



**Communities in Need:
HIV/AIDS Programs
Needs Assessment for
Babati District**

Support for International Change

Babati District, Manyara Region, Tanzania

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Table of Contents

I. Executive Summary _____	3
II. Acronyms _____	5
III. Introduction _____	5
IV. Methods _____	6
V. Results _____	9
HIV Education	9
Schools and Peer Education	9
Condoms	10
Voluntary Counseling and Testing	11
Stigma	13
High Risk Groups	14
People Living with HIV/AIDS	15
Other Organizations	17
Health Care Facilities	19
VI. Programmatic Implications _____	20
Education/Awareness Campaigns	20
Peer Education	21
Voluntary Counseling and Testing	21
Home-based Care Program	22
Additional Program Opportunities	23
VII. Strengths and Opportunities _____	24
VIII. Conclusions _____	25
IX. Appendices _____	26
Appendix A: Babati Stakeholders' Meeting Notes – Swahili	26
Appendix B: Leader Key Informant Interview Questions	37
Appendix C: Health Care Provider Key Informant Interview Questions	38
Appendix D: Informal Interview Notes	39
Appendix D: General Community Focus Group Questions	47
Appendix E: PLWHA Focus Group Questions	48
Appendix F: Teacher Focus Group Questions	50
Appendix G: Student Focus Group Questions	52

I. Executive Summary

Support for International Change (SIC) conducted a district-wide HIV/AIDS needs assessment in seven purposively selected wards from all four divisions throughout Babati District in February and March 2008. The objective of this study was to identify service gaps and potential challenges in HIV service provision in the rural, semi-urban, and urban wards of Babati District and subsequently use the results to inform SIC's program design and implementation.

Methods included 39 focus group discussions with general community members, people living with HIV/AIDS, teachers, and students; informal interviews with district level government officials; key informant interviews with NGOs, government officers and workers, community volunteers, health care providers, division and ward leaders; and a district-wide stakeholders' meeting. The general community member focus group discussions were divided by gender and age class.

Lack of HIV/AIDS Education in the General Community

Every focus group, rural to urban, reported that while they knew that AIDS exists, it kills, and there is no cure, they did not know how to protect themselves from HIV. Most people did not trust that condoms were an effective way to reduce the risk of HIV transmission and justified their distrust with inaccurate beliefs. The source of most of their education derived from media such as television, radio, and magazines. People felt they had nowhere to interactively ask questions regarding HIV/AIDS. Although this lack of knowledge encouraged fearful and stigmatizing attitudes toward PLWHA, most were eager to learn more about HIV if they had the opportunity.

Broken Communication Between Parents and Children

An information gap exists between parents and their children in regards to HIV/AIDS and reproductive health education. Most parents did not feel comfortable with their knowledge base to give advice to their children, especially regarding reproductive health. In the general community focus groups, a few parents reported to scare their children about HIV in hopes that they will choose to be abstinent. If this information was discussed in the home, parents and children were split based on gender. The youth admitted that it was not easy to discuss sexuality or health issues with their parents.

Positive Support for School-based Peer Education Programs

There was unanimous support for HIV education to be incorporated into the school system. Schools admitted to dedicating less than an hour a year to HIV education, if they taught it at all. Teachers stated that they did not feel that they knew enough about HIV to comfortably teach the material. Both students and teachers stated they were motivated to dedicate time and energy into creating a peer education program. There was some disagreement over the proper grade-level to start a PE program, but everyone approved all secondary school levels.

Riding the Wave of the National Testing Campaign

The National Testing Campaign has greatly increased the amount of resources the district government has allocated to promoting voluntary testing and counseling. While the number of people who were tested in the second half of 2007 drastically increased from previous years, the district hospital outreach team is

targeting the same locations routinely. Both leaders and the general public perceive the proportion of people who have previously tested to be small. People attribute this to fear, a lack of knowledge about the benefits of knowing your status, and stigma. Although VCT services may be provided in some of the local clinics, many people said that they preferred not to get tested at a location where they recognized the counselor.

Potential Collaboration with PLWHA Support Groups

Two central PLWHA support groups, Upendo Group and WAVIBA+, have large constituencies in Babati town and have rural branches in wards throughout the district. While these organizations have limited capacity to provide services, they are a great network for collaboration and introduction into the local community of PLWHAs. They identified themselves as ideal candidates for Home-based Care Providers and their highest priority concerns were nutritional and financial support.

Large Barrier of Stigma in Rural and Urban Areas

The clear lack of knowledge about HIV/AIDS in the district, leads to high levels of stigma and misinformation surrounding the disease. The general community and PLWHA unanimously agreed that the most prominent reason for hiding HIV positive status is because people are scared to get ostracized from their community, family, and friends. The attitudes of the community are reflected in the dependency of PLWHA to rely on outside support to provide basic needs.

Limited capacity for local NGOS

There is a disconnection between what organizations report they are doing, what the leaders are kept informed of, and the accessibility and marketing of services to community members. Most local organizations are limited to Regional Facilitating Agency funding, which is unreliable and not sustainable. These organizations need to build their capacity to secure outside funding or combine resources to be able to increase their impact on HIV/AIDS in Babati.

Programmatic Implications

The information gained in this assessment will directly impact SIC's program design and implementation the following areas: 1) every ward, from urban to rural, is in need of an educational awareness campaign. All leaders from governmental to religious to traditional should be involved in the process to increase impact and accessibility. Parents should be included in their children's education when possible. 2) There are no sustainable peer education programs existing in the schools. Secondary schools should be the top priority and teachers are motivated to take ownership with proper training. 3) There is a high demand for mobile VCT services. A partnership between the district VCT team and SIC is ideal, to diversify the testing locations targeted monthly and improve the quality of counseling. Using HBCPs will increase the number of testing opportunities and turnouts especially for the home-based VCT. 4) A recent partnership between Pathfinder International, SIC and the district government gave birth to a Home-based Care program in Mamire, Gallapo, and Magugu. 30 Home-based Care Providers were recently trained from these wards and will begin work in May. SIC will monitor their progress monthly as well as assist them with additional resources such as bicycles and transport reimbursements. 5) SIC will facilitate a monthly mobile CTC in Magugu and Gallapo due to the large patient concentrations and significant distance from Mrara Hospital.

II. Acronyms

ARV – Anti-Retroviral
CBO – Community-based Organization
CTC- Care and Treatment Center
CHW – Community Health Worker
DACC – District AIDS Community Coordinator
FBO – Faith-based Organization
FGD – Focus Group Discussion
HBC – Home-based Care
HBCP- Home-based Care Provider
MOI – Medical Officer In-charge
NGO – Non-governmental Organization
NTVCT – National Trainer of Voluntary Counseling and Testing
OI – Opportunistic Infection
OM – Older Men Focus Group
OW – Older Women Focus Group
PLWHA – People Living with HIV/AIDS
RFA – Regional Facilitating Agency
SIC – Support for International Change
STI – Sexually Transmitted Infection
VCT – Voluntary Counseling and Testing
VEO – Village Executive Officer
WEO – Ward Executive Officer
YM – Young Men Focus Group
YW – Young Women Focus Group

III. Introduction

Support for International Change (SIC) is a nongovernmental organization registered in the US, the UK, and Tanzania. SIC provides a comprehensive package of HIV/AIDS services in both Meru and Arusha Rural Districts. Within our current model, we enter into a ward with a volunteer-driven awareness campaign for 5-6 weeks. Volunteers educate rural communities about HIV prevention, promote HIV testing, and teach life skills in local schools. Following the campaign SIC creates peer education programs in secondary schools and 'Fight HIV' clubs in primary schools to sustain the education initiated by the volunteers. SIC also implements a community-based Community Health Worker (CHW) program that works at a village level to provide HIV education, create testing opportunities, and provide support for PLWHA. In combination with all these services, SIC provides mobile voluntary counseling and testing (VCT) at least monthly in each ward.

