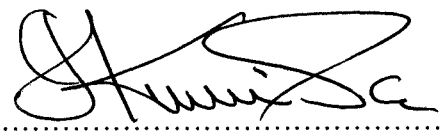
EFFECTS OF HIV/AIDS RELATED STIGMA AND DISCRIMINATION ON THE SOCIAL ECONOMIC STATUS OF PEOPLE LIVING WITH HIV/AIDS

A CASE STUDY OF WAJANE NA YATIMA WANAOISHI NA VIRUSI VYA UKIMWI MACHINBO STREET IN YOMBO DOVYA WARD, TEMEKE MUNICIPALITY DAR ES SALAAM

A PROJECT SUBMITTED IN PARTIAL FULLFILLMENT OF THE REQUIREMENTS FOR THE MASTER OF SCIENCE IN COMMUNITY ECONOMIC DEVELOPMENT IN THE SOUTHERN NEW HARMPSHIRE UNIVERSITY AT THE OPEN UNIVERSITY OF TANZANIA 2007

Supervisor Certification

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

Signature: 

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Declaration by the Candidate

I, Francis, Josephine Kayungilizi, declare that this project is my own original work, and that, it has not been presented and will not be presented to any other university/higher learning institution for a similar or any other degree award.

Signature .....

Date: 10th Oct. 2007

Dedication

This project paper is dedicated to my daughter, Kenshonga Maria Julius and it is also dedicated to my mother, Maria Cervina Kayungilizi, for your love, support, sympathy and encouragement. I appreciate having all of you.

Abstract

This paper presents a summary of social, economic and psychological problems that people living with HIV/AIDS face from community members as a result of stigma and discrimination related to HIV/AIDS. The project area is Yombo Machimbo in Yombo Ward, Temeke Municipality in Dar es Salaam City. The Project paper firstly defines stigma and discrimination and identifies problems faced by People Living with AIDS (PLWHA). The study focused on WAYAWAVI who are window/widowers and orphans living with HIV/AIDS in Yombo Machimbo, Temeke Municipality.

Some of the study recommendations were used for implementation of activities which would minimize stigmatization among community members. The study also addressed different aspects of implementation and participation which leads to sustainability of the project as the stigmatization related to HIV/AIDS is rampant. Finally the study identified some monitoring and evaluation mechanisms of the project.

Stigma and discrimination related to HIV/AIDS are permanent problems in many communities with high prevalence rate including Tanzania. This tends to affect the quality of care and services provided to people affected and infected with HIV/AIDS. This entails a huge problem in up take of HIV services such as voluntary counselling and testing, as well as prevention of mother-to-child transmission. Stigma and discrimination is caused by a number of things, including lack of knowledge among community members about transmission, risk and copying strategies.

Executive Summary

Until 2004 Tanzania had the prevalence of 7.8 per cent with regional, gender and age variations. Mbeya has the highest prevalence followed by Iringa and Dar es Salaam. In Dar es Salaam, Kinondoni had 15.1 per cent, Ilala 12 per cent and Temeke had 18.4 percent. According to the 2004 population and housing census (NBS, 2004) Temeke has a population of 771,470 of which 389,245 are male and 382,225 are female.

In this report, the case study is WAYAWAVI (OPHANS, WIDOWS/WIDOWERS WHO ARE HIV+) Yombo Dovya Machimbo Street, where the group meeting place is located. Yombo Dovya Ward has 36 widows, 18 widowers and 96 orphans who face stigmatization from the community they are living in. WAYAWAVI are widows, widowers and orphans as a result of HIV/AIDS. Some orphans are HIV+ while some are not. Self-stigmatization also is increasingly high which somehow influence others. This is followed by community stigma whereby community willingness to take care for the affected family members is low.

This makes the affected family members feel isolated and neglected. First, community members are not willing to co-operate with HIV+ population as they find them an extra burden that needs special attention and costly in terms of time and money. Second, community members' knowledge about HIV and its transmission is still low. They think that through attending, assisting or eating with orphans or widow who are infected with HIV leads to infections

The high proportion of the population expansion in Yombo and community at large clearly shows signs of stigma related to HIV. First, stigma in the this community is likely to lead to induced transmission because if one thinks that is isolated of being HIV+ can decide to deliberately transmit the disease through risk behaviour as a response to stigma. Second, increased mother-to-child transmission as most of pregnant mothers will fear to go for HIV test because of stigma. Third, increase in child labour because many children are not enrolled in school. Fourth, increasing Acquired Immune Deficiency Syndrome in death rates, poor performance, and decrease is economic development. Fifth, increase in the government expenditure in attending the affected people.

Currently WAYAWAVI are trying to fight stigma by establishing a group through which group members have developed activities like home-based care, care for orphans and legal assistance. Besides all these efforts, WAYAWAVI are in a very difficult situation because community members are reluctant to buy or get services from people whose sero status is known. Most orphans have no one to care; they cannot attend school because of various factors, including lack of school fees and school-related materials. Some orphans have opted to be employed at the age of schooling as a way to sustaining themselves and sometime to support their young ones. At the same time more transmission of HIV is likely because community members are not willing to go for HIV test and when tested they are not willing to disclose their status.

To address the situation an intensive community sensitisation programme was conducted at all streets in the ward. This approach seemed to be effective and applicable to other areas, which are facing similar problems. The programme implementation began in July 2006 where by two peer educators from each street received in class training on the aspects of the programme, WAYAWAVI have trained, teachers, influential people like religious leaders, herbalists and others.

Four community-based sessions have been conducted in two streets, respectively, and is on progress to other five remaining wards. WAYAWAVI have not yet received elementary knowledge of income-generating activities though negotiations to link them with Population Services International, a social marketing organisation, are on progress. Other activities as indicated in the work plan will be completed by September 2007.

With the implementation of community sensitisation programme it is expected that the level of stigmatization will go down and hence allow WAYAWAVI live happier and minimize chances of more transmissions. This will also create enabling environment to WAYAWAVI to participate in community social economic activities hence project sustainability.

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List of Abbreviations/Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARVs	Antiretroviral
BCC	Behaviour Change Communications
CBOs	Community-Based Organizations
CED	Community Economic Development
CCBRT	Comprehensive Community-Based Rehabilitation in Tanzania
HIV	Human Immunodeficiency Virus
HDI	Human Development Index
ILO	International Labour Organization
IGPs	Income Generating Programmes
NACP	National AIDS Control Programme
NGOs	Non-Governmental Organisations
PLWHA	People Living With HIV/AIDS
PASADA	Pastoral Activities and Services for People with AIDS

PSI	Population Services International
SFV	Siamin Foamy Virus
SIV	Siamin Immunodeficiency Virus
STDs	Sexually Transmitted Diseases
TACAIDS	Tanzania Commission for AIDS
T-MAC	Tanzania Marketing Company
UNICEF	United Nations Children Funds
UN	United Nations
UNAIDS	United Nations Programme on HIV and AIDS
UNFPA	United Nations Funds for Population Activities
UNIFEM	United Nations Development Fund for Women
UNDP	United Nations Development Programme
USA	United States of America
VCT	Voluntary Counselling and Testing
WAYAWAVI	Yatima na Wajane Wanaoishi na Virusi vya UKIMWI

Appendices

CHAPTER ONE

Community Needs Assessment (CNA)

This chapter describes the purpose of conducting Community Needs Assessment (CNA) before project formulation. It gives elaboration on sources of discussed information, methods used and ways of data analysis. The chapter provides information on the area where the project has been conducted; the mission and vision of the case study; the organization chart and findings of the conducted assessment. Community Needs Assessment was conducted in order to establish the real needs of the people. During the assessment the group members, local government authority, teachers, religious leaders and some of community members mentioned a number of problems. These include stigma and discrimination related to HIV/AIDS, law knowledge on HIV/AIDS, lack of orphanage centre, denial of WAYAWAVI rights and poor economic statuses of WAYAWAVI.

1.1 Community Profile

WAYAWAVI group was established in January 2005 with the registration number 156775. The organization is located at Machimbo Street Yombo in Dovya Ward, Temeke Municipality in Dar es Salaam. Yombo Machimbo is located within unplanned settlement and its population is estimated at 4285, being one of the seven streets constituting Yombo Dovya Ward. The ward's total population is estimated at 30,000 according to 2002 national census. The purchasing power of people in Temeke Municipality, including Yombo Dovya, is lower compared to other

municipalities due to a big number of people residing in this area, which is not formally employed but rather informally employed. The daily income ranges between 220/- and 1,500/- per family. Business activities are low and very few in which community members are involved. Most of them are engaged in very small-scale-based projects worth 2,000/- capital (like selling buns (maandazi) fish mongering, rice buns (chapati) and coconuts) – (Temeke Municipal Annual Report 2003). The group never had any income-generation activities though the group members have been involved in different activities. WAYAWAVI, as a group, was initiated by widows. Later on the group decided to incorporate orphans after realizing that they were facing the same problem, that is, stigmatization. Later widowers joined the group. Stigmatization was due to the reasons that these people were in one way affected by HIV/AIDS by either losing the partner or parents because of the disease and the low knowledge of community members on HIV/AIDS. The group was formed after seeing difficulties of fighting stigmatization and of social and economic difficulties faced by some of the community members in providing care and support.

WAYAWAVI has 147 active members. These members belong to different households from the seven streets of Yonbo Dovya. WAYAWAVI provides different support to its members. Yombo Dovya, like any other area in Tanzania, has very high spread of HIV/AIDS infection among its residents. Because of the prevalence rate there is an increase in the number of widows/widowers and orphans. HIV infection has generally affected every family in one way or the other. Despite the fact that

every family has been affected with HIV there is still a problem of stigmatization which community at large, government and other institutions need to work on.

1.2 The Power Structure of WAYAWAVI

WAYAWAVI has leadership structure comprising of chairperson, vice-chairperson and secretary/treasurer. This composition is made of people from different professions. They include business people and housewives. Some of them are informally employed while others are unemployed. They all work as volunteers.

1.2.1 Mission of WAYAWAVI

The group's mission is to fight stigma by performing sustainable work in collaboration with community and other organizations in delivering consolation, home-based care, legal services among the group members and the surrounding community.

1.2.2 Vision of WAYAWAVI

Its vision is to ensure that PLWHA are living in a stigmatization-free zone, respectively, getting all services without denial to their rights.

1.2.3 The Group Objectives

1) To build teamwork and strong relationship among the group members in the fight against HIV/AIDS-related stigmatization

2) To visit, advise and take care of PLWHA

3) To give psychological support on education and life in general to orphans so that they do not despair and involve themselves in risky behavior like drug taking and prostitution.

On orphans and widowers/widows living with HIV/AIDS in Yombo Machimbo: WAYAWAVI have realized stigmatization related to their HIV status from community members. To minimize stigma, the group has taken the following steps: First, to identify the group members whereby a total of 94 orphans, 35 widows and 18 widowers were earmarked. These groups have been organized to perform different activities, which help to solve some of the problems they are facing, including to consoling themselves, working on legal issues (for those who have been denied of their rights), care for orphans and others.

1.3 Community Needs Assessment

WAYAWAVI group members realized that there were a great number of widows, widowers and orphans in the Yombo Machimbo Community as a result of HIV/AIDS. These groups were facing problems of stigmatization when looking at various problems mentioned in the assessment. WAYAWAVI suggested having activities/projects which could provide information on HIV/AIDS and its related stigma and its effects to PLWHA and community in general. Therefore, stigma and discrimination was prioritised as the project on which activities should be designed for implementation. WAYAWAVI wished community members, development and

funding partners to participate in addressing the problem through creation of awareness to community members.

There were different sources of data collection used these include people infected with HIV and orphans. Community members were also taken as a focus group on which several questions were asked about HIV and related stigmatization, local government authority members on which discussion on issue of stigmatisation was conducted on orphans, teachers, guardians and caregivers. Data were analysed by use of SPSS, Graphical methods like pie charts, histograms and distribution table and figures.

Table 1: Prioritized issues and problems identified by WAYAWAVI during the Community Needs Assessment

Number	Problem	Consequences
1.	Stigma and discrimination	Devaluation, decrease of economic status among of PLWHA
2.	Orphanage	Increase of child labour and school dropouts
3.	Low knowledge of HIV/AIDS	Increased stigmatisation and more transmissions
4.	Denial of WAYAWAVI rights	Poor economic status to PLWHA
5.	Poor economic status to WAYAWAVI	Increased dependence of commercial sex workers and more HIV transmissions

(Source: WAYAWAVI, October Report 2005)

Stigmatization is due to the fact that HIV/AIDS is associated with unacceptable behaviours in the community like homosexual, prostitution and a notion that it is a punishment. Therefore, it is a life-long disease, which is incurable and highly linked to death. Most of community members are not aware of what HIV/AIDS means, its mode of transmission, how to prevent themselves from getting the disease and care for PLWHA.

The prevailing stigmatization level needs to be minimized. WAYAWAVI and Yombo Machimbo community need to transform from the current environment surrounded by stigmatization to new situation of positive perceptions and attitudes to PLWHA. This was to be worked on by first conducting vigorous community sensitization programme to different community groups and to the entire community.

Second, was by finding ways of improving and empowering economic situations of WAYAWAVI. This was so because it has been realized from community and literatures that stigmatization increases and becomes notable if the stigmatized person is not economically well off.

This led to the need of social study to establish factors leading to stigmatization. The findings could form a basis for recommending and implementing interventions to minimize stigmatization and improve access to resources. Information on community assessment has been collected through baseline survey whereby interviews were conducted to some of community members, WAYAWAVI and other stakeholders. Other methods were observations and documentary review.

1.4 Research Methodology and Tools Used in the CNA

The section presents the approaches and methodologies used during the project study. A combination of methods was used in undergoing this study; that is, presented in the following sections of this report. Other methods included in-depth interviews and focus group discussion with different members of WAYAWAVI.

1.4.1 Sample Size

A total of 50 respondents were interviewed and information related to the study was collected. Though this study was purposeful, the process of selecting respondents involved different groups in order to have a good mix of opinion in the functions of the WAYAWAVI.

1.4.2 Semi-Structured Methods

This is a technique which was widely used during the study. Interviews were conducted by using structured questionnaires. The used questions meant to collect information related to the objectives of the project study. During the data collection phase researcher used different techniques such as probing in order to collect more information useful for the project study. Specifically the process used in this method was that the data collector asked questions and listened or integrated informants/interviewees then noted down some notes on questionnaire sheets. In recruiting interviewees each was given a brief, verbal explanation of the survey and asked if they would be interested to take part. For those who were interested they were asked about a convenient time for interview. The method involved key

individual interviews, focus group like WAYAWAVI, guardians of orphans, teachers, counselors and local government authority leaders. The method also involved focus group discussions and brainstorming.

Key Findings from this Method

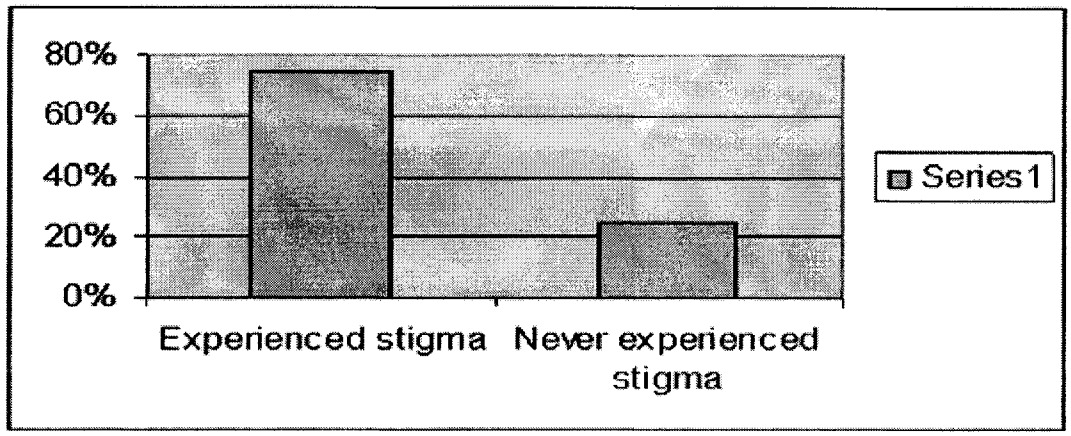
The following are results obtained based on the analysis conducted from the data collected using semi-structured interview. Findings for each section of the study were presented under each section of this report

The survey had two main respondents who were community members and the main project target WAYAWAVI. The following are the results obtained based on the analysis conducted from the data collected. Findings are grouped into the following groups. The first group includes WAYAWAVI - widows, widowers, and orphans. The other group includes respondents from community members, guardians and caretakers of people living with HIV and orphans.

1.4.3 Respondents (I): Orphans, Widowers and Widows Living with HIV (WAYAWAVI)

The study had revealed that most of people who are living with HIV could clearly define HIV/AIDS. This made 88 per cent of the total WAYAWAVI, who defined it as Human Immune Deficiency virus, which is mainly sexually transmitted. Stigma has been referred to as shame, not worth of living, a person with no social value 79 per cent while discrimination has been defined as isolation by 85 per cent and this is stigmatization.

