving replica projects. The table 16 below summarizes the evaluation plan.

**Table 25: Original Evaluation Plan**

<b>Objective</b>	<b>Activities</b>	<b>Indicators</b>	<b>Data Source</b>	<b>Methods/Tools</b>	<b>Person responsible</b>	<b>Time Frame</b>
1. Conduct community needs assessment of LKWIA group by December 2005	1. See ACC program coordinator 2. See WIA head office 3. See LKWIA leadership 4. Conduct needs assessment and problem identification	CBO enrollment	WIA head office visitors book and LKWIA meeting minutes	Verification of Minutes Visitors books LKWIA acceptance letter	Researcher and LKWIA	Sept to Dec. 2005
2. Come up with project problem statement by December 2005.	Discussions and write up	Accepted needs assessment and problem identified	LKWIA	Marked paper ICD 531 of needs assessment and problem identification	Researcher, LKWIA and course Instructor	Sept to January

<b>Objective</b>	<b>Activities</b>	<b>Indicators</b>	<b>Data Source</b>	<b>Methods/Tools</b>	<b>Person responsible</b>	<b>Time Frame</b>
3. Train 20 LKWIA group on HIV/AIDS by December 2006	Solicit funds, Facilitators, Transport, HLM and community sensitization centers	LKWIA readiness for training, No. of LKWIA attending sessions, No of people attending awareness creation sessions and no. of PLWHAS identified and referred	Attendance registers, referral patients registers and Facilitation reports	Checking of records	Researcher, Supervisor and WIA	March to September 2006
Sensitize community and PLWHAS	Solicit funds, Facilitators, Transport, HLM and community	Awareness increased	Reduction in stigma and referrals increased	Checking of records		

**Source: CEDPA Page 64**

## 5.6 Actual Evaluation Conducted

The objective/aim of actual monitoring was to keep the project in track, and report on progress towards the project goals and objectives.

### 5.6.1 What was evaluated?

- **Inputs:** Funds allocation, availability of trainers, number of enrolled trainees and their qualifications, training materials, period or time of training, information for evaluation and evaluators.
- **Process:** The evaluation followed the process in CEDPA Page 61-59 which involved; gathering information on all aspects of the project which include: Training needs assessment, before training test, training in relation to timetable, content coverage, post test performance, effectiveness and efficiency of the training (Work plan).
- **Output:** At this stage evaluation looked at the Inputs equating with the Process and out puts to see whether they were adequate or there were constraints.
- **Out come/Impact:** At this stage the assessment was to see whether the objectives had been achieved and whether there had been quality improvement in services provided by LKWIA, their confidence and enrolment of PLWHAS in care and treatment clinics.

### 5.6.2 Direct Indicators

- **Input:** number of participants, funds, facilitators, training materials,
- **Process:** participants attending sessions, number of sessions and to adherence according to the timetable.
- **Output:** Number of qualified trainees, and Number of training modules covered

### **5.6.3 Indirect Indicators**

- Customer's satisfaction (PLWHAS)
- Efficiency in service provision

### **5.6.4 Research Methodology used for Evaluation**

The methodology employed to collect the data for evaluation was mainly through:-

- Participatory role of both the researcher and LKWIA group members in open discussion and applying of structured questionnaires as shown in Appendix 10.
- Observation which involved, look, listen and learn technique as discussed in 5.4 above.
- Review of relevant documents which led to determine transparency, accountability and team spirit.
- Beneficiary assessment: consultation with project beneficiaries and other stakeholders in issues such as: signal constraints, provide feedback to improve activities

### **5.6.5 Stakeholders**

As recommended by CEDPA page 57 the first level evaluation was done by project staff (LKWIA and CED student). The course Instructor/Supervisors were responsible for evaluating the project through marking of work done by the student. The second level of evaluation was done by Community leaders, Arusha Municipality health department, WIA head office and the Regional Health Management Team from the Regional Health office through field visits and routine reports from the HBC coordinator. The CBO reported through the Health Management Information system (HMIS) to the Municipal council monthly performance reports.

**Table 26: Project Outputs:**

Objective	Output indicators
1. Conduct community needs assessment of LKWIA group by December 2005	List of needs
2. Come up with project problem statement by December 2005.	Problem statement
3. Train 20 LKWIA group on HIV/AIDS by December 2006	A) Number of women who attended training sessions B) Number of CBO members who practiced proper HIV/AIDS handling and care guidelines C) Quantity of HIV/AIDS learning materials availed
4. Conduct three community sensitization meetings in Lemara Kati to raise awareness on HIV/AIDS by December 2006	A) Number of community sensitization meeting conducted B) Number of people who attended each meeting C) Number of people who went for VCT
5. Refer 50% of HIV/AIDS patients for care and treatment of opportunistic infections by December 2006.	A) Number of home visits conducted by each CBHC B) Number of PLWHAS referred to Health Facilities

**Source: CEDPA, (1994) Page 63**



### 5.6.6 Presentation of Results

The analysis was done by LKWIA and CED student and presented to stakeholders through meetings and reports. Major issues featuring were: Review of project strategies, Effectiveness, Efficiency, Sustainability, Relevance and Impact. However, since the Researcher was keen in following up the project implementation there were no deviations.

