

SOUTHERN NEW HAMPSHIRE UNIVERSITY

&

THE OPEN UNIVERSITY OF TANZANIA

MASTER OF SCIENCE IN COMMUNITY ECONOMIC DEVELOPMENT 2007

**INCREASING ACCESS TO ANTI—RETRO VIRAL TREATMENT
FOR WOMEN AND GIRLS LIVING WITH HIV/AIDS**

THE CASE STUDY OF KIKUYU NORTH WARD, DODOMA REGION.

TOUFIQ, MUHAMMAD HASSAN

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**SUBMITTED IN PARTIAL FULFILMENT OF REQUIREMENT
FOR THE MSc IN COMMUNITY ECONOMIC DEVELOPMENT**

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Supervisor (s) Certification

The undersigned certify that have read this project paper and accept it is a scholarly work and therefore recommends it to be awarded a Master of Science Degree in Community Economic Development.

SUPERVISOR: HAMIDU A. SHUNGU

SIGNATURE: 

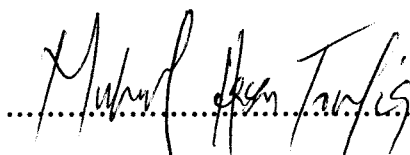
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Declaration by the Candidate

I, Muhammad Hassan Toufiq hereby certify that, this project is my original work, and that it has not been submitted for the similar degree in any other University.


.....
Candidate Signature

Dedication

This work is dedicated with love-to my late father, Hassan Toufiq Suleiman and my Beloved late mother Tatu Hassan Mangwela who have been the driving force in my life.

Abstract

The increasing accessibility to HIV/AIDS treatment for girls and women project supported the implementation of Tanzania government initiative to provide free ant-retroviral drugs for the people living with HIV/AIDS. The project ensured equitable access to HIV treatment and care, notably for acutely vulnerable populations such as girls and women. The project focused on following cross – cutting and institutional actions which facilitated program towards ensuring equitable access to HIV treatment for girls and women. Project objectives were: (1) to conduct information campaigns for interest groups on availability of HIV treatment, this had biggest impact on awareness of people on availability of HIV treatment. This was done in workshop manner and home visits. (2) To mobilize women and girls and encouraging couples counseling at voluntary testing for HIV centers to better ensure male involvement. This supported results oriented service delivery and enabled more people to be tested. In turn it reduced rate of new infections, and improved their access to HIV treatment. (3) To increase economic improvement for women and girls living with HIV through access to micro – credit programs, job and skills training and assistance with property and inheritance rights, these were done by lobbying and facilitating linkage of women and girls living with HIV/AIDS to micro – lending institutions, this had biggest impact on reducing income poverty among women and girls living with HIV/AIDS. Linking women and girls living with HIV/AIDS to legal services ensured their property and inheritance rights are respected by community members.

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Executive Summary.

Recent international initiatives to provide antiretroviral (ARV) treatment in Resource-poor countries have changed the landscape of the HIV/AIDS debate and signaled an unprecedented new phase in the struggle against HIV/AIDS. With an estimated 40 million people living with HIV/AIDS and 14,000 new infections every day, access to treatment is a challenge of global proportions. In sub-Saharan Africa alone, almost 4.5 million people need antiretroviral treatment, yet only 100,000 currently receive it. To develop effective treatment programs, national governments, international donors, and community stakeholders should ensure equitable access to HIV treatment and care, notably for acutely vulnerable populations such as women and girls.

People Living with HIV/AIDS have the right to comprehensive health care and other social services, including legal protection against all forms of discrimination and human rights abuse. However, People Living with HIV/AIDS may be required to meet some of the cost of the Highly Active Anti Retroviral Therapy (HAART) example pre and post-treatment laboratory tests. HIV/AIDS being a social, cultural and economic problem, women and girls need extra consideration to protect them from the increased vulnerability to HIV infection in the various social, cultural and economic environments as stipulated in the Tanzania National Policy on gender and equity. As high risk groups play a major role in transmission of HIV/AIDS, appropriate strategies shall be developed to reduce the risk of HIV infection and increase access to treatment among specific high risk groups. Given the vicious circle between HIV/AIDS and poverty, interventions for the control of the epidemic should be simultaneously related by poverty alleviation initiatives.

Chapter one deals with needs assessment, containing components like identifying needs, prioritizing needs, leveling the needs and methods used during needs assessment also it contains community profile and graphical content. In chapter two provision of antiretroviral treatment for people of living with HIV/AIDS, Problem statement, target community, stakeholders analysis, project goals is CED terms, project objectives and information of host organization are discussed. The chapter is basically problem identification. In chapter three Literature review which is divided into, the theoretical, empirical and policy have been dealt is this chapter. In chapter four deals with discussion on products & Outputs, Project Planning; which includes implementation plan, Inputs, Staffing Pattern and Budget, as well as project implementation. Chapter five discusses monitoring, evaluation and sustainability. This chapter explores the achievement of the activities implemented to accomplish CED objectives. It also discusses the sustainability of the project and the needs for additional study are also included in this part. It also contains the indicators used for Monitoring and Evaluation data collection methods analysis and findings. Chapter six deals with conclusion and recommendations – this conclude the thesis by highlighting the fact that, misinformation and skepticism ARV among historically excluded communities needs to be corrected with uniform messages at local level not only about availability but also how to access treatment furthermore stigma remains stubborn and resistant to initiatives and may also imprint upon accessing treatment – how treatment initiatives are best harnessed for anti-stigma projects is an important consideration.

List of Abbreviations

AIDS – Acquired Immuno Deficiency Syndrome

ARV – Antiretroviral

ART - Anti-Retroviral Therapy

CBOs – Community Based Organizations

GDP – Gross Domestic Product

HAARD - Highly Active Anti-Retroviral Drugs

HAART Highly Active Anti-Retroviral Therapy

HIV – Human Immuno Deficiency Virus

IDU – Injecting Drug User

MOH – Ministry of Health

MTCT - Maternal To Child Transmission

MTP - Medium Term Plan

NACP – National AIDS Control Programme

NGOs – Non Governmental Organizations

NSGRP – National Strategy for Growth and Reduction of Poverty

SMTP – Strategic Medium Term Plan

STDs – Sexually Transmitted Diseases

STIs – Sexually Transmitted Infections

STP - Short Term Plan

SPSS – Statistical Package for Social Sciences

UNDP – United Nations Development Programme

WHO – World Health Organization

UNAIDS – Joint United Nations Programme on HIV/AIDS

CHAPTER ONE: COMMUNITY NEEDS ASSESSMENT

Needs assessment is one the critical stages in the project development process. Systematic needs assessment is comparatively a new phenomenon in the development scene. Generally, needs are considered to be wants, aspirations, interests, and wishes of people. In development literature, needs are define as the discrepancies between “what is” {current set of circumstances} and “what should be” {desirable set of circumstances}. There is a growing consensus among development practitioners to consider needs assessment as a process to identify and measure gaps between “what is” and “what should be,” prioritize the gaps, and determine ways of bridging them.

1.0. Community Profile

The profile of community was designed and captured the important issues as population, which was classified to age, employment; which was classified into self employed, employed and not employed. The community was also classified by sex, education levels and HIV/AIDS status.

Support to meet psychological, spiritual, economic, social and legal needs

In community profile the following important ingredients were captured; political /administrative structure, demographic features, economic activities, social stratification and power relations, leadership pattern and power relations, organizations and their functions or activities, cultural facets or traditions, health, sanitation, and nutrition levels, education, resources and strengths.

AIDS related mortalities are changing the demographic profile of the region. Without significant intervention, life expectancy will decrease from 61 years without HIV/AIDS to 46 years without the epidemic (Somi 2003)

The major vulnerable and affected group includes women 15-24 years old, orphans and vulnerable children 0-18 years old (WHO 2004)

The impact of HIV/AIDS in Dodoma region is 167 rates per 100,000 (NACP/MOH 1998). The number of cases is a poor indicator of situation since these are simply the number of cases reported by hospitals and extrapolated, the rates may be higher.

HIV/AIDS is gradually draining both management and professional personnel and the productive work force with a negative macro and micro impact on the economy if left unchecked.

Dodoma is one of the poorest regions in the country with a GDP per capita of at Tshs 154,722 (2001) (National website).

It is estimated that between 60 and 70 percent of the annual income is derived from the proceeds of which traditionally used to be categorized as food crops which include: maize, sorghum, beans, pearl millet, oilseeds cassava and paddy.

Animal husbandry is the second dominant economic activity in the Region. Proceeds from livestock products are estimated to account for 35 percent of the annual regional GDP.

The overall objective of the existing primary education system in the country is to achieve Universal Primary Education i.e. 100 percent enrollment of children who are of school age (7 – 13 years). The focus of education is to provide practical and relevant education through self-help, which in the long run will influence economic growth and poverty reduction in the region. The region has a total of 576 primary schools. The Region faces the problems of the shortage of school buildings, furniture and equipment, primary school teachers, school drop-outs and other basic facilities.

The Region is actively engaged in solving this problem by involving the people through popular participation in the construction of School building hostels for girls, providing school meals and improving academic performance.

Currently, the Region has 47 Secondary schools out of which 14 are privately owned. Due to limited secondary school in the Region a few students secure places in these schools within the region.

It is evident from the above explanations that more than 80 % of the standard VII leavers are not selected for secondary Education and therefore join the Region 's labour force every year, Some of that who don't get Secondary education placement are recruited in various Vocational Training Institutes both private and public which are allocated in the Region. This includes training for elementary computer skills.

Dodoma urban district has a population of 324, 347 people which is male 157, 469 and female 166,878. (Tanzania census 2002). The population of people in Kikuyu area is 3735 male and 2980 Female which totals to 6715 (Tanzania Census 2002)

Dodoma Region lies at 4o to 7o latitude South and 35o – 37o longitude East. It is a region centrally positioned in Tanzania and is bordered by four regions namely: Manyara in the North, Morogoro in the East, Iringa in the South and Singida in the West. Much of the region is a plateau rising gradually from some 830 metres in Bahi Swamps to 2000 metres above sea level in the highlands north of Kondoa.

1.1. Community needs assessment

There was great interest in needs assessment between 1965 and 1975 by scholars in academia. This field has had its greatest growth since 1975. In order to learn how to conduct a needs assessment, it is necessary to see what the methods are and how they fit into project planning. Almost all the sources in the literature dealing with needs assessment make an attempt to define the term. The terminology of needs assessment can be various for “assessors” (Csete, 1996). Csete used synonyms for needs assessment such as needs analysis, goal analysis, task analysis, and front-end analysis (Csete, 1996, p. 2). Kaufman, (1985), stated “needs assessments involve identifying and justifying gaps in results, and placing the gaps in prioritized order for attention” (Kaufman, 1985, p. 21). The difference between needs assessment and needs analysis is that needs assessment “provides a fine determination of where a need is coming from, and provides clues to how the need may be reduced or eliminated” (Kaufman, 1985, p. 21). Previously, there were definitions that define needs assessment as being part of an overall planning process or analysis and leading to the development of a deficiency model. There are decision-based definitions that define needs assessment by what it does (this is a rare find). These definitions then lead to discrepancy models (Sweigert, 1969). For example, Sweigert explains that “an assessment of needs is a process by which information is made available to decision-makers at the time they need it to make decisions.” Another of the same type of model is the Coffing-Hutchinson Needs Analysis Methodology (R. T. & T. E. Hutchinson, 1974). “A need is a concept of some desired set of conditions. A need is a concept of what should be.” The most common of the definitions in the literature is the one that emphasizes the discrepancy between two sets of factors (Heinkel, 1973).

Heinkel understands needs as the “gaps between current outcomes and achievements and desired outcomes and achievements for learners, implementers, and the community.” The term “needs assessment” is used to designate a process for identifying and measuring gaps between what is and what ought to be and then prioritizing the gaps and determining which of the gaps to work on to obtain closure (Trimby, 1979). To summarize, there are models that are goals, planning based-deficiency models, decision-based discrepancy models, and discrepancy based models (most used). Here, needs assessment is defined as “any systematic approach to setting priorities for future action” (Witkin, 1984, p. ix). To form a model of needs assessment, there are models that are participatory form (where target groups defined their own need), expert form (needs defined by outside experts), and combination form (target group and outside experts define their needs). Interviews, questionnaires (qualitative), and surveys (quantitative) are models of instrumentation (Dalton, 1996). The best model for this paper as frame work for decision making is *Model for Needs Assessment* by the Coffing-Hutchinson Needs Analysis Methodology (R. T. & T. E. Hutchinson, 1974). The most important feature of the methodology is that it allows full participation of the target group in the total process. The decisions regarding needs and their priorities are made by the individuals concerned.

All the primary beneficiaries were involved in the process. These included people living with HIV/AIDS, men, women and girls effected families, community based organizations orphans, traditional healers, and government officials in health and community development departments.

1.1.1. Identifying the needs.

A one day community seminar with participation of community members and teachers was convened by Mama Africa, 20 participants were involved. The workshops managed to list the following needs on HIV/AIDS pandemic.

1. Building of community centre for people living with HIV/AIDS
2. To increasing accessibility to HIV/AIDS treatment for Women and Girls
3. Legal protection for Widow of HIV/AIDS pandemic.
4. To develop skills to manage small businesses

1.1.2. Prioritization of needs

The needs were prioritized by using Coffing – Hutchinson needs analysis methodology.

Each participant was asked to go through the list of needs carefully and place a check mark (V) against each need that she/he considers important for the Kikuyu ward.

Participants were asked to go over checked items again in the list and circle the three most important ones.

It was agreed that a checked item (V) is equal to 1 point and a circled item (O) is equal to 10 points. each participant was asked to read his/her score for each need statement and record the scores on the needs prioritization scoring sheet drawn on the new print.

After recording all scores the total was computed to set the group score for each need statement. The items with highest scores were the needs received highest priority.

See worksheet number 1

The resources and constraints assessment was conducted then we formulated goals, objections and activities. (For details see Appendix 1)

At each point stakeholder views were solicited and incorporated into the project document.

NEEDS PRIORITIZATION SCORING SHEET. WORKSHEET 1

TABULATION OF SCORES OF PARTICIPANTS

		A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	TOTAL
1.	Increasing accessibility to HIV/AIDS treatment for women and girls.	10	1	10	10	1	10	1	10	1	1	10	1	10	1	10	10	1	10	1	10	119
2.	Legal protection for widow/ women /girls living with HIV/AIDS	10	1	10	10	10	1	10	1	10	10	1	10	1	10	1	1	1	1	1	1	101
3.	To develop skills to manage small businesses and accessing small loan institutions	10	1	10	1	1	1	10	1	1	10	1	10	1	1	10	1	1	10	1	10	92
4.	Building community centre for people living with HIV/AIDS	1	1	1	1	1	1	1	1	1	1	1	1	1	10	1	1	10	1	1	1	38

A number of beliefs, customs, traditions and habits affect the accessibility to HIV/AIDS treatment of women and girls, these include; widespread human rights abuses, sexual violence and coercion, cross- generational sex, economic dependency of women and girls and discriminatory access to education, health care and inheritance rights.

The subordinate status of women combined with the ongoing stigma surrounding HIV, continues to be a driver of the inaccessibility to HIV/AIDS treatment for women and girls. Fear of ostracism and violence exacerbate the will of women and girls to go far HIV testing and treatments.

Most women seek treatments from traditional healers knowing that they can be cheaply and adequately treated so by involving traditional healers, it is seen as most effective way in increasing accessibility of women and girls in modern HIV/AIDS treatments.

Gender based violence inequalities are found in this community males have control over female.

Mtaa ladders are responsible for information collection and transmitted through public rallies, News papers, Radios and television. In this area there is in fact no project working on increasing accessibility of treatment for women and girls. There are projects working on HIV/AIDS related activities. These include;

Tailoring project for people living with HIV/AIDS, which target women.

Revolving fund project for people living with HIV/AIDS, targets both men and women.

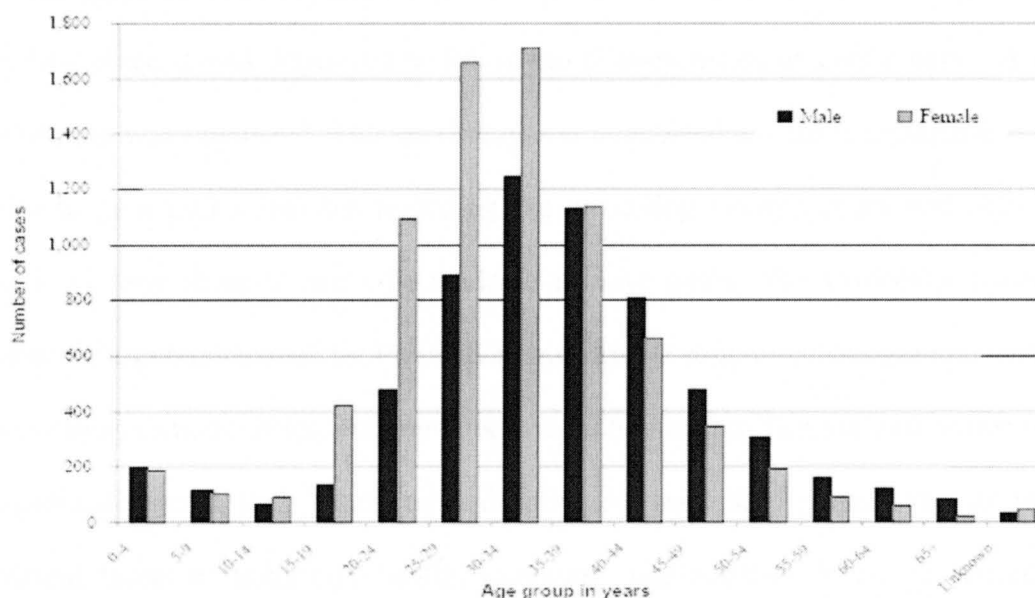
Economic empowerment and food supplies project for people living with HIV/AIDS serve men, women and orphans.

The organizations associated with these projects are;

Kimonge Group – Roman catholic church which assist men and women living with HIV/AIDS. They must be Christians and Catholics.

Mennonite Women Group Compassionate International comprising of Moravian Church, ELCT, These provide food, small grants for people living with HIV/AIDS and they must be Christians. While these address the issue of HIV/AIDS in the line of economic empowerment, ours addresses both economic empowerment and accessibility to HIV treatment for women and girls. Of 200 women and girls living with HIV in Kikuyu area, Dodoma region only 10 are now taking treatment this number is expected to be 60 with the intervention of project and accessed to small loans for special groups.

AGE AND SEX DISTRIBUTION OF REPORTED AIDS CASES*
Tanzania, January-December 2001



* Reported cases estimated to be 20% of total AIDS cases

Source: National AIDS Control Program, Ministry of Health

Organization groups which will BENEFIT and may face COST form project (See Appendix 2)

1.2. Community Needs Assessment Methodology

1.2.1 Research Method

At the onset of the study, participatory techniques (such as transect walks, community mapping, listing of health problems and timelines) were conducted in Kikuyu. Communities to build rapport and gain insight into the general community layout and structure. The use of multiple methodologies to acquire data ensured triangulation and validity of the findings. Ms excel and SPSS software systematically were used to analyze data.

1.2.1.1 Quantitative survey methods

Investigator felt it critical to have baseline understanding of the community is knowledge attitude and behaviors around availability of AIDS treatment. Researcher administered a survey systematically, selected. The data was ensured, cleaned and analyzed using SPSS.

1.2.1.2 Data collection process

It was important to define and understand the characteristics of a community.

In first place it was important to know the characteristics of community. A one day workshop was organized. This workshop was conducted to enable organization to know how to gain useful insights regarding the prevailing circumstances and help them to consider how changes could be made to achieve goals. The workshop discussed the aspect of community such as; Political/administrative structure, demographic features and population characteristics, economic activities, Social stratification and power relations, organizations and their functions and activities, leadership pattern and its influence, cultural facets or traditions, health, sanitation, and nutrition level, education, critical issues and problems.

It was also agreed that the following sources of information should be consulted,;

Documents or files in government offices/NGOs (e.g. Health Office, Health Center),

reports or surveys pertinent to the topic, informal leaders in the community, senior citizens and NGO personnel

The workshop developed technical tool to gather information as shown below:-

Characteristics of the community	Information needed	Source	Techniques / methods	instruments
Accessibility to HIV/AIDS treatment	<ul style="list-style-type: none"> ▪ HIV/AIDS prevalence ▪ Deaths ▪ Quality of life of people living with HIV/AIDS especially women/girls ▪ Treatment knowledge ▪ Treatment availability ▪ Costs 	<ul style="list-style-type: none"> ▪ Records in hospital/ health worker, ▪ Selected house holds ▪ Selected community members 	<ul style="list-style-type: none"> ▪ Review of records ▪ Interviews ▪ Questionnaires 	Questionnaires
Social economic	<ul style="list-style-type: none"> ▪ Gender ▪ Population ▪ Employment status ▪ Social status (married, unmarried, separated, widower, widow) ▪ Education status (not educated, primary, secondary and tertiary) ▪ Beliefs and traditions ▪ Family structure ▪ Community relations ▪ Power structures ▪ Physical resources ▪ 	<ul style="list-style-type: none"> ▪ Selected house holds ▪ Review of reports 	Interviews	Interview guide
Organizations	<ul style="list-style-type: none"> ▪ Type of activities implementing ▪ Similarity and dissimilarity of activities 	<ul style="list-style-type: none"> ▪ Selected organizations 	Questionnaires and interview guides	Questionnaires and interview guides

Source; stakeholders workshop

Thereafter the organization members in the workshop developed a questionnaire inquiring the information listed above. The field visits were conducted and information was collected.

Survey Design and Sampling

1.3 Description of the major feature of survey in relation to the project.

Background

The increasing accessibility to HIV/ADS treatment for girls and women project supported the implementation of Tanzania government initiative to provide free anti-retroviral drugs for the people living with HIV/AIDS. The project ensured equitable access to HIV treatment and care for notably for acutely vulnerable population such as girls and women.