Figure 1: Stigma Experience



Source: Field Data and Consultations.

Seventy-five per cent of all WAYAWAVI members, including widows, widower and orphans have faced different kinds of stigmatization; attitudes and actions as figure 1.1 shows. Only 25 per cent of them have never realized any stigmatizing action. As literatures show a person with persistent problem is likely to face stigma. So, even those who said they did not face stigmatization were the ones who could not realize the stigmatizing actions and attitudes. Most of people living with HIV experienced more stigmatization from family members than the ones they face from community members.

Another question was: How can a person living with HIV realize he or she is being stigmatized? This can be realized by family members feeling ashamed of him/her as 89 per cent of total respondents were not willing to work, share things with an HIV+ person even in an activity which is not likely to cause transmission. Stigmatization could be demonstrated in different forms e.g. family members could pretend to be helpful to a sick person by making sure that all services are extended to the person in

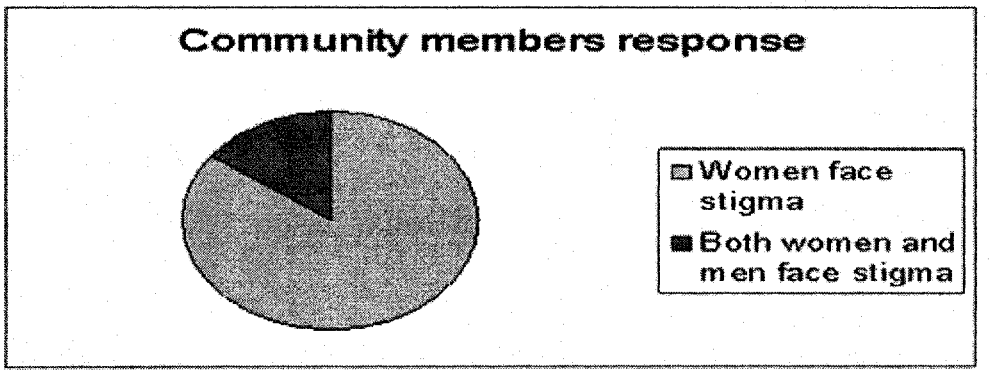
his/her bedroom. In so doing he/she is not allowed to the sitting room because the family members are ashamed of him.

Inadequate knowledge of HIV and its transmission is the main reason leading to HIV/AIDS-related stigma and that made a total of 65 per cent responses, while 25 per cent of other respondents reported that when PLWHA are dependent to their relatives, this also increases stigmatization.

Communities at large do agree that there is a way in which stigma and discrimination can be avoided. Ways that have been suggested were 65 per cent of respondent suggested that; PLWHA need to be empowered socially and economically. For orphans they need to be supported to go to school because through education they could support their living.

Eighty-five per cent of all respondents admitted that women face more stigma than men. This was exactly what happened in Namibia where a woman lost her husband because of HIV. Her father-in-law told her that was the one who transmitted the infection to his son and chased her out of the house.

Figure: 2: Facing stigma between women and men



Source: Field Data and Consultations

One hundred per cent of people living with HIV/AIDS agreed that stigmatization could lead to more transmissions among community members. After having knowledge on HIV status, most of WAYAWAVI lost their economic activities and orphans who were in schools could not continue, 50 per cent of homemakers also remained without economic activities among 60 per cent who had income-generating activities. Economic activities, which WAYAWAVI were involved in, included fish/food vending (80 per cent) and tailoring (10 per cent). One of them was an employee of a big company in the city, but she could not continue working because of her illness.

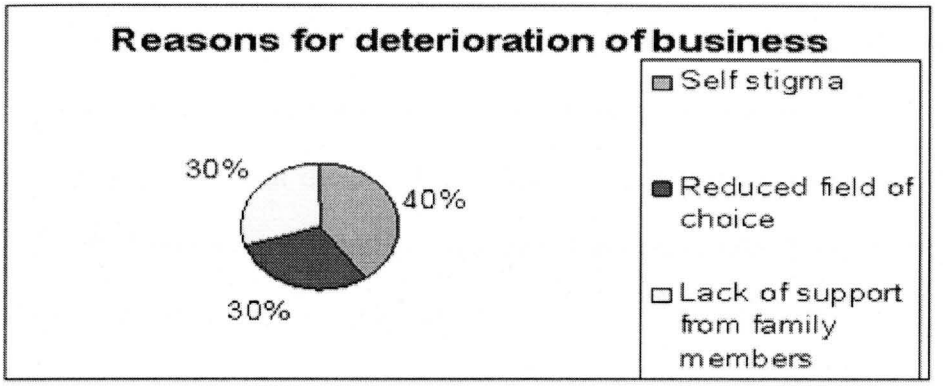
On the question intended to get information on which appropriate economic activities for PLWHA would be involved, the study revealed that most of WAYAWAVI members had changed their prior types of business. 45 per cent of them were working as peer educators to the community where they were getting some token

allowances from different organizations doing activities related to HIV prevention. These included Municipal AIDS activities co-ordination office, PASADA, SHIDEPHA+ and TACAIDS. 35 per cent of respondents were involved in mending and selling clothes while 20 per cent were working as fish/food vendors.

All respondents in food vending points complained over the community as experiencing stigma on their business and 80 per cent of others, who were doing other activities not related to food vending, also complained on stigma. On the question of how they had realized community members had stigma on their economic activities, they mentioned situations like avoid buying things prepared by WAYAWAVI. Some people used one's status to provoke them when there was a misunderstanding. Most of them also showed there was a very big economic variation status before and when the HIV status was known. 75 per cent of them have noted a very big difference because of the known status.

Thus, most of WAYAWAVI agreed that there was close relationship between stigmatization and deterioration of their business. The reason was unreliable health, which had reduced field of choice of business to engage with. This made 30 per cent of all respondents. Others complained of being weak to get involved in business. The other reason accounted for 40 per cent was self-stigma on which most of WAYAWAVI, after realizing their sero status, thought that they were not healthy enough to continue with their activities. Some of them also mentioned lack of support from other family members. For example, 30 per cent of the housewives were denied of their property rights and left helpless.

Figure 3: Reasons for deterioration of business



Source: Field Data and Consultations

1.4.4 Respondent (II): Community Members

This category of respondents had the following marital status groups. 69 per cent of both male and female were married, 19 per cent were single and 20 per cent widows. This indicated that most of community members were married couples. So when prevalence among this group increases, it is likely to be higher. A potential number of community members would be affected because of the dominant marital status in the area. The (Ministry of Health and Social Welfare Report 2006) indicated that 56 per cent of all infected cases were married couples. Among people interviewed gender balance was represented by 65 per cent female and 35 per cent male.

The literacy level in this study has been represented as follows: 94 per cent of community members were Standard Seven leavers. Such people should be able to correctly read, write and count. The ability to read, write and count increases with higher education starting with secondary education.

Community members perceived HIV/AIDS, as follows: 39 per cent believed that HIV is causative and a very bad disease without cure. This too promoted stigmatization because the infection was closely associated with sense of incurability and death; on the other hand, 72 per cent of the population had knowledge that HIV/AIDS is a normal disease. These figures reveal that the knowledge level of HIV/AIDS (definition) was still low and only 28 per cent could clearly define HIV as human immune deficiency syndrome.

The question weather community members had exposure to people living with HIV/AIDS intended to measure the magnitude of HIV prevalence in the area. About 83 per cent of respondents had relatives, friends or neighbours who were living with HIV. This showed that the prevalence rate was very high given the level of knowledge indicated in likelihood of stigmatization. Knowledge on HIV was still very low because most of community members were not willing to go for HIV testing. This made 89 per cent and left only 11 per cent who were willing to go for HIV testing.

About 78 per cent of the community members reported that they were not willing to go for HIV testing because of fear of being isolated, blood pressure, tension and lack of help from family and community members unless one could economically support him/herself because of expected level of stigmatization. Though 22 per cent of the total respondents were willing to go for testing, most of them were hesitant to reveal their test results. This indicated fear of stigma among community members.

On whether community members believed that people who were infected with HIV were responsible for getting infected, only 29.4 per cent supported the statement while 70.6 per cent were of the opinion that those infected were not responsible for this but it was an accident.

Level of stigma and discrimination was reflected in this study as 78 per cent of community members admitted that they thought one could get HIV infection through sharing spoons, plates, clothes, bathrooms and the like. Because 78 per cent were in fear of being transmitted and only 22 per cent did not fear and reasoned that there was no need of fear because that was not among ways which could lead to HIV transmission.

Contradictorily, the study also revealed that community members reported as 'not true' to say that most of the people, who were infected with HIV, got the transmission from their infected relatives. These accounted for 94.4 per cent and only 5.6 per cent agreed that transmission from infected relative was possible. On the question of how this was possible, 94.4 per cent of respondents agreed but said mainly through sexual intercourse.

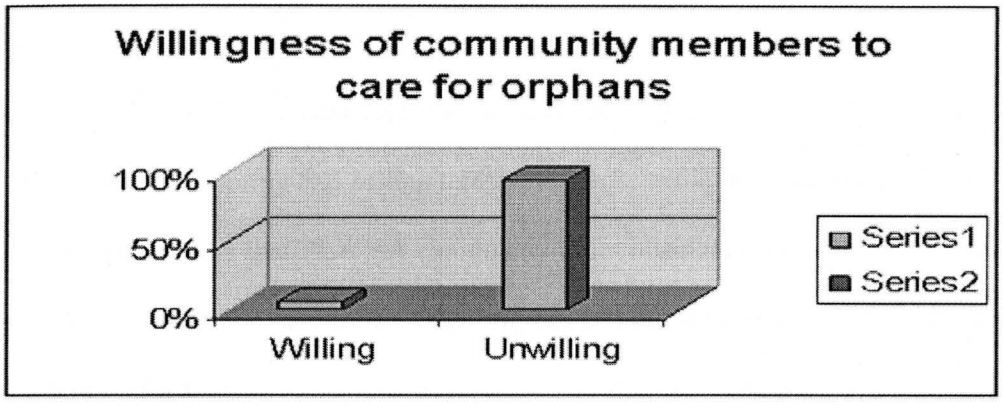
The study revealed that the community recognized socio-economic development and other contributions of people living with HIV. This composed about 61.1 per cent while 27.8 per cent were of the opinion that allocating resources to this group was costly, saying that 27.8 per cent HIV+ people had no life ahead and no one knew when these people would die. While 89 per cent reasoned that they should be given all the rights because they stand equal rights besides their HIV status. 61 per cent of

responses were that all community members deserve equal participation in social and economic activities, access to property and resources regardless of the overall HIV status.

Eighty-nine per cent of community members were opposed to the idea that HIV+ patients should be discharged from hospitals regardless of their general health status. This followed as soon as HIV tests results were out. This question was posed to gather information on community members' views in regards to minimized standards of services to people living with HIV in different service settings. This included services in health setting whereby most of the community members complained that their relatives were given substandard services after their HIV+ test results were out, while only 11 per cent were of the opinion that they must be discharged.

The study has also revealed that most of the community members were not willing to take care of orphans; as they would wish to care for their own children. The total responses of those who would not wish to care of orphans as own kids were 94.4 per cent of all respondents, while only 5.6 per cent were willing to care for the orphans.

Figure 4: Community willingness to take care of orphans



Source: Field Data and Stakeholders Consultations

This also offers contradictory information even though before it was revealed that 61.1 percent of community members were of opinion that all individuals deserve equal rights regardless of one's health status, the same community was not willing to support orphans as 89 per cent of respondents felt bad when sharing services with a person whose HIV status is known and only 11 per cent were not. 89 per cent of community members felt bad to eat food prepared by HIV+ people because they felt that in so doing, they exposed themselves to transmission. Others had different views. This supports the literatures that in most cases community members were not willing to buy foods prepared by people whose HIV status was known.

This is like one case in Angola in 2006 where people were not willing to get services from a tearoom operated by a group of women who were HIV+ as 89 per cent feared to be infected with HIV. Others accounted for 89 per cent

The question: What kind of activities do people, whose HIV status is known should be involved, intended to know what the community think was appropriate to this group. Most of them said PLWHA should involve themselves in activities not related to food vending. 77 per cent said they should take part in activities like decoration, selling clothes, tailoring and selling telephone cards, while the remaining 23 per cent were of the opinion that PLWHA can do any other business including food vending. All proposed activities are those, requiring big capital, a thing most of the PLWHA could not afford.

The people were also tested if they knew what stigma and discrimination was and the response was great. All respondents were able to mention some of stigmatizing actions and attitudes. 78 per cent defined discrimination as isolation while 11 per cent said it was a shame and bad thing which happen to a person with abnormalities or different features from community expectations.

At the same time all the respondents were able to mention some actions which discourage stigma and discrimination. Some of these actions were love and happiness. Another way was to give any assistance which could empower them like enrolling them to vocational schools, capital assistance and freedom of speech.

Another question was on whether there was a possibility of those who were HIV-positive to deliberately transmit the infection to others. 89 per cent accepted this and the remaining 11 per cent said the opposite. The reasons given were because of stigmatization. But the respondents were not happy with the idea of HIV testing to be made mandatory, saying that this was another way of stigmatization - people had

freedom of choice; they only needed to be sensitized on the need to go for HIV testing.

1.4.5 Observation Method

This is the methodology which involved the researcher to make physical visit to a study population and record information as they happen in their actual settings. This method was used in order to back up information collected by using semi structured questionnaire.

Key findings from this method

In this study observation was applied to all respondents looking at what one was saying if reflected the fact. It was revealed from their body language that 95 per cent of all community members' respondents had stigma to PLWHA though in their explanation some of the respondents discouraged stigmatization actions and attitudes. The method was also used to see ability and quality of service given to an orphan or a person who is HIV/AIDS infected by the caregivers at time of visit. The study revealed that 79 per cent of caretakers were trying their level best to make sure that they deliver required services and 21 per cent showed signs of being tired especially those taking care of clients with AIDS. When they were asked why the response was that it was an exercise that no one knew when it ends.

1.4.6 Documentary Review Method

This method is the collection of information which can be done through reading records. This can be literature, files, ledgers, attendance registers and others.

Key findings from this method

Reviewing secondary sources like documents, books, files and statistics was carried out by chairman of local government authority who provided data of orphans in the ward and Machimbo street, WAYAWAVI secretary provided data on both widows/widowers and number of orphans registered as WAYAWAVI members and from PASADA who are doing VCT in the area provided data on people's habits in getting VCT services. This method was used to collect information from counsellors that is PASADA and for validation purpose.

This was done to compare results obtained from interviews and observations like number of PLWHA who were ready to expose their HIV results with family members and number of people who did not fear to be given their HIV results. The study revealed that 86 per cent of all clients who went for test and found HIV+ were not ready to share the results with neither a family member nor a friend. When they were asked why, the y said that they feared to be pinpointed as people with problems who need to be isolated as this would damage their images in the community. It was also revealed that among one hundred community members who went at PASADA for HIV testing, 46 per cent of them were reluctant to take the results thinking that if they are found positive that meant the end of their social acceptance which would

lead into death. This indicated some levels of self-stigma among community members.

Up-take habits of VCT Services by Yombo Dovya Community Members

From the assessment it was realized from most of the counsellors' ledgers that most of Yombo and Temeke Community in general was very low on taking VCT services. It was noted that 70 per cent of community members, who went for the test, were those ones who had health problems for the past three to six months and a 69 per cent went for VCT after being advised by their doctors. Only 10 per cent could found HIV negative but the rest were found HIV positive. From the study it was revealed that though PASADA and SHIDEPHA provide care and support services to PLWHA, the up-take of services was little as HIV clients felt ashamed to be seen going to those facilities being visited by service providers from PASADA and SHDEPHA+.

Number of Orphans in the Ward/Street

From CNA it was noted that Yombo Dovya Machimbo Street had a total of 134 orphans. This gives an estimate of every house having 1 to 2 orphans, meaning every house had an orphan.

Number of widows/widowers and orphans by WAYAWAVI

From CNA it was revealed that the group members were as follows; 35 widows, 8 widowers and 93 Orphans. These were registered as members of the group. It was revealed that almost in each four houses, one house has a widow/widower or orphan.

1.4.7 Case Studies and Stories Methodology

This is defined as a technique for collecting information through examining historical and other records, literature and proverbs. The process used to undertake this method was to visit WAYAWAVI and made discussions with them then listened to their backgrounds this was also used to collect some data from caregivers, parents and guardians of orphans.

Key Findings from this Method

There were different factors mentioned in this assessment which contribute to widows, widowers and orphans. It was found that most of orphans found in such situation (orphans) because of HIV/AID. Also 98 per cent became widows and widowers after losing their spouses because of HIV/AIDS. From orphans the study revealed that some lost their parents due road and train accidents. 24 per cent and 86 per cent of them was because of HIV/AIDS.

