

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

MASTERS OF SCIENCE IN COMMUNITY ECONOMIC DEVELOPMENT

**REDUCING SPREAD OF HIV/AIDS PANDEMIC: THE CASE OF KIGAMBONI
AREA, DAR ES SALAAM**

**“SUBMITTED IN PARTIAL FULFILLMENT OF REQUIREMENTS FOR THE
M.SC.IN COMMUNITY ECONOMIC DEVELOPMENT IN THE SOUTHERN
NEW HAMPSHIRE UNIVERSITY AT THE OPEN UNIVERSITY OF
TANZANIA”**

2007

GERVAS MARTIN FYORO

SUPERVISOR'S CERTIFICATION

This is to certify that I have gone through the Project report titled "Reducing Spread of HIV/AIDS Pandemic: The case of Kigamboni Area Dar es Salaam" and found it comprehensive and satisfactory for partial fulfilment of the requirement for the Msc .in Community Economic Development at Southern New Hampshire University and Open University of Tanzania.

Dr.Sinda Hussein SindaSignature.....Date.....

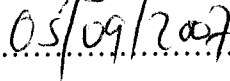
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DECLARATION

I declare that this project is not a replicate of any project submitted to any institution for the same purpose.

Signature.....

Date.....

DEDICATION

I dedicate this project to my Lord Jesus Christ; this is to say that the success of this project work it is because of his strength and protection. Without forgetting my employer President Office, my family that is; my beautiful Wife Mrs. Veronica Martin Luyagaza, my lovely children Fiona, Gerard and James for their invaluable cheerfully, moral and spiritual support.

ABSTRACT

This project report is about the reduction of HIV/AIDS spread, the case of Kigamboni community at Temeke District, in Dar es Salaam city. The area has many people of different tribes, but the majorities are fishermen (the Kojan) from Tanzania Island (Zanzibar). There are different customs, tradition beliefs and many other norms/taboo. The continual infection of HIV /AIDS was a major concern of Kigamboni residents. The major factor that causes the spread of HIV/AIDS is ignorance among residents in Kigamboni area.

The Kigamboni population rate is about 400,000 people according to 2002 population and housing census, at present but the number might be high due to continual immigration from various areas as the result of globalization for fishing, tourism, and agriculture activities available in Kigamboni. The lack of basic education, ignorance and poverty are the added factors that had the positive impact on the spread of HIV/AIDS within the community of Kigamboni area, regardless the measures that had been taken by the government of Tanzania under TACAIDS and the NGO under – WAMATA, ANGAZA to combat the spread of HIV/AIDS within area.

About one hundred community members received educational materials on control of spread of HIV/AIDS and Voluntary Counseling and Testing.

EXECUTIVE SUMMARY

The Project was undertaken in the city of Dar es Salaam in Tanzania located at the Eastern Coast of Indian Ocean. Dar es Salaam has three Districts (Municipalities) which are Temeke Municipality, Kinondoni Municipality and Ilala Municipality. The city of Dar es Salaam is bounded with Indian Ocean on the East, and Coast region on the North, West and South. The dwellers of Dar es Salaam are employed in public institutions or non-governmental organizations, Businessmen, Businesswomen and some of them cultivating small farmers of fruits and vegetable.

The population of Dar es Salaam is about 3,000,000 according to 2002 population and housing census. Since Dar es Salaam is the capital and Industry town, many people from neighborhood and other regions visit Dar es Salaam for Trade purposes, that's to sell their crops and buying of commodities from industries. Dar es Salaam has the biggest harbor and international airport. The harbor serves other land locked countries like Zambia.

The community of Dar es Salaam is mixed with the different tribes from within and outside the country, this the side effect on both aspects of man's life. This was the study carried out by an NGO called Angaza Peer Educators and Counseling Center (APECC) located at Kigamboni (head office) with a branch office at Buguruni. The organization performs its duties in Kigamboni ward. Project activities undertaken by APECC are categorized into the following groups; Counseling, HIV/AIDS Testing, Home visits, Counseling and Training Youth, Research and workshops.

The continual spread of HIV/AIDS infections was a major concern of the community members of the Kigamboni ward; this was revealed during the community needs assessment conducted in 2006. The project of reducing the spread of HIV / AID was started in response to a situation to be addressed as part of the organization's vision. The Project has not fixed time duration by which time will be concluded since it depends on the decrease of infections.

The most affected are women at the age 30-34 and men at the age 40-44 of Kojan tribe. Women and girls are often the most vulnerable but men and boys also experience gender related risks and vulnerabilities to HIV/AIDS.

The major causes are temporal marriages among Kojan fishermen, both income and non income poverty, prostitution especially among young ladies, presence of Navy Camps in the area has resulted into many soldiers to practice unsafe sexual intercourse, high traditional alcoholic practices and drug addiction within young boys and young girls especially along the beaches of Kigamboni and practices of local circumcision for both girls and boys.

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TABLE OF CONTENTS

SUPERVISOR'S CERTIFICATION.....	ii
COPYRIGHT	iii
DECLARATION	iv
DEDICATION	v
ABSTRACT	vi
EXECUTIVE SUMMARY.....	vii
ACKNOWLEDGEMENT	ix
TABLE OF CONTENTS	x
LIST OF TABLES	xii
LIST OF FIGURES.....	xiv
ABBREVIATIONS.....	xv
CHAPTER ONE: COMMUNITY NEEDS ASSESMENT	1
1.1 Community Profile of Kigamboni.....	1
1.1.1 Economic Activities	2
1.1.1.1 Fishing.....	2
1.1.1.2 Agriculture	2
1.1.1.3 Mining Activities- Stone Quarries	3
1.1.1.4 Trade	3
1.1.1.5 Tourism	3
1.1.1.6 Handicraft Work.....	3
1.2 Community Needs Assessment.....	5
1.2.1 Research Design.....	5
1.2.2 External Validity	6
1.2.3 Internal Validity	6
1.2.4 Reliability	7
1.2.5 Sample size.....	7
1.2.6 Methods of Data Collection	8
1.3 Analysis of Data	9
1.3.1 Methods of data Presentation	10
1.4 Research questions	11
1.4.1 Findings.....	11
CHAPTER TWO: PROBLEM IDENTIFICATION.....	18
2.1 Problem Statement	18
2.2 Stakeholders' analysis	26
2.3 Project goals and their targets	27
2.4 Project Objective	29
2.5 Study Objective	30
CHAPTER THREE: LITERATURE REVIEW	31
3.1 Theoretical Literature Review.....	31
3.2 Empirical Literature Review	37
3.3 National HIV/AIDS Policy	46
3.3.1 Principles that guide the National Policy on HIV/AIDS	51

CHAPTER FOUR: IMPLEMENTATION	54
4.1 Products and Outputs	54
4.2 Project Planning	55
4.3 Project Implementation Report	56
4.4 Project Implementation Gantt chart	56
4.5 Budget	56
4.6 Staffing Pattern.....	56
CHAPTER FIVE: MONITORING, EVALUATION AND SUSTAINABILITY	60
5.1 Participatory monitoring	60
5.2 Participatory evaluation.....	65
5.3 Sustainability.....	70
CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS	72
6.1 Conclusion.....	72
6.2 Recommendations	73
REFERENCES.....	76
APPENDICES.....	78

LIST OF TABLES

Table 1: Daily Basic Needs * Family Expenditure per Day (Tsh) Crosstabulation

Table 2: Family Expenditure Per Day (Tsh) * Nature Of Employment Cross tabulation

Table 3: Level of education * Relationship between ignorance & HIV/AIDS

Crosstabulation

Table 4: Relationship between Poverty & HIV/Aids * Relationship Between Prostitution
& Beach Goers. Cross tabulation

Table 5: Number of respondents * Relationship between Kojan temporary marriage &
spread of HIV Crosstabulation

Table 6: Number of respondents * Relationship between Price of condom & spread of
HIV/AIDS Crosstabulation

Table 7: Males and Females tested HIV/AIDS in Kigamboni area in the year 2004

Table 8: Males and Females tested HIV/AIDS in Kigamboni area in the year 2005

Table 9: Staffing Pattern

Table 10: Project Planning

Table 11: Project Implementation Report

Table 12: Direct and Indirect Indicators

Table 13: Gender of respondents * Use of condoms Crosstabulation

Table 14: Gender of respondents * Materials on control of spread of HIV/AIDS
Crosstabulation

Table 15: Gender of respondents * Number of partners Crosstabulation

Table 16: Direct and Indirect indicators

Table 17: Gender of respondents * Application of VCT knowledge Crosstabulation

Table 18: Gender of respondents * Application of condoms Crosstabulation

Table 19: Gender of respondents * Understood the VCT materials Crosstabulation

Table 20: Gender of respondents * Importance of one partner Crosstabulation

LIST OF FIGURES

Figure I: Females and Males tested HIV/AIDS in Kigamboni area

ABBREVIATIONS

AED – Academy for Educational Development

AIDS – Acquired Immune Deficiency Syndrome

AMREF – Africa Medical Research Foundation

APECC - ANGAZA Peer Education Centre

CBO – Community Based Organization

CED – Community Economic Development

FGDs – Focus Group Discussions

GDP – Gross Domestic Product

GNP – Gross National Product

HAARD – Highly Active Anti Retroviral Drugs

HAART – Highly Active Anti Retroviral Therapy

HIV – Human Immunodeficiency Virus

IDU -Injection drug users

IOCD – International Conference on Population and Development

MSM - Men who have sex with men

MUCHS – Muhimbili University College of Health Science

NGO – Non-governmental Organization

PLHA – People Living with HIV/AIDS

SIDA – Swedish International Development Agency

SIV – Simian Immunodeficiency Virus

SPSS – Statistical Package for Social Science

TACAIDS – Tanzania Commission for AIDS

UARP- University wide AIDS Research Program

UNAIDS – United Nation AIDS Organisation

VCT – Voluntary Counseling and Testing

WAMATA – *Wanawake Madaktari wa Tanzania*

WHO – World Health Organization

CHAPTER ONE: COMMUNITY NEEDS ASSESMENT

This chapter presents detailed information of Kigamboni area that is; the community profile, methods used to conduct Community Needs Assessments and major economic activities, which include fishing, agriculture, handcraft work, tourism, trade, and mining activities-stone quarries. It also presents the vision and mission of the ANGAZA Peer Education Center (APECC).

1.1 Community Profile of Kigamboni

The term community profile refers to the direction and dimensional changes, challenges in life daily. Historical background of Kigamboni is believed that, the first place to establish residence was between 1920's immediately after world I war. Germans reserved the area as a place for military bases and any other arm activities such as rangers etc. During the British rule fishing activities were allowed and other activities such as small cultivation particular coconut, vegetables and any other coastal belt products. People from Pemba Island, Comoro and zone and some from mainland invaded the area, up to 1940's the place was started to be known, as services like ferrying were initiated. Banyans Shiraz people established Stone quarry activities where tribes such as *Waha*, *Makonde* from sisal plantations were recruited. But eventually such activities were discouraged.

Kigamboni has changed dramatically, following the globalization process, especially in tourism, of late there are many hotels resorts, campsites and public and private owned beaches has been opened for both tourists and people of different lifestyles. Kigamboni

is highly populated, however the leading populated municipal is Temeke municipality, which has about 400,000 people makes $\frac{2}{3}$ of the of Dar es Salaam population.

However, increased number of people in Kigamboni has in one way or another brought some negative effects to economic life and social life such as the spread of HIV/AIDS.

1.1.1 Economic Activities

Basically, the kigamboni community profiles, lies on the following category of economic activities;

1.1.1.1 Fishing

Different people are enjoying in fishing activities, from different places, some from Tanzania mainland, while some from Tanzania Island (Zanzibaries – Kojan). Foreign fishing ships, used to fish through the shore-belt of kigamboni.

The fishing activities are the core function of the residential settlements, followed by other activities. Fishing is the main economic activity of the most Kigamboni people, it supports people to earn income and sustain life needs.