In 2008, SIC expanded into Babati District in Manyara Region, a primarily rural district centered on the fork of two major trucking routes and featuring a high-density of guesthouses, a risk factor in the spread of HIV. SIC conducted this assessment for the purpose of understanding the current state of HIV/AIDS and the services provided in the district. Through this assessment, we hoped to identify service gaps and potential challenges in HIV service provision in both the rural and urban wards of Babati District and subsequently use the results to inform SIC's program design and implementation.

IV. Methods

Sample size and selection

We *purposively* selected one ward to assess from each of the four divisions of Babati District and two additional wards from the Babati Town Council specifically as well as Babati Town Ward. The Babati district government identified four of the selected wards as the highest priority sites for HIV services. We also included Babati Town Ward and two very rural wards selected by the division leaders. In each ward, we used a combination of tools to assess the needs of that community, with a focus on the general community, teachers, students or peer educators, and PLWHA. Key informant interviews were used to target local leaders, dispensary or clinic staff, and other NGOs. Relevant NGOs, government officials, and known patient support groups were assessed regardless of their location.

From each of these wards we randomly selected two villages, one central village and one remote village to target unless all of the villages were homogenous in which case we only targeted one village, giving us a total sample size of 12 villages (four in the Town Council and eight in Babati District). In the case of the general public, we asked ward leaders to recruit five individuals from each category (young men, young women, adult men, and adult women) from each of the two villages. Within these groups, we requested that half of the group have some formal education and half of the group not have formal education. There were occasionally a few people from neighboring villages that participated.

We classified the seven selected wards into *urban*, within Babati town borders, *semi-urban*, along a major access road, and *rural*, at least 5km off a major access road (see Table 1). The assessment team was centrally located in Babati Town and entered the target ward daily by truck.

Table 1. Participant breakdown for both FGD sessions and interviews into urban, semi-urban, and rural wards.

Group Type	Urban		Semi-Urban		Rural	
	# of Groups	# of Participants/ Interviewees	# of Groups	# of Participants/ Interviewees	# of Groups	# of Participants/ Interviewees
General	3	27	16	167	8	73
PLWHA	2	15	2	15	-	-
Primary Teachers	1	10	-	-	-	-
Secondary Teachers	1	10	1	4	1	8
Primary Students	1	8	-	-	-	-
Secondary Students	1	10	1	6	1	8
Division Leaders	1	1	1	2	1	1
Ward Leaders	1	2	4	8	2	4
Health Providers	1	3	1	1	1	2
TOTAL	12	86	26	203	14	96

Tools

Stakeholders Meeting

All the current stakeholders involved in HIV/AIDS programs in Babati District were invited to a meeting in Babati town. The stakeholders were identified through the Regional Facilitating Agency (RFA) and through word of mouth. Each NGO, FBO or Community-based organization (CBO) was asked to send a representative to the meeting. The meeting was designed to introduce SIC and identify the goals, strengths, weaknesses, and potential collaboration opportunities for all HIV-related organizations in Babati (see Appendix A). Notes from this meeting were shared back to all of the 20 stakeholders who attended within a week of the meeting.

Key Informant Interviews

This method targeted NGOs, government officers and workers, community volunteers, health care providers, division and ward leaders. Each respondent answered a variety of questions from a standard question list depending on their field of work. The questions were designed to extract information about their experience and knowledge of service provision in this area (see Appendices B and C). The interviews took 30-60 minutes. Higher level district officials and a few NGOs were interviewed in October 2007 and this information was considered in the assessment, but their interviews were less structured (Appendix D).

Focus Groups

This method targeted PLWHA, peer educators, students, teachers (excluding head teachers), male and female youth (ages 18-30), and male and female adults (ages 31-60). By inviting ten participants to each group, we attempted to get a range of 8-12 participants. In total, 30 PLWHA, ten primary school teachers, 21 secondary school teachers, eight primary school students, 23 secondary school students, and 267 general community members participated in their appropriate focus group discussion (FGD). In order to assess the comparability and viability of the information collected, demographic information was taken anonymously from each participant (see Table 2 and 3). The FGDs were designed to answer questions in the following categories: HIV education, schools and peer education, condoms, Voluntary Counseling and Testing, stigma, people living with HIV/AIDS (PLWHA), other organizations, and the quality of local health care facilities.

Table 2. Focus group composition.

Type of Group	# of Focus Groups Held	Average # of Participants per Group	Average Age per Group	Average % female
General Community	27	10	36.2	50.2
PLWHA	4	7.8	30.2	59.3
Teachers - Secondary	3	7.3	30	65.8
Teachers - Primary	1	10	41	90
Students - Secondary	3	8	17	46.7
Students - Primary	1	8	14.1	50
TOTAL	39	8.5	28.1	60.3

Table 3. A summary of the general community demographics.

Total number of participants		267
Average number of participants in each group		10
Average Age (years)	Older Women	42.7
	Older Men	52.6
	Younger Women	25.2
	Younger Men	24.6
Religion (percentage)	Christian	58.0
	Islamic	40.5
	Other	1.6
Average Number of Children	Older Women	5.3
	Older Men	7.1
	Younger Women	1.6
	Younger Men	1.4
Average education level (std)	Older Women	4.5
	Older Men	5.2
	Younger Women	7.5
	Younger Men	7.2

A facilitator administered the questions, and two note takers recorded the responses. The group was presented with eight to ten questions and discussion was encouraged with standard prompts (see Appendices E–H). Each question had a unique theme. If the question had multiple parts, each section of the question was given individually and discussion recorded. The FGD took 45 minutes to an hour and participants were given soda for their cooperation. In the case of the general community FGD sessions, participants were given lunch and a soda or the money equivalent, as they were required to wait until all four groups have finished to be returned back to their village. To avoid the future expectation of payment, the terms of compensation were explicitly discussed at the beginning of each group. However, this still proved to be a problem in Mamire Ward.

Administration

The SIC District Manager, Erica Mackey, and Assistant District Manager, Raphael Robert, administered this assessment. An additional note taker was hired from Upendo Group for many of the sessions. After the first session, we asked him to remain quiet about his affiliation with the PLWHA support group as it could have potentially affected the results. A sub-goal of this assessment is for SIC to personally enter into potential communities and begin a working relationship. For this reason, it was preferential to involve permanent staff members in administering the assessment.