Survey objectives;

The overall objective of the survey was to get better understanding of barriers to the access of HIV/AIDS treatment for girls and women as well as formulate appropriate measures to ensure equitable access to HIV/AIDS treatment for affected women and girls.

Specific objectives;

Analyze causes or motivation for increased gender barriers to the HIV/AIDS treatment.

Access the role of internal and external factors in decision for voluntary HIV testing and attending treatment.

Critically assess the context of access and /or failure of the HIV/AIDS treatment program

Survey design.

In order to increase accessibility of infected girls and women to HIV/AIDS treatment, of now only 10 women and girls the project intends to rise this number to 60 including couples as well women and girls. The survey begins with identifying the initial domestic conditions {economic, social and political} in their homes.

These initial conditions were mostly determined by domestic developments. I took these conditions as given, rather than trying to explain them, but they are crucial in decision/making for voluntary HIV/AIDS testing care and treatment. From the perspective of economic, I was interested in employment. Social characteristics of the population and ability of person to decide was also important but from another angle to reasoning external context also had a strong bearing on decision to attend voluntary HIV testing and treatment, education and health facilities are also important aspects to look on.

These forces may enforce or derail the course of accessibility of HIV/AIDS treatment for women and girls. Added to the influence are institutional constraints, which determined to what extent the set goals at the time one decides to go for HIV testing and eventually attending HIV/AIDS treatment by Anti retroviral drugs are met.

Thus the outcomes of project were considered a result of interaction of many factors need to be critically analyzed in order to understand the context of failure or success of country's effort to provide free anti-retroviral treatment.

The dependent outcomes were employment growth {capital accumulation physical} and equity, social welfare {health} of women and girls living with HIV/AIDS.

These variables in the post-project implementation were compared with pre-project implementation period. This design emphasized on multidisciplinary analytical approach in understanding the problem.

Thus, in terms of analyzing the success of the project in particular case of Kikuyu, my design brought together a cogent and thorough analysis of economic, social political and institution condition prior to {initial condition} sought by {targets} brought about by the project.

These approaches were rather complementary than substitutable, and the most salient and relevant ones were mapped both as qualitative and quantitative variables. They were constructed in a manner that allowed comparison across time. The variables were also be able to highlight the adherence of the same number of girls and women registered for HIV/AIDS treatments. I used information from both secondary and primary sources in order to thoroughly meet the objectives of this survey.

Secondary data sources

Secondary data collection involved a review of relevant information/published documents on provision of free anti-retroviral drugs for people living with HIV/AIDS especially girls and women in Tanzania and globally. Other information were gathered from key institutions involved in the design and implementation of the program, including ministry of Health, ministry of Women gender and community Development, local government to mention but a few.

Primary data sources

In order to fill information gaps, structured questionnaires and checklist were administered. Guided interviews were undertaken and involved all interest groups.

Structured questionnaires and checklist these involved asking questions aimed at getting information on economic status, availability of treatment, HIV prevalence, socio profile, community profile and etc.

Checklists and guided interviews were used in identifying characteristics of community

Thus, information was collected from all levels of both policy making levels and field operation/grassroots level.

The statistical package for social sciences software was used to analyze data, and the results were reported in bar charts, cross tabulation, frequency tables, pie charts and graphs.

1.4 Identification of the question that structure survey designs.

I, then used this design to test a set of generalized propositions. These propositions were;

Accessibility of women and girls living with HIV/AIDS to retro-viral drug treatment is determined by the level of economic, external pressure and the influence of stakeholders and interest groups.

Couple voluntary HIV testing and counseling is more likely to be successful in mobilizing public support and avoid gender barriers to access HIV treatment.

Donor community, government and local communities' commitments and transparency are important for the momentum and sustainability of the HIV/AIDS treatment program.

1.5 Type of design

The survey was conducted for the same number of 60 respondents including men women and girls, who were enrolled to the treatment regime and linked to small loan programs.

The data collected focused on their adherence to treatment and economic growth and identify if there were barriers and violence they encountered in the process of attending treatment.

1.6 Explanation of the characteristics, benefits and concerns of the designs of my choice.

The survey is to find out about	Concerns of sampling	Concerns of designs	Its result	Type of design
Barriers to women and girls living with HIV/AIDS in accessing anti-retroviral drugs and address them.	Same sample of 60 including men as well women and girls living with HIV/AIDS	Conducted ; After every three months	Increase access to HIV/AIDS treatments for girls and women.	Longitudinal Panel.
Knowledge and information on HIV/AIDS and availability of treatment	Sample of 56 different interest	Conducted twice	Increased knowledge and information on availability of treatment	Longitudinal trend.

1.7 Determination of the internal and external validity of the survey;

The survey tools were administered to the same group of people on different occasions and then correlating the score from one time to time.

The alternative forms; different forms of survey were given to two groups that have been randomly selected.

The determination of equivalence was done by comparing the mean score of standard deviations of each form with the survey and by correlating the scores on each form with the scores on the other.

The survey was divided into two equal parts and correlated the scores on one half with the scores on the other half.

Internal validity

Determination of Internal validity was done through the following:-

Casual review of how good an item or group of items appears was assessed by individuals with no training in the subject matter under survey.

Formal expert of how good on item or series of items appears was assessed by individuals with expertise in some aspect of the subject under survey

Measurement of how well the items or scale correlates with gold – standard measures of the same variable this was done by adapting the international publications and surveys already done.

Measurement of how well the item or scale predicts expected future observations, this enabled to predict outcomes or event of significant that the item or scale might subsequently be used to predict.

because the above techniques worked right then the survey provided a consistent measure of important characteristics despite background fluctuations.

1.8 Sampling

A stratified random sampling under probability sampling was employed because we were going to have accurate view of the whole group and was representative of the general affected and women and girls living with HIV/AIDS population and general population.

Including other stakeholders a number of 116 respondents were approached and administered with survey forms.

1.9 Response rate:-

The number of people who were expected to respond to the survey;

As stated above there were two types of questioners; one which surveyed on treatment barriers among the Women and Girls and the other was on knowledge and information about the HIV/AIDS and availability of treatment.

For the survey questionnaire on barriers to access HIV/AIDS treatment 60 respondents were approached and for the survey questionnaire on knowledge, information and availability of treatment 56 respondents were targeted. In order to have substantial credibility of survey the researcher managed to have an high response rate.

To capitalize on that a face to face interview was used as tool to collect information.

Also the information in the questionnaires showed an obvious differences exist among respondents and non-respondents in such factors as age, education, experiences and income status.

1.10 Conclusion

This survey proved and identified barriers to HIV treatment for women and girls also highlighted on the knowledge of community on information HIV/AIDS treatment availability.

On documented four types of barriers in accessing treatment, those which highly affect women and girls living with HIV/AIDS were identified. The results were basis on implementation of future activities.

Characteristics of the Survey

1.11 Types of survey instruments;

- In depth interviews with key informants;
- People living with HIV/AIDS
- Families
- Health workers
- Care givers
- Community leaders
- Traditional healers

1.11.1 The questionnaires were administered by members of community based organization and interviews were conducted by the members of the organization;

Structured questionnaire interviews for both male and female from of a survey;

Documentary evidence: by establishing sources of data on the subject of investigation that is already available, known and documented.

Direct observation and documentation of relevant factors.

1.12 Contents;

There were 2 types of questionnaires, namely form 1, the aim of this was to assess the HIV/AIDS treatment availability information and knowledge in the community.

The responses determined whether community had knowledge and information on availability of HIV/AIDS treatment, form 2; The aim of this form was to generate information about barriers to accessibility to HIV/AIDS treatment with Anti-retroviral drugs from selected interest groups.

1.12.1 Number of questions;

The forms have entries and items as indicated below;-

Form Number 1 has four entries namely;

Knowledge and information (four items)

Using treatment (five items)

Effects of treatment (three items)

Obtaining the treatment (six items)

Form number 2 has four entries with items into the brackets namely;

Organization factors (five items)

Physical factors (three items)

Financial factors (two items)

Social factors (five items)

1.12.2 The forms contained a series of close ended and open ended questions

1.12.3 HIV/AIDS treatment information, knowledge and attitudes survey form number 1 is a 16 – questions (items) survey with open – ended questions.(items), Form number 2, is 14 – guide close ended questions, (items) assessing the barriers to accessibility to HIV/AIDS treatment for women and girls.

1.13 Psychometrics characteristics

1.13.1 Scales;

A summative scale was selected for the purpose of this survey. This is because the scale aligns people according to controversial or debatable statements.

1.13.1.1 Content;

The questionnaire/ form number 2 used the interval rating scale of (yes, no, don't know), (low, medium, high), (short, medium, long), (good, bad, neutral and), (positive, negative, neutral) in different entries for form no 1.

1.13.1.2 How questions were scored;

The score were made according to the number of item in each survey entry. The items which were favorable and not – favorable were assigned a numerical weight.

1.13.1.3 How questions were combined into scales;

The person's score was algebraic sum of her/his responses to the each item in each entry.

1.14 Reliability;

1.14.1 The survey forms were given to two different groups for responses, the groups were randomly selected.

The responses from all groups' forms had almost the same means for each entry.

The survey form number 1 means for each entry was organization factors (4.52,) physical factors, (4.55.) financial factors (4.53) social factors (4.43).

For form number 2, the means for entries are as; information/knowledge for HIV/AIDS (4.33), use of treatment, (4.07), effects of treatment (4.07) and accessing treatment (4.07)

1.14.2 Adequacy of reliability for survey's uses; as since the means of responses from all groups' forms were almost the same it appeared that the forms had consistently met with physical functioning.

1.14.3 Adequacy of descriptions and methods for establishing reliability;

The methods yielded consistent measures of important characteristics despite background fluctuations.

1.15 Validity;

Refers to whether are not the instrument measure what it claim to measure.

1. 15.1 The casual review of how good an item or group of items appears, this was done by Mama Africa officials.

Formal expert review of how good an item or series of items of form appears, this was done by public health specialist from Dodoma General Hospital.

As the questions were adapted from international organizations survey, thus the items and scale correlated with gold standards measures of the same variable.

Measurement of how well the item or scale predicts expected future observations was done to predict outcomes or events of significance that the item or scale might subsequently be used to predict

1. 15.1 The validity or the meaningfulness of the interviews was determined by pre-testing

the schedules with members of Mama Africa and some people living HIV/AIDS.

1. 16 Administration;

The administrators were trained on research techniques and were involved in developing survey, tools and pre-testing.

1.16.1 Characteristics of survey administrators;

Public health nurse, teachers, form four leavers and others, CED student.

1. 16.2 Training, recruitment and deployment;

The survey administrators were trained on various techniques of survey the training lasted for 6 hours.

1.16.3 Quality Assurance;

The questions for questionnaire were adapted from UNAIDS/UNICEF – ILO/UNESCO/WHO/WORLD BANK Handbook on Access to HIV/AIDS treatment.

1. 16.4 Length of time to complete each survey; each survey took 20 minutes

1.16.5 The entire survey was completed in 3 days time.

1.17 Relevant literature and other surveys on the same topic

Community involvement and mobilization, including that of people living with HIV/AIDS has proven to be an essential element in an effective and sustainable response to HIV/AIDS (Gregson *et al* 2002). This means involving civil society organizations from the outset in designing and implementing HIV/AIDS programs focusing on prevention, treatment preparedness and literacy, gender, orphans and vulnerable children, and adherence support.

In programs around the world, community mobilization has been shown to reduce stigma and discrimination, to relieve the burdens on the health care system, and to help provide better treatment, care, and prevention services. Indeed, one of the challenges to scaling up treatment programs is responding to the broader needs of the effected communities, including management of opportunistic infections and psychosocial support.(Sidley, 2000)

Community engagement is critical for the effective delivery and support for ARV treatment and that such engagement has been an indispensable element in reducing

stigma, relieving the burden on the public health system, supporting good treatment and prevention outcomes, and building social capital in communities. (Doyal,2001)

In resource –poor settings, wider public debate will be critical to focus on treatment access and equity issues, such as gender; rural versus urban; children, including orphans and other vulnerable children and street kids; sex workers; and other populations at risk. Community engagement, and the accompanying support for civil society groups, will be an essential element in addressing these issues.(Watts, 2002)

At this time of increased national and international engagement on HIV/AIDS, there is reason to hope that the new resources will also strengthen the pronounced. Accordingly, equal access by women and girls should be factored into the development of appropriate eligibility criteria for treatment.(Oxfarm, 1998)

1.17.1 List of relevant literature and other survey on the same topic;

The treatment programs in Botswana and South Africa demonstrate that women can indeed be reached with treatment regimens, provided they have opportunities to access the public health care system and provided that adequate referral systems are in place.(Marrison *et al* 2004) The survey on accessibility to HIV/AIDS treatment in South Africa and Botswana for women and girls revealed the factors affecting access to treatment as below;

1. Types of health system;

Drugs and other forms of treatment are generally used within the various health systems of a country. Health system can be defined as public (meaning that they are provided and funded by the government) or private (meaning that they are provided and funded by commercial means or NGOs).

Traditional health systems also often function alongside other systems or, in some cases, provide an important source of care that is that easily available and accessible.

Public health system is a way that governments fulfill their duty to provide for the well – being of their people. Each country has a different method of doing this; one common way is by providing funds from the national budget to spend on health. The public health system may provide care and treatment without charge, or user fees may be charged, with the person paying all or part of the costs. Services are usually supported by national policies to control costs and to ensure safe and effective use of treatments.

Private health system is not funded by the government and they may or may not participate in government health policies or guidelines on the use of treatments. This depends on the laws about health care in a particular country. Examples includes:

Doctors, care providers, hospitals and clinics that charge for their services and drugs;

Licensed pharmacies, wholesalers and general stores that sell drugs and medical supplies;

Insurance schemes that pay for health care in return for a regular payment from the client;

NGOs/CBOs that may or may not charge for their services;

Informal providers such as markets traders and unlicensed treatment providers.

Traditional health systems involve traditional healers and the use of traditional medicines.

They are common in many countries and are important because:

In some places, they may be the main source of health care that is available locally and easily accessible;

They provide alternatives if medical treatment causes side – effects or other problems; and

They often provide socially or culturally acceptable ways to deal with illness.

Traditional healers also have a working relationship with medical practitioners in the public and private health systems. Where this happens, it can be possible to encourage traditional healers to:

Provide care and symptom relief for HIV/AIDS – related illness;

Teach people about harmful practices;

Dispel myths about HIV/AIDS;

Teach people about HIV prevention; and

Refer people to health facilities.

2. Economic and political factors;

The economic and political situation of a country also access to HIV/AIDS treatment. The poorest countries have the heaviest burdens of illness and HIV/AIDS can make existing difficulties even worse. It is much harder for people to resist infections if they do not have adequate physical and financial security, food and education. If there is an overall lack of money – both nationally and individually – there are fewer funds for care and treatment. (Cohen, 2003)

Political will, which involves deciding to make HIV/AIDS a priority, can drive action on access to HIV/AIDS treatment.

This often depends on commitment from the most senior people in power – from presidents to community leaders. Political will, can change official priorities for health care and is also important for reducing stigma and discrimination. (Pinho,2003)

3. Stage of the epidemic;

The stage of the HIV/AIDS epidemic in a country effects how many people need treatment. In turn, this affects the demands on local health systems.

Another survey on accessibility to HIV/AIDS treatment for women and girls was conducted in Thailand, the survey revealed different types of barriers to access to HIV/AIDS treatment for women and girls. These included;

Financial barriers – such as the cost of drugs and the need to prioritize other general supplies, such as food;

Organizational barriers – such as poor administration of treatment services and lack of skilled staff;

Physical barriers – such as treatment facilities being distant and transport not being available; and

Social barriers – such as stigma being associated with a treatment and people being concerned about confidentiality.(Singhanetra, *et al* 2001)

Further, in an enabling environment, women are willing to proactively organized around systems of support and care at the community level. A critical challenge, then, is to expand opportunities for interaction with the health care system and use available entry points and referral mechanisms to provide more comprehensive services for HIV – positive women, including counseling, social and economic support services, and safe shelters for women.

These experiences underscore that outreach should be expanded beyond pregnant women to includes non pregnant women, adolescent girls, women visiting family planning and reproductive health centers, youth clinics, and sex workers. (de Visser, *et al* 2002)

1.18 Survey methods;

1.18.1 Design;

This survey was longitudinal

Trend design

In all 12 months A particular group of people including people living with HIV/AIDS were studied on their knowledge and information on availability of treatment together with the barriers to access HIV treatment However after the information campaigns another study was conducted on their knowledge and if they have been able to challenge the barriers identified for those enrolled for treatment.

1.18.2Type of design;

This design is regarded as descriptive since the focus was to identify barriers to accessibility of women and girls living HIV/AIDS to Anti – retroviral drugs.

1.18.3 Limits on internal and external validity;

The validity of this design may be threatened if person with serious health problems are by chance more often assigned to one program over the other or by a different drop out rate.

Due to the nature sensitivity of topic and the issue validity, both qualitative and quantitative (triangulation) methods were applied in order to explore the required information for the survey. Some of respondents were not able to read and write, therefore approaching interview methods gave an opportunity to illiterate people to express themselves.

Awareness of certain limitations in the design of the present survey enabled the surveyors to take these limitations into account in interpretations of the findings.

1.19 Sample;

Since it is unlikely that marginalized group such as People Living with HIV/AIDS (PLWAHs) will reveal themselves, one is generally unable to rely on probability sample even if the whole population of the region could be identified. Non random sampling methods were selected. Random sampling techniques were used in both qualitative and quantitative surveys, since truly representative sample was impossible to obtain due to the fact that this is a hidden population.

Therefore in consultation with the members of Mama Africa Community based Organization, a non – random convenience sampling was selected for the present survey. The geographical scope was limited to Kikuyu North, Dodoma urban district.

Serum status

Table: 1

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid not tested	31	26.7	26.7	26.7
positive	57	49.1	49.1	75.9
negative	28	24.1	24.1	100.0
Total	116	100.0	100.0	

Sex of respondent

Table: 2

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid male	42	36.2	36.2	36.2
female	74	63.8	63.8	100.0
Total	116	100.0	100.0	

1,19.1 Response rate:-

The number of people who were expected to respond to the survey;

As stated above there were two types of questionnaires; one which surveyed on treatment barriers among the Women and Girls and the other was on knowledge and information about the HIV/AIDS and availability of treatment.

For the survey questionnaire on barriers to access HIV/AIDS treatment 60 respondents were approached and for the survey questionnaire on knowledge, information and availability of treatment 56 respondents were targeted. In order to have substantial credibility of survey the researcher managed to have an high response rate.

To capitalize on that a face to face interview was used as tool to collect information. Also the information in the questionnaires showed an obvious differences exist among respondents and non-respondents in such factors as age, education, experiences and income status.

Potential biases;

Having a member of Mama Africa sitting down with the respondents to administer the interview schedule reduced the anonymity aspect, increasing the risk of non – responses to certain questions. Furthermore, the results could have been distorted if some respondents were not perhaps giving completely honest responses. Self-completion questionnaires have a propensity for such corruption by the differences in respondents. It would have been useful to build in a second line of enquiry as check on the result-perhaps holding in-depth discussions with a cross-section of the participants. The researcher had neither the finances nor the time to provide this back-up.

Tape recording of discussion and allowing other relevant people to be interviewed to validate some of the information provided by the PLWA/Hs would have aggravated the fears of the PLWA/Hs about the risk of involuntary disclosure and could not be used.

1.20 Research Method

The essence of the methodology is to work as matter of necessity to come up with valid and reliable findings. The research work specifically data and information collection were conducted in Kikuyu, Dodoma Region. Therefore was an opportunity for me to access various reports, books, papers, articles, journals, cases and other relevant information on the ARV programs in the country.

1.20.1 Research data collection tools

Data and information for the community needs assessment were gathered mainly from three principal sources.

1.20.1.1 Secondary/Documentary sources.

Most of community profile data and information on HIV / AIDS treatment were derived from relevant documents, which were thoroughly examined. Such document include MKUKUTA, HIV/AIDS National Policy, News Papers, Dodoma Region Profile and WHO Policy Guideline on increasing Access to HIV Treatment.

1.20.1.2 Personal Interviews

Structured interviews were conducted and the following groups of people were interviewed. People living with HIV, traditional healers, Mtaa leaders, Health Assistants, CBOs members, affected families and orphans to gather with other CBOs

1.20.1.3 Observation

This enabled to gather first hand data on behaviors of people on treatment knowledge and sensitivity of treatment. This was done by observing kind of questions community members asked concerning ARV treatment. Information obtained from these methods have greatly assisted in understanding among other things the level of awareness and knowledge about ARV treatment, the motivating factors contributing to the accessibility and level understanding by the community on HIV/AIDS treatment consequences.

1.21 Research findings

1.21.1. Analysis;

The analysis of data based on a behavior- change and results were analyzed and presented on percentages because it is descriptive statistics. Score means were used to determine reliability of the survey instruments.

1.21.2. Results;

The results were presented in bar charts, frequency tables, percentages, tables, cross tabulations and pie charts.

1.21.3 Relation between results of the surveys' objectives and research or study in question.

As study hypothesis says;

Accessibility of women and girls living with HIV/AIDS to anti retro –viral drugs treatment is determined by the level of economic, external pressure and the influence of stakeholders and interests groups.

Couple voluntary HIV testing and counseling is more likely to be successful in mobilizing public support and avoid gender barriers to access HIV treatment.

Donor community, government, local community commitments and transparency are important for the momentum and sustainability of the HIV/AIDS treatment program.