1.1.1.2 Agriculture

Agriculture is practiced but in small scale, however, earlier people were engaged in crops production, both cash crops and food crops, such as coconuts and cash nuts; while people engaged into food stuff crops as a whole especially vegetable and fruits.

1.1.1.3 Mining Activities- Stone Quarries

Started in *Mjimwema* area in Kigamboni ward under *Shiraz, banyas* as the capital owners while the most stonebreakers were *Waha, Ngoni, Makonde* from up country.

1.1.1.4 Trade

Trade is done under small and medium sizes. Business are mainly of selling clothes, cash crops, foodstuff crops and many non-food stuff crops just to mention but a few.

1.1.1.5 Tourism

Kigamboni had been set up as a very key on tourism industry in Dar es Salaam city and Tanzania as a whole. Beautiful hotels, resorts, pubs, and beaches had been built and established in Kigamboni coast, such are: Kipepeo, Bongoyo island, Sinda Island, Gendeyeka, Amani, Kim, Ras Kutani, to mention a few. These hotels, beaches, resort and pubs had attracted both tourists and other ordinary people to visit the place. Tourism in Kigamboni, had changed life of people economically, residents being employed, and some people sell foodstuffs.

1.1.1.6 Handicraft Work

The Makonde do practice both carving and sell their handicraft products to tourists and the visitors, as the result now the sector employs majority of *Makonde* who reside in Kigamboni. Generally, economic activities carried out in Kigamboni have resulted in improvement on living status of people of Kigamboni and to the Growth National Product (GNP). Although Kigamboni is known, internationally especially on Tourism industry, it faces some constraints such as; some people visit the area while they are

HIV/AIDS infected hence become HIV/AIDS spreaders and Heroin sellers and foreign culture which seems to distort the traditional culture, such foreign cultures including putting ear rings for young men and leg chains for women.

Therefore education, public lecture and public counseling from governmental agents, personal initiatives, and NGO'S, in the area – Kigamboni, had a partly positive future to itself and to the nation of Tanzania, both economically and socially. ANGAZA Peer Education Center (APECC) is an NGO based in Kigamboni, which has vision and mission as explained below:

It is APECC'S Vision to have a Tanzania society where by HIV/AIDS epidemic is tackled in holistic way.

It is APECC'S mission to increase response, access, knowledge quality of HIV/AIDS services and behaviour change communicated to children, youth and people living with HIV/AIDS in Tanzania through training, counseling, home care, spiritual counseling, testing and sensitization.

Projects undertaken with APECC are categorized into the following groups; Counseling, HIV/AIDS Testing, Home visits, Counseling and Training Youth, Research and Workshops. There are eleven members were involved in the projects for implementation of the organization activities. The project of reducing the spread of HIV / AID has begun and it's a part of the organization's vision.

The Project had no fixed duration by which will be concluded since it depends on the problem of HIV/AIDS whether it has been solved or not. Project started in late 1990's, located at Kigamboni and being hosted by APECC in Dar es Salaam. The project aims to

reduce spread of HIV/AIDS through provision of education materials on how to control the pandemic and voluntary counseling and testing. The project was a Community based project, therefore the project aimed to serve Children, Youth and People living with HIV/AIDS.

1.2 Community Needs Assessment

The community needs assessment aimed at assessing the sustainability of the ANGAZA PEER EDUCATING CENTRE (APECC) through Asset Based Approach both tangible and non-tangible assets. This involved assessment of those CBOs resource pentagon (RP) that is physical, material, financial, human and social resources.

1.2.1 Research Design

The survey on the sustainability of ANGAZA PEER EDUCATING CENTRE was both Cross-sectional and Longitudinal in terms of design.

Cross-sectional Design

Under cross-sectional design data were collected from the field between October 2005 and August, 2006 in Kigamboni area.

Longitudinal Design

With longitudinal survey designs, data were collected over time. At least, three variations particularly useful, however, the study used this design partially as it will trend data to assess the performance of ANGAZA PEER EDUCATING CENTRE through existing records.

Performance assessment over the past five year that is 2000, 2001, 2002, 2003, 2004 and 2005 were employed to compare the results.

A random sample of 105 respondents was applied using self-administered questionnaires distributed and supervised by programme supervisor.

1.2.2 External Validity

External validity was determined as follows, results from the community or group of people – ANGAZA PEER EDUCATIONG CENTRE in the following ways:

- Extensive pilot testing of the results obtained.
- Choosing the method that is most precise and accurate such as interviewing and observation especially for those respondents who cannot read and write.

Anonymity: questionnaires were used so as to hide respondents' identity in improving validity. Confidentiality is a cornerstone for external validity.

Convenience: questionnaires let people work at their own speed and when and where they want.

1.2.3 Internal Validity

The study guaranteed internal validity by carefully structuring interviews and questionnaires so as could be comprehensive, consistent and precise. A questionnaire pre-testing was done to determine the internal validity for the surveying instruments.

1.2.4 Reliability

Reliability was guaranteed by making sure that the questionnaires were adequate, precise, exhaustive and mutually exclusive.

Adequacy of reliability for surveys used the adequacy of reliability was assured by making a sample, which is large enough to be representative.

Adequacy of Description and methods for establishing reliability methods used for establishing reliability include the questionnaires and focus group discussion. Gender, occupation and age group.

1.2.5 Sample size

There were two approaches, which were used in determining sample size according to Kothari (1984). To specify the precision of estimate-desired sample and then to determine the sample size necessary to ensure it. Bayesian Statistics: To weight cost of additional value against the expected value of the additional information. Since the population is finite (2000 people) then sample size can be estimated by the formula:

$$N = \frac{Z^2 C^2 S^2}{E^2}$$

N = Sample size.

E = the acceptable error (precision)

Z = standard variable at a given confidence level

S = Standard deviation

C = Coefficiency of Variation

Probability sampling

Survey used a simple random sampling as it provided an equal chance for every element to be included in the sample. This helps to reduce the sampling bias. Every member of ANGAZA PEER EDUCATION CENTRE had an equal chance to be involved in the sample by assigning names and numbers in small pieces of pages and mixed them thoroughly through and pick every piece randomly until a number of 100 respondents was obtained.

Survey response rate

The responses rate was 100 percent for ANGAZA PEAR EDUCATION CENTRE members and Kigamboni community. Close follow-up by the researcher guaranteed the response rate to that tune.

1.2.6 Methods of Data Collection

In –person interview Method

In –depth interviewing was used to the ANGAZA PEER EDUCATION CENTRE members to explore their opinions, views, outlook and expectation on the sustainability of ANGAZA PEER EDUCATION CENTRE. The CED practitioners facilitated the interviewing process, the interviewee were members of APECC, local Government leaders, Religious leaders, cell leaders and poetical leaders. The interview was guided with survey questions as stipulated in questionnaire 1 and 2 in the appendices.

Survey Observation Method

Survey observation was used to explore the real situation of ANGAZA PEER EDUCATION CENTRE in terms of types of projects carried out, membership, systems

used in book-keeping and their organization chart. A CED practitioner assisted by the local Government leaders and APEEC'S leaders were involved in the process.

Record review method

The method was used to study the performance of ANGAZA PEAR EDUCATION CENTRE over a specified period of time so as to enable making a trend analysis. Record from Kigamboni health center and APEEC were used during the process.

Focus group discussion Method

Members of ANGAZA PEER EDUCATION CENTRE were also interviewed in groups and the subject matter was thoroughly discussed by both the interviewer and respondents. The method was guided by survey questions as stipulated in questionnaire 1 and 2 in the appendices.

Key informants interview

This was applied to the key members of ANGAZA PEER EDUCATION CENTRE such as leaders and donor agencies. The method also was guided by survey questions as stipulated in questionnaire 1 and 2 in the appendices.

1.3 Analysis of Data

Survey data Analysis techniques

The survey data was analysed by the following technique:

- **Descriptive Statistics:** This was used to analyse both descriptive and numerical attributes of respondents such as sex, age, literacy, income and so on. These techniques included both measures of central tendency (such as mean,

medium, and mode) and measures of variables such as range, variance, and coefficient of variation, standard deviation and Gini coefficient).

Correlation Analysis: this method was used to analyse the relationship between variables. The following method was used, Karl Pearson's Moment Correlation Coefficient (r); this was used to determine the degree of correlation between two variables in case of ordinal data where ranks are given to the different values of the variables.

1.3.1 Methods of data Presentation

Several techniques are available for presenting survey data. However, for the sake of this project data were presented in tables. The following tools have presented the collected data:

Tabular presentation

Data have been presented by using both simple tables and cross tables methods especially for descriptive attributes. Data analysis embraced all the concepts of processing operation, which include:

Editing: - Was done by careful scrutiny of the completed questionnaires to ensure that the data are accurate consistent with other facts gathered, uniformly entered and as completed as possible. Both field editing and central editing were carried out. The former refers to translating or writing what has to be written in abbreviated or illegible form at the time of recording responses.

Central editing took place after the fieldwork at the host organization APEEC in collaboration with ACIST consultant.

Coding: The responses were assigned numerals or other symbols so that they can be put into a limited number of categories or classes. The responses were both are exhaustive and mutually exclusive. They were assigned numbers such as 1, 2, 3 For simplicity of data using SPSS.

1.4 Research questions

Two different questionnaires were administered in two different occasions to test for reliability of the results.

1.4.1 Findings

Generally, in all occasions the results were the same as presented below. The tables hereunder represent the results of two research questions administered in two different occasions.

i) Research questions

What is your expenditure for your family per day?

How do you meet your daily basic needs?

Table 1 below expresses the family expenditure in relation to the life of community in Kigamboni. It reveals also the ways used by families to meet their daily basic needs. About 40% of families live on an average of 1,000Tshs-Tsh1, 500 per day. This implies that most of families live under poverty line. This may be due to the presence of HIV/AIDS pandemic in Kigamboni.

TABLE 1: Daily Basic Needs * Family Expenditure per Day (Tsh) Crosstabulation

Daily basic needs		Family expenditure per day (Tsh)					Total
		0-500	501-1000	1001-1500	1501-2000	2001-2500	
Yes	Count	1	1	2	1	0	5
	Expected Count	.4	3.4	.3	.2	.6	5.0
	% Within Meet of daily basic needs	20.0%	20.0%	40.0%	20.0%	.0%	100.0%
	% Within Family expenditure per day(Tsh)	25.0%	3.2%	66.7%	50.0%	.0%	11.1%
No	Count	3	30	1	1	5	40
	Expected Count	3.6	27.6	2.7	1.8	4.4	40.0
	% Within Meet of daily basic needs	7.5%	75.0%	2.5%	2.5%	12.5%	100.0%
	% Within Family expenditure per day (Tsh)	75.0%	96.8%	33.3%	50.0%	100.0%	88.9%
Total	Count	4	31	3	2	5	45
	Expected Count	4.0	31.0	3.0	2.0	5.0	45.0
	% Within Meet of daily basic needs	8.9%	68.9%	6.7%	4.4%	11.1%	100.0%
	% Within Family expenditure per day (Tsh)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

ii) Research questions

Where are you employed?

How do you do to meet your daily basic needs?

Table 2 below shows the employment status in relation to daily basic needs. In Kigamboni areas about 75% are self-employed. This express that poverty within the area as it was observed by the researcher affects most of people who lives Kigamboni, since most of them are engaged in small business and small trades whereas they tend to earn little income. Only those who are employed by government, some NGO and

international organizations have better life. Majority that has a direct impact to the spread of HIV/AIDS in Kigamboni argued this.