Limitations

A couple of noteworthy factors arose in administering the assessment tools. In many of the general FGD sessions, a leader of a support group was hired as a note taker. In two cases in Mamire, a participant recognized him and knew his HIV-positive status, which may have skewed our results for those two general groups. In both Magugu and Gallapo, one of the general focus groups had a positive support group member as a participant, which also may have affected the opinions expressed in the group. Additionally, multiple people collected the participant information. It is difficult to know if this changed the participants' responses to questions like education level or openness to answer questions such as marital status.

V. Results

General HIV Education

Although many organizations identified our selected sites as areas in which they work, the lack of HIV/AIDS education in the community and in the school system was very apparent. When first asked if they thought that their community knows about HIV/AIDS, everyone said definitely. However when prompted for the depth of their knowledge, nearly all of the groups knew only that HIV exists, it kills, and there is no cure. These facts alone made many people terrified of interacting with PLWHA, which in turn promoted stigma.

Most people received their education from the media such as the radio, television, and magazines, as well as religious centers like mosques and churches. People from almost every ward said they got information from the government leaders at village and ward meetings, but all of the leaders said they needed more education. Only a small number of people mentioned that they had attended a seminar about HIV from the district or an outside organization (Mamire and Magugu). When asked if other organizations had come to their village or ward to teach, the large majority said either that nobody had come or that an organization had come once or twice, but years ago (see OTHER ORGANIZATIONS). Magugu and Mamire Wards were the areas most visited by outside organizations, but still almost every group admitted to being unsure about modes of transmission and common myths. One group in Mamire unanimously agreed that condoms cause fungus.

The majority of people could not identify a single place to go and ask a question about HIV. A few older women suggested the clinic as the appropriate location for pregnant women. Some of the older men from the rural wards of Ufana and Duru said that only the women had the chance to ask questions, and they confirmed that they did this at the weekly women's clinic at the Ufana and Duru Dispensaries.

Most parents did not speak to their children about HIV/AIDS in depth. They reported to scare them about the existence of HIV and encourage them to stay abstinent. Outside of this, parents did not feel confident enough to teach their children more information. If a discussion happened at all, parents and children divided themselves based on gender. In almost all cases, reproductive health was never discussed in their households. A couple of older women laughed at the thought of fathers talking to their children about these issues.

Overall, people were eager to learn more. We gave each group a chance to ask three questions of their own at the end of each session. This gave us an opportunity to gauge their knowledge level of HIV. Almost every group asked the same first two questions. (1) How can you be infected with HIV? (2) Can a condom really protect you from HIV? The third question varied. The uncertainty about the basics of HIV proves that education is lacking in all of the seven wards, from rural to urban.

Schools and Peer Education

There was unanimous support for HIV education to be incorporated into the school-wide curriculum. Teachers at Ndeki Secondary in Ufana mentioned that they taught about HIV in their biology classes, but that it was covered for less than an hour per year. The students from the same schools denied ever getting

any HIV education in school. Most teachers stated that they did not feel that they knew enough about HIV to comfortably teach the material.

People had mixed opinions about whether HIV education was appropriate for primary schools and at what grade level it should start. Almost all general community groups and leader groups offered the range of standard three to standard six as the starting age (ages 9-16). A heavily weighed factor was when children were old enough to understand the material. Some people in more urban settings suggested that it was more advantageous to start teaching students at younger ages. There were extremes with one younger woman from Magugu suggesting to start with standard one and one older woman in Ufana believing the best starting point with secondary school. Only a few people suggested a link between learning about HIV at an early age and immoral behavior. Generally, opinions differed within each ward, and there were no systematic differences between rural and urban settings. Most people separated HIV education from condom education, and suggested a younger age set for HIV education than for condom education (see CONDOMS).

None of the schools, primary or secondary, had pre-existing peer education programs, although some secondary schools had FEMA clubs or counseling clubs that met once a month (Babati and Magugu). The teachers of Babati Day Secondary and Babati Primary School were excited about the prospects of such a program. This excitement could be due to the expectation that they would receive payment to oversee it. One teacher commented that if there were HIV seminars for teachers, they would expect 20,000 Tanzanian shillings a day as a stipend. In other schools, the teachers suggested motivation such as t-shirts, supplies for teaching, or even beer and soda (Ufana). The activities that were suggested by teachers were fairly consistent with the activities brought forth by students and included: sports and games, playing drums and singing, choirs, drama, videos, teaching their peers in small groups, and going to other schools to teach. For these activities they suggested that they would need books and pamphlets about HIV/AIDS, supplies for sports, t-shirts, teaching supplies, and possibly a TV for showing videos. Teachers from Magugu Secondary thought the best time for peer educators to meet was Saturday or after school, although they were happy to spend that the time to help them). As for recruiting, some thought that the peer educators should be recommended by the teachers and then voted on by the students (Ufana). Other students thought the teachers should be excluded from the process altogether, and they should elect a peer-leader for each class to keep their activities organized (Magugu).

Condoms

The issues of condom education, availability and use were controversial in almost every focus group. The division and ward leaders were unexpectedly liberal in their views of condoms. They all said that it was acceptable to teach about condoms for both primary and secondary school students, but that an emphasis should be put on abstinence instead of being faithful and using condoms for primary schools. With the exception of Ufana and Mamire, all the leaders thought condom education could start with standard four or five. Some of the division leaders suggested that the parents be consulted on the issue of condoms. The Ufana Ward Executive Officer thought that because they were more rural and their tribe was more conservative, condom education should start with standard seven. The Mamire leaders suggested that if younger students heard about condoms, they would be encouraged to have sex. While the Babati Ward Executive Officer and Counselor thought that rumors of primary school students getting pregnant in their schools justified early condom education. When told

that the Tanzanian government policy started with standard four, all of the leaders agreed that if done tactfully, that would be acceptable.

General community focus groups varied quite drastically on their views of condoms. Some elders in Mamire suggested that, "children could steal money from their homes to go and buy condoms". One younger man in Babati town asked the group, "Are you telling me that kids in standard four do not get pregnant? ... Condoms help with issues outside of AIDS". Generally, people in the rural wards thought condom education should start in late primary or secondary school (Ufana and Duru). In the semi-urban and urban areas, the younger groups usually pushed for condoms to be taught earlier. (Although)

The older groups thought it should begin closer to secondary school, giving the reason that it is impossible to talk to young children about sexual issues because they will not understand or because it will encourage them to have sex earlier.

Every group knew where condoms were available. The most commonly mentioned locations were local stores or the dispensary. Many of the older women groups admitted to never having seen a condom before. One older man in Mamire summarized what many other older men groups suggested, saying "Many people do not have faith in condoms, except some younger people use them, but not us elders". Their reasoning was that they wanted more children or that condoms were immoral. There was a slight trend toward the rural wards having less information about condoms. Overall, most people admittedly do not use them, and they did not think other people in their community used them even though they were available.

The question about whether or not condoms were moral was widely debated. Again, more rural and older groups tended to believe that condoms are immoral while younger and more urban groups thought condoms were acceptable. The issue of the morality of condoms came from religious leaders. Some groups stated that they thought condoms were not immoral because the government endorsed them, but that they were immoral in the view of the church (Mamire OW and OM).