> "...We used to live a happy life with our parents. Because of this deadly disease we are in this situation. In 1992 our father died after having diagnosed with TB. We were left with our mother whom we

lived together to 1995 when our mother also died because of pneumonia. Then during the burial of our mother, I heard our eldest aunt talking to his brothers that both our parents have died of HIV/AIDS." Quote from one of the orphans involved in this study.

1.4.8 Diagramming Method

This method involved key individual interviews focus group discussions and brainstorming. This method was used to track information like activity profile, daily routines of the host organization and also to see the trend of the problem. The researcher visited and held discussions with the host organization members in order to exactly establish WAYAWAVI activities and the findings were as follows: -

WAYAWAVI, being a group of people infected and affected with HIV, realized that there was a great number of PLWHA including orphans, who were real facing stigmatization. The group suggested having a project which could sensitize WAYAWAVI and community in general on HIV/AIDS-related stigmatization and discrimination, which could minimize social and economic problems to PLWHA. This would lead to happier and prolonged life to people in this group. WAYAWAVI wished to involve community at large in a fight against stigmatization. Since WAYAWAVI managed to minimize stigmatization among the group members but had done very little on community level.

During discussions with different WAYAWAVI members, it was revealed that they would not make any difference to community towards minimizing the problem. However, in appropriate matter of fact the group members (WAYAWAVI) had no skills and other supports which would lead to implementation of their thoughts. Therefore, there was need to sensitise the group members on HIV and its related stigma as this would make them know the concept and then reach the community on the street. As in the discussion, it was realized that most of WAYAWAVI members had reached Standard Seven with no any other additional profession with the exception of six members who reached ordinary level education with tailoring, cookery and business skills.

1.4.9 Research Methodology for Community Needs Assessment

During the community needs assessment, sample size comprising 13 respondents, who were WAYAWAVI members, four teachers and ten community members including guardians/caregivers. Different methods were used to collect needs assessment data for instance, semi-structured interviews and observation documentary review (Fink, 1985 and Mikkelsen, 1995) was used to collect some of the information from WAYAWAVI and guardians/caregivers. Diagramming method (Mikkelsen, 1995) was also used to track information like activity profile and daily routine of the host organization and also to see the trend of the problem. In this assessment, reviewing of secondary sources such as documents, books, files and statistics as described by Fink, 1985 and Mikkelsen, 1995 was also applied in data collection during the study.

1.4.10 Research Design for CNA

Research design used for the CNA was descriptive. There were different focus group discussions, case studies, diagramming from WAYAWAVI members as well as community members. Subsequently, in designing CNA, different secondary sources were used, such as going through WAYAWAVI records like attendance registers, types and frequency of support that had not been received by neither orphans nor windows/ widowers, as well as going through different literatures and documents which had similar information on HIV/AIDS-related stigmatisation issue in order to be more exposed in this area. Internet was also used to help in designing this project; as some of literatures were downloaded and read for this purpose.

1.4.11 Survey Instruments

Various instruments were used to collect information during the survey such as brainstorming, observation and semi-structured interviews were conducted through administration of questionnaires. These methods of discussion and interviews were used to collect data through focus group discussions and in-depth interviews with key informants. Secondary information was collected through records review. These methods were selected because different information was needed from different groups and sources.

The instrument used was semi-structured. Questionnaire was the main method through which most of information was collected. This was done in form of interview. With this instrument the data collector was able to:

To give introduction, this described what was to be done in the interview and for what purpose. Through this the person interviewed would be impressed with the importance of interview and give the information accordingly.

It allowed the data collector to give explanation or repeat a question to people who had problems in understanding, hearing, reading and writing etc

1.4.12 Research Questions

1) Can HIV/AIDS-related stigma and discrimination reduce the chances of disclosure?

2) Is stigmatization due to low understanding and ignorance on HIV?

3) Is stigmatization a function of denial of access of education, income and resources?

4) Is HIV/AIDS-related stigma and discrimination frustrating prevention, care and support efforts?

5) Does HIV/AIDS-related stigma and discrimination affect those who disclose their status?

1.4.13 Sample Size and Selection Criteria

The survey used random sampling to get a total sample of 50 people who were interviewed. This included WAYAWAVI and community members. Since

WAYAWAVI was a group in Yombo Machimbo community, the study had two kinds of samples. These included WAYAWAVI and community members. Some interviewees were included because of the importance of their positions and their connection to the survey

1.4.14 Analysis and Interpretation of Major Results

In analyzing data, the surveyor used SPSS that is descriptive statistics mainly including percentage. Use of percentage of responses to do analysis was due to the fact that this was useful in describing the spread of scores or views.

1.4.15 Presentation of Information

Results were presented in percentage of knowledge, choice, views, attitudes, beliefs, understanding perception and others, which show proportions of all responses as represented by respondents. So this allowed by a surveyor to compare views, knowledge, attitudes on HIV/AIDS and stigmatization related to the pandemic.

1.4.16 Eligibility for Participation in the Survey

Persons, who were eligible to participate in the study, first, were WAYAWAVI because they were the ones who were directly affected by stigma and discrimination related to HIV/AIDS. So through them the surveyor received first-hand information on the impact of stigma and discrimination. Second, were community members because they were the people taking care of the orphans and were also taking care of relatives, friends and neighbours who were living with HIV. These people had their

perceptions, attitudes and knowledge on HIV and how to live with people who were HIV+. The survey was descriptive.

1.4.17 Determining the Internal and External Validity of the Survey

Validity was ensured through use of interview, which was tested on its stability by being tested and retested to see if it gave the same information. Asking questions to the same group to compare the scores from both instruments, that is; too used concurrent validity by using self-administered questionnaire and also using the same questionnaire to administer interview. This convinced the surveyor that was able to get accurate information because when a respondent answered the question the surveyor was in a position to learn on facial expression, body language and the like. This was useful because the surveyor could link words and actions to get the correct answer. All these were done to make sure that the questions and answers gave the right information.

To come up with effects of stigma and discrimination related to HIV/AIDS to people living with HIV, the surveyor had also consulted a good number of literatures on different studies, which have been made on this phenomenon. Most of these have addressed social effects, stigma in health service settings, workplaces and on community effects related to HIV/AIDS stigma and discrimination although there might be some studies (out of my sight) on something related to this study. Thus, the researcher was convinced that this survey came out with some useful information.

1.4.18 Internal Validity

Since the survey used random sampling, that even for those groups or persons who were involved by virtual of their positions, were selected by the use of random sampling. Since random sampling was likely to give valid representation by giving equal chances to all population to be included in the sample. Though, the sample was small, yet it was also representative because of use of probability sampling.

1.4.19 Reliability

The survey used homogeneity to see if the survey results were reliable and consistent, use of SPSS, comparison of one surveyed group to another to check reliability of answers and usage of the survey. Because of probability sampling the survey expected errors of not more than 10 percent.

1.4.20 Validity

The questionnaires were given to a focus group just to see if respondents were able to understand the questions and give answers. This worked out well. Concurrent validity was done to compare responses and attitudes and content validity to see if questions given accurately represented the attitudes that they intend to measure.

1.4.21 Survey Sampling

The surveyor expected to have a total number of 50 respondents from whom 25 respondents were widows and widowers. The remaining were from other groups that

included 20 community members, including caretakers of orphans and 5 orphans aged 14-17 years.

1.4.22 Response Rate

The survey response rate was 88 percent and this has been possible as it was the random sampling and administered questionnaire through interviews to all respondents. The surveyor was able to choose another respondent in case of missing the first one. This was applicable to all respondents.

1.4.23 Number of Questions

Community members had a total of twelve questions to answer. This group was given that number of questions because in this case the community is expected to give valuable information since a survey seeks to know their attitudes, knowledge and perception, on HIV/AIDS, people living with the infection and their suggestions on how to address its related stigma and discrimination, which affects PLWHA.

WAYAWAVI members had only ten questions addressing on how to live positively with challenges of stigma and discrimination, what they refer to stigma and discrimination, what they thought led to stigma and discrimination and what kind of income-generating activities they thought could be feasible while working in environment of stigma and discrimination.

1.4.24 Psychometric Characteristics

In general some questions were open ended while others were semi open ended. The open-ended questions were on background information which included age, sex, marital status and gender. While Semi open ended had questions which needed a respondent to say Yes or No and these questions were followed by why, how, where, when and who that is how questions were combined in scale. This was done purposely to let the surveyor explore more information from the respondents.

1.4.25 Administration

There were two recruited administrators who were secondary school leavers. Both had good experience of working in this area because they have been working as casual data collectors at the T-Marc Research Unit for three years. These persons worked as administrators in administering the questionnaires. During collection of data both of them worked closely with ward authorities and WAYAWAVI. This made it easer for community members to accept the survey.

1.4.26 Quality Assurance

Assurance has been done through making sure that all of the data collectors reached the number of people assigned asked all relevant questions and spent time as planned. Others conducted face-to-face interviews to cover all who could not read or write and clearly understand the questions. Also this approach gave ample time of linking between words and actions or facial expression on the information given.

The collected information was validated by use of secondary data mainly from reports of providers of counseling and testing services.

1.4.27 Length of time for the Entire Survey to be completed

The survey was completed within 11 days from 1st March 2006.

List of relevant literatures and other surveys on the same survey

1) Stigma and discrimination related to HIV/AIDS in health setting by ENGENDER HEALTH in Angola 2002

2) Stigma, Discrimination and Attitudes to HIV and AIDS in India 2004

3) Fighting HIV/AIDS and related stigma to HIV/AIDS in China 2005

1.5 Graphical Content

The infection of women is catching fast in Sub- Saharan Africa and 77percent of those affected are female. There also 2000 cases of children under 15 years of age and about 12000 in ages between 15-49, 50 percent of them in ages between 15-24. (The Christian Science Monitor December 1st 2004. Most of them in Eastern Central and Southern Africa these include Sourth Africa, Tanzania, Namibia, Botswana, Swaziland, Lesotho, Zambia, Zimbabwe, Malawi, Congo, Brazzaville, Kenya and Uganda. The question comes why more women than men in African countries are HIV sero-positive. How HIV/AIDS is understood in various cultures and belief systems in tropical Africa? According to a report released by UNICEF at the end of

2003 11 millions in children under age of 15 have lost one or both parents to HIV/AIDS.

It is estimated by the end of the decade (2110) number is likely to have jumped to 20 millions. Carol Bellamy the executive director of UNICEF warned "They orphans are a crisis that is massively growing long-term problems and unless governments and the international community intervene. (Financial Times Friday January 23 2004). Young women too appear to be particularly at risk, partly because of the pressure they face from men. In sub Saharan African countries to have sex (Most unprotected) early with their peers as well as other men who believe that having sex with teenage girls reduces chances of contracting HIV/AIDS.

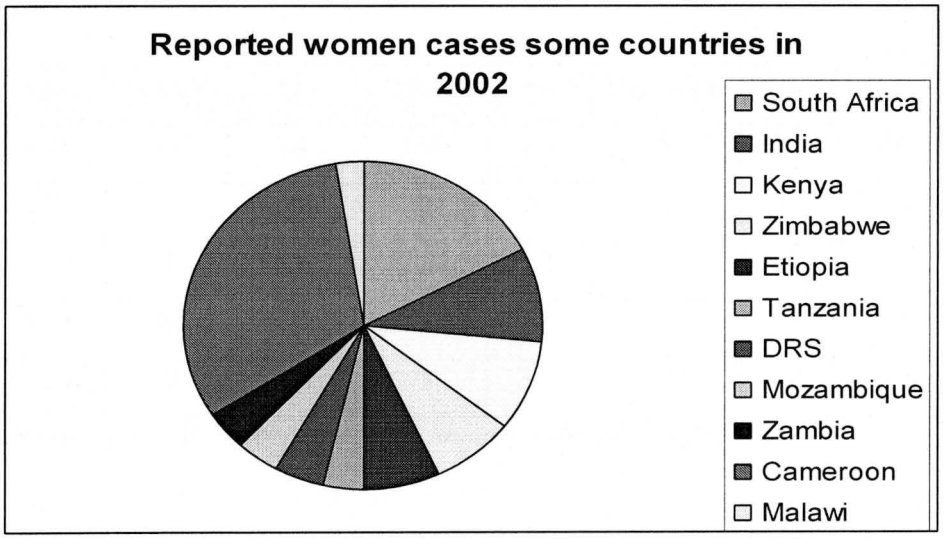
As pointed out earlier, the present knowledge on the spread of HIV/AIDS was very high as reported by many researchers (Tumbo-Masabo, 1996, Global AIDS epidemic, 2004 and Weiss, 1993). The gaps remain in understanding of HIV/AIDS prevention, especially with respect to male, female and adolescent girls. The researchers' contribution to this survey is not only academic but also work closely with WAYAWAVI and community at large in the struggle against HIV/AIDS-related stigma.

Despite political and social epidemic, women account for nearly half the 46 million people living with HIV worldwide. Women account for 47 percent, or nearly 17 million people of all HIV carriers worldwide compared to 25 percent in Latin America and 35 percent in Caribbean (ibid, 2004). In sub-Sahara, 57 percent of

adults with HIV are women, and young women aged 15-24 are three times as likely to be infected young men.

In African countries, women's lesser access to education and lower levels of illiteracy contribute to their more limited access to information about STDs and HIV (de Bruyn, 1992; UNAIDS, 1997). According to the UNDP Human Development Report (2002) HDI country rank for people living with HIV/AIDS, women percentage for the age group of 15-49, South Africa 2,700,000, India 1,500,000, Kenya 1,400,000,Zimbabwe 1,200,000, Ethiopia 1,100,000, Tanzania 570,000,DRC 670,000, Mozambique 630,000, Zambia 590,000, Cameroon 5,000,000 and Malawi 440,000

Figure 5: Distribution of reported women AIDS cases in some of the countries 2002



Source: United Nations Development Program Report 2002

These figures clearly demarcated that women need special interventions in the prevention in order to reduce the trend of infection. Indeed, AIDS is rooted in the dynamics of gender relations grounded in social behavior and social inequality. Property, illiteracy, gender discrimination, lack of access to correct and timely information, health services and violation of human rights all improved the transmission of HIV.

The table below shows that female aged between 15 and 19 years and 20 and 24 years have higher infection rate than male. This indicates that females have higher transmission rate than male in these age groups. Thus, the rate suggests that most individual acquire infection during the late adolescence, assuming a median incubation period of around ten years.

Table 2: Shows transmission rates between Female and Male by age.

Age	Female	%	Male	%	Unknown	%	Total	%
0-4	126	3.4	166	5.4	9	0.2	310	4.4
5-9	71	1.9	73	2.4	1	0	145	2.1
10-14	28	0.8	38	1.2	1	0	67	1
15-19	96	2.6	51	1.7	5	0.1	152	2.2
20-24	539	14.7	78	5.8	11	0.2	728	10.6

Source: NACP Report Number 17: January-December 2002

Please *note; that the unknown represents people who could not be easily categorized by gender because of nature of names*

Temeke Municipal Council AIDS co-ordinator report on World AIDS Day 2005 shows that the HIV spread is going up. It shows the number of voluntarily tested people and their results - the trend of five years. This was from December 1, 2006.

Table 3: Summary of people reported to receive VCT services and their results

Year	Counselled	Tested for HIV	Tested Positive (HIV)	%
2000	6,112	6,112	1,611	26
2001	8,235	8,235	2,060	25
2002	10,451	7,838	3,543	45
2003	14,978	11,897	5,157	43
2004	20,562	20,562	7,780	38
2005	13,071	12,100	6,224	51

Source: The Temeke Municipal Council AIDS Co-ordinator World AIDS Day Report

The Council, in collaboration with CCBRT, has helped about 456 people living with HIV in Temeke receive different services, including ARVs on which 192 were men and 264 were women.

AIDS crisis increases poverty, it thrusts households back on ever more limited resources as it removes wage earners from employment, reduces the ability to engage in smallholdings or agricultural work, deflects resources to medicines and healthcare and draws down on savings or capital (Kelly, 2000). The situation is worsened through the reduction of employment opportunity as industries adjust to its impact, and the decline in economic growth through the loss of skilled human resources and the use of resources for consumption rather than production and investment.

CHAPTER TWO

Problem Identification

This chapter presents on information collected from the target community identified and the problem, which needs to be worked on. In order to minimize the level of stigma to the target group, WAYAWAVI have formed a group, which would enhance their fight against stigma. The group's purpose was to identify ways, which would minimize the level of stigma among themselves and the community surrounding them. Group members were responsible to console each other and to take care of any member who needed assistance. This approach was expected to go through and transform the entire community of Yombo Machimbo.

This has been partly successful at WAYAWAVI; they have been able to console each other and give assistance to any group member who was in need. As for the community there had been efforts to reduce stigma but were not successful. The failure was due to lack, of moral, human resources, material and financial support and other resources.