TABLE 2: Family Expenditure Per Day (Tsh) * Nature Of Employment Cross tabulation

Family expenditure per day(Tsh)		Nature of employment				Total
		Self employed	Government employed	Employed by NGO	Employed by international organization	
0-500	Count	3	0	1	0	4
	Expected Count	3.2	.3	.4	.2	4.0
	% Within Family expenditure per day (Tsh)	75.0%	.0%	25.0%	.0%	100.0%
	% Within Nature of employment	8.3%	.0%	25.0%	.0%	8.9%
501-1000	Count	29	1	1	0	31
	Expected Count	24.8	2.1	2.8	1.4	31.0
	% Within Family expenditure per day(Tsh)	93.5%	3.2%	3.2%	.0%	100.0%
	% Within Nature of employment	80.6%	33.3%	25.0%	.0%	68.9%
1001-1500	Count	1	1	0	1	3
	Expected Count	2.4	.2	.3	.1	3.0
	% Within Family expenditure per day (Tsh)	33.3%	33.3%	.0%	33.3%	100.0%
	% Within Nature of employment	2.8%	33.3%	.0%	50.0%	6.7%
1501-2000	Count	0	1	1	0	2
	Expected Count	1.6	.1	.2	.1	2.0
	% within Family expenditure per day(Tsh)	.0%	50.0%	50.0%	.0%	100.0%
	% within Nature of employment	.0%	33.3%	25.0%	.0%	4.4%
2001-2500	Count	3	0	1	1	5
	Expected Count	4.0	.3	.4	.2	5.0
	% within Family expenditure per day(Tsh)	60.0%	.0%	20.0%	20.0%	100.0%
	% within Nature of employment	8.3%	.0%	25.0%	50.0%	11.1%
Total	Count	36	3	4	2	45
	Expected Count	36.0	3.0	4.0	2.0	45.0
	% within Family expenditure per day(Tsh)	80.0%	6.7%	8.9%	4.4%	100.0%
	% within Nature of employment	100.0%	100.0%	100.0%	100.0%	100.0%

iii) Research questions

What is your level of education?

Do you think ignorance contribute to the spread of HIV/AIDS?

Table 3 below expresses the relationship between education and HIV/AIDS in Kigamboni area. Most people who were interviewed on the issue of ignorance as attributor factor to the spread of HIV/AIDS spread within the area; they agreed that ignorance has increased the spread of HIV/AIDS.

TABLE 3: Level of education * Relationship between ignorance & HIV/AIDS
Crosstabulation

Level of education		Relationship btn ignorance & HIV/AIDS		Total
		Yes	No	
Below std seven	Count	11	0	11
	Expected Count	10.3	.7	11.0
	% within Level of education	100.0%	.0%	100.0%
	% within Relationship btn ignorance & HIV/AIDS	26.2%	.0%	24.4%
Std seven	Count	30	2	32
	Expected Count	29.9	2.1	32.0
	% within Level of education	93.8%	6.3%	100.0%
	% within Relationship btn ignorance & HIV/AIDS	71.4%	66.7%	71.1%
second ary school	Count	1	1	2
	Expected Count	1.9	.1	2.0
	% within Level of education	50.0%	50.0%	100.0%
	% within Relationship btn ignorance & HIV/AIDS	2.4%	33.3%	4.4%
Total	Count	42	3	45
	Expected Count	42.0	3.0	45.0
	% within Level of education	93.3%	6.7%	100.0%
	% within Relationship btn ignorance & HIV/AIDS	100.0%	100.0%	100.0%

iv) Research questions

Do you think poverty increase the spread of HIV/AIDS?

Do you think people who go to beaches do practices prostitution?

Table 4 below explains issue of poverty and HIV/AIDS and relations between prostitution and beach goers, 88.6% of population argued that poverty has direct relations with spread of HIV/AIDS within the area of Kigamboni 97.5% of population showed that prostitution has a direct linkage with beach goers. So poverty, prostitution and beach goers have direct relationship towards the spread of HIV/AIDS within Kigamboni area.

TABLE 4: Relationship between Poverty & HIV/Aids * Relationship Between Prostitution & Beach Goers. Cross tabulation

Relationship between poverty & HIV/AIDS		Relationship between prostitution & beach goers.		Total
		Yes	No	
Yes	Count	39	5	44
	Expected Count	39.1	4.9	44.0
	% Within Relationship between poverty & HIV/AIDS	88.6%	11.4%	100.0%
	% Within Relationship between prostitution & beach goers.	97.5%	100.0%	97.8%
No	Count	1	0	1
	Expected Count	.9	.1	1.0
	% Within Relationship between poverty & HIV/AIDS	100.0%	.0%	100.0%
	% Within Relationship between prostitution & beach goers.	2.5%	.0%	2.2%
Total	Count	40	5	45
	Expected Count	40.0	5.0	45.0
	% Within Relationship between poverty & HIV/AIDS	88.9%	11.1%	100.0%
	% within Relationship btn prostitution & beach goers.	100.0%	100.0%	100.0%

v) Research question

Do you think that Kojan temporary marriage do spread HIV/AIDS?

Can Kojan temporary result into spread of HIV/AIDS?

Table 5 below has sighted on the behaviour of Kojan people on the issue of temporary marriage and HIV/AIDS within Kigamboni area. About 66.7% respondents argued that temporary marriage done by Kojan people contributed much to the spread of HIV/AIDS. This was according to male, while 93.3% female argued that Kojan people with their behaviour of temporary marriage contributes much to the spread of HIV/AIDS.

TABLE 5: Number of respondents * Relationship between Kojan temporary marriage & spread of HIV Crosstabulation

Number of respondents		Relationship between Kojan temporary marriage & spread of HIV		Total
		Yes	No	
Male	Count	5	10	15
	Expected Count	11.0	4.0	15.0
	% within Number of respondents	33.3%	66.7%	100.0%
	% within Relationship btn Kojan temporary marriage & spread of HIV	15.2%	83.3%	33.3%
Female	Count	28	2	30
	Expected Count	22.0	8.0	30.0
	% within Number of respondents	93.3%	6.7%	100.0%
	% within Relationship btn Kojan temporary marriage & spread of HIV	84.8%	16.7%	66.7%
Total	Count	33	12	45
	Expected Count	33.0	12.0	45.0
	% within Number of respondents	73.3%	26.7%	100.0%
	% within Relationship btn Kojan temporary marriage & spread of HIV	100.0%	100.0%	100.0%

vi) Research question

Do you think that price of condoms lead to increase of spread of HIV?

Can price of condoms lead to spread of HIV in your community?

Table 6 below reveals that price of condoms within Kigamboni area has a direct impact to the spread of HIV/AIDS. It has expressed the prevailing poverty situation of Kigamboni community that made them to afford the price of condom. About 93.3% argued that price of a condom is high compared to the purchasing power of most people within the area of Kigamboni where by 6.7% responded that price of condom does not have an impact on the spread of HIV/AIDS within Kigamboni.

TABLE 6: Number of respondents * Relationship between Price of condom &spread of HIV/AIDS Crosstabulation

Number of respondents		Relationship btn Price of condom &spread of HIV/AIDS		Total
		Yes	No	
Male	Count	1	14	15
	Expected Count	1.0	14.0	15.0
	% within Number of respondents	6.7%	93.3%	100.0%
	% within Relationship btn Price of condom &spread of HIV/AIDS	33.3%	33.3%	33.3%
Female	Count	2	28	30
	Expected Count	2.0	28.0	30.0
	% within Number of respondents	6.7%	93.3%	100.0%
	% within Relationship btn Price of condom &spread of HIV/AIDS	66.7%	66.7%	66.7%
Total	Count	3	42	45
	Expected Count	3.0	42.0	45.0
	% within Number of respondents	6.7%	93.3%	100.0%
	%within Relationship btn Price of condom &spread of HIV/AIDS	100.0%	100.0%	100.0%

CHAPTER TWO: PROBLEM IDENTIFICATION

This chapter presents the major concern of the Kigamboni community after prioritization of all the needs that were identified. It also presents the initiatives at the Government and International level, which were taken/continue being taken to combat the spread of HIV/AIDS pandemic in the area. Key stakeholders that were involved during the process were AMREF officials, Local Government Leaders, KYC (KIGAMBONI YOUTH CENTRE), PATH FINDER International, Foundation For Civil Society, Kigamboni Community, Religious leaders and Traditional Leaders & APECC Members.

2.1 Problem Statement

The global pandemic of HIV/AIDS has now entered its third decade. Research conducted over the past decade has revealed that gender roles and relations directly and indirectly influence the level of an individual's risk and vulnerability to HIV infection. Gender is also a factor in determining the level and quality of care, treatment, and support that HIV-positive men and women receive, the burden of care taken on largely by women, and the negative economic and social consequences of AIDS. These realities demonstrate the necessity of comprehensively integrating gender considerations into all levels of HIV/AIDS programming in order to enhance our response to the pandemic. Integration will not only benefit women and girls who are often the most vulnerable – but men and boys who also experience gender related risks and vulnerabilities to HIV/AIDS (UNAIDS, 1999).

HIV/AIDS is a major development crisis that affects all sectors. During the last two decades the HIV/AIDS epidemic has spread relentlessly affecting people in all walks of

life and decimating the most productive segments of the population particularly women and men between the ages of 20 and 49 years. The increasing number of AIDS related absenteeism from workplaces and deaths reflects the early manifestation of the epidemic leaving behind suffering and grief. Others include lowering of life expectancy, increasing the dependency ratio, reducing growth in GDP, reduction in productivity, increasing poverty, raising infant and child mortality as well as the growing numbers of orphans.

The children under the age of ten years bear the brunt of the impact of AIDS and for them the impact is much longer lasting than for adults. The epidemic is serious threat to the country's social and economic development and has serious and direct implications on the social services and welfare. Given the high HIV prevalence in the society, and in the absence of cure, the devastating impact of the epidemic is incomprehensible (UNAIDS, 1999).

The 2003-04 Tanzania HIV/AIDS Indicator Survey included HIV tested of over 10,000 men and women. Results show that 7 percent of Tanzanian adults HIV prevalence is slightly higher among women than men in all areas of the country. Urban residents have considerably higher infection levels than rural residents (10.9 percent vs. 5.3 percent). Women get infected earlier than men. Prevalence for both women and men increases with age until it reaches a peak: for women at age 30-34 (13 percent) and for men, at age 40-44 (12 percent). The HIV rates in Mbeya and Iringa are almost twice the national average. The rate in Dar Es Salaam is also much higher than the country average. Rates are lowest in Kigoma and Manyara.

Overall, 7 regions have rates below 5 percent. For both men and women, HIV prevalence increases with education. Adults with secondary or higher education are 50 percent more likely to be infected with HIV than those with no education. Women and men who are separated, divorced or widowed have a significantly higher rate of HIV infection than currently married or never married respondents. HIV prevalence increases with wealth. Infection rates are three times higher among those in the highest wealth quintile than those in the lowest wealth quintile.

The HIV status of almost 8 percent of couples is discordant, meaning that one partner is infected and the other is not. This points to an urgent need for HIV prevention education, counseling and testing, as most of these couples do not know their status. Women with 2 or higher risk sexual partners (non marital, non cohabiting) have much higher rates of HIV infection.

The continual of HIV/AIDS infections was a major concern of the community members of the Kigamboni ward; this was revealed during the community needs assessment conducted in 2006. Regardless of different measures being undertaken to combat the spread of this pandemic, the number of people who tested positive between the years 2004-2005 increased significantly as shown in tables below;

Table 7: Males and Females tested HIV/AIDS in Kigamboni area year 2004

YEAR 2004						
MONTH	TESTED			POSITIVE		
	Male	Female	Total	Male	Female	Total
January	13	17	30	2	7	9
February	8	12	20	3	8	11
March	9	17	26	-	9	9
April	5	12	17	2	4	6
May	13	20	33	1	6	7
June	5	14	19	3	7	10
July	18	19	37	2	3	5
August	10	14	24	2	7	9
September	15	19	34	3	11	14
October	11	17	28	1	8	9
November	12	19	31	5	4	9
December	17	24	41	3	10	13
TOTAL	136	204	340	22	84	111

Source: Field Survey TACAIDS-2004

Table 8: Males and Females tested HIV/AIDS in Kigamboni area in year 2005

YEAR 2005						
MONTH	TESTED			POSITIVE		
	Male	Female	Total	Male	Female	Total
January	10	11	21	2	3	5
February	19	19	38	6	9	15
March	17	23	40	5	10	15
April	12	16	28	3	6	9
May	19	29	48	2	6	8
June	15	36	51	1	8	9
July	14	23	37	4	6	10
August	19	29	48	3	9	12
September	13	31	44	1	8	9
October	11	28	39	2	3	5
November	7	20	27	2	8	11
December	11	23	34	2	3	5
TOTAL	167	288	455	33	79	113

Source: Field Survey TACAIDS-2005

The most affected are women at age 30-34 and men at age 40-44 of Kojan tribe. Women and girls are often the most vulnerable but men and boys also experiences gender related risks and vulnerabilities to HIV/AIDS.