Outside of their immorality, other reasons that dissuaded people from using condoms were the rampant myths about their use. These myths included, but were not limited to, the idea that condoms come with the virus already inside, they cause fungus, they break easily, they have holes in them,, and that they decrease pleasure. Regardless of their stated views of condoms, every single person who participated in the focus groups or interviews had endless questions and curiosity about the proper use of condoms.

Voluntary Counseling and Testing

Voluntary counseling and testing (VCT) is currently the most accessible HIV/AIDS service in Babati District. The Mrara district hospital VCT team reported 33,796 people accessing VCT services in 2007 with an HIV prevalence rate of 3.4%. The large majority (83.4%) of these were tested between October and December of 2007 during the heat of the national testing campaign when the district hospital focused their resources on testing at the traveling district market. While this number greatly increased with the onset of the national testing campaign, less than 10% of the total population in Babati District were tested in 2007, and this is unrealistically assuming that everyone who tested was a new client. Internal research suggests that over half of the clients had previously tested one or more times.

When asked to identify a location to get tested, most wards listed either their local dispensary and then the district hospital or the Dareda Mission Hospital. Most community members had accurate information, although some did not know all the sites that testing was available. Leaders seem to have limited information and more misconceptions than the community about where it is available. Most misconceptions happened when people assumed testing was available at the local dispensary or health clinic (see Table 4).

Table 4. Identified VCT sites versus actual VCT sites for all seven of the targeted sites.

	Leaders	General Community	Actual
Babati (U)	Mrara Hospital, Police Mess, Red Cross, Division leader offices	Mrara, Zack Mission, Red Cross, Dispensaries	Mrara, Police Mess, Red Cross, Zack Mission Hospital
Bonga (SU)	Bonga Health Center	Mrara, Bonga Health Center, Red Cross	Mrara, Bonga Health Center, Red Cross
Gallapo (SU)	Gallapo Dispensary	Mrara, Gallapo Dispensary, Dareda Mission, Red Cross, Selian Hospital Arusha	Mrara, Gallapo Dispensary, Dareda Mission, Red Cross, Selian Hospital Arusha
Mamire (SU)	Mamire and Endakiso Dispensaries	Mrara, Mamire and Endakiso Dispensaries, village or ward office when other organizations or the district comes	Mrara, Mamire and Endakiso Dispensaries, village or ward office when other organizations or the district comes
Magugu (SU)	Magugu Health Center, Red Cross, Market when Mrara comes for VCT	Magugu Health Center, Compassion	Mrara, Magugu Health Center, Red Cross, Market when Mrara comes for VCT
Duru (Ru)	none	Duru Dispensary, Riroda Health Center, Mrara, Dareda Mission, Bonga Dispensary	Riroda Health Center, Mrara, Dareda Mission, Bonga Dispensary
Ufana (Ru)	Ufana Market when Mrara comes for VCT	Ufana Dispensary, Monthly when Haydom comes to test at the Ufana Dispensary, Bashnet Dispensary,	Bashnet Dispensary, Ufana Market when Mrara comes for VCT, Dareda Mission

Everyone, with the exception of a few people in Babati town, agreed that the number of people who have been tested is small in relationship to the population. The most common reasons that people have not been tested in the past were that people are scared and that there is no clear benefit to getting tested and knowing your status. One woman in Babati said, "I know myself that my behavior is not good, so I am scared to test".

Stigma also seemed to be a big deterrent for people to access VCT. One young woman in Mamire said "I am scared to lose my friends if I test positive". Many others said that their community would ostracize them, which was also consistent with the responses to the stigma-focused questions. Some people thought that they would die faster if they tested and learned they were positive rather than just ignoring it (Magugu).

The groups from the rural wards of Ufana and Duru were the only groups to address the issue of accessibility of VCT (Ufana OM and Duru). This indicates that for urban and semi-urban areas, education and stigma are the major barriers, whereas in rural areas accessibility is also a significant testing barrier. A few people from each semi-urban area did comment that confidentiality was an issue when people tested at the local dispensary or health clinic. In those cases,

people preferred an outside source to conduct the VCT. They considered the district hospital an outside source.

Stigma

Overall, there is clear evidence for a lack of knowledge about HIV/AIDS, which leads to high levels of stigma and misinformation surrounding the disease. All of the groups felt that many people living with HIV were hiding their status from the community. The general community and PLWHA unanimously agreed that the most prominent reason for hiding one's HIV positive status is that people are scared to get ostracized from their community, family, and friends.

i. PLWHA Concealing Their Status

Overall, many said that PLWHA are ashamed, with varying opinions on whether they should be ashamed. Those who said they should be ashamed attributed that to the idea that HIV is contracted if you are not faithful to one partner (Ufana OW and Duru OW). Many of the very rural youth agreed that it was very shameful to have HIV and that is why people hide their status (Duru and Ufana). An older man from Ufana suggested, "If we had more education, then we would probably not think it is shameful". The younger men and women from Gallapo thought that families often were ashamed of their relatives that were HIV positive. While they would be willing to care for them, they would hide their HIV status from others, indicating that family obligations and community perceptions are almost equally important. Only one older woman thought that it was not an issue of shame and she thought people should come out with their status so they could get help (Bonga OW). All the patient groups thought that there was not enough of an apparent benefit for many people to reveal their status.

Someone in every group said there are people in their community hiding their status. One woman in Gallapo summed up the views of many others by saying, "Some people hide (their status) because they want to continue to have sex and infect others". The younger men in Bonga mentioned that people were not open because they would lose their jobs, while the younger women thought that people would think you were a prostitute if you revealed your status. All general groups from Babati town and a PLWHA support group (WAVIBA+) said that many people who were hiding would not go to the hospital for medicine because they feared being recognized.

PLWHA also agreed that the amount of education was not enough to combat stigma, and there were not enough services available to make it worth the risk to advertise your status for those living with HIV (all groups). A PLWHA in Gallapo who is open about her status explained that when she walked around the village, children would scream and run.

In stark difference from the ward and village level results, the district level government leaders identified stigma as decreasing and almost non-existent. The government's measure for the decreasing stigma was the willingness of people to stand in line to get tested during the national testing campaign. This might not be the best indicator in this case.

ii. Interacting with PLWHA

Many people revealed that they were not comfortable interacting with someone outside of their families that had HIV (Babati and Bonga). Some of their reasons were that they did not know their intentions or their education level in regards to modes of transmission. Many thought that they would have no problem

interacting with PLWHA if they received some HIV education first. People did suggest that interacting with PLWHA was good for the PLWHA and that their disease was just like any other disease (Bonga and Babati). Others mentioned that they could interact with them in ways that would not transmit HIV. However, nobody was certain about the correct modes of transmission although the older men in Mamire suggested that it could not be transmitted through air.