**Table 27: Summary of Evaluation findings**

Goal/Objective level	Question	Purpose of question	Actual Outcome
Goal: "Have a LKWIA group which is capable and confident in caring PLWHAS and Lemara Kati community with awareness on HIV/AIDS".	To what extent have LKWIA members improved in service provision?	It assessed whether the intentions of the project had been met/ achievement.	Confident LKWIA members due to knowledge and skills acquired.
Objectives: Build capacity of 20 members of LKWIA on what entails care taking to PLWHAS by December 2006. Establish socio-economic characteristics through stigma reduction using mass sensitization meetings by December 2006	Were set objectives achieved?		Needs assessment and Research reports and Training Manual in place. 20 LKWIA members trained. Three Community sensitization meetings conducted.

Goal/Objective level	Question	Purpose of question	Actual Outcome
<p>Ensure 50% of HIV/AIDS patients' were referred to Health Facilities for treatment by December 2006</p> <p>Raise Voluntary Counseling and Testing (VCT) acceptance by 20% by December 2006.</p> <p>Establish treatment supporters to ensure adherence to drugs by all PLWHAS by December 2006.</p>			<p>50% PLWHAS referred to Health Facilities</p> <p>VCT services increased by 30%</p> <p>Family supporters available to collect and administer drugs to PLWHAS in homes</p>
Effectiveness	To what extend the project results and project purpose been achieved?	Determined whether training had changed performance in service provision.	Services provide according to HBC standards as per WHO guideline and motivated
Impact	What were the wider effects caused by the project?	Determined Extend of the project contribution - comparing the situation before the project and after	PLWHAS when asked appreciated that there is great improvement in services they received after the project was implemented.

**Source: Designed by Researcher (2006).**

## **5.7 Sustainability**

Sustainability relates to ways in which there would be project continuity, capacity to continue functioning regardless of changes in funding sources. The project is supposed to survive by using its own resources (Human, Material, Finance and Logistics), even after external sources of funding have ended, (CEDPA, 1994).

### **5.7.1 Sustainability Elements**

Sustainability can be measured only several years after project closure. However in this case sustainability came just before the project ended considering the following:

#### **5.7.1.1 Financial**

To promote long term sustainability in financing the project, the beneficiaries were urged to strengthen their income generating activities of beads making, gardening and registered their CBO to obtain soft loan from the government through the Municipal council where by the government had issued one billion shillings to each Region. Also, Pathfinder has enrolled the CBO in credit society called VIKOBA and the chair person was trained for three weeks as a trainer of trainers. VIKOBA operate like SACCOS and the CBO had shown saving mobilization and repayment trend.

#### **5.7.1.2 Political**

The project was in line with the national multisectoral HIV/AIDS policy, Regional and local level policies, thus it was acceptable. In addition, Regional, Council and local level leaders supported this project because HIV/AIDS were declared a disaster which requires combined efforts of many actors.

### **5.7.1.3 Social Circumstances**

The circumstances that could affect the host community and the viability of the project in the future were addressed through Community sensitization meetings. Sensitization was geared to reduce stigma and discrimination to PLWHAS which constitute major factors in inhibiting service utilization, openness and proper response for the HIV/AIDS epidemic. By the end of this project Lemara Kati ward Community attitudes had changed due to knowledge imparted to them by LKWIA after they were trained.

### **5.7.2 Sustainability Plan**

Over time the following steps were taken to ensure that the researcher's expectations of sustainability to the future are met.

**Step one:** The researcher ensured that LKWIA project continued with the spirit of not being Donor dependent. The researcher empowered them with knowledge on the advantages and disadvantages of being Donor dependent. Thus, they were urged to strengthen their own sources of resources through member ship contributions, beads and gardening projects.

**Step two:** The Researcher urged Municipal Authority Health department to include LKWIA in their budget under Community initiatives cost centre which get funds allocation from Basket Fund Grant.

**Step three:** The Researcher ensured that LKWIA was linked across a continuum of care with variety of partnering Care and treatment clinics like Mount Meru Regional Hospital, Tutunzane Pathfinder HIV/AIDs programmes and establishment of functional referral system.

