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MASTTER OF SCIENCE IN COMMUNITY ECONOMIC DEVELOPMENT (2007)

Awareness on Behaviour Change Toward HIV/AIDS.

"A CASE OF KIBAIGWA WARD, KONGWA DISTRICT-DODOMA"

SUBMITTED IN PARTIAL FULFILMENT OF REQUIREMENTS FOR THE MASTER OF SCIENCE IN COMMUNITY ECONOMIC DEVELOPMENT.

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TABLE OF CONTENT

ABBREVIATIONS

ABC	Abstinence, Being faithful to one partner and Condom use
AIDS	Acquired Immune Deficiency Syndrome
BCC	Behaviour Change Communication Campaign
CBO	Community Based Organization
CCP	Centre for Communication Programs
CED	Community Economic Development
CSO	Civil Society Organization
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
GSMF	Ghana Social Marketing Foundation
HEART,	Helping Each other Act Responsibly Together
HIV	Human Immune Deficiency Virus
ILO	International Labour organization
IMAU	Islamic Medical Association of Uganda
JOH	Journey of Hope
MTP	Medium Term Plans
NACP	National HIV/AIDS Control program
NGO	Non Governmental Organization
PLWA	People Living With Aids
SABC	South Africa Broadcasting Cooperation
STD	Sexual Transmission Diseases
UAC	Uganda Aids Commission
UNAIDS	United Nation Program on HIV/AIDS
UNAJAKI	Ukimwi Na Jamii Kibaigwa
USAID	United State Agency for International Development
VCT	Voluntary Counselling and Testing
WHO-GPA	World Health Organization –Global Program on AIDS

SUPERVISOR CERTIFICATION

The undersigned certifies that he has read this project paper and accepts it as a scholarly work and therefore recommends it to be awarded Master of Science Degree in Community Economic Development.

Supervisor: Dr S. A. C. Waane

Signature.....

Date.....20.10.2007.....

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DECLARATION

I, Gowelle Mathias Boniface declares that this project paper is my own work, and that it has not been submitted for the same or similar award to any other University or Higher Learning Institution.

Signature of Student .....

Date .....

DEDICATION

This work is dedicated to my beloved wife Esther Gowelle and my son Rodney Gowelle for their tolerance and encouragement they extended to me during my study.

ACKNOWLEDGEMENT

This study report is a result of combined efforts of a large number of people to whom I am grateful. I would like to express my sincere gratitude to all whom in one way, or another, assisted me materially or morally in preparing and accomplishing this work. It is difficult to mention here each and everybody who rendered that assistance. In, particular, I would like to thanks members of UNAJAKI CBO and in general the people of Kibaigwa for their mutual cooperation from the initial stage of developing this project up to its implementation.

I thank my wife Esther Gowelle who provided both financial and moral support without which the funding of this project paper and indeed entire course would not have been possible.

Special thanks go to Dr S.A.C Waane who supervised this work tirelessly and wisely to its final conclusion. I am also grateful to Mr. Michel Adjibodou and Felician Mutasa who initially guided me in the development of this project work.

My sincere thanks are extended to CBHI Team Leader Mr Willem who allowed me to proceed with the study for the whole period required and who assisted in reviewing this report. I would like to express my deep gratitude for the hospitality and kindness of all respondents, project members and leaders in the project area.

ABSTRACT:

Kibaigwa is one of the 14 wards in Kongwa district having 3 villages and 16 sub villages. The area is popular due to the presence of an international maize market, which has accelerated the flow of people from different areas within and outside the country. This flow in one way or another has accelerated the increase in number of people living with HIV/AIDS.

UNAJAKI through Community Need Assessment conducted with assistance from CED Student, implemented Project on behavioural change toward HIV as a way of reducing the number of new HIV infections.

Through this project UNAJAKI managed to train 60 peer educators who are used to train and created awareness at sub villages' level, and 15 families with PLWA. The CBO create awareness on HIV/AIDS through seminars and meetings accompanied by organized drama. As a result of these awareness and reduction of stigma, people are now willing and confident to undergo HIV testing.

EXECUTIVE SUMMARY:

This paper explains how the project on behavioural change toward HIV/AIDS was been implemented in Kibaigwa ward. The project was implemented by a CBO known as UNAJAKI. The project concentrated on raising awareness on behavioural change as a way of fighting the problem of increase in number of people living with HIV.

Awareness on HIV/AIDS was created to Community members through meetings, trainings as well as using leaflets. Awareness meetings were held at sub village level whereby drama, role plays, and acrobat were used in mobilizing, entertaining and educating people on the epidemic. Condoms were distributed to community members during meetings as well as to those who were visited the UNAJAKI office for the sake of having condoms. Also, UNAJAKI provided counselling services in its office and linked with Dispensary for those who were ready for HIV testing.

The project was implemented following a community need assessment which was conducted in the area. Through the assessment, the increase in number of people living with HIV/AIDS was seen to be a most pressing problem in Kibaigwa ward.

Most of youth, truck drivers, and commercial sex workers are practicing unsafe sex and they have a tendency of having more than one sex partner. People in the project area have a tendency of having more than one wife, practicing Female Genital Mutilation and seeking treatment from traditional healers. These behaviours and attitudes expose them to a risk of being contracted with HIV. The project intended to have community which is free from traditional practices as well as from all attitudes and behaviours which accelerates the spread of HIV. The project goal was to reduce the number of people living with HIV/AIDS in the ward by preventing the new infections. In order to the project to achieve its goal, the objective of creating awareness to the community members on HIV/AIDS using trained peer educators was implemented.

Through this project, there is a positive behaviour change among the community members. Many people are going for HIV test, the use of condom among youth increased as many youth go to UNAJAKI office for condoms, people are aware on the risk of having many sex partners, the rare of inheriting widows continue to decrease as well as stigma especially among the relatives of PLWA.

Behaviour change is the only solution to HIV/AIDS, people need to abstain sex, be faithful to one sex partner who is HIV negative or properly use condom. HIV/AIDS campaigns need to focus on behaviour changes and should reflect the reality of the people by studying people's interests, norms, culture and beliefs for positive results.

CHAPTER ONE

1. Introduction

1.1. Districts back ground information

Kongwa is among the five district of Dodoma region. It covers an area of 4041km^2 which is 9.8 % of the total area of Dodoma region. It is 86 km east of Dodoma municipality, extending from longitude 36^0 15 to 36 East and latitude 5.30^0 to 6^0 south.

The district has 3 divisions, 14 wards and 67 villages with 281 sub villages. The neighbouring districts are Kiteto in the north, Mpwapwa in south, Dodoma rural in the west and Kilosa district of Morogoro region in the East.

According to the 2002 Population and Housing Census, Kongwa district has a population of 249,760 people of which 129,662 are female and 120,098 are male with a total of 50,877 house holds. The growth rate is 2.3 per annual. Most of residents (90%) live in rural areas relying on agriculture and livestock keeping for their subsistence and money income.

1.2. Kibaigwa ward profile

Kibaigwa is one of the 14 wards in Kongwa district, in Mlali division with three villages. The project (HIV/AIDS) implemented in all the 3 villages within the ward i.e. Kibaigwa, Ndulugumi and Kinangali with a total of 16 sub villages. Kibaigwa

is located along the Morogoro to Dodoma main road, at a distance of approximately 100 km from Dodoma and 160 km from Morogoro.

Demographic feature:

Based on the 2002 Population and Housing Census the Ward has 15,426 people of which 7,521 male and 7,905 female. The area has 3,437 households with an average size of 4.5 people per household. People in this area are engaged in agriculture and business as their main activities.

Social services;

Education

Kibaigwa ward has four primary schools, 8 nursery schools and 3 secondary schools, one being owned by government and three by private. The majority of the residents have primary level education, and some have not gone through formal education system. Therefore most of them can read and write.

Health services

Community members are accessing health facilities easily since in the area there are 5 dispensaries, which are 2 and 3 government and private owned respectively. Also the area has 16 drug shops.

Water supply

The ward has a good system of water supply especially in Kibaigwa village where there is piped water and a functioning water committee. In Kinangali

village there is a shortage of water but the village is under World Bank program to be supplied with water this year.

Other services

In kibaigwa there is an international maize marker, through which it is easy for the community members to obtain maize.

People get commodities from 68 shops; there are about 18 food vendors who provide food services in the area. Also there are 15 bars and 6 local brew bars such as Tutamu, Ukiro, Sam next; Sangara, Hilton and Paris (beer bar), Piga bao and kwa Muhangawi (local) were people go to entertain themselves. In order to accommodate guests there are 20 guest house and about 3 petrol stations.

Employment

Many people in Kibaigwa Ward are self employed in the informal sector, particularly in agriculture and business; few have been employed in formal sectors as teachers. Many youth works in the maize market as casual labourers.

Income

Most of the people (90%) in this area earn a low income, their incomes range from 50,000 to 200,000 TSH per year as most depend on agriculture to earn their incomes.

The agriculture products highly depend on the amount of rain received in a year as the area is almost semi desert.

1.3. Community need assessment

Needs are considered to be wants, aspirations interests, and wished of the people. In development literature, needs are defined as the discrepancies between "what is" (current set of circumstances) and "what should be" (desirable set of circumstances).

Need assessment can be considered as a process to identify and measure gaps between "what is" and "what should be" prioritize the gaps, and determine ways of bridging them. Therefore, the concept of Community Need Assessment connotes a process by which an assessment of the current situation in the community is undertaken, value-based judgements regarding the preferred or desired situation are reached, and some determination of priority status of local needs is made.

Kibaigwa is a busy place due to the presence of a maize market. Many people from within and outside the country like Kenya, Uganda, Malawi and Zambia come to buy maize here. Therefore, there are interactions of different people from different areas and countries with different interest as well as behaviour. This interaction contributes highly to the spread of HIV in the area.

1.3.1. Methods used during need assessment

Different methods were employed during need assessments, Focus Group Discussion (FGD) were conducted to the community members in exploring the problems they face. During FGD, community members were grouped according to the age and sex. There was a group of elderly, youth, adult men and women.

The groups were used in order for each group to be free to explain the needs which they feel the community face without being interfered by other sex or age group also, to provide chance to those who cannot speak up at large meetings to express their views. Later in the joint meeting the needs were discussed and prioritised in order to receive community agreement on the identified needs.

Interviews and structured discussions were conducted to UNAJAKI members in order to obtain specific qualitative and quantitative information on the needs which the Kibaigwa community face.

The observation method was used to see how people live and the problems which they are complaining about. The CED student and UNAJAKI members were visiting market are, bar (including those which sells local beers) and truck stands to see how people behave while in those areas. Through observations, it was noted that many young girls who come to Kibaigwa for employment purpose find themselves jobless and they fail to go back to where they come from. As a

result they engage themselves with sexual business regardless of their young age. Also, some people under the influence of alcohol were seen to be not keen for safe sex.

Also, reports from different sources such as from the dispensary and Community Development Officer in the ward were reviewed to ascertain the problems affecting the community. Reports were reviewed in order to know the identified problems, trends and the solution taken in addressing them. According to information from UNAJAKI, about 35 girls were engaging in prostitution and some are as young as 14 years of age.

Consequently many people were suffering and dying in the area due to HIV/AIDS. According to the HIV/AIDS Surveillance Report of 2002, the prevalence of HIV infection among pregnant women attending Antenatal Clinic (ANC) in Kibaigwa was 11%, while according to the 2004 report the prevalence rate in Kibaigwa was 8.7%. in contrast the District Report of 2006 indicated the prevalence in the district to be 11.7% with Kibaigwa leading.

1.3.2. Steps used during Community Needs Assessment

During Community Needs Assessment the following steps were followed to come up with the felt need of the people in the project area.

1. ***Identification of needs***

In this stage, using the methods described above, community members in their respective groups and categories came up with lists of needs which they thought their community face.

2. ***Prioritization of needs***

The groups i.e. CBO members, youth, elderly, government leaders, adult men and women ranked their needs according to priority. That means each group ranked its list of needs as per their preferences. In prioritizing, the scoring method was used whereby the highest score was five and the lowest was 1, indicating that the higher the score the serious the problem is and opposite is a case.