Social factor which includes community view on treatment, social implication for women and men treatments users, sensitivity of treatment and cultural beliefs yielded results as shown in tables and figures below:-

Community view on treatment

Table: 3

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid positive	20	17.2	17.2	17.2
negative	74	63.8	63.8	81.0
neutral	22	19.0	19.0	100.0
Total	116	100.0	100.0	

Social implications for Male treatment users**Table: 4**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid positive	65	56.0	56.0	56.0
negative	29	25.0	25.0	81.0
neutral	22	19.0	19.0	100.0
Total	116	100.0	100.0	

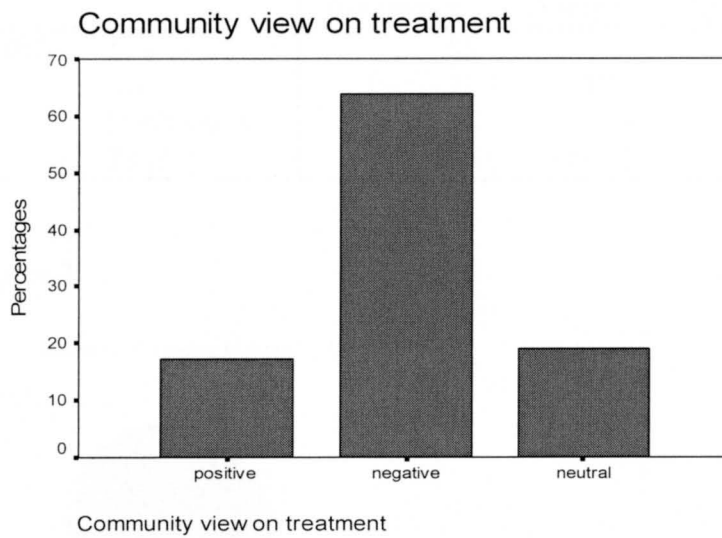
Social implication for Female treatment users**Table: 5**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid positive	40	34.5	34.5	34.5
negative	63	54.3	54.3	88.8
neutral	13	11.2	11.2	100.0
Total	116	100.0	100.0	

The reasons given were that women and girls may not access HIV/AIDS treatment because they have certain belief about the treatment. For example, they may think that drugs would not make a difference to them, or that unpleasant side-effects outweigh the benefits. Attitudes towards HIV/AIDS could also prevent people from accessing HIV/AIDS – treatment.

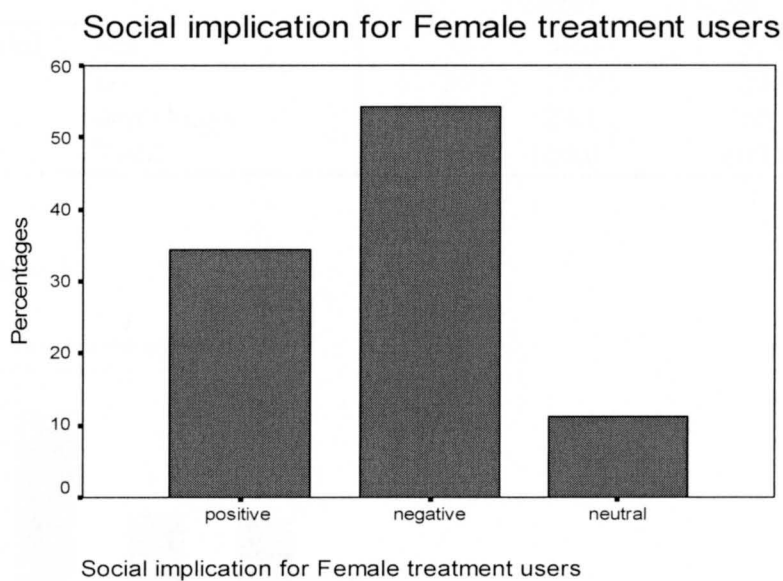
Bar Charts

Figure 1



The reason given was that women are at risk of being subjected to violence and abuse upon disclosing their HIV status, especially when they are the first to be diagnosed and are blamed for bringing the virus into the household.

Figure 2

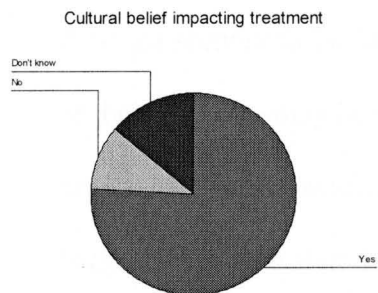


Cultural belief impacting treatment

Table: 6

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Yes	88	75.9	75.9	75.9
No	12	10.3	10.3	86.2
Don't know	16	13.8	13.8	100.0
Total	116	100.0	100.0	

Figure 3

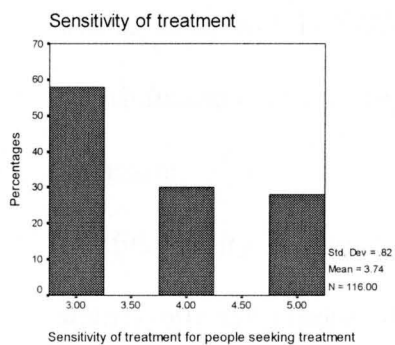


Sensitivity of treatment for people seeking treatment

Table: 7

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid yes	58	50.0	50.0	50.0
no	30	25.9	25.9	75.9
don't know	28	24.1	24.1	100.0
Total	116	100.0	100.0	

Figure 4



Generally the following important issues were uncovered;

Secrecy about a person's HIV status can result from people being afraid to talk about HIV/AIDS in their families or communities.

People experiences stigma when they feel ashamed or are made to feel ashamed about HIV/AIDS. People may also fear that others will blame them for it.

When people living with HIV/AIDS are treated unfairly, they suffer discriminations. People may fear that their HIV status will be obvious to others if they are seemed to be having treatment. This could result in loss of work or home, or their children may be stopped from going to school.

Sometimes health workers refuse to provide treatment for people living HIV/AIDS because they fear that they may become infected. They may also believe that they do not have sufficient technical skills to provide treatment;

Fear of stigma and discrimination can also prevent people from seeking treatment.

But if people living with HIV/AIDS are included in family and community activities and involved in prevention, care, support and treatment work, this can be a very effective way of reducing stigma and discrimination.

People may think that HIV/AIDS mostly affects people in specific groups, such as sex workers, men who have sex with men, gays or homosexuals and injecting drug users. Often these groups are already discriminated against or have poor access to health care, and HIV/AIDS adds to their difficulties. Overcoming stigma and discrimination is an important way of improving their access to HIV/AIDS treatment.

Confidentiality is about sharing sensitive information (such as a person's HIV status) only with those who really need to know. The person most affected by the information – the person living with HIV/AIDS – is the 'owner' of the information.

Others must respect their wishes about sharing it. Wherever possible, the person living with HIV/AIDS should be encouraged to share the information him/herself with those who really need to know. If this cannot be done, the person's consent must be obtained before passing the information to others. If people feel that their HIV status will remain confidential, they will be more likely to seek counseling, testing, treatment and support.

Another important barrier, which has impeded women and girls in accessing HIV treatment, was financial following the low economic status of women and girls.

This account for 62% of all respondents. Women and girls living with HIV/AIDS, their families and communities often face difficult choices about the costs of treatment especially laboratory and follow up tests.

Last but not least under this hypothesis are physical barriers. This accounts for 53% of all respondents. Since Kikuyu north is outside the boundaries of town.

Physical access to HIV/AIDS treatment is much more difficult. Some of the physical barriers include the following;

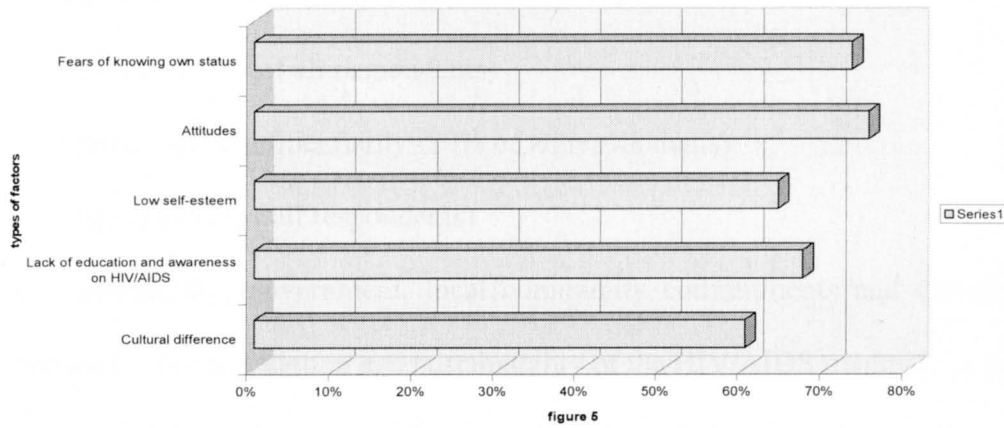
Health facilities far away, with people having to travel distances with inadequate transport.

The terrain is difficult to cross, because of hills.

There is few vehicles and other forms of transport.

For the hypothesis number 2, a number of internal and external factors in deciding for voluntary HIV testing were identified, their percentages are shown in figure 5 and figure 6 respectively (appendix 2-3). Hereunder are the identified factors:-

Internal factors in decision for voluntary HIV testing N= 116



Internal;

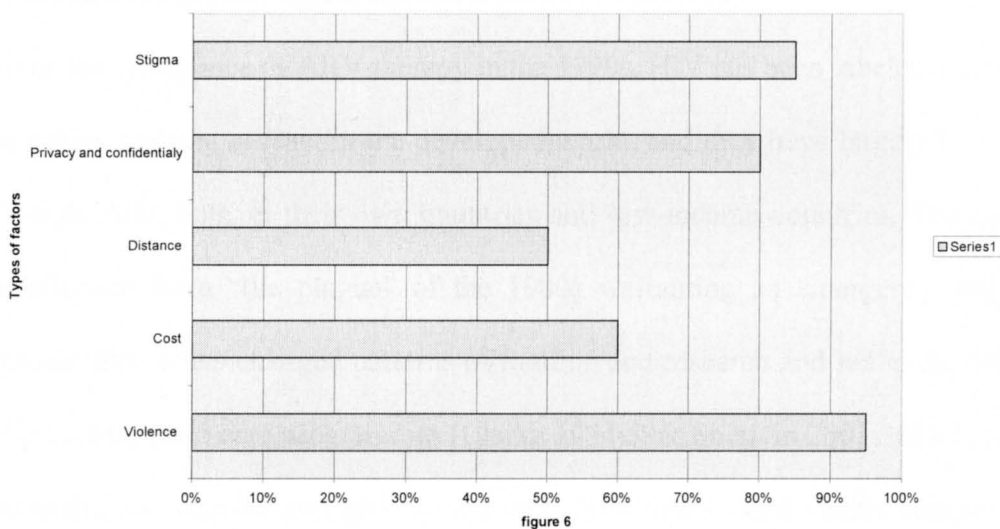
Cultural difference (60% of all respondents)

Lack of education and awareness in HIV/AIDS (67% of all respondents)

Low self esteem (64% of all respondents)

Attitudes (75% of all respondents)

Fears of knowing own status.(73% of all respondents)

External factors in deciding for voluntary HIV testing
N =116

External;

Violence especially for women and girls (95% of all respondents)

Costs (60% of all respondents)

Distance (50% of all respondents)

Privacy and confidentiality (80% of all respondents)

Stigma (85% of all respondents)

Donor community, government, local community commitments and transparency are important for the momentum and sustainability of the HIV/AIDS treatment program:-

The experiences of the women living with HIV in Kikuyu north, and in country and internationally have not always received the attention commensurate with the amount of suffering reported. Global advocacy groups have been criticizing the antipathy towards HIV that has emerged in higher-income countries that seem to consider the AIDS epidemic as one of the many catastrophes with which the developing world has to contend. Despite the fact that sub-Saharan Africa is home to 10% of the world's population, it is the poorest and the most severely affected by the HIV/AIDS pandemic, bearing 70% of the global burden.

HIV/AIDS has refocused attention on Africa but action has been limited and little has been achieved in slowing the epidemic (Benatar 2002:168).

Since the emergence of ARV therapy in the 1990s, HIV has been labeled a chronic illness by policy makers, at least in the developed world, and they have largely become passive towards AID, both in their own countries and low-income countries. The effect of this redefinition from "the plague" of the 1980s warranting an emergency response, to a chronic illness has changed patterns of funding and research and led to the scaling down of prevention and care programmes (Clarke 1994:596; Sherwin 2001:361).

Nevertheless, women and girls living with HIV/AIDS need health education to learn skills to prevent re-infection with different strains of HIV and to maintain lifestyle changes to prevent the transmission of HIV to others. Access to ARVs has been identified as an emergent risk factor, leading firstly to a propensity of HIV +ve people to

have unprotected sex, and secondly, because of poor adherence to the medication, to an increase in super-infection with resistant strains of HIV. Speaking from experience, the women and girls living with HIV/AIDS, they need greater involvement in matters that concern their well-being.

People living with AIDS or HIV want to be trained to fully understand HIV and AIDS, take care of themselves and agitate for the right to access to care, including ARV therapy and support (UNAIDS 1999:3)

1.22. Conclusions.

Throughout this survey, I have able to prove that women and girls living with HIV/AIDS faces barriers to access ARV treatment and information on availability of treatment.

Although there are about four barriers that to organizational, physical, social and financial. (UNAIDS, WHO, WORLD BANK, 2002).

Social and financial rank first and second respectively. Financial barriers is high because of the fact that people are not aware that treatment is free except for laboratory tests.

The survey has also proved that there is direct relationship between taking treatment and community support. Thus strong emphasis should be pressed to foster community mobilization for treatment support.

Political leaders of Tanzania have made commendable progress in challenging the public's denial inside the country and have also lobbied globally for financial support and transfer of skills and resources. To redress the barriers to accessing care and support, an effort must be made to make services locally available.

This will make Tanzania unique and is in contrast with the plight of the vast majority of people living with HIV/AIDS in other developing countries, who lack even the most basic care and support services. (Tanzania Human Development Report, 2005)

1.23. Summary of important points;

This survey indicated that there are possibilities for sustaining scaling up and improving HIV/AIDS care, treatment and support for women and girls living with HIV/AIDS.

Women and girls with HIV infection face multidimensional challenges in dealing with HIV/AIDS. They require self care throughout the acute and chronic stages of their illness.

Women and girls listed a number of desired services, interventions that needed to be met. The women and girls living with HIV/AIDS identified the needs as; Access to ARVs

Legal assistance

Nutrition advice

Long term supportive peer counseling

Economic assistance

The cultural perception that women might be the ones bringing AIDS into the home, infecting their children and sexual partners burdened the women with additional stress.

Identification of HIV-infected person requires active HIV counseling and testing programmes and public interest in obtaining such services.

1.24. How findings compare with those of other surveys

Obstacles identified in my survey are more or less the same as those in Botswana, South Africa and Thailand. However, the subordinate status of women combined with the ongoing stigma surrounding HIV, continues to be barrier to accessibility to treatment for women and girls living with HIV/AIDS. Community mobilization for treatment preparedness including mechanisms for delivery of ARVs, information and education

campaigns, reduction of stigma and discrimination, advocacy, adherence, social support, and referrals to other social and economic resources are issues of high resolve.

1.25 Implications and recommendations

1.25.1 Information campaigns should be designed to address the obstacles that women and girls face in accessing health care, ranging from cost of treatment, transportation, and child care.

The project needs to ensure that the community is mobilized for support of treatment program.

Monitor and evaluate the outcome of treatment program.

The project must ensure that the well-being socially and economically of people living with HIV/AIDS is enhanced so that they can participate in productive activities.

1.26. Recommendations (next steps)

I think some people are aware that there is treatment, however they do not know how they can go about it. The people living with HIV/AIDS especially women and girls and their families should be thoroughly educated on comprehensive care, with emphasis in;

Diagnosis

Treatment

Referral and follow –up

Nursing care

Counseling

CHAPTER TWO: PROBLEM IDENTIFICATION

In the past years there has been a sea change in global awareness of the magnitude of the HVI/AIDS pandemic. The world now realizes it is far more than a health crisis: that it ravages whole communities and threatens the stability and future of nations. As a result of this awakening, national leaders and development practitioners are mobilized and united as never before to focus joint efforts and leverage the resources needed to give people access to the full spectrum of prevention, care and treatment services.

In Tanzania the first three AIDS cases were reported in 1983 in Kagera region. By 1986 all the regions in Tanzania Mainland had reported AIDS cases. By the end of 1999 there were some 600,000 cases of HIV/AIDS and a similar number of orphans. It is also estimated that over 2 million people are infected with HIV/AIDS; 70.5 percent of whom are in the age group 25-49 years, and 15 percent 15-24 years. Over 72,000 new born babies were HIV infected. Women get infected at much earlier age. Among the new infections in women 69% were in the 15-24 age groups.

HIV is transmitted from one person to another mainly through heterosexual intercourse which accounts for about 90 per cent of all infection. HIV infection can also be transmitted from a mother to her child during pregnancy and during childbirth or from breastfeeding. Other modes of infection HIV transmission can be through infected blood, blood products, donated organs or bone grafts and tissues. (For desired situation see needs identification worksheet below)

Number of AIDS rates per 100,000 people as reported by UNDP in the Tanzania Human Development Report is 365.0 (Ministry of Health). By the end 1998 the UNDP reported that;

HIV- 1 prevalence among pregnant women in rural areas in 1997 ranged widely from 7.3% to 44.4%.

PROJECT IDENTIFICATION WORKSHEET

PRESENT SITUATION	DESIRED SITUATION	WHAT NEEDS TO BE DONE TO BRIDGE THE GAP
Limited Accessibility of women and girls living with HIV/AIDS to treatment	Increasing accessibility of women /girls living with HIV/AIDS to treatment	Organized information campaigns on availability of HIV/AIDS treatment
Many of people living with HIV/AIDS in the community lack business skills and have a access to micro lending program	People living with HIV/AIDS have skills to manage their business and access the loans	Linking people living with HIV/AIDS to organizations providing training on business skills and lending institutions.
Community violates the legal and civil rights of women and girls living with HIV/AIDS	Community respect the legal, human and civil rights of women and girls living with HIV/AIDS	Legal literacy campaigns and linking women and girls living with HIV/AIDS to free legal services.

HIV- 1 prevalence among pregnant women in urban areas ranged from 22 to 36%

The HIV infection rate among blood donors for 1998 was 8.5% males and 11.8% for female.

The impact of HIV/AIDS in Dodoma is 167 rates per 100,000 NACP/MOH (1998). The number of cases is a poor indicator of the situation since these are simply the number of cases reported by hospitals and extrapolated, the rates may be higher.

The World Bank estimates that AIDS will reduce real GDP growth from 3.9% without AIDS to 2.8% to 3.3% with AIDS during the period 1985 to 2010.

Overall, the HIV/AIDS epidemic has the potential to kill at least one-fourth of the country of entire adult population over the next years if left unchecked.

It can devastate the already low human development indicators and drive down life expectancy by 10 years or more. With the critical MOST of the infected persons already present in Tanzania and little discernible change in sexual behavior, the HIV/AIDS epidemic is probably the single greatest threat to Tanzania's future.

The government of Tanzania in 1988 established the National AIDS Control Programme (NACP). The latter implemented Third Strategic Medium Term Plan (SMTP) for 1998 – 2002 for the prevention and control of HIV/AIDS and STDs. The SMTP was supported by ten donors as of September 1999 and another six joined this coordinated campaign to broaden and increase the impact of HIV/AIDS projects.

Effective government and donor actions and are above all, catalytic and empowering for local communities. The medium term plan III strategic encouraged multi- sectoral approaches based in local communities and using local organizations to raise awareness. A number of Tanzanian NGOs and CBOs have responded to the nation's manifest need for AIDS education and prevention activity.

HIV/AIDS is incurable and likely to remain so for at least few years of this decade. Extensive research and some human trials have been conducted in the search for a vaccine that could stop the spread of the disease but more has yet been successful. Advance has been made in treating patients' opportunistic infections and in reducing the viral load in the body through the use of AZT, protease inhibitors and a 'cocktail' of the drugs. Fortunately the Tanzania government has made the financial and political investment to extend ARV treatment for 400,000 people living with HIV/AIDS.

"The whole society must now wake up and fight together against this calamity. Unless we end this conspiracy of silence, all of us, the whole nation, shall perish" - President Benjamin William Mkapa

"Treatment can turn AIDS from a death sentence into a chronic illness ... Now that we have the medical capacity to save and improve the lives of millions of people, there is no other moral or practical choice."

- President William Jefferson Clinton

"The way we deal with AIDS in Africa will determine Africa's future."- Secretary General Kofi A. Annan

This initiative of the government of Tanzania and donors to provide free Anti-retroviral treatments for the people living with HIV/AIDS debate and signal unprecedented new phase in struggle against HIV/AIDS.

2.0 The extent of problem;

2.1 Introduction

The increasing accessibility to HIV/AIDS treatment for girls and women project supported the implementation of Tanzania government initiative to provide free - anti retroviral drugs for people living with HIV. The project ensured equitable access to HIV treatment and care, notably for acutely vulnerable populations such as girls and women.

The project focused on cross cutting and institutional actions which facilitated progress towards ensuring equitable access to HIV treatment for girls and women.

2.1.1 Problem to be solved;

For people to use treatment, it must not only be available but also accessible. This means that the treatment should be found in the appropriate place and that it should be easy for people to obtain and use properly.

Barrier to access to treatment is anything that prevents a person from getting the treatment they need. There can be many barriers for people living with HIV/AIDS. These barriers may be related to;

A service – such as its location, costs, staff attitudes, skills or facilities and services offered. For example, a clinic might only be open during the day when many people living with HIV/AIDS are working.

The context – such as the political, economic and cultural situation in which treatment is provided. For example, women might not be able to access treatment for STIs because sex is taboo subject or because of the stigma of being seen at an STI clinic.

Attitudes to treatment – such as the knowledge and beliefs of community members.

For example local people might believe that HIV counseling and testing are only for members of high – risk groups such as sex workers.

There are many different types of barriers to access to HIV/AIDS treatment. These include;

Financial barriers – such as the cost of drugs and the need to prioritize other general supplies such as foods.