The major causes are temporal marriages among Kojan fishermen, both income and non income poverty, prostitutions especially among young ladies, presence of Navy Camps

in the area has resulted into many soldiers to practice unsafe sexual intercourse, high Traditional alcoholic practices and drug addiction within young boys and young girls especially along the beaches of Kigamboni and practices of local circumcision for both girls and boys.

If there will no measures to be taken this may lead to increased death among young boys and girls as the result the working age group will diminish dramatically. Due to the fact that HIV infection is mainly through heterosexual intercourse, HIV/AIDS is a social, cultural and economic problem, which touches on the private lifestyles of individuals. Therefore the risk of HIV infection is highest among young people, and especially girls. Girls and women in our social and cultural environment are more vulnerable to HIV infection as they do not have control over their sexuality. Poverty increases the vulnerability HIV infection as some women engage in high-risk sexual behaviour for survival.

National response

Nation Response initiatives against the HIV / AIDS epidemic are guided by the following general principles. These principles have to be taken into account and included in all plans, programmes and projects: -

- (1) The protection of health is basic Human Rights of the people of Tanzania.
- (2) Combating AIDS needs the involvement and participation of the entire society,
- (3) Combating AIDS is a priority and an integral part of the development policy of the country and is supported by continuously strong political and government commitment at all levels,

- (4) Success and synergies can only be achieved through multi-sectoral and multidisciplinary approaches necessitating effective coordination and partnerships of all actors under government leadership,
- (5) The Human Rights of persons living with HIV / AIDS are respected and their active participation in programming and implementation are pursued,
- (6) Intervention are based on scientifically and ethically sound approaches (“best practices”) respecting the dignity, values and cultural diversity of the people, Due attention will be given to cost-effective interventions, and Programmes and interventions are “people-centered” assisting and empowering communities, families and individuals to develop their own responses (“AIDS-competence”) to the challenges and threats of HIV / AIDS and to learn from the experiences of others.

International Donor Initiatives

From April 2001 to September 2003, the International Center for Research on Women (ICRW) led this research initiative in three African countries: Ethiopia, Tanzania and Zambia. ICRW’s research partners were the Miz-Hasab Research Center in Ethiopia; the Department of Psychiatry, Muhimbili University College of Health Sciences (MUCHS) in Tanzania; and Zambart1 and Kara Counseling and Training Trust (KCTT) in Zambia. The initiative was funded by the United States Agency for International Development through the Academy for Educational Development’s (AED) CHANGE Project, with additional support from the CORE initiative, the Swedish International Development Agency (SIDA), and the Positive Action program of GlaxoSmithKline.

In particular, the objectives of the study were to:

- Disentangle the underlying factors that perpetuate or mitigate stigma;
- Document how stigma is influenced by the context in which it occurs;
- Analyze how stigma and discrimination are experienced by people with HIV and others who are affected by the disease;
- Understand how stigma and discrimination affect access to HIV prevention, testing, disclosure, care, and support efforts; and
- Make recommendations for interventions.

In Tanzania Muhimbili University College of Health Science (MUCHS) researchers sought to learn about the experiences of people living with HIV and AIDS with stigma and their experiences as they disclosed their status over time. To this end, MUCHS enrolled voluntary counseling and testing (VCT) clients who were HIV-positive at the time of VCT and interviewed them over a period of 10 months.

MUCHS interviewers explored HIV-related stigma and discrimination within a health care training setting. They conducted focus group discussions (FGDs) and interviews with nursing and medical students and instructors at a medical training facility to assess knowledge, attitudes, and fears about HIV and AIDS, people living with HIV and AIDS, and care and support of those affected by and infected with HIV.

Summary of findings about causes of Stigma and Discrimination for People Living with HIV/AIDS.

- Most respondents know how HIV is transmitted, but more detailed knowledge of other aspects of HIV and AIDS is incorrect or missing altogether.

- Incorrect knowledge combines with fear of death from HIV to perpetuate beliefs in casual transmission and, by extension, avoidance of those living with HIV.
- People recognize the role of limited knowledge in perpetuating stigma and are eager to acquire more detailed knowledge about HIV and AIDS.
- HIV is associated with socially “improper” sex. Consequently, people with HIV and AIDS are stigmatized for their perceived immoral behavior.
- Religious beliefs contribute to stigma by considering HIV as punishment from God for sexual sins.
- At the same time, religion and faith-based organizations offer comfort, care, and psychological and spiritual support to people with HIV and AIDS, as well as basic precepts for not stigmatizing people with HIV and AIDS.
- Many respondents’ expressed good intentions to not stigmatize, but stigma persists because people do not recognize words and actions as stigmatizing.

2.2 Stakeholders’ analysis

The following were the stakeholders who participated during project implementation;

- Development partners
- AMREF
- Local Government Leaders
- KYC (KIGAMBONI YOUTH CENTRE)
- PATH FINDER International

- Foundation For Civil Society
- Kigamboni Community
- Religious Leaders
- Traditional Leaders & APECC Members

2.3 Project goals and their targets

This project aimed to achieve the following goals during the period 2003 to 2007.

GOAL 1 [OVERALL IMPACT] Reduce the spread of HIV in the country.

Indicator: Percentage of young aged 15-24 years who are HIV infected

Target: By 2007, Reduction by 30 percent

GOAL 2: (OVERALL IMPACT) Reduce HIV transmission to infants under 17 years

Indicator: Percentage of HIV-infected infants born to HIV-infected mothers.

Target: By 2007, reduction by 20 percent

GOAL 3 :(ADVOCACY) Political and government leaders consistently give high visibility to HIV / AIDS in their proceedings and public appearance.

Indicator: The percentage of national fund spent by the government on HIV/ AIDS.

Target: By 2007, involve all political parties in fight against HIV/AIDS

GOAL 4: (STIGMA AND DISCRIMINATION) Political leaders, public and

Private programmes, projects and interventions address stigma and discrimination and promote the respect for the Human Rights of persons living with HIV / AIDS

Indicators: Number of high-level events and programmes, projects and interventions having anti-stigma and anti-discrimination measures included.

Target: By 2007, involve all political parties in fight against stigmatization and discrimination.

GOAL 5 : (DEVELOPMENT) HIV / AIDS concerns are fully integrated and

Prioritized in the National Poverty Reduction Strategy and Tanzania Assistance Strategy

Indicator: PRSP and TAS have fully incorporated the HIV/AIDS dimension in the long-term development strategy.

Target: By 2007, HIV/AIDS issues are fully integrated into development agendas

GOAL 6 : (PREVENTION) Reduce the prevalence of STIs in the population.

Indicator: Percentage of patients with STI at health care facilities, who are appropriately diagnosed, treated and counseled.

Target: By 2007, 70 percent of patients in 80 percent of health facilities appropriately diagnosed, treated and counseled.

GOAL 7: (PREVENTION) Increase the Knowledge of HIV transmission in the population.

Indicator: Percentage of young people aged 15 – 24 years who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.

Target: By 2007, at least 95 percent of young men and women aged 15 – 24 have access to Information Education including peer education and youth specific HIV Education.

GOAL 8: (CARE AND SUPPORT) Increase the number of Persons living with

HIV/AIDS who have access to a continuum of Care and Support from Home/Community to Hospital levels.

Indicator: Percentage of health facilities with the capacity to deliver appropriate care for persons living with HIV/AIDS.

Target: By 2007, People living with HIV/AIDS will have a continuum care and support in Kigamboni area.

GOAL 9: [impact mitigation] Reduce the adverse effects of HIV/AIDS on orphans.

Indicator: Reduced number of Orphans in Kigamboni area.

Target: By 2007, the number of orphans as the result of HIV/AIDS will be reduced in Kigamboni area.

2.4 Project Objective

The project aimed at assigning the methods to reducing the rate of HIV new infections. According to this project new infection can be divided into two categories. First category is one who is negative but now transmitted to a positive status (acquired HIV). Second category is one who is positive and continues to acquire a new virus different from that he/she had before. This may mean strong than the later and it can speed to AIDS which can accelerate the death.

2.5 Study Objective

To assess the impact of education on VCT and educational materials disseminated to community members in Kigamboni.

CHAPTER THREE: LITERATURE REVIEW

This chapter presents a theoretical and empirical literature review. Under theoretical literature review, it explains the meaning of HIV/AIDS, origin of HIV/AIDS, infection with HIV, ways in which HIV cannot be transmitted, diagnostic test of AIDS, relationship between HIV and poverty, stigma and HIV/AIDS. On the other hand empirical literature review presents practical evidence from various studies on HIV/AIDS.

3.1 Theoretical Literature Review

Globally, 40 million people were estimated to be living with HIV and AIDS at the end of 2001. Sub-Saharan Africa is clearly the worst affected region. With 28.5 million people living with HIV and AIDS (PLHA) in 2001, sub-Saharan Africa accounts for more than 70 percent of all HIV and AIDS cases in the world. Over two million of the three million deaths due to AIDS in 2001 occurred in sub-Saharan Africa. AIDS is now the leading cause of death in sub-Saharan Africa and the cause of a 15- year drop in life expectancy in the region, from 62 to 47 years. New HIV infections are highest among young people, and young women have consistently been found to have higher (in some cases as much as six times as high) prevalence rates of HIV than men of the same age (UNAIDS 2002).

Meaning of HIV/AIDS

AIDS is an acronym that stands for Acquired Immune Deficiency Syndrome. It is not just one disease but a collection of life-threatening diseases (including certain very harmful viruses and other infections, including tuberculosis, a rare form of pneumonia

and various forms of cancers) that attack the body when its immune system is severely compromised (WHO 2003). HIV – Human Immunodeficiency Virus, causes AIDS. Infection with the Human Immunodeficiency Virus is indicated by the presence of antibody to the virus in the bloodstream. The majority of persons with HIV infection will have no symptoms at first. However, after an incubation period of several months to years, the immune system is often compromised to a point where patients begin to develop infections characteristic of the Acquired Immunodeficiency Syndrome (AIDS).

The origin of HIV and AIDS

The illnesses associated with AIDS were first noted by physicians in the early 1980s when they observed that many younger men and women were developing these serious illnesses and dying very quickly. After some years of research, they found that HIV caused this syndrome. It is not yet known whether HIV is a new disease agent or whether it has been present among people for many years but more recently has evolved into a more destructive form. The most widely accepted theory about the origin of HIV in humans was first infected by similar viruses that affect certain species of monkeys (SIV – Simian Immunodeficiency Virus) and that the SIV then evolved into HIV. The simian virus most likely infected humans who were hunting for monkeys and cut themselves, thus allowing the infected blood of the monkeys to enter into the human bloodstream. In 1983 scientists in France discovered the virus that caused AIDS and the routes of transmission were confirmed. The virus eventually became known as the human immunodeficiency virus (HIV). There are 2 different types of HIV. **HIV-1** the

most common type found worldwide and **HIV-2** found mostly in West Africa (WHO 2003).

Infection with HIV

HIV is present in varying concentrations in certain body fluids, including blood, male and female sexual fluids, and breast milk. The ways in which a person could be infected through contact with the infected body fluids of another person are:

- **Contact with infected blood** – i.e., through transfusions, sharing of hypodermic needles and syringes, use of scalpels or other sharp and skin-piercing instruments without prior sterilization. The most efficient way to transmit the virus is by administering a transfusion without prior screening of the blood. The reason for this is that a large quantity of infected fluid has a direct route into the bloodstream of the uninfected person;
- **Penetrative sexual relations with an infected person** – The virus could be transmitted through sexual contact from a man to a woman (the most common means of transmission), from a woman to a man, from a man to a man and (in rare situations) from a woman to a woman. Infection does not occur with every sexual contact, but it **could** occur through any such contact;
- **Infected mother to child** – An infected mother could infect her child while still *in utero* (the virus can pass through the placenta); during the birth process (when the child comes into contact with much infected fluid and/or blood of the mother), or during breast-feeding. Without any special intervention, mother-to-child transmissions could occur in approximately 1/3 of all births, which involve an infected mother. However,

clinicians have found that one dose of an antiretroviral medication shortly before the mother is about to deliver and one dose of the same medication administered to the child shortly after birth can reduce significantly the possibility of mother-to-child transmission.