3. ***Levelling of needs***

Each group came up with the prioritized list of needs in the joint meeting in order to get a community agreement on the most impressing need. All lists were displayed and the needs were re-prioritized according to their impact as experienced by the community.

4. **Deciding on what needs to be addressed**

After problems /needs being prioritized the community decided on what need to be addressed first based on the resources and the seriousness of the problem.

1.3.3. Community Need Assessment results:

The need assessment result shows that HIV/AIDS was a major problem and was given a first priority by the community to be addressed as indicated in the table bellow.

Table 1: **Need assessment results**

Needs identified	Groups and their scores						Total score	Rank
	Youth	CBO	Elderly	Women	Men	G/leaders		
Malaria	2	3	3	4	4	4	**20**	4
Diarrhoea	2	2	2	3	2	3	**14**	8
Trachoma	2	2	2	3	1	3	**13**	9
Poor H&S	2	3	3	3	3	3	**17**	7
HIV/AIDS	4	5	4	5	4	5	**27**	1
Solid waste	3	3	3	2	3	4	**19**	6
Low income	5	4	5	4	3	4	**25**	2
Water	2	3	3	5	3	3	**19**	5
Street children	5	4	4	4	3	4	**24**	3

Source: Findings 2006

HIV/AIDS was seen to be a big challenge to Kibaigwa community as it affecting their social, political as well as economical development as many people dying with AIDS.

Thereafter a survey was conducted to explore further the causes of the problem (HIV/AIDS) in terms of behaviours and attitudes in order to come up with an appropriate initiative for addressing it.

1.4. Research methodology and discussion of findings

1.4.1. Research Design

The survey findings were used in advising the CBO (UNAJAKI) to come up with an appropriate initiative to address HIV/AIDS problem. Thus the survey used cross-section design since the data was just collected once and based on it UNAJAKI came up with the plan and strategies on how to combat the epidemic. Also, the survey was descriptive as it intended to provide information on the existing problem of HIV/AIDS as well as to explore more on the factors which fanned the spread of HIV in the ward in terms of attitudes and behaviours.

1.4.2. Research methodology

Face-to-face interview (inter-person interview), observations, records/document studies and case studies were used in data collection during the survey. The survey didn't use the mailed self-administered questionnaires due to limited time and lack of enough preparation in terms of financial and contact to the respondents.

Face to face interview was used in order to get feeling of the interviewees and to get clarity on responses from them. It helps to know how people perceive the problem understudy by looking at the way they answered the questions and through their facial expression.

Observation was used in order to get primary data on the behaviours and variety of interactions of the people under study. Also, the method was used in order to identify issues that people under study might be unaware of or are unwilling or unable to discuss during interview. Therefore, through observation the researchers managed to know how people interact and behave while in the market places, bars and in guesthouses.

Document studies were used because they were locally available. No cost was involved in getting them. It was also easy to get data which showed the historical trends of the problem. These documents provided information concerning the magnitude of the problem in the area and what had been done so far in addressing it.

Case studies were also used in order to compare the findings from other surveyors and the findings of this survey.

1.4.3. Contents

Number of questions

The survey comprised a total of 20 questions that were used as a guide during interviewing the selected sample size of the survey.

Content of the questions

Most of the questions were concerned with attitudes and behaviours of the community members toward safe sex. Questions on number of sexual partners' and wives people had intended to check how people behave in regard to the exchanging sexual partners. Also there were questions concerning the attitude of the people on using condom and the frequency of using condom with their partners and non-regular partners. There were questions on Female Genital Mutilation and exchanging wives among friends. These questions were intended to explore the traditional practices that are associated with the spread of HIV/AIDS. Other questions were checking the relationship between taking alcohol and the spread of HIV.

Response types

Mainly three types of questions were used i.e. multiple choice, numeric and text open ended questions. In multiple choice questions, the respondents were required to choose among the listed answers and for numeric question the respondents were required to indicate the number of sexual partners they had in the last six months. And for the text open ended question the respondents were

required to suggest what measures could be taken to address the problem in their area. Therefore, most of the responses were yes and no, to the questions which were concerned with the frequency and number of the sexual partners; the checklist response were used whereby the respondents were required to select one answer among the provided list of answers. Generally there were open-ended and closed ended responses.

1.4.4. Psychometrics characteristics

Scales

This survey used mainly two types of scale i.e. rating/measurement (especially nominal and ordinal scale), and category scale.

Content

Nominal scale was used on the question in which the respondents were required to indicate the sex they belong to. And, an ordinal scale was used whereby respondents were required to indicate their highest level of education which they had achieved.

The category scale was used, where the respondents were required to select one among the listed answers. E.g. the questions which were concerned with attitude of drinking alcohol, they were required to select one among the listed responses i.e. always, some times, rarely etc.

Questions scoring

The questions were scored based on participants' responses e.g. yes or no, yes meant that the respondent agree and no disagree. The responses which were in

terms of numbers i.e. one, two, three and more than three, that meant the higher the number the bigger the problem or the higher the risk of getting HIV.

Combining questions into scales

The survey questions were branched in such a way that if the participants saw that the question asked to him or her is not appropriated, he or she was not suppose to answer it in steady the next question was asked to him or her.

1.4.5. Validity

Questionnaires were tested in terms of its content and face validity, but criterion and construct validity were not tested since the questionnaires were not compared by the gold-standard measure which are used to measure the same factors i.e. to measure attitudes and behaviours which were associated with the increase of HIV infection.

In checking face validity the questions were given to four people to look at its appearance. This helped the participants to have similar view on the way the questions look like. And, in terms of content validity, the questions were given to Ward Community Development Officer and District HIV/AIDS Coordinator to review its contents and checking whether the questions represents attitudes and behaviours need to be surveyed. This helped to have good flow of the questions and to determine whether the questions were clear to the respondents.

Adequacy of validity for survey's uses

The survey questions accurately represented the attitudes and behaviours that intended to be measured.

Adequacy of description and methods for establishing validity

It helps surveyors to get the intended information on the problem under study, since the questions were clear and it touches the attitudes and behaviours, which are being practiced by the people in the study area.

Limits on internal and external validity

Some identified attitudes and behaviours had no direct cause to the problem and could not generalize the findings into other areas or regions since some of the attitudes and behaviours, which were being practiced by people of this area, are not being practiced in other areas e.g. Female Genital Mutilation.

1.4.6. Sampling methods

Kibaigwa Ward has three villages, in selecting village to be surveyed non-probability sampling was used (purposive sampling) whereby the village in which the international maize market is allocated was selected. This village was selected since there are more interactions of people from different district, regions and countries and is the most active or busy village in the ward. Probability sampling (simple random sampling) was used to get the sample of people who were participated in the survey exercise.

How sample size was chosen?

No calculation was used to get sample size; the number of respondents to be surveyed was decided by the surveyor based on the time allocated for the exercise and his financial position, thus the sample size of 60 respondents were used in this survey.

Potential biases

In selecting respondents surveyors were biased in terms of sex since many respondents were female. This was because females were more willing to responds to questions compared to male. Also, based on the statistics it showed that females were more affected with HIV/AIDS compared to males.

Analysis

In analysing the survey data, comparison method (Mann-Whitney U test) was used to analyse the female and male responses. The analysed data was presented by using bar, line and pie charts.

1.4.7. Survey Administration

Characteristics of survey administrators

The survey was conducted by three people i.e. CED student and two other members as assistants surveyors. The selected interviewers were the people living in the survey area, thus they were similar to respondents and they were very familiar with the area under study. They had experience in conducting research since they had conducted research on the use of condom among truck drivers in the survey area before.

Training to interviewers and other data collectors

One-day orientation session took place to the interviewers on the objective of the survey and on how to use the survey instruments. This was done in order to have a common understanding of the instruments and procedures of conducting the survey.

Quality of data

Monitoring of the surveyors during survey was done to ensure that the survey was administered uniformly, and it was done by telephone. At the end of each day interviewers met to evaluate the exercise. Also, the interviewers were provided with guided questions to ensure the same questions were being asked to respondents and in the same way.

Length of time to complete each survey

It took almost 15-20 minutes to interview one person and this depended on responses from the interviewee, some were slow in answering the questions.

Length of time for entire survey to be completed

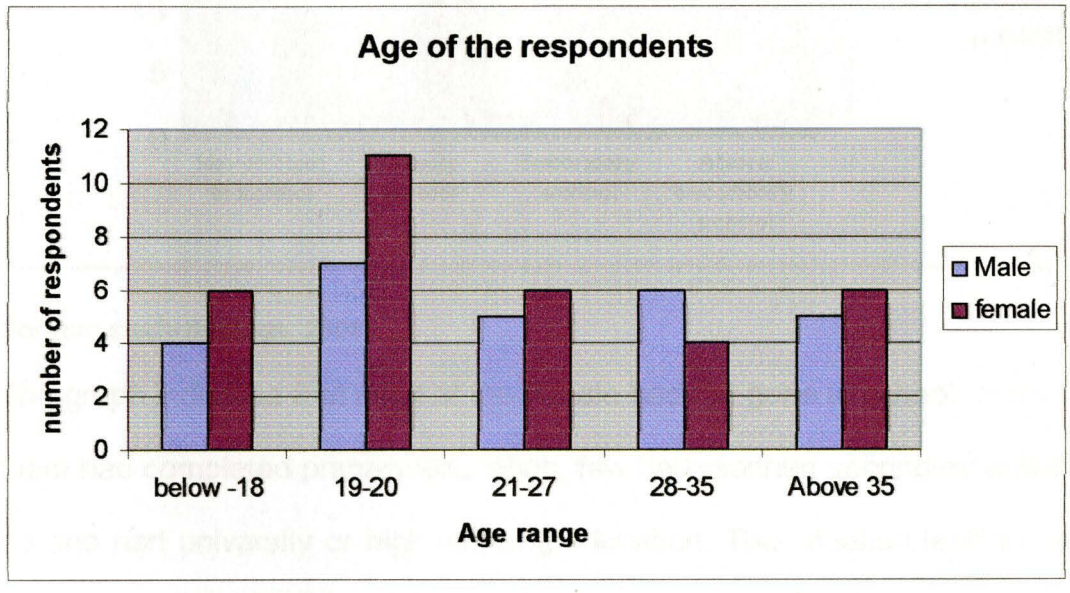
The survey was conducted in five days, and in those days the researchers managed to interview all 60 intended respondents.

1.4.8. Survey findings /results

Respondents

The survey had a range of 18 to more than 35 years old of the respondents and majorities were ranging from 19-20 years of age and followed by age range of 21-27 as shown in the bar chart bellow.

Figure 1: Age of respondents



Source: study findings, 2006

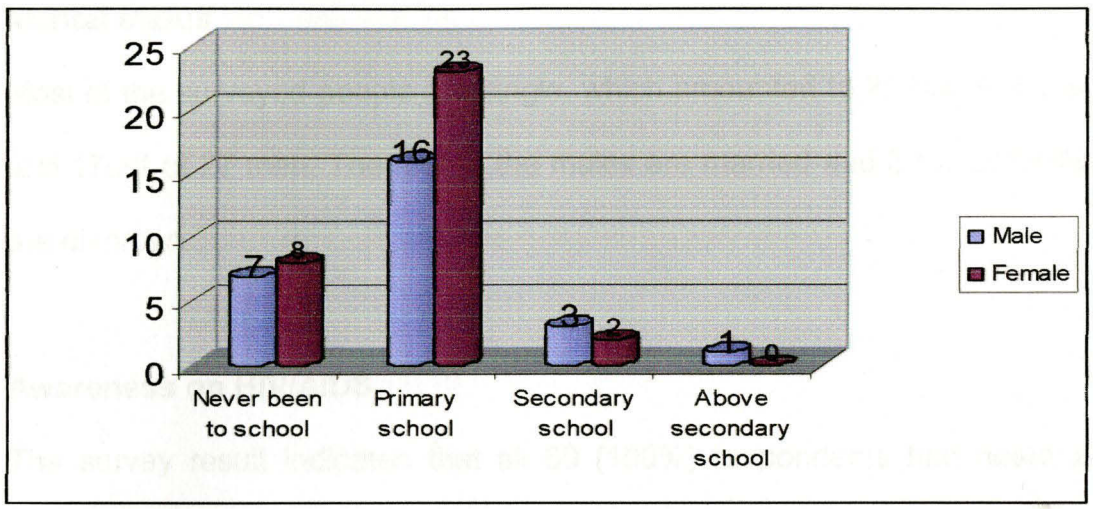
The bar chart indicates that most of the surveyed people were in the age of 19-20 years and when you look at the range of age of the surveyed people all were in the age of high risk with regard to HIV infections.