Organizational barrier such as poor administration of treatment services and lack of skilled staff.

Physical barriers – such as treatment facilities being distant and transport not being available; and

Social barriers – such as stigma being associated with a treatment and people being concerned about confidentiality.

Any work on HIV/AIDS treatment must respond to the real needs of people living with HIV/AIDS and of the community. An assessment should start by looking at the HIV/AIDS situation in the community, the impact of HIV/AIDS on the community, the type of treatment people need, what they currently do when they need treatment and what existing resource are available.

An assessment can also look at what a person does about illness and how that is influenced by different factors and people including family, friends and the community. Learning what happens to people on their journeys to seek treatment helps to build an understanding about the overall strengths, weaknesses, and gaps of existing services in the community. It is also important to understand the community's attitudes towards illness and the community's perceptions of risk that those involved in providing treatment may face.

2.1.2 Problem Statement.

The HIV/AIDS crisis disproportionately affects women; women are infected at higher rates they are economically less able to care for themselves or all family members, they can infect their new born children and they are the ones who become primarily responsible for AIDS orphans. Many infected women are higher than in rural areas which remove substantial numbers of educated women from the productive labor force.

Biologically women are more susceptible to most sexually transmitted diseases than men, at least in part because of the greater mucosal surface exposed to a grater quantity of pathogens during sexual intercourse. In addition, the risk of transmission of STDs including HIV infection is greater whenever the vaginal mucosa is damaged. As a result of such factors most STDs including HIV infections, are more transmitted more readily from men to women than from women to men.

These biological factors are compounded by social cultural ones. In many parts of the World women have little or no control over decisions relating to sexuality, nor do they have control over their sexual behavior of their male partners or the use of condoms for the prevention of STD/HIV infection or pregnancy.

Treatments with antiretroviral therapy can transform HIV/AIDS from a devastating and deadly disease to a chronic illness and enable people living with HIV/AIDS to attain an improved quality of life as we do said the traditional healer. Patients are liberally able to return to their and are likely to experience few opportunistic infections.

Treatment is also indispensable element of prevention and therefore can be part of comprehensive approach that combines prevention, care and treatment. Availability of treatment can lead to a significant reduction in new infections. ARV treatment has provided hope that HIV-positive people can lead active, health lives.

The uptake in treatment is influenced by financial, physical and social factors, and reflects many of the long-standing barriers that women have faced in accessing health care. However in era of HIV/AIDS, these factors are often exacerbated by threats of violence, abandonment; especially lose of economic support and fear of isolation and discrimination.

In Kikuyu North area there are about 200 women who are living with HIV/AIDS. Interview with those people revealed that traditional barriers to health care for women include; cost for services especially pre treatment-laboratory tests, distance to a health facility and a quality of care. Delay in making decision to seek treatment (by individual, the family or both, depending on decision makers and status of women). Delay in reaching health facilities (including travel time and cost of transportation) and delay in receiving treatment (including shortage of equipment, trained personal, and competence of personal), have hindered women's access of quality HIV/AIDS care and treatment.

The differential use of health services related to gender and socio-economic status. Indeed cost and distance often work together to affect the decision making process, since longer distances means higher transportation costs which are especially relevant for poor, rural woman. The stigma and shame associated with sexually transmitted infections compounded by attitudes of health care providers, contribute to delay in seeking treatment.

Girls in particular often face greater stigma in seeking information and services related to STIs, which takes on greater urgency given that the presence of STIs increases the risk of HIV/AIDS transmission.

Power relations within the family often preclude women from making their own decisions to seek health care, since they often must seek approval from their spouse or other senior family member.

CBOs member interviewed pointed out that this circumscribes women's ability to travel and determines whether the family will pay the cost of treatment. This consideration frequently applies unequally to women, men, girls, and boys with the prevalence for treating the males. Social dynamics are an obstacle of treatment for women.

Violence against women and the threat of violence affect multiple aspects of HIV prevention and care. Women risk being subjected to violence and abuse upon disclosing their HIV status "especially when they are the first to be diagnosed and are blamed for bringing the virus into the household" said divorced women living with HIV/AIDS. "This causes many women to lack autonomy in decisions about HIV testing and compelled to seek permission from their partners" said the Mtaa leader.

HIV/AIDS being a social, cultural and economic problem, women and girls need extra consideration to protect them from the increased vulnerability to HIV infection in the various social, cultural and economic environments as stipulated in the National Policy on Gender and equity.

The CBO I am working with, among other objectives it aims at improving the living condition of people living with HIV/AIDS.

The community based organization is working in Kikuyu North, Dodoma region a place hard hit by AIDS. A number of interviews conducted, reports provided secondary data information.

2.3 Hypothesis tested were;

Accessibility of women and girls living with HIV/AIDS to anti retro –viral drugs treatment is determined by the level of economic, external pressure and the influence of stakeholders and interests groups.

Couple voluntary HIV testing and counseling is more likely to be successful in mobilizing public support and avoid gender barriers to access HIV treatment.

Donor community, government, local community commitments and transparency are important for the momentum and sustainability of the HIV/AIDS treatment program.

2.4. Target Community

All the primary beneficiaries were, involved in the process. These included people living with HIV/AIDS, men, women and girls, effected families, community based organizations, orphans, traditional healers, and government officials in health and community development departments.

They have participated in preparation of project document. At each point stakeholders' views have been solicited and incorporated into the project document. Plans for project preparation and project implementation both included provisions for on going consultation and participation throughout the process.

2.5. Stakeholders involved included;

Mtaa Leaders – This is elected leadership usually after five years and among their key responsibilities is to make sure that policies and decisions of the council on one side and decisions of ward government on the other side are implemented.

Health Assistants

These are responsible for community health education. They also assist professional staff with mundane duties. They are responsible in informing residents about the services of all community agencies and to refer people in need to the agencies.

Traditional Healers

Traditional healers are plentiful and culturally accepted health care providers in Kikuyu area. Traditional healers after experiencing a divine “call” (often through a dream or traumatic illness) will undertake training from a willing healer. The duration of training varies and competence is assessed by the individual trainer.

Traditional healers represent a broad range of practices, including herbalism and spiritualism, as well as range of individuals who call themselves diviners, priests and faith healers, among other terms.

The following points are made in favour of collaboration according to interview and (Oja and Steen, 1996).

- Traditional healers often outnumber doctors by 100 to more in most African countries. They provide a large accessible, available, affordable trained human resource pool.
- Traditional healers possess many effective treatments and treatment methods.
- Traditional healers provide client – centred, personalized healer care that is culturally appropriate, holistic, and tailored to meet the needs and expectations of the patient. Traditional healers are culturally close to clients, which facilitates

communication about disease and related social issues. This especially important in the case of STDs.

- Traditional healers often see their patients in the presence of other family members, which sheds light on the traditional healers' role in promoting social stability and family counseling.
- When traditional healers engage in harmful practices, there is a public health responsibility to try to change these practices, which is only possible with dialogue and cooperation. Research has shown that traditional healers abstain from dangerous practices when educated about the risks.
- Traditional healers are generally respected health care providers and opinion leaders in their communities, and thus are treating large numbers of people living with HIV/AIDS. Healers have greater credibility than village health workers (who are often their counterparts in village settings), especially with respect to social and spiritual matters.
- Since traditional healers occupy a critical role in African societies, they are not likely to disappear soon. They survived even strict colonial legislation forbidding their practice. Even with the rapid sociocultural changes occurring the variety of psychosocial problems that arise from conflicting expectations of changing societies.

People Living with HIV/AIDS

These are people who have been infected with HIV (UNAIDS 2005)

CBO members

Community based organization members are the members of the CBO paying monthly fees and activities in the organization's activities (Mama Africa constitution, 2000)

Affected Families and Orphans.

Affected families these are families who live with person living with HIV/AIDS (FHI, 2002). Orphans this refers to child who may not be HIV positive but may have lost one or both parents due to HIV. (UNAIDS, 2005)

Other CBOs

CBOs these are organizations that provide social services at the local level. They are non-profit organization who are based primarily on volunteer efforts.

This means that CBOs depends heavily on voluntary contributions for labour, material and financial support (Yvette *et al* 2006)

2. 6. Project goals.

To increase and ensure equitable access to HIV treatment for women and girls living with HIV/AIDS.

2.6.1 Project objectives.

To conduct six information campaigns for interest groups on availability of treatments in Kikuyu area by 2007.

To mobilize 50 women and encouraging 10 couples counseling at VCT and MTCT to better ensure the involvement of male partners in Kikuyu by 2007

To increase economic empowerment for 40 women living with HIV through access to micro-credit programs, job and skills training and assistance with property and inheritance rights in Kikuyu area by 2007

2.7 Host organization.

Name of the organization managing the project; Mama Africa Women Group

The project is implemented by only Mama Africa Women Group.

The project is located at Kikuyu North P.O BOX 235, Dodoma, cell 255 754 491986

2. 8 Mission statement of CBO;

This is the overall purpose according to which an organization operates .

This is statement that shows, target group, methodology, product offered, can be reviewed as circumstances change

Mission statement

Mama Africa Group is determined in educating community/society on scourges of HIV/AIDS through participatory involvement in educating, sensitization and research.

The CBO defined the project goals as relevant to their mission because this project has brought the group around the common purpose. This has enabled the organization to plan project that is consistent with organizational objectives.

Interest groups were willing to participate in the project because of ownership of project generated through involving them in identifying issues and needs in the community, prioritizing them, generating alternative strategies to address them, and tracking down the most appropriate strategy to implement the project.

Commitment among the actors and target groups assured that the project will achieve its goals because the project evolved from the grassroots and it is their initiative and creativity, are the one who defined their needs, problems and issues: developed plans and strategy to meet these needs.

CHAPTER THREE: LITERATURE REVIEW

By the end of 1999, it is estimated that 33.6 million adults and children were living with HIV/AIDS, and 16.3 million had already died. In the same year there were 5.6 million new infections of which 4 million were in sub-Saharan Africa. Cumulatively, it is estimated that 13.2 million children have been orphaned globally by HIV/AIDS and about 9.4 Million are in Africa alone. (United Nations 2002).

In the African continent the first AIDS cases were also reported in early 1980s. By 1987 the epidemic had become concentrated in most of countries in sub-Saharan Africa. Of the estimated 33.6 million cases of HIV infections in the world about 23 million cases are in Sub Saharan Africa, Tanzania being one of the most affected countries.(The United Republic of Tanzania, HIV/AIDS National Policy 2001)

Due to the fact that HIV infection is mainly through heterosexual intercourse, HIV/AIDS is a social, culture and economic problem, which touches on the private lifestyles of individuals. Therefore the risk of HIV infection is highest among young people, and especially girls. Girls and women in our social and cultural environment are more vulnerable to HIV infection as they do not have control over their sexuality. Poverty increases the vulnerability of HIV infection as some women engage in high risk sexual behavior for survival. (WHO 2002)

The time has come to recognize and issue clear guidance and criteria to clarify how the imperatives, beyond HIV/AIDS or even the health sector, are directly linked to women's vulnerability to infection and to their ability to access and adhere to care and treatment.(WHO/UNAIDS 2002).

This literature review is an account of what has been published on ensuring access to HIV/AIDS treatment of women and girls by accredited scholars and researchers. This literature review will be treated in theoretical, empirical and policy.

3.1 Theoretical literature review;

AIDS or Acquired immunodeficiency syndrome or acquired immune deficiency syndrome is defined as a collection of symptoms and infections resulting from the depletion of the immune system caused by infection with the human immunodeficiency virus, commonly called HIV (WHO 1985).

The body has an immune system that helps keep out infections. Immune system keeps out infections the way a house protects one from rain and cold.

HIV is a virus that attacks the immune system. HIV enters the body slowly invisibly and breakdowns the immune system over time, HIV breakdowns the body the same way termites destroy a house. (Orbone, 1996)

When the immune system can no longer protect the body from infections, a person has AIDS (UNAIDS, 2001)

The body becomes like a house that falls apart and can no longer be protected from rain and cold.

The symptoms of AIDS are primarily the result of conditions that do not normally develop in individuals with healthy immune systems. Most of these conditions are opportunistic infections that can be treated in healthy people.

Stage I: HIV disease is asymptomatic and not categorized as AIDS

Stage II: include minor mucocutaneous manifestations and recurrent upper respiratory tract infections.

Stage III: includes unexplained chronic diarrhea for longer than a month, severe bacterial infections and pulmonary tuberculosis or

Stage IV: includes toxoplasmosis of the brain, candidiasis of the esophagus, trachea bronchi or lungs and Kaposi's sarcoma; these diseases are used as indicators of AIDS.

Since the beginning of the epidemic, three main transmission route of HIV have been identified namely, sexual, blood to blood product and mother to child (*WiseInfo.info* accessed on 06/04/2006).

i). Voluntary Counseling and Test (VCT):-

Provides of all segments of the population, an opportunity to access complete and accurate information on HIV/AIDS. This is a critical entry point to prevention, care, support and treatment for all people, and particularly for those already infected and affected. It enables a person to confidentially explore and understand his or her risk of HIV infection, provides an opportunity to fully comprehend the implications of one's sero status and to learn about precautions for protection and for preventing the further spread of HIV infection. VCT facilitates personal, and more informed decisions about HIV testing. (Kipitu, 2005)

In the event of a positive HIV test result, counseling strengthens strategies for coping with the immediate stress, possible stigma, psychological and social impacts. It provides referrals to appropriate facilities for care, support and treatment and promotes more informed choices for the future. (AID report, 2004)

Voluntary Counseling and Testing (VCT); is the process by which an individual undergoes confidential counseling to learn about his/her HIV status and to exercise informed choices in testing for HIV followed by further appropriate action. A key underlying principle of the VCT intervention is the voluntary participation. HIV counseling and testing are initiated by the client's free will.(WHO,1997)

Counseling in VCT consists of pre-test and post-test counseling. During pre-test counseling, the counselor provides to the individual /couple an opportunity to explore and analyze their situation, and consider being tested for HIV. It facilitates more informed decisions about HIV testing. After the individual / couple has received accurate and complete information they reach an understanding about all that is involved. In the event that, after counseling the individual decides to take the HIV test, VCT enables confidential HIV testing. (Pinel, 1999)

ii) Voluntary;

Seeking knowledge of HIV status is voluntary. The decision to pursue testing for HIV must be made by the client who seeks counseling and testing services. (Kipitu, 2005)

iii) Client;

A person seeking health care services including VCT, is a client and not a patient. Patients are considered passive recipients of treatment /care/hospitalization, whereas clients are “consumers” who make a choice whether or not to avail of a certain services. (Kipitu, 2005)

iv) Counseling for HIV/AIDS;

Counseling is essentially a confidential dialogue between an individual / couple (male/female) and a counselor, aimed at enabling the individual to make personal decisions in the context of HIV/AIDS. The counseling process includes an evaluation of personal risk of HIV transmission and acceptance of preventive behaviour. HIV counseling is a behaviour change interaction aimed at HIV prevention.(Afuayi, 1999)

Pre-test counseling provides an opportunity for clients to explore their risk of HIV, to learn about strategies for prevention of HIV, and helps clients decide whether or not to take HIV test. Counseling must be offered to any client who is considering taking an HIV test. After the test, there is a session called post-test counseling and clients are informed of their HIV test result during this interaction.

3.1.1 The window period;

The window period is described as the time it takes for a person who has been infected with HIV to “seroconvert” (test positive) for HIV antibodies. A person who tests during the window period may receive a negative test result even though s/he may be HIV positive. Prior to testing, it is important to determine risks and possible exposure to HIV in the window period and any potential exposure must be followed by a re-testing at the end of the window period (usually after three months). (Colebundes et al, 1997)

3.1.2 A woman;

A woman is an adult female human being, as contrasted to a man, an adult male, and a girl, a female child. The term woman (irregular plural: women) is used to indicate biological sex distinctions, culture gender role distinctions, or both. In the age context it is between 19-45 years old. (WHO, 1989)

3.1.3 A girl;

Is a female human child, as contrasted to a male child, which is a boy. The term “girl” is used to indicate biological sex distinctions, cultural gender role distinctions, or both. An adult female human is a woman. A woman may be referred to colloquially as a “girl” in certain contexts; for example the word is commonly used when discussing adult females in relationships, such as in the word girlfriend, which is often simply abbreviated to “girl”, age limit is 13-18 years.(WHO, 1989)

3.1.4 Access to treatment;

For people to use treatment, it must be available meaning that it can be found anywhere that is appropriate.

Access to drugs depends on four key factors;

Rational selection – choosing drugs that are safe, effective, valuable to public health and guaranteed to be of good quality.

Affordable price – governments and individuals must be able to afford their essential medicines and maintain people's health;

Sustainable finances – the money to pay for treatments must continue to be available when needed and in changing circumstances.

Teliable health systems, access to drugs needs to be supported by system that ensure availability whenever the drugs are required. (Harries et al, 2001)

There is currently no cure or vaccine for HIV/AIDS. Infection with HIV leads to AIDS and ultimately death. However patients may live for many years following diagnosis because of the availability of the highly active antiretroviral therapy (HAART).

In the absence of HAART progression from HIV infection to AIDS occurs at a median of between nine to ten years and median survival time after developing AIDS is only 9.2 months. HAART dramatically increase the time from diagnosis to death and research continues in drug treatments and vaccine development (UNAIDS 2002).

ART means treating retroviral infections like HIV with drugs. The drug do not kill virus. However they slow down the growth of the Virus. So when the Virus is slowed down, so is HIV disease. Antiretroviral drugs are referred to as ARV. ARV therapy is referred to as ART. (AIDS info net 2005).

ART slows down the HIV from multiplying and less viruses attack the immune system. ART helps the immune system get strong so it can keep out opportunistic infections. Just like repairing a house helps keep out the rain (USAID 2005).

3.1.5 HIV testing;

People often ask for an HIV test because they have some symptoms such as continual diarrhoea. A laboratory test, to check a sample of blood, can confirm the diagnosis. Sometimes trained health workers can diagnose HIV infection without testing, because the person's pattern of illness strongly suggests that HIV is the cause.

However, testing, like any form of treatment, should be carried out only with the informed consent of the person.

Early testing and diagnosis for HIV can be very helpful because, when know their HIV status, they can act both to take care of themselves and to avoid passing the virus on to others. If the results is positive, they can get the care and support they need for living with HIV/AIDS. (MSH,2000)

This process should be accompanied by appropriate information, counseling and support to help the person to cope with the news, to seek the treatment that they need, and to plan for the future.

3.1.6 Antiretroviral therapy (ART)

In the booklet called Basic facts about Anti-retroviral therapy by family health international, the following main issues concerning Anti-retroviral treatment were outlined:-

If immune system is very weak, one may consider taking treatment called ART. The full name for ART is antiretroviral therapy. If your immune system is still strong, there are other ways that you can protect yourself from opportunistic infections. As having nutritious foods.

3.1.7 How ART works

ART slows down the HIV virus from multiplying and therefore less viruses attack the immune system. ART helps the immune system get strong so it can keep out opportunistic infections. Just like repairing a house helps keep out the rain.

When people take ART they get sick less often and feel better for longer periods of time.

CD4 TEST

The strength of your body immune system can be determined by a doctor through a CD4 test.

Even if you do not feel sick, your doctor may advise you to take a CD4 test. After this test is done, the doctor is able to advise you on how to keep your body healthy.

3.1.8 Opportunistic Infections;

Infections that attack the body when it is weak are called opportunistic infections.

Opportunistic infections enter the body when the immune system is weak the way rain enters a house that is falling apart. Opportunistic infections cause very serious problems when a person's immune system is weakened by HIV/AIDS.

Just as a house that is well kept lasts longer, a person who takes good care of him or herself will live longer. That is why it is important to protect yourself from opportunistic infections. .

ART is several different medicines; when you take ART, you take several different tablets every day. ART medicines work together as a team to slow down HIV.

ART medicines do not work alone.

ART Does Not Cure HIV; ART does not get rid of all the HIV, it keeps it from spreading. For ART to work, you must take all the ART tablets at the same time, everyday if you miss tablets, HIV will spread and the ART will not be able to stop it.

The booklet continues by acknowledging the fact that:-

ART is a big decision your doctor can help you learn about ART, but the decision has to be made by you. You have to take tablets every day, for the rest of your life. You may have to eat and drink at certain times; others may find out you have HIV when they notice the medicines you are taking. Some ART drugs and food don't work well together.

Making a Commitment to ART;

Start ART only when you are ready to make a life – long commitment. Stopping and starting, and missing tablets stops the ART from working. Taking some of the tablets, but not the others, also stops ART from working.

The booklet also highlights the following:-

Ask someone to help you remember; your doctor can help you think of ways to help you take your medicines. It helps to have someone you trust, a family member or friend to help you remember to take your ART tablets.

3.1.8.1 ART side effects;

When you start ART you may have some discomfort called side effects. Tell your doctor who may then be able to make the medicines easier to take. For a few people ART can cause more serious side effects. Tell your provider right away about any side effects, even the minor ones. This will help you avoid any serious health problems.

ART does not cure HIV;

If you are taking ART, you can still give HIV to someone else. ART does not prevent re-infection from HIV; if you are taking ART, you can still get HIV again. This may make your immune system weaker. Protect yourself from HIV; while you are taking ART, continue to protect yourself and others by using a condom or not having sex. Remember by engaging in unprotected sex you can still infect others. Go to VCT centers for HIV protection counseling; Clinics with a Voluntary counseling and Testing {VCT} sign can help you talk to your partner about HIV and protection.

3.1.8.2 ART and pregnancy;

It is very important to tell your doctor if you are pregnant or want to have a baby.

You can get pregnant while you are using ART. Ask you're about family planning choices. Your doctor can help you make a decision about what methods to use. If you get pregnant while using ART, there is a small chance that you will give HIV to your baby.

Some ART medicines are safer during pregnancy than others;

Some ART medicines are safer to use while you are pregnant. Talk to your doctor about which ART medicines to use.

And, remember, tell your doctor right away if you are pregnant or want to have a baby.