In an attempt to fight against the problem WAYAWAVI collaborates with partners, community and other interested institutions with combined efforts to reduce stigmatization. The main intervention was the community sensitisation programme, which created awareness to community members on HIV/AIDS and related stigma and discriminations to PLHAs. Its objective was to ensure that at least 70 percent of the community members were reached and informed on the theme by the end of

September 2007. This would be obtained through different activities like training, workshops, film shows, public address announcement, community meetings and non-stigma promotion events.

The benefit of this exercise would be realised that after the community being sensitized stigma would decrease from the current level of over of 95 to 25 percent. In sensitizing the community all the WAYAWAVI members were reached. The members, ranging between fourteen years and above have been trained and equipped with knowledge of HIV and related stigma, which would help them minimize self-stigma. Fifteen peer educators, who were also working with PASADA, attended two-day in-class training and incorporated in implementation of the project. It was expected that these peer educators would continue working with some of project partners and collaborators and other interested partners on areas of HIV/AIDS.

Since peer educators were trained and oriented to work, as volunteers they would be ready to work with different programmes on HIV and stigma related. Community sensitisation programme so far conducted in six streets and community members have received the first round sessions. By the end of the project the group and community in general will be having knowledge on stigma concept and be able to mention some basic things which discourage stigma. WAYAWAVI would engage in micro-economic activities and get support from community members as the level of stigma would be minimized. It was also expected that during the period under review of the project implementation, WAYAWAVI would receive elementary financial management skills to manage the money generated out of their business. Another activity was that all the widows would be trained on income-generation activities and

linked to SIDO, the organization that supports different communities in the country by giving small grants and loans with a reasonable interest rate.

The community would receive information at once through the use of influential people like political leaders, Members of Parliament, counsellors and religious leaders, as these people were vital for its sustainability.

Others were health providers within the community locality, herbalists and teachers of both primary and secondary schools. All community members were involved in any relevant activities.

Stigmatization therefore would be minimized through implementation of vigorous sensitization programme on HIV/AIDS to different groups and community members in general would be transformed from the perception that interacting with PLWHA is not exposing one to the risk of being transmitted. Inclusion of income-generating activities to WAYAWAVI was vital as it has been realized from community members, WAYAWAVI and literature that if PLWHA are not economically sound, they increase the level of stigmatization and the vice versa is evident.

2.1 Identification of the Problem

Based on the needs mentioned in the community needs assessment different problems/needs were mentioned. However WAYAWAVI suggested that the problem of stigmatization should be given the first priority for the reason that number of people infected and affected was rampantly increasing. The survey revealed that there were 35 widows, 8 widowers and 134 orphans in the street during the survey.

The widows, widowers and orphans in Yombo Dovya Machimbo are facing self-stigma and stigma from community members. The roles and responsibilities of different stakeholders are well defined and known in Yombo Dovya and no efforts have been done to identify and/or establish a project that will address this gap.

The Tanzania Government Policy discourages stigma and dissemination related to HIV/AIDS. However there are situations where this is not possible due to low knowledge on HIV/AIDS, which exists among Tanzanians. The Problem of HIV/AIDS related stigma seem to go in pace with the prevalence increase. Although there are efforts, bylaws and guidelines of handling people infected or affected with HIV, stigmatisation is still persistent as results this situation creates problems to the affected groups and community in general like increase of transmission that is mother to child transmission, poor uptake of VCT services school dropouts, commercial sex works and street children. This situation has great impact on the future generation as well as the government expenditure to infected and affected people. Yombo Dovya Machimbo does not differ from other wards in Temeke Municipal in the country or elsewhere with high prevalence rate. Yombo Dovya suffers from an increase of PLWA including orphans. Based on information collected it is almost every family has an orphan and in every four households one has widow or widower this indicates fast growing number of PLWHA, affected number of people and increase in related stigma.

2.2 Statement of the problem

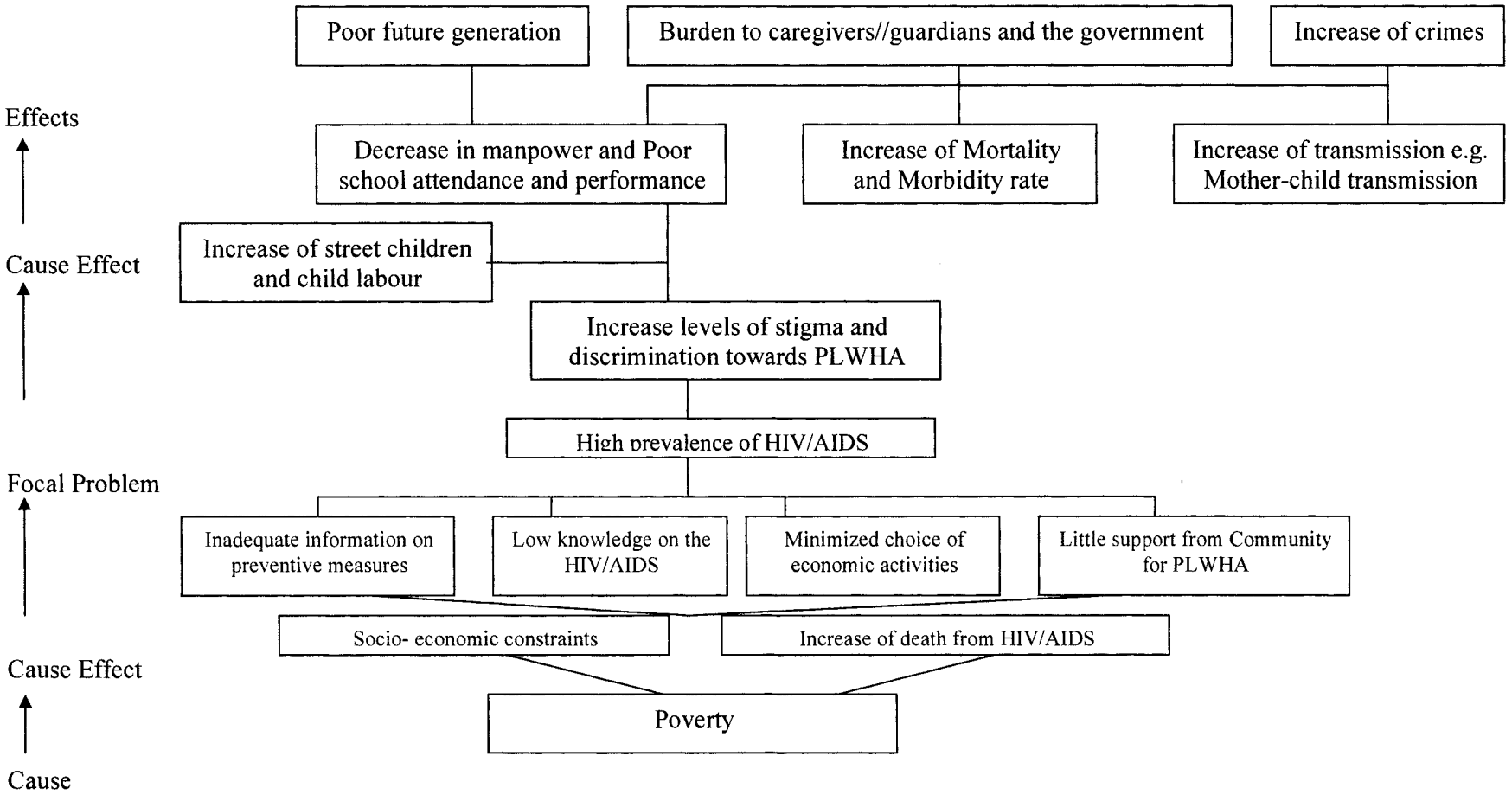
Community assessment revealed that stigmatisation related to HIV/AIDS is rampant within community members. The widows, widowers and orphans in Yombo Dovya Machimbo are facing self-stigma and stigma from family and community members. The roles and responsibilities of different stakeholders are well defined and known in Yombo Dovya and no efforts have been done to identify and/or establish a project that will address this gap. So the programme of community sensitisation, which was on progress, was in line to real meaning of WAYAWAVI group.

2.3 Problem Tree

There were various causes and affects mentioned during the problem identification, which resulted to an increased number of PLWHA and orphans. Inadequate knowledge on HIV, low education levels that led to prostitution, mother to child transmission, blood transfusion family disintegration and poor social services. Major causes mentioned in this particular case included an increase in poverty, which has direct link with socio-economic constraints and increased death from HIV/AIDS. This situation contributes to child labour, street children and increased number of PLWHA. Eventually; this problem increases social discouragement, burden to caregivers/guardians, and loss of national manpower as well as poor future generation. The community members needed to be transformed to have positive attitudes to PLWHA. The most effected group involved people who were living with HIV in general and particularly women and orphans. Stigmatization was due to low knowledge the community had on HIV transmission and prevention. If the problem

remained without immediate measures it would have led to more transmissions, more orphans, poor acceptance of voluntary counselling and testing services and likelihood of the increase in number of women involved in commercial sex works.

Problem Tree



2.4 Target Community

Target community is the group(s) of people who are involved in the project as beneficiaries based on the goal and objectives set for the particular project.

The following tables show the degree of participation that the target community had in this project. It also shows how individual target community were empowered and transformed by the project.

Table 4: Degree of participants

Target Group	Degree of Participation	Contribution to the Project	Project Empowerment	Project transformation
WAYAWAVI	High	• WAYAWAVI participation and willingness to provide information and testimonials	Psychologically, Socially	Built sense of being cared, loved and felt as part of the entire community
Guardians/ caregivers and Community	High	• Provision of information, willingness, sharing of ideas • Actively attend sessions and give testimonials	Social exposed, Support initiative	Able to interact and share ideas.
Political, religious, teachers,	High	• Worked as change agents • Willingness to	Of the a two days in class training on the main aspects of	Built a sense of taking the fight as their social

Target Group	Degree of Participation	Contribution to the Project	Project Empowerment	Project transformation
(Influential) people)		use their influence in changing the community outlook.	the project	responsibility
Two Peer educators from each street	High	• Willingness too be the main presenters during sensitisation • Willingness to create awareness trough house to house visit, seminars and camp sensitization	Received two days in class training	Empowered to present the required information

Source: Field data and Consultation

Stakeholders are individuals or group of individuals with a direct interest or stake in a particular sector/program/project (Chikati). Stakeholders can also be defined as individuals, group of individuals, or institutions that are important audience, client groups, beneficiaries, supporters or investors in the organization (CEDPA, 1999). These can be found within and outside the community. The following table shows a list of stakeholders and their roles in the project.

Table 5: Roles of Stakeholders

Stakeholder	Roles
Yombo Machimbo Community	• Participated in sensitisation sessions on HIV/AIDS and related stigmatisation • Participation and providing information
Temeke Municipal AIDS Coordination Office	• Supported WAYAWAVI initiatives by providing contributions in different forms • Conducted sessions on HIV/AIDS • Ensured availability of preventive measures as well as well being of PLWHA
WAYAWAVI	• Worked as change agents and as role models during sessions on fight against stigmatisation.
Yombo Ward (LGA – Local Government Authorities)	• Supported WAYAWAVI initiative • Created political willingness environment for the project
CBOs these are PASADA and SHIDEPHA PLUS and TACAIDS	• Contributed/Supported (in any form) to the project and shared experience • Provided voluntary counselling and testing services (VCT) • Provided ARVs services • Provided IEC materials these were brochures, leaflets and posters on HIV/AIDS and stigmatisation
Marie Stopes, PSI and T-Marc	• Ensured condom availability by opening more outlets stocking condoms • Conducted sessions and events aiming at promoting proper and consistence usage of condoms. • Ensured availability of reading materials on HIV/AIDS and preventive measures

Source: Field data and Consultation

2.5 Project Goal and Objectives

2.5.1 Project Goal

The project goal was to improve social economical situation of WAYAWAVI

2.5.2 Objectives of the Project

2.5.2.1 Overall Objective

To minimize stigma and discrimination related to HIV/AIDS in Yombo Machimbo neighbourhoods which would lead to harmony, improved economic status, care and support to WAYAWAVI

2.5.2.2 Specific Objectives

1) Mobilize human and financial resources to be used in implementation of the sensitization. program

2) Identify strategies for empowering WAYAWAVI guardians and caregivers and community in general in order to support WAYAWAVI

3) Increase levels of uptake of VCT and ARV services due to minimized level of stigmatization.

4) To sensitize community on importance of supporting WAYAWAVI as well as project initiatives

5) Sensitize influential people and the entire Machimbo community and ensure that there is a good level of community transformation on the outlook towards WAYAWAVI.

6) Improve the group performance in conducting sensitization and education campaigns against stigmatization.

7) Ensure that WAYAWAVI are provided with appropriate information on HIV/AIDS and related stigma and provided with training this will improve their economic status.

8) Ensure that the project involves all stakeholders for its sustainability

2.6 Host Organization

WAYAWAVI was the main implementer and host of the project. It was established in 2005 with the mission of fighting stigma by performing sustainable work in collaboration with community and other organisations in delivering consolation, home based care and legal services among the group members and the surrounding community. Its vision was to ensure that PLWHA are living in a stigmatization free zone and respectively getting all of their rights.

The group faced financial problems because it had no financial sources therefore it did not own any bank account. It depended much on the group member's volunteering to perform different activities. Because of financial problems, this entailed the likely hood of most activities to be highly affected. Thus one would try

to value energy and time spent voluntarily to perfume the group's activities and spending the same resources to perform individual activities. The chances were that most of members would prefer to involve in individual activities. Since the group belonged to the same community, it stood the better chances of getting support from community members. The group also interlinked with other government and other non governmental organisations like Yombo Local Government Authority, Temeke Municipal AIDS coordination Unit and health office. Others partners were PASADA and SHIDEPHA PLUS provided VCT, and ARV services. T- MARC, Marie Stopes, and TACAIDS these organisations had different roles in the Ward and the Municipality in general.

CHAPTER THREE

Literature Review

This chapter presents on what theorists have said on HIV, its essence, stigma in general, causes of stigma, stigma related to HIV/AIDS and why stigma related to the disease. Another part is imperial literature, which gives detailed information on what others who have done studies related to the subject, said with examples of HIV/AIDS-related stigma in different settings like at family level, working place and community. There are also a good number of testimonials from people who have faced HIV/AIDS-related stigma from different environments. Finally, is policy literature whereby the study has been able to see exciting international and local policies to safe guard those who belong into stigmatized groups.

3.1 Theoretical Literature Review

3.1.1 What is HIV/AIDS?

AIDS is caused by infection with a virus called human immunodeficiency virus (HIV). This virus is passed from one person to another through blood-to-blood contact and mainly through sexual intercourse.

As an independent AIDS organization founded in 1986, AVERT has taken a dedicated interest in the ongoing debate about what causes this condition. As well as investigating the harmony position, we have followed and carefully considered the

arguments of the dissenter minority who claim that HIV is harmless or even that it might not exist. Different theorists have given their views on HIV/AIDS.

3.1.2 The Hunter Theory

The most commonly accepted theory is that of the 'hunter'. In this scenario, SIV was transferred to humans resulted from chimps killed and eaten or their blood getting into cuts or wounds of hunters. Normally the hunter's body would have fought off SIV, but on a few occasions it adapted itself within its new human host and become HIV-1.

An article published in 'The Lancet' in 2004, also shows how retroviral transfer from primates to hunters is still occurring as of to date. In a sample of 1099 individuals in Cameroon, they discovered that (1 percent) were infected with SFV (Simian Foamy Virus), an illness which is similar to SIV, was previously thought only to infect primates. All these infections were believed to have been acquired through the butchering and consumption of monkey and chimpanzee meat. Discoveries such as this have led to calls for an outright prohibit on bush meat hunting to prevent simian viruses being passed to humans.

April 2001 it was announced that no trace had been found of either HIV or chimpanzee SIV. A second analysis confirmed that only macaque monkey kidney cells, which cannot be infected with SIV or HIV, were used to make chat. While this is just one phial of many, most have taken its existence to mean that the OPV vaccine theory is not possible.

3.1.3 HIV/AIDS Prevalence rate among Women

Women and young people are especially vulnerable HIV infection levels tend to be higher among women than men. The proportion of adults living with HIV/AIDS who are women is approximately 58 percent. Young women are especially vulnerable for biological, cultural and social reasons. In general, many Tanzanians with HIV/AIDS female and male first become infected during adolescence. (Tanzania and HIV/AIDS, 2004)

3.1.4 HIV/AIDS and Related Stigmatization

Around the world, HIV/AIDS is emotionally highly associated with fear, stigma and discrimination; misunderstanding, myths and mistreatment are outcomes of sense of panic that surrounds HIV/AIDS. Again talking or having discussions on long life and life treating illness is stressful and disturbing to the community. As community members it is important to be aware of these feelings, thoughts and attitude about HIV/AIDS otherwise there will be strong effects out of the situation as time suggests.