Education level

About 65%of the respondents were Standard Seven Leavers, 25% have not gone through formal school system, 8.3% had reached secondary school and

1.7% had university education or higher learning institution educations as shown below.

Figure 2: Education level of respondents



Source: study findings, 2006

The graph indicated that most of the female had not gone to school, and most of them had completed primary education, few had reached secondary school and no one had university or high learning education. The situation lead to most of female in this area to be job less and were forced to work as casual labours in the market, bars, restaurants and guesthouses. Due to low income gained in their occupations they were forced to engage in sexual business in order to earn supplement for their living.

Generally, the education level among the community members in the area are low, most of the kids do not attend school and are being used for grazing

animals (cattle and goats) thus the awareness level on importance of school among the parents are low.

Marital status

Most of the surveyed people are single, which amounted to 20 out of 33 women and 17out of 27 men. The rest of the males are married and 3 out of 13 female are divorced.

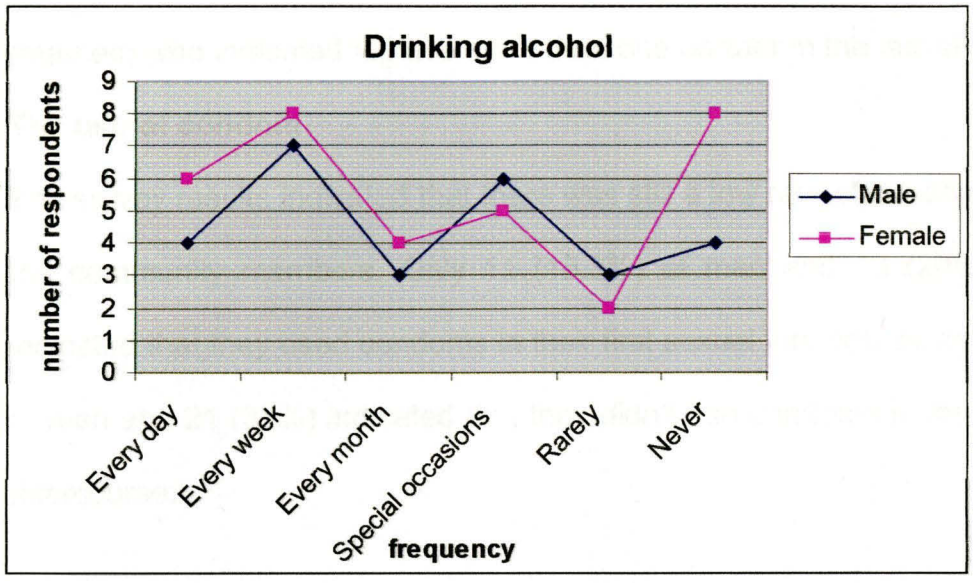
Awareness on HIV/AIDS

The survey result indicated that all 60 (100%) respondents had heard about HIV/AIDS either through radios, campaigns or from their friends. This indicates that most of the community members are aware of HIV/AIDS but the challenge is on how they put in practices what is advocated about HIV/AIDS.

People's behaviours and attitudes

The result indicated that most of the interviewed people are taking alcohol although some are not taking it daily as it indicated in the chart below.

Figure 3: Tendency of drinking alcohol



Source: study findings, 2006

This indicates that there is some relations between taking alcohol and the spread of the disease since the result reveal that those who are taking alcohol are likely to practice unsafe sex and have many sexual partners under the influence of alcohol.

Sex partners

On the issue of having multiple sexual partners, the survey data showed that 11 (18.3%) male and 5 (8.3%) female indicated to have one partner in the past six months before the survey. The proportional differ between the married and unmarried males and females. Most of the unmarried women i.e. 24 (40%) and unmarried men 15 (25%) indicated to have more than one partner in the last six

months before the survey, compared to 6.7% of men and 1.7% of women (married) who indicated to have more than one partner in the last six months.

The use of condom

The survey results indicated that there was still a low rate of condom use among the community members. Only 11 (18.3%) of men and 12 (20%) of women indicated that they used condoms in their first sexual intercourse and 16 (26.7%) of men and 21 (35%) indicated that they didn't use condoms in their first sexual intercourse.

Most of respondents indicated that they do not to use condoms with their sexual partners i.e. 45 (75%) and only 15 (25%) indicated to use condom. It was revealed that the decision to use condom was in the hands of men, women cannot decide whether to use condom or not and since most of the women have not gone to school they can not argue about it.

Traditional Practices

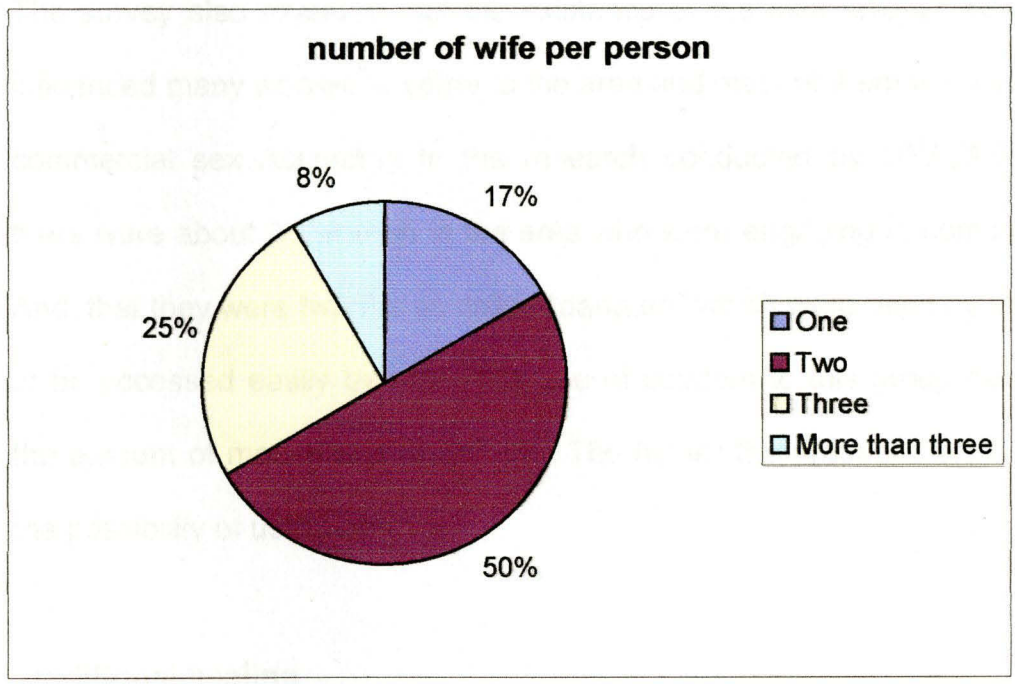
The survey revealed that, the tradition of circumcision /mutilation put those who were circumcised at risk of being affected with HIV. Data indicates that out of 33 interviewed women 27 (45%) had undergone genital mutilation and 4 (6.7%) men had been circumcised traditionally. These groups are at risk of being affected by HIV due to fact that the exercise was being practiced in non-sterile

environments i.e. the instruments which were used and shared without proper sterilization.

Number of wife per person (man)

Survey data indicated that people in this area had a tendency of having more than one wife as shown in the chart below.

Figure 4: Number of wife per person



Source: study findings, 2006.

Looking at the data more than 80% indicated that people in the survey area had more than one wife. And, most of the older men tend to marry young girls, which lead to majority not fulfilling their family obligations (including sexual satisfaction) as results their wives look for extramarital sex partners.

Still in the area there was a tendency of people inheriting widows although not at high rate, since only 20% of the respondents indicated so. Also about 14 (23.3%) respondents indicated that in the area there was a tendency of sharing wives among friends especially among the Masai people. They do so by believing that relationship among friends would become strengthened. Therefore, those who had such a habit were at risk of being affected by HIV.

The survey also revealed that the existence of the international maize market influenced many women to come to the area and most of them were engaging in commercial sex According to the research conducted by UNAJAKI in 2005, there were about 35 women in the area who were engaging in commercial sex. And, that they were two the so called "danguro" which were used by that women to be accessed easily by men. The use of condom to this group depended on the amount of money one (man) has. The higher the amount offered the lower the possibility of using condom.

Traditional healing

Through Focus Group Discussion during survey it was discovered that most of the people in the area preferred to get treatment from traditional healers. Most of the traditional healers considered tattoos to be a remedy for some illness, the use of non-sterile blades and knives was very high, and as a result transmission of HIV from one person to another was highly probable.

Through observation findings revealed that in the area of study there was a special market day twice per month whereby people from a far come to buy or sell their commodities. Those days were the meeting days with partners. During market days the local brew shops become very active and busy as people drink, dance and under the influence of alcohol they practice unsafe sex.

1.4.9. Research conclusions

1.4.9.1. Summary of important points

Most of the people in the study area seemed to have more than one wife, and most of the unmarried men and women did practice sex with more than one partner. Also most of the people were not using condom, thus they were practicing unsafe sex with their partners and even with non-frequent partners. The existence of a maize market in the area increased the inflow of people from different areas, it accelerated the tendency of people for having many sexual partners especially truck drivers and many girls were engaged in sexual business.

There are a tendency of inheriting widow, sharing wives among friends, practicing Female Genital Mutilation and seeking treatment from traditional healers due to traditional norms and beliefs.

Therefore all the above seemed to be major contributing factors to the increase in HIV/AIDS infection in Kibaigwa area.

1.4.9.2. Implications and recommendation

Implications

These findings imply that there were many factors that contribute to the increase of the problem in the area, and thus in trying to combat the problem different techniques and approaches should be used. In order to be successful in addressing the problem a multisectoral approach should be employed as there are social-cultural and economic factors that make people to be at risk of getting HIV.

Recommendations

The survey discovered much behaviour that put people at risk of being affected by HIV, thus the initiatives that would emphasize for behavioural change should be introduced and to make it more successful peer educators should be trained and used in the course of implementation.

There was a need to train youth on entrepreneurships, and establish Ward Loan Fund for youth and women, so that they can employ themselves in small business activities instead of staying idle and being forced to engage themselves in commercial sex as their means of earning their living.

By laws should be established (by Ward Government) in the fight against HIV in the following areas:

- Widows should not be inherited
- Wives should not be shared among friends

CHAPTER TWO

2. PROBLEM IDENTIFICATION

2.1. Problem statement

The increase in death cases related to AIDS is a big challenge in the small town of Kibaigwa. This was discovered during Community Need Assessment which was conducted together by CBO members and other project stakeholders including community members of Kibaigwa Ward. The CNA revealed that many people have infected and affected with HIV/AIDS as a result it slow down economic development of the people in the area. Kibaigwa being a business centre for maize attracts many people to come and trade in the area. With the interaction of people from different countries, people are practicing behaviours that put them at risk of being affected by HIV. As a result, the number of people living with HIV/AIDS in the area is increasing tremendously.

2.1.1. Affected groups

Children

Many groups are affected with this situation i.e. children who lost their parents and others contracted HIV from their mothers during deliveries. Those who lost parents become orphans and end up living in the streets (street children) as they do not have relatives to take care of them or do not receive proper care from their relatives.

Women

Another affected group is women. Despite constitutional guarantees of equality between sexes and affirmative action in favour of women, the position of the women remains unchanged. This is due to cultural beliefs and practise, poor education, economic disempowerment, polygamy, prostitution and their biological makeup which make them to be a high risk group in relation to HIV/AIDS.