Since HIV infection is mainly through heterosexual intercourse, HIV/AIDS is a social, cultural and economic problem, which touches on the private lifestyles of individuals. Therefore the risk HIV infection is highest among young people, and especially girls. Girls and women in our social and cultural environment are more vulnerable to HIV infection as they do not have control over their sexuality. Poverty increases the vulnerability to HIV infection as some women engage in high-risk sexual behaviour for survival (WHO, 2003).

Ways in Which HIV cannot be transmitted

Coughing or sneezing, insect bites, touching or hugging, water or food, kissing, public baths, handshakes, work or school contact, using telephones, swimming pools, sharing cups, glasses, plates, and other utensils

A diagnostic test for AIDS

AIDS is diagnosed when physicians observe the clinical signs of the life-threatening diseases that attack the body when the immune system is significantly compromised or destroyed. An AIDS diagnosis also can be given when the person has a very low level of T-cells or CD-4 white blood cells, which are needed to coordinate the body's response to disease through its immune system. HIV is particularly attracted to these T4 or CD-4 cells and, once it enters into these cells, it destroys them.

There are several tests – done on blood specimens or on certain mucous cells scraped from the inside of the mouth – to determine if HIV has infected a person. These tests only indicate whether infection is present. They do not predict whether or when the immune system will be compromised to the point that the body will be prone to the life threatening illnesses associated with AIDS.

Epidemiological and biomedical research has long established a link between an individual's sex and his or her risk of HIV infection. It is well known, for example, that physiological factors account for the more efficient transmission of infection from an infected man to a woman than from an infected woman to a man (WHO 1994; Foundation for Women 1997). More recently, however, research has also identified the role that gender plays in determining individual risk and vulnerability in the HIV/AIDS epidemic. Socio-cultural norms about masculinity and femininity, and the unequal power relations between men and women that arise from those norms, conspire with biological and physiological factors to compound individuals' risk of infection, resulting in epidemics of significant size and proportion in different parts of the world.

Whereas 'sex' defines the biological distinction between women and men, 'gender' is a social construct that differentiates the power, roles, responsibilities, and obligations of women from that of men in society (WHO, 2003).

HIV/AIDS is both a disastrous pandemic and at the same time a challenge to our nation. It is a disaster because it is killing a lot of our young men and women at their most productive age; it is a challenge because we must have at our disposal plans and implementation strategies to arrest the onslaught of this pandemic. Since the first three

cases of AIDS were reported in 1983, HIV infection has spread throughout the country and hundred thousands of people in all walks of life have lost their lives. Surveillance reports indicate a two-fold increase of HIV prevalence from 7.2 to 13.3 percent among female blood donors during the last ten years (1990 – 2000). This shows that the epidemic is still growing and, with no effective cure or vaccine in the near future, it will continue to grow unless serious and effective measures are taken by all of us, individually and collectively to curb the epidemic now.

HIV/AIDS AND POVERTY

It has been well established that poverty significantly influences the spread and impact of HIV/AIDS. In many ways it creates vulnerability to HIV infection, causes rapid progression of the infection in the individual due to malnutrition and limits access to social and health care services. Poverty causes impoverishment as it leads to death of the economically active segments of the society and breadwinners leading to reduction in income or production.

Stigma and HIV/AIDS

HIV/AIDS related stigma is one of the key challenges in the prevention and control of the epidemic. In Tanzania, like in other countries in South of the Sahara, stigma against HIV/AIDS remains very strong and plays a major role in fuelling HIV infection. In our community HIV related stigma tends to be firmly linked in people's minds to sexual behaviour. This attitude puts PLHAs into unnecessary hostile and embarrassing situation, they face discrimination and sometimes neglect. Worse still stigma leads to secrecy and denial that tends to hinder openness about the HIV and prevents people from

seeking counseling and testing for HIV. This leaves hundreds of thousands of apparently healthy looking people who are infected with HIV transmitting the infection to hundreds of thousands of uninfected people. Therefore in fighting the epidemic, every effort shall be put into breaking the long deadly silence on HIV/AIDS all sectors at all levels. This involves health workers, political and government leaders, religious leaders, NGOs, PLHAs, community leaders and families.

3.2 Empirical Literature Review

3.2.1 The Impact of Gender on the HIV/AIDS pandemic in developing countries

In many societies the dominant ideology of femininity dictates that ‘good women’ are expected to be ignorant about sex and passive in sexual interactions (Rao Gupta and Weiss 1993; Paiva 1993). A recent analysis of levels of knowledge about HIV/AIDS prevention in 23 developing countries found that levels of knowledge are almost always higher among men than among women, with 75% of men, on average, having accurate knowledge about HIV/AIDS transmission and prevention as compared to roughly 65% of women (Gwatkin and Deveshwar-Bahl 2001). This knowledge imbalance greatly hinders women’s ability to be informed about risk reduction.

Some studies have shown that a lack of knowledge or incomplete knowledge also fosters the development of fears and myths about condom use. For example, studies conducted in diverse settings – Brazil, Guatemala, India, Jamaica, Mauritius and South Africa – have found that women did not like using condoms because they feared that if the condom fell off inside the vagina it could get lost or travel to the throat, or that a woman’s reproductive organs would come out when the condom was removed (Rao

Gupta and Weiss 1993). Even when a woman is informed or has accurate information about sex and HIV prevention, the societal expectation that a woman, particularly a young woman, should be *naïve* makes it difficult for her to be proactive in negotiating safer sex.

Simultaneously, prevailing norms of masculinity expect men to be more knowledgeable and experienced about sex. This assumption puts men – particularly young men – at risk of infection because such norms prevent them from seeking information or admitting their lack of knowledge about sex or protection. Many men, as a result, have erroneous information about sexual and reproductive health (Barker and Lowenstein 1997; UNAIDS 1999).

Fidelity versus Multiple Partnerships

In many societies the dominant ideal of femininity emphasizes uncompromising loyalty and fidelity in partnerships. It is this ideal that distinguishes a ‘good’ woman from a ‘woman of the street’ and defines sexual practices linked to reproduction as moral and those that are linked to pleasure as immoral (Rao Gupta and Weiss, 1993).

In sharp contrast, in many societies it is believed that variety in sexual partners is essential to men’s nature as men and that men will inevitably seek multiple partners for sexual release (Mane, Rao Gupta et al. 1994; Weiss, Whelan et al. 1996; Rao Gupta 2000). Results from sexual behaviour studies from around the world indicate that heterosexual men, married and single, as well as homosexual and bisexual men, have higher reported rates of partner change than women (Sittitrai 1991; Orubuloye, Caldwell et al. 1993; Rao Gupta and Weiss, 1993). Recognition and condoning of multiple sexual

partnerships for men but not for women sets a double standard for sexual behaviour that seriously challenges the effectiveness of HIV prevention efforts that expect men to be faithful and reduce the number of sexual partners (Rao Gupta, 2000).

Moreover, breakdowns in men's ability to meet some masculine norms, such as providing for the family, can result in men seeking self-esteem by fulfilling other masculine norms, such as engaging in sex with multiple partners (Silberschmidt, 2001). This underscores the need for HIV/AIDS prevention efforts to change the gendered norms of sexuality, if interventions are to be effective.

3.2.2 The California Collaborations in HIV Prevention Research

Dissemination Project is designed to disseminate information about prevention intervention projects and to serve as a resource to be used by California local health departments and community-based organizations. To support these efforts, the State Office of AIDS (OA) and the University wide AIDS Research Program (UARP) joined forces in 1998 to provide funding for HIV/AIDS community research collaborations and to foster partnerships among researchers, community-based AIDS service organizations, and local health departments.

The Research Summary series is part of a larger set of resources developed as a response to the statewide public health need to support evidence-based planning, design, and evaluation; to build community research capacity; and to disseminate information on HIV/AIDS prevention interventions.

The research team included Lynae Darbes, Center for AIDS Prevention Studies (CAPS), UCSF, and Gail E. Kennedy and George W. Rutherford, Institute for Global Health,

UCSF. All three are members of the Cochrane Collaborative Review Group on HIV Infection and AIDS.

Although we are entering the third decade of the HIV pandemic, there is yet no cure or vaccine. At this time, our principal means for deterring the further spread of HIV remains behavioral risk prevention interventions. Thus, developing and implementing interventions that focus on behavioral prevention are of utmost importance.

Although the epidemic has reached into most segments of society, the disparity of its scope continues to be striking. Recent statistics have demonstrated a significant overrepresentation of people of color among new HIV infections. With regard to African Americans specifically, this disparity has been evident since the first reports of what we now call HIV/AIDS. As early as 1982, African Americans were found to comprise 23% of the cases reported, while making up only 12% of the entire U.S. population. This trend has continued, and worsened. Recent statistics show that over 50% of new HIV infections are occurring among African Americans, although they still account for only about 12% of the U.S. population.

This overrepresentation of African Americans is consistent across the major behavioral risk groups for HIV infection: men who have sex with men (MSM), injection drug users (IDU), heterosexuals, and youth/adolescents. For example, of the over 25% of AIDS cases in men in the United States contracted through drug use and heterosexual transmission, more than half were in African American men. Among women and adolescents, African Americans have the most cases of HIV infection and AIDS compared to other racial groups.

These figures underscore the necessity for examining evidence for prevention interventions aimed at African Americans, focusing on the primary risk groups (Lynae *et al.*, 1998).

Components of Effective Interventions

Certain components were shared by the majority of interventions that achieved positive behavioral changes, including skills training, cultural sensitivity, gender sensitivity, and interventions longer in time, number of sessions, or both. General statements regarding these components include the following.

i) Interventions designed to reflect specific needs and/or characteristics of the African American community produced more positive behavior change

For example, some studies altered traditional prevention messages to make them more relevant to the African American community, and most had African American facilitators. Although this approach would necessitate that interventions be delivered to groups composed of all African American participants, it appears that this is an important element for an effective intervention. When culturally sensitive interventions were compared with less culturally relevant interventions, without exception, the more sensitive intervention produced more positive behavior change.

ii) Interventions that took into account gender differences as well as cultural differences were more effective

Several studies (e.g., Cohen *et al.*, 1992a; O'Donnell *et al.*, 1995) reported on differential effects of interventions due to gender. For example, condom use is a very important aspect of HIV prevention; however, it is a method that is entirely dependent upon the

male partner's choice. Interventions that were aimed toward increasing condom use by men were most effective when addressing behavioral skills to teach men proper condom use technique, whereas interventions addressing women were more effective when focused on training in communication skills, to help them better discuss their preference for condom use with partners. (Condom-use messages may not seem relevant to women, who often feel that, while they might agree in theory, whether or not a condom is used is ultimately not under their control.) However, several interventions conducted exclusively with women produced positive results (e.g., Carey et al. 2000; Kelly et al., 1994), suggesting that this is a successful means of improving HIV prevention with women.

iii) Longer duration interventions in general had more effects that are positive

(e.g., Rotheram-Borus et al., 1997; St. Lawrence et al., 1995). One study tested whether it was the actual amount of time spent in the delivery of the intervention or the number of sessions that was more influential. The authors reported that even though two groups had spent the same amount of time in sessions (10.5 hours), those participants who had received the 10.5 hours over seven sessions demonstrated significantly more positive behavior change than those participants who had received the 10.5 hours over three sessions. Although this might increase the difficulty and cost of future interventions, this approach could improve the likelihood of long-term positive behavior change. Given that sexual and drug-use risk behaviors can be experienced as pleasurable, changing to what is seen as less pleasurable behaviors can be met with resistance. The cognitive

changes needed to effect such behavior change require time for the new information to be incorporated. Providing information on one day may not be sufficient to change behaviors that have been in place for years. However, there is evidence that there could be an optimal length of interventions that are too intensive may not prove feasible, while interventions that are too brief may not produce significant and/or longstanding change. Interventions composed of three to five sessions appeared to balance the need to provide multiple sessions and achieve positive effects while remaining feasible (e.g., DiClemente and Wingood, 1995; Kelly et al., 1994).

