

**COMMUNITY RESPONSE TO HIV/AIDS: A CASE OF PASTORALISTS IN
KILOSA DISTRICT, TANZANIA**

BY

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**A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE
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ABSTRACT

A study to assess the response of pastoralist community towards HIV/AIDS was conducted in two villages of Kilosa district in Morogoro region. A cross sectional research design was adopted whereby a purposive sampling technique was used in combination with simple random sampling method so as to obtain a sample of 51 adult respondents and snow-ball technique was used to obtain 42 youth respondents. In addition 20 key informants were sampled. A structured questionnaire was the main instrument used in data collection. Checklists were used for key informants and focus group discussions (FGDs). The data were statistically analyzed using SPSS computer programme to obtain frequencies and percentages. Results have shown that all respondents were aware of the HIV/AIDS pandemic. More than 90% showed positive attitudes towards HIV/AIDS and PLWHA. Education level was observed to be statistically associated with HIV/AIDS testing status at $p < 0.05$. Individuals with primary education were more likely to go for HIV testing than those with no formal education. Also the study observed negative and positive responses shown by individuals and households towards HIV/AIDS. Negative responses observed were: taking children out of school, sending children to relatives, selling of productive assets (livestock) for food and medical costs, skipping some meals and depending on wild food. The positive observed responses included asking for loans, selling labour and move to crop farming. Generally, response by civil society organizations (CSOs) were observed to be positive such as care and support for infected and affected individuals and households by providing material support such as monetary, food, clothes, medical care and medicine, moral or spiritual support, guidance in counselling and testing for HIV/AIDS and mitigation of HIV/AIDS. Central government responses were also very positive such as educating the community on HIV/AIDS, care and support for PLWHA.

DECLARATION

I, STELLA JOAS MGHASE, do hereby declare to the Senate of Sokoine University of Agriculture, that this dissertation is my original work and that it has neither been submitted nor being concurrently submitted for degree award in any other institution.

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Date

The above declaration is confirmed

Prof. J Msuya
(Supervisor)

Date

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The work is dedicated to my beloved parents Mr. Joas Mghase, Mrs. Defress Mghase and my late sister Edonelais Mariki who laid foundation of my education. God bless them.

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LIST OF ABBREVIATIONS

| | |
|---------|--|
| ABC | - Abstain from sex, Be faithful, Use of Condoms |
| AIDS | - Acquired Immune Deficiency Syndrome |
| AMREF | - African Medical and Research Foundation |
| ARVs | - Anti Retro- Virals |
| ASDS | - Agriculture Sector Development Strategy |
| ASLMs | - Agriculture Sector Line Ministries |
| CBO | - Community Based Organization |
| CHACC | - Council HIV/AIDS Control Coordinator |
| CMAC | - Council Multicultural AIDS Committees |
| CSOs | - Civil Society Organizations |
| CSPD | - Child Survival Protection and Development |
| CTC | - Care and Treatment Clinics |
| FAO | - Food and Agriculture Organization |
| FBO | - Faith Based Organization |
| FGM | - Female Genital Mutilation |
| FHI | - Family Health International |
| HBC | - Home Based Care |
| ICRW | - International Center for Research on Women |
| IFPRI | - International Food and Policy Research Institute |
| IMPA | - Implementing AIDS Prevention and Care |
| KKKT | - Kanisa la Kiinjili la Kilutheri Tanzania |
| LGA | - Local Government Authorities |
| LGAs | - Local Government Authorities |
| MDG | - Millennium Development Goal |
| MKUKUTA | - Mkakati wa Kukuza Uchumi na Kuondoa Umasikini Tanzania |
| MOH | - Ministry of Health |
| NACP | - National AIDS Control Programme |
| NGO | - Non- Government Organization |
| OVC | - Orphans and Vulnerable Children |
| PLWHA | - People Living with HIV/AIDS |
| SEAGA | - Socio-Economic and Gender Analysis |
| SPSS | - Statistical package for Social Science |
| STIs | - Sexually Transmitted Infections |
| TACAIDS | - Tanzania Commission for AIDS |
| TDHS | - Tanzania Demographic and Health Survey |
| THIS | - Tanzania HIV/AIDS Indicator Survey |
| THMIS | - Tanzania HIV/AIDS and Malaria Indicator Survey |
| TzPPA | - Tanzania Participatory Poverty Assessment |
| UN | - United Nations |
| UNAIDS | - Joint United Nations Programme on HIV/AIDS |
| UNDP | - United Nations Development Programme |
| URT | - United Republic of Tanzania |
| VCT | - Voluntary Counseling and Testing |
| WHO | - World Health Organization |

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background Information

In Tanzania the first cases of HIV/AIDS were reported in Kagera region in 1983. The first three cases were however followed by a rapid spread of the pandemic such that by 1986 all regions of Tanzania Mainland had reported AIDS cases (NACP, 2004). The epidemic has evolved from being rare and new disease to a common household problem, which has affected most of the families in Tanzania. The development of HIV/AIDS epidemic has its clear impact on all sectors of development, through not only pressure on AIDS cases care and management of resources but also through debilitation and depletion of economically active population especially young women and men aged 15-45 years (NACP, 2004). In 2003 Tanzania Mainland was estimated to have about 1 820 000 people living with HIV (840 000 females and 960 000 males) (NACP, 2004). Tanzania HIV/AIDS situation analysis was performed in 1997 showing a worsening epidemiological situation whereby the epidemic has rapidly spread into rural areas (THIS, 2005).

The major route of HIV infection in Sub-Saharan Africa is through heterosexual intercourse, estimated to account for 93% of all adult cases, followed by vertical transmission and blood transfusions (UNAIDS, 1999). Research in developing countries on the socio-economic impacts of HIV/AIDS on households has shown the main impacts to be social, psychological and economical (UNAIDS, 1999). Rural subsistent households are often more acutely affected than urban families (Hunter *et al.*, 1997). They suffer loss of productive labour, loss of income, loss of food reserves, savings and assets that are diverted to meet health care and funeral costs (Hunter *et al.*, 1997). Additionally, educational opportunities are reduced, as children are withdrawn from school to care for

the sick or to do odd jobs for extra income. Reduced levels of nutrition have been found in poor households (Loewenson *et al.*, 1997).

Since the HIV/AIDS epidemic has emerged as a global problem with a disastrous impact on survival and human development it has also created fear, social anxiety and feeling against humanity. Negative attitude towards infected persons and AIDS patients today are widespread and have greatly hindered the overall control of the epidemic (NACP, 2004). At the community level, as the HIV/AIDS epidemic deepens, the socio-economic impacts widen to affect the whole community, resulting in an adverse long-term effect on community structure and function (Tibaijuka, 1997). The loss of human resources affects all institutions and community structures, and these losses need to be controlled. Community problems that arise include the need to support an increasing number of orphans, reduced participation of the community in neighbourhood and community activities, increased homelessness and increased crime. In other words, social cohesion is threatened, a situation that increases the risk of HIV transmission (Tibaijuka, 1997).

1.2 Problems Statement

The interlinkages between HIV/AIDS, crop production and food security are increasingly getting well documented (FAO, 2005; Loevinsohn *et al.*, 2003). However, the impacts of, and mitigation strategies for HIV/AIDS on livestock production are less well understood (Engh *et al.*, 2000). There has been little research on the links between HIV/AIDS and pastoralism (Morton, 2003). In addition, very little information exists about the impact on the specific aspects of animal husbandry and future management strategies in affected households (Goe, 2005). Therefore in order to improve conditions for rural families living with HIV/AIDS and help sustain their income base, national policy makers and development partners working in this field need to have a good understanding of the

linkages and coping strategies already being exercised by the families and communities themselves. We need to cast light on what strategies work in a sustainable way and what costs are involved in ensuring the success of such initiatives. The proposed study intends to investigate how pastoralist communities respond to the pandemic. The study will attempt to identify the responses that prove to be positive and recommend them for scaling up and discourage the ones that have negative implications.

1.3 Justification

The study intends to identify individual, household and community responses to HIV/AIDS among pastoralists communities in Kilosa district. It will also suggest areas for potential improvement and consideration by policy makers and form the basis from which an advocacy strategy may be developed. Since many countries in sub-Saharan Africa have failed to bring the epidemic under control, there is still a lot to be done regarding HIV prevention (URT, 2004). According to Millennium Development Goals (MDG), the spread of HIV/AIDS should be reduced to half by the year 2015 (UN, 2005). It is also a plan and goal of the National Strategy for Growth and Poverty Reduction (NSPR) to have reduced HIV prevalence among 15-24 years old from 11% in 2004 to 10% in 2010 (The Tanzania Government, 2005). The current study is relevant as it is in line with National Multi-sectoral Strategic Framework (NMSF) for HIV/AIDS in which research activities and dissemination and use of research findings are encouraged (URT, 2001).

1.4 Objectives of the Study

1.4.1 Main objective

To investigate the responses of pastoralists communities towards HIV/AIDS pandemic in Kilosa district.

1.4.2 Specific objectives

- (i) To identify the responses to HIV/AIDS by the stakeholders in the community (individuals, households, community as a whole, civil society and local leadership).
- (ii) To assess the general knowledge on HIV/AIDS, attitudes and beliefs of people about HIV and people living with HIV/AIDS (PLWHA).
- (iii) To assess how the known “Best practices” on HIV/AIDS (prevention, care and treatment, and mitigation) are being implemented by the stakeholders in the study area.
- (iv) To examine the awareness, perception and actual practices among stakeholders on the strategies employed or recommended by the government such as agricultural strategies and the multi-sectoral strategies for HIV/AIDS.

1.5 Main Research Questions

1. How is the community responding to HIV/AIDS and its impact/effect? For example individuals, households, community as a whole, local government, local leaders, civil society and central government?
2. How are the known “Best practices” of HIV/AIDS being implemented by the above stakeholders for example use of ABC by individuals, establishment of VCT centers by the government and civil societies and care and support to orphans?

3. What are the general knowledge, attitudes, feelings and beliefs on HIV/AIDS and PLWHA among rural communities?
4. How are the recommended national strategies such as the agricultural sector HIV/AIDS and multi-sectoral HIV strategies been implemented, accepted and achieved by stakeholders?

1.6 Conceptual Framework

HIV/AIDS comprises of different issues, which have to be addressed in totality so as to combat the epidemic successfully. The community response towards HIV/AIDS impacts may be influenced by individual attitudes towards HIV/AIDS and PLWHA, not only that but also the economic status of an individual may also influence the individual response towards HIV/AIDS. The institutional management of the organizations may also influence the response of these organizations towards HIV/AIDS since these organizations work under the government rules and regulations. The study anticipates that, social cultural and economic factors of an individual are affected by background characteristics which have influence on HIV/AIDS response. Therefore this particular study will identify the response of communities towards HIV/AIDS pandemic. The response will be determined basing on individual, household, whole community, civil societies, central and local leadership responses (Fig. 1).