Some women in Mamire and Duru said that if her husband had HIV, she would not leave him, but she would stop having sex with him, while a couple of young women in Mamire and Magugu said that they would definitely leave their husbands if they learned their husbands were HIV-positive. When asked about a person outside their family being open about their status, one of these same women said, "community members will probably beat them". Older men in Duru thought that there was no reason to interact with someone with HIV unless that person was completely open about their status. They felt that PLWHA stigmatized themselves by keeping their status secret, and it made the community concerned about the reasons behind that. This seemed to be a common theme across rural and urban settings.

When asked if people in the community would feel comfortable buying fruit from a person who had HIV, there were mixed responses. More urban areas like Babati, Magugu, and Mamire seemed to feel that the correct answer was that they would have no problem buying from someone with HIV. When the question was clarified by the statement that we were asking about the population on a whole and not about them personally, almost everyone, except in a few groups in Mamire, agreed that it would be difficult for that fruit seller to get business. This was consistent in both rural and urban areas. A few people were concerned about eating at a restaurant at which a PLWHA worked. One woman in Mamire was concerned that, "there might be accidental blood in the food".

The older men group in Bonga said that people would lie about this question, but in reality, it would be very difficult to get people to interact with PLWHA. One candid young man in Babati admitted, "with my current education about HIV, I would not feel comfortable interacting at all with someone with HIV. I would run away". The youth in Duru also agreed that many people would run the other direction if they know someone had HIV. Stigma against people with HIV is real and present in rural, semi-urban, and urban settings.

High-Risk Groups

Community members commonly targeted drunks, traveling businessmen, drivers, young women, secondary students, and guesthouse attendants as potential high-risk groups for HIV transmission. A few groups generalized that all people were equally at risk to contracting HIV. In areas that were along the Arusha-Dodoma or Arusha-Singida roads (Bonga, Magugu, Babati), the focus groups identified a link between the high-density of guesthouses and increased amount of sex work. People in Gallapo also highlighted a commerce link between Mbuguni Ward in Arusha and Gallapo Ward in Babati. Mbuguni has a high concentration of PLWHA partly due to its proximity to the Mererani mines in Simanjiro District. Many of the trucks that deliver goods to Gallapo from Mbuguni sleep overnight before departing back to Arusha. In addition, all areas, especially rural, identified local bars as harboring high-risk groups.

Babati district has a traveling monthly market that moves to a different ward daily. The wards included in this needs assessment that host the monthly market (Magugu, Mamire, Gallapo and Ufana) also identified the vendors and the crew of these markets as high-risk.

Finally, Bonga Ward is uniquely located on Lake Babati. The young men of Bonga identified fisherman as a high-risk group, especially the fishermen that live in the housing specified for them alone. Through an informal interview with the leader of one of the PLWHA support groups, the Mdori area, which was not targeted by the needs assessment, was also identified to contain a high-risk group in the fishing industry.

People Living with HIV/AIDS

All of the following information came from PLWHA who are open about their status and members of positive support groups. Common themes from every focus group was gratitude for the free government ARV program, but frustration toward the complications involved in adhering to it and the current state of stigma in their communities.

i. Care and Treatment Centers

People attend the Care and Treatment Centers (CTC) most commonly at the Mrara District Hospital in Babati and Dareda Mission Hospital in Dareda. There were some PLWHA who travel to the CTCs at Haydom Hospital in Mbulu, Selian Hospital in Arusha, or Mount Meru Hospital in Arusha either because they are familiar with the doctors there or because they do not want to be seen at the local hospitals. Everyone goes monthly for the medication, but sometimes they go twice a month if they also need a medical check-up. Some said that they occasionally miss appointments due to lack of bus fare (Magugu and Gallapo). One person walks 20kms one-way from Gallapo ward to Mrara Hospital to get medication monthly. Some of PLWHA reported that they stopped going to the CTC completely and started to seek services from traditional healers if the bus fare was too difficult to produce monthly (Gallapo). At the CTC, everyone said they receive counseling, ARVs, and CD4 counts every six months. Some received treatment for opportunistic infections, and a few people in Gallapo got chest x-rays for free.

When asked for additional services or improvements that would be helpful at the CTCs, many thought that counseling should be included in every visit and that food should be provided (Babati and Gallapo). Some suggested that there are not enough drugs to accommodate all PLWHA who get services at Mrara Hospital and that the CTC room was too small so people had to wait outside in clear sight of others (Gallapo). A couple of people have been told to buy medicine (they could not remember what it was for), which was too expensive for them to afford, and they asked for help with medication costs (Magugu and Gallapo). All of the semi-urban groups suggested that the CTC should be moved closer to their areas rather than them going to Mrara Hospital every month (Gallapo and Magugu). Everyone was supportive of the mobile-CTC concept.

ii. Home-based Care Providers

Although the government hospital has trained 26 people to be Home-based care providers, 13 of them are hospital clinicians and only 13 of them are community members. They are mostly focused in town, but Magugu, Gallapo, and Mamire all had one clinician HBCP and one community HBCP (Mrara Interview). When asked about existing HBCPs, many said family and friends did not receive any training because there is only one HBCP in their ward, and they did not even have a first-aid kit (Magugu and Babati). Another person stated, "I do not want HBCP to visit my house. First, I do not want my family to know I am HIV positive. Second, for now this HBCP has nothing to give me (Babati)." However, many other PLWHA

liked the idea of the HBCP teaching the families, friends, and neighbor in order to reduce stigma.

When prompted for recruitment suggestions for HBCP, most people thought PLWHA listen to and trust other HIV positive people. They identified only PLWHA as people who are able stay motivated to provide consistently high-quality services and to encourage others to disclose their status.

iii. Family and Community Support

While most people admitted it was very difficult to solicit any support from family or friends, a few people did get some help such as bus fare to get to the hospital or offers from immediate family members to pick up the ARVs from the hospital. Others were stigmatized by their own children (Magugu, Mamire, and Gallapo). "There is no support from the village government," one PLWHA from Gallapo pointed out in reference to the Pathfinder International Home-based Care trainings. "They chose only one HIV positive person to be a HBCP out of 8 people."

iv. Traditional Healers

All the groups said there are traditional healers and there are some PLWHA who are going to seek help from them. Some thought it might be due to the pressure from their family to find a cure. They did not think they were effective because most of the people who received services from the traditional healers did not survive (Gallapo). One group said there is no relationship between PLWHA and traditional healers (Magugu). All the division and ward leaders thought that if we called a meeting for the traditional healers in the area, most of them would come and would appreciate the effort, but it would be difficult to change their practices or create a referral system.

v. Support Groups

Although the issue of support groups was being discussed with members of support groups (WAVIBA+, WAVIGASH+, WAVIMA+, Bahappe, and Upendo Group), many people suggested that others were reluctant to join because there was no apparent benefit to being open about their status. A few people said that others were scared to look like prostitutes or that people denied that they have HIV because of superstitions (Gallapo and Babati). For those in the groups, they occasionally help each other with bus fare to get to the hospital, with food, money for rent, and education on how to live with HIV and the correct uses of ARVs. A couple people joined a group to fight stigma by disclosing their status and admitted that it is easier to get support as a group rather than as an individual (Babati, Gallapo, and Magugu).