Truck drivers and Commercial sex workers

Truck drivers and commercial sex workers are other affected group, due to the practice of unsafe sex. These groups are mobile and usually have multiple partners make them very vulnerable to HIV/AIDS infection. In Kibaigwa it is estimated that there are about 35 sex workers (girls).

HIV/AIDS causes the increase in number of vulnerable groups in Kibaigwa as it indicated below.

Table 2: **Vulnerable groups**

Group	Sex		Total
	Male	Female	
Orphans 0—17 yrs	246	250	496
Street children 5---17	84	68	152
PLWA	38	53	91
Widow	44	88	132

Source: UNAJAKI findings July 2005.

2.1.2. Accelerating factors

There were many factors which contributed to the increase in number of people living with HIV/AIDS in the area, to mention some:

The existence of an international maize market causes a great inflow of people from different areas, which in turn leads girls to engage in commercial sex. In general it is known that these sex workers do not apply safe sex as money is more important to them.

Girls migrate from village to Kibaigwa looking for jobs. They often resort to commercial sex with truck drivers, who come to collect maize as they don't have enough money to survive or even to return to their village.

Traditional beliefs and practices such as Female Genital Mutilation, sharing wives among friends, having more than one wife and inheriting widows accelerating the problem of the spread of HIV/AIDS in the area.

Lack of awareness on HIV/AIDS preventions makes people to practice unsafe sex. People do not use condoms because they believe that using condom reduces enjoyment of sex and that even if you use it they can't protect them from having HIV since condoms have poles/holes that allow virus to penetrate.

Stake holders' efforts

Government, in collaboration with CSOs are working in reducing if not alleviating the problem. UNAJAKI created awareness on behavioural change to community members using trained peer educators. The awareness raising on the pandemic was done through meetings, seminars and drama.

The situation required action to be taken; otherwise many people would die (especially young ones) and as a result there would be a decrease in labour power as well as production. The number of orphans and street children would increases, which in one way or another would be a threat to the community life. Life expectance of the people in Kibaigwa would continue to decrease. Further more the problem of child labour would be increase since most of the children would be engaged in risk work due to lack of care from relatives after their parents died.

2.2. Target community

The target group of the project were people living with HIV/AIDS, the youth, people who were working in bars and guesthouses and generally the whole community of Kibaigwa Ward. The UNAJAKI members were the ones, who spearheaded the implementation of the project. Community participation in the project cycle helped the project to be effectively implemented by the community members. Through the project, community members were empowered in terms

of knowledge on the HIV/AIDS and how they could prevent themselves from being infected.

2.3. Project Stake holders

The project had different stakeholders including the target groups who contributed to the achievement of its objectives. The roles that they played varied from the requirements of the project according to the phases of the project. The key stakeholders of the project were community members of Kibaigwa ward, World Neighbours organization, UNAJAKI members, the government at village and district level, Action Aid and Health Workers both public and private. Their roles could be summarised as follows:

Table3*:* **Stakeholders roles and responsibilities.**

Stake holder	Roles	Expectations
UNAJAKI members	▪ Conceived project idea ▪ Implementing the planned activities	Achieve all the planed objectives
Other Community members	▪ Conceived project idea ▪ Implementing the planned activities	Reduced HIV/AIDS infections/deaths
District authorities	▪ Provide a legal entity for the group to operate	See UNAJAKI expanding its coverage to another area
Village government	▪ Organize meetings for awareness ▪ Assisting the organization in selecting peer educators	Community members are strong and engage in development activities
UNAJAKI leaders	▪ Facilitate CBO's meetings ▪ Link members with stakeholders	The project becoming strong financially and continue to save community.
World Neighbours &Action Aid	▪ Funding of the project ▪ Monitoring the organization activities	The project become sustainable
Health Workers	▪ Provide technical input/advice ▪ Testing HIV	More people are aware and go for testing
CED student	▪ Conduct survey ▪ Monitor project activities	Produce monitoring and evaluation system

Source: Project implementation 2006

2.4. Project goal

The goal of the project was to reduce the number of people living with HIV/AIDS in Kibaigwa ward by creating awareness on the behaviours that put people at risk of being affected by HIV.

2.5. Project objectives

In order to achieve the goal, the project had the following objectives:-

- To mobilize resources within and outside the CBO for project implementation
- To create awareness for behaviour change by using 60 trained peer educators
- To monitor and evaluate the CBO's activities.

Resources:

Resources in terms of funds and personnel were needed for project implementation. UNAJAKI wrote proposals and submitted to World Neighbours and Action Aid organization. UNAJAKI secured TTS 2,500,000 and 2,700,000 from World Neighbour and Action Aid respectively. The funds were secured at different time and all were used in implementing this project.

2.6. Host organization

The project was managed by UNAJAKI which was formed in 2002. The CBO is registered and does different activities such as

- Counselling services before HIV testing
- Awareness creation on HIV/AIDS to community members in Kibaigwa ward
- Taking care of orphans and children who are living in difficult circumstances
- Home based care
- Reduction of poverty through mobilizing income generating groups

Contact details:

Location of CBO office: In Kibaigwa village along the Morogoro to Dodoma main road.

Address: C/o Abdullah Salehe P.O.BOX 58 Kibaigwa

Mob. Phone: 0754014029

CHAPTER THREE

3. LITERATURE REVIEW

3.1. Theoretical literature:

3.1.1. Introduction

AIDS (acquired immunodeficiency syndrome) was first reported in the United States in 1981 and has since become a major worldwide epidemic. AIDS is caused by HIV (human immunodeficiency virus). By killing or damaging cells of the body's immune system, HIV progressively destroys the body's ability to fight infections and certain cancers. People diagnosed with AIDS may get life-threatening diseases called opportunistic infections, which are caused by microbes such as viruses or bacteria that usually do not make healthy people sick.

More than 900,000 cases of AIDS have been reported in the United States since 1981. As many as 950,000 Americans may be infected with HIV, one-quarter of whom are unaware of their infection. The epidemic is growing most rapidly among minority populations and is a leading killer of African-American males ages 25 to 44. According to the Centers for Disease Control and Prevention (CDC), AIDS affects nearly seven times more African Americans and three times more Hispanics than whites. In recent years, an increasing number of African-American women and children are being affected by HIV/AIDS. In 2003, two-

thirds of U.S. AIDS cases in both women and children were among African-Americans.

3.1.2. HIV Transmission

HIV is spread most commonly by having unprotected sex with an infected partner. The virus can enter the body through the lining of the vagina, vulva, penis, rectum, or mouth during sex.

Risky behaviour

HIV can infect anyone who practices risky behaviours such as

- Sharing drug needles or syringes
- Having sexual contact, including oral, with an infected person without using a condom
- Having sexual contact with someone whose HIV status is unknown

Infected blood

HIV also is spread through contact with infected blood. Before donated blood was screened for evidence of HIV infection and before heat-treating techniques to destroy HIV in blood products were introduced, HIV was transmitted through transfusions of contaminated blood or blood components. Today, because of blood screening and heat treatment, the risk of getting HIV from such transfusions is extremely small.

Contaminated needles

HIV is frequently spread among injection drug users by the sharing of needles or syringes contaminated with very small quantities of blood from someone infected with the virus.

It is rare, however, for a patient to give HIV to a health care worker or vice-versa by accidental sticks with contaminated needles or other medical instruments.

Mother to child

Women can transmit HIV to their babies during pregnancy or birth. Approximately one-quarter to one-third of all untreated pregnant women infected with HIV will pass the infection to their babies. HIV also can be spread to babies through the breast milk of mothers infected with the virus. If the mother takes certain drugs during pregnancy, she can significantly reduce the chances that her baby will get infected with HIV. If health care providers treat HIV-infected pregnant women and deliver their babies by caesarean section, the chances of the baby being infected can be reduced to a rate of 1 percent. HIV infection of newborns has been almost eradicated in the United States due to appropriate treatment.

Saliva

Although researchers have found HIV in the saliva of infected people, there is no evidence that the virus is spread by contact with saliva. Laboratory studies reveal that saliva has natural properties that limit the power of HIV to infect, and

the amount of virus in saliva appears to be very low. Research studies of people infected with HIV have found no evidence that the virus is spread to others through saliva by kissing. The lining of the mouth, however, can be infected by HIV, and instances of HIV transmission through oral intercourse have been reported.

Scientists have found no evidence that HIV is spread through sweat, tears, urine, or feces.

Casual contact

Studies of families of HIV-infected people have shown clearly that HIV is not spread through casual contact such as the sharing of food utensils, towels and bedding, swimming pools, telephones, or toilet seats. HIV is not spread by biting insects such as mosquitoes or bedbugs.

Sexually transmitted infections

If you have a sexually transmitted infection (STI) such as syphilis, genital herpes, Chlamydia infection, gonorrhoea, or bacterial vaginosis appears, you may be more susceptible to getting HIV infection during sex with infected partners.

3.1.3. Early Symptoms of HIV Infection

If you are like many people, you will not have any symptoms when you first become infected with HIV. You may, however, have a flu-like illness within a month or two after exposure to the virus. This illness may include: Fever, Headache, Tiredness and Enlarged lymph nodes (glands of the immune system easily felt in the neck and groin)

These symptoms usually disappear within a week to a month and are often mistaken for those of another viral infection. During this period, people are very infectious, and HIV is present in large quantities in genital fluids.

More persistent or severe symptoms may not appear for 10 years or more after HIV first enters the body in adults, or within 2 years in children born with HIV infection. This period of "asymptomatic" infection varies greatly in each individual. Some people may begin to have symptoms within a few months, while others may be symptom-free for more than 10 years.

Even during the asymptomatic period, the virus is actively multiplying, infecting, and killing cells of the immune system. The virus can also hide within infected cells and lay dormant. The most obvious effect of HIV infection is a decline in the number of CD4 positive T (CD4+) cells found in the blood-the immune system's key infection fighters. The virus slowly disables or destroys these cells without causing symptoms.

As the immune system worsens, a variety of complications start to take over. For many people, the first signs of infection are large lymph nodes or "swollen glands" that may be enlarged for more than 3 months. Other symptoms often experienced months to years before the onset of AIDS include

- Lack of energy
- Weight loss
- Frequent fevers and sweats
- Persistent or frequent yeast infections (oral or vaginal)
- Persistent skin rashes or flaky skin
- Pelvic inflammatory disease in women that does not respond to treatment
- Short-term memory loss

Some people develop frequent and severe herpes infections that cause mouth, genital, or anal sores, or a painful nerve disease called shingles. Children may grow slowly or be sick a lot.

People with AIDS are easily affected by opportunistic infections because the immune system is so ravaged by HIV that the body cannot fight off certain bacteria, viruses, fungi, parasites, and other microbes.

Symptoms of opportunistic infections common in people with AIDS include

- Coughing and shortness of breath
- Seizures and lack of coordination

- Difficult or painful swallowing
- Mental symptoms such as confusion and forgetfulness
- Severe and persistent diarrhea
- Fever
- Vision loss
- Nausea, abdominal cramps, and vomiting
- Weight loss and extreme fatigue
- Severe headaches
- Coma

Children with AIDS may get the same opportunistic infections as do adults with the disease. In addition, they also have severe forms of the typically common childhood bacterial infections, such as conjunctivitis (pink eye), ear infections, and tonsillitis.

People with AIDS are also particularly prone to developing various cancers, especially those caused by viruses such as Kaposi's sarcoma and cervical cancer, or cancers of the immune system known as lymphomas. These cancers are usually more aggressive and difficult to treat in people with AIDS. Signs of Kaposi's sarcoma in light-skinned people are round brown, reddish, or purple spots that develop in the skin or in the mouth. In dark-skinned people, the spots are more pigmented.

During the course of HIV infection, most people experience a gradual decline in the number of CD4+ T cells, although some may have abrupt and dramatic drops in their CD4+ T-cell counts. A person with CD4+ T cells above 200 may experience some of the early symptoms of HIV disease. Others may have no symptoms even though their CD4+ T-cell count is below 200.