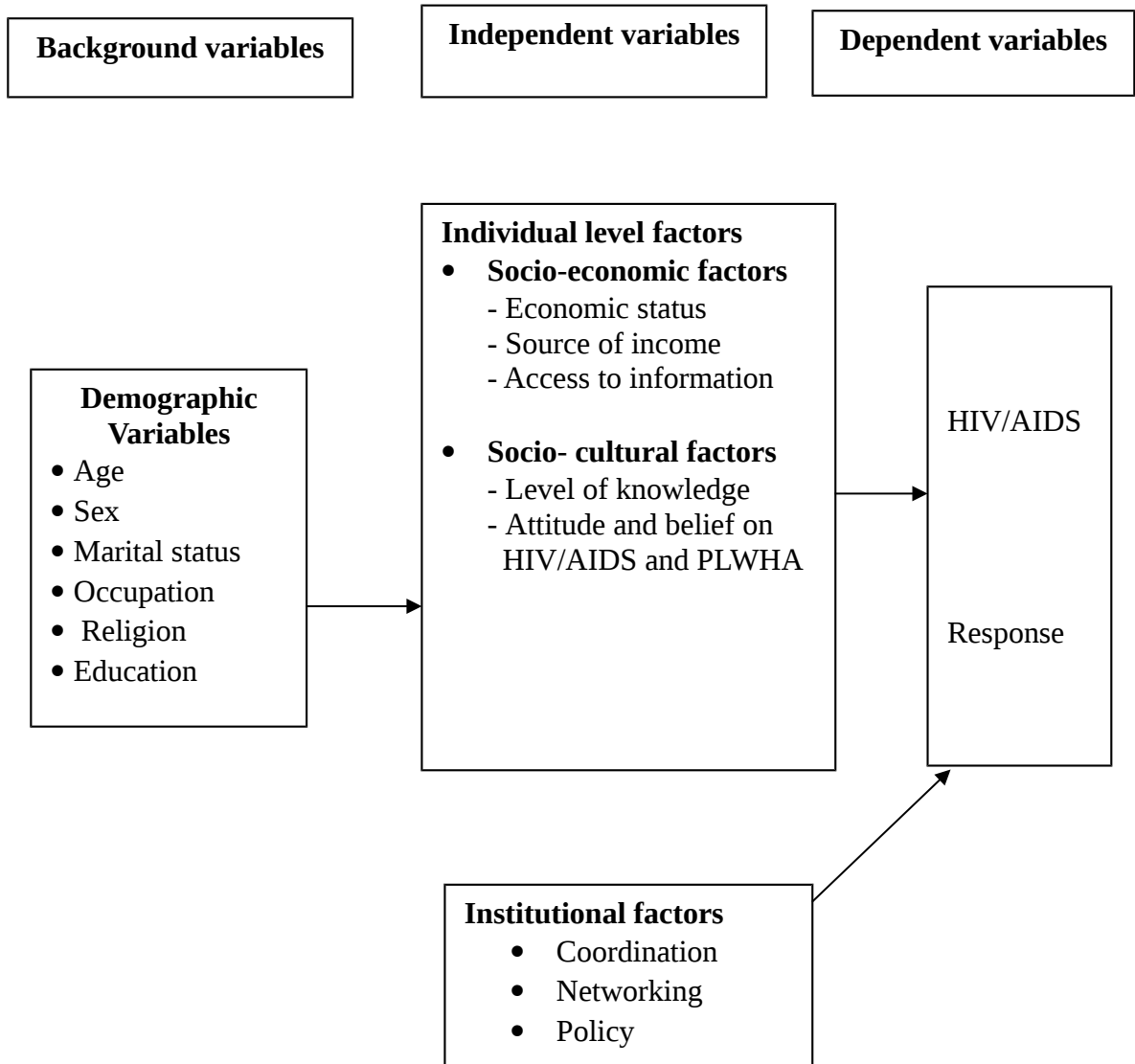


Figure 1: Conceptual framework depicting the variables that were considered

1.7 Ethical Considerations

Ethical considerations were followed throughout this study. Consent was obtained orally after a respondent was informed about the research. Confidentiality to the information provided by the respondents and the organizations was ensured.

CHAPTER TWO

2.0 LITERATURE REVIEWS

2.1 Meaning of HIV and AIDS

Acquired Immune-Deficiency Syndrome (AIDS) is the name given to the total fatal clinical condition that results from long term infection with Human Immunodeficiency Virus (HIV). HIV progressively damages the body's immune defense system preventing the body from protecting itself against infection that would otherwise be rendered harmless. AIDS leads to death of lymphocytes responsible for defending the body against invading microbes thus leaving the affected person susceptible to microorganisms with which he had previously lived with. The body becomes susceptible to diseases and opportunistic infections (NACP, 2000). These opportunistic infections may develop into illness, which would not normally occur in healthy people (Massele *et al.*, 1991). These opportunistic infections include tuberculosis, *Kaposi sarcoma* (tumour of skin), pneumonia, diarrhoea and severe weight loss. Death is not caused directly by HIV but one or more of these.

2.2 The Global Situation

HIV/AIDS is a global disaster that has attracted attention all over the world. In 2007 a total of 33.2 million people were living with HIV around the world out of which 30.8 million were adults (UNAIDS, 2007). The same report found that over 6800 persons become infected with HIV every day.

According to UNAIDS (2007), a total number of deaths were 2.1 million; out of which adults were 1.7 million and children under 15 years were 330 000. Over 5700 persons were reported to die from AIDS every day mostly because of inadequate access to treatment

services. Sub-Saharan Africa remains the most seriously affected region, with AIDS remaining the leading cause of death of its people (UNAIDS, 2007).

2.3 National Response towards HIV/AIDS

Concerted efforts to control the epidemic in Tanzania started in 1985. Since then national responses to the epidemic has been diverse and variable both in nature and scope (URT/NACP, 2002). In spite of intense prevention activities 14 112 new cases of AIDS were reported in 2001 alone and the cumulative reported AIDS cases were 144 498. The epidemic is now the leading cause of adult mortality (URT/NACP, 2002) and it is likely to reduce life expectancy by 10 years in the year 2010. By early 2003, under the leadership of TACAIDS, Tanzania had put into place its first National Multi-Sectoral Strategy Framework on HIV/AIDS (2003-2007). The strategy stressed the need to address four main thematic areas: prevention, care and support, mitigation and socio-economic impacts and cross-cutting issues including advocacy, stigma and discrimination (URT, 2003a). The government has taken another important step to make HIV/AIDS a high priority (TACAIDS, 2005) by regularly allocating funds in its annual budget to central, region, district and government agencies to respond to the epidemic (URT, 2003a). It also funds civil society groups to provide information and services to reduce transmission and care for people living with HIV/AIDS (URT, 2006).

HIV/AIDS testing

Although HIV/AIDS testing programs exist in Sub-Saharan Africa, many people still do not get tested and they get health care only when they are already severely compromised (Phaladze, 2005). Testing in Tanzania is done either at voluntary basis or at point where sick person needs treatment that involve blood transfusion, or examination. However, this is only possible where services are provided. This means that few cases are tested and data

available at blood testing and volunteer counseling are underestimated (TACAIDS, 2006). Some churches request counseling and testing before marriage for the purpose of avoiding joining two individuals with different HIV/AIDS status. Data on VCT tend to overestimate the prevalence while blood testing points underestimate it. For example reports in Temeke Municipal VCT test in 2005 show 20% prevalence while Blood Testing Center (BCT) shows only 6.8% (CMAC, 2006).

2.4 Community Response

Community is a specific group of people usually living in a common geographical area who share a common culture, arranged in a social structure and exhibit some awareness of their identity as a group (Allman *et al.*, 1997). Community coping responses take the form of different organizational groupings such as social support groups, informal associations, self-help groups, community-based organizations supported by external development agencies, and AIDS service organizations. Madembo (1997) in Zimbabwe, and Rugalema (1998) in Tanzania, found that burial societies are established indigenous social support organizations that provide mutual assistance to members in rural areas in the event of death and illness. They offer a measure of financial security in the event of bereavement and also cater for some of the other social needs of their members. As part of the package, burial society members also devote part of their time to assisting the bereaved by cultivating their fields. In a number of African countries, AIDS organizations formed by infected and affected people play an increasing role in the response to the epidemic although the number of PLWHA involved is still tiny compared with the full scale of infection (Rugalema, 1998). One specific example of rural community initiated HIV/AIDS mitigation in Malawi is community based food banks found in a number of villages (Mike, 2003). In that arrangement food banks are established for funerals whereby each household contributes a certain amount of maize every year.

2.5 Civil Society Organizations and Their Response to HIV/AIDS

Shariff and Albee (2000) defined civil society organizations (CSO) as organized groupings, which occupy the public space between the state and the individual citizen. People across the globe are re- discovering the attaching importance to civil society (Shariff and Albee, 2000). This realm extends well beyond them to encompass people's organizations, trade unions, human rights bodies, religion groups, community based organizations, policy activists bodies, associations of business and professional people's organizations and others. All may be found in domain termed civil space, and thus called civil society organizations (Shariff and Albee, 2000). In this study CSOs will mean a collective term for NGOs, FBOs, and CBOs.

A report prepared by Haapanen (2007) on civil society in Tanzania shows that HIV infections has shown a declining trend during the last few years due to efforts from different sectors of the society. The author also indicated that, the stigma around PLWHA was gradually decreasing as attitudes towards these people become more positive, the successes that emanated not only from the government initiatives but also from the awareness raising and advocacy work of various CSOs throughout the country. CSOs have been involved in running clinical and home based care for HIV/AIDS patients, which have a very important complementary role together with governmental efforts (Haapanen, 2007). A study conducted by Family Health International (FHI) through its implementing AIDS Prevention and Care (IMPACT) Project found that the faith based groups have the opportunity both to have a very strong role in preventing HIV/AIDS by teaching their own faith orientation and rules of living as well as providing compassionate care for those infected to promoting safer behaviors to avoid HIV transmission, particularly among young people (Dadian, 2004). For example, IMPACT in Rwanda launched several community based prevention projects for youth partnership with Catholic organizations

and dioceses in the nation's capital of Kigali and throughout the country. Those FBOs were the strongest community based organizations in Rwanda and had considerable success in reaching youth and other audiences with behaviour change interventions (Dadian, 2004).

Also UNAIDS secretariat recognize that civil society plays a key role in the response to the AIDS epidemic in countries around the world (UNAIDS, 2007). Civil society speaks with many voices and represents many different perspectives. For example, FBOs are involved at all level of the response including provision of various services in schools, hospitals, clinics, temples, mosques and churches such as:

- Home based care for families affected with HIV through women groups and volunteers
- Care of orphans and vulnerable children in homes and extended family
- An established network of religious leaders living with and affected by HIV- to speak out and provide support
- Leadership development- engaging religious leaders to speak out on stigma and discrimination

Many people find great comfort from spiritual leaders during chronic illness, even if people have not been actively involved with a church or religious groups (WHO, 2002). Addressing spiritual needs is an important aspect in any aspect of care. Spiritual needs of the patients must be determined and attended to appropriately thus the need to involve faith- based organization FBO (NACP, 2005). Religions leaders are often called upon to provide guidance, counseling and spiritual support to HIV/AIDS patients and families but

are asked by the government to refrain from claiming to cure AIDS through prayers (NACP, 2005). Spiritual needs of patients must be determined and attended to appropriately (MOH, 2005).

According to Barnett *et al.* (2001), the NGO community has played a critical role world wide in response to the HIV/AIDS epidemic. In many countries NGOs were providing basic prevention, education and care for those infected with HIV/AIDS before the government acknowledged that it was a national problem.

2.6 Households Response towards HIV/AIDS

People have to cope with the consequences of HIV/AIDS at individual and household levels. This has led people to sell assets (including productive assets like cattle or land) for cash and withdraw children from school so that they can contribute to family income (Hunter *et al.*, 1997). At the community level, it has led people to pool resources so that they can care for HIV/AIDS orphans. These after-the-fact coping strategies help people survive but also form a critical step in preparing them to recover from impoverish forces and reclaim their well-being (Drinkwater, 1993). Households that have higher incomes or better alternative resources are better able to cope with the impact of HIV/AIDS. Poor households that have no margin to absorb the extra costs of HIV illness are the most vulnerable to the epidemic (Sauerborn *et al.*, 1996). Table 1 gives a summary of the strategies used by households to cope with impact or consequences of HIV/AIDS.

Table 1: Household coping strategies

| Strategies aimed at improving food security | Strategies aimed at raising and supplementing income so as to maintain household expenditure patterns | Strategies aimed at alleviating the loss of labour |
|--|---|---|
| Substitute cheaper commodities (e.g. porridge instead of breads) | Income diversification | Intra-household labour reallocation and withdrawing of children from school |
| Reduce consumption of the items such as meat and milk | Migrate in search of new jobs | Put in extra hours |
| Send children away to live with relatives | Loans | Hire labour and drought power |
| Replace food item with indigenous wild vegetables | Sale of assets | Decreasing area cultivated |
| Begging | Use of savings or investments | Relatives come to help |
| | | Diversify source of income |

Source: UNAIDS (1999).

2.6.1 Household coping strategies aimed at improving food security

Sauerborn *et al.* (1996) in Burkina Faso and Barnett *et al.* (1995) in rural Uganda found that some households cut back the number of meals when faced with food shortages. Begging has been identified as a survival strategy in times of need whereby Sauerborn *et al.* (1996) indicates that this survival strategy is practiced when the households that are at risk have been pushed into calamity. Rural households that cannot meet their food requirements, or obtain cash through agricultural production, undertake a range of income-generating activities such as selling firewood, brewing millet beer, selling livestock, building fences, handicrafts, tailoring, and petty trade to supplement their income (Barnett *et al.*, 1995; Sauerborn *et al.*, 1996). In Malawi, Munthali (1998) reports that households cope by doing ganyu (casual labour). In rural Zambia, some members of rural households were reported to migrate to urban areas in search of employment so that they can remit

some income to their rural area, while some work in neighbours' fields as casual labourers so as to earn some income (UNDP, 1997).

2.6.2 HIV/AIDS and head of household

In several places households remain under the head of either children or elders because HIV/AIDS has killed those prime individuals. In Uganda more than 80% of the reported HIV/AIDS cases are among people 15- 45 years old (ICRW, 2003) who are mostly the heads of household. Since these people constitute a significant proportion of the productive work force, their eventual illness and deaths reduce the family labour force, jeopardizing income flow and food security. In Tanzania the most affected age is 15-49, whereby the prevalence rate for this group in Morogoro is 5.1-10% (TACAIDS, 2006).