Some highlights of stigmatisation attitudes, behaviour and action in community include blaming those who are infected with HIV by associating the infection with social unwanted behaviour, health workers try to minimize standards of service to people who belong to stigmatized group. Others are family members or relatives who share test results to other people without patient will employers who demand testing conditions as the prerequisite for getting job and other services. Habit of segregating

HIV patients in special beds or wards while there is no need for that and discharging HIV patient regardless of their overall health status.

Stigma is harmful because it can lead to feelings of shame and guilt to people living with HIV/AIDS. It can cause individuals to be isolated, and it can cause them to do things, or omit to do things, that harm others or deny others services or entitlements. People living with HIV/AIDS have been segregated or ill-treated in schools and hospitals; refused employment or offered inferior types of employment, denied the right to marry and find a family; required, when returning to their national country to submit to an HIV test, denied the right to return to their national country on suspicion of being HIV-positive denied visas or permission to enter when seeking to travel to other countries, and attacked, wounded or killed because of their sero positive status.

Stigma, which is HIV-related, refers to all unfavourable attitudes, beliefs, and policies directed towards people perceived to have HIV/AIDS. This also affects their loved ones, close associates, social groups and communities. Patterns of stigma which include devaluing, discounting, discrediting and discriminating against the affected groups this strengthens existing social inequalities especially those of gender sexuality and race. These are at the root of HIV-related stigma by Evving Goffiman (getceusnow.com/portal/file/aid.com) in his research and his book on Landmark Book on Stigma (1963) described stigma as an attribute deeply discrediting within a particular social interaction.

This shows public attitudes towards "people/person who has attributes that are different from social expectation is reduced in our minds from a whole and usual person to attained discounted one" and continued to clarify that stigma is divided into abominations body that is various physical deformities and blemishes of individual character that is weak, ill, mental disorder, imprisonment, addiction, homosexuality and unemployment. Other lines of stigma are tribe stigma of race, nation and religious beliefs that are thought lineage and equally contaminate all members of a family (Link and Phelam 1965).

Stigma is a process, not a thing. Stigmatization describes a process of devaluation that involves the identification of 'undesirable differences' the creation of 'spoiled identities', processes of distancing and of personal and societal denial. It is also the process by which people place themselves outside the epidemic, seeing them as somehow protected and quite unlike those who are stigmatized (Cheney and Smith 1999).

They continue that diseases associated with the highest degree of stigma share common attribute in the community that the population with diseases is seen as responsible for getting the illness. That it deserves that punishment because of the associated behaviour, the disease is progressive and incurable, the disease is not well understood among the community members and the symptoms cannot be hidden. Therefore people infected with HIV are often blamed for their condition and many people think that HIV can be avoided if individuals make better moral decision. Second is that, HIV is untreatable, and it is nevertheless a progressive and incurable disease it fits qualities of problems with stigma. Many people in community poorly

understand HIV, which causes them threatened of just presence of the disease and HIV related symptoms are gross, ugly and disruptive in social relations and interactions (Stoddard 1994).

But again stigma does not come naturally; rather individuals who generate stigma as response to their own fear create the situation. This result to the affected people to be forced to leave their homes, lose their jobs or be subjected to violent assault. HIV-related stigma affects activities related to HIV prevention including resistance to testing, which leads to further transmissions of HIV like mother-to-child transmission and individual's responses to testing HIV positive (Cheney and Smith 1999).

The fear of being stigmatized because of HIV/AIDS has some relationship to people's decision about being tested for HIV. One-third of the population responded that they do not prefer to be tested because of what community members will think of them. This confidentially played a roll in their decision not to have the test. A Keiser Health Poll report (2000).

In the research done to have the test to bisexual men who were unaware of their HIV status, two-thirds of the participants expressed fear of discrimination against people with HIV and that was the reason for not volunteer testing (Stall at el 1996). There are also reports of severe psychological responses to notification of being tested HIV+ including denial anxiety, depression and suicidal (Cheney and Smith 1999).

Stigma and discrimination related to HIV/AIDS as a core business issue has led to different groups, organizations, community and profit-making organizations. To find ways of dealing with the problem it is important to make efforts to fight the spread of the disease in the working environment. UNAIDS has made stigma and discrimination the theme of its 2002-2003 World AIDS Day. It briefs its member companies on issues relating to stigma and discrimination and negative impact to companies without HIV/AIDS programmes. Stigma and discrimination enables spread, which has been unchecked over the last 20 years. UNAIDS characterizes HIV-related stigma as devaluation of those living or associated with the epidemic and it defines the discrimination as the unfair and unjust treatment of an individual based on real or perceived status. Stigma and discrimination associated with HIV/AIDS is one of the greatest barriers of preventing further infections and to accessing the care, support and treatment services for PLWHA to live productive lives.

For example, even in Tanzania there are companies with this policy of HIV testing with good reasons that the company would wish to know its peoples health status so that positive people are given special consideration during placement and assignment allocation. But the fact is that, instead of those reasons, when one is found positive is not given the offer. This can be used as a factor for redundancy or low consideration in case of any development including career development. A rational policy on this would be testing new employees after they have gone through the probation period and demonstrated ability to work for the position this would prove that the testing is for good intention.

Stigma reduces the labour supply, as qualified and able workers fall out consideration as a result of discriminatory hiring and promotion practices. In a survey conducted, in Trinidad and Tobago it was found that 50 percent of HIV-positive persons do not apply for employment because they fear discrimination and feel they will not be hired based on their employment HIV testing as is permissible by law and commonly practised in many companies.

Tanzania and HIV/AIDS (2005) journal shows that in its research at least one out of nine adults is HIV-positive. Among women attending different antenatal care clinics on the mainland 9.69 percent tested HIV-positive 1000 women. In the journal it also indicates that HIV infection continues to be higher among women than men. It is approximately 58 percent of the proportion of women in adults living with HIV/AIDS because of biological, cultural and social reasons while men are at 42 percent.

The journal also indicates that AIDS-related deaths have increased the number of orphans. By December 1999 about 960,000 children lost their fathers; 525,000 lost their mothers and 165,000 lost both parents, so with this trend the community needs to be sensitive on HIV and stigma because the number of orphanage doubled between 1996 and 1999. The prevalence rate too indicates increase of the epidemic that among 15-24 age brackets as of 2001, Dar Es Salaam had 10-19 percent among 100 people who donated blood. When coming to knowledge among community genders, women tend to be less knowledgeable than men. Because women who felt risk of HIV infection in 1989 (539), 1996 (439), differently from men.

The level of stigma is also higher because most of Tanzanians are not sure that sharing plates with a person with AIDS is safe 59 percent of women and 64 percent men in population researched. There is also little condom use among regular partners. In 2002 about 24 percent women and 35 percent men had used the condom. This indicates that women prevalence rate will continue to be higher because few of them use condoms as one of the methods of HIV/AIDS prevention and few of them know where to get condoms – 53 percent were women while men 72 percent. Again there are a few women who can ask to use condom - women 49 percent and men 56 percent. Women think that a person who looks unhealthy is the one who is HIV/AIDS infected and the opposite is safe.

ENDENDER HEALTH Angola (2001) reveals that women are loosing their jobs, getting off their homes, women are being blamed by the community or women are being beaten by their husband because of HIV infection in the family even though the essence of transmission is not hers but she has only become a scapegoat.

The United Republic of Tanzania, Prime Minister's Office National Multi-Sector Strategic Framework on HIV/AIDS (2003-2007) has the following on stigma and discrimination that political leaders, public programmes, projected and international campaigns should address stigma and discrimination and promote the request for human rights of persons living with HIV/AIDS with an indicator of number of high events and programmes, projects, and international campaigns having anti-stigma and anti-discrimination measures. This is very important because looking at the epidemic trend, Temeke Municipality declaration on extensive programmes on stigma and discrimination related to HIV/AIDS is inevitable.

Stigma and discrimination can arise from community-level responses to HIV and AIDS. The harassing of individuals suspected of being infected or of belonging to a particular group has been widely reported. It is often motivated by the need to blame, punish and in extreme circumstances can extend to acts of violence and murder. Attacks on men, who are assumed gay, have increased in many parts of the world, and HIV and AIDS-related murders have been reported in countries as diverse as Brazil, Colombia, Ethiopia, India, South Africa and Thailand (P.T Thomson 2003)

In December 1998, Gugu Dhlamini was stoned and beaten to death by neighbours in her township near Durban, South Africa, after speaking out openly on World AIDS Day about her HIV status.

3.1.5 Causes and Effects of Stigma

In the context of the global epidemic, the causes of stigma are many, including lack of understanding of HIV/AIDS, myths about the transmission of HIV, chauvinism stemming from initial reports of infection among socially marginalized groups, lack of availability of treatments for HIV, irresponsible media reporting, the fact that AIDS is incurable; social fears about sexuality, and fears related to illness and death.

Over time studies have shown decrease in severe reactions to being notified of positive test results. But at each level a decision to disclose sero positivist may either enhance access to support and care or expose a person to potential stigma and discrimination. Ideation Coates et el 1987 Ostrow at el 1989 and Chesney and Smith 1999 Another writer adds that, members of community do fear to get tested because

of this explanation (Weinborger 1992). HIV/AIDS-related stigma and discrimination are the greatest barriers to preventing the spread of HIV, to providing adequate care, treatment, and support, and to alleviating the impact of the disease.

To address HIV/AIDS-related stigma and discrimination, there is a need to do three things to prevent HIV/AIDS-related stigma from forming; challenge HIV/AIDS-related discrimination where it occurs; and challenge and equalize the human rights violations that follow from such discrimination. All these can be obtained through community sensitisation because this will address misconceptions and lead to PLWHA a more reproductive life.

While HIV/AIDS-related stigma is immediate, its origins lie deep within the society. It plays into, reinforces, and reproduces existing social inequalities. Therefore, tackling stigma involves dealing not only with its surface manifestations, but also its roots. From studies done, over twenty years of experience has shown that there are clear links between HIV/AIDS-related stigmatization and sexual, gender, race, class relations and divisions in society.

Too frequently, women, commercial sex workers, homosexuals and black people have been blamed for causing the epidemic. AIDS is widely perceived as disease of "others", of "outside". This is reflected in outwardly contradictory sets of statements such 'AIDS is a Western disease' and 'AIDS is an African disease', or 'AIDS is a women's disease' and 'AIDS is caused by men' etc. Factors, which contribute to HIV/AIDS-related stigma, are a life-threatening disease. People are scared of contracting HIV. The disease is associated with behaviours (such as homosexual and

injecting drug-use). These groups by virtual of their behaviour are already stigmatized in many societies. People living with HIV/AIDS are often thought of as being responsible for becoming infected, religious or moral beliefs lead some people to believe that, having HIV/AIDS is a result of moral fault such as promiscuity or 'deviant sex' that deserve to be punished.

Stigma, discrimination, and negative attitudes to HIV and AIDS of infected people have been trends. Earlier, during the AIDS epidemic, a series of powerful images were used. This reinforced and legitimized stigmatization as HIV/AIDS was a sort of punishment (e.g. for immoral behaviour), HIV/AIDS as a crime (e.g. in relation to innocent and guilty victims), HIV/AIDS as war (e.g. in relation to a virus, which needs to be fought), HIV/AIDS as terror (e.g. in which infected people are demonized and feared), HIV/AIDS as affliction of those set apart.

Together with the widespread belief that HIV/AIDS is shameful, these images represent 'ready-made' but inaccurate explanation that provide a powerful basis for both stigma and discrimination. These stereotypes also enable some people to deny that they personally are likely to be infected or affected.

Stigma is a powerful tool of social control. Stigma can now be used to marginalize, exclude and exercise power over individuals who are in the category. While the societal rejection of certain social groups (e.g. 'homosexuals, injecting drug users and commercial sex workers') may predate HIV/AIDS, the disease has, in many cases, reinforced the stigma. By blaming certain individuals or groups, society can excuse itself from the responsibility of caring for and looking after such groups. This

is seen not only in the manner in which 'outside' groups are often blamed for bringing HIV into a community, but also is how such groups are denied access to the services and treatment they need.

There is almost hysterical kind of fear at all levels, starting from the moment scientists identified HIV/AIDS, social responses of fear, denial, and stigma and discrimination have accompanied the epidemic. Discrimination has spread rapidly, fuelling anxiety and intolerance against the most affected groups.

Across the world the global epidemic of HIV/AIDS has shown itself capable of triggering off responses of compassion, solidarity and support, bringing out the best in people, their families and communities. But the disease is also associated with stigma, oppression and discrimination, as individuals affected or believed to be affected have been rejected by their families, their loved ones and their communities. This rejection holds as true in the rich countries of the North as it does in the poorer countries of the South.

Sexually transmitted diseases are well known for triggering off strong responses and reactions. In the past, in some epidemics, for example TB, the real or supposed contagiousness of the disease has resulted in the isolation and exclusion; 'Debbie' speaking to the National AIDS Trust, UK, 2002 httt://www.avert.org/aidsstigma.htm

Stigma lowers workforce morale and diminishes interest at the working place. In the working environment the attitudes of fellow workers can also have negative impact.

Employees were more concerned about stigmatization by colleagues than about discrimination from their employers, more than 90 percent of employees agreed that community members will point a finger at them and gossip, whereas 23 percent would lose their jobs if are tested positive (A.P Stewart 2005).

3.1.6 Forms of HIV/AIDS-related Stigma and Discrimination

In some societies laws, rules and policies can increase the stigmatization of people living with HIV/AIDS. Such legislation may include compulsory screening and testing, as well as limitations on international travel and migration. In most cases, discriminatory practices such as the compulsory screening of 'risk groups', both further the stigmatization of such groups as well as creating a false sense of security among individuals who are not considered at high-risk. Laws that insist on the compulsory notification of HIV/AIDS cases and the restriction of a person's right to secrecy and confidentiality, as well as the right to movement of those infected have been justified on the grounds that the disease forms a public health risk.

There is a need to look at the importance of human rights. Stigma, discrimination, and Human rights violations form a vicious cycle. Stigma causes discrimination; discrimination leads to violations of human rights; human rights violations legitimize stigma; and the stigma leads to more discrimination.

HIV-related stigma and discrimination remains massive and barrier to effective fighting of the HIV and AIDS epidemic. Fear of discrimination often prevents people from seeking treatment for AIDS or from admitting their HIV status publicly. People with (or suspected of having) HIV may be turned away from healthcare services, employment, refused entry to foreign country. In some cases, they may be expelled from home by their families and rejected by their friends and colleagues. The stigma attached to HIV/AIDS can extend into the next generation, placing an emotional burden on those left behind.

3.1.7 The Way Forward

Denial goes hand in hand with discrimination, with many people continuing to deny that HIV exists in their communities. Today, HIV/AIDS threatens the welfare and well being of people throughout the world. At the end of 2005, 40.3 million people were living with HIV or AIDS and during the year 3.1 million died from AIDS-related illnesses. Combating the stigma and discrimination against people who are affected by HIV/AIDS is as important as developing the medical cures in the process of preventing and controlling the global epidemic.

So how can progress be made in overcoming this stigma and discrimination? How can we change people's attitudes to AIDS? A certain amount can be achieved through the legal process. In some countries people who are living with HIV or AIDS lack knowledge of their rights in society. They need to be educated so that they are able to challenge the discrimination, stigma and denial that they meet in society. Institutions and other monitoring mechanisms can enforce the rights of people living

with HIV or AIDS provide powerful means of mitigating - the worst effects of discrimination and stigma. However, no policy or law can alone combat HIV/AIDS related discrimination.

The fear and chauvinism that lies at the core of the HIV/AIDS discrimination needs to be tackled at the community and national levels. A more enabling environment needs to be created to increase the visibility of people with HIV/AIDS as a normal part of any society.

3.2 Empirical Literature

In a study done by ENGENDER HEALTH in Angola (2002) shows that only 40.2 percent knew that HIV virus could be tested 48.8 percent know that shaking hand with HIV+ person does not transmit AIDS, and 50 percent people knew that working, eating with HIV+ person cannot spread the virus. Many people (59.8 percent) were not willing to work with people who are HIV-positive. Only 17.1 percent knew that there is a possibility of reducing mother-to-child transmission.

In 2005 UMLEF Dr. Harch supported the production of a manual for medical students to teach them to be respectful in treating patients especially HIV/AIDS patient, where the doctor insisted on slowing stigma by putting more efforts to services like home care to the patients, the psychological support and nursing care to the end of life.

The doctor continued by explaining that society ignorance has led to people living with HIV to form separate social groups because they do not only suffer from the diseases associated with HIV/AIDS only but also stigma and isolation. "I real see a massive awareness campaign needed". He again sees that the most affected group is women who face most discrimination.

Another example of fighting against stigma and discrimination in HIV/AIDS is in China where vice-president's speech and the Ministry of Health are currently doing something about the elimination of HIV/AIDS-related stigmatization. Stigma seriously affects the population, which belongs to the infection, and hence barrier to fight spread of the disease. HIV/AIDS-related stigma is a global issue, so it still remains an important thing to fight against in response to HIV/AIDS and therefore China has done the following: Political commitment, law enforcement, government policy, social marketing and community mobilization.