Observations that longer interventions tend to be more successful have also been discussed in earlier reviews of HIV prevention interventions.

iv) Peer educators were shown to be as effective as professional staff

Several interventions found no differences in the effectiveness of the intervention when delivered by peer educators versus professional staff. This result was consistent for both school-age populations and adults. This finding could be important in determining the feasibility of translating interventions to the community. Community agencies often do not have the staff or funds to provide facilitators comparable to those used in academic interventions. However, if the same training used for peers in the academically based interventions can be used to train volunteers in schools or community-based agencies, the chances of reaching those people most at risk are increased, at substantially less cost.

Other writers have written different books concerned HIV/AIDS

Some of these authors have been described below: -

i) Gender mainstreaming in HIV/AIDS: Taking a Multisectoral Approach, by Commonwealth Secretariat, Maritime Centre of Excellence for Women's Health. 2002. Commonwealth Secretariat/Stylus Publishing, 2283 Quicksilver Drive, Sterling, VA 20166. 2012. 164, illus., bibliog... (New Gender Mainstreaming Series on Development Issues) 085092-655-\$17.95.

(Descriptors: Gender Analysis; Men; Women; Young People; Canada) "The ultimate goal of gender mainstreaming is to achieve gender equality. It requires that both men's and women's concerns are considered in the design, implementation, monitoring and evolution of policies and programmes in all political, economic and societal spheres so that women and men benefit equally." With this in mind, the Commonwealth Ministers Responsible for Women's Affairs mandated that a Gender Management systems (GMS) be developed, being "a holistic system-wide approach to bringing a Gender perspective to bear in the mainstream of all government policies, plans and programmes." The GMS for HIV/AIDS strives to ensure that there is integration of gender into all government policies, programmes and activities that impact on the epidemic.

ii) Science of Marijuana, by Leslie L. Iversen. 2002. Oxford University Press, 198 Madison Ave, New York, NY 10016. 283p., bibliog., index. ISBN 0-19-515110-0pbk. (Descriptors: Marijuana; Physiological Effects; Pharmacology; Cannabis; Adverse Effects).

The use of Marijuana has long been advocated as an alternative way to treat AIDS; unfortunately, it is illegal in most Western countries, thus preventing its use for medical purposes. "This book seeks to describe what is known about how marijuana acts in the

brain, and to compare the profile of marijuana with other drugs that are used because of their euphoriant or psychostimulant effects-cocaine, mphetamines, heroin, alcohol, and nicotine.”

“The attitudes against the use of marijuana are deeply entrenched but large-scale clinical trials are beginning to show that these attitudes are in jeopardy. Of interest to AIDS patients is the interest in controlling wasting. Other researchers are looking at the use of marijuana in the treatment of pain, multiple sclerosis, glaucoma, epilepsy, bronchial asthma, and mood disorders and sleep. This is by far one of the best books that discuss Marijuana in terms of its use throughout the world. It is not biased, presenting the good and bad sides of marijuana use. As more clinical trials are established, we will know more of how this drug may benefit many individuals throughout the world. A recommended book for all public and academic libraries.

iii) Studies and Gender Research, PO.Box 1156 Blindern, NO-0317 Oslo, Norway..82p.bibliog.ISBN 82-7864-011-4. Order from

<http://www.nikk.uio.no/forkningsprojeckt/livingfortomorrow>

(Descriptors: Education; Estonia; Young People) the living for Tomorrow project has grown out of years of activity in Eustonia where it is “aimed to combine gender theory and research with action implementation to approach youth. Sexual safety and HIV prevention with challenging focus on gender.

iv) HIV Vaccines in Canada: Legal and Ethical Issues: An Overview, By David Garmaise. 2002. Canadian HIV/AIDS Legal Network, 417 Rue St- Pierre,Ste 408, Montreal, Quebec. (Descriptors: vaccines; Canada; Ethics) This overview provided by

Canadian HIV/AIDS Legal Network gives a summary of the major legal and ethical issues related to the development and delivery of an HIV vaccine in Canada. Established Safe Injection Facilities in Canada: Legal and Ethical Issues, by Richard Elliot, Ian Malkin, and Jennifer Gold. 2002. Canadian HIV/AIDS Legal Network, 417 Rue St Pierre, Ste. 408, Montreal, Quebec, H2Y 2M. 68p., bibliog.. ISBN 1-896735-39-8. Order from <http://www.clearinghouse.cpha.ca>(Descriptors: Legal Aspects; Ethical Aspects; Canada; Switzerland; German; Netherlands; Australia)

Injection drug use is continuing problem throughout the world. “ People who inject drugs face serious potential health risk, including fatal and non-fatal overdoses and blood borne diseases such as HIV/AIDS and hepatitis C. “In order to reduce the potential harm to drug users, one idea is to establish safe injection facilities or safe injection sites or supervised injection facilities.

3.3 National HIV/AIDS Policy

The overall goal of the National Policy on HIV/AIDS (2001) is to provide for a framework for leadership and coordination of the National multisectoral response 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, protection and supporting vulnerable groups, mitigating the social and economic impact of HIV/AIDS. It also provides for the framework for strengthening the capacity of institutions, communities and individuals in all sectors to arrest the spread of the epidemic. Being a social, cultural and economic problem,

prevention and control of HIV/AIDS epidemic will very much depend on effective community based prevention, care and support interventions.

The local government councils will be the focal point for involving and coordinating public and private sectors, NGOs and faith groups in planning and implementing of HIV/AIDS interventions, particularly community based interventions. Best experiences in community-based approaches in some districts in the country will be shared with the local Councils.

SPECIFIC OBJECTIVES OF THE POLICY

Prevention of Transmission of HIV/AIDS

- (i) 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.
- (ii) To prevent further transmission of HIV/AIDS through: -
 - (a) Making blood and blood products safe, and
 - (a) Promoting safer sex practices through faithfulness to partners, abstinence, non-penetrative sex, and condom use according to well informed individual decision. The key issue of moving from abstinence or condom use to another strategy depends on testing in between.

- (b) Early and effective treatment of STIs in health facilities, with special emphasis on high-risk behaviour groups and early diagnosis of HIV infection through voluntary counseling and testing.

HIV TESTING

- (i) To promote early diagnosis of HIV infection through voluntary testing with pre- and-post test counseling. The main aim is to reassure and encourage the 85 – 90% of the population who are HIV negative to take definitive steps not to be infected, and those who are HIV positive to receive the necessary support in counseling and care to cope with their status, prolong their lives and not to infect others.
- (ii) To plan for counseling training and accreditation of training programs in Tanzania to ensure that counseling in HIV/AIDS abides by a common code of practice.

CARE FOR PLHAs

- (i) To provide counseling and social support services for PLHAs and their families.
- (ii) To combat stigma and strengthen living positively.
- (iii) To provide adequate treatment and medical care through an improved health care system this aims at enhancing quality of life.
- (iv) To establish a system of referral and discharge that links hospital services to community relationship while ensuring that the quality of supervision for hospital care is comparable to that of home care.

- (v) To ensure availability of essential drugs the treatment of opportunistic infections. With the current availability of Highly Active Anti Retroviral Drugs (HAARD). In the market, PLHAs may be required to meet the cost of the drugs. The government in collaboration with the private sector will work out modalities for procurement and management of HAARD.
- (vi) To ensure that the cost of counseling and home care is reflected in the National and local Councils Budgets for Health care and Social Welfare Services. Modalities will be developed for the establishment of the AIDS Trust Fund to support community-based initiatives including home based care and orphans.
- (vii) To involve and support communities in the provision of community based and home care services.

SECTORAL ROLES AND FINANCING

- (i) To strengthen the sectors, public, private, NGOs, Faith groups, PLHAs, CBOs and other specific groups to ensure that all stake holders are actively involved in HIV/AIDS work and to provide a framework for coordination and collaboration.
- (ii) To ensure strong and sustained political and Government commitment, leadership and accountability at all levels.
- (i.) To establish a framework for coordinating fund raising activities, budgeting, and mobilization of human and material resources for activities throughout Tanzania.
- (iv) To influence sectoral policies so as to address HIV/AIDS.

- (v) To encourage and promote the spirit of community participation in HIV/AIDS activities. This includes community representation in national and district for fund raising, strategic planning and implementation by all sectors. It also includes ward level and village level strategic planning for prevention of transmission of HIV/AIDS and STIs as well as care and support of PLHAs, their dependants/families and orphans.

OTHER OBJECTIVES

- (i) To monitor the efforts towards community mobilization for living positively with HIV / AIDS in order to cope with the impact of the epidemic while safeguarding or affected directly by HIV / AIDS in the community.
- (ii) To identify Human Rights abuses in HIV / AIDS and to protect PLHAs and everyone else in society against all forms of discrimination and social injustice.
- (iii) To provide appropriate effective treatment for opportunistic infections at all levels of the health care system.
- (iv) To work closely with the Ministry of Home Affairs, NGOs and faith Groups in the fight against drugs sub-stance abuse that increases the risk of HIV transmission.
- (v) To prohibit misleading advertisements of drugs and other products for HIV / AIDS prevention, treatment and care.

3.3.1 Principles that guide the National Policy on HIV/AIDS

- (a) The new emerging challenges from International Conferences i.e. 1994 International Conference on population and development (IOCD), 1995 the Beijing Conference and 1995 the Copenhagen World Social Summit, and all human rights conventions which were signed and ratified by the Government shall provide a frame for the formulation of HIV/AIDS policy and implementation.
- (b) All members of the community have individual and collective responsibility to actively participate in the prevention and control of the HIV/AIDS epidemic. National response shall be multi-sectoral and multidisciplinary.
- (c) Strong political and Government commitment and leadership at all levels are necessary for sustained and effective interventions against HIV/AIDS epidemic.
- (d) HIV/AIDS is preventable. Transmission of infection is preventable through changes in individual behavior, hence education and information on HIV/AIDS, behavioral 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 behavior at the community and individual levels.
- (e) Individuals are responsible for protecting themselves and others from contracting infection through unprotected sexual intercourse and / or unsterilized piercing objects.
- (f) The community has the right to information on how to protect its members from further transmission and spread of HIV/AIDS.

- (g) Communities and individuals have the right to legal protection from willful and intentional acts of spreading HIV/AIDS while safeguarding the rights of PLHAs and other affected members by providing counseling and social support.
- (h) The objectives in the national response will be most effectively realized through community based comprehensive approach which includes prevention of HIV infection, care and support to those infected and affected by HIV/AIDS and in 9 close cooperation with PLHAs.
- (i) HIV related stigma plays a major role in fuelling the spread of HIV infection. Combating stigma must be sustained by all sectors at all levels.
- (j) There should be access to acceptable and affordable diagnosis and treatment of STIs and opportunistic infections in all health facilities.
- (k) Pre – and – posttest counseling for HIV testing shall observe professional ethics, with emphasis on confidentiality and informed consent.
- (l) All linked HIV testing must be voluntary, with pre – and – post test counseling, and all testing for other health conditions must conform to medical ethics, i.e. Informed consent.
- (m) PLHAs have the right to comprehensive health care and other social services, including legal protection against all forms of discrimination and human rights abuse. However, PLHAs may be required to meet some of the cost of the Highly Active Anti Retroviral Therapy (HAART).