In some cases when parents are sick of AIDS, children have to resume some of responsibilities of heads of household and help out by searching wild foods or by working to boost household earnings (Gillespie and Kadiyala, 2005). This is mainly because ability of their parents to perform productive activities becomes tremendously reduced while healthy care costs increase. As a result children's education suffers because of missed schooling, they may even be withdrawn from school altogether due to having no school fees. In Zimbabwe, 18 percent of households with HIV/AIDS cases have removed one or more children from school as a coping mechanism in response to lack of food (Gillespie and Kadiyala, 2005). Very young children, who are also victims, spend about 80% of their time looking after their parents (Help Age- Tanzania, 2004), which brings them into economical crises and sexual abuse.

2.7 Coping Strategies by Individual PLWHA

When a sick victim is a breadwinner then the household members will be forced to find an alternative source of income for food and other necessary requirements. Decrease of food availability and access within the household forces individuals to seek the alternative ways of obtaining food. The strategy used is that of selling out properties by the family involved (TzPPA, 2002). Secondly HIV/AIDS cause young generations to be pulled out of school to boost the family ability to provide care for the ill and to maintain its current livelihoods (IFPRI, 2002). Children may be forced to engage in child labour for attaining money for caring the sick parents or for attaining daily requirements (IFPRI, 2002).

Drops in ability to produce and depletion on household income, occur dramatically as more adults are affected. This follows continuous use of savings. Once the savings are finished, the family seeks food support from relatives, borrow money or sells its productive asserts (FAO, 2001). Households are thus likely to have less working capital to finance their farming and may as well see their fixed capital eroded (IFPRI, 2002).

2.8 Gender and HIV/AIDS

AIDS has disproportionately affected vulnerable groups including women, children and the poor. The probability of a poor person becoming infected with HIV is almost 3 times higher than that of a well off one (Ricardo, 1997). The probability of a poor woman becoming infected is 13 times higher in Sub-Saharan Africa and 9 times in Latin America than for affluent women from the western world.

HIV/AIDS affects both sexes but it is not gender neutral. Women especially younger ones are biologically more susceptible to contracting HIV than men in a given sexual encounter (IFPRI, 2002). Women are physiologically, economically, and culturally more at risk of

HIV infection and AIDS (Gillespie and Kadiyala, 2005). Male-to-female transmission of HIV is two to four times more possible than that of female-to-male transmission (Burger and Weiser, 2001).

Furthermore, culturally women are less likely to negotiate condom use with husbands or other partners. The norms of virginity and the culture of silence regarding sex restrict adolescent girls access to information about sex and heighten the risk of sexual coercion (Collins and Rau, 2000). All these put women at more risk to HIV/AIDS. The death of husband thus often results in the dissolution and relocation of the household. This means a widow from HIV/AIDS has less access to the family's asset and prone to food security.

For women living in pastoralist areas, rights to security, freedom from inhuman or degrading treatment, information, education, expression, association, privacy and confidentiality are hard to come by (Morton, 2003). This compromises their ability to gather information on HIV/AIDS and take measures to avoid infection.

2.9 Cultural Practices

Cultural practices among the pastoralist have been cited as the lead fuel in accelerating HIV infection in pastoralist areas (Sammy and Mohamud, 2005). In particular, wife sharing, wife inheritance, ritual cleansing, use of un-sterilized instruments in childbirth, female genital mutilation (FGM), male circumcision and surgery by traditional medics, body tattooing and piercing have been singled as being high risk cultural practices (Sammy and Mohamud, 2005).

2.10 Conflicts and Displacement

Pastoral communities in East Africa have come to be associated with ceaseless conflict. Conflict generates several avenues for vulnerability to HIV/AIDS (Sammy and Mohamud, 2005). It also accounts for a reasonable percentage of rural-urban migration and associated exposure to HIV/AIDS. This occurs as displaced persons, deprived of any livelihood resources (livestock) become vulnerable to exploitation, including sexual contact with high-risk persons. Conflict is also associated with rape, impoverishment and a breakdown of social order, which contribute directly to the spread of HIV/AIDS (Ruto Pkalya *et al.*, 2004).

However, there has been very little research on linkages between HIV/AIDS and livestock-related livelihoods where livelihoods depend on livestock (Goe and Stranzinger, 2002). This is despite the facts that pastoralists represent a significant proportion of the rural population in many countries where the effects of HIV/AIDS have long been felt, such as Kenya and Uganda, that many pastoralists are already poor, and that virtually all are heavily vulnerable to external shocks and trends such as drought, armed conflict and encroachment on rangelands. Haslwimmer (1994) described the situation in Rakai District Uganda, an area of extreme endemic. She reports a loss of livestock through forced sales to meet medical and funeral expenses, loss of labour through deaths of adult men, and the inability of widows and orphans to acquire the necessary livestock production skills.

CHAPTER THREE

3.0 METHODOLOGY

3.1 Description of the Study Area

The study was conducted in Kilosa district, one of the districts involved in pastoral activities in Morogoro region. Specifically, the study was conducted in villages located at Dumila and Ludewa wards, where high level of interaction occasioned by business activities and highways put many at high risk of HIV infections.

Kilosa is one of the six districts constituting Morogoro region. Others are Morogoro urban, Morogoro rural, Kilombero, Mvomero and Ulanga. The district is located in central Tanzania 300 kilometers west of Dar es Salaam. It borders with Morogoro rural district to the East, Kilombero district and Iringa region to the South. Others are Dodoma region to the West and Tanga and Arusha regions to the North.

According to 2002 census, the district has a population of 489 513 with an average of 4.5 person per household (CSPD, 2005). There are two rainy seasons. The long rains, which start in late March and last till June, and short rains, which last from October to December. Most villagers are subsistence farmers growing maize, cassava, and sorghum. There is increasing number of petty traders. Most households keep domestic animals such as chickens, ducks, goats and cattle. There are small and medium keepers who migrate searching for pastures and water, who keep about 80% of the livestock. The major ethnic groups in the district are Pogoro, Kaguru, Sagara, Gogo, Maasai and Barabaig (URT, 2002). Kilosa District has started to implement Home Based Care (HBC) for People Living with HIV/AIDS (PLWHA) and other chronic illnesses such as Diabetes mellitus, Epilepsy, Carcinoma, Tuberculosis, Mental illness and Heart diseases. The program was

initiated due to the increased number of patients with HIV/AIDS and chronic illnesses. The hospital bed occupancy due to HIV/AIDS and related diseases is 50 – 60% (Morogoro newsletter, 2005).

3.2 Research Design

A cross sectional design was applied whereby data were collected at a single point in time from a sample selected to represent large population (Babbie, 1990). This design was used because it is suitable not only for purposes of description but also for the determination of relationship between variables.

3.3 Sampling Procedures

3.3.1 The sample

Purposive sampling technique was used to select villages involved in pastoralist activities from each ward of Dumila and Ludewa. From each of two villages selected (Twatwata and Kwambe) a list of pastoralist's households was obtained using up-dated village register. This list was treated as a sampling frame from which a random sample of 51 pastoralist households was drawn for study. Also snow-ball method was employed to get a total number of 42 youth pastoralists. Purposive sampling procedure was also employed to obtain representative CSOs that are dealing with HIV/AIDS, government coordinator of HIV/AIDS and local leaders. The sampling units for the study included community members, representatives from the selected CSOs, local community leaders, government leaders and PLWHA. People living with HIV/AIDS were purposively selected by visiting the Care and Treatment Clinics (CTC) and Voluntary Counseling and Testing (VCT) services found in respective places for focus group discussions.

3.3.2 The sample size

The total sample size was calculated as shown below, which was 93 pastoralists' respondents of which 42 were youth and 51 were heads of household and therefore adults. Adults were selected randomly from each village (2 villages) while for youth snow ball technique was used. For focus group discussions, 20 participants living with HIV/AIDS were selected. The District Council HIV/AIDS Control Coordinator (CHACC) and 6 civil society organizations leaders and 12 local leaders were interviewed as key informants.

Sample size calculation using formula:

$$n = \frac{z^2 pq}{d^2}$$

Where:

n = sample size

z = standard normal deviate, set at 1.96 (≈ 2.0) corresponding to 95% confidence level.

p = proportion in the target population estimate, if not known use 50%

q = 1.0 - p

d = degree of accuracy desired, set at 0.05 or 0.02

Therefore

$$n = \frac{z^2 pq}{d^2} = (2)^2 = \frac{(0.50 \times 0.50 = 4 \times 0.25)}{(0.05)^2} = \frac{4 \times 0.25}{0.0025} = \frac{1}{0.0025} =$$

= 400 respondents.

However average household size among the pastoralists communities is known to be as high as 8. Therefore a sample size of 400 divided by 8 was considered to be sufficient number of households, that is 50 households or head of households.

3.4 Data Collection Procedure

The method for data collection was structured interview using an interview schedule with standard set of questions. The interviews were administered to respondents separately. Unstructured interview using a list of general questions was employed to key informants from local and central government leaders, civil society organization leaders and focus group discussions. The researcher with the help of enumerators did the task of interviewing the respondents.

Moreover, the Maasai are known to be notoriously resistant in giving inside information to strangers when ultimate use of information is uncertain. A Maasai person is likely to give no information about the community unless authorized by a recognized local leader. In our case, however, we were accompanied by a guide specifically chosen for us by the local leader. The guide introduced us to the respondents and often acted as an interpreter whenever we talked to people who were not fluent enough in Kiswahili. Secondary data was obtained from various sources such as the Kilosa District Council and various reports on HIV/AIDS such as NACP and TACAIDS.

3.5 Data Analysis

Data collected from the primary sources were analyzed using Statistical Package for Social Sciences (SPSS) computer programme. Descriptive statistics such as frequencies, percentages and means were used. On the assessment of the pastoralist's responses towards HIV/AIDS, chi-square statistic was used to test for relationship between variables. For the case of attitudes, index was calculated using component principal analysis.

3.6 Study Limitation

The following were some of problems encountered during data collection:

- Conflicts over resource use, particularly land and water between sedentary agriculturists and nomadic pastoralist have been on the increase recently. In Ludewa villages of Kilosa district these conflicts became so serious to an extent of claiming lives of some individuals in 2000 and 2008. Therefore due to conflicts between farmers and pastoralists, the time for data collection was postponed for several months and some of respondents were reluctant to give information for fearing that we were sent by the government to spy on them.
- Organizations were unable to provide quantitative data during the time of face to face interview which required intensive follow ups resulting into underreporting of the number of people reached for care and supports.

CHAPTER FOUR

4.0 RESULTS AND DISCUSSION

4.1 An Overview

This chapter describes and discusses the results of the study. It is divided into six sections whereby the first one presents the characteristics of the respondents interviewed. Then knowledge and attitudes on HIV/AIDS and PLWHA are given before results on the use of HIV/AIDS “Best practices” by the stakeholders are shown and discussed. The last two sections present community members` response to HIV/AIDS impact/effects and response to the agricultural sector HIV/AIDS strategies by the stakeholders.

4.2 Background Characteristics of the Respondents

The background characteristics of the respondents considered were age, sex, marital status, religion, education and occupation.

4.2.1 Age

The age ranged between 27 – 64 years for the adult respondents and 15 – 34 years for the youth respondents. The age distribution of the respondents is presented in Table 2. Whereas the majorities (52.9%) of the adult respondents were above 40 years old, all the youth respondents (100%) were below 40 years old.

4.2.2 Sex

Sex distribution of the respondents is given in Table 2. Ninety percent of adult respondents were male and only 9.8% were female. Similarly, the majority of youth respondents were male (88.1%) and only 11.9% were female. The few number of female respondents was due to their culture which hinder female from meeting outsiders and expressing their views.

4.2.3 Level of education

The distribution of the respondents by the level of education is shown in Table 2. Further examination of relationship between education and HIV/AIDS testing status will be discussed later, due to the fact that very big number (72.5%) of adult respondents and youth respondents (57.1%) belonged to only one category (no schooling).

Table 2: Demographic characteristics

| Variables | Adults (n=51) | | Youth (n=42) | |
|-------------------------|---------------|---------|--------------|---------|
| | Number | Percent | Number | Percent |
| Age | | | | |
| 40 years and below | 24 | 47.1 | 42 | 100.0 |
| Above 40 years | 27 | 52.9 | 0 | 0.0 |
| Sex | | | | |
| Male | 46 | 90.2 | 37 | 88.1 |
| Female | 5 | 9.8 | 5 | 11.9 |
| Education levels | | | | |
| No Schooling | 37 | 72.5 | 24 | 57.1 |
| Attended Primary School | 14 | 27.5 | 18 | 42.9 |

4.2.4 Marital status

Marriage is an important factor of exposure of women and men to sexual intercourse, which is the leading mechanism to HIV infection in Tanzania (TDHS, 1996). Table 3 shows that there are 92.2% married and 7.8% widowed adult respondents while all youth respondents were single (100%). In this community polygamy is still prevalent with 61.5 percent being in polygamous marriages. Of all respondents who have been in marriages (past and present) close to two thirds were polygamous. Early marriage is still relatively common in Africa. The average age of brides is 15 years in Niger, 16.4 years in Cameroon and 17.5 years in Bukina Faso. Marriage often occurs between young girls and considerably older men. In Cameroon the average age difference between husband and wife is 15 years while in Kenya it is seven years (Kishor and Neitzel, 1996). Young women married too older men have less power in decision making around sexual intercourse,

childbearing and birth control, and are less able to protect themselves from STDs exploitation or abuse (Noble *et al.*, 1996; and Kishor and Neitzel, 1996).