Case study - What Happened in Uganda by Green, E. Nantuya, V Stoneburner, R and Stover, J. 2002 considered Uganda to be one of the world's earliest and best success stories in overcoming HIV. Uganda has experienced substantial declines in prevalence, and evidently incidence, during at least the past decade, especially among the younger age cohorts. The decline is attributed to a number of factors including high level of political support, decentralized planning and implementation of behavioral change communication (BCC). Interventions addressed women and youth, stigma and discrimination, involvement of religious leaders and faith-based organizations; effective voluntary counseling and testing and effective management of sexually transmitted infections were also considered.

On political commitment the Chinese President, Hu Jintao, visited HIV/AIDS patients in Youan hospitals. This reflects that the entire population needs to be full of love to HIV/AIDS-positive population because this may prolong their lives. The Chinese Premier, Wen Jiabao, had Spring Festival Lunch with HIV patients and their families and took photographs with AIDS patients and orphans.

All these programmes in China have led by policy which has dramatically reduced stigma and discrimination in the community, parents of children from families which have negative attitude now allow their children to play with children from families with HIV/AIDS and the study shows from 2003 people have knowledge about HIV/AIDS, they are less afraid of people caring HIV.

In Hubey many villagers came to the teashop that is operated by people with HIV/AIDS to drink tea. This suggests that use of social marketing to improve HIV/AIDS-related issues remain an important tool to fight HIV/AIDS by ensuring distribution of protective measures including condom distribution accompanied with behaviour change communication to promote consistence use of the measures. China also invited HIV-positive people to join the team, which was made with a purpose of increasing knowledge and show possibilities of living longer with HIV. These were arts and sports people such as Cunxin Pu, Wenli Jiang, Yao Ming and Magic Johnson as public figures of HIV awareness creation.

3.2.1 Women and Stigma

The impact of HIV/AIDS on women is particular acute. In many developing countries, women are often economically, culturally and socially disadvantaged and lack equal access to treatment, legal and financial support and education. In a number of societies, women are mistakenly perceived as the main transmitters of sexually transmitted diseases (STDs).

Together with traditional beliefs about sex, blood and the transmission of other diseases, these beliefs provide a basis for the further stigmatization of women within the context of HIV and AIDS. HIV-positive women are treated very differently from men in many development countries. Men are likely to be 'exempted' for their behaviour that resulted in their infection, but this is not the case to women.

An Albania woman, Luiza, who fights HIV/AIDS-related stigma and discrimination, lost her husband of AIDS and she is positive along with her three kids except, the elder one.

This was reported in UNICEF Real (2003) that people do not want to talk about death from HIV and sex because it combines the two of the greatest taboos which go together or seem to have close relationship. This is also a recommended approach to fight stigmatization in community. Children too are not left behind as a result of mother-to-child transmission. When kinds are sick mothers are obliged to leave work and take care of their sick kids. "Luiza was forced to quit her job as finance manager to take care of her children while leaving alone".

The whole idea of being unemployed mother is an independent and potential problem to sustain the family. Stigma continues to reflect bad impact and social acceptance to people living with HIV in the community. "I remember the hesitant look of the nurses, and was like we were death for them, even the cleaning lady refused to clean the room where my children were admitted". In the majority of developing countries, families are the primary caregivers to sick members. There is clear evidence of the importance of the oral support that the family plays in providing support and care for people living with HIV/AIDS. However, not all families' response is positive.

Infected members of the family can find themselves stigmatized and discrimination against within the home. There is also mounting evidence that women and non-heterosexual family members are more likely to be badly treated than children and men." My mother-in-law tells everybody; 'Because of her, my son got this disease. My son is a simple as good as gold, but she brought him this disease". In a study done in India in 2001 on HIV-positive women aged 26, it shows that the husbands who infected women, many abandon them living with HIV or AIDS.

Rejections by wider family members are also common. In some African countries, women, whose husbands have dies of AIDS-related infections, have been blamed for their deaths. HIV-positive mothers of three abandoned by her husband because of her infection status "My mother-in-law has kept everything separate for me - my glass, my plate - they never discriminated like this with their son.

"By Children Rights Information Networks, October 24, 2006 millions of children already orphaned or infected by the disease were being overlooked as governments and donors drew up strategies to fight HIV and AIDS. This oversight was hobbling the development of some of the world's poorest countries, it said. The number of orphans will continue to rise for at least the next decade and progress in education, health and development will remain a distant dream," said Esther Guluma, head of UN children's fund (Unicef) in West and Central Africa. Even if the number of new HIV/AIDS infections among adults were to peak today, the number of orphaned children would continue to rise because it took around a decade from the time of infection for a person to die, Guluma (2004) said.

By UN Integrated Regional Information Networks, October 27, 2006 awareness of the AIDS pandemic is generally high in northern Uganda, but the message has not hit home with some men, who are still too afraid of the stigma against the disease to seek treatment. Charles Odong, who works with Meeting Point, a local non-governmental organization (NGO), said women made up about two-thirds of their patients and were generally more willing to volunteer to be tested for HIV.

A counselor attached to the AIDS clinic at St Joseph's, Beatrice Opira, confirmed that far more women volunteered for HIV testing than men. "Men still seem to be greatly affected by stigma, and do not want to be seen openly going for testing," she said.

> "I discovered I was HIV-positive last year when I got very ill," Said Lucy Lalam, in her early twenties.

> "My husband knows my status but has refused to go for testing - he keeps putting it off and I'm worried he will get sick and die soon if he doesn't get treated."

Sylvia Ocan says her husband abandoned her and their two children, and married another woman when he found out she was HIV-positive, accusing her of having been unfaithful. He died about a year later, never having been tested.

Source: http://allafrica.com/stories/200610270884.html

St. Paul's Trust of India, saving lives of PLWHA need empathy, not sympathy, spoke Dr. KI Jacob at the 1st National Conference of the AIDS Society of India 2005. Dr Jacob told participants that helping patient's live healthy and meaningful lives was the best thing healthcare providers could do.

Dr Jacob, the person, who founded St. Paul's Trust in 1991, works with organization in Samalkot, India. The Trust takes care of more than 5,000 HIV-positive people, including 220 HIV-positive children and close to 6,000 children of people living with HIV/AIDS. The challenge is to ensure that they are able to live their life which is productive, with dignity, and without stigma or discrimination.

At the Trust, children are not required to work. Instead, they study in public schools. The school administration, students and families receive intensive sensitization to HIV/AIDS issues, so the children can study in an environment free from stigma and discrimination. Out of the 220 HIV-positive children, 100 are studying in the lower grades at school.

St Paul's Trust also promotes income-generation programmes (IGPs). To do this, people with HIV/AIDS are provided with between 500 and 5,000 rupees (between 12 and 115 US dollars) to start various kinds of small-scale businesses. Not all people living with HIV/AIDS are able to endure heavy agricultural labour work, so alternative IGPs are extremely important to allow them to sustain themselves with dignity. Some of the Trust's beneficiaries engaged in selling milk, fish and flowers, while others collected plastic and other old bottles for recycling, mobile pet business, which are small 'general stores', and opened mini-hotels.

The people who have been helped report little stigma or discrimination. But the main challenge, says Dr Jacob, is not only helping start small-scale enterprises, but in sensitizing the community enough that the products or services will be bought. Income generation programmes are a form of occupational therapy, because they help to restore and maintain people's sense of worthiness. Culturally, this is also appropriate because bread-winners will benefit from more respect at home and within the community.

Another example of IGPs is the 25 young people living with HIV/AIDS who volunteered as 'positive speakers'. These speakers have made a big difference in addressing stigma and discrimination within the region. They have also promoted the formation of Coastal Network of Positive People (CNP+), now a completely independent network directly supported by the state AIDS Control Society and Family Health International.

A key lesson to draw from these experiences is how crucial it is to work with local government administrations and to sensitize them towards HIV/AIDS. Dr Jawahar Reddy, district collector is now highly supportive of initiatives geared towards improving care and support facilities for people with HIV/AIDS. Very recently he gave a part-loan-part-grant of 15,000 rupees (345 US dolars) to 200 Dalit women living with HIV.

Dr Eddy has also helped improve the access of the poorest people, especially those living with HIV, to government help schemes. Another example of a good return that sensitization to HIV/AIDS of officials can have, Dr Reddy invited over 100 HIV-positive women to his bungalow last World AIDS Day, and his family had breakfast together with them. Such gestures go a long way to addressing stigma and discrimination.

Reducing stigma in the healthcare setting is also crucial to effective support for people living with HIV/AIDS. It took Dr Jacob more than five years to sensitize the staff of the 900-bed Kakinada General Hospital, so they could provide good quality, appropriate healthcare to people with HIV with no stigma or discrimination.

To do this, Dr Jacob invited groups of hospital staff to interact with people with HIV/AIDS, so they could understand care and support issues. Empathy, not sympathy will help the world understand that people with HIV/AIDS can and should live dignified, productive lives. This report was written at the 1st National Conference of the AIDS Society of India, held in New Delhi, April 2-4, 2005.

The need for people living with HIV/AIDS to participate in the process of designing HIV/AIDS prevention programmes was stated repeatedly throughout the conference. Paradoxically however, people living with HIV/AIDS are often reluctant to become involved because of the pervasive HIV/AIDS-related stigma and discrimination that adversely impacts their health and social well-being. Support for PLWHA is directed by ethical guidelines to provide health and care services to those living with and affected by HIV/AIDS - especially persons who are marginalized and/or poor- and ensuring that services are accessible to all without discrimination according to age, gender, life-style or economic status.

3.2.2 Employment

While HIV is not transmitted in the majority of workplace setting, the supposed risk of transmission has been used by numerous employers to terminate or refuse employment. There is also evidence that if people living with HIV/AIDS are open of their infection status at work, they may as well experience stigmatization and discrimination by others.

> "Nobody will come near me, eat with me in the canteen, nobody will want to work with me, I am an outsider here," said HIV-positive man, aged 27 in India.

Pre-employment screening takes place in many industries, particularly in countries where the means for testing are easily available and affordable. In poorer countries screening has also been reported as taking place, especially in industries where health benefits are available to employees. Employer-sponsored insurance schemes

providing medical care and pensions for their workers have come under increasing pressure in countries that have been seriously affected by HIV and AIDS. Some employers have used this pressure to deny employment to people with HIV or AIDS. "Thought we do not have a policy so far, I can say that if at the time of recruitment there is a person with HIV, I will not take him. I will certainly not buy a problem for the company. I see recruitment as a buying-selling relationship. If I don't find the product attractive, I will not buy it." Reported from The Head of Human Resources Development, India (2002).

The Department of Health developed an action plan and welcome comments especially from people living with or affected by HIV as follows. The action plan sets out a clear concern and sets an agenda. All suggested interventions are relevant and valuable.

Intervention (i): The Dissemination of Information

The college welcomes the intention to review and update the health promotion tool kit. It would be helpful to give a clear deadline for this exercise to occur, and indicate what aspects to stigma and discrimination should be addressed.

Intervention (ii): Acquisition of Skills

The suggested production of a guide to rights and entitlements of people with HIV is an essential and highly relevant component of the action plan. Its format, structure and production will require careful consideration, as will need to address issues of language and methods of dissemination.

Intervention (iii): Counselling Approaches

Currently, the action plan indicates the importance of counselling being available. It would be appropriate to ask the commissioners of sexual healthcare in local Primary Care Trust to ensure that appropriate counselling for stigma and discrimination issues is made available.

Intervention (iv): Greater Involvement of People Living with HIV

The report correctly outlines the opportunities for those living with HIV to have input into the development and commissioning of services. Greater involvement of people living with HIV in a wide variety of groups is a key to reducing stigma, and the Department of Health may wish to consider commissioning research into the current barriers to such participation and how these barriers may be overcome.

Intervention (v): Challenging Discrimination

It may be difficult for individual to know where to start when they feel they may have suffered discrimination. It would, therefore, be important to ensure clear guidance for a user of services on what to do and where to go if an individual feels they have suffered from discrimination, although it has achieved clear distinction between HIV-related strategy and relevant other strategies. Nevertheless, it would be right to include other policies, such a social inclusion, narrowing health inequalities and empowerment of excluded people; and human rights. The document should also link HIV-related stigma and discrimination to relevant client groups. In addition other groups are students, women and refugees. Finally, in referring to other strategies, those carrying blood born viruses, injecting drug users and former drug

users will be in need of opportunities to access services, and should be aware of opportunities set out in the action plan.

To implement the following Aspects are important: -

1) Services investment – in design of services, integration with appropriate generic services including primary care and local specialist services that invite easy access, good means of care, adequate training opportunities for health professional staff, local audit and action on user perspectives, emphasis on holistic care, and continuity across the service and geographical boundaries.

2) Engagement with the media, a subject which is almost entirely missing in the plan, with specific action points to monitor and challenge media treatment that encourages HIV-related stigma and discrimination, to influence current affairs and agendas, such matters as soap story lines and mass circulation editorial policy.

3.2.3 Healthcare

Many reports reveal the extent to which people are stigmatized and discriminated against by healthcare systems. Many studies reveal the reality of withheld treatment, non-attendance of hospital staff to patients, HIV testing without consent, lack of confidentiality and denial of hospital facilities and medicines. Stigma, discrimination and attitudes to HIV and AIDS, the heads of departments that makes them pathologically, scared of having to deal with an HIV-positive patient. Wherever they

have an HIV patient, the responses are shameful" - A retired senior doctor from a public hospital, currently working in a private hospital in India.

A survey conducted in 2002, among some 1,000 physicians, nurses and midwives in four Nigerian states, returned disturbing findings. One in 10 doctors and nurses admitted having refused to care for an HIV/AIDS patient or had denied HIV/AIDS patients admission to a hospital. Almost 40 peer cent thought a person's appearance betrayed his or her HIV-positive status, and 20 percent felt that people living with HIV/AIDS had behaved immorally and deserved their fate. One factor-fuelling stigma among doctors and nurses is that fear of exposure to HIV as a result of lack of protective equipment. Also at play, it appears, was the intention of not having medicines for treating HIV/AIDS patients, who therefore were seen as 'doomed' to die.

Lack of confidentiality has been repeatedly mentioned as a particular problem in healthcare settings. Many people living with HIV/AIDS do not get to choose how, when and to whom to disclose their HIV status. When surveyed recently, 29 percent of persons living with HIV/AIDS in India, 38 percent in Indonesia, and over 40 percent in Thailand said their HIV positive status had been revealed to someone else without their consent. Huge differences in practice exist between countries and between healthcare facilities within countries. In some hospitals, signs have been placed near people living with HIV/AIDS with words such as 'HIV-positive' and 'AIDS' written on them.

3.2.4 Responding to Stigma and Discrimination

In developing a response to HIV/AIDS-related stigma and discrimination, we first need to carefully understand about what HIV/AIDS-related stigma and discrimination are, where they come from, and what they do. Then we need to understand the connections between HIV/AIDS-related stigma and discrimination, and human rights violations.

The United Nations Declaration of Commitment on HIV/AIDS is an important tool around which to organize our work. We need to act in each of the key areas identified in it: Education includes formal and non-formal like community sensitisation, inheritance, employment, social and health service, prevention, support and treatment, information, and legal protection.

3.2.5 Examples of Concrete Steps that should be considered are:

1) Awareness campaigns to help people understand the unfairness and injustice of stigma and discrimination.

2) Good and quality education in and out of schools to provide people with the facts and to change attitudes and behaviour.

3) Ensuring that treatment, prevention, care and support services are accessible to all.

4) Leadership and commitment on the part of politicians, church leaders, sports, personalities, movie stars, and others to challenge HIV-related discrimination, spearhead public action, and act against discrimination.

5) Involving people living with HIV/AIDS fully in the response to the epidemic.

6) Monitoring human rights violations and ensuring that people are able to challenge discrimination and receive redress national administrative, judicial and human rights institutions.

7) Training for healthcare workers and others in situations where stigmatisation and discrimination have been found to be prevalent.

8) Activism and grassroots organized by people living with, and affected by, HIV/AIDS.

3.3 Policy Review

In Tanzania there exist multi-sector strategies to prevent and control HIV/AIDS which explains on doing extensive education and social marketing treatment, provision of care to HIV/AIDS patients and protect positive people's rights in the fight against HIV/AIDS. At national level HIV/AIDS prevention and treatment conference made on June 20, 2005 emphasized on taking care of PLWHA.

With a theme of one care policy (Asia Society Fighting against stigma and discrimination of HIV/AIDS) made law in 2004 "Laws or Prophylaxis in China and treatment of communicable diseases in peoples of China. This was the first Law in

China to eliminate social discrimination against people with infectious diseases. This reflects how China cares for its people and protects the legal rights of the infected ones.