3.1.4. Main Global and Regional trends

Promising developments have been seen in recent years in global efforts to address the AIDS epidemic, including increased access to effective treatment and prevention programmes. However, the number of people living with HIV continues to grow, as does the number of deaths due to AIDS. A total of 39.5 million [34.1 million – 47.1 million] people were living with HIV in 2006 – 2.6 million more than in 2004. This figure includes the estimated 4.3 million [3.6 million – 6.6 million] adults and children who were newly infected with HIV in 2006, which is about 400,000 more than in 2004.

In many regions of the world, new HIV infections are heavily concentrated among young people (15-24 years of age). Among adults 15 years and older, young people accounted for 40% of new HIV infections in 2006. **Sub- Saharan Africa** continues to bear the brunt of the global epidemic. Two thirds (63%) of all adults and children with HIV globally live in sub- Saharan Africa, with its

epicentre in southern Africa. One third (32%) of all people with HIV globally live in southern Africa and 34% of all deaths due to AIDS in 2006 occurred there. Decline in national HIV prevalence are being observed in some sub – Saharan African countries, but such trends are currently neither strong nor widespread enough to diminish the epidemics' overall impact in this region. Almost three quarters (72%) of all adult and child deaths due to AIDS in 2006 occurred in **sub- Saharan Africa:** 2.1 million [1.8 million – 2.4 million] of the global total of 2.9 million [2.5 million -3.5 million]. Overall sub – Saharan Africa is home to an estimated 24.7 million [21.8 million – 27.7 million] adults and children infected with HIV, 1.1 million more than in 2004.

Tanzania trends

In Tanzania the first cases of AIDS were reported in 1983 in Kagera region. By 1986 all regions reported cases. It was estimated that 1.4 million [1.3 million -1.6 million] adults and children were living with HIV in the United Republic of Tanzania at the end of 2005, making it one of the most–affected countries in the world. Here, too, HIV infection levels have diminished somewhat from 8.1% to 6.5% nationally between 1995 and 2004 (Somi et al., 2006), and from 14% to 11% among pregnant women in Dar es Salaam between 1995 and 2003 (Urassa et al., 2006). In Mbeya and Iringa, the worst- affected regions in the country, HIV infection levels ranged between 15% and 19% in several urban

areas in 2004 (Swai et al., 2006, National Bureau of Statistics Tanzania and ORC Macro, 2005).

On the other hand, high HIV prevalence has been observed at rural antenatal site: 8% and 11% at Ilembo and Igamba in the Mbeya region in 2004 (Swai et al., 2006). According to projections, the number of new HIV infections in rural areas (where about three quarters of the country's population live) could be twice as high as in urban areas by 2010. This reinforces the need to ensure sufficient resources for prevention, treatment and care are also developing in rural parts of the country (Somi et al., 2006)

HIV transmission is estimated to be about 90% through heterosexual contact, less than 5% is attributed to mother to child transmission during pregnant and during child birth or from breast feeding, and less than 1% related to blood transfusion, other transmission routes like intravenous drug use, professional accidents or through traditional skin practices are rare.

The main factors determining and driving the spread of HIV in Tanzania are the prevailing sexual relations especially involving young persons and underlying economic, social and cultural factors.

Sexuality is still a taboo in many families, school and in public education. Traditionally male dominates gender relations and poor economic opportunities impact negatively on the capacities of the girls and women to determine their sexual relations, thus making them more vulnerable to HIV infection. Cultural practices in some ethnic groups compound these risks.

The climate of stigma and discrimination surrounding HIV/AIDS and continued resistance by important segments of the society e.g. religious organizations provide the background for the continued spread of virus.

3.1.5. HIV and Sexual Behaviours trends among young people

In 2001, the United Nations' declaration of Commitment on HIV/AIDS outlined a goal of reducing HIV prevalence by 25% in young people in the most affected countries by 2005, in order to monitor progress in preventing new infections. Determining real time trends in HIV incidence, and in particular the impact of prevention programmes on HIV incidence – ideally requires longitudinal studies of large numbers of people. Given the practical difficulties of conducting such studies, it has been proposed to use HIV prevalence in young women aged 15-24 attending antenatal clinics as a proxy measure for incidence.

To assess progress towards this goal, a country in which national prevalence exceeds 3% was asked by the WHO/UNAIDS working Group on Global HIV/AIDS and STI surveillance to participate in this endeavour. HIV prevalence

has declined since 2000/2001 in eight of 11 countries with sufficient data to analyse recent trends among young people. In **Kenya,** HIV prevalence among young pregnant women declined significantly by more than 25% in both urban and rural areas. Similar declines were evident in urban areas in **Côted'Ivoire, Malawi,** and **Zimbabwe,** and in rural parts of **Botswana**. Less prominent (and non-significant) declines were observed in urban **Botswana, Burundi** and **Rwanda** and in rural **Tanzania** and **Zimbabwe**. There was no evidence of a decrease in HIV infection levels among young people in **Mozambique, South Africa** or in **Zambia.**

Using results from national surveys conducted at least twice in the same country during the period 1992 – 2005, trends in behaviours among young people were assessed. In **Kenya,** behaviour trend data point to a significant reduction over time in the kinds of sexual behaviour that place people at risk of HIV infection. The proportion of young persons having sex with no- regular partners decreased in **Haiti** (men only), **Kenya** and **Malawi** (young men and women), and **Zambia** (women only), but increased in **Cameroon**, and **Uganda** (women only). Meanwhile, condom use rates with non- regular partners seemed to increase in some of the surveyed countries, including **Cameroon South Africa**, , **Tanzania** and **Uganda** (young men and women), **Malawi** (young men only), and **Kenya** and **Zambia** (young women only). In a few countries, most notably **Cameroon**, there appeared to be simultaneous shifts towards both safer and high –risk behaviours with increases in the percentages of young people who engage in

high –risk sexual activities occurring alongside rising rates of condom use during casual sex with a non- regular partner.

Unfortunately, relatively few countries were able to provide extensive behavioural trend data for young people and many countries had insufficient or no data on HIV prevalence trends among young people- including some of the countries with exceptionally high HIV prevalence in Southern Africa. This reinforces the need to expand HIV surveillance activities as a matter of urgency. The future course of the world's HIV epidemics hinges in many respects on the behaviours young people adopt or maintain, and the contextual factors that affect those choices. Some recent, positive changes are evident among young people in parts of the Caribbean and sub-Saharan Africa, particularly in East Africa.

In Tanzania, due to culture men have more power compared to women when it comes to decisions making at the household level. According to a survey conducted by National Bureau of Statistics in 2004, indicated that 8 out of 10 Tanzanians feel that wife is justified to refuse having sex with her husband if she knows that he has a sexually transmittable disease. While 7 in 10 women and 8 in 10 men believe that a wife is justified in asking that they use a condom if she knows her husband has a sexually transmitted infection.

On the issue of educating children of age 12-14 about the use of condom to avoid HIV/AIDS, about 60% of Tanzanian are in favour of the idea, however adults of age 50 -60 are less likely than younger ages to support the idea.

More men have more than one sexual partner in Tanzania as compared to women. Some traditions and religions allow polygamy, and since most of men are economically well-off compared to women it is easier for then to have more sexual partners. The proposition differs between married and unmarried men; unmarried men tend to have more sexual partners compared to married men.

The majority of Tanzanians do not go for VCT, and even those who are tested and found to be positive are not ready to disclose their status. This is due to the fact that stigma is still high, so people avoid to be segregated by relatives, friends and society in general and thus, they do not disclose their status.

3.1.6. Impact of HIV/AIDS

Adult mortality in Tanzania has increased considerably in recent years due to HI/AIDS and it is estimated that is now the leading cause of death among adult. The World Bank projected in 1997 that the workforce would become younger (age of 29 instead of 31 years by 2010) less educated and trained as a result of HIV/AIDS. Projected cumulative losses to the labour force (15- 45) due to HIV/AIDS in Tanzania 2005, 2010 and 2015 as shown in the table bellow.

Table 4: **Projected losses of labour force in Tanzania**

Year	**2005**		**2010**		**2015**	
	Total No	%	Total No	%	Total No	%
Loss	1,322,600	6.3	2,080,200	8.8	2,858,300	10.6

Source: ILO, 2004.

Mortality due to AIDS is now rising faster for women than for men; whereas mortality losses due to HIV/AIDS of women were below those of men in 1995, in the year 2015 the losses of women will be 25% greater. It is estimated that Tanzania would lose 1,483,000 female workers to AIDS as compared to 1,375,000 male workers by 2015. (ILO report 2004)

Due to HIV/AIDS the life expectancy at birth has becomes low. The World Bank estimated that by 2010 because of HIV/AIDS, life expectancy would be reduced to 47 years as opposed to the projected 56 years without AIDS.

The proportion of children under 15 years who are orphans has increased rapidly due to HIV/AIDS. By 2001; 1.1% had lost both parents 6.4 % had no father and 3.5 % had no mother.

Information and education programmes are essential to combat the spread of the epidemic and to foster greater tolerance for people living with HIV/AIDS. Effective education can contribute to the capacity of a community to protect

themselves against HIV infection and bring about attitudinal and behavioural change. Information and education should be provided in a variety of forms, and not necessarily rely exclusively on the written word. Programmes should target and tailored to the age, gender, sexual orientation, sectoral characteristics and behavioural risk factors of the community and its cultural context.

Peer education has been found to be particularly effective, as has the involvement of people living with HIV/AIDS in the design and implementation of HIV/AIDS interventions Information programmes should, where possible, be linked to broader HIV/AIDS campaigns within the local community, region or country. The programmes should be based on correct and up-to-date information about HIV/AIDS.

In response to the epidemic, the Government of Tanzania with technical support from the World Health Organization Global Programme on AIDS (WHO-GPA) formed the National HIV/AIDS Control Programme (NACP) under the Ministry of Health. NACP formulated Short Term Plan (1985 – 1986), and three 5 years Medium Term Plans (MTP), MTP-1 (1987–1991), MTP–11(1992-1996) and MTP–111 (1998–2002). Initially HIV/AIDS was perceived purely as a health problem and the campaign to deal with it involved health sector only through the National AIDS Control Programme. The national response concentrated on developing strategies to prevent, control and mitigate the impact of HIV/AIDS

epidemic, through health education, decentralization, and multi-sectoral response and community participation.

3.2. Empirical literature

3.2.1. The case of Uganda

HIV prevalence had declined significantly in Uganda, and now it is considered to be one of the world's earliest and best success stories in overcoming HIV. Uganda had experienced substantial declines in prevalence and evidently incidents during the past decade, especially among young age cohorts.

Regarding prevalence, according to the U.S. Census Bureau/joint United Nations Programme on HIV/AIDS (UNAIDS), national HIV prevalence peaked at around 15% in 1991 had fallen to 5% as of 2001and continue to fall in the recent years. This dramatic decline in prevalence is unique worldwide.

The fall in HIV prevalence in Uganda is due to a number of behavioural changes which were a result of a large variety of interventions which have been taking place in Uganda, these include:

- There was a high –level political support with multi-sectoral responses in Uganda. In 1986, the President of Uganda responded to evidence of a serious emerging epidemic with a proactive commitment to prevention that continues to the present. In face to face interaction with Ugandans at all levels he emphasized that fighting AIDS was a patriotic duty requiring

openness, communication and strong leadership from the village level to the State House.

- In Uganda there was a Behaviour Change Communication campaign (BCC), which reached the general populations and key target groups such as female sex workers and their clients, soldiers, fishermen, long-distance drivers, traders, bar girls, police, and students without creating a highly stigmatising climate. In 1986, Uganda established a National AIDS Control Program (ACP), which launched an aggressive public media campaign that included print materials, radio, billboard, and community mobilization for a grass roots offensive against HIV. In 1994, the ACP become the STD/AIDS control programme and has since trained thousands of community –based AIDS counsellors, health educators, peer educators, and other types of specialists. The leaders being the once who spearheaded the campaign, the general population in both urban and rural areas eagerly joined the fight against AIDS. Spreading the word involved not just "information and education" but rather a fundamental behaviour change based approach to communicating and motivating. It should be noted that the Uganda's approach to BCC has relied more on "non-electronic" mass communication, which was community –based, face-to-face, and culturally appropriate.