4.2.5 Religion of the respondents

It is important to understand religious affiliations of communities by understanding how they perceive HIV/AIDS, as religion forms a large part of cultures worldwide. Christian faith is prevalent in the study area to the almost total exclusion of other religions. Eighty six percent of adult respondents belonged to Christian faith, 3.9% Muslims and 9.8% were believer of traditional religion (Table 3).

Table 3: Distribution of the adult respondents by social characteristics

| Variables | Number | Percent |
|-----------------------|---------------|----------------|
| Marital status | | |
| Married monogamous | 16 | 30.7 |
| Married polygamous | 31 | 61.5 |
| Widowed | 4 | 7.8 |
| Occupation | | |
| Farming | 30 | 58.8 |
| Livestock keeping | 51 | 100.0 |
| Doing business | 11 | 21.6 |
| Religious leader | 16 | 31.4 |
| Village leader | 8 | 15.7 |
| Religion | | |
| Christian | 44 | 86.3 |
| Muslim | 2 | 3.9 |
| Traditional religion | 5 | 9.8 |

4.2.6 Occupation

Occupation in this study refers to any legal means at which an individual earns income, where it is broadly defined to include home production, self-employment, salaries, wages and transfers (Bonnard, 2003). The distribution of the respondents according to their occupation is indicated in Table 3. All the adult respondents were keeping livestock (100%). Only 58.8% of the respondents were involved in both livestock keeping and

farming, which is not surprising because this study was conducted in pastoral society where farming is minimal.

4.2.7 Household composition

Table 4 shows that most of the households (47.1%) had 8 - 13 members, followed by 35.3% who had 2 – 7 members, also 13.7% had 14-19 members. Only 3.9 % had 20 members and above. The overall mean of household size was 9.7 people within the sampled villages negating the popular belief that pastoralist households are big owing to their polygamous nature.

Table 4: Household composition of adult respondents

| Categories of number of household members | Number | Percent |
|--|---------------|----------------|
| 2-7 | 18 | 35.3 |
| 8-13 | 24 | 47.1 |
| 14-19 | 7 | 13.7 |
| 20 and above | 2 | 3.9 |
| Total | 51 | 100.0 |

4.3 Knowledge and Attitudes on HIV/AIDS and PLWHA

4.3.1 Knowledge concerning HIV/AIDS

Knowledge was tested about HIV/AIDS among pastoralist community. Respondents were asked if they have ever heard of the HIV or an illness called AIDS, if they know the way HIV/AIDS is transmitted and sources where they can obtain HIV information. They were also asked if they discuss HIV/AIDS with their partners and their perceived risk of acquiring HIV/AIDS. Each of the aspects is presented below.

(a) Mode of HIV transmission

Tables 5 and 6 summarize the results on knowledge and attitude about HIV/AIDS. All respondents interviewed have heard of HIV/AIDS epidemic. The vast majority of adult respondents (92.2%) know that AIDS can be contacted from woman to man through sexual contact while 70.6% of adult respondents believed that mosquitoes, tsetse flies and bedbugs cannot transmit HIV/AIDS. Also 64.3% of youth respondents know that healthy-looking person can have AIDS virus then can transmit them easier.

Table 5: Level of comprehensive knowledge about HIV/AIDS among pastoralist community

| Questions | Correct | | Incorrect | |
|--|---------|---------|-----------|---------|
| | Number | Percent | Number | Percent |
| Adult respondents questions | | | | |
| Healthy young people do not get AIDS | 28 | 54.9 | 23 | 45.1 |
| Using condom during sexual intercourse can prevent AIDS | 35 | 68.6 | 16 | 31.4 |
| Virus can be transmitted through sweat | 30 | 58.8 | 21 | 41.2 |
| Virus can be transmitted through blood | 30 | 58.8 | 21 | 41.2 |
| AIDS can be cured if detected in earlier stages | 44 | 86.3 | 7 | 13.7 |
| A man can not contact AIDS from woman | 47 | 92.2 | 3 | 5.9 |
| Mosquitoes, tsetse flies and bedbugs transmit of HIV | 36 | 70.6 | 15 | 29.4 |
| Religious leaders are among people who can not be infected with HIV | 40 | 78.4 | 11 | 21.6 |
| To get washed after every sexual contact protects one against HIV infections | 41 | 80.4 | 9 | 17.6 |
| Youth respondents questions | | | | |
| Healthy- looking person can have AIDS virus | 27 | 64.3 | 9 | 21.4 |
| HIV/AIDS can be transmitted from mother to child | 19 | 45.2 | 8 | 19.0 |
| Having STDs increase the chance of an infant getting AIDS during delivery | 18 | 42.9 | 24 | 57.1 |

Therefore the most widely known mode of transmission in this community is heterosexual contact as the majorities of the respondents answered the given questions correctly. These findings confirmed the studies done by Kishindo (1995), AIDS (1996) and Balint (1998) who also established the main mode of transmission of HIV in Sub-Saharan Africa to be through heterosexual contacts.

It was revealed from this study that, the majority of youth respondents perceived their risk of contracting HIV to be low (59.5%), very few (7.1%) perceived to have moderate risk and 33.3% of respondents thought to have high risk of contracting HIV/AIDS. Also 59.5% of youth respondents talk about HIV/AIDS with regular partners, only 28.6% of youth respondents have no regular partners (Table 6).

Table 6: Knowledge of youth respondents concerning HIV/AIDS

| Response | Number | Percent (n=42) |
|---|---------------|-----------------------|
| Perceived risk of contracting HIV/AIDS | | |
| Low risk | 25 | 59.5 |
| Medium risk | 3 | 7.1 |
| High risk | 14 | 33.3 |
| Talked about HIV/AIDS with regular sex partner | | |
| Talked on HIV/AIDS | 22 | 52.4 |
| Not talked on HIV/AIDS | 8 | 19.0 |
| No regular partner | 12 | 28.6 |

(b) Knowledge of mother-to-child transmission

Current strategies on HIV/AIDS in Tanzania are geared towards improving the health of HIV infected mothers and reducing the transmission of the virus to their children during pregnancy, labour, delivery, and post-delivery through breastfeeding as outlined in the National Policy on HIV/AIDS (Prime Minister's Office, 2001). As shown in Table 5, forty five percent of youth pastoralists know that HIV/AIDS can be transmitted from mother to child and 42.9% were sure that having sexually transmitted diseases (STDs) increase the chance of an infant getting AIDS during delivery.

(c) Knowledge about the means of prevention on HIV/AIDS

Findings in Table 7 indicate that 59.5% of youth pastoralist were sure that use of condom can prevent HIV/AIDS, this is approximately the same to adults pastoralist who 68.6% agree that the use of condoms can prevent getting HIV/AIDS (Table 5). Also 57.1% of youth respondents were sure that avoiding sex with prostitutes can prevent HIV/AIDS. Also 54.8% of youth respondents agree that to stay faithful with one partner can prevent one from getting HIV/AIDS. Only 26% of youth respondents agreed with the statement that abstaining from sex can prevent HIV/AIDS (Table 7).

Table 7: Distribution of youth respondents by the opinions about proper modes of HIV prevention

| Variables | Number | Percent (n=42) |
|--|---------------|---------------------------|
| Nothing to do | 11 | 26.2 |
| Abstain from sex | 11 | 26.2 |
| Use condoms | 25 | 59.5 |
| Use condoms with high risk partners | 9 | 21.4 |
| Be faithful to one partner | 23 | 54.8 |
| Limit number of sex partners | 17 | 40.5 |
| Avoid sex with prostitutes | 24 | 57.1 |
| Avoid sex with homosexual | 5 | 11.9 |
| Avoid blood transfusion | 16 | 38.1 |
| Avoid injection | 11 | 26.2 |
| Avoid kissing | 4 | 9.5 |
| Avoid mosquitoes bites | 0 | 0 |
| Seek protection from traditional healers | 0 | 0 |
| Take vitamins | 0 | 0 |

The findings observed by Barker and Ricardo (2005) noted that, many people don't view abstinence as a reasonable option for prevention; instead the prevention method cited by most of people is condom use and in several settings is the only preventive behaviour, spontaneously mentioned. However there are various barriers to their use, including religious belief, self- risk perception, access to condoms and negotiation with a partner.

(d) Source of information about HIV/AIDS

As shown in Table 8, the main source of information on HIV/AIDS for youths was friends/peers (42.9%), followed by the media particularly radio (33.3%), then relatives (28.6%). Others were Television (16.7%) and government healthy care workers (21.4%). Newspapers and Library were the least important source of HIV/AIDS information, which may be due to the fact that high percent of this community have not attended to school and therefore they do not know how to write and read.

Table 8: Response of youth respondents on the source of information about HIV/AIDS

| Media | Number | Percent (n=42) |
|-------------------------------|---------------|-----------------------|
| Nowhere | 18 | 42.9 |
| Government health care worker | 9 | 21.4 |
| Private health care worker | 2 | 4.8 |
| Relatives | 12 | 28.6 |
| Friends | 18 | 42.9 |
| Radio | 14 | 33.3 |
| TV | 7 | 16.7 |
| Newspapers | 3 | 7.1 |
| Library | 2 | 4.8 |

4.3.2 Attitude of adult respondents towards HIV/AIDS and PLWHA

HIV/AIDS related stigma could partially be attributed to the fact that it is sexually transmitted disease (THIS, 2005). National policy on HIV/AIDS has identified stigma as one of the challenges in prevention and control of the epidemic (URT, 2001). People living with HIV/AIDS face discrimination and are sometimes neglected because of hostile attitude which lead to secrecy and denial which hinder people from seeking counseling and testing for HIV, which is crucial in fighting the epidemic (URT, 2001).

In this study attitude of respondents towards HIV/AIDS and PLWHA was sought using Likert attitudinal scale. The Likert scale that was constructed had twelve statements that

carried positive and negative statements about HIV/AIDS. Respondents were requested to say whether they strongly agree, agree, undecided, disagree or strongly disagree against each statements. As shown in Table 9, the first statement shows that majority of adult respondents strongly disagree with the statement (43.1%), this means that respondents had the opinion that HIV/AIDS is not punishment from God. Thirty nine percent of respondents strongly agree with the statement that names of people with HIV/AIDS should be made public to avoid sexual contact with them; this statement can show how this community is aware about the presence of the epidemic.

Findings in other statements show that 47.1% of respondents strongly agree with the statement that people with HIV/AIDS are careless and don't care whether they infect others while 47.1% of respondents were not sure if the use of condom during sexual intercourse protect one from HIV/AIDS. Fifty five percent strongly disagree with the statement that staying without sexual practices can make one to be weak and 58.8% strongly agree with the statement that condom using encourages prostitution behaviour to both men and women.

Also the majority of the respondents (47.1%) agree with the statement that having many sexual partners encourage HIV transmission. According to the results it can be said that the awareness on HIV/AIDS in this community is high even though the perception on condom use for adults respondents was uncertain as shown in some statements that the majority were not sure if the use of condom during sexual intercourse protects one from HIV/AIDS and that condom use encourages prostitution behaviour to both men and women. Most of the adult respondents received high score on all positive statements about HIV/AIDS and relatively low score were obtained to all negative statements. This implies that the respondents have positive attitude towards HIV/AIDS.