The ward leaders said support groups are receiving support from the government. However, only one group got funding from the RFA and one group reported that they did not have a good working relationship with their village government (Gallapo).

vi. Additional Service Suggestions

The groups were asked to give their top three priorities for additional support services. In every group, the discussion began with the need for proper nutrition and improved daily health. In some cases, people felt there should be food hand-outs. Others suggested focusing on sustainable projects to help overcome the attitude of many PLWHA that they cannot work and have to wait for support

(Gallapo and Babati). People from all groups prioritized a community garden, a chicken or goat program, or a milk-cattle program. One person from town was worried about a water source for a garden (Upendo Group).

A few people in town wanted help building a house so they could avoid paying rent each month (Babati).

Other Organizations

There is an apparent disconnect between what organizations state that they do, what the leaders are informed is happening, and the accessibility and marketing of services to community members (see Table 5). The community identified most organizations as delivering services once or twice a year. The NGO list in Table 4 is limited to the organizations that attended our stakeholders' meeting or that responded to visits, emails, and calls.

Many people identified AFNET for delivering food to PLWHA in 2005 or 2006. Almost all of the other organizations were said to have come only once or twice before to teach a seminar about HIV. Many leaders, community members, and health clinicians identified the Red Cross as a testing service, but said that most people had not received their results yet. Apparently, they take blood on one day and set a date to return with the results, at least two weeks later in which the blood is sent to KCMC in Moshi for testing. This approach was not received well by the community as many who had tested were still waiting to hear their status.

In the stakeholders' meeting, it was clear that many organizations have the right intentions, but are not able to meet their goals due to financial restrictions. Most of the smaller NGOs and all of the CBOs rely solely on the Regional Facilitating Agency to fund all of their projects and that money is often late or limited. By building the capacity of these organizations to gain funds or expertise, the overall impact on HIV would greatly increase.

There is a strong and motivated presence of PLWHA through both the Town Council and District. Either the Upendo Group or WAVIBA+ had a sub-group in five of the seven wards that we selected. The town groups had over one hundred members each and the semi-urban groups ranged from 30-60 members. While they currently have limited capacity to provide services, they did offer a comfortable environment for PLWHA to express their issues and concerns and support each other.

Table 5. Comparison of all HIV related NGOs, FBOs, and CBOs that were said to have worked in target wards (Needed to be mentioned by one person in the focus group or interview to be identified).

	Organizations	Leaders (Division or Ward)	Community Members	Health Care Providers	Schools	PLWHA
Babati (U)	AFNET, DANEBBA, FIDE Trust, GIYEDO, Ishi Campaign, MRACO, Prinmat, Uhai na Ukweli, Umoja wa Makatekista, UPAA, Upendo Group, WAVIBA+	Red Cross, Upendo Group, WAVIBA+	Angaza, GIYEDO, Ishi Campaign	AFNET	Ishi Campaign	AFNET, BEDA, PRINMAT, UMATI, Umoja wa Makatekista
Bonga (SU)	AFNET, DANEBBA, FIDE Trust, Ishi Campaign, MRACO, Umoja wa Makatekista, UPAA, Upendo Group, WAVIBA+	MRACO	Ishi Campaign, Marie Stopes, MRACO, Red Cross	N/A	N/A	N/A
Gallapo (SU)	AFNET, DANEBBA, FIDE Trust, GIYEDO, Ishi Campaign, UPAA, WAVIBA+	Diocese of Mt. Kilimanjaro, FIDE Trust, WAVIGASH+	AFNET	AQUIRE (VCT), Marie Stopes, Life and Living (Diocese of Mt. Kilimanjaro)	N/A	AFNET, FIDE Trust
Mamire (SU)	AFNET, DANEBBA, FIDE Trust, Ishi Campaign, UPAA, WAVIBA+	AFNET, FIDE Trust; DSW, Maarifa ni Ufunguo, ADRA, Diocese of Mt. Kilimanjaro, MAMIRE +	Kisirikikiva, UMATI	N/A	N/A	N/A
Magugu (SU)	AFNET, DANEBBA, GIYEDO, Ishi Campaign, UPAA, WAVIBA+, World Vision ADP	World Vision ADP; Compassion, Diocese ya Mt. Kilimanjaro, Upendo Group, Washawasha	Angaza, Compassion, Life and Living, Red Cross, World Vision ADP	N/A	FEMA, Red Cross, WAVIBA+	AFNET, Compassion, World Vision ADP
Duru (Ru)	AFNET, DANEBBA, Ishi Campaign, UPAA, WAVIBA+	AFNET; Catholic Church Mbulu	Catholic Church Mbulu, Ishi Campaign	N/A	N/A	N/A
Ufana (Ru)	AFNET, DANEBBA, Ishi Campaign, LISO, UPAA, WAVIBA+	LISO	none	Marie Stopes	Marie Stopes (advertising testing)	N/A

Health Care Facilities

Clinicians or doctors from a rural dispensary, semi-urban health clinic, and urban hospital were interviewed to understand more about the health care facilities accessed by PLWHA. The CTC service at Mrara District Hospital in Babati town is available three days during each week (Monday, Wednesday and Friday). The hospital listed CTC services to include free monthly ARV treatment, medical exams, Opportunistic Infections (OI) treatment, CD-4 counts every six months, and x-rays for TB diagnosis. While PLWHA also agreed that these are the available services, many people said that there was not enough time to access all of them during a normal CTC day. The District AIDS Community Coordinator (DACC) commented that the District Hospital CTC staff is limited as there are only three trained Home-based Care Providers and a few nurse's assistants. The main CTC team includes the DACC, Medical Officer In-charge (MOI), and National Trainer of Voluntary Counseling and Testing (NTVCT) and they are always busy with other responsibilities. (See PLWHA: CARE AND TREATMENT CENTERS for suggested improvements.)

Some HIV-related services are also provided at other locations. The semi-urban Gallapo Health Clinic always provides free VCT services to anyone, and they provide free OI treatment for people enrolled in the ARV program. The rural Ufana Dispensary cannot provide VCT services because their trained counselor was transferred and no other services are provided for PLWHA, although most of the community members still think that VCT is available (Ufana general). Bashnet Health Center was within a reasonable distance from Ufana and most people were referred there, Haydom Hospital in Hanang, or Dareda Mission Hospital which has a CTC.

When asked about recruiting for HBCP, the health care providers suggested that PLWHA be HBCPs because it will help to get those who are concealing their status to disclose their status and receive support. The doctor at the Gallapo Health Clinic said that it is easier for PLWHA to share their information and experiences with each other and that it is not easy to reveal their status to government leaders. Members of the community should be involved in choosing the people they want to be HBCPs, not just village and ward leaders (Mrara Hospital). The District Hospital CTC staff also suggested that their department should be connected to the Out-Patients Department in order to help reduce stigma. As it is now, PLWHA wait outside and are isolated from the rest of the hospital on CTC days.

The District hospital has plans to build five satellite CTC sites within the district. They have trained all the support staff at each location, but they have yet to build the facilities. In the meantime, both hospital staff and PLWHA noted the need for mobile CTC to Gallapo and Magugu due to the high volume of clients and distance to the hospital. They identified transport as the only barrier to initiating this program as the staff and medications were sufficient.