- Condom social marketing played a key role in combating HIV/AIDS in Uganda. It was reported that more commercial sex workers become aware and were greater users of condom in Uganda.
- Religious leaders and Faith-Based Organization have been active and in the front lines of the responses to the epidemic. Religious Institutions actively participating in AIDS education and prevention activities e.g. Mission hospital were among the first to develop AIDS care and support programme, Islamic Medical Association of Uganda (IMAU) piloted an AIDS education project in rural Muslim communities that evolved into a large effort to train local religious leaders and lay community workers.

3.2.2. The case of Ghana

Ghana's first national HIV/AIDS prevention program, *Stop AIDS, Love Life*, was launched in February 2000 by the Ministries of Information and Health, the Ghana AIDS Commission and the Ghana Social Marketing Foundation (GSMF), with technical assistance from CCP and support from USAID. The first phase, "Shattering the Silence," integrated mass media and community level interventions by promoting greater use of HIV-protective behaviours—**A**bstinence, **B**eing faithful to one partner and **C**ondom use (ABC). Mass media interventions included television and radio spots, a music video by well known artists, mobile video screenings and dialogue in community rallies throughout the country, and wide dissemination of HIV/AIDS print materials.

Researchers measured the impact of the first phase and found a dramatic rise in condom sales, increased knowledge and awareness of sources of infection and prevention, and an increase in perception of personal risk. Subsequent phases of the campaign emphasized compassion for those living with HIV/AIDS, and involved tribal leaders and religious leaders. The Christian Council of Ghana is now coordinating religious groups in implementing the *Reach Out, Show Compassion* phase of the program. The new program aims to increase the number of religious organizations and congregations and humanitarian groups engaged in HIV/AIDS issues. Training programs for 900 clergy, Imams, and other religious leaders are being held throughout Ghana to help set up compassion programs. Television and radio spots also support a compassionate response by quoting directly from the Bible or Koran where compassionate behaviour is demonstrated. Because cultural and community contexts are frequently cited as critical to behaviour change in Africa, the *"Journey of Hope"* (JOH) life skills tool was developed by CCP for the *Stop AIDS Love Life* program. The JOH helps to establish the link between an individual's goals in life and current HIV prevention behaviours. It also includes fun and interactive activities that help to build supportive social networks in communities. CCP also, helped develop the award-winning television serial drama *"Things We Do for Love,"* the number-one rated television show in Ghana, according to an independent ratings survey. The show, which is Ghanaian written, produced and

directed with support from the GSMF, CCP and USAID, has been broadcast since 2001. It focuses on issues relevant to youth and HIV/AIDS.

3.2.3. The case of Zambia

The *Zambia Integrated Health Package Communication and Community Partnership* (ZIHPCOMM) is implemented by CCP in partnership with CARE, Africare, and the Manoff Group. The Helping Each other Act Responsibly Together (HEART) campaign, now in its second phase, was designed for youth by youth. It reaches 15-19-year-olds through five television spots that promote abstinence/delay or consistent condom use. Complementary radio spots and songs (in seven local languages) and a range of print materials contribute to efforts to encourage abstinence as a social norm, or consistent condom use for those who choose to remain sexually active. Approximately 74 percent of male viewers and 68 percent of female viewers said the spots prompted them to talk with others, decide to abstain from sex until more mature, or use a condom. *FACEAIDS: AIDS in the Workplace* is a program that builds awareness at work sites about HIV prevention through group education and prevention sessions, training of peer educators among the employees, distribution and promotion of male and female condoms, and referrals to VCT and family planning services. This program also assists in the formulation of an HIV/AIDS policy for organizations. HIV/AIDS prevention and VCT-related information is also included in *The Better Health Campaign*, which engages communities in the process of

improving their own health, particularly in light of ongoing health reforms. The multimedia campaign featured a different health topic each month and included HIV/AIDS. *The Neighbourhood Health Committee (NHC) Strengthening Package*, through a distance education radio program, training and health information cards, also addressed HIV prevention and services. *Youth Grants to Africa Alive!*, YM, YAO and Africa Directions also reach primarily young people through music, sports and schools with HIV/AIDS messages.

3.2.4. The case of Tanzania

ISHI (meaning "live") campaign launched in 2001, is probably Tanzania's most successful HIV/AIDS campaign aired at the youth. It began as a one day event for world AIDS day when the Tanzania Commission for HIV/AIDS, with support from The Johns Hopkins University and in collaboration with USAID decided to organize a series of sports-centred awareness activities on HIV/AIDS for the youth.

"USIONE SOO! SEMA NAYE" meaning "Don't be shy talk to your partner" has become a popular, powerful and inspirational slogan known to many youth people across the country. The message behind ISHI is abstain from sex, stay faithful by sticking to one partner who is not infected or use condom.

The series of activities developed into a campaign for urban youth that has now spread across all the 26 regions of Tanzania Mainland and Zanzibar. To

enhance youth ownership the campaign is led by a group of 15 youths in each region, commonly known as Youth Advisory Group who receives technical guidance from NGOs, government leaders and religious organization.

The group has a responsibility of increasing awareness on HIV/AIDS among youth, promote use of the voluntary counselling test among youth, and to recommend abstinence, remain faithful to one partner and using condom.

Different methods are used to effectively disseminate information to youths, such as through performing arts groups at community rallies and public gatherings: for the youth in school, teachers are being involved to reach them through sports, essay competitions and debates. The out of school youth are mobilized through community rallies.

3.2.5. The case of South Africa

More people in South Africa are aware of HIV/AIDS and took considerable measures to change their behaviours. This becomes positive due to a powerful television drama (TshaTsha) about young adults living in a rural South Africa town impacted by HIV/AIDS. The play has led to improved altitudes about HIV/AIDS, stigma living openly and positively with HIV and faithfulness among its viewers.

TshaTsha being a gritty Nguni language drama was used and focuses on lives of several youth people exploring love sex and relationships in a world affected by realities of the AIDS Pandemic.

Thus, TshaTsha is more than a television drama it provides solid thought provoking educational concepts in a context of South Africans, it found to be realistic and entertaining. Instead of providing simple answer TshaTsha engages viewers in an ongoing dialogue about making health decisions in a world where AIDS is a day to day reality. In additional, being broadcast nationally, the series is aimed at South Africa Schools, correctional institutions, churches and communities to stimulate conversations about the complexities of living with HIV and AIDS in a country hard hit by the virus.

According to National Audience rating data provided by SABC (South Africa Broadcasting Cooperation Limited) TshaTsha reaches an average of 1.8 million viewers each week and TshaTsha weekly themes are modified into radio drama called "Body mind and soul" which reach 6 million listeners through 60 community radio stations. The various radio and television stations offer listeners the opportunity to discuss the themes on the air after wards. SABC Radio also holds a live "drive time" talk show for 30 minutes the day after TshaTsha is broadcast.

Through TshaTsha programmes viewers were more likely to have positive altitudes about HIV issues addressed in TshaTsha, including stigma towards people living with HIV/AIDS.

Viewers were more likely to practice HIV preventive behaviours such as abstaining from sex, being faithful to one partner, having sex less often, using a condom to prevent HIV or using condom at last sex. Viewers were more likely to undergo voluntary counselling and Testing (VCT) to determine their HIV status.

Knowledge and general awareness about HIV/AIDS increased among the viewers and various self reported shift in HIV altitudes beliefs, practices and behaviours occurred.

Looking at these cases we learn that in order to succeed in combating HIV/AIDS awareness/training should focus on behaviour change, and comprehensive behaviour change-based strategy/approaches, ideally involving high-level political commitment and a diverse spectrum of community –based participation should be reinforced.

3.3. Policy review

3.3.1. Tanzania Policy on HIV/AIDS

The National Policy on HIV/AIDS was approved in 2001, with the overall goal of providing a framework for leadership and coordination of National multi sectoral

responses to the HIV/AIDS epidemic. This includes formulation, by all sectors, of appropriate interventions that will be effective in preventing transmission of HIV/AIDS and other sexually transmitted infections, protecting and supporting vulnerable groups, mitigating the social and economic impact of HIV/AIDS.

One of the specific objectives of the Policy on prevention of transmission of HIV/AIDS is to create and sustain an increased awareness of HIV/AIDS through targeted advocacy, information, education, and communication for behaviour change at all levels by all sectors.

This hinges on effective community involvement and empowerment to develop appropriate approaches in prevention of HIV Infection, care and support to those infected and affected by the epidemic including widows and orphans.

The Policy emphases that, since over 80% of HIV/AIDS infection is through sexual intercourse, prevention of sexual transmission is the key in the control of the HIV/AIDS epidemic. Thus, efforts to reduce the spread of the disease should be through raising public awareness of the risk and change of behaviours that put individuals at the risk of contracting or transmission of HIV and other sexually transmitted diseases.

To ensure the Policy is implemented more efforts will be on strengthening the role of all the sectors, public, private, NGOs, faith groups, PLWA, CBOs and

other specific groups to ensure that all stakeholders are actively involved in HIV/AIDS works and provide a frame work for coordination and collaboration.

Among others, the National Policy on HIV/AIDS will be guided with the following principle "HIV/AIDS is preventable! Transmission of infection is preventable through changes in individual behaviour, hence education and information on HIV/AIDS, behavioural change communication as well as prevention strategies are necessary for people and communities to have the necessary awareness and courage to bring about changes in behaviour at the community and individual levels." Thus, the fight against HIV will not be successful if the community members have not changed their behaviours toward health risks. That means the Policy promote safer sex practices through faithfulness to partners, abstinence, non-penetrative sex and condom use.

3.3.2. National Health Policy

The 1990 Tanzania Health Policy was reviewed in 2002 with the aim of providing direction towards improving sustainability of health status of all the people by reducing disability, morbidity and mortality, improving nutritional status and raising life expectancy. Its mission is to improve the health and the wellbeing of all Tanzanians with a focus on those at risk and encourage the health system to be responsive to the needs of the people.

The national response to the HIV/AIDS epidemic consist of developing strategies to prevent, control and mitigate the impact of the epidemic. In the presence of HIV/AIDS the health sector will continue to leads the national response on technical issues related to:

1. Prevention and control of HIV transmission strategies which include:

Sexually Transmitted Infections (STIs), Blood safety, Prevention of mother to child transmission, .Design, develop and distribution of IEC print and electronic massages and materials, Voluntary Counselling and Testing (VCT).

Care of HIV/aids patients at both facility level and Community home base and Provision of treatment for opportunistic infections and eventually Anti-retroviral Therapy

2. Impact mitigation and support to affected and infected individuals and addressing the issue of stigma.
3. Management and coordination of the health related technical aspects of the national response.
4. Supporting and guiding biomedical and health related research on HIV/AIDS

The Policy emphasize on the use of various methods of advocacy and health education to address epidemic such as HIV/AIDS. According to the Policy, advocacy and Information Education and Communication are the fundamental aspects towards improvement of health status of the people, as it promote

positive health behaviours and life style for social change at all levels focusing mainly at the individual, the family and the community.

3.3.3. UN Personnel Policy:

In 1991, the UN adopted a forward-looking, comprehensive Policy in respect of UN system staff and HIV/AIDS.

The UN Personnel Policy on HIV/AIDS says that, the UN will make sure that all staff and their families know about HIV so that they can protect themselves and others, and so that they can work with HIV-positive colleagues without fear of becoming infected. The UN will make sure that staff has access to good quality training and condoms to avoid infection.

The Policy says that, the UN will provide support and counselling services to any of its staff or their families upon request. It also says that a person's HIV status is his/her own affair and must be treated by the UN and all its offices as confidential at all times.

The Policy guarantees that no one will be discriminated against because of HIV. No one will be required to have an HIV test to gain employment, remain employed, or have his/her contract renewed. People who are ill because of HIV infection will have the same rights and benefits as people who are ill through any other cause. This applies to al staff, from the secretary –General to short-term, locally employed staff.