Table 9: Adults attitudes towards HIV/AIDS and PLWHA (%)

| Statement on attitude | Strongly disagree | Disagree | Undecided | Agree | Strongly agree |
|---|--------------------------|-----------------|------------------|--------------|-----------------------|
| HIV/AIDS is God's punishment for wicked people | 43.1 | 11.8 | 9.8 | 13.7 | 21.6 |
| People with HIV/AIDS should be legally separated from others | 9.8 | 35.3 | 5.9 | 33.3 | 15.7 |
| Names of people with HIV/AIDS should be made public to avoid sexual contact with them | 15.7 | 2.0 | 5.9 | 37.3 | 39.2 |
| People who got AIDS through sex or drug use have got what they deserve | 17.6 | 27.5 | 11.8 | 31.4 | 11.8 |
| One can protect him/herself from HIV by using condom correctly every time having sex | 11.8 | 7.8 | 33.3 | 25.5 | 21.6 |
| People with HIV/AIDS are careless and don't care whether they infect others | 3.9 | 9.8 | 7.8 | 31.4 | 47.1 |
| People protect themselves from getting infected by abstaining from sex | 5.9 | 23.5 | 15.7 | 29.4 | 25.5 |
| Using condom during sexual intercourse protect one from AIDS | 7.8 | 15.7 | 47.1 | 17.6 | 11.8 |
| Staying without sexual practices makes one to be weak | 54.9 | 13.7 | 17.6 | 9.8 | 3.9 |
| Condom using encourages prostitution behaviour to both men and women | 5.9 | 5.9 | 15.7 | 13.7 | 58.8 |
| Having many sexual partners encourage HIV transmission | 3.9 | 7.8 | 0.0 | 47.1 | 41.2 |
| From religious point of view using condom is not ethical | 15.7 | 11.8 | 17.6 | 31.4 | 23.5 |

Score index of attitude towards HIV/AIDS

For the purpose of simplifying the analysis, categories 1 and 2 (strongly agree and agree) were merged and re-categorized as 1 (agree), while category 3 was re-categorized as 2 (undecided) and categories 4 and 5 (strongly disagree and disagree) re-categorized as category 3 (disagree). Therefore responses were grouped into three categories namely

agree, undecided and disagree. In all positive statements every “Agree” response was given a score of 3 while “undecided” scored 2 and “Disagree” scored 1. For all negative statements every “Agree” response was represented by 1 while “Uncertain” was represented by 2 and “Disagree” was represented by 3. The criteria that were used in the construction of the score index are presented in Table 10.

Table 10: Criteria used in score index of attitude towards HIV/AIDS and PLWHA

| Argument/Question | Response | Score |
|---|-----------------|--------------|
| HIV/AIDS is God’s punishment for wicked people | Agree | 1 |
| | Undecided | 2 |
| | Disagree | 3 |
| People with HIV/AIDS should be legally separated from others | Agree | 1 |
| | Undecided | 2 |
| | Disagree | 3 |
| Names of people with HIV/AIDS should be made public to avoid sexual contact with them | Disagree | 1 |
| | Undecided | 2 |
| | Agree | 3 |
| People who got AIDS through sex or drug use have got what they deserve | Agree | 1 |
| | Undecided | 2 |
| | Disagree | 3 |
| One can protect him/herself from HIV by using condom correctly every time having sex | Disagree | 1 |
| | Undecided | 2 |
| | Agree | 3 |
| People with HIV/AIDS are careless and don’t care whether they infect others | Agree | 1 |
| | Undecided | 2 |
| | Disagree | 3 |
| People protect themselves from getting infected by abstaining from sex | Disagree | 1 |
| | Undecided | 2 |
| | Agree | 3 |
| Using condom during sexual intercourse protect one from AIDS | Disagree | 1 |
| | Undecided | 2 |
| | Agree | 3 |
| Staying without sexual practices makes one to be weak | Agree | 1 |
| | Undecided | 2 |
| | Disagree | 3 |
| Condom using encourages prostitution behaviour to both men and women | Agree | 1 |
| | Undecided | 2 |
| | Disagree | 3 |
| Having many sexual partners encourage HIV transmission | Disagree | 1 |
| | Undecided | 2 |
| | Agree | 3 |
| From religious point of view using condom is not ethical | Disagree | 1 |
| | Undecided | 2 |
| | Agree | 3 |

The data for measuring attitudes towards PLWHA and HIV/AIDS were analyzed and scores ranged from 12 to 60. Categorization of the scores was done as following: low attitude (12 – 29), indifferent (30 – 31), and high attitude (32 – 60). Using this categorization, 90.2% of the respondents had high attitudes towards PLWHA and HIV/AIDS while 5.9% of the respondents had low attitude and 3.9% were indifferent (Table 11).

Table 11: Attitudes of adult respondents towards HIV/AIDS and PLWHA score

| Level of attitude towards PLWHA & /HIV/AIDS | Percent |
|--|----------------|
| Low attitude | 5.9 |
| Indifferent | 3.9 |
| High attitude | 90.2 |

Further findings from focus group discussions (FGDs) agreed with these results that the community has come to terms with the presence of HIV/AIDS amongst themselves and accepts to support affected and infected person within the community.

4.4 Use of HIV/AIDS “Best Practices” by the Stakeholders

In this study, HIV/AIDS “Best practices” were considered to include the use of “ABC” principles by the individuals, and establishment of VCT centers by the government and non-governmental agencies. Others included care and support to orphans. “ABC” stands for Abstain from sex, Be faithful to one partner and Condoms use.

4.4.1 Individual responses to the use of “ABC”

During informal discussions with leaders of non-governmental organization called PARAKUYO COMMUNITY BASED ORGANIZATION it was argued that abstinence and faithfulness are not concepts immediately accepted in the Maasai community. They clearly showed that Maasai have a tradition of shared sex where by a man can take another

man's wife and sleep with her. Similarly the use of condoms may be difficult to be fully accepted by the Maasai women because for them sexual satisfaction comes by a man ejaculating inside a woman and not any other way.

Informal discussions with groups of male youths revealed that, the warriors (morani) have several girlfriends because it is part of their life. They engage in free sex without condoms but once they go to the towns, they don't have sex because they are afraid of the women there because some are infected with HIV/AIDS. This shows that abstaining was implemented by the youth especially when the environment was not conducive.

There are no official statistics on HIV prevalence specifically within the Maasai community. Although health officials do not believe the problem is "too bad" yet, there are signs that some men are not as careful when it comes to sex issues. For example, the District HIV/AIDS coordinator remarked that when the Maasai men go into town, they earn money and some of them indulge in drinking and this changes their behaviour and some of them do contract sexually transmitted diseases and so they are obviously at risk from HIV/AIDS. The youth respondents were asked on what they thought was important to reach the young with messages on HIV/AIDS prevention. Fifty seven percent of them suggested that it is important to develop a role-play or performing arts, which includes ways of preventing HIV infection (Table 12), while about one quarter (23.8%) did not know what can be done.

Table 12: Youth suggestions on what can be done to reach young people with messages on HIV/AIDS prevention

| Suggestion | Number | Percent |
|------------------------------------|---------------|----------------|
| Important to develop role play | 24 | 57.2 |
| Not important to develop role play | 8 | 19.0 |
| Don't know | 10 | 23.8 |
| Total | 42 | 100.0 |

Table 13 shows the suggested messages considered important in the role – play game or performing arts. The main issues mentioned include use of condoms (54.8%), be faithful to one partner (54.8%), limit number of sexual partner (54.8%), avoid sex with prostitutes (52.4%), avoid blood transfusion (40.5 %) and abstain from sex (21.4%).

Table 13: Suggested messages to be included in role-play games to reach young people

| Options | Number | Percent (n=42) |
|--|---------------|-----------------------|
| Nothing | 14 | 33.3 |
| Abstain from sex | 9 | 21.4 |
| Use condoms | 23 | 54.8 |
| Use condoms with high risk partners | 16 | 38.1 |
| Be faithful to one partner | 23 | 54.8 |
| Limit number of sex partners | 23 | 54.8 |
| Avoid sex with prostitutes | 22 | 52.4 |
| Avoid sex with homosexual | 13 | 31.0 |
| Avoid blood transfusion | 17 | 40.5 |
| Avoid injection | 16 | 38.1 |
| Avoid kissing | 4 | 9.5 |
| Avoid mosquitoes bites | 1 | 2.4 |
| Seek protection from traditional healers | 1 | 2.4 |
| Take vitamins | 1 | 2.4 |

Performing arts method is effective at gathering people due to its entertainment nature thus community members are entertained and educated at the same time. The performing arts can be in forms of poems, drama, story telling, traditional dancing and comedies. HIV/AIDS prevention is the only hope for overcoming the pandemic in the absence of treatment. Hung *et al.* (1998) contended that the key to preventing AIDS is to stop the transmission of the virus before it enters the human body.

Response on sources of condoms among youth

Knowledge of a place to get condoms is a necessary precursor to use of condoms. As shown in Table 14, the majority of youth respondents indicated that condoms can be obtained from the pharmacy shops (76.2%), other respondents said that condoms can be obtained from the health center (21.4%) and from kiosks (21.4%).

Table 14: Reported places where condoms can be obtained by the youths

| | Number | Percent (n=42) |
|-------------------------|--------|----------------|
| Pharmacy shops | 32 | 76.2 |
| Kiosks | 9 | 21.4 |
| Health center/ hospital | 9 | 21.4 |
| Market | 0 | 0.0 |
| Bar | 3 | 7.1 |
| Others | 6 | 14.3 |

4.4.2 Establishment and use of VCT services

Voluntary HIV counseling and testing take two facets (SAT 2003); the first is when a person goes for HIV screening willingly without being forced in anyhow. This testing is associated with pre and post test counseling. The second component of this aspect is for a person who is found infected during the test. The counseling provided to this person is not the same with that during the test. This second component of counseling is continuous such that a person is counselled on how to accept the situation and live positively with that HIV status. The organizations such as AFNET, PARAKUYO COMMUNITY BASED ORGANIZATION and KIPHA (Kilosa People Living with HIV/AIDS) conduct both facets of counseling.

Knowledge of HIV status can empower individuals to take precautions to protect against either acquiring or transmitting the disease. Consequently, Tanzania has established a number of voluntary counseling and testing (VCT) sites across the country and encourages their use by the general population. However, as a result of either lack of knowledge as to the importance of testing or for other reasons, most people in the country have not yet been tested (THIS, 2005). The general average figure for Tanzania on HIV/AIDS counseling and testing prior to the launch of the national HIV-testing campaign in July 2007 was estimated to be only about 15%. By the end of June 2008, over 4.8 million people were screened for HIV through the national HIV-testing campaign, and overall HIV prevalence was found to be 5.4% (I-TECH, 2007).

As shown in Table 15 only 29.4 percent of adults and 23.8% of youth respondents reported to have ever undertaken HIV test, pretest counseling and received the results. Counsellors encourage PLWHA to recognize and develop ways in which they can deal more effectively with the problem (SAT, 2003). The fact that 70.6% of adult respondents and 76.2% of youth respondents did not test for HIV/AIDS this was due to the following: the majority of adults respondents (51%) and youth respondents (47.6%) argued that they were sure of not having HIV/AIDS while 23.5 percent of adults respondents and 19 percent of youth respondents said that they were afraid of being tested. Few adults and youth respondents complained that there are no voluntary counseling and testing centers (VCTs) in their villages (5.5% and 9.5%).

Table 15: Respondents information towards HIV /AIDS testing

| Questions | Adults (Percent) (n=51) | Youth (Percent) (n=42) |
|--|----------------------------|---------------------------|
| Where HIV testing takes place | | |
| Test done at VCT center | 35.3 | 43.4 |
| Test done at government healthy center | 19.6 | 26.3 |
| Ever tested and got results | | |
| Tested & get results | 29.4 | 23.8 |
| Not tested for HIV/AIDS | 70.6 | 76.2 |
| Reasons given for testing | | |
| Asked for test | 7.8 | 2.4 |
| Offered and accepted for test | 11.8 | 14.3 |
| Required for test | 9.8 | 7.1 |
| Reasons given for not testing | | |
| Afraid | 23.5 | 19.0 |
| Sure of not having HIV/AIDS | 51.0 | 47.6 |
| Lazy/no time to go | 10.6 | 4.8 |
| No testing centers at the village | 5.5 | 9.5 |

Through informal discussions most of the respondents complained that no counseling and testing centers are found in their villages. Most of them are located in the urban and peri-urban areas where it is costly to reach. The results of counseling services are similar to that of Harding (2003), that only 10% who need testing in low and middle- income countries

have access to counseling and testing services. The respondents were also asked about the places where test can be done. Table 15 shows that 35.3% of adult respondents and 43.4% of youth respondents revealed that HIV test is done at VCTs while 19.6% of adult respondents and 26.3% of youth respondents said that HIV test is done at the government healthy center.

Interview done with the leaders from six selected CSOs (SOS CHILDREN VILLAGE TRUST FUND, KIPHA, APDOM, WAVUDU, WOMEN ASSOCIATION (KKKT), PARAKUYO COMMUNITY BASE ORGANIZATION) (refer Table 24) said that they operated HIV voluntary counseling and testing centers. These CSOs have professional personnel in counseling and testing. The interview with the Council HIV/AIDS coordinator (CHACC), noted that VCT services especially the components of testing and ARVs provision is mostly done by the government due to medical ethics attached to the services.