- (n) Research is an essential component of HIV/AIDS inter-vention, including prevention and control. Multisectoral and multidisciplinary research undertaken by various sectors shall abide by institutional sectoral research regulations.
- (o) HIV/AIDS being a social, cultural and economic problem, women and girls need extra consideration to protect them from the increased vulnerability to HIV infection in the various social, cultural and economic environments as stipulated in the National Policy on Gender and equity.
- (p) As high-risk groups play a major role in transmission of HIV, appropriate strategies shall be developed to reduce the risk of HIV infection among specific high-risk groups.
- (q) Given the vicious circle between HIV/AIDS and poverty, interventions for the control of the epidemic should be simultaneously related by poverty alleviation initiatives.

CHAPTER FOUR: IMPLEMENTATION

This chapter presents a planned and actual implementation of the project, the products and output of the project. It also presents the staffing pattern and the total estimated budget of the project.

4.1 Products and Outputs

The project was able to accomplish the following items by the end of the semester three (in a span of 18 months).

Products:

ANGAZA PEER EDUCATION CENTRE members got the knowledge and skills on;

- Bookkeeping,
- feasible and viable leadership structures,
- diversified income generating activities,
- Monitoring and evolution systems.
- 340 People participated in Voluntary counseling and testing (VCT) at Kigamboni Health Centre as shown below;.

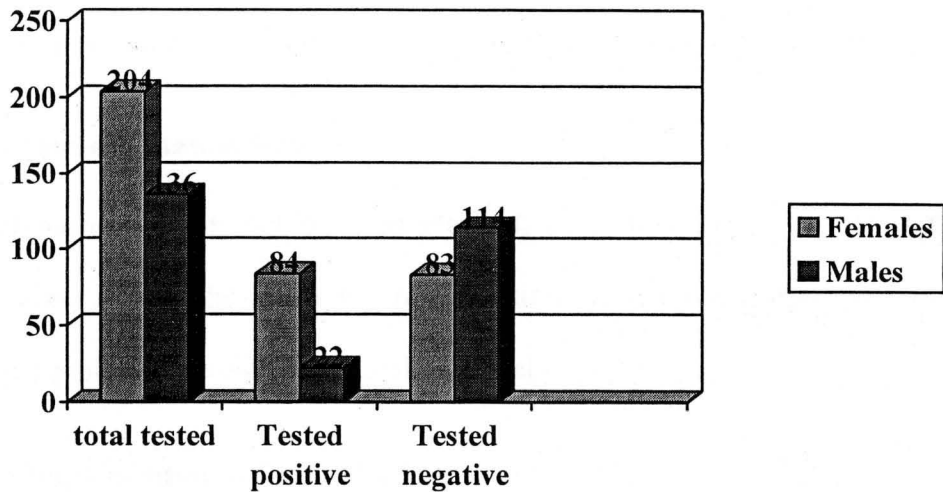


Figure 1: Females and Men tested HIV/AIDS in Kigamboni area

Outputs:

- 100 members of ANGAZA PEER EDUCATION CENTRE trained on Bookkeeping
- 50 new identified income generating activities
- 50 group leaders trained on leadership
- 10 samples of Monitoring and Evaluation (ME) systems developed.

4.2 Project Planning

The project was planned to last for 15 months, and it carried out the following list of activities; twenty seminars on use of drug abuse and gender issues, established a network specifically for fighting against HIV/AIDS called “UMADUKI” (*Umoja wa Asasi Zisizo za Kiserikali dhidi ya Ukimwi Kigamboni*), mobilization and sensitization on the importance of VCT, conducted five popular theatres and video show on education of

HIV/AIDS, dissemination of information materials on HIV/AIDS, participatory monitoring and evaluation (See table 10).

4.3 Project Implementation Report

The project carried out its activities as planned, however other resources were not adequately met, and as the result the planned timeframe for accomplishment of all activities was prolonged to eighteen months (See table 11).

4.4 Project Implementation Gantt chart

All project tasks as planned were listed, organized, and scheduled into phases, the planning activity using Gantt Chart was done through estimation of the starting date of the project, general working times and duration, thereafter listed activities were organized in a hierarchy, and finally tasks were scheduled into start to start and start to finish criterion (see appendix 4).

4.5 Budget

The general budget of the project was Tsh 2,000,000/= whereas, amount for human resources was Tsh 800,000/=:, transportation was Tsh 500,000/=:, workshops and seminars was Tsh 300,000/= and other direct costs was Tsh 400,000/= (see appendix 3).

4.6 Staffing Pattern

A staffing plan included leaders of “APEEC” and other stakeholders outside the organization with their specific duties (See table 9).

Table 9: Staffing Pattern

TITLE	JOB DESCRIPTION	SUPERVISORY ROLE
Technical advisor(CED Practitioner)	Project coordinator	Supervise adherence of the work plan
APEEC leaders	Mobilize Community Members and organize all activities to be executed	Ensure availability of community member at the right time as planned.
Stakeholders(AMREF, Central And Local Government leaders, KYC (KIGAMBONI YOUTH CENTRE),PATH FINDER International, Foundation For Civil Society, religious and traditional Leaders &APECC Members	Carry out their specific duties	Ensure stigmatization and discrimination environment free to people living with HIV/AIDS (PLHAs).

Table 10: Project planning; Overall goal of the project was to reduce the rate of new infections of HIV/AIDS in Kigamboni area.

Activities	Project month			Resources needed.	Person/group of people organ Responsible
	1-4	5-11	12-15		
Conducting 20 seminars on use of drug abuse and gender issues.				Stationeries , money for allowances (transport & meal allowance) and venue	Youth, Local community councilors, Local Kigamboni Street leaders, traditional customer leader (<i>Makungwi</i>) & CED Practitioner
Established a network specifically for fighting against HIV/AIDS called "UMADUKI" (<i>Umoja wa Asasi Zisizo za Kiserikali dhidi ya Ukimwi Kigamboni</i>)					Motomoto group, KYC, ANGAZA, Ngurumo group, YAC & Home gardeners grup
Mobilization and sensitization on the importance of VCT					Kigamboni Health Centre, Youth, Local community councilors, Local Kigamboni Street leaders, traditional customer leader (<i>Makungwi</i>) & CED Practitioner
To Conduct 5 popular theatres and video show on education of HIV/AIDS					Youth, Local community councilors, Local Kigamboni Street leaders, traditional customer leader (<i>Makungwi</i>). & CED Practitioner
Dissemination of information materials on HIV/AIDS					
Participatory monitoring				Funds and Human resources.	AMREF, ANGAZA and Pathfinder's officials. Youth, Local community councilors,
Participatory evaluation				Stationeries & Funds	Local Kigamboni Street leaders, traditional customer leader (<i>Makungwi</i>) & CED practitioner.

Table 11: Project implementation report

Study Objective	Activities	Resources	Unmet resources	Time frame(Project month)	
				Planned	Actual
To assess the impact of education on VCT and educational materials disseminated to community members in Kigamboni.	i) Conducting 20 seminars on use of drug abuse and gender issues. ii) Established a network specifically for fighting against HIV/AIDS called "UMADUKI" (<i>Umoja wa Asasi Zisizo za Kiserikali dhidi ya Ukimwi Kigamboni</i>) iii) Mobilization and sensitization on the importance of VCT iv) To Conduct 5 popular theatres and video show on education of HIV/AIDS v) Dissemination of information materials on HIV/AIDS.	Stationeries, money for allowances (Transport & meal allowance) and venue	Inadequate financial resources	1-4	1-6
	vi) Participatory monitoring	Funds & human resources	Inadequate financial resources	5-11	7-14
	vii) Participatory evaluation	Stationeries, Funds for Transport & meal allowance	Inadequate financial resources	12-15	13-18

CHAPTER FIVE: MONITORING, EVALUATION AND SUSTAINABILITY

This chapter presents detailed information on participatory monitoring and evaluation. Both monitoring and evaluation were participatory in the sense that it involved member of APEEC and other stakeholders outside the APEEC. It also, presents information on the aspect of sustainability elements, institutional sustainability and sustainability plan. Monitoring and evaluation questions were used in the process respectively.

5.1 Participatory monitoring

Insiders and outsiders were involved in preparing a participatory monitoring system. Outsiders were ANGAZA officials, Pathfinder officials, AMREF, TACAIDS, PASADA & SHIDEFA⁺, Political party leaders namely *Chama Cha Mapinduzi* (CCM) and CUF Civic United Front whereas the insiders were members of APECC.

Representative sample

Due to time constraint a sample of 30 people chosen at random out 100 people chosen during the Community Needs assessment was used during the evaluation process.

Step 1: Reasons for monitoring

APECC members discussed whether participatory monitoring could help them or not in the course of implementing the project. The main reasons for monitoring were as follows;

- To see if the project was on track as planned, that is an ongoing picture of the project so that they could make decisions either to continue or make some rectifications.

- To see if human resources and other non-human resources were adequate as anticipated and are used efficiently in the course of project implementation.

Step 2: Objectives and activities

All insiders & outsiders did reviewing of the project goals, objectives and activities.

Step 3: Monitoring questions

The following questions were used to gather information during the participatory monitoring process;

1: What is your gender?

i) Male ii) Female

2: How many training package on Voluntary Counseling and Testing (VCT) have you received so far?

i) One ii) Two iii) Three

3) Have you understood the importance of using condoms during sexual intercourse?

i) Yes ii) No

4) Have you received the materials on controlling the spread of HIV/AIDS?

i) Yes ii) No

5) After receiving training on behavioral change how many partners do you have now?

i) One ii) Two iii) More than two

Step 4: Direct and indirect indicators

The direct and indicators which were used during the participatory monitoring process have been summarized in the table below;

Table 12: Direct and Indirect Indicators

Question number	Indicators
2	Number of training packages
3	Number of condoms distributed
4	Number of information materials disbursed
5	Number of partners

Step 5: Information gathering tools

Tools that were used during the participatory monitoring process;

- Kigamboni Health center records
- Focus group discussion
- Structured interview

Step 6: Person / organization did the monitoring

The following people participated during the participatory monitoring process;

- APECC members
- CED practitioner
- Officials from the AMREF, PASADA, SHIDEPHA⁺, Pathfinder International and ANGAZA

Step 12: Combined results presentation for all information gathering tools

Table 13: Gender of respondents * Use of condoms Crosstabulation

Gender of respondents		Use of condoms		Total
		Yes	No	
Male	Count	14	1	15
	Expected Count	14.0	1.0	15.0
	% within Gender of respondents	93.3%	6.7%	100.0%
	% within Use of condoms	50.0%	50.0%	50.0%
Female	Count	14	1	15
	Expected Count	14.0	1.0	15.0
	% within Gender of respondents	93.3%	6.7%	100.0%
	% within Use of condoms	50.0%	50.0%	50.0%
Total	Count	28	2	30
	Expected Count	28.0	2.0	30.0
	% within Gender of respondents	93.3%	6.7%	100.0%
	% within Use of condoms	100.0%	100.0%	100.0%

Generally both males and females have changed their behaviors toward use of condoms during sexual intercourse. Their proportion was same that is 93.3% (See table 13).

Table 14: Gender of respondents * Number of training packages of VCT Crosstabulation

Gender of respondents		Number of training packages on VCT			Total
		One	Two	Three	
Male	Count	0	1	14	15
	Expected Count	.5	2.5	12.0	15.0
	% within Gender of respondents	.0%	6.7%	93.3%	100.0%
	% within Number of training packages of VCT	.0%	20.0%	58.3%	50.0%
Female	Count	1	4	10	15
	Expected Count	.5	2.5	12.0	15.0
	% within Gender of respondents	6.7%	26.7%	66.7%	100.0%
	% within Number of training packages of VCT	100.0%	80.0%	41.7%	50.0%
Total	Count	1	5	24	30
	Expected Count	1.0	5.0	24.0	30.0
	% within Gender of respondents	3.3%	16.7%	80.0%	100.0%
	% within Number of training packages of VCT	100.0%	100.0%	100.0%	100.0%

Overall, majority of males and females have received more than one training on Voluntary counseling and testing. However, the proportion of males was 58.3% greater than 41.7% of females (See table 14).