Your doctor can help you make a decision about what to do.

The booklet concluded that:-

Taking ART;

It helps to have someone you trust, a family member or friend, to help you remember to take your drugs. It takes practice to remember to take your ART drugs. Here are some ways to help you remember; Put the ART drugs where you will take them. Take the ART drugs at the same time everyday. .

How to remember ART;

Write notes, use stickers, clocks, or calendars to remind you to take your ART.

Plan ahead for work and safaris; Plan ahead for work, plan ahead for how you will take the ART when you are at work, if you go on safari, pack more tablets than you need. This will give you enough tablets if you stay away longer. If you forget to take your tablets; don't take twice the tablets at the same time. Skip the missed tablets and return to your regular schedule.

If you are having problems taking your ART drugs; if you are missing a few tablets a week, for a few weeks tell your doctor. If you don't tell anyone they can't help you

If you want to stop taking ART;

Before you stop taking ART, talk to your doctor. You must stop all your ART pills at the same time. ART medicines work together like a team. They do not work alone.

Never share your ART drugs keep ART in a safe place; like all medicines, keep ART in a safe away from children.

Starting ART again after you have stopped;

You might be able to start taking them again later. Sometimes ART does not work as well if you stop for a while and start again later. Talk to your doctor if you are thinking of starting ART again. It is very important to take the right ART medicines.

3.1.9 Treatment;

Treatment is a key element of care and support for people living with HIV/AIDS. It can be:

Curative – curing disease either temporarily or permanently;

Preventive – preventing disease from happening or becoming worse; and

Palliative – reducing symptoms in order to reduce discomforts and distress.

However, treatment is not just part of a linear process of ensuring that drugs are accessible to those who need them.

For medicines to be effective there should also be access to other forms of care and support. These can even without drugs, provide some relief from illness and improve a person's well –being. They also encourage better use of drug treatment when it is necessary.

For example, if people have support from their communities and have food and clean water, they will be better able to resist illness, but they are also likely to benefit more from medicines when they need them.(UNAIDS, 2003)

Treatment needs vary depending on the stage of illness. These effects where treatment should take place and what resources are required. The needs of people living with HIV/AIDS should be central to deciding where treatment is provided. People living with HIV/AIDS need treatment to be accessible in different location at different times. Sometimes it can start in one place {such as hospital} and continue in another {such as a person's home}.

This can be better for the person who is ill, and it may reduce the cost and complexity of the work. When treatment is being given in different locations, it is important to have effective coordination of information, resources between the places.

3.1.9.1 Linking treatment and prevention

HIV prevention aims to prevent the transmission of HIV and reinfection. HIV/AIDS – related treatment aims to improve the quality of life of people living with HIV/AIDS.

HIV prevention and HIV/AIDS – related treatment support each other in many ways;

Well –designed HIV prevention activities can lead to increased voluntary counseling and testing {VCT}, which in turn can lead to broader and quicker access to treatment for people living with HIV/AIDS.

Well – designed HIV prevention activities can reduce fear and stigma around HIV/AIDS, which in turn improves the quality of life of people living HIV/AIDS as they become more accepted and understood in their families and communities.

Through VCT, people can learn about HIV prevention and, if they are HIV –positive, be given information about how to live safely with the virus and plan for the future. VCT also helps people to get assistance early on and to learn about possible treatments for health problems that may occur. For example, VCT can be helpful for preventing tuberculosis {TB} and sexually transmitted infection {STIs}.

If women learn that they have HIV/AIDS, because of prevention programmes and VCT services, they can access services which, if they become pregnant, will reduce the chance of passing on HIV to their unborn or newborn children. Women and men might also choose to increase contraceptive use.

Access to care and support has been shown to increase condom use and other preventive behaviour among people living with HIV/AIDS. These positive changes can be reinforced when care and treatment programmes deliberately promote and distribute condoms.

Increased availability of care and increased visibility and acceptance of people living with HIV/AIDS makes the broader population more aware of HIV/AIDS and increase safer behaviour. (Sangiwa, *et al* 2000)

3.1 .9.2 Accessibility of treatment

For people to use treatment, it must not only be available but also accessible. This means that the treatment should be found in the appropriate place and that it should be easy for people to obtain and use properly.(UNAIDS, 2003)

Sometimes, drugs for a treatment can be available locally but are not accessible. This might occur because;

People cannot afford the right drugs.

The treatment provider discriminates against people living with HIV/AIDS and refuses to give them the drugs.

The treatment provider does not have the right skills to give the drugs and It is too difficult for people living with HIV/AIDS to get where the drug is available. (UNAIDS, 2003)

A barrier to access to treatment; is anything that prevents a person from getting the treatment s/he needs. According to (UNAIDS, 2003); there can be many barriers for people living with HIV/AIDS. These barriers may be related to:-

A service – such as its location, cost, staff attitudes, skills or facilities offered. For example, a clinic might only be open during the day when many people living with HIV/AIDS are working.

The context – such as the political, economic and cultural situation in which treatment is provided. For example women might not be able to access treatment for STIs because sex is a taboo subject or because of the stigma of being seen at an STI clinic

Attitudes to treatment – such as the knowledge and beliefs of community members. For example, local people might believe that HIV counseling and testing are only for members of high-risk groups such as sex workers. (UNAIDS, 2003)

There are many different types of barriers to access to HIV/AIDS –related treatment.

These include:-

Financial barriers – such as the cost of drugs and the need to prioritize other general supplies, such as food;

Organizational barriers- such as poor administration of treatment services and lack of skilled staff;

Physical barriers – such as treatment facilities being distant transport not being available;

and Social barriers – such as stigma being associated with a treatment and people being concerned about confidentiality. (UNESCO, 2002).

3.1.10 The basic elements of treatment work;

3.1.10.1 A supportive relationship for treatment work;

Supportive relationships aim to improve the quality of people's lives. They are at the core of providing effective treatment for people living with HIV/AIDS.

Supportive relationships are important in HIV/AIDS – related treatment work for the following reasons:-

They bring together someone who needs treatment and someone who can respond to those needs in a supportive and effective way;

They are based on identifying the needs of the person seeking treatment and helping that person to live a better and longer life;

They are two-way-with both people needing openness, cooperation and information for treatment to be effective; and they are based on trust and need to grow over time. (UNESCO, 2002)

There are many kinds of supportive relationships such as that between a doctor and a patient and that between a community volunteer and someone who is ill at home.

Supportive relationships in treatment work are built and maintained in different ways:-

Making treatment available and accessible helps to build trust within supportive relationship.

Supportive relationships promote good use of treatment – because even drug-based treatments need a supportive environment in order to work properly.

People living with HIV/AIDS can both help themselves and support others affected by HIV/AIDS. Any relationship involving people living with HIV/AIDS needs to be based on a positive attitude and a belief that treatment is worthwhile.

A health worker who prescribes HIV/AIDS – related drugs has special technical knowledge and skills that people needing treatment often do not have. The skilled helper and the person living with HIV/AIDS should decide together what treatment is useful and what effect it might have on the person's life, not just medically but also economically and socially.

A person living with HIV/AIDS needs to be respected as someone who can make choices about treatment. Treatment will be more effective if the helpers, with technical knowledge, encourage people living with HIV/AIDS to be actively involved in their own treatment.

A person living with HIV/AIDS who helps her/his seronegative partner to avoid infection, and a seronegative person who supports a person living with HIV/AIDS to maintain treatment use, are also examples of supportive relationships (UNESCO,2002)

3.1.11 Adherence

3.1.11.1. What is adherence?

Adherence refers to how closely follow a prescribed treatment regimen. It includes your willingness to start treatment and your ability to take medications exactly as directed.

(Beatty *et al* 1997)

3.1.11.2 Is adherence important for HIV treatment

(Ickovics *et al* 1997) Uncover that, adherence is a major issue in HIV treatment for two reasons:

- Adherence affects how well anti-HIV medications decrease your viral load. When you skip a medication dose, even just once, the virus has the opportunity to reproduce more rapidly. Keeping HIV replication at a minimum is essential for preventing AIDS-related conditions and death.
- Adherence to HIV treatment helps prevent drug resistance. When you skip doses, you may develop strains of HIV that are resistant to the drugs you are taking and even to drugs you have not yet taken. This may leave you with fewer treatment options should you need to change treatment regimens in the future. Because drug – engaging in risky behavior can have especially serious consequences.

Although there are many different anti-HIV medications and treatment regimens, studies show that your first regime has the best chance for long-term success. Taking your drugs correctly (adherence) increases your odds of success.

3.1.11.3 Why is adherence difficult for many people with HIV?

HIV treatment regimens can be complicated; most regimens involve taking multiple pills each day. Some anti-HIV medications must be taken on an empty stomach, while others must be taken with meals. This can be difficult for many people, especially for those who are sick or are experiencing HIV symptoms or negative drug side effects. (Shelton *et al* 1998).

Other factors that can make it difficult to adhere to an HIV treatment regimen include:

- Experiencing unpleasant medication side effects (such as nausea)

Viral load: the amount of HIV in a sample of blood.

- Sleeping through doses
- Traveling away from home

- Being too busy
- Feeling sick or depressed
- Forgetting to take medications. (*Ibid*)

3.1.11.4 What can I do to adhere to my treatment regimen?

(Hecht, *et al* 1998) propose that, there are many things you can do to better adhere to your treatment regimen.

One of the most important things you can do when starting a treatment regimen is to talk with your doctor about your lifestyle. He or she will then be able to prescribe a regimen that works best for you. Topics you should address with your doctor include.

- Your travel, sleep and eating schedule
- Possible side effects of medication
- Other medications you are taking and their possible interaction with anti-HIV medications
- Your level of commitment to following an HIV treatment regimen

Many people adhere well to their treatment early on, but find adherence becomes more difficult over time. Talk with your health care provider about adherence during every visit. Your commitment to treatment plan is critical; studies show that patients who take their medications correctly achieve the best results.

3.2 Empirical literature review;

There are few examples of developing countries making the financial and political investment to extend ARV treatment beyond the privileged few, with Brazil being the first – and until 2002 the only – developing country to guarantee universal access to treatment (Presidential decree, 1996).

Botswana – a country with 38.8 percent prevalence, (UNAIDS, UNICEF, and WHO 2002), the highest in the world, but also a middle – income country in Africa started to offer ARVs through the public health system.

This program has been made possible through a joint initiative of the government of Botswana, the Bill and Melinda Gates Foundation, and the Merck Company Foundation, known as the African Comprehensive HIV/AIDS Partnerships (ACHAP).

Other partnerships include a collaborative research partnership between the Botswana Ministry of Health and the Harvard AIDS Institute, and one between the government and the Centers for Disease Control and Prevention to set up sites across the country (Marrison *et al* 2004).

Despite the realities of stigma and discrimination, data from Botswana indicate some promising developments that may help address obstacles to treatment. Although the uptake in testing and treatment has been slower than expected, more women than men are accessing VCT and treatment services.

Approximately 11,000 patients are on ARVs, with 6,000 in Gaborone, of whom 57 percent are female. In the other nine sites, 70 percent are female (ACHAP website accessed on January 2006). The fact that more women than men are being tested seems to be linked to referrals from MTCT programs or antenatal clinics, to more women practicing health seeking behavior, and generally to being more accustomed to public health services. In addition, women are increasingly organizing to provide care and support services in nongovernmental and community – based organizations.

The typical example is as below from Haiti; the active community support offered to patients was key to the dramatic clinical responses visible to everyone, including neighbors, accompaniers, physicians, and nurses.

Patients for whom therapy resulted in full viral suppression became known as HIV-treatment successes in their communities and proved to be valuable human resources for HIV prevention activities. In addition, Partners in Health believes that the stigma associated with AIDS has diminished as a result of the dramatic responses to therapy.

Decreased stigma is reflected in an increased willingness of patients to discuss their diagnosis openly, an increased demand for HIV testing, and a reduced number of patients' complaints regarding abusive behaviors of family members or neighbors. For example, within the first 2 years of the programme's existence, utilization of the clinic's free HIV counseling and testing services increased by more than 300%. Moreover – in contrast to reported emotional problems among health care workers in areas without available AIDS treatment – staff morale in the HIV Equity Initiative was significantly boosted by the provision of the life-saving treatment. (Lampitey *et al*, 2001)

Adeline contracted HIV far from home, in Port-au-Prince, when she was only 18 years old. She attended the clinic just a few years later when she had an episode of pneumonia. The additional diagnosis of herpes zoster and HIV infection resulted in treatment of opportunistic infections for almost 10 years. By 1999, her chronic diarrhea no longer responded to the treatment, and her weight had dropped to 36 kg, within the first five weeks of treatment with zidovudine, lamivudine, and indinavir, she gained 12 kg. (Farmer *et al* 2001)

On rights issues, The Kenya project revealed the following:-

In the wake of the HIV/AIDS epidemic, problems related to women's rights to property and inheritance in Kenya has escalated as women are widowed by AIDS.

Through activities supported by the Emergency Plan, this critical issue has been brought to the attention of leaders in Nyanza province, the region with the highest HIV prevalence and highest number of AIDS deaths in Kenya. In this province many women are widowed and have little access to food or shelter. Supporting their property and inheritance rights addressed one of their greatest areas of vulnerability, providing the stability needed to raise children and take care of their own needs. (Mbwika *et al*, 1999)

In 2005, the Emergency Plan, through USAID's POLICY project, supported a workshop with the Kenya National Commission for Human Rights to address the problem of women's inheritance and rights of property in the Luo ethnic group in Nyanza. The workshops provided an opportunity for the Luo Council of Elders, women leaders, political leaders, the provincial administration, and local and national organizations to explore the inheritance problem. Community women presented their personal experiences of the discriminatory practices in their culture, as well as those in Kenyan law. The project organized eight participatory community workshops, where widows and orphans vividly described the experience of losing land and other inheritances.

The community meetings resulted in immediate alleviation of inheritance issue through traditional and local government structure. Prior to this Emergency Plan-funded project, the 150 elders from this community had never focused on women's rights. The Council of Elders now wants to restructure their organization to better address the plight of women and orphans and property ownership and inheritance.

This work has helped to fundamentally shift the power dynamics between the sexes and lessen the ignorance and distortion within the Luo community, leading to a strong partnership in addressing the plight of women and orphans and vulnerable children.

In Kenya, the federation for women lawyers helps people living with HIV/AIDS (PLWHA) on issues around property and inheritance as well as rape and sexual assault. (Sangiwa *et al*, 2000)

Another good example of project is that of Lakay Social Clubs in Haiti, which supported HIV/AIDS prevention services for commercial sex workers by offering income-generation and education alternatives to prostitution. The Lakay project had two main objectives: reducing the incidence of sexually transmitted infections and HIV/AIDS among women in prostitution and their clients, and helping these women to abandon the sex trade.

To address the second objective, the “Other Choice” program provided commercial sex workers with socio-economic alternatives to prostitution. The program offered the women with training courses in subjects such as cooking, sewing, computer skills, arts and cosmetology. With these new skills, the program assisted women to find new jobs and abandon the sex trade. Former commercial sex workers were integrated into the “Other Choice” program as peer trainers, further enhancing the program’s ability to reach other women who are still involved in prostitution. (Family Health International, 2002)

Through September 2005, the Other Choice program trained more than 1,400 women, many of whom have partially or fully removed themselves from prostitution. (Sangiwa *et al* 2000)

However, the subordinate status of women, (Hurlburt *et al* 2004) combined with the ongoing stigma surrounding HIV, continues to be a driver of the AIDS epidemic in Botswana.

Joy Phumaphi, the former minister of health of Botswana and currently assistant director general for family and community health of WHO, described the uptake in VCT services by women as “a positive effect driven by a negative catalyst,” (Cohen, 2003) referring to the higher infection rates among women and girls. According to the study by different scholars as (Hardon *et al* 2006) Their studies established that ART coverage differs dramatically between and within countries. Thailand, Botswana and Uganda, were the governments rapidly responded to treatment needs, are now treating more than half of those requiring ART. Other countries, like Tanzania, India, Nigeria, Vietnam and Ghana have extremely low coverage, see table below:-

Country	Estimated number of sites	Estimated number of people (o-40 years) in need of ART	Percentage in need actually treated
Ghana	5	61,000	7%
Botswana	32	84,000	85%
Uganda	175	148,000	51%
Tanzania	44	263,000	3%
Kenya	250	273,000	24%
Nigeria (II)	71	636,000	7%
South Africa	183	983,000	21%
Vietnam	74	25,000	12%
Thailand	890	135,000	60%
India	74	785,000	7%
Moldova	2	< 1000	39%
Peru	50	12,000	52%
Dominican Republic	...	15,000	17%

Source; Universal access by 2010 10 challenges on the way (HAI) 2005

To ensure equitable access, the coverage of treatment sites has to be nationwide. In Ghana and Kenya, both the northern and the north-eastern regions were found to have very limited access to treatment. In South Africa most people receiving treatment were concentrated in three provinces (Gauteng, Western Cape and KwaZulu Natal). In the Dominican Republic, there is a lack of access to treatment in the poorest regions in the southwest, along the Haitian border, and in several eastern cities and towns with relatively high of HIV-IDS).

In India, the government prioritized the implementations of its ART programme in hospitals attached to medical colleges in states with a high prevalence of the disease.

According to study on Barriers to Accessing Antiretroviral Therapy in Kisesa, Tanzania, the following were highlighted; the researchers (Mshana *et al* 2006) start by stating that the focus of their study was locally perceived and experienced barriers to accessing the new ART program. While other studies have emphasized factors that discourage people from HIV-testing or affect adherence levels, earlier research in Kisesa suggested that while testing was on the rise, a significant concern was that the first individuals willing to

obtain treatment would face hurdles to reaching the program that could threaten its expansion into rural communities.

(Mshana *et al* 2006) further elaborates that consultation with men and women throughout Kisesa confirmed that while knowledge of ART and its potential benefit was widespread, they had many realistic doubts about successful distribution and uptake. Villagers identified local poverty as a major inhibitor of treatment seeking, particularly as the livelihoods of PLHA tend to be precarious.

While misconceptions about drug price contributed to this perception and could be clarified, associated costs of transportation to BMC, loss of income during time spent there, and improved dietary intake could prove prohibitively expensive. Individuals who had received VCT in Kisesa district also resented the need to regularly travel to Mwanza, particularly because the hospital had a Reputation As Confusing And Unfriendly To Villagers.

(Mshana *et al* 2006) pin pointed that at the same time however, group discussions expressed enthusiasm and support for bringing ART to the community, and all contacted self identified HIV-positive respondents volunteered for pilot referral and exhibited motivation to overcome potential hurdles.

As operation research, this study aimed to facilitate as well as document individuals' progress from referral to eligibility screening and enrolment in therapy. We could subsidize travel to the hospital and employ two nurses to register Kisesa patients and guide them through clinical procedures.

(Mshana *et al* 2006) further state that although not sustainable at the programmatic level, these efforts removed the logistical barriers to accessing ART, demonstrating that this in itself greatly reduced potentially inhibiting factors.

Table; Perceived Barriers to Accessing Antiretroviral Therapy

	<i>Perceptions of barriers to accessing ARV</i>	<i>Suggested solution</i>
Financial constraints	<p>They are expensive so only those people with a high income buy them (FGD, 5 women, 18-30)</p> <p>... we don't have enough food at home... I actually sat down and started thinking that it is possible that today I may be having food, but the next day you go (hungry) without food, maybe these drugs would affect me. (Respondent 9, women, 1st interviews)</p> <p>You are supposed to eat a balanced diet there before taking those medicines, so if you don't... and then you take those medicines they can overpower you, so you find it's better to just leave them, due to lack of that food you need (FGD 4, men, 18-30)</p>	<p>Food and cash supplements for patients and families</p> <p>Income-generation and skills-building projects to offer ongoing support.</p>
Reaching the hospital	<p>You may go there and be kicked like a ball. Maybe you arrive there and you give him/her your referral slip, you will wait a long time without being attended. (FGD 3, women, 18-30)</p> <p>The other bad thing is that if you go to Bugando without money, they will completely not care about you....</p> <p>Be, there are good services if you have money, but if you don't have money, the services are not good.</p> <p>(Respondent 6, male, 1st interview)</p> <p>...you have to be familiar, because when you arrive at Bugando...you find at the gate a security guard who doesn't know even Sukuma language... (FGD 14, men, 18-30)</p>	<p>Drug distribution in local clinics</p> <p>Provision of transportation by programme</p> <p>Improvements to hospital efficiency</p>

Sustaining treatment	<p>...one who can take after some time gives up hope “I have been taking these drugs for many days now and I think it is enough... if I am to be cured I will be cured and if not, then I don’t care even if I die, let me stop taking</p> <p>Those drugs.” (FGD 10, men 31-59)</p> <p>I don’t want to tell anyone. I just wanted it to be my own secret... that is why I (would be) making it a secret that I will be taking them (ARV)... Because (others) may think ‘aa, every day he is taking medicine... what are they for? ... everyday he is taking them even if he is not sick.’ (Respondent 7, male, 1st interview)</p>	<p>People who travel should take their medication with them</p> <p>Family support for HIV + members</p> <p>Better education on HIV and ARV to reduce stigma</p>
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Source; Barriers to Accessing Antiretroviral Therapy in Kisesa, Tanzania a Qualitative Study of Early Rural Referrals to the National Program

The treatment program in Haiti, Botswana, South Africa and Mwanza Tanzania demonstrate that women can indeed be reached with treatment regimens, provided they have opportunities to access the public health care system and provided that adequate referral systems are in place. Further, in an enabling environment, women are willing to proactively organize around systems of support and care at the community level.

A critical challenge, then, is to expand opportunities for interaction with the health care system and use available entry points and referral mechanisms to provide more comprehensive services for HIV- positive women, including counseling, social and economic support services, and safe shelters for women.

These experiences underscore that outreach should be expanded beyond pregnant women to include non pregnant women, adolescent girls, women visiting family planning and reproductive health centers, youth clinics, and sex workers.