3.3.4 International HIV/AIDS alliance workplace policy

The Policy aim in minimising the possibility of HIV infection for Alliance staff and their partners and dependents, to manage and mitigate the impact of HIV/AIDS on the work of the Alliance and eliminate stigma and discrimination in the workplace on the basis of real or perceived HIV status, or vulnerability to HIV infection.

The Policy indicate that: only medical criterion for recruitment is fitness to work. HIV infection does not, in itself, constitute a lack of fitness to work. There is no obligation on applicants or staff to inform the Alliance of their HIV status. And, HIV screening will not be required either as a condition of recruitment or for continuation of employment, unless required by law (e.g. for duty travel).

The policy insist in provision of information and training on the workplace issues raised by the epidemic, on appropriate responses, and on the general needs of people living with HIV/AIDS and their carers. It insists the information provided to be gender sensitive, as well as sensitive to race, disability, and sexual orientation.

The policy says that, HIV infection is not a cause for termination of employment. Staff with HIV-related illness will continue in employment as long as they are medically fit for available, appropriate work. Staff with HIV/AIDS will be accorded the same benefits and conditions as apply to termination due to other serious illnesses.

CHAPTER FOUR

4. Project implementation

4.1. Introduction

The section explains how the planned activities were implemented and the project outcome to the community members.

4.2. Planned product and output.

Through the planned activities the project expected to generate the following outputs; to have 60 trained peer educators in the whole ward, 20 trained families living with PLWA, 32 awareness meetings conducted at sub village level, about 200 people received counselling and testing services and 20,000 condoms distributed to community members. As a result of these outputs the project expected the community members to be seen have changed their behaviours which put them at risk of being affected by HIV. The project expected to see the number of people using condoms increased, people are open and freely to talk about HIV/AIDS, people becomes more faithful to their partners as well as reduces the number of non regular partners, people are no longer inheriting widows and practising traditional circumcisions Generally the project expected to see the increased knowledge on HIV/AIDS among community members and eventually decreased in HIV infections in the project area

4.3. Project implementation plan

The project is implemented by UNAJAKI members and other stakeholders. In order to reach the intended goal the project planned to implement the following objectives and activities.

Table 5: **Implementation plan:**

objective	activities	Time frame	resources	Person responsible
To mobilize resources for project implementations	Prepare proposal (s) and submit to different donors	Nov-Dec 05	Stationery	CED student
	Organize one fund raising event	Jan 06	Funds	UNAJAKI Chair person
To create awareness on behaviour change to community members in kibaigwa ward using trained peer educators	Identifying peer educators	Jan 06	Transport stationery	UNAJAKI team
	Train 60 peer educators	Feb –Marc 06	Facilitator Funds for meal ,accommodation Facilitation fee Stationery	UNAJAKI Chair person
	Train 20 families of people living with HIV/AIDS	March 06	Facilitator Funds (meal, accommodation &facilitation fee) Stationery	UNAJAKI Chair person
	Organizing and conducting awareness meetings	Apr o6 on going	Transport Stationery Funds	UNAJAKI Chair person
	Providing counselling services to community members and liking them with dispensary for HIV testing	May 06 on going	stationery	UNAJAKI counsellors
Monitoring group activities	Mentoring project activities trough reports and field visit	Monthly & quarterly	Transport Stationery	CED Student
	Carrying mid term and end of project evaluation	August 06 & Feb 07	Stationery Transport	CED Student

Planned budget

In order to implement the planned activities the project intended to use TTS 5,375,000, this being only the cost of carrying out the project activities. The budget doesn't include salary and benefit cost, since members of the CBO were working voluntarily. Only compensation in terms of food and transport during awareness meetings were given to them. For more detailed budget see an appendix 2.

4.4. Actual implementation:

Different stakeholders such as community members, District authorities, village governments, health workers, donors and CED student were involved in implementation of the project. UNAJAKI members in collaboration with community members spearheaded the implementation of the project. It was the CBO members who prepared plans and put into actions. The district authorities provided the go ahead of the CBO to implement the project in the Ward. Village leaders played a great role in mobilizing community members to attend the awareness meetings as well as to assist the CBO in preparing the meeting places. Health workers worked closely with CBO in testing people for HIV after being counselled by the CBO counsellors. Donor (World Neighbour and Action Aid) financed the project activities and trained the CBO members on proposal writing and project management. And, CED student worked closely with the

CBO in identifying community needs, conducting survey and monitoring the project.

Through its objectives the following were observed as a project achievements;

Resource mobilization for project implementation

The project managed to prepare proposals which were sent to World Neighbours and Action Aid. Through these proposals the CBO managed to be funded by World Neighbours TSH 2,500,000 on December 2005 and 2,700,000 by Action aid on October 2006. But, the CBO didn't manage to organize a fund raising event which was planned as indicated in table 4. UNAJAKI members, government leaders and community members supported the implementation of the project financially and materially. All acquired funds/resources were used in implementing the project activities as it indicated in appendix 1.

Awareness on behaviour change

The project managed to identify and train 60 peer educators i.e. 40 (66.7%) youth and 20 (33.3%) workers who work in bars and guesthouses. 15 members of families with PLWA were trained, although it was planned to train 20 families.

The CBO through peer educators managed to organize and conduct 32 awareness meetings, and through these meetings about 24,000 i.e. 10,000(41.7%) men and 14,000(58.3%) women received HIV/AIDS information.

Training for families with PLWA helped to minimize the degree of stigma among the relatives and helped them to be able to protect themselves from being affected with HIV when taking care of their patients. Also, the training helped other families with PLWA to come up, and up to now about 90 PLWA disclosed their status.

The training to bar and guest workers helped to ensure the availabilities of condom in their working places, and to spread information to their customers and their counterpart workers.

Through counselling activity, about 115 people were counselled i.e. 46 (40%) male, 69 (60%) female. Out of these, 97 went for testing i.e. 38 (39.2%) male and 59 (60.8%) female. It was found that 9 people were tested positive i.e. 3 (33.3%) male and 6 (66.7%) female.

Monitoring activities

Through monitoring of project activities, the CBO found other problems which need to be addressed in their area as indicated in the table bellow:

Table 6: Problems need to be addressed

	Orphans 0-17 yrs			**Children in difficult circumstances 4-17 yrs**			**People with Chronic diseases(including HIV)**			**Widow**			**Sex workers**		
	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T
	301	317	618	114	138	252	136	246	382	84	128	212	-	45	45
%	48.7	51.3	100	45	55	100	36	64	100	40	60	100	0	100	100

Source: UNAJAKI 2006

CHAPTER FIVE

5. Monitoring, evaluation and sustainability

5.1. Introduction

The process of monitoring and evaluation is a primary means of collecting and analysing information and is thus essential for good project management. To be effective, monitoring and evaluation should be participatory and should be an integral part of project planning and implementation. It should be noted that Monitoring and evaluation are two complementary, but separate functions, which often serve distinct purposes.

5.2. Participatory Monitoring

"Monitoring is the continuous and systematic collection of information over the lifespan of a project which allows adjustments to be made and objectives to be refined. Monitoring involves setting indicators for achievement or progress and the means of measurement of those indicators. It provides the information on which evaluation can be based". (CONCERN, 1996)

Monitoring is a process of systematic and critical review of an operation with the aim of checking operations and adapting it to circumstances that includes the following activities: ongoing review, systematic documentation, analysis and decision making (PIM, Germann and Gohl, 1996)

Monitoring being a routine ongoing assessment of activities applied to assess resources invested (inputs), services delivered (outputs) by the project and outcomes that are related to the project, the project used different methodologies in collecting information. Such methods are; project monthly reports, observations, interviews with organization members and field visit through which focal group discussions with organization and community members were carried out.

5.2.1. Reason for monitoring

The project had undergone monitoring of its activities in order:

i) To ensure that input, work schedule and output are proceeding according to plan i.e. that project implementation is on course.

ii) To provide record of input use, activities and result

iii) To warn of deviations from initial goals and expected outcome

iv) To know alternative courses of action given the new circumstances

v) To produce information base for future evaluation of the project

5.2.2. Monitoring research methodology

Different methodologies were used in collecting information during monitoring; such methods are; CBO reports, Observation, FGD and interview during field visits.

Reports were used for checking the progress of the implementation of the planned activities. And, usually the CBO submitted report to CED student and donor in monthly base, explaining planned activities for that month, activities undertaken, achievements, challenges, lessons learnt and the activities planned for the following month. This help to identify the gaps and to tress the progress of the project monthly as goes with the planned activities.

Field visit were used in verifying how the activities are being done in the target area through observation and discussions with community members in the project area. Observation helps to know how the project has an effect on people's behaviours by looking at the way they behave and act in the different areas as regard to HIV infections.

Discussions with community members intended to explore how the community perceive on the implementation of the project, and to what extent they feel the project will deriver the intended outcomes. It tried to get the inner feeling of the community members as the way of checking the value added of the project to

community members. These discussions in one way or another provided the indication on the strength and weakness of the project as regard to achievement of the stipulated outcomes.

Table 7: Monitoring questions, indicators, and data collection tools

Monitoring questions	Indicators	Data collection tool	Who monitor
Are the community members aware with the project?	Level of participation in CBO activities by community members	Interview Checklist	UNAJAKI chairperson
Does the CBO have resources required for project implementation?	No of activities carried out	Funded proposal financial report	UNAJAKI chairperson
Have peer educators been identified and trained	No of trained people Training report	Interview	UNAJAKI chairperson
Have awareness raising sessions been conducted to the community members	Number of meetings conducted No of people who received counselling services No; of condom distributed	Observation FGD Field visit	UNAJAKI chairperson
Are the project results shared among organization members	Minutes	Interview	UNAJAKI chair person

Table 8: Monitoring plan

Objective one: To mobilize resources for project implementation					
Activities	**Indicators**	**Data source**	**Method /tool used**	**Personal responsible**	**Time frame**
Prepare proposal(s) and submit to different donors	No of proposals prepared No of proposals funded	CBO report Financial records	Structured discussion interview	UNAJAKI chair person	Nov- Dec 05
Organize fund raising events	No of fund raising event conducted	CBO's report	Formal discussion Interview	UNAJAKI chair person	Jan 06
Objective two: To create awareness on behaviour change to community members in kibaigwa ward					
Identifying peer educators	No of identified educators	Reports Community members	Interview	UNAJAKI chair person	Jan 06
Train 60 peer educators	No of trained people Training report	Community members Reports Trained peer educators Organization members	Interview Check list	UNAJAKI chair person	February –march 06
Train 20 families of people living with HIV/AIDS	Training report No of trained families	Family with PLWA Reports	Interview Report	UNAJAKI chair person	March –Apr 06

Activities	Indicators	Data source	Method /tool used	Personal responsible	Time frame
Organizing and conducting awareness meetings	No of awareness meetings conducted No of condom distributed	Community members Peer educators Reports	FGD Interview Observation Reports	UNAJAKI chair person	Apr 06- Jan 07
Providing counselling services to community members and liking them with dispensary for HIV testing	No of people who received counselling services No of people who tested HIV	Reports Ward dispensary CBO members Community members	Observation Interview Reports	UNAJAKI chair person	May 06 – Feb 07
Objective three: Monitoring group activities					
Mentoring project activities trough reports and field visit	No of field visit conducted Field visit report	CBO reports Community members CBO members Government leaders	FGD Observation Questionnaires	CED student	Dec 05- Feb. 07
Carrying mid term and end of project evaluation	Evaluation report	CBO documents Community members	Field visit Structured questions Observations	CED student	August 06 and Feb. 07

5.2.3. Actual implementation

Management information system

MIS can be referred to a system designed to collect and report information on a project and project activities to enable a manager to plan, monitor and evaluate the operations and performance of the project.

In order to have an effective monitoring system, the CBO established a management information system. The system comprise of a set of indicators which were used to see if the changes were occurring or not, information needed for monitoring, the frequency of data collection, format and procedure for collecting, recording and reporting data, and system of analysing the collected data.