Table 14: Gender of respondents * Materials on control of spread of HIV/AIDS Crosstabulation

Gender of respondents		Materials on control of spread of HIV/AIDS		Total
		Yes	No	
Male	Count	14	1	15
	Expected Count	14.0	1.0	15.0
	% within Gender of respondents	93.3%	6.7%	100.0%
	% within Materials on control of spread of HIV/AIDS	50.0%	50.0%	50.0%
Female	Count	14	1	15
	Expected Count	14.0	1.0	15.0
	% within Gender of respondents	93.3%	6.7%	100.0%
	% within Materials on control of spread of HIV/AIDS	50.0%	50.0%	50.0%
Total	Count	28	2	30
	Expected Count	28.0	2.0	30.0
	% within Gender of respondents	93.3%	6.7%	100.0%
	% within Materials on control of spread of HIV/AIDS	100.0%	100.0%	100.0%

Majority of males and females received reading materials on control of spread of HIV/AIDS pandemic. Their proportion was the same that is 93.3%(See table 14).

Table 15: Gender of respondents * Number of partners Crosstabulation

Gender of respondents		Number of partners		Total
		One	Two	
Male	Count	13	2	15
	Expected Count	13.5	1.5	15.0
	% within Gender of respondents	86.7%	13.3%	100.0%
	% within Number of partners	48.1%	66.7%	50.0%
Female	Count	14	1	15
	Expected Count	13.5	1.5	15.0
	% within Gender of respondents	93.3%	6.7%	100.0%
	% within Number of partners	51.9%	33.3%	50.0%
Total	Count	27	3	30
	Expected Count	27.0	3.0	30.0
	% within Gender of respondents	90.0%	10.0%	100.0%
	% within Number of partners	100.0%	100.0%	100.0%

Generally, majority of males and females changed their behaviors toward the number of partners. Majority had only one partner; however, the proportion of females was 51.9% greater than 48.1% of females(See table 15).

5.2 Participatory evaluation

Evaluation was summative in the sense that both outsiders and insiders participated in planning on what could be evaluated, how the evaluation would be conducted, how results would be analyzed and presented. Nonetheless, the insiders took responsibility and control of the whole process supported by outsiders. The following steps were used during the process.

Step 1: Review of objectives and activities

The APECC members who were insiders and outsiders reviewed the objectives and activities.

Step 2: Review of reasons for evaluation

Both insiders and outsiders discussed the reasons for evaluation. The main reason of summative evaluation was to see whether the project achieved its objectives.

Step 3: Evaluation questions

1: What is your gender?

i) Male ii) Female

2: Have you applied the knowledge you have acquired on Voluntary Counseling and Testing (VCT)?

i) Yes ii) No

3) Have you started applying condoms during sexual intercourse?

i) Yes ii) No

4) Have you read and understood the materials you have received on controlling the spread of HIV/AIDS?

i) Yes ii) No

5) Have you understood now the importance of having one partner?

i) Yes ii) No

Step 4: People/ organization did the evaluation

The following people organization participated in carrying out the evaluation process;

- APECC members
- CED practitioner
- Officials from the AMREF,PASADA,SHIDEPHA⁺ ,Pathfinder International and ANGAZA

Step 5: The following were the either direct or indirect indicators for each question during the participatory evaluation process;

Table 16: Direct and Indirect indicators

Question number	Indicators
2	Application of knowledge
3	Use of condoms
4	Behavioral change
5	Behavioral change

Step 6: Information gathering tools

Information, which was used during the participatory evaluation, was obtained from either of the following sources;

- Structured interview
- Kigamboni Health centre records
- APECC weekly record

Step 7: Skills that were used during the participatory evaluation are;

- Interviewing skills
- Mentoring skills

Step 8: Information gathering and analysis time frame

The evaluators gathered information as planned before, that is at the end of the life span of the project.

Step 9: People who gathered information

The following people /or group of people were responsible with gathering of information;

- APECC members
- CED practitioner
- Officials from the AMREF,PASADA,SHIDEPHA⁺ ,Pathfinder International and ANGAZA

Step 10: Combined results presentation for all information gathering tools.

Table 17: Gender of respondents * Application of VCT knowledge Crosstabulation

Gender of respondents		Application of VCT knowledge		Total
		Yes	No	
Male	Count	14	1	15
	Expected Count	14.0	1.0	15.0
	% within Gender of respondents	93.3%	6.7%	100.0%
	% within Application of VCT knowledge	50.0%	50.0%	50.0%
Female	Count	14	1	15
	Expected Count	14.0	1.0	15.0
	% within Gender of respondents	93.3%	6.7%	100.0%
	% within Application of VCT knowledge	50.0%	50.0%	50.0%
Total	Count	28	2	30
	Expected Count	28.0	2.0	30.0
	% within Gender of respondents	93.3%	6.7%	100.0%
	% within Application of VCT knowledge	100.0%	100.0%	100.0%

Generally, majority of males and females have started applying the knowledge on VCT.

Their proportion was the same that is 93.3% (See table 17).

Table 18: Gender of respondents * Application of condoms Crosstabulation

Gender of respondents		Application of condoms		Total
		Yes	No	
Male	Count	14	1	15
	Expected Count	14.0	1.0	15.0
	% within Gender of respondents	93.3%	6.7%	100.0%
	% within Application of condoms	50.0%	50.0%	50.0%
Female	Count	14	1	15
	Expected Count	14.0	1.0	15.0
	% within Gender of respondents	93.3%	6.7%	100.0%
	% within Application of condoms	50.0%	50.0%	50.0%
Total	Count	28	2	30
	Expected Count	28.0	2.0	30.0
	% within Gender of respondents	93.3%	6.7%	100.0%
	% within Application of condoms	100.0%	100.0%	100.0%

Majority of females and males have started using condoms during sexual intercourse.

Their proportion was the same that is 93.3%(See table 18).

Table 19: Gender of respondents * Understood the VCT materials Crosstabulation

Gender of respondents		Understood the VCT materials		Total
		Yes	No	
Male	Count	14	1	15
	Expected Count	14.0	1.0	15.0
	% within Gender of respondents	93.3%	6.7%	100.0%
	% within Understood the VCT materials	50.0%	50.0%	50.0%
Female	Count	14	1	15
	Expected Count	14.0	1.0	15.0
	% within Gender of respondents	93.3%	6.7%	100.0%
	% within Understood the VCT materials	50.0%	50.0%	50.0%
Total	Count	28	2	30
	Expected Count	28.0	2.0	30.0
	% within Gender of respondents	93.3%	6.7%	100.0%
	% within Understood the VCT materials	100.0%	100.0%	100.0%

Majority of males and females have ready and understood the voluntary counseling and testing materials they have received. Their proportion was the same that is 93.3%(See table 19).

Table 20: Gender of respondents * Importance of one partner Crosstabulation

Gender of respondents		Importance of one partner		Total
		Yes	No	
Male	Count	14	1	15
	Expected Count	14.0	1.0	15.0
	% within Gender of respondents	93.3%	6.7%	100.0%
	% within Importance of one partner	50.0%	50.0%	50.0%
Female	Count	14	1	15
	Expected Count	14.0	1.0	15.0
	% within Gender of respondents	93.3%	6.7%	100.0%
	% within Importance of one partner	50.0%	50.0%	50.0%
Total	Count	28	2	30
	Expected Count	28.0	2.0	30.0
	% within Gender of respondents	93.3%	6.7%	100.0%
	% within Importance of one partner	100.0%	100.0%	100.0%

Majority of males and females have understood the importance of having only one partner. Their proportion was the same that is 93.3%(See table 20)

5.3 Sustainability

The Project identified the following sustainability elements that in one way or another may affect the attainment of APEEC's Vision and feasibility of the Project are; continuum of ignorance about HIV/AIDS in Kigamboni area, inadequacy of financial resources for execution of various activities, extreme poverty among community members of Kigamboni

Nevertheless, for a Project to be sustainable there is a need of continuing mobilizing financial resources from various donors. Additionally, mainstreaming people living with HIV/AIDS into development projects.

Of late “APEEC” has made some progress on soliciting funds for sponsoring the continuing project activities from Tanzania Social Action Fund (TASAF), the fund has promised to offer financial support in a form of grant from now onward up to December 2008.

This project will be sustainable following the knowledge on control of HIV / AIDS imparted to males and females in Kigamboni area. However, the presence of voluntary counseling and testing practitioners at Kigamboni Health Centre guarantees the sustainability of the project

CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

This chapter presents detailed information on full and partial achievement of the overall objective of the project, which aimed to reduce the spread of HIV/AIDS pandemic in Kigamboni area. It also presents the way forward on combating the spread of HIV/AIDS pandemic. Generally the project partially achieved its overall objective.

6.1 Conclusion

The stigma surrounding HIV has resulted in attempts by people and communities to ease their fears by perceiving certain “other” groups to be “at risk” rather than considering the possibility of acquisition through their own behaviors. When socially distanced from the threat in this way, people are less likely to change their behaviors such as by adopting safer sex practices. Furthermore, if the environment is not favorable to behavior change overall, then simply adopting preventive measures serve as indication of possible infection and invites discrimination.

Testing and counseling have also been shown to aid prevention. For example, people who received positive test results in Kigamboni started to take measures to prevent transmission to others and begun to seek appropriate treatment. It has also been pointed that when people receive a negative test result but confront important issues through counseling they will reduce their high-risk behaviors; evidence for this behavior change is mixed and a recent review of testing and counseling studies found no significant effect. Yet when persistent stigma and discrimination exist, concerned individuals feel reluctant to be tested due to fears of discriminatory repercussions. If s/he realizes that a

positive test result will result in isolation, harassment, loss of employment, and denial of health services, for example, then a person fearing that s/he may have been infected in the past will prefer to remain in ignorance, especially in circumstances where confidentiality cannot be ensured. The anticipation of "... blame may lead to continued high incidence, as those who are really infected do not come forward, are not identified, and therefore continue to transmit the virus".

Finally, the stigma surrounding HIV-*associated* behaviors such as drug use or certain sexual practices also pose barriers to successful prevention. Implementation of "harm reduction" measures such as condom provision for both male and female sex workers, needle exchanges, and detailed sex education for adolescents may prove impossible due to fears that they promote behaviors that remain socially unacceptable.

6.2 Recommendations

Being in the project study had come to the following substance recommendations.

- Government leaders of the City of Dar es Salam need to take initiatives to combat the spread of the HIV/AIDS in Kigamboni area by introducing Public lectures on HIV/AIDS. Public Health extra campaign from family level to Ward and to a division level that people can enquire satisfactory knowledge of the killer disease, through either direct its institution or through different donors and NGOs.
- Government should implement good services to Kigamboni area. i.e proper infrastructure, ferry system as to improve living standard so that poverty can be

eradicated, hence combat the prostitution among female to control the spread of HIV/AIDS.

- Government should put on emphasis regulations to the Beach hotels owners and any other who hold tourism industry in Kigamboni area to contribute economic development of the area by employing the Kigamboni people as first priority.
- Government should put an emphasis to the owners of Tourism industries as whole to follow and observe the African values to the area in order to protect the youth of Kigamboni not to be absolved by the foreign cultures hence left forgot their origin.
- Government should put emphasis on introduction of HIV/AIDS education to Primary schools, secondary schools, colleges and Higher Institutions of Kigamboni so that to penetrate the awareness of the killer disease in the area.
- People should accept the challenges of the behavioral change in daily living, especially in sexual relations, having only one-partner or use safe tools for sex relations.
- Fishermen such as Kojani people should stay one place as a permanent residence, not moving from one place to another, more over should get permanent marriage in order to stop divorced marriages, which could stop the spread of HIV/AIDS.
- The Military Authority in Kigamboni should conduct several HIV/AIDS seminars, workshops, counseling and any other trainings concerned to spread the knowledge and awareness of the disease to among soldiers of that area.

- Emphasis also to be made for decision makers (politicians and Government officials) to be part and parcel on the ongoing awareness campaign by making the talk, like what has been shown by His Excellence Jakaya Mrisho Kikwete President of the United Republic of Tanzania. This will definitely inculcate the HIV/AIDS education to the community.

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