Table; Expectations versus Experiences of Antiretroviral Therapy Enrollment

<i>Respondent</i>	<i>Expectations</i>	<i>Experiences</i>
7-month pregnant women with a young child who knows husband is also HIV-positive.	Interested to enroll herself and child Concerned about transport fare, food at the hospital and who might accompany her. Has told husband, who is supportive. Does not want anyone else to discover her status, including project fieldworkers.	Able to attend BMC without difficulty Husband agreed to serve as "treatment buddy" Grateful that all services are free, including antenatal care. Despite side-effects, noticed benefits and feels stronger. Refuses participation in support groups or home-based care
Women living with extended family, with a poor relationship with her brother and his wife. Her own children had all died.	Very concerned about disclosure to family, particularly "stern" brother who dominates household. Discloses to mother Wants to access ARV because has been very ill and weak and no longer able to "pound cassava."	First visit to BMC unsuccessful; had to return to complete tests. Mother accompanied her, started therapy and felt "relief" Terrified of brother and sister-in-law, unwilling to join support group while living in their household. This respondent died soon after a follow-up interview, allegedly due to family's denial of adequate food when she became ill.
Pregnant women with a 7-year-old child.	Worried about children's future so wants to prolong life to care for them Has not disclosed to partner and does not want to be contacted at home, or come to office where she might be spotted	Able to disclose to partner before referral, he accompanies her No difficulties accessing BMC and receiving drugs Gained 3 kg and feels healthier Willing to join support group and have home visits
Man living with wife and extended family for whom he is financially responsible.	Fatalistic about death as HIV is a "bomb that has gone off" but wants to prolong life to work and make provisions for family Adamant that will not disclose to anyone, including family. Does not want a "buddy"	Able to access BMC and finished 2 rounds of ARV by follow-up interview Gained 21 kg and feel positive Changed attitude and disclosed to many community members; actively promote VCT and ARV to friends

ARV, antiretrovirals; BMC Bugando Medical Center; VCT, voluntary counseling and testing

Source; Barriers to Accessing Antiretroviral Therapy in Kisesa, Tanzania a Qualitative Study of Early Rural Referrals to the National Program

It is still unclear whether the experience of treatment programs in Botswana, Haiti, Kenya and South Africa can be replicated in other acutely affected countries, especially those where women face greater obstacles in accessing health care, where public health infrastructure is less developed, and where cost-sharing issues may be more pronounced. Accordingly equal access by women and girls should be factored into the development of appropriate eligibility criteria for treatment.

3.3 In the policy review

The WHO/UNAIDS policy statement on ensuring equitable access to antiretroviral treatment for women (2004), identified that to adequately address gender issues in the scale up of ART, action is required in development of a supportive policy environment that:

Advocating for gender equality

Ensuring equity within the health system

Expanding eligibility criteria

Promoting the active participation of people living with HIV

In the Tanzania HIV/AIDS Policy the following on the care for PLHAs have been outlined:

To ensure availability of essential drugs the treatment of opportunistic infections.

With the current availability of Highly Active Anti Retroviral Drugs (HAARD) in the market, PHLAs may be required to meet the cost of the drugs.

The Government in collaboration with the private sector will work out modalities for procurement and management of HAARD.

To ensure that the cost of counseling and home care is reflected in the National and Local Councils Budgets for Health and Social Welfare Services. Modalities will be developed for the establishment of AIDS Trust Fund to support community based initiatives including home based care and orphans.

To involve and support communities in the provision of community based and home care services.

In many developing countries, Tanzania being the one, poverty, inequality between men and women are both strongly linked to spread of HIV/AIDS, care and treatments.

Gender and age analysis shows the ways in which women and girls of various ages are vulnerable to the infection, and in need of support to enable them to have access to quality treatment and care. Violence against women and girls is aggravated in societies where high instability or conflict exists. All these factors contribute to the fact that there are more female than males newly infected every day. They also result in women being likely to contract HIV and fall sick with AIDS at a younger age than men.

From the National Strategy for Growth and Reduction of Poverty (NSGRP) by the Vice President's Office (June, 2005) under cluster quality of life and social well being it is stated clearly that, this cluster addresses the second cluster addresses human capability, survival and well-being. A social protection framework becomes necessary to address vulnerability and provide for social security, health insurance, and specific vulnerable groups, like orphans, people living with HIV and AIDS, people with disabilities and the elderly.

Improvement of quality of life and social well-being depend on the provision, affordability and access to quality food and service like education, information, health, water, HIV and AIDS treatment and prevention, and social protection programmes.

CHAPTER FOUR: IMPLEMENTATION

Education and awareness raising in the community have been critical in preparing communities to accept treatment. TAC's range of treatment literacy activities include:

- Community education and awareness campaigns using posters, videos, booklets, brochures or pamphlets and t-shirts
- Curricular for health care providers, for people on treatment and for peer educators; support groups and networks of people living with HIV
- Teaching aids such as health diaries and calendars, treatment side effects charts; broadcast media programmes, radio or TV programmes
- Instructional or participatory materials to guide discussions, role plays and interactive exercises
- Marches and new community branches of TAC.

Growing number of national and international non-governmental organization (NGOs) recognize the need to communicate effectively around ART.

The challenges for local organizations involved in treatment literacy is that people need to have a basic understanding of HIV before they can understand ART and that information about HIV and ART" changes fast.

Programme experience demonstrates that the process of developing treatment literacy materials is important. People living with HIV and AIDS and those taking treatment should participate in the development, review and evaluation of materials to ensure they are appropriate, relevant and meet people's real needs (UNESCO/WHO, 2006). Guardians and supporters also have an important role to play here. There are factsheets and other participatory treatment literacy materials that can be reviewed and adapted for local use (International HIV/AIDS Alliance, 2005; ITPC, 2005; AIDS Law Unit, no date; Treatment Action Campaign, 2006; HIV I – Base, 2006) When adapting materials there are some general rules to follow.

It is important to use images and examples that are relevant to local contexts, ensure information is clinically appropriate and also be aware of the challenges of copyright and protected materials.

This chapter explains the implementation of project activities, which are based on each objective of the project.

(i) Project products / outputs

	Objectives	Indicators
1.	To conduct six information campaigns for interest group on availability of HIV/AIDS treatment in Kikuyu area by 2007.	<ul style="list-style-type: none"> • Number of identified affected families. • Number of girls, women and couples attending the information session day • Number of affected families enrolling their paints for treatments
2.	To mobilize 50 women and girls and encourage 10 couple counseling at VCT and MTCT to better ensure the involvement of male partners in Kikuyu area by 2007.	<ul style="list-style-type: none"> • Number of women, girls and couples accepted counseling at VCT and MTCTC • Number of infected women, girls and couples enrolled for treatment • Number of infected women, girls and couples continuing receiving HIV/AIDS treatment. • Number of home visits made by project staff
3.	To increase social and economic empowerment for women through access to micro – credit programs, job skill training and assistance with property and inheritance rights by 2007	<ul style="list-style-type: none"> • Number of women and girls living with HIV/AIDS informed and linked to micro – credit and legal services facilities. • Number of women and girls living with HIV/AIDS attending job and skills training. • Number of women and girls living with HIV/AIDS doing income generating activities as a result of our project.

(ii) Project planning

To achieve the project objectives, community based organization convened three days information session for various interest groups. The workshops were forum from which different barriers to access ART drugs for women and girls were disclosed as per survey conducted on needs assessment.

After that the road maps were installed by each participant, followed by home visits to identify and enroll all women and girls infected and possible to be treated, encourage couples to go for voluntary HIV counseling and testing which were done through home visits.

(iii) Implementation Plan

OBJECTIVE: To conduct 6 information campaigns for interest groups on availability of treatments in Kikuyu area by 2007

SNO.	ACTIVITIES	PROJECT MONTHS												RESOURCES NEEDED	PERSON RESPONSIBLE
		1	2	3	4	5	6	7	8	9	10	11	12		
1.	Enrolling and retaining women and girls in treatments.			✓										Stationery, funds	Facilitators Project leadership Interest groups.
2.	Identification of interest groups.	✓													
3.	Conduct information campaign workshops.		✓												

OBJECTIVE: To mobilize 50 women and encouraging 10 couples counseling at VCT in MTCT to better ensure the involvement of male partners in Kikuyu by 2007

SNO.	ACTIVITIES	PROJECT MONTHS												RESOURCES NEEDED	PERSON RESPONSIBLE
		1	2	3	4	5	6	7	8	9	10	11	12		
1.	Community mobilization for treatment preparedness.	✓												Stationary funds.	Health workers Project leadership.
2.	Encourage people to attend VCT.				✓	✓	✓	✓	✓	✓					
3.	Visiting families in the target area.			✓											
4.	Make a list of women and couples to be involved.	✓													

OBJECTIVE: To increase social economic empowerment for 40 women through access to micro-credit programmes, job and skill training and assistance with property and inheritance rights in Kikuyu area by 2007

SNO	ACTIVITIES	PROJECT MONTHS												RESOURCES NEEDED	PERSON RESPONSIBLE
		1	2	3	4	5	6	7	8	9	10	11	12		
1.	Identify the groups of women to be involved in the program.			✓										Stationery	Project leadership
2.	Generate and share information on availability of credit women and special groups.				✓									Funds	Project advisor
3.	Lobby and link women to the institution which provide skills and capacity building on entrepreneurship.				✓									Interest groups.	Interest groups
4.	Promoting the enrollment and retention of girls in school.					✓							✓		
5.	Protecting women and girls by linking them to legal services facilities.						✓								
6.	Advocate for people living with HIV to provide with loan.						✓								
7.	Monitoring.			✓			✓						✓		
8.	Evaluation.						✓						✓		

(iv) Inputs:

For project implementation, the organization will need to have the following:

Number of hours of training: This will be done by training four CBO members on data collection techniques. They will be trained for one day. Also two members will be sent to legal Aid provision organization where will be trained on property and inheritance rights for women and girls living with HIV/AIDS

The other requirement is the training manual, this is very useful because is guideline for delivering information on availability of treatment.

Finances are required to cover the costs of implementing project activities as allowances for participants, lunch and refreshments, room hire and stationeries.

Participants who include; people living with HIV/AIDS, traditional healers, local and central government officials, community members and families live with people having HIV/AIDS.

(v)Staffing pattern:

The responsibility for initiating and making final decisions for the organization has been reserved for the board members and chief executive director.

At department level each head is accountable for implementing the overall organizational plan as it applies to his/her unit and for design of a structure within this framework fitted to need organization.

- The organization's senior management group or team is available to study the overall needs, analyze the existing organization situation, and suggest modifications and improvements in accountability of heads.
- Conduct research to discover new improved methods of organization and then inform, teach heads the principles of organization adopted to develop their abilities to review and improve their sections.

(vi) Budget:

The project needs Tshs 2,521,565/= to cover the following costs

Personnel	35,490/=
Direct costs	305,490/=
Workshop costs	2,096,000/=
Unforeseen 5%	120,075/=
Total budget	2,521,565/=

4.0 Project implementation report**4.1 Community mobilization:-**

With assistance of Mama Africa staff, people learning with HIV/AIDS taking Anti Retro Viral drugs and not started taking treatment in Kikuyu area, Dodoma region, we talked to people to help them with disclosure of their serum status and treatment compliance.

One person living with HIV/AIDS and taking Anti Retro Viral drugs used to explain to the people not already taking Anti Retro Viral drugs ‘that treatment has irreversibly broken the equation between AIDS and death.’

It allows us to begin to undo the social stigmas and phobias that make prevention so difficult to talk about frankly and to practice effectively. ‘Hence we announce to all, treat the people now’.

As such community became mobilized and caused a significant group of people become aware of shared concern, common need and decided together to take action in order to create a shared benefits.

This action was helped by the participation of an external facilitator. However, momentum for continued mobilization came from within the concerned group.

4.2 Conduct Information campaign workshops:-

Information is vital in comprehensive care, support and treatment activities. These workshops aimed to build practical skills for people living with HIV/AIDS that are in the need of treatment.

4.2.1 Preparation of training manual

It was important to develop a manual that explain the practical ways to understand plan and undertake work on HIV/AIDS treatment. The manual was resource that helped:-

Build practical skills among people living with HIV/AIDS by using participatory activities and sharing experiences.

Provide a training resources; for individuals

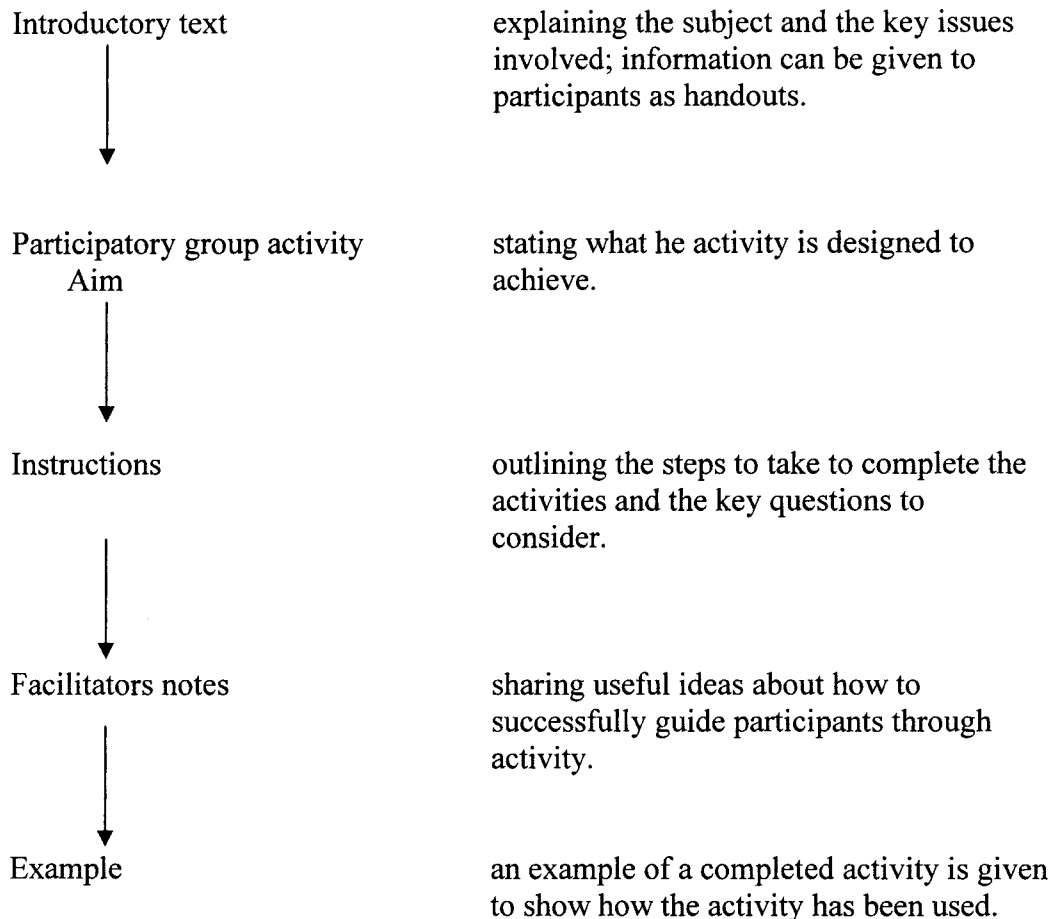
Facilitate learning about HIV/AIDS treatment work for people living with HIV/AIDS.

The manual was not about the clinical management aspects of HIV/AIDS treatment. The handbook addressed the wider issues around HIV/AIDS.

Treatment and what people living with HIV/AIDS nice need to do if they become involved on want to become more involved. The training manual is in Swahili language and was developed by consulting different publications by the International HIV/AIDS, Alliance the World Health Organization (WHO) and the (UNAIDS).

The manual covers key definitions, concepts, assessment methods planning steps ski associated with effective HIV/AIDS treatment work and keeping track of such work. As a response, the manual that was developed is a collection of information, tools and lessons on a range of topics related to improving access to HIV/AIDS treatment for people living with HIV/AIDS especial women and girls.

For the most part, the content of chapters follows the format below:-



The manual also provides information on human and legal rights of people living with HIV/AIDS.

4.2.2 Information workshops:-

Six workshops each of three days were conducted; the workshops involved key interest groups.

Mama Africa staff and CED students were involved. The workshop objectives were:-

1. To strengthen the participants' existing knowledge and conceptualization of community mobilization for voluntary couple counseling and improved access to care, support and treatment.
2. To gain input from the participants the appropriateness of the treatment program.

3. To strengthen the skills and build the confidence of people living with HIV/AIDS to fight for their human and legal rights and engaging themselves in income generating activities together with participating in micro-lending institutions.

4.2.3 The action planning:-

Each participant prepared talk home application plan which detailed activities to be implemented in order to achieve project and organization goals. The framework of back home plan included; date, activity, place, resources required and comments

4.2.4 Workshop evaluation:-

Pre and post knowledge evaluation was done in each information campaign the evaluation framework included, knowledge of HIV/AIDS treatment issues, and expectation these were done before and later again the knowledge expectations of participants were assessed and content of session.

4.3 Enrolling women and girls with HIV/AIDS in treatment program.

For HIV patient to start treatment must have CD4 count 200. During all information campaigns few were already attained these eligibility criteria for treatment. However it was agreed that all those who are positive should be kept in close monitoring and when ready should be enrolled for treatment.

Sixty two people participated in the training;

Women living with HIV/AIDS -40

Men living with HIV/AIDS -2

Couples living with HIV/AIDS

Untested man living with HIV/AIDS -2

HIV men and women living with HIV/AIDS -(4)

Orphans living with HIV/AIDS living with HIV/AIDS -2

Widower/widow each living with HIV/AIDS -(2)

Traditional leaders living with HIV/AIDS -2

Government officials living with HIV/AIDS (VEO, WEO) -2

Regional leaders living with HIV/AIDS -2

At tented families living with HIV/AIDS (family) -2

The workshop created a forum from which interest groups exchanged experiences and shared information on credit opportunity for women and girls who are able to work.

CHAPTER FIVE: MONITORING, EVALUATION AND SUSTAINABILITY

5.0 Monitoring plan

The improvement of quality of life and social well being of women and girls with HIV/AIDS is subject to continued adherence to treatment by patients and organization capacity to manage the project.

The project monitoring was carried out by leadership and other stakeholders. The monitoring was done to know whether the patients are adhering to the treatment and if yes their quality of life and social well being would be enhanced.

The project monitored the quantity and quality of work of HIV/AIDS treatment progresses

A monitoring form was used to assess:- Implementation by participants of project activities. The information (qualitative) about women and girls treatment helped to show:-

The frequency people attended the clinic.

The number of people seen and their health problems.

Their gender and age.

The number of community health education and awareness talks given.

We also used qualitative methods of monitoring which depended on observation, careful listening and questioning of the people receiving treatment.

5.1 Monitoring

The monitoring was carried out by leadership together with beneficiaries. The monitoring was conducted to have information for three domains;

1. Inputs – Resources going into conducting and carrying out the project. These included staff, materials, finance and time

Process – set of activities in which resource (Human and financial) are used to achieve the results expected from project (example number of workshops or number of training sessions)

Outputs immediate results obtained by the project through execution of activities (e.g number of patients visited, number of families and patients reached, number of people attended VCT, number of patients by gender / sex, couples enrolled for ARV treatment, number of patients linked to micro lending programs.

Performance Information to Measure Access to HIV/AIDS treatment for girls and women living with HIV program results impact .

Information categories	Data to gather	Using the information	Making decisions
<p>Characteristics of socio- economic target groups</p> <p>Factors influencing accessibility to treatment.</p>	<ul style="list-style-type: none"> ▪ Income levels ▪ Infrastructure(health facilities, distance to health facilities ▪ Education levels. ▪ Property and inheritance rights ▪ Age of marriage ▪ Cost of services ▪ Decision making ▪ Status of women/girls ▪ Travel time and transportation cost to health centers ▪ Stigma ▪ Violence and abuse 	<ul style="list-style-type: none"> ▪ Determining what influences acceptance of HIV/AIDS treatment. ▪ Determining whether the current treatment users will influence the accessibility treatment. 	<ul style="list-style-type: none"> ▪ Allocation of effort and resource to maximize access to HIV/AIDS treatment. ▪ Formulation of objectives and selection of target groups for maximum program impact.
Demand for use of HIV/AIDS treatment	<ul style="list-style-type: none"> ▪ Source of supply of drugs/ medicines ▪ Cost of pre- treatment laboratory tests. 	<ul style="list-style-type: none"> ▪ Determining whether the drugs supply is compatible with users 	<ul style="list-style-type: none"> ▪ Provide more comprehensive services for HIV-positive women/girls.

Adherence to treatment of HIV/AIDS by infected women / girls	<ul style="list-style-type: none"> ▪ Rates of girls/ women routinely attending treatments ▪ Welfare of HIV/AIDS patients receiving treatments 	<ul style="list-style-type: none"> ▪ Determining how satisfied users are with HIV/AIDS treatments program 	<ul style="list-style-type: none"> ▪ Expand opportunities for interaction for interaction with health care systems.
Quality of services	<ul style="list-style-type: none"> ▪ Application of clinical protocols ▪ Behavior, competence and experience of staff. ▪ Physical environment of clinic 	<ul style="list-style-type: none"> ▪ Take action to lobby to improve existing services. 	
Characteristics of community participation and support.	<ul style="list-style-type: none"> ▪ Level of community participation. ▪ Amount of community financing. ▪ Approaches to follow up. 	<ul style="list-style-type: none"> ▪ Deciding the best strategy to increase community involvement and motivation. 	<ul style="list-style-type: none"> ▪ Assess prospects for community self financing of HIV/AIDS treatment program.

Source; stakeholders workshop

5.2 Objectives and activities

As discussed in the preparation of project the monitoring was continuous field visits conducted four times in the project time. The objective was to assess to what extent project;

It undertaken consistently with each design or implementation plan.

Is directed toward the specified target group.