To insure that each CBO member was familiar with the system, one day training was conducted for them on how to use the developed management information system.

5.2.4. Steps used in monitoring process

Both progress and performance of the project were monitored. Monitoring was done first by the CBO members and the organization leaders were responsible for monitoring the members and the task under them. Also, monitoring was done

by CED student and Donor(s) through field visit and routine (monthly) reports from the CBO.

Data were collected and recorded on a monthly base in relation to stipulated indicators. When collecting information different tools/methods were used, such as interview to CBO members, observation to the CBO activities, Focus Group Discussions and check list. The required information was collected from monthly reports, beneficiaries, Government officials, CBO members and peer educators. The information for monitoring was collected by CBO members, peer educators and project advisor (CED student).

Analysis of collected information was performed at each functional level of management i.e. at the level of organization, project advisor and the donor.

The findings were reported through monthly progress reports and oral presentation organized by the UNAJAKI leaders. All problems were identified and changes made accordingly.

The information was manually kept in the files for further references and saves as a base for project evaluation.

5.2.5. Monitoring findings

Monitoring results indicated that, there is a good link between CBO and health workers. But, some improvements were needed in record keeping on the number of people who are going for HIV test as a result of the work done by the project. Therefore, it was seen that, there is a need for developing a special form which will be used for keeping records.

All project activities were implemented as planned although some times rain affected a timetable for awareness meetings at sub village level.

5.3. Participatory Evaluation

"Evaluation is a retrospective assessment of performance against project objectives at a particular point in time (i.e. review) or after the completion of a project (i.e. ex-post analysis). It may take different forms e.g. internal (self) evaluation, joint evaluation, external evaluation, etc. Evaluation should (if the project is to continue) result in follow-up action plans on the basis of approved findings and recommendations." (CONCERN, 1996)

5.3.1. Reasons for evaluation

Evaluation being the process of gathering and analysing project information, thus in this project evaluation were carried out in order;

i) To find out how effective the project is

ii) To see whether objectives have been achieved

iii) To learn how well things are being done

iv) To learn from experience so future activities can be improved

Table 9: Evaluation questions

Evaluation questions	Indicators	Data collection tools	Evaluators
Are community aware of the project	Lever of participation	FGD Interview Observation	Evaluation team
Is organization capable to implement the project	Number of activities done	Reports	Evaluation team
Are there any changes brought by the project	Number of condom distributed Number of people going for VCT	Field visit FGD Observation	Evaluation team
Are project activities sustainable	Number of strategies in place Level of community participation	Reports	Evaluation team

Table 10: Evaluation objectives

objectives	Performance indicator	Expected out comes
To describe the project achievements at the community level	Number of awareness meeting conducted	Increased in condom use More people request for VCT
To measure the extent to which the project objectives have been achieved	Organization performance level	All activities carried out
To examine the capacity of the organization to sustain its activities	Level of involvement of project stakeholders	Increased stakeholders participation

5.3.2. Implementation

There are different types of evaluations depending on the objective being evaluated and the purpose of the evaluation. In this project, Formative and Summative evaluations were used in evaluating the project objectives as well as activities.

5.3.3. Formative evaluation.

Formative evaluation is a method of judging the worth of the program/project while the program activities are forming or happening. Formative evaluation focuses on the progress (Bhola 1990)

Formative evaluation being a process of ongoing feedback on performance was conducted by CED student and CBO leaders to find out the extent of the project implementation and to determine improvements needed to attain the project objective.

This evaluation process conducted in monthly basis whereby the project reports were reviewed to check the extent to which a project proceeding according to plans and the challenges which the project faces. Also monitoring evaluation was conducted through field visit, whereby CED student visited the training and awareness meetings conducted by the project, checking in with training participants and discussing with CBO members.

The feedback of the evaluation were shared and discussed with CBO members in monthly meetings, and improvements were done accordingly.

5.3.4. Summative evaluation

Summative evaluation is a method of judging the worth of a program/project at the end of the program activities. The focus is on the outcome (Bhola 1990)

Summative evaluation was conducted on February 2007 which involved different stakeholders such as donors, District officials, District HIV coordinator, one external facilitator, CBO members, CED student and community members in the project area.

The selected evaluation team was based on required skills for undertaking a comprehensive and participatory evaluation, such skills are monitoring and evaluation, facilitation and research skills. This evaluation was conducted to assess the project outcome and impact to the community for entire one year of implementation.

5.3.5. Evaluation research tools

Different methods were used in collecting information during these evaluations. Such methods are; Focus Group Discussion with target beneficiaries in the project area, this was used in order to get primary information from them on the value added by the project to the community. Through this method discussions

were held with different groups such as youth, drivers, and families living with PLWA. Different views were provided by these groups in regard to the project achievements.

Literature review which involved analysing the various documents written on the project was used, whereby the Review Team gone through all project documents to assess what were intended to be done and what have been done by the project in achieving the intended outcome and impacts.

Observation was used in verifying how and to what extent the project has brought changes in people's behaviours toward HIV risks. This was done by observing the way people act while in different occasions like bar, how many people visit the UNAJAKI office for counselling and taking condom and the way people treat PLWA

Also, interviews with the CBO members and questionnaires to community members were used in collecting information. These were used in order to assess the capability of the CBO in implementing the project and the extent to which the project reached its objectives.

And, briefing on the project by the funding stakeholders (organization), and discussions at a district level with Community Development Officer and District

HIV/AIDS Coordinator were used in data collection. This helped in getting different views on how the project was implemented and the achievements observed as a result of the project

5.3.6. Source of information during evaluations

Different sources of information were used during evaluation, such as; CBO members, community members, project documents (project proposal, survey report, monthly and quarterly reports) and peer educators.

Information collected during summative evaluation was analysed, the preliminary results presented and shared in a meeting with CBO members in late February 2007. The final results of the evaluation were disseminated to stakeholders in March 2007.

5.3.7. Evaluation findings

Evaluation results indicated that community members were sufficiently involved in the project activities. This was revealed by the high turn up of community members in awareness meetings, high demand of condoms and the increase in number of people who went for counselling and testing HIV.

It was observed that the CBO has good relations with leaders at village, ward, and district level and dispensary workers. But more efforts were needed to strengthen the linkages with other NGOs and CBOs which were working in a similar field within and outside the area.

The evaluation results revealed that, peer educators were 100% willing to work voluntarily but the CBO should find a way for the peer educators to be given incentives which would motivate them to work longer with the CBO.

People had started to change their behaviours, as it was observed that many people were demanding condoms from the CBO. Also the number of people who were going for counselling and testing for HIV was increasing annually. Despite the fact that people were aware and willing to use condoms, the accessibility of condoms was a problem to most of the sub villagers, as what was being provided by the CBO was not enough. And, it was discovered that the accessibility to female condoms was more difficult compared to male condoms, the CBO was providing mainly male's condoms.

Looking at the sustainability issue, it was discovered that the sustainability strategies needed to be more focused and operational to ensure the sustainability of the CBO.

Generally the project objectives to some extent were realised, as most of the planned activities (90%) were carried out by the CBO. This became possible because the CBO got assistance from external source (organization) to implement the project and the community members were cooperative in

implementing the CBO activities. Also, the support provided by government officials created a favourable environment for the project implementation.

5.4. Sustainability of the Project:

5.4.1. Introduction

Project sustainability refers to the capacity of the project to continue functioning, supported by its own resources (human, material and financial) even when external source of funding have ended.

5.4.2. Sustainability elements

The CBO was formed voluntarily by community members without external forces. It started to organize and addressing different community needs using their own resources without any assistance from external sources although on a very small scale. Therefore, the project is expected to be sustainable as CBO members work as a team and are willingly to contribute their resources for CBO activities.

Financially, the CBO had already started income generating project of keeping pigs and selling maize and the fund generated would be used to sustain the organization activities. The UNAJAKI is paying the office rent using the annual fee contributed by its members.

Politically, the CBO had gained a lot of support from Government leaders at all levels i.e. village to national level. Village, ward, district leaders and members of parliament have been very much interested with the project and they usually visited the CBO to check the progress of the project and for providing some support to CBO. For example. Deputy Minister of Water Miss Shamsha Mwangunga supported the CBO by providing one computer, a printer and 10 bicycles.

The CBO received a lot of support from community members. Community members were fully participating in CBO activities; this was due to the fact that from the beginning the community was involved in identifying the need. Also, in doing its activities the CBO networked and collaborated with the District Council and other organizations such as Action Aid.

Institutionally, the CBO has well trained staff members for counselling, trained peer educators and drama group which were used in project activities. The CBO yearly does conduct review of their activities and they do involve different stakeholders in that review. So far the organization had registered and has its own constitution which is flexible to the changing internal and external environments.

5.4.3. Sustainability plan

The CBO will ensure quality work in order to receive recognition and more support for its activities from community members, government officials and donors.

Community members will be involved in every stage of project cycle for all projects which will be carried out by the CBO.

The CBO will continue paying for office rent using annual membership fee as well as that the CBO members will continue working voluntarily and contributing funds for CBO activities when the need arises.

The CBO will organize different fund raising events or campaigns such as preparing dinner for fund raising and sending the contribution letters to potential stakeholders for the same purpose.

The CBO will work closer with Government officials at all levels i.e. village to national level by inviting them to the organization and providing reports of their activities.

With the knowledge and skills gained on proposal writing, the CBO will continue approaching other donors for supporting organization activities.

5.4.4. Institutional plan

The organization which funded the project (World Neighbours) promises to continue providing support to CBO in terms of capacity building and assist the CBO to link with other donors who have interest in funding its activities.

CHAPTER SIX

6. Conclusion and recommendation

6.1. Conclusion

HIV/AIDS is more than a health issue; it is now global security concern. All development sectors have been affected with HIV/AIDS. Thus, in fighting it requires an integrated efforts from community, religious, Non –Government Organizations and Government leaders at all levels i.e. village up to national level.

The project intended to create awareness on behaviour change toward HIV. Initially UNAJAKI with assistance from CED student undertook a community need assessment which resulted to the implementation of this project.

In implementing the project different stakeholders were involved i.e. community members, Government officials at different levels, CBO members and NGOs. And, different participatory methodologies were employed i.e. FGD, structured and unstructured interviews, field visit, and structured discussions.

The project succeeded to train peer educators and families with PLWA and through these training people were aware of HIV/AIDS and the rate of stigma to PLWA decreased especially among the family relatives.

Through awareness meetings the project managed to change people's behaviour toward using condom and going for HIV test. As the demand for condom increased in the project area and more people were going for VCT.

Despite of all these achievements, the organization faced the challenge of accessibility of condoms especially female condoms and the increase in number of PLWA and orphans who need assistance from the CBO.

6.2. Recommendation

Since HIV/AIDS is more associated with behavioural attitude, more efforts should be directed towards sexual behavioural change including delaying sexual activity, abstaining, being faithful, "zero grazing", and using condom.

Before introducing the project, need assessment should be conducted in order to identify the real felt needs of the community and to come up with appropriate initiative to address the identified problem. Due to the fact that people's behaviours and attitudes differ from one place to another some times they depend on the culture and beliefs of the people in a particular area. Community members need to be involved from problem identification up to project evaluation in order to get their support, and this will help in sustaining the project activities.

In creating awareness on HIV/AIDS different approaches/ methods need to be employed, e.g. seminars, meetings, radio programs, radio drama series, radio and television spots, pamphlets, posters, a comic-style booklet, and youth-friendly training for peer educators that disseminates HIV/AIDS messages. Also, the project can produce an HIV/AIDS question and answer book for peer educators. That book will provides up-to-date information about HIV and answers to frequently asked questions on a full range of HIV and AIDS related issues.

In developing radio and television programmes for HIV/AIDS awareness, some study of the community which the programmes target is required. The study will help to know the culture, norms, beliefs and the interests of the community. Thus, the programmes which will be developed will attract people since they will reflect their interests and reality of their daily life.

In implementing the project it needs a well established link with project stakeholders i.e. community members, government officials, NGOs, and donor(s). Stake holders need to be informed of the progress of the project through reports and participation in monitoring and evaluating the project.

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