3.3.1 Care of People Living with HIV/AIDS

3.3.2 Objectives

The main objective is to promote appropriate nutritional, social and moral support to People Living with HIV/AIDS (PLHA) to enable them to enjoy a good quality of life, remain productive and live much longer with the HIV/AIDS. It is a challenging area considering the absence of established modalities and mechanisms to provide such support. The community, NGOs, CBOs, private sector and religious groups are critical in facilitating this intervention. As VCT momentum increases there will be hundreds of thousands of PLHAs who will need support. The policy states as follows;

1) PLHAs shall have access to holistic healthcare. This includes clinical, medical care, counselling and social welfare services. Healthcare shall extend beyond the hospital confines to include planned discharge and back up for home-based care.

2) PLHAs shall have access to counselling as well as access to information on how to live positively with HIV/AIDS while protecting themselves and others from further transmission.

3) PLHAs shall have the responsibility to participate fully in the activities of the community.

4) Institutions and community care providers have a duty to care for people infected with HIV without discrimination on the basis of their HIV sero-status.

5) Institutions shall provide quality care following existing institutional care guidelines and treatment guidelines issued by the government.

6) Home care and hospital care complement each other. There shall be a strategic plan articulating this complementary relationship with a budget for each component in the local government councils.

Source: The Prime Minister's Office, National Policy on HIV/AIDS (Dodoma November 2001)

The government currently drafts the first HIV/AIDS Act in which it clearly states the rights of HIV infected people and their family members that should be protected, meaning that not to suffer any discrimination as a result of being HIV+. Secondly, provision of free ARV drugs to AIDS patients who are living in rural or have financial difficulties though in urban. Thirdly, is free ARV to women who are infected to control mother-to-child transmission, HIV testing to newborn babies, free schooling for orphaned by HIV/AIDS. Care and economic assistance to the households of people who are HIV, that HIV+ are given necessary economic support and those who are able to work are encouraged to be productive so that they can

increase their income. We should say that poor understanding of HIV/AIDS is the primary factor and cause of fear and stigma.

Freedom from discrimination is a fundamental human right founded on principles of natural justice that are universal and perpetual. Recent resolutions of the United Nations Commission on Human Rights (2003) made it clear the term or other status in the various international human rights. Instrument should be interpreted to cover health status, including of those living with HIV/AIDS; and that discrimination on the basis of AIDS or HIV status, actual or presumed, is prohibited by existing international human rights standards. Therefore, discrimination against people living with HIV/AIDS or those believed are infected, is a clear violation of their human rights.

Stigma threatens employee's health and entails lose of the potential benefits of a company some companies report that even when they have established HIV polices that people can get treatment services, a key challenge is encouraging employees who are infected to make use of these services. Fear of stigma discourages employees from learning and treating their condition because of concerns on confidentially or privacy of service delivery.

Role of business and non-business firms in combating discrimination at workplace has vital contribution to fight against AIDS. There is a range of responses that the business sector can take to fight against AIDS-related stigma and discrimination at workplace. The ILO Code of Practice on HIV/AIDS advocates that even minimum employers should implement HIV policies to ensure there is no discrimination

against employees based on real or perceived HIV status, and to ensure employee confidentiality. In establishing non-discriminatory workplace policies, ILO 2002 sends a strong message to governments and other sectors to implement these policies as well as fostering a more supportive workplace, the adoption of non-discrimination policies is a clear public commitment that helps counter, fear and stigma that still typically hinders communities' responses to the epidemic.

To be effective, HIV non-discrimination policies need to have the active endorsement of management regionally, centrally and nationally. To enhance its non-discriminatory policies consumer products manufacturer, Unilever Limited (2001) has developed a manager's training programme to reach out to high-level staff and ensure that operational decision-making works both to upgrade employee rights and combat HIV related stigma and discrimination at the workplace.

The management team feels it is very important for workers to see this commitment believing to go far in developing mutual trust between employers and employees and facilitating an environment where people are willing to undergo voluntary HIV testing and possibly disclose their HIV status.

Similarly, UK headquartered Standard Charted Bank (SCB) (2000) has developed a roadmap programme management which requires the company board to be fully informed and involved in strategic decisions relating to the HIV policy. (SCB) also ensured Board level involvement in their programme through training of HIV champions who lead policy implementation in their capacity as managing directors and vice-presidents at national level operations.

The involvement of trade and employee representatives in the formulation of policies has been important in ensuring employee support. Many mining companies operating in South Africa have worked in teams with local trade unions when developing their non-discrimination policies. The AngloGold (2000) policy, for example, was developed in agreement with five United Nations recognizing that HIV/AIDS poses a threat to the employees, their families, communities, company and its stakeholders. 'As part of the policy the company, in partnership with training department and workers associations will develop and maintain responsible and effective programmes to minimize impact of HIV/AIDS on all its stakeholders. This is one of the examples that many companies can copy as social responsibility to make intervention in the fight against AIDS spread and harmony creation to workers who already belong into this group.

While having the general aim of tackling HIV/AIDS-related discrimination, non-discrimination policies need to be adapted to comply with national legislation and judicial decisions. Petroleum companies established their policies regionally to account for such differences. The company's policy on HIV/AIDS for the Africa region and at any operational site need to be more specific this implies that, in response to HIV-related stigma and discrimination should start at grassroots to national levels to make a feasible fight. As it is for the Zimbabwe Ministry of Natural Resources (2003) has an HIV policy in which issues of stigma and discrimination related are well-covered including provision of protective measures like ensuring availability of condoms, increase knowledge on availability of ARVs.

This policy is implemented from unit level with three to five employees to the ministry level.

The establishment and implementation of a non-discrimination policy is the cornerstone effective HIV workplace programme, underpinning campaigns to promote the take-up of voluntary counselling and testing as well as treatment. Non-discrimination policies are an entry point around HIV/AIDS and should be viewed as the foundation for a larger HIV/AIDS response reach and comprehensive designed workplace programmes can support effectiveness of policies. These counter misperceptions, change negative attitudes of employees and subscribe their families and local communities.

Typically, comprehensive workplace programmes concerning discrimination, awareness and prevention, voluntary counselling and testing, care and treatment are vital HIV fight interventions. Many such company policies have first been developed by subsidiaries in heavy regions before being rolled out company-wide. This sustained efforts to tackle stigma at workplace, foster prevention and treatment efforts in the HIV/AIDS response. Companies and their leadership also have the opportunity to develop innovative strategies on stigma and discrimination far beyond the workplace both through programme implementation and direct advocacy.

1) Corporate policy and company branding, Apparel manufacturer, Levi Strauss, Foundation (1999) promotes non-discrimination practice that benefits employees and organization in general. Workers are encouraged to protect the rights of those with real or perceived risk for contamination; they are also

linked to their global brand to HIV/AIDS as part of a campaign to raise awareness more broadly to epidemic.

2) High-level advocacy is also of great importance, Christopher Kirubi, CEO of Haco Industries (2001), a leading company products manufacturer in Kenya, completed an HIV diagnostic test on national AIDS day and sent the message that he did not fear any association with HIV and also encouraged workers to get tested and learn their status.

3) Community partnership, Tata Iron and Steels India (2001) response to HIV/AIDS is a continuum between the community and the workplace. They take their awareness on discrimination efforts into the surrounding community by actively working and promoting the well being of high-risk groups.

Therefore, enhancing the role of business in tackling stigma and discrimination is critical to reduction of HIV/AIDS. In partnership with NGOs and government, the business sector can also effectively extend the reach of its programme to benefit local communities and greater political commitment to uphold the rights of people living with HIV/AIDS.

The need for action to tackle the stigma associated with HIV was identified in the India National Strategy for Sexual Health, and HIV in 2001 a commitment to publish an HIV stigma action plan was made in the strategy's implementation action plan in 2002. During the interim period, while this action plan has been in development, things have not stayed still. The National AIDS Trust undertook the 'Are YOU HIV intolerant?' campaign, and more recently the development of resources for health

workers and employers. Stigma and discrimination have featured explicitly in a wide range of guidance, recommended standards and good practice for those working in the HIV field, including the Recommended Standards for NHS HIV services.

Perhaps as a response, numerous countries have now enacted legislation to protect the rights and freedoms of people living with HIV and AIDS and to safeguard them from discrimination. Much of this legislation has sought to ensure their right to employment, education, privacy and confidentiality, as well as the right to access information, treatment and support. Governments and national authorities sometimes cover up and hide cases, or fail to maintain reliable reporting systems. Ignoring the existence of HIV/AIDS, neglecting to respond to their needs with HIV/AIDS 'can never happen to us' are some of the most common forms of denial.

These denials fuel AIDS stigma by making those individuals who are infected to appear exceptional.

The United Nations Programme on HIV/AIDS (UNAIDS) described the conceptual framework of the 2002-2003 World AIDS Campaign, whose theme was 'HIV/AIDS-Related Stigma and Discrimination', and whose slogan is 'Live and Let Live'. In this article, Peter Aggleton provides a conceptual overview of the relationship over the stigma and discrimination associated with HIV and AIDS and the human rights violations that ensue from them, with the goal of demonstrating the interconnectedness of these concerns. He also provides some examples of concrete steps that can be taken to counter the stigma, discrimination and human rights violations.

CHAPTER FOUR

Implementation

This chapter presents on the actual implementation of the project, achievements realized and expected ones. These are presented as project outputs; like number of community members who were consulted and were to be consulted before the end of the project. Others are project implementation plan showing activity, objectives, responsible person, indicators, resources are also presented. Inputs required in performing planned activities budget, and staffing patterns, which shows every person responsibility from the target group to community members.

4.1 Product and Output

In any performed activity results are expected to be realised at the end. For the purpose of this project the following expected to be achieved after two years

1) To reach a total of 5,950 (70 per cent) of Yombo Dovya community member with information on HIV-related stigma through providing education sessions, promotion events and distribution of Behaviour Communication Change reading materials.

2) Involve by 95 per cent of collaborators and partners who were identified to be carrying activities related to HIV/AIDS who would perform different roles in the implementation of the project.

3) Link by 100 per cent widows and widowers with institutions like SIDO and government agency that offers grants and loans. These are given to different community groups for small income generation activities at a reasonable interest rate. Others are non-governmental organisations like; T-Marc, Marie Stopes and PSI Tanzania who have different social marketed products like condoms, water treatments, treated nets and other services. These products are useful to WAYAWAVI as will protect them against related diseases like malaria and others. WAYAWAVI can also get some income through selling these products because can access them at a lower price that will give them a reasonable margin after resell

4.2 Project Planning

Project planning for this survey took place at the beginning; different components of the project were accorded with time duration to be accomplished depending on the nature of the activities in specified components. Components with many activities were accorded with more days so as to be accomplished. Planning is done in order for a project or program to achieve its objective (s) within a specific period in the community. That means there should be system or directives set for implementation. It should also specify the objectives, activities, period of time, responsible person as well as the resources to be used in implementing the project. The use of Ghant chart was used to locate time duration per activity.

4.2.1 Project Planning and Implementation

The table below describes the whole plan and implementation of the project of WAYAWAVI initiatives for orphans, widows and widowers at Yombo Dovya. It indicates activities, period and budget set as well as responsible person for the activity implementation.

Table 6: Shows the Projected Implementation plan

Objective	Activity	Indicators	Data source	Methods/Tools	Person Responsible	Budget Tshs	Comment Budget	Timeframe
To minimize level of stigma by 90% by	Sensitisation sessions to: - - Train peer educators - Train local cutting - Train teacher - Train authorities - Train WAYAWAVI	- 5000 people to be trained. - 14 peer educators trained. - 90% teachers to be trained - 100% collaborators trained. - 100% orphan from 14 & above	- Authority - Local Authority - Local Authority - Local Authority - WAYAWAVI - WAYAWAVI - Local Authority - Local Authority - LA / WAYAWAVI	- Presentations, stationery, brochures and leaflets - Trainers - Trainers - Trainers - Trainers	SHIDEPHA + PASADA TACAIDS, PASADA Do Do Do Do D0 Do CED Student	5000,000	Allowance to trainers and WAYAWAVI	Train by 2007 Sep. 2005 Sep. 2006 Apr. 2007 Aug. 2006 Apr. 2007 Sept.2006 Sept 2006 May 2006 May 2006

Objective	Activity	Indicators	Data source	Methods/Tools	Person Responsible	Budget Tshs	Comment Budget	Timeframe
	- Train Orphan - Train political leaders - Train Guardians - Train religious leader.	trained. - 100% political leaders trained. - 100% orphans guardians Trained. by 95% - 95% re	- Municipal Medical Office - Local Authority	- Trainers - Trainers - Trainers				Nov. 2006
Get 95% of WAYAWAVI involved in income generation	- Training WAYAWAVI - Train orphans aged 14 and above.	95% of widow/widowers are involved in income generations	To be determined	Training manual Training manual	SIDO. SIDO/ Marie Stopes, T-Marc and PSI	1000000	Refreshment to attendees Printing of learning materials	March 2007
Getting WAYAWAVI financial Assistance	-Proposal writing -Visiting different agencies	Amount of fund and in kinds assistances received	To be determined	-Transport - Time	WAYAWAVI top management -CED Student.		Done; mostly received assistance was in mankind	March 2006-March 2007

Source: Field data and consultations.

4.2.2 The Total Costs and Sources

The total estimated budget was Tshs 1.5millions which was to be contributed by different organisations. These were TACAIDS, PASADA, T-Marc, Marie Stopes and Temeke Municipal AIDS Unit covered the cost of in class training and community based activities on HIV/AIDS and stigmatization. SIDO covered costs of training on income generating activities. While WAYAWAVI in collaboration to Local Government authority covered the cost of training of Financial accounting to the Management to WAYAWAVI members. The project received most of assistances from different organizations in kind.

4.2.3 Project Inputs

In implementation of different project activities the following inputs were required.

Table 7: Shows inputs that were required to implement the project

Objectives	Inputs
Train peer educators and all groups which received in-class training	Funds, Stationery refreshment, typing and printing, Two trainers
To reach community at large with information on HIV/AIDS and its related stigma and discrimination	Transport, funds Stationeries, Photocopies, three personnel.
To reach community at large with preventive measures information and products	Transport, mobile film equipment, products Venue, three personnel.
To sensitize community on effects of HIV/AIDS, related stigmatisation as well as group initiative	Transport, Venue, Stationery, two Personnel per session times seven streets
To maintain the peer educators work morale	Funds, Transport, Stationery,

Objectives	Inputs
To ensure WAYAWAVI empowered and provided with appropriate training for carrying on the group initiatives	Transport, Stationery, Typing and printing, Photocopies, Drinks/Snacks, One Personnel

Source: Field Data and Consultation

4.2.4 Staffing Patterns, Roles and Job Description

1) Chairperson of the local government authority was the overall seer of all activities to be implemented in the project area.

2) WAYAWAVI chairperson with assistance of CED liaised with organizations performing different aspects in the project and gave authority on group activities expenditure.

3) Assistant chairperson on absence of the chairperson she did all the above functions.

4) WAYAWAVI group members performed all tasks as per the secretary directives and their major role was to work as role models and given testimonials

5) Community members - the main role was to attend the sessions and contribute their physical support as necessary as possible.

6) **CED student** worked closely with the organisation secretary and provided technical assistance in implementation of the project.

- Conducted the survey
- Participated in community sensitization sessions
- Provided technical assistance on proposal writing for request of assistance from different agencies
- With assistance of the group secretary prepared report for different activities
- Participated in conducting monitoring and Evaluation for the project.
- Provided any other assistance needed by WAYAWAVI falling within the capacity

4.2.5 Project Implementation

The following part elaborates about the actual implementation of the project. The implementation was based on the objectives set during planning.

4.2.6 Project Implementation Report

The project implementation report describes the actual work which was done for the period of the CED project. There were six objectives implemented as shown below.

4.2.7 Sensitization to WAYAWAVI, Different Groups and Community in General

Under this objective CED student in collaboration with WAYAWAVI managed to accomplish the following activities;

Table 8 Sessions conducted in Community sensitization

Name of Activity	Number of Participants	Comments	Month/Date
Training to peer educators	14	Effectively done	Sept 2005
Training to Local Government/ Political leaders	135	Not well attended	Sept 2005
Teachers Guardians Religious Leaders	12 176 11	Well attended by 3 teachers from each school, Religious leaders and guardians	May 2006
Sensitization to WAYAWAVI on HIV /AIDS and related stigma	35 Widows 8 Widowers 46 Orphans	Was attended by 100% by all eligible participants	Sept 2006
Training and link WAYAWAVI on Income Generation Activities	27 Widows 5 Widowers 22 Orphans	Well attended by all eligible participants Able to link the participants with SIDO, T-Marc	Feb 2007

Source: Field Data and Consultation

4.2.8 Mobilization of Social and Financial Resources for Implementation of Activities

Under this objective CED student in collaboration with WAYAWAVI prepared three proposals to be sent to different organisations for financial and resources assistances. The proposals were sent to TACAIDS, PASADA, Temeke Municipal AIDS Coordinators Office, SHIDEPHA+, T-Marc and Marie Stapes. The first proposal was sent to SIDO requesting for training on Income Generating Activities) to

WAYAWAVI. The proposal asked about getting small grants and loans for the target group. The group received the following from SIDO; elementary knowledge on entrepreneurship and SIDO advised the trainees to form groups a criterion that would make them access the grants and loans.