This monitoring addressed the following questions;

- 1) To what extent the planned activities actually realized? Are we making progress toward achieving our objectives?
- 2) What services are provided, to whom, when, how often, for how long and in what context?
- 3) How well are the services provided?
- 4) What is the cost per unit services?

5.2.1 Indicators used in Monitoring and Evaluation;

	Objectives	Indicators
1.	To conduct six information campaigns for interest group on availability of HIV/AIDS treatment in Kikuyu area by 2007.	<ul style="list-style-type: none"> • Number of identified affected families. • Number of girls, women and couples attending the information session day • Number of affected families enrolling their paints for treatments
2.	To mobilize 50 women and girls and encourage 10 couple counseling at VCT and MTCT to better ensure the involvement of male partners in Kikuyu area by 2007.	<ul style="list-style-type: none"> • Number of women, girls and couples accepted counseling at VCT and MTCTC • Number of infected women, girls and couples enrolled for treatment • Number of infected women, girls and couples continuing receiving HIV/AIDS treatment. • Number of home visits made by project staff
3.	To increase social and economic empowerment for women through access to micro – credit programs, job skill training and assistance with property and inheritance rights by 2007	<ul style="list-style-type: none"> • Number of women and girls living with HIV/AIDS informed and linked to micro – credit and legal services facilities. • Number of women and girls living with HIV/AIDS attending job and skills training. • Number of women and girls living with HIV/AIDS doing income generating activities as a result of our project.

5.3 Monitoring methodology;

5.3.1 Research Method

The psychosocial, contextual and behavior dimensions of taking HIV/AIDS treatment are better suited to qualitative methods that capture values, attitudes and beliefs, than to quantitative tools. Qualitative methods are highly useful in exploring motivation and underlying factors supporting discriminatory behaviors. Research methods used included focused group discussions and structured questionnaires.

5.3.2 Study design

Cross – sectional study with no control groups. The repeated study determined a information campaigns' effect on women and girls living with HIV/AIDS on accessibility of HIV/AIDS treatment, legal protection of women and girls living with HIV/AIDS,

couple counseling and micro – credit accessibility of women and girls living with HIV/AIDS.

5.3.3 Approach to monitoring

Participatory monitoring approach was used; the historical and descriptive-analytical approach was used. This approach enables comparisons and analyses of things like behavior change. Furthermore, such a descriptive/analytic approach is a good instrument for putting various events obtained from the field in proper historical perspective.

5.4 Sample;

A random sample of 50 people were involved in the study

5.5 Data collection tools,

Data and Information for this study were gathered mainly from two principal sources:

5.5.1. Focus group discussion;

A group of six people were interview together by a skilled interviewer with a carefully structured interview schedule. Forty eight people were involved in this fashion.

The questions focused around people's attitudes toward women and girls taking HIV/AIDS treatment, stigma, care and support, the influence of project activities on real or incipient behaviour change.

Selection of participants, the participants in this interview were those who started taking treatment, women and girls / men living with HIV, those not tested and HIV negative men and women.

5.5.2. Structured questionnaires;

These were questionnaires that involved asking specific questions aimed at getting information on accomplishments of project that enabled indicators of each objective to be measured. Questions were open – ended and closed. They were source of qualitative and quantitative information.

They gathered information on how many people were enrolled in the treatment, drop outs, adherence of patients to the treatment regimen, how many counseling sessions were done in a day.

Participants were drawn from project area, women and girls living with HIV/AIDS men/women HIV negative and not tested, clinic attendees.

5.6 Analysis of Data;

The data was analyzed by using SPSS

5.7. Presentation of Data,

Data were presented in cross – tabulations, bar charts, tables, frequencies and percentages

Number of home visits made by project staff;

Over a past one year project had conducted six information campaigns on availability of HIV/AIDS treatment, which involved 120 people. At the end of each information campaign, the participants prepared an action plan which highlighted on the fact that, the informed people should go around the Word and sensitive the community at large on availability of HIV/AIDS treatment.

The sample of 50 community members with different HIV serum status were interviewed on how many times were visited by the peer educators, the results are as below:-

Table 8 Statistics

		serum status	How many times you have been visited by trainer?
N	Valid	50	50
	Missing	0	0

Table 9 **Serum status**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not tested	10	20.0	20.0	20.0
	Positive	32	64.0	64.0	84.0
	Negative	8	16.0	16.0	100.0
	Total	50	100.0	100.0	

Table 10**How many times you have been visited by trainer?**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not visited	5	10.0	10.0	10.0
	Once	9	18.0	18.0	28.0
	Twice	17	34.0	34.0	62.0
	Over three times	19	38.0	38.0	100.0
	Total	50	100.0	100.0	

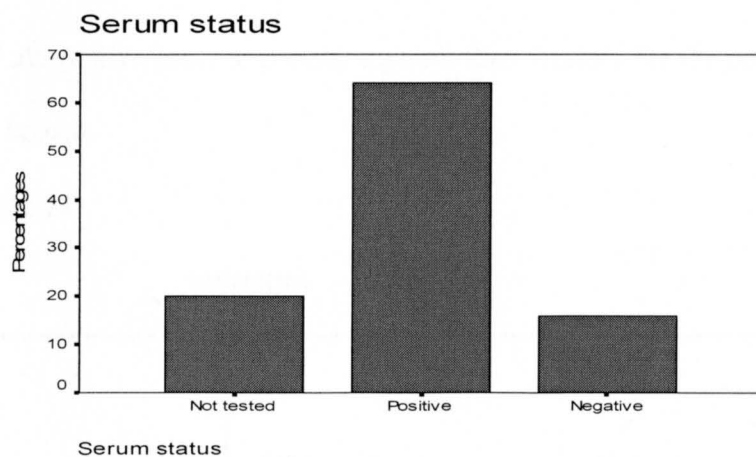
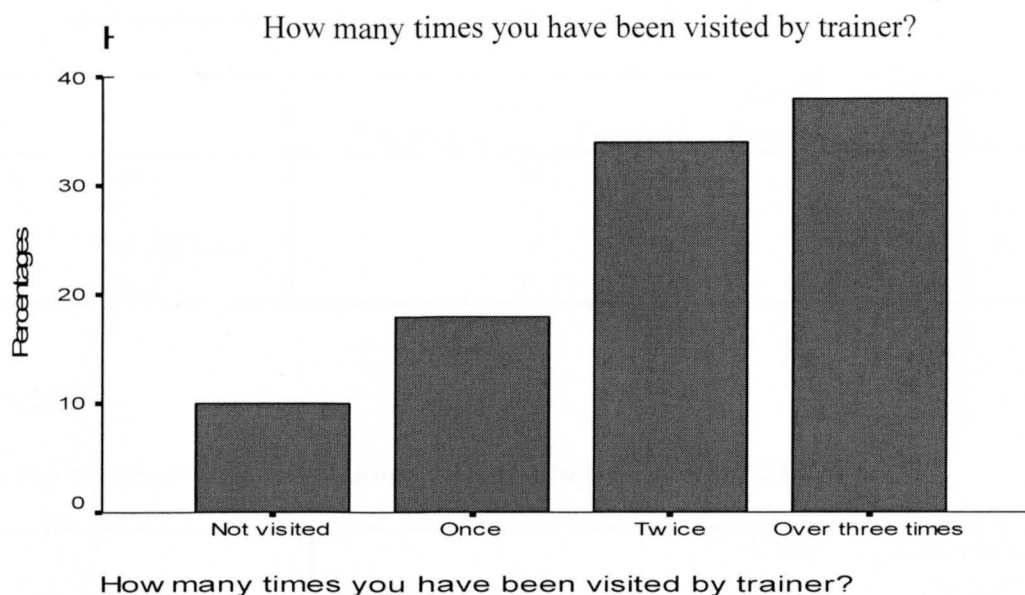
Bar Charts**Figure 7**

Figure 8

Number of women and girls living with HIV/AIDS informed and linked to micro – credit and legal services facilities as well as number of women and girls living with HIV/AIDS doing income generating activities as a result of our project.

The monitoring visits conducted identified that after thorough information campaigns, community members have started to view HIV/AIDS treatment as somewhat acceptable and alternative income generating activities feasible for the people living with HIV/AIDS see below:-

Table 11**Statistics**

		If alternative incomes are proposed are they feasible?	Does the message include any hope for the people living with HIV/AIDS?
N	Valid	50	50
	Missing	0	0

Table 12**If alterative incomes are proposed are they feasible?**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	36	72.0	72.0	72.0
	No	8	16.0	16.0	88.0
	Do not know	6	12.0	12.0	100.0
	Total	50	100.0	100.0	

Table 13**Does the message include any hope for the people living with HIV/AIDS?**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	31	62.0	62.0	62.0
	No	5	10.0	10.0	72.0
	Do not know	14	28.0	28.0	100.0
	Total	50	100.0	100.0	

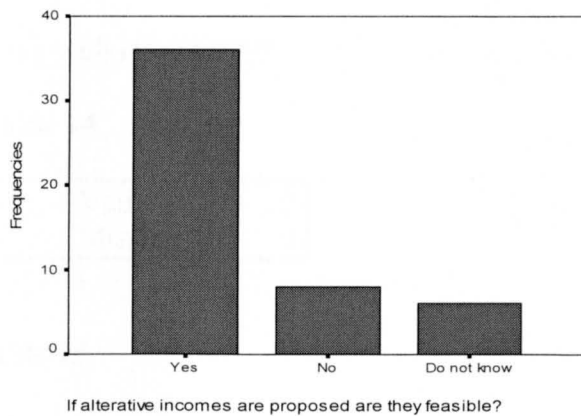
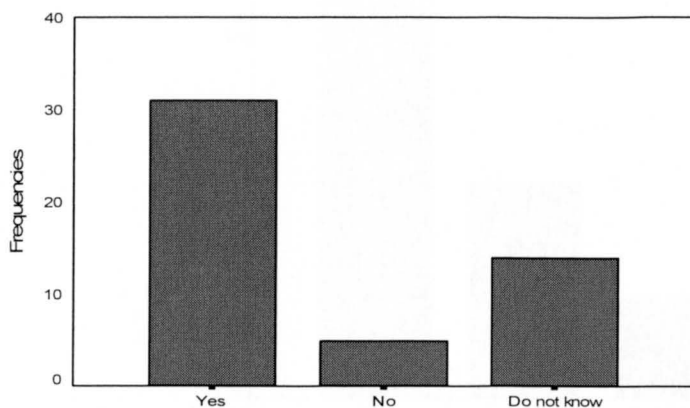
Figure 9

Figure 10

Does the message include any hope for the people living with HIV/AIDS?

Also the community has started to view that, the legal, civil rights of women and girls living with HIV/AIDS as vital in the comprehensive care, support and treatment of people living With HIV/AIDS

Frequencies

Statistics

Is the community respects the legal, human and civil rights of widows, women and girls living with HIV/AIDS?

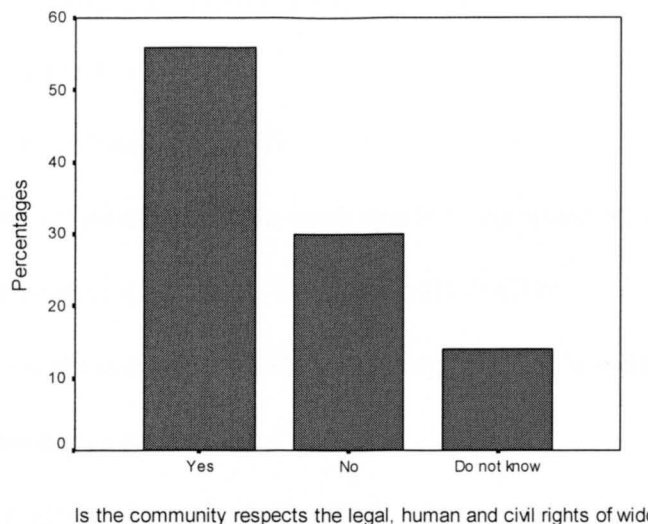
Table 14

N	Valid	50
	Missing	0

Table 15

Is the community respects the legal, human and civil rights of widows, women and girls living with HIV/AIDS?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	28	56.0	56.0	56.0
	No	15	30.0	30.0	86.0
	Do not know	7	14.0	14.0	100.0
	Total	50	100.0	100.0	

Figure 11

Is the community respects the legal, human and civil rights of widows, women and girls
Living with HIV/AIDS?

5. 8 Conclusions and recommendations

5.8.1 Stigma:-

HIV/AIDS associated stigma is still fuelled in Kikuyu North by low public awareness and fair. A part from the free treatment offered by the government, the people living with HIV/AIDS and their families face severe social problems, especially when many of the patients are unemployed. Establishment of social protection nets for People Living with HIV/AIDS, especially for AIDS affected children and promotion of income generating initiatives are of special consideration for HIV/AIDS affected individuals and families.

5.8.2. Prevention of Mother to Child Transmission

The Government and ministry of Health and social welfare made commitment to ensure universal access to Voluntary Counseling and Testing for all pregnant women in the country. Physicians of mother clinics are trained on HIV VCT of pregnant women and prophylactic ARV treatment management of HIV positive pregnant women, but the testing capacity and reporting systems need further improvement.

5.9 Evaluation:-

The evaluation was involving looking at results of monitoring. The evaluation was done to answer the following:-

What has been achieved?

What difference has the work made to improve quality of life and socio well being and treatment of people living with HIV/AIDS.

How does the achievement match the organization's goals?

What has been the costs?

The key reasons to evaluate the work were:-

To improve the effectiveness and efficient of work.

To help with future choices and decisions.

To learn lessons that can be shared within the organization and with others.

To increase accountability to those who have an interest in the work.

5.9.1 Evaluation Methodology

5.9.1.1 Research Method

This study conducted as survey it collected, information from a variety group of people. It was questions and responses included open-ended and close-ended approaches. The responses took the form of rating on scale. Participatory qualitative and quantitative methods were used. SPSS software was used to analyze data.

5.9.1.2 Sources of information and data collection tools

Data and information for this study were gathered mainly from two principal sources:

5.9.1.2.1 Structured questionnaires;

These were questionnaires that involved asking specific questions aimed at getting information on accomplishments of project that enabled indicators of each objective to be measured. Questions were open – ended and closed. They were source of qualitative and quantitative information.

They gathered information on concept and design, assessing outcome and impact. Participants were drawn from project area, women and girls living with HIV/AIDS men/women HIV negative and not tested, clinic attendees. Primary and secondary data were collected. Primary data were through interviews and Secondary data were collected from hospital cards, registration books and patient records.

Evaluation were; that which intended to improve performances (formative) and that conducted to determine the extent to which anticipated outcomes are produced (summative). This was intended to provide information about the weaknesses of the project.

5.9.1.2.2 Secondary/documentary sources

Most of impact data and information on the impact of the project were derived from relevant documents, which were thoroughly examined. Such documents include reports at the Mama Africa Office, Ward Executive Office, Reports of the trainees and other CBOs. Information obtained from these methods have greatly assisted in understanding progress and impact of the project.

Monitoring and evaluation were conducted by Mama Africa and CED student. The basic skills for monitors and evaluators were such as mathematics listening skills and research techniques.

5.9.2. Study design

A cross sectional study; this is a post intervention survey. It aims at determining the information campaigns effect on recruited peer educators, trainers were assessed for their skills at informing community on availability of HIV/AIDS treatment and increasing accessibility to HIV/AIDS treatment of women and girls.

Involved in both evaluation and monitoring were:-

People living with HIV/AIDS

Care providers

Family living with affected people

Clinic staff

A total number of 55 people have been involved both in monitoring and evaluation.

5.10 Analysis and presentation of results.

As objectives of the project the project managed to identify 17 number of affected families and managed to conduct six information campaigns and 57 patients have been enrolled for treatment and are continuing to receive treatment.

Number of couples have been mobilized for attending VCT and MTCTC see the table below and appendix 9;

Family living with people infected with HIV/AIDS * Sex of respondent Crosstabulation

Table 16

		Sex of respondent		Total
		Male	Female	
Family living with people infected with HIV/AIDS	Yes	8	9	17
	No	3	10	13
Total		11	19	30

For patients taking treatment, their health and social well being had been improved as such they are now able to do economic and productive activities.

The patients especially women are taking vegetable and fruits to households. The fruits and vegetables are collected from the business people from market on loan basis; they just take profit from the sales

Serum status**Table 17**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid not tested	31	26.7	26.7	26.7
positive	57	49.1	49.1	75.9
negative	28	24.1	24.1	100.0
Total	116	100.0	100.0	

Age of respondent**Table 18**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Adult	81	69.8	69.8	69.8
young	35	30.2	30.2	100.0
Total	116	100.0	100.0	

Sex of respondent**Table 19**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid male	42	36.2	36.2	36.2
female	74	63.8	63.8	100.0
Total	116	100.0	100.0	

However stigma remains stubborn and resistant to initiatives and may also imprint upon accessing treatment – how treatment initiatives are best harnessed for anti-stigma projects is an important consideration. Stigma undoubtedly reinforces a tendency towards non-disclosure for fear of discrimination. See figures and tables below:-

Do you experience discrimination in taking treatment?

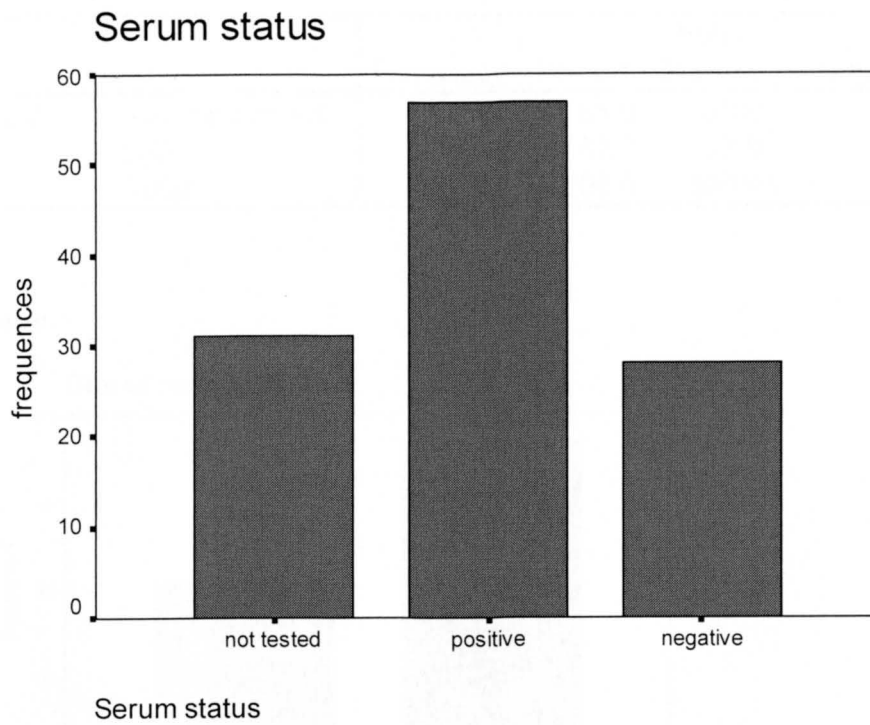
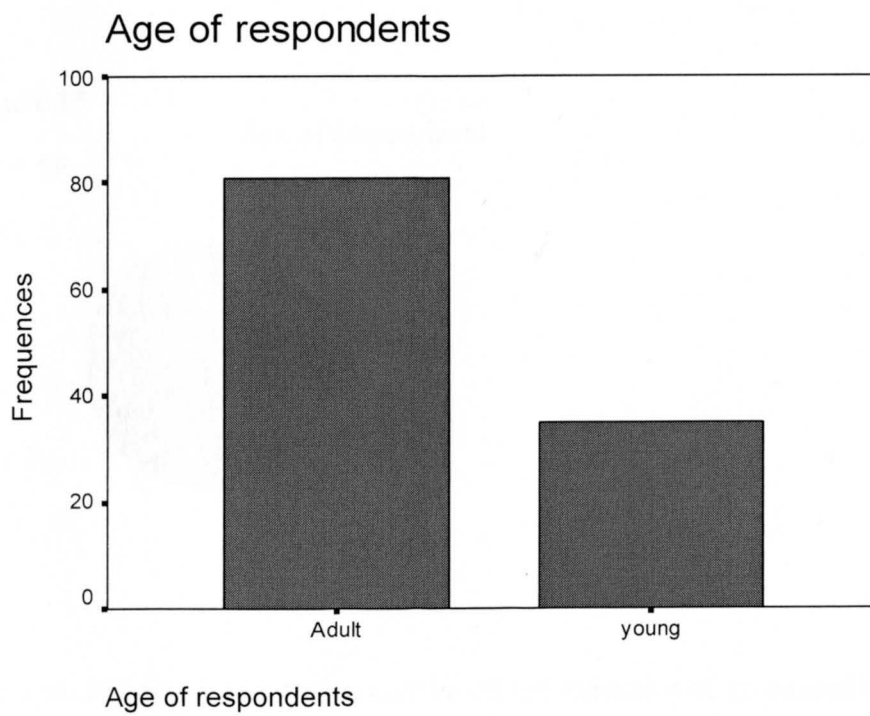
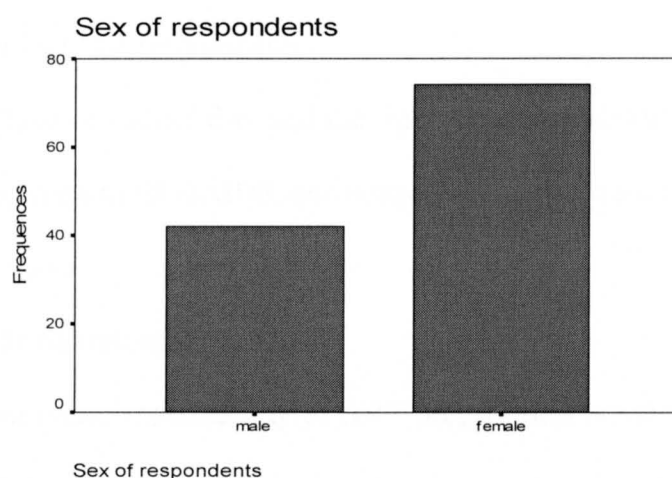
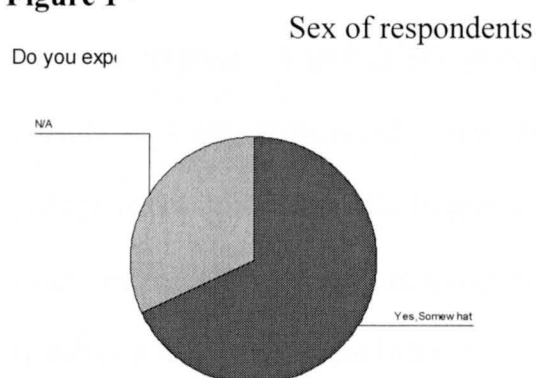
Figure 12**Figure 13**

Table 20

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes, Somewhat	17	68.0	68.0	68.0
	N/A	8	32.0	32.0	100.0
	Total	25	100.0	100.0	

Figure**Figure 15**

The evaluation and monitoring confirmed the existence of an extensive response to HIV care and treatment which appears to respond and change according to community needs. Also misinformation and skepticism concerning ARV among historically excluded communities needs to be corrected with uniform messages at local level not only about

availability but also how to access treatment furthermore stigma remains stubborn and resistant to initiatives and may also imprint upon accessing treatment – how treatment initiatives are best harnessed for anti-stigma projects is an important consideration.