All the health care facilities had open and optimistic views of their working relationships with other organizations. Many people did not object to having multiple organizations working in the district as long as they were working effectively and reporting clearly to the appropriate sources.

VI. Program Implications

Education/Awareness Campaigns

Every area, rural, semi-urban, and urban, exhibited the need for HIV education or an awareness campaign. Babati town can potentially be combined with another rural ward for a campaign and can continually be targeted by every awareness campaign on weekends or with special events. The government has done an impressive job of promoting certain messages with signs or on the radio and most people know that AIDS exists, and many know that it kills and there is no cure. Beyond that, there is not much certainty of the facts. The lack of understanding of basic HIV information encourages the stigmatization of PLWHA in rural and urban environments. Many people suggested that we target education on a sub-village (kitongoji) or street (mitaa) level. While this is what we already do in our campaigns, it was suggested that advertising and government support are the most important drawing points. Many people also expressed the importance of using religious leaders, churches, and mosques as an efficient way to diffuse information. Religious leaders should be involved from the beginning in any awareness campaign.

Parents should be targeted through the schools or sub-village leaders. Many of the parents will over-lap with the community member groups, but it was very important to students, teachers, and the general community that parents are involved in what their children are learning. Many parents attributed their limited communication with their children about reproductive health to their lack of knowledge on the topic. By advertising through both the schools and the leaders, we will double our chances of reaching as many parents as possible in the six-week awareness campaign. We could also start a parents club that would be monitored through the field officers, but this might prove too much effort for the outcome. However a quarterly or bi-annual parents meeting would keep parents connected to the peer education program.

Everyone was in support of teaching about condoms to secondary school children, and most people were in favor of teaching about condoms to primary school children starting in the range of standard three to five. Since the government policy is to begin condom education with standard four, this will remain our baseline. We will, however, adjust the amount of information that is given to standard four and five students about condoms. We will suggest to volunteers that they should assess their class to see if they are mature enough for the condom demonstration. We will also target churches and mosques with general HIV information to attempt to limit the amount of mixed messages the community is receiving. Since many people said they do not use condoms because of common myths or because they do not know how to use them, condoms should be discussed with and the demonstration done for all appropriate groups.

As most of the general community, teachers, and students had never spoken candidly with someone with HIV, including PLWHA in seminars and at testing days to teach and answer questions would be a very valuable tool. The note taker's positive status was occasionally revealed after the focus groups were finished and people generally had constructive questions and instinctively did not stigmatize him, as if he was a teacher of a classroom. In a testing day at a Magugu secondary school, students inundated the PLWHA with questions.

Peer Education

There are no sustainable, existing peer education programs in the wards that we assessed. In some cases, we can use or merge with an existing, but fairly non-active Counseling Club, Health Club, or Fema Club to help promote the program. In town we can also collaborate with the Ishi Campaign. It was difficult to get the primary school students to participate in the focus group, which is in keeping with the need SIC has identified in Arusha to build life skills first and then develop the peer educator activities. By creating 'Fight HIV' clubs in primary schools, the leadership skills will begin to emerge that are needed to make a successful peer education program in the secondary schools.

The students did not have many new ideas for activities, but they did have many suggestions emphasizing games and drama. A couple of students and teachers mentioned multi-media as a discussion point. One idea would be to have the supplies to show videos and hold discussions afterwards. In some cases, we could do this both in and out of the school setting as to attract out-of-school youth to this informal educational setting. Volunteers could identify locations to play videos in the evenings and use it as an attraction to do night teachings. Babati is much safer than Arusha and volunteers will be able to be more independent with their scheduling.

It appears that it is going to be a challenge to get the teachers in town to participate and stay motivated. Particularly in Babati town schools, the teachers were straightforward about their need to be paid. Either we will need to improve our recruiting system for teachers, involve and excite the headmaster, or restructure the secondary school program so that the teachers are not a pivotal component in the town schools. For primary schools, we can use the ward education officer (MEK) to help motivate the teachers. By encouraging the MEK to take ownership over the program, the teachers might be more willing to put their time and energy into implementing it. We should create relationships with the MEKs early and make efforts to keep them involved. We could even try to run a workshop for the MEKs and head teachers in potential wards to incorporate their ideas into the foundations of the PE program.

Voluntary Counseling and Testing

In most people's perceptions, only a small proportion of the population had tested previously for HIV. The barriers to testing were that people did not understand the benefits of knowing their status, fear, stigma, and accessibility in rural areas. However, it was clear that increased awareness of HIV education at a community and individual level are the first steps toward encouraging the community to get tested. Most people preferred to test from a source outside of the community, specifically the local health clinic or dispensary, which indicates a high demand for mobile VCT services.

Many people were unsure about the window period explanation from the district hospital, which indicates that the education portion of the counseling services should be increased and improved. This is also consistent with our observations of the counseling standards in the district. When possible, and especially when we expect large turnouts, we should add one staff member to the mobile VCT team for the sole purpose of educating. HBCP would be ideal candidates for this position. By running a mini-seminar or question and answer session before pre-counseling, we will be able to decrease the load on the counselors and ensure that everyone is getting correct information. We could train some of the AFNET community volunteers or support group members to be part of an education team when we test in areas where we do not have HBCPs.

It was also suggested that we offer testing days on a village basis regularly or even sub-village during the awareness campaign. In our experience testing in Babati, village leaders are not always reliable when it comes to following through with advertising. When they do put forth the effort, we have consistently had large turnouts. To combat unreliability, we should use multiple sources to advertise or post the advertisements ourselves. Religious leaders could also be effective advertising tools, but we will need to increase the effort put into building and maintaining those relationships.

Many people, including the patient groups, liked the idea of home-based counseling and testing. The older men in particular suggested that this was an excellent way to get entire families to test. We will use HBCPs in our first three wards to promote this service, but we will also advertise to all the patient groups in case they know of people who want to be tested privately. We also had a large interest by secondary school students and teachers to provide VCT at the school sites. This can be done after school for students and teachers who are interested.

Home-based Care Program

Until April of 2008, the Home-based Care programs in Babati were largely non-existent or relatively informal. As stated earlier, the 26 government trained community volunteers did not have any resources, with the exception of bicycles, and covered entire wards with patient loads of over 30 PLWHA in some cases (Mrara Interview and Informal Interview Notes). Many of the local organizations that claim to provide HBC support are usually referring to casually visiting PLWHA at their homes.

In March of 2008, Pathfinder International, through the district and ward level government, selected 30 community members from Gallapo, Mamire, and Magugu Wards to receive the standard government HBCP training and begin providing services in May 2008. These providers will receive monthly motivation and first-aid kits from Pathfinder through a supervisor system monitored by the district government. These kits include: latex gloves, antiseptic, bandages, Panadol, bleach, scissors, soap, Vaseline, an apron, a plastic bed sheet/mackintosh, writing tools, a flashlight, an umbrella, and a pair of rubber boots. The consumable supplies will be refreshed monthly by the ward supervisor.