(a) Relationship between age and HIV testing for status

The study also attempted to test for relationship between age of respondents and the testing status. The test results are summarized in Table 16 whereby those in 40 years and below are more likely than others to have been tested. The chi-square statistical test showed that there is significant relationship ($p < 0.05$) between the testing status and the age of the adult respondents.

Table 16: Chi-square statistical test results for relationship between age category and HIV testing status

| Age category of adults | Tested | Have not tested | df | Sig. (2-sided) | Chi-Square value |
|------------------------|------------------|------------------|----|----------------|------------------|
| 40 years and below | 11(45.8%) | 13(54.2%) | 1 | .019 | 5.510 |
| 41 years and above | 4(15.4%) | 22(84.6%) | | | |
| Total | 15(30.0%) | 35(70.0%) | | | |

Figures in parenthesis are the percentages of the respondents

(b) Relationship between level of education and HIV testing

The results of chi-square testing showed that there is statistical significant relationship ($p < 0.05$) between level of education and HIV/AIDS testing status (Table 17) in both adults and youths. Those who attended primary school were more likely to test than those who did not attend school. Uganda has reduced HIV/AIDS prevalence from 14% in the early 1990s to about 4.1% in 2003; an important tool in this success was the use of information campaigns to educate individuals the important of testing (Bakilana *et al.*, 2005). Individuals that were more educated were the most likely to have adopted safer behaviour including visiting VCT centers, delaying their sexual debut and using condoms. This pattern of safer behavior was even stronger among women; there is evidence that more educated women were having fewer sexual partners (Bakilana *et al.*, 2005). Education has been called a ‘social vaccine’ against HIV/AIDS because education empowers individuals with appropriate skills to receive and act on knowledge including knowledge about HIV/AIDS (Bakilana *et al.*, 2005).

Table 17: Chi-square statistical test results for relationship between level of education and HIV testing

| | Tested | Have not tested | df | Sig. (2-sided) | Chi-Square value |
|--------------------------------|-----------------|------------------------|-----------|-----------------------|-------------------------|
| Education level adults | | | | | |
| No schooling | 7(19.4) | 29(80.6) | 1 | .009 | 6.822 |
| Attended primary | 8(57.1) | 6(42.9) | | | |
| Total | 15(30.0) | 35(70.0) | | | |
| Education leveled youth | | | | | |
| No schooling | 3(12.5) | 21(87.5) | 1 | .047 | 3.948 |
| Attended primary school | 7(38.9) | 11(61.1) | | | |
| Total | 10(23.8) | 32(76.2) | | | |

Figures in parenthesis are the percentages of the respondents

4.4.3 Care and support for orphans and vulnerable children

In this context, an orphan was defined as an individual under age 18 who has lost one or both parents. A vulnerable child was defined as a child under age 18, with one or both parents being very sick unable to provide the child with basic needs. This study found that within the households surveyed, 15.7% reported to have member of the household been very sick or died and 9.8% complained to live with child/ children whose parents have been very sick and died with the disease considered to be HIV/AIDS (Table 18).

Table 18: Reported household member(s) been very sick/died for at least in the past three months

| Extent of vulnerability in household | Number | Percent (n= 51) |
|--|---------------|------------------------|
| One member of household was very sick/died | 4 | 7.8 |
| Two members of household were very sick/died | 1 | 2.0 |
| Three members of household were very sick/died | 2 | 3.9 |
| Four members of household were very sick/died | 1 | 2.0 |
| No member in the household was very sick/died | 43 | 84.3 |
| Live with a child whose mother/ father died/been very sick for at least three months | 5 | 9.8 |

The study also included questions about care and supports that were administered by CSOs to the households with orphans and vulnerable children. In the case of households with either orphans or vulnerable children, questions were added as to whether the household had received any external support (other than that from family or friends). Several types of support are shown in Table 19. About eight percent of respondents received medical support, 13.7% of respondents received emotional support such as companionship and counseling, 15.7% of interviewed respondents received material support such as clothes, food and money, and 11.8% of respondents received practical support such as help with housework, legal services and support with schooling. URT (2003b) recommends support activities to be sustained in close relation with the existing traditional family and

community systems (extended families), which are unable to absorb the challenge of increased number of orphans.

Focus group discussions indicated that strong kinship and communal ties are still found among the communities in the study area. This has helped to meet needs for medical care, education, food and clothing for AIDS orphans.

Table 19: Reported care and support for orphans and vulnerable children

| Care and support | Number | Percent (n=51) |
|--|---------------|-----------------------|
| Material support such as monetary, clothes and food | 8 | 15.7 |
| Practical support such as household work, training for caregivers, legal services, | 6 | 11.8 |
| Medical support such as medical care or medicine | 4 | 7.8 |
| Social, emotional or spiritual support such as companionship or counseling | 7 | 13.7 |
| No OVCs found in the household | 43 | 84.3 |

4.5 Community Members` Response to HIV/AIDS Impacts

This section presents results on how community responds to the impacts of HIV/AIDS; it includes individual response, household response, civil society response and action by the local and central government leadership. Stakeholders in provision of HIV/AIDS care and support are all those involved in care and have a role to play in the delivery of various services (AMREF, 2005). In this study different types of stakeholders were identified dealing with HIV/AIDS and its effects in Kilosa district. These include people living with HIV/AIDS, households, NGOs (KIPHA), FBOs (KKKT WOMEN ASSOCIATION) and CBOs (PARAKUYO COMMUNITY BASE ORGANIZATION) and local and central governmental leaders. Some specific aspects of roles were unique to the specific players but others were overlapping to some extent. Every stakeholder was found to be important

and making vital contributions to the total care system and mitigation. The identified responses by each of the mentioned stakeholders are presented and discussed below.

4.5.1 Response by individuals and households

(a) Household coping strategies with food shortage

Food shortage has made individuals to develop different strategies in order to cope with the situation (Ishengoma 1998). Some of them are easy to recover while others are relatively difficult (Maxwell and Frankenberger, 2002). Table 20 summarizes the coping strategies that were mentioned to be used by the affected/infected households and PLWHA. It appears that dietary modification strategies were most common. They included skipping meals, move to relatively cheap food and reducing varieties of meals per week. Some non-dietary strategies were also common including dependence on relatives or friends and welfare-threatening selling of assets. Others were selling of labour and asking for loans.

Table 20: Reported coping strategies for affected households

| Coping strategies | Percentage (n=8) |
|-----------------------------------|-------------------------|
| Dietary modification | |
| Move to relative cheap food | 33.3 |
| Reduce varieties of meal per week | 4.5 |
| Skipping some meals | 51.0 |
| Depended on wild food | 48.0 |
| Non- dietary modification | |
| Selling labour | 17.0 |
| Depend on relatives/friends | 34.0 |
| Selling productive assets | 23.3 |
| Asking for food or monetary loans | 19.0 |

(i) Dietary modification

All the dietary modifications were ease to be recovered according to Maxwell and Frankenberger (2002). Skipping meal seems to have been adopted by the majority (51%) while reducing varieties of meal per week had the lowest percentage (4.5%) as shown in

Table 20. Similar findings were obtained by Rugalema (1998) in Tanzania, Sauerborn *et al.* (1996) in Burkina Faso, and Barnett *et al.* (1995) in rural Uganda. These results are compatible with the study conducted in Somalia where it was found that 57.3% of the study households depended on wild food, 49.1% reduced number of meals per day and 48.1% moved to comparatively less expensive foods while 39.2% sold child labour to obtain food (UN 2004). At an individual level, HIV infection essentially accelerates the vicious circle of inadequate nutrients intake and that leads to malnutrition while malnutrition increases the risk of HIV transmission from mothers to babies and the progression of HIV infection to full blown AIDS (Piwoz and Preble, 2000).

(ii) Non – dietary strategies

The respondents who depended on relatives and friends for obtaining their food were the largest group (34%) followed by those who sold assets (23.3%), while those asking for food or monetary loans were 19% and 17% sold their labour to obtain food (Table 20). A study in Kenya reported same coping strategies of obtaining assistance from relatives and friends, casual employment to work in other people's farms as labourers and asking for loans from self-help groups (Winrock International, 2002). However selling labour by people living with HIV/AIDS is contrary to recommendations given to PLWHA, which require them to do light works and avoid straining themselves due to reduction in body strength (TFNC, 2003).

(iii) Welfare threatening strategies

Strategies that are considered to threaten welfare of an individual PLWHA or his/her household are more difficult to recover after adopting them (Maxwell and Frankenberger, 2002). They are difficult to recover because they tend to leave a permanent effect to an individual household or community concerned. They include selling of assets especially

productive ones. Pastoralists have the unique economic strategy that relies almost exclusively on livestock. Examination of the causes for livestock sales can give a valid estimate of the extent to which the pandemic has affected livestock breeding. Though it was not possible to isolate medical care and related costs, respondents whose household members considered to be affected with HIV/AIDS revealed that 23.3% of households sold their asset to earn food and medical care (Table 20). Types of assets reported to be sold included livestock, as it is the main productive asset for pastoralist communities. Similar findings were reported by IFPRI (2001) where people had to sell productive assets to meet life expenses including healthcare and food. In Uganda, 65% of the AIDS affected households sold household properties to pay for food and other services (FAO, 2001). Selling of productive assets affects individuals and households welfare because the ability to regain sold assets is difficult.

(b) Household coping strategies aimed to raise income

Study results in Table 21 show that 13.7% of the infected and affected households reported of the acute decrease of incomes while 13.7% reported variation in livestock production. About twelve percent of affected household sold livestock to cover medical related costs while 9.8% moved to farming activities to earn more income. Growing pressure on the decrease of income has resulted into large numbers of pastoralists moving out of pastoralism and diversify into other economic activities, including crop farming, petty trade, and urban wage employment mostly as watchmen (Ruto Pkalya *et al.*, 2004). Other studies noted that rural households that cannot meet their food requirements undertake a range of income-generating activities such as selling firewood, brewing millet beer, selling livestock, building fences, handicrafts, tailoring, and petty trade to supplement their income (Sauerborn *et al.*, 1996).

Table 21: Impacts of sickness/death in affected households

| Impact | Percentage (n=51) |
|--|--------------------------|
| Variation in livestock production | 13.7 |
| Decrease in purchased items including food | 13.7 |
| Acute decrease in household incomes | 13.7 |
| Move to crop farming | 9.8 |
| Selling of assets (livestock) to cover medical costs | 11.8 |

(c) Household coping strategies aimed at alleviating the loss of labour

Intra-household labour reallocation and taking children out of school among household members is the most frequently used strategy to cope with expected production losses resulting from adult morbidity and mortality (URT, 2006). Table 22 shows that 58.8% of the respondents reported that they knew other households whose children have been taken out of school as a coping response to labour loss. Furthermore, from focus group discussions with PLWHA they explained that intensive use of child labour was a major strategy typically used by the afflicted households during care provision.

As shown in Table 22, about 39% of adult respondents reported to know households whose children have been absorbed within the extended family network. Although children are not directly involved in care provision they are involved indirectly, by fulfilling mother's and father's roles in some domestic and livestock activities (such as collecting water and firewood, looking after the animals and preparing food for the rest of the household) (URT, 2006). IFPRI (2001) called the phenomenon a sacrifice of tomorrow's livelihood in order to survive today. Depriving children education exemplifies the dilemma of the ultimately "destructive" coping strategy.

Table 22: Reported cases of taking children out of school

| Response | Percent (n=51) |
|-----------------------------------|-----------------------|
| Know children taken out of school | 58.8 |
| Know children taken by relatives | 39.2 |
| Know nothing | 11.8 |

(d) Inter-generational consequences

The disease has impacted attendance at school for the children of affected adults. The long-term significance of this is catastrophic, as these children will not have the benefit of formal education, which is crucial for poverty reduction, improved health, and enhanced livelihood possibilities (URT, 2006).

As shown on Table 23, the majority of youth respondents (57.1%) had the opinion that HIV/AIDS was causing loss of knowledge on livestock keeping due to the fact that most adults die with the knowledge before transferring it to the younger generation. Seven percent of youth respondents felt that most of money for keeping livestock is lost in caring HIV/AIDS victims, and another 7% of youth respondents thought that the services from trained personnel and experts (researchers, extension workers and others) decrease/lost as a result of HIV/AIDS.

Table 23: Opinions expressed by youth respondents on the impacts of HIV/AIDS on livestock keeping

| Opinion | Number | Percent (n=42) |
|--|---------------|---------------------------|
| HIV/AIDS cause loss of knowledge on livestock keeping | 24 | 57.1 |
| Most of money for keeping livestock is lost | 3 | 7.1 |
| Manpower of the community is lost | 1 | 2.4 |
| Most adults die with the knowledge before transfer to young ones | 15 | 35.6 |
| Most affected become confused | 2 | 4.8 |
| Decrease of services from trained personnel and experts | 3 | 7.1 |

The death of adults has strong inter-generational consequence in that it limits the ability of the next generation to acquire relevant livelihood skills because adults die before passing down their knowledge. Loss of indigenous knowledge about traditional farming methods and livestock keeping will occur if members of the household or the elderly are not able to pass on their knowledge to subsequent youths (URT, 2006).