It has come to my notice that a lack of disclosure and lack of knowledge about ones own HIV status might also negatively impact on scaling, up with people dying without knowing their status. Stigma undoubtedly reinforces a tendency towards non-disclosure for fear of discrimination.

Whilst confidentiality and the right to privacy remain pivotal to a human rights – based approach to HIV/AIDS, encouragement of openness, even protection for those NGO wish to do so.

5.11 Sustainability

The future sustainability of ART programmes is not only dependent on the mobilization of global resources and adequate government planning. It will also depend on the speed at which resistance to ARVs develops and the extent to which prices of second line treatment, paediatric drugs and diagnostics will decrease. On both fronts, there is little room for optimism. A global HIV drug resistance surveillance network (HIVResNet) has already been set up to monitor resistance. Such data will be of great use to national policymakers. Anecdotal data suggests that resistance levels are high. Indeed in India, a study indicates that already as many as 20% of ART-naïve PLWA may be resistant to first-line ARVs in Southern India.

In resource-constrained settings, cost and long-term program sustainability are legitimate concerns of political and public health leaders. Therefore, a successful ART implementation plan should consider cost-effectiveness as a major factor and make an honest attempt to address program sustainability.

▪ **Resource mobilization**

- Establishing cost sharing with income sliding scale
- Encouraging workplace ART, PMTCT and PEP initiatives
- Establishing tax levies and providing tax exemption of funds raised
- Approaching local groups and persons in the Diaspora for support
- Accessing international initiatives
- Promoting public-private partnerships.

▪ **Cost – saving strategies**

- Realization of national ART implementation plan
- Harmonization and enforcement of national guidelines in diagnosis & treatment
- Integration of services, activities and programs
- Promotion of local production of ARVs
- Improvement of drug and associated supplies management
- Establishment of quality assurance systems for services and commodities
- Training and motivating staff with incentives to be cost conscious

This program has been developed with the active participation of people living with HIV especially women and girls as strategy for HIV treatment and care. They have been involved at all levels to adequately consider their perspectives in planning, implementation, monitoring and evaluation.

Project has built capacity of Mama Africa to implement further activities by developing a trainer's manual together with that Mama Africa staff has attended training on legal and civil rights for people living with HIV/AIDS. These will ensure management sustainability of project. Informed trainees will continue to conduct information campaigns to others.

CHAPTER SIX: CONCLUSIONS AND RECOMMENDATIONS

In order to ensure equal access to treatment and care, it is necessary to have an understanding of the biological and social differences and the differing needs of men and women. Socio cultural inequalities that disproportionately affect women cannot be dealt within the context of health alone. They also require a supportive environment promoting, among other things, equal protection under the law, equal access to education, and opportunity and the ability to earn a living. Links between health services and organizations working on issues with a bearing on HIV/AIDS would be very beneficial in helping to provide a supportive referral network. Examples are legal protection, assistance with property and inheritance rights, literacy programmes, jobs and skills training, microcredit programmes, and women's shelters.

Project goals

To increase and ensure equitable access to HIV/AIDS treatment for women and girls living HIV/AIDS

The results of evaluation showed that the goals and objectives of the project have been realized.

The results have shown that engaging public sector through community based organizations were critical in expanding the coverage and impact of community based treatment

6.1 Results for Objective 1:

To conduct six information campaigns for interest group on availability of HIV treatment by 2007.

As you see that the number of people visited by the trainees over three times account for 38.0%, twice 34%, once 18% and not visited 10.0%.

However in communities affected by HIV/AIDS people are confronting significant challenges to accessing treatment, these include widespread stigma and discrimination,

misinformation, lack of information on ART and insufficient resources to meet basic nutrition needs or travel costs to health clinics for care as 68% of women and girls living with HIV have experienced discriminations in taking treatment.

6.1.1 Recommendations for objective 1;

In light of my experience, I would recommend others attempting similar project to abide to the following:-

- Communication around anti-retroviral therapy is required for an effective and comprehensive response to HIV/AIDS that includes and makes linkages between prevention, treatment care and support.
- Treatment literacy leads to improved health outcomes, better adherence to drug regimens and higher uptake of voluntary counseling and testing services.
- The process of developing treatment literacy materials is important and should include people living with HIV/AIDS and those taking ART and their guardians and supports who can either enable or obstruct adherence
- Communities need to be prepared to support their members taking ART. This means reducing stigma and discrimination and dispelling myths.
- Community care and treatment responses should be recognized as an important component of greater access to treatment.

6.2 Results for Objective 2:

To mobilize 50 women and encouraging 10 couple counseling at VCT and PMTCT to better ensure the involvement of male partners in Kikuyu by 2007.

Under this objective, the project managed to encourage

Married	men	4
Married	women	9
Cohabiting	men	2
Cohabiting	women	4
Total		19

Out of these 6 couples were new, the actual planned were 10. Also managed to encourage 40 women to go for VCT. In this objective the planned numbers were not accomplished the reasons might be;

Some of couples who test positive, the women part experienced significantly more discrimination from their partners, families and community members than HIV negative, positive men did. From my experience it is recommended that, men and community members should be educated about perinatal transmission and offering VCT services outside antenatal clinics, since men rarely visit these clinics.

Public education campaigns need to highlight the advantages of testing and treating all family members. To involve more men is based partly on a belief that this will decrease discrimination against women.

In case of number of women mobilized to be low, is that when women go to the VCT and found HIV positive and disclose their HIV status, many face dramatic negative repercussions on their own and their children's will being.

6.2.1 Recommendations for objective 2;

In the light of my experience, I would like to recommend that other similar project should look at:-

Increasing gender equity in HIV/AIDS programs and services

The treatment program should be designed to provide equitable access to services for both women and men. Specific approaches should be included like: collecting disaggregated data by sex to monitor the number of women and men receiving services; designing treatment service delivery to reduce barriers to women's access and participation; reaching out to men through prevention of mother –to-child HIV transmission centers and offering them HIV counseling and testing services; and mitigating the burden of care on women and girls by linking treatment and care programs

with community efforts that provide resources such as food, support for school expense, household help, farm labor and child care.

Reducing violence and coercion

Sexual and other forms of abuse against women and girls fuel the spread of HIV. The practice or threat of sexual violence against women and girls puts them at increased risk of HIV infection by creating situations in which women are unable to voluntarily abstain from sex or negotiate condom use. The treatment program should support the activities of community – and faith – based organizations to change social norms that perpetuate male violence against women, train couples in negotiation and conflict resolution, and strengthen policy and legal frameworks that outlaw gender-based violence. This supports HIV post exposure prophylaxis in clinical settings for survivors of violence; development of couple HIV counseling; partner notification strategies; health workers' awareness of and skills to address violence; and links with community and social services that provide protection and care for victims of violence.

Addressing male norms and behaviours

Practices such as multiple and concurrent sex partners, cross-generational sex, and transactional sex increase vulnerability to HIV infection, particularly among women and girls. To address these issues, the donors should support community-based prevention programs and media messages with a focus on positive norms for boys and men; couples HIV counseling and testing as an opportunity to address gender norms and reach men; programs to address alcohol and substance abuse; and special programs with the armed services focusing on responsible male behaviour.

6.3 Results for Objective 3:

To increase economic empowerment for 40 women living with HIV/AIDS through access to micro credit programs, job and skills training and assistance with property and inheritance rights in Kikuyu area by 2007.

The results show that, community members have started to acknowledge the rights of women especially property ownership and inheritance. The evaluation on indicated that communities gained understanding on different rights of women, importance of giving credits to the women living with HIV/AIDS taking treatment as their will being is very promising. Referral services to micro-finances institutions were mainstreamed to all information campaigns activities. Implying that during campaigns women living with HIV/AIDS taking treatment were informed on existence of micro-finance institutions and their services. The project managed to train one CBO staff and she became a paralegal.

In economic activities, the project managed to link about 25 women with business people in the central market. These women are taking fruits and vegetables to sell in the streets and in the evening they return money to the owner and taking 10% commission from the sales. However, some women living with HIV/AIDS faced stigma for people not purchasing fruits and vegetables, especially when vegetables and fruits are wet. This was seen during the first monitoring assignment, I proposed that they should Hawk their products in the areas where are not known as are HIV positive and it worked well. The time has been limiting factor it is expected to link all 40 women living with HIV /AIDS in the next 9 months that is from January 2007. Since the project is continuing the number will be met.

6.3.1 Recommendations for objective 3;

In the light of my experience, I would recommend to those trying to implement similar project to look serious on the following important issues, that the project should contain aspects as:-

Increasing women's legal protection

Many of the practices that increase women's vulnerability to HIV and limit their capacity to manage its consequences are reinforced by policies, laws and legal practices that institutionalize discrimination against women.

The state should support efforts to review, revise and enforce policies that protect victims of sexual violence; support women's property and inheritance rights; enhance women's access to legal assistance; and eliminate gender inequalities in civil and criminal codes.

Increasing women's access to income and productive resources

The state must recognize that a lack of economic assets increases the vulnerability of women and girls to HIV infection. Government should support efforts to provide women with economic opportunities to avoid high-risk behaviours, seek and receive health care services, and care for their families. Such efforts should include micro-enterprise and micro-credit activities for HIV-positive women, programs to ensure that girls are given equal opportunity to attend school and vocational training, and skills and management training targeted to offer economic alternatives to prostitution.

6.4 Description of the steps to further this or similar project:-

Communicating and preparing individuals and communities to understand and support people on ART is an important component of a comprehensive response to HIV and AIDS that includes prevention, treatment, care and support. Accurate information communicated through a variety of formats using appropriate channels is needed in all places where ART is introduced so that communities become 'treatment literate'. Civil society organizations need support to facilitate this process, which should include the active participation of local leaders, community members, families and women and girls living with HIV and who are on treatment. This in turn needs to be part of a broader empowerment agenda where people and communities can actively engage with health providers around their treatment and are able to negotiate health and social situations. Engaging with individuals and communities effectively around ART can improve women and girls living with HIV/AIDS quality of life, contribute to greater uptake of voluntary counselling and testing services and lead to a greater belief in the effectiveness of ART.

Stigma related to HIV creates a vicious cycle that leads to discrimination and the deprivation of people's rights.

Because of the low visibility of ordinary people living positively, with HIV, the real face of AIDS remains unseen and AIDS – related stigma proliferates. Incorporating people living with HIV as VCT staff can significantly change people's attitudes to AIDS.

There is a need to challenge traditional customs and beliefs and to acknowledge the vulnerability of women to HIV via the vulnerability of their partners. Men must be brought into frank and honest discussions about sexual behaviours that facilitate transmission and must acknowledge their responsibility in maintaining their partners' and children's health.

7.0 BIBLIOGRAPHY

Anita Hardon, & Colleen Daniels, (2006) Universal Access by 2010 10 Challenges on the way (Health Action International)

Atueyi, I. (1999). "Drug information, Education and Communication." *West African Journal of Pharmacy* 13 (2): 10- 13

Brazil guaranteed universal and free access to ARVs by presidential decree in November 1996.

Celentano DD, Galai N, Sethi AK, Shah NG, Strathdee SA, Vlahov D, *et al.* Time to initiating highly active antiretroviral therapy among HIV-infected injection drug users. *AIDS* 2001; 15(13):1707–15.

Colebunders, R., Karita, H. Taelman, and P. Mugenyi. (1997). "Antiretroviral Treatment in Africa." *AIDS* 11 (suppl B): S107-S113.

Coffing, R.T. & Hutchinson, T.E. (April 1974). Needs Analysis Methodology:

A Prescriptive Set of Rules and Procedures for Identifying, Defining and Measuring Needs. ERIC Document Reproduction Service. ED 095 654.

Csete, J.M. (April, 1996). Needs Assessment: What difference does (and Can)

It Make? Paper. American Educational Research Association. New York: ERIC Document Reproduction Service. ED 396 002.

Chesney, M., Ickovics, J., for the Recruitment Adherence and Retention Committee of the ACTG. "Adherence to combination therapy in AIDS clinical trials (1997)." Annual Meeting of the AID clinical Trials Group, Washington, D.C., July 1997

Deeks, SC, Loftus, R, Beatty, G, et al, "Incidence and predictors of virological failure of indinavir or zidovudine in an urban AIDS clinic." [abstract] International Conference on Anti-microbial Agents and Chemotherapy. Toronto. October, 1997

Edlin BR, Seal KH, Lorvick J, Kral AH, Ciccarone, DH, Moore, LD, Lo, B. Is it justifiable to withhold treatment for hepatitis C from illicit-drug users? *New England Journal of Medicine*, 2001, 345 (3): 211-5.

Escaff re N, Morin M, Bouhnik AD, Fuzibet JG, Gastaut JA, Obadia Y *et al.* Injecting drug users' adherence to HIV antiretroviral treatments: physicians' beliefs. *AIDS Care* 2000; 12:723–30.

Family Health International. (2002). "Comprehensive HIV/AIDS Prevention, Care and Support Programming."

Farmer, Paul, f. Leandre, J.S . Mukhejee, et al. (2001). "Community-Based Approaches to HIV treatment in resource-poor settings." *The lancet*. Vol 358 (9279) 404-9.

Gerry Hillary Mshana, Joyce Wamoyi, Joanna Busza, Basia Zaba, John Chagalucha, Samuel Kaluvya and Mark Urassa (2006) Barriers to Accessing Antiretroviral Therapy in Kisesa Tanzania, A Qualitative Study of Eerly Rural Referrals to the National program. AIDS PATIENT CARE and STDs Volume 20, Number 9, 2006

Harries, A.D; D.S .Nyangulu, N.J. Hargreaves, O. Kaluwa, and F.M. Salaniponi. (2001)."Preventing Antiretroviral Anarchy in Sub-Saharan Africa." *Lancet*. 358: 410-414.

Hecht, FM, Colfax, C., Swanson, M., Chesney, M., Ò Adherence and effectiveness of protease inhibitors in clinical practice. Ó Fifth Conference on Retroviruses and Opportunistic Infections. Chicago, February 1998

Heinkel, O. (1973). Priority Determination for Vocational Education Through a Formal Needs Assessment. San Diego, CA.: ERIC Document Reproduction Service. ED 086 295, 1973.

Information supplied by ACHAP, website accessed in January 2006.

Jakab, Melitta and Chitra Krishnan. (October 3, 2001). *Community Involvement in Health care financing: Impact, Strengths and weakness: A Synthesis of the literature*. Washington, DC: World Bank

June 2001. "The Global Strategy Framework on HIV/ AIDS." Geneva, Switzerland.

J. Stephen Morrison and Heather Hurlburt, Botswana's Strategy to Combat HIV/AIDS: Lessons for Africa and president Bush's emergency Plan for AIDS Relief, a conference report of the CSIS Task Force on HIV/AIDS (Washington, D.C.: CSIS, January 2004).

Kalichman SC, Graham J, Luke W, Austin J. Perceptions of health care among persons living with HIV/AIDS who are not receiving antiretroviral medications. *AIDS Patient Care STDS* 2002; 16(5):233–40. Orrell C, Bangsberg DR, Badri M, Wood R. Adherence is not a barrier to successful antiretroviral therapy in South Africa. *AIDS* 2003; 17(9):1369–75.

Kaufman, R. (July/August, 1985). Needs Assessment, Needs Analysis, Objectives and Evaluation. *Performance & Instruction*, 24, 21

Lamphey, Peter R. and Helene D. Gyle. (2001). *HIV/ AIDS Prevention and Care in Resources-Constrained Settings*. Arlington, VA: Family Health International.

Lerner BH, Gulick RM, Dubler NN. Rethinking non adherence: Historical perspectives on triple drug therapy for HIV disease. *Ann Intern Med*. 1998 Oct 1; 129(7):573-8.

Liechty CA, Bangsberg DR. Doubts about DOT: antiretroviral therapy for resource-poor countries. *AIDS* 2003;17:1383–7.

Management Science for Health (MSH). (2000). *International Drug Price Indicator Guide*. MSH. Morrison and Hurlburt, Botswana's Strategy to Combat HIV/AIDS.

Marta Chechetto – Salles and Yvette Gayer (2006) *Community Based Organization Management handbook for CBO Pact*.

Nieuwkerk, PT, Cisolf, EM, Van Leeuwen, R, et al. Ò Self-reported adherence to ritonavir/ saquinavir and ritonavir /saquinavir/ stavudine in a randomized clinical trial:

preliminary results. Ó [abstract 32362] XII International Conference on AIDS, Geneva, June 1998

Osborne, C.M. (1996). "HIV/ AIDS in resources- poor Settings: Comprehensive Care Across a Continuum." *AIDS* 10 (suppl 3): S61-67

Oja C, Steen J : The traditional health practitioner : a key figure in future prevention and control of HIV/AIDS on the community level, in Cabrera C, Pitt D, Staugaard F. *AIDS and the Grassroot : Problems, Challenges and Opportunités*. Ipelegeng Publishers 1996. Gaborone, Giteburg, Nairobi.

Pecoul, Bernard, Pierre Chirac, Patrice Trouiller, and Jacques Pinel. (1999). "Access to Essential drugs in poor countries." *JAMA* 281(4): 361-367.

Prienti JJ, Massari V, Descamps D, Vabret A, Bouvet E, Larouze B, *et al*. Predictors of virologic failure and resistance in HIV-infected patients treated with nevirapine- or efavirenz-based antiretroviral therapy. *Clinical Infectious Diseases* 2004; 38(9):1311–6.

Rachel Cohen, "Positive Replication: The MSF Experience providing HAART in Developing Countries," ICR / GAAN meeting on U.S Strategy for Rapid Scale-up of ARV Treatment, Washington D.C., December 12,2003.

Regan, L. & Dalton, C.J. (19 May - 30 June 1998). Class Syllabus. EDER 675
- Instructional Development. University of Calgary, Canada.

<http://www.ucalgary.ca/~rllogass/eder675/comments.htm>

Report of the global AIDS epidemic, Geneva, UNAIDS, (2002).

Rugalema, Gabriel, Silke Weigang, and James Mbwika, (1999). *HIV/ AIDS and the Commercial Agricultural Sector in Kenya* . Rome, Italy: Food and Agriculture Organization.

Shelton, MJ, Esch, LD, Hewitt, RC, Cousins, S., Morse, CD. Ò The Impact of patient reported adherence with antiretroviral therapy on virologic response. Ó [abstract 1-170], 35th Inter science Conference on Antimicrobial Agents and Chemotherapy, San Diego, September, 1998

Sweat M, S. Gregorich, G. Sangiwa, et al. (2000). “Cost - Effectiveness of Voluntary HIV-1 Counseling and Testing in Reducing Sexual Transmission of HIV-1 in Kenya and Tanzania.” *The lancet*, 356 (9224): 113-21.

Sweigert, R. (1969). Unpublished Paper “Needs Assessments and Discrepancy Models.” Amherst, MA: University of Massachusetts.

The Government of United Republic of Tanzania (2001) National HIV/AIDS Policy.

The Government of United Republic of Tanzania (2002) Census Report and National website.

The United Republic of Tanzania (2005) National Strategy for Growth and Reduction of Poverty, Vice President Office.

Trimby, M.J. (December, 1979). Needs Assessment Models: A Comparison. Educational Technology. 24-28.

UNAIDS, UNICEF, and WHO, Botswana: Epidemiological Fact sheets on HIV/AIDS and Sexually Transmitted Infections, (2002) Update (New York: UNAIDS, 2002).

UNAIDS.December 2001. “AIDS Epidemic Update.” Geneva, Switzerland.

UNAIDS and Kaiser Media Manual on HIV/AIDS (2005)

UNDP (1999) Tanzania Human Development Report the State of Progress in Human Resources Development, February (2000).

UNESCO (2002) A Cultural Approach to HIV/AIDS Prevention and Care Towards A Handbook for India Overall Assessment Case Studies.

United Nations (2002) UN Office for the coordination of Humanitarian Affairs.

Integrated Regional Information Network (IRIN). Ethiopia: Focus on AIDS and the elderly. 2nd January 2006 <http://www.irinnews.org>

USAID (2005) Development Report

World Health Organization (WHO). 1997b. *Standard treatment and Essential Drugs for HIV related Conditions: Access to HIV – related Drugs* (DAP/ 97.9)

WHO (2002), <http://www.who.int/inf-fs/en/fact239.htm>, accessed on 2/1/2006

WHO/UNAIDS (2004) Policy statement

WiseInfo. info accessed on 06/04/2006

Witkin, B.R. (1984). Assessing Needs in Educational and Social Programs.

San Francisco, CA: Jossey-Bass.