SIC will act as in implementing partner for the district government. We will use these same 30 HBCPs in our Community Health Worker Program. To address the transport issue raised by the existing government HBCPs and PLWHAs, we will give one bicycle to each village to be shared between the providers serving that village. Additionally, SIC will continue to reimburse patients' transport costs between their home and the closest CTC. On the day of travel, a stipend for food will also be reimbursed. These transport reimbursements will be monthly for patients in Mamire and occasionally for patients in Magugu and Gallapo when their medical needs cannot be met by the mobile CTC. The field officer responsible will work closely with the HBC supervisor from the local health facility to ensure that the HBCPs stay motivated and give quality care to their patients. All patient progress will be monitored through a reporting system to SIC's central office from monthly ward-level meetings with HBCPs, SIC Field Officer, PI Supervisor, and occasionally the District HBC Coordinator.

In the case of Gallapo and Magugu, there are relatively large rural patient support groups who have 47 and 40 members, respectively. The presence of large rural

support groups without many services available indicates that these areas have large concentrations of PLWHA and many people that have not revealed their status because the benefits of being open are few. Both Gallapo and Magugu wards are over 20km away from Mrara Hospital, which makes monthly visits extremely challenging for people living with HIV. Health providers and PLWHA both suggested that these two sites were ideal for monthly mobile CTCs. In cooperation with the CTC and district medical officials, we will start a mobile CTC program in May. This will reduce the cost of transport reimbursements and give patients an opportunity to get a medical exam from the CTC doctor if necessary. There are trained CTC clinicians at both the health clinics in Gallapo and Magugu, but since they have no previous practical experience and one of the major concerns from patients in both these wards was the issue of confidentiality with people in their local clinics, we will begin by bringing CTC staff from the Mrara Hospital. In the future, we can incorporate the local clinicians if confidentiality problems improve. Dareda Ward in Bashnet Division also has a growing support group with 13 members, but they are within walking distance to the Dareda Mission CTC.

The issue of food support came up in every PLWHA focus group. The current food handouts are inconsistent and funded through small RFA grants. Community gardens and chicken, goat and milk-cow programs were all positively discussed by PLWHAs. In cases where a member of a support group could donate land in exchange for labor, a community garden would have a fairly low start-up cost. There are still questions about sustainability and management of these gardens. Another possibility would be to partner with organizations like FIDE Trust or Farm Africa to help train the stakeholders in the program about proper management and monitor the progress and labor schedule.

Another means of improving quality of life is initiating a micro-lending program (VICOBA). This could be easily set up through the existing support groups, as there are many members to combine for collateral.

Additional Program Opportunities

i. Traditional Healer Trainings

As mentioned previously, traditional healers are present in all of the wards that we assessed, and they are treating PLWHA. The prospects of setting up a referral system are unlikely, but giving them an opportunity to ask questions and be exposed to correct information is beneficial. There is an organized group of traditional healers that communicate at a regional level, and we obtained the leaders' contact information. We can use this contact to invite the traditional healers in the district to a two- or three-day workshop and gauge their response to the information from there. Keeping the local leadership particularly the counselors (Diwani) and influential elders involved as much as possible will give us a better chance of having the healers stay open to the new information.

ii. Parents Training

All groups emphasized the importance of keeping parents involved with their children's education, especially regarding health-related topics. A couple of ideas were previously suggested for reaching out to parents, but this should be emphasized to volunteers and teachers so it is seen as a clear priority. These seminars could focus on reproductive health and parent-child communication and then have a section for parents to ask difficult questions that their children might have brought up at home.

iii. Fundraising Workshop for Stakeholders

We could hold a workshop focused on fundraising techniques for small organizations or groups to increase the amount of impact that the stakeholders as a whole have on reducing the impact of HIV/AIDS in Babati. We could also give them feedback on grant proposals in order to increase their chances of approval. Additionally, we can work with the PLWHA groups to find funding for self-generated projects or VICOPA opportunities.

iv. 'Mazoezi ya Kutosha' Day

A constant theme in PLWHA groups was concern about nutrition and daily health. For this we started an exercise club that meets once a week at the SIC office in Babati town. Everyone stretches and either power walks or runs around Lake Babati. When we return to the office, we stretch again and talk about the importance of proper exercise. We finish each meeting by eating fruit and drinking clean water. This also gives people a chance to sit together and talk. The event is meant to raise spirits, encourage good health practices, and create a networking opportunity for PLWHA. If the club continues to grow, we could look for additional funding to get exercise gear or possibly travel to different locations to exercise. If there is a lot of momentum, we can try to expand this model to other support groups in more rural wards.

VII. Strengths and Opportunities

Every group agreed that HIV/AIDS is one of the largest problems of their lifetime. Many used the same analogy saying, "*It is like an accident along the road*" (*Duru and Ufana*). When prompted for reasons, many focused on the fact that there is no cure, many people are dying from this disease, and that it is a nation-wide or worldwide issue. In the very rural areas where people are not sure if they have ever seen anyone with HIV, they still highly prioritized HIV as a concern for Tanzania as a whole.

Education levels and attitudes towards PLWHA were similar across rural and urban areas. Areas that have had relationships with previous organizations or attention from the district hospital, such as Magugu and Mamire wards, tended to have slightly more HIV information or more accepting attitudes toward PLWHA, but that was not consistent enough to leave these wards out of our programs. Duru and Ufana wards had much lower known concentrations of PLWHA, raising the question of whether or not extremely rural wards should be a lower priority in initiating PLWHA services. Education programs should be a high priority in these areas as the current knowledge is small, and it is a good opportunity to promote prevention education and sensitize the community. The semi-urban wards had large PLWHA concentrations. This could be attributed to the fact that all these wards are close to a major commerce road. In these areas, there is more transient traffic and more business, which would suggest that other wards that sit on these roads and have a decently sized urban center would have high patient concentrations like Mdori, Gidas, and Dareda.

Although there are many organizations based in Babati town, the general focus groups revealed that there is still a large gap in HIV education. PLWHA in town can easily and independently access Mrara Hospital, so education should be the highest priority. Combining education with the mobile VCT unit will increase the amount of people who decide to test and improve accessibility to VCT opportunities. However, there are multiple places in town that people can test for

free on a daily basis. Volunteers can continue to target Babati town with seminars and awareness events regardless of the ward in which they are living. SIC can also continue to collaborate with Upendo Group and WAVIBA+ for temporary employment opportunities and to build their capacity.

VIII. Conclusion

Overall, there is a cooperative environment amongst the district government and stakeholders when it comes to supporting each other. Most of the smaller organizations would not exist if it were not for the RFA. The district hospital has also exhibited a desire to collaborate and a willingness to use their resources when necessary to improve services through outreach to the more rural areas. Outside of the hospital, the district level leadership is fairly removed when it comes to coordinating the stakeholders.

Through the informal interviews, the key informant interviews, the focus groups, and the stakeholders meeting, we acquired a wealth of information on the current HIV/AIDS situation in Babati district. There is an apparent lack of access to correct HIV education in all areas of the district, which increased levels of stigma toward PLWHA. SIC achieved the goal of introducing themselves at a community level. Most of the community was extremely receptive to the process and appreciated a chance to have their voices heard.