4.5.2 CSOs response to HIV/AIDS impacts

Civil society organizations (CSOs) play a key role in the response to the AIDS epidemic in countries around the world where HIV/AIDS epidemic has posed a lot of challenges in the communities and nations as a whole, (UNAIDS, 2007). People infected and affected by the epidemic face a lot of life challenges ranging from social to economic. CSOs are doing a range of interventions in mitigating the impact. In this particular study, impact mitigation was subdivided into care and support of people living with HIV/AIDS (PLWHA) and support of orphans and vulnerable children (OVCs).

(a) Response of civil society organizations towards HIV/AIDS in Kilosa district

Different CSOs dealing with HIV/AIDS were identified together with programs they were running. It was learned from the coordinator of HIV/AIDS (CHACC) in Kilosa District that although many CSOs have been claiming to be involved with supporting PLWHA, in reality only few were actively involved. Six organizations were selected to identify their response to HIV/AIDS and PLWHA. Findings are summarized in Table 24 such as APDOM dealing with HIV/AIDS intervention for pastoralists community in Kimamba A & B, KIPHA (Kilosa People Living with HIV/AIDS) dealing with HIV intervention and fighting against HIV/AIDS in Kilosa District and WAVUDU (Watu wanaoishi na Virusi vya Ukimwi Dumila) dealing with HIV/AIDS mitigation in Dumila ward. Others were Parakuyo community based organization dealing with HIV intervention in Twatwatwa and Parakuyo villages, SOS Children Village Trust Fund dealing with care and support for orphans and vulnerable children in Ludewa ward and women association (KKKT) dealing with women development and HIV/AIDS. The organizations reported that home visits were done regularly in order to provide moral support to the sick persons and family members.

Table 24: Selected CSOs dealing with HIV/AIDS in Kilosa District

| | Name of organization | Main activities undertaken | Area for implementation | Type |
|---|--|--|--------------------------------|-------------|
| 1 | APDOM | Pastoralist and HIV/AIDS | Kimamba A & B wards | Local NGO |
| 2 | KIPHA (Kilosa People Living with HIV/AIDS) | HIV intervention and Fighting against HIV/AIDS | Kilosa District | Local NGO |
| 3 | WAVUDU | HIV/AIDS mitigation | Dumila ward | Local NGO |
| 4 | Parakuyo community based organization | HIV intervention | Twatwatwa, Parakuyo villages | CBOs |
| 5 | SOS Children Village Trust Fund | Care and support for OVC | Ludewa ward | CBO |
| 6 | Women Association (KKKT) | Women Development and HIV/AIDS intervention | Kilosa Town | FBO |

The visits also provided opportunity to assess their physical needs and meet those needs through practical measures such as provision of drugs and basic needs. Needs identification was mentioned to be useful because needs were not only met by organizations that conducted home visits but also other organizations that provided support through referral services. Provision of drugs was done at home of the sick person while basic needs provision was done at the village or “mtaa” government office. PLWHA or their representatives for those who were bed ridden collected basic needs from the village offices.

(b) Care and support for people living with HIV/AIDS

Care and support for people living with HIV/AIDS (PLWHA) is important not only for making infected people live longer but also for reducing the transmission of HIV. According to Dowshen (2007), most people do not develop AIDS symptoms for 10 to 12 years and others remain symptom free for much longer. However, Hubley *et al.* (1995)

pointed out that, a person dies 1-2 years after showing AIDS symptoms when no care is provided.

Interviews with the key informants revealed that, CSOs` interventions have led to reduced stigma. As a result, more community members are going for HIV test and HIV positive people are joining HIV groups. Also, there have been positive community initiatives such as contribution for travel costs for people living with HIV/AIDS (PLWHA) to attend care and treatment clinics (CTCs) and provision of basic needs for PLWHA, orphans and vulnerable children. However, CSOs argued that lack of permanent settlement in this community was a big problem, which causes poor linkages between organizations and the affected and infected households.

4.5.3 Government response on HIV/AIDS

(a) Local Government responses

In 2003, TACAIDS produced the National Multi-sectoral Strategies Framework on HIV/AIDS (2003-2007) which stipulated that Local Government Authorities (LGAs) were needed to play a crucial role in planning and coordinating HIV/AIDS interventions that are implemented by various organizations and communities in the districts in order to ensure sustainability, coordination and ownership of the interventions (URT, 2003a). Following this, District and Village HIV/AIDS committees were created under TACAIDS Act of Parliament to lead the planning, resource mobilization and coordination of local responses (URT, 2001c). These efforts included a call of all sectors to take new measures to respond to the epidemic. Government funding support to CSOs helps the Local Government Authority to take on the role of planning and coordinating HIV/AIDS interventions while benefiting from the efforts of CSOs. Government funding is coordinated by TACAIDS, which has contracted Regional Facilitating Agencies (RFAs) to manage the funds in

regions and zones. The interview with the key informants on how money was channeled to CSOs indicated that the action plans of CSOs were submitted to the District Council; the RFA together with the District Council officials selected the plans that were worthy to finance. The selection process was based on the areas of operations and priority HIV/AIDS thematic areas given by the District Council.

In Kilosa district there are about 36 civil society organizations dealing with HIV/AIDS interventions. The study revealed that 41.5% of CSOs depended on donor funding and that only few CSOs were funded by individual members for implementing their activities (Table 25). Donors make decisions, which influence local NGOs priorities that are then turned into interventions frameworks, which might not suit local conditions.

Table 25: Reported main sources of funds for CSOs dealing with HIV/AIDS in Kilosa District

| Sources of funds | Percent (n=36) |
|--|-----------------------|
| Donor funding | 41.5 |
| Internal sources | 30.1 |
| Government funding | 20.6 |
| Individual funding(member contributions) | 7.8 |

(b) Central government response to HIV/AIDS

The interviews with key informants (central government leader in Kilosa district) revealed that the government provided support and services for PLWHA and OVC in the following form:

- Guidance in counseling for PLWHA
- Help in initiating the income generating groups
- Provision of clothes, school facilities and food for orphans and vulnerable children
- ARVs provision for people living with HIV/AIDS

Some of the problems reported to be faced when services and support were provided included the following:

- Difficult in identification of respective infected and affected individuals as the majority of pastoralist (Maasai) are reluctant to give personal information,
- The problem of services and support failure or delay to reach the intended people because of bureaucracy involved
- Low budget for supporting infected and affected people.

Formal discussions with the central government leader on the contribution made by health sector on the pandemic, revealed that Kilosa District has started to implement Home Based Care (HBC) for People Living with HIV/AIDS (PLWHA) and chronic illnesses such as HIV/AIDS. The Ministry of Health and Social Welfare through the National AIDS Control Program provided 14 bicycles for HBC providers and drugs were purchased for health facilities, including hospitals, health centers and dispensaries. The benefits realized from HBC included the community sensitized to desist from discriminating PLWHA, reduced hospital bed occupancy through HBC, HIV/AIDS infection is reduced, community members looking after patients by HBC saves time for other productive activities.

4.6 Agricultural Sector Responses to HIV/AIDS

The agriculture sector has been implementing measures in HIV/AIDS epidemic prevention and control at least since 1997, originally through the UNAIDS funded “Strengthening AIDS Education and Research in Agricultural Sector” project. Over the past few years, some funds have been made available for this purpose from UNDP, GTZ and FAO (URT, 2006). In response to multi- sectoral nature of the epidemic, the National Framework for

HIV/AIDS has requested various government ministries to develop sector-specific HIV/AIDS strategies. One of them been the Agricultural Sector HIV/AIDS Strategy.

In line with the combined overall goals of the National Multi-Sectoral Strategic Framework on HIV/AIDS, the MKUKUTA, and Agricultural Sector Development Strategy, the goal of this Agricultural Sector HIV/AIDS Strategy is to prevent further spread of HIV/AIDS and improve the livelihoods and quality of life on HIV/AIDS-affected communities. The Agricultural Sector Strategy to HIV/AIDS is organized around nine strategic priority areas that will guide agricultural programming and planning in high impacted communities and that aim to:

- Empower orphans and vulnerable children in agricultural, pastoral and fishing communities and provide them with opportunities for long term livelihood security
- Empower rural widows and female headed households to reduce their vulnerability and to mitigate the impact of HIV/AIDS on their livelihood
- Improve access to and adoption of labour saving technologies and practices to overcome food security problems among households affected by HIV/AIDS
- Increasing disposable income and assets among households affected by HIV/AIDS
- Improve food and nutrition value
- Strengthen social community support
- Prevention of property grabbing
- Capacity building of Agriculture Sector Line Ministries (ASLM) staff
- Action oriented impact and mitigation research

Several key actors at national, regional and local level are responsible for implementing the Agricultural Sector HIV/AIDS Strategy including the Agriculture Sector Line Ministries (ASLM) in collaboration with other central government ministries, LGAs, Civil Societies Organizations (CSOs), and communities. Development Partners play a supportive role in implementation of the strategy (URT, 2006). The interviews with key informants (CHACC and central government leader) revealed that the implementation and coordination of the strategy at the local level is done by the District Executive Director’s office in collaboration with the civil society organizations.

Interviews with village and “mtaa” leaders (key informants) showed that the Agricultural Sector HIV/AIDS Strategy for supporting people living with HIV/AIDS, orphans and vulnerable children has not been implemented in their area. Also 100% of the respondents revealed that no supports were provided by Agricultural institutions (Table 26).

Table 26: Reported situation of supports for Agricultural Sector HIV/AIDS Strategy in the area

| Response | Number | Percent |
|--------------------------------------|---------------|----------------|
| No support for Agricultural sector | 12 | 100.0 |
| There are supports for Agric. sector | 0 | 00.0 |
| Total | 12 | 100.0 |

CHAPTER FIVE

5.0 CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

The following aspects of conclusions are made from the findings of this study:

- (i) Results from the study indicate that there is high awareness on HIV/AIDS prevention measures among the respondents, as all respondents know some preventive methods on HIV/AIDS.
- (ii) HIV/AIDS best practices such as the use of “ABC”, care and support for orphan and vulnerable children and the use of VCT are to some extent being implemented in the community. The use of condoms has been observed to be implemented by few youth respondents while abstaining was implemented by majority of youth the time found out of their home seeking job at town. Supports and care for orphan and vulnerable children were provided by different CSOs and the government.
- (iii) More negative individual and household responses towards HIV/AIDS were noted in this study than the positive ones. Negative responses included taking children out of school, sending children to relatives, selling of assets (livestock) for food and medical costs, skipping some meals and depending on wild food. The positive responses were asking for loans, selling labour and move to crop farming.
- (iv) Responses by the CSOs, central and local government were noted to be mostly positive such as care and support for infected and affected individuals and households, provision of education on HIV/AIDS in general, and guidance in counselling and testing for HIV/AIDS.

- (v) The agricultural Sector HIV/AIDS Strategy for supporting people living with HIV/AIDS, orphans and vulnerable children have not been implemented in the area. This may be due to the fact that, the programme was planned to begin in high impacted communities, which Kilosa is not included for the time being.

5.2 Recommendations

- (i) There should be a continuous effort to maintain achievement made on the level of awareness. More emphasis should be on programmes geared on promoting behavioral change.
- (ii) No counselling and testing centers were found in the study area, most of them were located in urban and peri- urban areas where it is expensive to reach. Effort is thus needed to ensure that pre-test counseling and post- test counselling are available to all people who need it.
- (iii) Lack of permanent settlements for the community results on poor support and care for infected and affected individuals. The government should find the solutions for the issue.
- (iv) Finally, there is a need for multidisciplinary action on the response to HIV/AIDS at the grass-root level as well as community level. The responses proved to be positive in this study area should be scaled up and the negative responses should be discouraged.

5.3 Areas for Further Research

The findings presented in this study are results of a survey conducted in two villages of nomadic pastoralist and they cannot be representative of the total population of pastoralist in Tanzania. Consequently, there is a need for more studies in other areas where pastoralists are found. These include Arusha, Manyara, Bagamoyo and Handeni.

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APPENDICES

Appendix 1: Proposed interview schedule for pastoralists households

Questionnaire No.....

Village.....

Ward.....

Date.....