The second proposal was sent to T-Marc, Marie Stopes, and PSI asking these organisations to assist on giving the health products like condoms, Insecticides, mosquito nets and water treatment kits to WAYAWAVI at lower prices. This proposal first aimed at making WAYAWAVI sell and easily access health products for prevention of related diseases. Second was that by buying and reselling products from these organisations would have let them generate some income. The organisations accepted the proposal and assisted accordingly.

By the end of the project four widows, three orphans and one widower had started to sell these products between WAYAWAVI and community in general. The third proposal was sent to TACAIDS, Temeke Municipality AIDS Coordinators office, PASADA and SHIDEPHA+. This proposal aimed at getting technical assistance of conducting the project activities especially on community sensitisation. The organisation accepted the proposal and supported the project in different ways, like conducting training both in class and community based sessions, provided some reading materials and other take away products.

CHAPTER FIVE

Monitoring Evaluation and Sustainability

Monitoring, evaluation and sustainability of the project mainly looked at the original plan of each activity. Monitoring and evaluation of actual performed activities with consideration to sense of activities sustainability were parallel carried out. This chapter highlights the impact of the project and also how the performed activities were trying to transform the community members' attitudes towards PLWHA. Also usage of project set indicators and targeted groups in all aspects.

5.1 Project Monitoring

Monitoring is a routine tracking of priority information about a program, its input and intended outputs. It is the process of keeping track of day to day program. Monitoring involves record keeping and regular assessment (TACAIDS, 2004). Based on implementation of activities, monitoring was done to asses the status of the project. It included identifying problems uncounted during the implementation and finding the solutions. Monitoring helped the implementer to asses whether objectives set had been achieved or not and whether the project was carrying out its planned activities. Further more monitoring helped to assesses objectives through the mentioned activities. Different forms of information track were developed and these outlined, the goals, how, when and challenges on each activity monitored.

5.1.1 Original Monitoring Plan

The original plan of monitoring aimed at looking on the following;

1) Number of training sessions conducted by peer educators.
2) The number of awareness creation meetings conducted
3) The number of men and women reached with information per month
4) The package of knowledge provided to the different community groups both in class and out of class.
5) Monitoring of time, human resource and money spent per each activity
6) Monitoring was on going and addressed all activities according to the implementation plan
7) Tracking of activities the sites included; PASADA, Municipal Health Office, community officers, SHIDEPHA+, teachers, community and others to track if every stakeholder performed their role as expected.
8) Monitoring was done by different interested groups like Municipal AIDS co-ordination offices, Municipal Medical Office, Community Development Office, and other, as would be identified. If the project would be financially capable an independent consultant would be hired to do mid-term and annual evaluations.

5.1.2 Actual Monitoring Key findings

The project implementation started in September 2005 and the following have been achieved:

1) Monitoring of stakeholders participation in implementation of the project aspects like on reading materials and protective measures, which have been distributed to different trained community groups, including the community in general. Different partners such as TACAIDS, PASADA and SHIDEPHA+ conducted different sessions for in class groups and distributed 5000pcs of brochures leaflets, posters, and other give away material with information on HIV/AIDS and related stigma. Municipal AIDS Coordinator, T-Marc, Marie Stopes and PSI made condoms available both for free distribution and for sale. WAYAWAVI members participated in every session provided testimonials in session and performed any activity as needed.

2) Community member's attendance was over 6000 people who have been reached through different sessions conducted in seven neighbourhoods, general meetings and gatherings and trained influential groups like teachers, political and religious leaders and others.

3) Monitoring of peer educators ability in presenting the needed massages during sessions. After receiving the detailed in class training most of them were able present the required information, answer common questions on HIV/AIDS and stigma.

4) It was revealed that level of self-stigmatization among the group members (WAYAWAVI) and community members in general had decreased as the results of the intervention.

5.1.3 Research Methodology for Monitoring

Monitoring plan was prepared before conducting actual monitoring work. During monitoring work data were collected through semi-structured interviews, whereby questionnaire were administered to respondents and some of information were collected through focus group discussions as well as reviewing secondary sources like project documents and statistics. Various field visits were also conducted during the project implementation.

Monitoring process was done continuously based on the set indicators that included; number of sessions done both in class and in community, number of meeting/strategies developed, number of community members reached, willingness of community members to participate in different project activities and level of stakeholders to participate in the project as well as number of visits done and information collected.

Collected data were entered and analyzed with Statistical Package for Social Science (SPSS, 11.5) and Microsoft Excel. These programs were basically used to analyze and to prepare statistical charts and graphs of the results. During data analysis, descriptive statistics such as frequencies, means and percentage were used to analyze information obtained from respondents. The analysis for this study involved an

assessment of different indicators over time and level of change were assessed based on the extent the planned activity has been implemented.

5.1.4 Management of Information System

Management Information System (MIS) was the basis for undertaking the task. Computer application made it possible t arrange the different data and information collected and analysed. Different software has been used in the study. These included use of Microsoft Packages and SPSS which was specifically used for statistical application purposes.

However another methodology applied was the use of developed forms on events, and reading materials, other information and take away materials. All information collected on each event was combined in the monthly activity report. Currently, there were two activity reports. There was a format developed as the event report in which daily reports were entered. This produced a spreadsheet of all events done in a month. It made management of information simple.

5.1.5 Summary Monitoring

The 9 table below summarises the monitoring tasks. It shows goal, objectives of different activities how and what was monitored

Table 9: Summary of the monitoring tasks

Objective	Planned Activities	Actual Output	Time planned	Time implemented	Indicator	Tools
To mobilize social and financial resources for WAYAWAVI	To visit different stakeholder. To write project funding proposals Conducting monitoring and evaluation (M & E) of support/ contributions received	Visit NGOs, Agencies Presented 3 proposals M & E done	8 Month	4 months	No. of support received in both financial and kind	Report and list
To develop strategies for sensitising WAYAWAVI parents / guardians/ care givers and community in order to support people affected and PLWHA.	Meeting with WAYAWAVI / guardians caregivers and community members	Four meetings done to do partial M & E	9 months	months	No. of meetings, done strategies developed	Effectively done
To determine levels of transformation of the group members	Consulting with, WAYAWAVI	Done	September 2006	February 2007	Levels identified	Report written

Objective	Planned Activities	Actual Output	Time planned	Time implemented	Indicator	Tools
To Sensitise community on HIV/AIDS and related stigma as well as group initiatives	Identified community groups to receive both in class and community based sessions Meetings with community members	Both public and non-meetings and made presentations and discussions.	May, 06	July 06	Willingness of community members	-Observations -Interviews -Written reports
Identified factors and effects led by Stigmatisation related to HIV/AIDS and their effects to affected and PLWHA	Consulting with WAYAWAVI/ guardians/ caregivers and community	Interviews and discussions done	July 06 Onwards	August 06	Factors identified	Analysis of data and Report written
To build WAYAWAVI capacity on Income Generation projects	Meeting with WAYAWAVI staff. Collecting information in relation to carried economic activities Visit WAYAWAVI office to see the progress of the projects Identify training needs for WAYAWAVI projects	Meetings done, information collected, Visits done	Jan, 06 on wards	March, 2006	Data collected, Meeting done	Report and minutes

Source: Field Data and Consultation

5.2 Evaluation

In this project, evaluation was done in order to assess the relevance of the project during the whole project period in order to have reasonable decision on which activity had great output and therefore to continue with. Evaluation was made on annual basis during implementation of the project as follows (May 2006 and April 2007) there were some evaluations made through meeting with all stakeholders on monthly basis evaluating the progress of each activity others were as follows;

Review on the project objectives

1) Evaluating the effectiveness and efficiency of the project on peoples' reactions when being tested HIV-positive and to PLWHA
2) Enhancement of the project performance.

5.2.1 Performance Indicators in Evaluation

1) Number of community members who were attending the sessions

2) Number of behavioral change communications sessions done and reading material distributed

3) Number and content of sensitization sessions conducted to community groups.

4) Strategies developed for home visits for guardians of orphans, widows, and other community members in general.

5) Number of involved potential partners in area of sensitization and sustainability of the project in general.

6) Percentage of community members who could give basic explanation of effects of stigmatization during sessions and evaluation

7) Number of community members going for HIV counseling and testing

8) Number of community members who were willing to disclose their HIV status

9) Percentage of potential partners and collaborators involvement in the programme implementation

10) Number of special events on HIV-related stigma, which would be done in the community (cinema, promotion)

11) Percentage of community members who can mention at least two advantages and disadvantages of stigma.

12) Percentage of WAYAWAVI connected with PSI for income-generation activities on social marketed products.

5.2.2 Actual Evaluation Key findings

Generally evaluation noted that the project was feasible. However lack of funds affected the implementation of most of activities and made some of activities to be slowly implemented because of depending on volunteering. During evaluation it was noted that the prepared proposals, which were sent to different organizations, were honored by in-kind. WAYAWAVI received 5000 of reading materials, 45 T-shirts, products, trainers and other as give away materials from TACAIDS. The evaluation also revealed that more that 6000 community members were reached trough different sessions and gatherings. It was again revealed that Yombo Dovya community members were responsive and ready to volunteer their energy and time as much as possible.

5.2.3 Research Methodology for Evaluation

Evaluation conducted for this project was formative, which is an on-going evaluation-taking place during execution of the project. The evaluators chose formative evaluation because wanted to have independent data in each activity within a certain period of time. Lack of enough resources limited the level of evaluation as frequent or quarterly evaluation was not possible, however annual evaluations took place and different indicators were evaluated.

Different sources of data were also used to capture information to be evaluated such as reviewing secondary data from WAYAWAVI, counsellors, and Government Authority records. There were also various interviews made with key informants

such as WAYAWAVI, care givers and guardians, Local Government leaders and teachers. WAYAWAVI staffs were involved through discussions in the process of analysing or assessing data for evaluation of the project implementation. Key results in each time during evaluation were compiled and the second evaluation compared first results with the second results.

5.2.4 Formative Evaluation

Formative evaluation would evaluate on how the project has been able to transform community members from negative to positive attitude on PLWHA. Others were efficacy and applicability of the approach for improvement, sustainability and the productivity would also be evaluated. The following expected to be achieved from different targeted community groups.

From Teachers Looking at Minimized Stigmatization of Orphanages

It was noted that complains from orphans on the subject of being mistreated by the guardians, class teachers and fellow students decreased, orphans and other students had good interactions in class and out of class.

From Local Government Authority and Community Members

Findings from evaluation indicated a decrease of complains from WAYAWAVI and other community members

From WAYAWAVI

This group reported on reduced stigmatisation attitudes, words and actions among community members like those of not buying foodstuffs from their outlets and the like. Note that whole evaluation activities aimed at looking on what has been achieved as a result of awareness creation programme for such a period.

5.3 Sustainability of the Project

In spite of the project time frame; eighteen months, the project span was too short, however efforts were made to plan in such a way that it would create a room for political, social and political sustainability (CEDPA, Handout 11A).

5.3.1 Sustainability Elements

These are features which help to identify and measure the extent to which various stakeholders would continue to pursue and support the objectives after the project. It also involves the continuation of programs, institutions and funding (Chikati...)

5.3.2 Social Sustainability

In social perspective the project would only be successfully through community participation in all stages of the project implementation. Awareness creation done to community members and other stakeholders through in class and community sessions was enough in a sense that; most of community members consulted were willing to take part in implementation of the project. Some were wiling to offer kind contributions, financial (though very limited) and so on. This would create the sense

of belongingness or community project ownership. It is believed that support from community will be helpful that to this kind of project taking into consideration that the problem of HIV/AIDS related stigmatization is likely to affect everybody in the community.

5.3.3 Financial Sustainability

During the study it was note that there were financial constraints in operating the project. The project needed some funds to run its activities like procurement of materials and other related needs for conducting different sessions but it was difficult to get funds. So this was a problem for project sustainability. But steps have been taken by WAYAWAVI in collaboration to CED student to write and submit a proposal to different agencies for this purpose.

5.3.4 Political Sustainability

The project received political support from the community and therefore it could be suitable in this respect. Local Government Authority officials were willing to participate whenever they requested to do so.

5.3.5 Sustainability and Institution Plan

Based on the above elements, various measures were taken to make sure that the project would continue for a long term. Measured involved training WAYAWAVI on different skills like preparing project proposals, IGA, HIV/AIDS related stigma care and support to PLWHA . Establishment of linkage with other organisations,

which are doing activities, related in this area and community members in general and the remaining partners like PASADA, TACAIDS and the Municipal AIDS Co-ordination Office to make the initiated activities continuous and achieve the remained targets.

It is to the expectation of the implementers that, these groups, peer educators, health providers, collaborators (PASADA), TACAIDS, SHIDEFA, HIPOTECK, Municipal Council, and community development officers are in the community performing different roles as they are doing in the project implementation. It is therefore expected that they would continue delivering the same services in the community

The trained peer educators, teachers and others who were well equipped with this knowledge would continue with implementation of the project aspects. The tools, which used to track implementation progress, were left to WAYAWAVI and local government authority office to perform the same purposes. At the same time since the community was linked to different current project implementers (organizations), it will help the community to get services on these areas.

CHAPTER SIX

Conclusion and Recommendations

This chapter presents conclusion based on what have been studied and revealed in this project of sensitizing community on HIV/AIDS and related stigma and discrimination to WAYAWAVI and PLWHA. Lastly the chapter points out recommendations in relation too what have been revealed with consideration of the fact that PLWHA are increasing rampantly. Therefore there is a need for having strategies to handle the problem of HIV/AIDS related stigma.

6.1 Conclusion

The survey results concluded on questions as follows:

First, it was revealed that hundred percent of community members' knowledge on HIV was not low because most of them could define the pandemic, even though most of community members' views were ambiguous on ways of transmission. So when doing community sensitization emphasis was put on sources and prevention. Level of stigmatization implied that community member's knowledge on HIV/AIDS transmission needed to be improved that is why they feared to share or take care of persons living with HIV or sero status was known.

Second it was realized that stigmatization led to poor uptake of life prolong medicines like ARVs. Stigmatization led to unemployment as most of WAYAWAVI, who were employees lost their jobs after exposing their health status, stigmatization also led to child labor and prostitution Also prevalence rate of HIV was even higher than what was reported in different reports including the government report of 7 per cent because the study realized that almost every community member had a relative who were HIV+.

Third, it was realized from the question that stigmatization frustrated HIV prevention efforts. In the study it was reported that stigmatization related to HIV made community members hesitant from going for voluntary counseling and HIV testing. The community members also admitted that because of stigmatization they were not ready to expose their status. During sensitization more emphasis was given on encouraging community members to go for VCT services.

Fourth, it was revealed that stigmatization had social and economical impact, which affected those who exposed their sero status. It was proved from WAYAWAVI that exposure of their status had greatly affected their economic situations as community members could not buy goods and services provided by WAYAWAVI. From literature review and field consultation it was also realized that if PLWHA were not economically well to support their lives, stigmatization level doubled and the vise versa.

Fifth Stigmatization was a very big problem in Tanzania, which needed to be addressed by conducting community sensitization programme. Results obtained implied that a combination of activities like distribution of reading materials, prevention measures and conducting community events of sensitization were useful and would bring about HIV/AIDS knowledge and minimize related stigmatization in the community. It was also suggested that through sensitizing different community groups including influential people were likely to minimize stigmatization related to HIV/AIDS.

The survey results conceded with a study done in Angola by Engender Health 2002, which aimed at minimizing stigmatization in the health service settings. Health workers were sensitized on HIV/AIDS-related stigmatization and this improved health services to PLWHA.

6.2 Recommendations

1) With the collected information, therefore, there was a need to conduct a vigorous community sensitization programme on HIV/AIDS and related stigmatization aimed at reducing the identified problems. These included orphans and displaced children, denial of human rights, unwillingness for HIV test, which led to more transmissions and prostitution as results of minimized chances to engage in economic activities.

2) It is important to establish and implement specific education and awareness rising programmes for community stakeholders so that they can know and perform their roles.

3) Government departments and agencies responsible for empowerment programmes should work with community-based groups to identify and implement jointly IGA for PLWHA so as to reduce dependency and vulnerability.

4) This kind of project is suggested to be carried out in different areas of Tanzania to reduce HIV/AIDS-related stigmatization and minimize chances of new infection while extending lessons learnt from WAYAWAVI to other parts of the country.

5) The surveyor suggests that there should be independent plans and implementation of programmes, which would take care of orphan-related issues like shelter, food and education.

6) The surveyors suggest that further research should be carried on how income-generating activities can be used to reduce stigmatization to PLWHA.

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