### **5.7.3 Institutional Plan**

The Researcher is an employee of Regional Health services in Arusha Region. HIV/AIDS is among critical issues addressed by the Regional Secretariat, Ministry of Health and the nation as a whole. Due to such facts there were no doubts that the sustainability elements would be addressed in order to support this project in the long term. The Institutionalization would be through incorporation of HBC services in the Comprehensive Council Health Budget.

## CHAPTER VI

### 6.0 PROJECT CONCLUSIONS AND RECOMMENDATIONS

#### 6.1 Conclusions

Among the challenges facing hospitals is the increasing number of patients with HIV/AIDS and the increasing burden that the HIV/AIDS pandemic is placing on hospitals and healthcare systems, making it difficult for the systems to function effectively. To alleviate such a problem WHO invented HBC so that HIV/AIDS patients can be able to remain within the communities in their own homes and with their family and friends close to them and get comfort. The challenge is the community response to allowing patients to remain at home due to stigma. LKWIA had mobilized themselves and were providing care for people living with HIV/AIDS in their homes.

However, among the challenges facing communities and community-based organizations working in HIV/AIDS throughout the world are the continually dwindling resources and rising expectations (WHO, 2006). As Communities and their local organizations attempt to use local resources as much as possible. The most important local resource is the community members; and therefore volunteer labor is a key input just like LKWIA did.

Knowledge of the caregiver, however, was inadequate to face such challenges of providing care. Building skills among family members and friends of people living with HIV/AIDS, so that they could be Home Based caregivers and thereby meet patients day to day care needs (e.g. making them comfortable, ensuring better nutrition and hygiene, changing dressings, administering simple medications and keeping their spirits up) required a comprehensive training approach and perhaps more close supervision.

In response to this challenge LKWIA project had developed a learning resource package/manual, which aimed to equip the caregiver, the supervisor and any home-based care participant with the skills which ensured that the home-based care program worked effectively. The training strategy was aimed at enabling community-based organizations, caregiver faith based organizations and caregivers themselves to ensure that HIV infected persons received a recommended package of care services at home. The components of the package included: medical care (both nursing and clinical), support and counseling, psychosocial support (including spiritual support), AIDS education, health education, nutrition, hygiene and sanitation.

The training manual was prepared specifically to suit the context and knowledge gap of LKWIA to improve their ability to provide home based care program.

The project had shown success in real CED project due to its collaborative process undertaken by a University student, WIA (NGO) and LKWIA (CBO) *in* combating Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) using HBC strategy. The spread of HIV/AIDS world wide has been extensive, affecting thousands of individuals, families, and communities. Innovative approaches are needed to reach more communities in the fight against the epidemic.

To be effective, approaches must involve all sectors, community and must reach out to individuals unwilling, or unable, to access voluntary counseling, testing, care and treatment. It was found that the project was successful in involving women care givers from within the community. Increased referrals for HIV testing, care and treatment as well as distributing information about HIV/AIDS to Lemara Kati community had increased awareness and open ness thus reducing stigma.

In this study, the Researcher analyzed job satisfaction in LKWIA Community-Based HIV/AIDS service provision. Through this project the Researcher was able to see LKWIA members providing psycho-social relief to PLWHAS. Thus, the project goal and objectives were achieved.

## **6.2 Project Recommendations**

Basing on the above findings, the Researcher records the following:

1. Since HIV/AIDS imply high costs for most households, especially in low-income settings like Lemara Kati, the consequences of AIDS are devastating. Innovative strategies on how best to assist households are thus requested and may include: Food, shelter, clothing and referral to care and treatment services being offered to AIDS cases.
2. Researchers need to employ results in answering specific policy questions. However, scope remains for more impact studies to be conducted in developing countries in general and in certain high prevalence countries that explore the urban/rural dynamics of and clients' perceptions and behavior in seeking care and support which is necessary to better understand the epidemic.
3. The role of community-based organizations, non-governmental organizations and other stakeholders in combating HIV/AIDS is important thus, LKWIA project can be replicated to other areas with similar contexts.
4. Larger studies generally have more statistical power, but smaller, in-depth studies can be equally valuable. A careful stratification of sample populations can enhance the quality of cross-sectional studies. Qualitative methods should be used



to complement the current reliance on survey-based methods of data collection. More longitudinal studies are required to explore the long-term impacts of HIV/AIDS. HIV/AIDS training for HBC and should be standard in studies of this nature, while cognizance should be taken of the dangers of employing local people as fieldworkers in studies of such sensitive nature.

5. Further scope on empirical data analysis from impact studies is required, thus, Research data sets should be made accessible to more researchers. In the longer term, an attempt at standardizing core modules in impact studies could help to improve our understanding of the impact of HIV/AIDS to a larger extent.

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