A. General information

1. Sex of respondents

| | |
|---------|-----------|
| 1= male | 2= female |
|---------|-----------|

2. Age.....

3. Marital status

| | |
|------------|------------------------|
| 1= married | 3= divorced/ separated |
| 2= widowed | 4= never married |

4. What is your education level?

| | |
|--|---|
| 1= no schooling | 3= secondary- completed form VI - completed form IV -attended for few years |
| 2= primary - completed primary - attended for few years | 4= diploma |
| 3= vocational training | 5 = university |

5. Number of household members.....

6. What is your occupation?

| | |
|------------------------|----------------------------|
| 1= peasant | 3= religious leader |
| 2= livestock keeping | 4= village leader |
| 5= government employee | 7= Self employee (specify) |
| 6= business person | 8= others (specify) |

7. What is your religion?

| | |
|--------------|-------------------------|
| 1= Christian | 3= Traditional religion |
| 2= Muslim | 4= others (specify) |

B: Knowledge about HIV/AIDS

8. Please indicate whether each of the following statements is TRUE or FALSE

(a). Healthy young people do not get AIDS

TRUE FALSE.....

(b). Using condom during sexual intercourse can prevent AIDS

TRUE FALSE.....

- (c). Virus can be transmitted through sweat
TRUE.....FALSE.....
- (d). Virus can be transmitted through blood
TRUE.....FALSE.....
- (e). AIDS can be cured if detected in earlier stages
TRUE..... FALSE
- (f). A man cannot contract AIDS from a woman
TRUE FALSE.....
- (g). Insects like mosquitoes, tsetse flies and bedbugs are good transmitters of HIV
TRUE.....FALSE.....
- (h). Religious leaders are among people who can not be infected with HIV
TRUE.....FALSE.....
- (i). To get washed after every sexual contact perfectly protects ones against HIV infections.
TRUE..... FALSE.....

C: Attitudes, feelings and beliefs of people on HIV and PLWHA and HIV best practices.
Attitudes on HIV & PLWHA & HIV best practices

9. What is your opinion on the following statements? Use the scale below;

Strongly agree= 5, Agree= 4, Undecided= 3, Disagree= 2, Strongly disagree=1

| No. | ITEMS | SCORE |
|-----|---|-------|
| 1 | HIV/AIDS is God's punishment for wicked people | |
| 2 | People with HIV/AIDS should be legally separated from others | |
| 3 | Names of people with HIV/AIDS should be made public to avoid sexual contact with them | |
| 4 | People who got AIDS through sex or drug use have got what they deserve | |
| 5 | One can protect him/herself from HIV by using condom correctly every time having sex | |
| 6 | People with HIV/AIDS are careless and don't care whether they infect others | |
| 7 | People protect themselves from getting infected by not having sex at all (abstaining) | |
| 8 | Using condom during sexual intercourse protect one from HIV/AIDS | |
| 9 | Staying without sexual practices makes one to be weak | |
| 10 | Condom using encourages prostitution behaviour to both men and women | |
| 11 | Having many sexual partner encourage HIV transmission | |
| 12 | From religious point of view using condom is not ethical | |

C: General Head of household information

10. Were you born in this village?

1 = Yes, 2 = No ()

11. If no where were you before.....

12. What are the major reasons for migrating to this village/place?.....

13. In your household is there one/several person(s) has(ve) been very sick for at least three months /died after been very sick for at least three months
 1 = Yes 2 = No
 (If no move to question number 27)
14. If yes how many household members died /sick.....
15. Had this person/any of these persons been very sick for at least three months before dying? Be very sick, I mean that they were too sick to work or do normal activities around the house
 1 = Yes 2 = No ()
16. In your household, is there at least one child whose mother and/or father died or has(ve) been very sick for at least three months.
 1 = Yes 2 = No ()

I would like some information about the help or support that your household has received from anyone besides your relatives, friends or neighbors for that/those person(s).

- a) Any material support, such as monetary support, clothes or food for which you did not have to pay?.....
 - b) Any practical support, such as help in household work, training for caregivers, or legal services, for which you did not have to pay?.....
 - c) Any kind of medical support, such as medical care or medicine, for which you did not have to pay?
 - d) Any kind of social, spiritual, or emotional support, such as companionship or counseling from a trained counselor which you received at home and for which you did not have to pay.....
17. Is there any variation in livestock production before and after death/sickness in your household?1 = Yes 2 = No
- 18 Has households experienced a decrease in purchased items including food as a result of sickness/death (Contributing towards orphans)
 1 = Yes 2 = No ()
19. Has there been an acute decrease in household income as a result of sickness/death?
 1 = Yes 2 = No
20. Has there been a diversion from livestock keeping to farming due to death/sickness?
 1 = Yes 2 = No
21. Has there been an increase in land/livestock sale as a result of sickness/death?
1 = Yes 2 = No

22. Who own livestock in this household?

| | |
|--------------------------|--|
| 1 = Male | |
| 2 = Female | |
| 3 = Both male and female | |
| 4 = Others (specify) | |

23. Do traditions and norms allow widow /children to inherit properties like livestock and other properties left by husband?
 1 = Yes, 2 = No ()
24. Have you ever heard of an illness called AIDS? 1 = Yes 2 = No
25. Do you know a place where you could get an HIV test if you wanted to?.....
 1 = Yes 2 = No

- 26. If yes where was the test done?.....
 - 1. VCT center
 - 2. Government healthy center
 - 3. Care and treatment clinics
 - 4. District hospital
 - 5. Others (specify)
- 27. I don't want to know the results, but have you ever been tested to see if you have the AIDS virus? 1 = Yes 2 = No
(If No go for number 35)
- 28. When was the last time you were tested?.....
 - 1. Less than 12 months ago
 - 2. More than 12 months ago
- 29. The last time you had the test, did you yourself ask for the test, was it offered to you and you accepted, or was it required?.....
 - 1. Asked for test
 - 2. Offered and accepted
 - 3. Required
- 30. I don't want to know the results, but did you get the results of the test?.....
1 = Yes 2 = No
- 31 There are many reasons why people do not get tested for HIV, can you tell me why you have not been tested?.....
 - 1. Afraid
 - 2. Do not want to know
- 32. Are you aware of households where there has been an increase in the number of household dependences?..... 1 = Yes 2 = No
- 33. What coping strategies/safety nets exist in your community that could cushion against impacts of HIV/AIDS?
.....

Thank you for your cooperation

Appendix 2: Proposed interview schedule for Youth pastoralists

Questionnaire No.....

Village.....

Ward.....

Date.....

| 1 | How old are you? | Years old..... Does not known..... | | | | | | | | | |
|-----------------------------|---|---|--|-----|----|---------------------|---|---|-----------------------------|---|---|
| 2 | Sex of respondents | Male..... Female..... | | | | | | | | | |
| 3 | What is the highest level of school you attended? | None Completed primary school Attended primary school for few years Completed form VI Completed form IV Attended secondary school for few years Post-secondary | | | | | | | | | |
| 4 | Do you have access to a television that works? | No..... Yes..... | | | | | | | | | |
| 5 | Do you have access to a radio that works? | No..... Yes..... | | | | | | | | | |
| 6 | Have you ever heard of an illness called HIV/AIDS? | No..... Yes..... | | | | | | | | | |
| 7 | During the past three months have you heard or seen anything on the radio, television or newspaper about the following: | <table border="1"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>HIV/AIDS prevention</td> <td>1</td> <td>0</td> </tr> <tr> <td>The play for life game plan</td> <td>1</td> <td>0</td> </tr> </tbody> </table> | | Yes | No | HIV/AIDS prevention | 1 | 0 | The play for life game plan | 1 | 0 |
| | Yes | No | | | | | | | | | |
| HIV/AIDS prevention | 1 | 0 | | | | | | | | | |
| The play for life game plan | 1 | 0 | | | | | | | | | |
| 8 | If you have a question about HIV/AIDS, who do you ask or where do you go to get the information? | Nowhere Government health care worker (doctor /nurse)..... Private health care worker (doctor/nurse)..... Community health worker..... Family planning clinic provider..... Husband/wife (spouse)..... Other relatives..... Friends..... Radio..... TV..... Newspapers/magazines..... Library..... Community or public meetings..... Others, specify | | | | | | | | | |

| | | |
|----|--|---|
| 9 | Do you know if there is anything a person can do to avoid getting AIDS? | No..... Yes..... Don't know..... |
| 10 | In your opinion what can a person do to avoid getting AIDS? | Nothing Abstain from sex..... Use condoms Use condoms with high-risk partners Limit sex to one partner/be faithful to one partner Avoid sex with prostitute..... Avoid sex with homosexual Avoid blood transfusion..... Avoid injections Avoid kissing Avoid mosquito bites Seek protection from traditional healer Others (specify)..... |
| 11 | Is it possible for a healthy-looking person to be infected with the AIDS virus? | No..... Yes..... Don't know..... |
| 12 | Do you know someone personally who has AIDS or the virus that causes AIDS or someone who died from AIDS? | No..... Yes..... |
| 13 | Can AIDS be transmitted from a mother to a child? | No..... Yes..... Don't know..... |
| 14 | Have you ever talked about HIV or AIDS with your or regular sex partner? | No..... Yes..... No regular partner..... |
| 15 | How much are you at risk of contracting HIV/AIDS? Would you say: no risk at all, medium risk or high risk? | No risk at all..... Medium risk..... High risk..... |
| 16 | Do you know if having a sexually transmitted disease can increase the chance of a person getting AIDS? | No..... Yes..... |
| 17 | Where can one obtain a condom? | Pharmacy..... Kiosk..... Health center/hospital..... Market..... Bar..... Others..... |
| 18 | During the past month, did you encourage anyone to use condoms to avoid HIV/AIDS and other | No..... Yes..... |

| | | |
|----|---|--|
| | sexually transmitted diseases? | |
| 19 | If a person knows that he or she has AIDS or the virus that causes AIDS, do you think that he/she should keep it private or tell other people in the community? | Should keep it private..... Should tell others..... Others (specify)..... Don't know / not sure..... |
| 20 | Do you think that it would be useful to develop a " role play" of what to do to avoid getting infected with the HIV/AIDS virus? | No..... Yes..... Don't know..... |
| 21 | Please write in the column in the right what things should be included in a role play to avoid getting infected with the HIV/AIDS virus | Nothing Abstain from sex..... Use condoms Use condoms with high-risk partners Limit sex to one partner/stay faithful to one part. Limit number of sex partners ... Avoid sex with prostitute..... Avoid sex with homosexual Avoid blood transfusion. Avoid injections ... Avoid kissing Avoid mosquito bites Seek protection from .traditional healer Take vitamins..... Others(specify)..... |
| 22 | I don't want to know the results, but have you ever been tested to see if you have the AIDS virus? (If no move to 24) | No..... Yes..... |
| 23 | I don't want to know the results, but did you get the results of the test? | No..... Yes..... |
| 24 | There are many reasons why people do not get tested for HIV. Can you tell me why you have not been tested? | Does not want to know/afraid Is sure she/he does not have HIV... Is sure she/he is HIV positive Lacks of anonymity/ people at VCT know him/her Costs too much Lazy/ no time to go Plans to go Undecided Others (specify)..... |
| 25 | Place where test done | Test done at..... 1. VCTs center 2. Government healthy center 3. Care and treatment clinics |

| | | | | | |
|----|--|---|-------|------|-------|
| | | 4. District hospital 5. Others (specify) | | | |
| 26 | Do you feel that HIV/AIDS can cause loss of knowledge on livestock keeping? | No..... Yes..... If yes how? | | | |
| 27 | How are tasks divided between women and men, girls and boys, when it comes to livestock? | Men | Women | Boys | Girls |
| | | | | | |

Appendix 3: The interview checklist for key informants

A. CSO

1. What services are you offering to people affected and infected with HIV/AIDS?
2. What are your sources of funds?
3. What are the problems facing you in delivering services to people living with HIV/AIDS?
4. Do you receive any assistance from the government? If yes which assistance.
5. In your opinion, what coping strategies should be considered more effective for affected /infected household with HIV/AIDS?
6. What are your plans for improving the coping strategies for household infected with HIV/AIDS?

B. CHACC and Central government leaders

7. What services are you offering to people/organization taking care for people affected and infected with HIV/AIDS?
8. What are your sources of funds?
9. What are the problems facing you in delivering services to people living with HIV/AIDS?
10. In your opinion, what coping strategies should be considered more effective for affected /infected household with HIV/AIDS?
11. What are your plans for improving the coping strategies for household infected with HIV/AIDS?

C. Local leadership

1. Is there any support from government institutions such as agricultural sector HIV/AIDS strategies supporting household infected with HIV/AIDS and vulnerable children and widows?

1 = Yes, 2 = No ()

2. If yes what among the following supports are applicable in your village? Use the scale below; Very applicable = 5, Somehow applicable = 4, A little applicable =3, Very little applicable = 2, Not applicable at all = 1.

| Statements | Score |
|--|-------|
| 1. Support to orphans | |
| 2. Empowering rural widows and vulnerable female headed households | |
| 3. Labour-saving technology and practices | |
| 4. Increasing disposable income and assets | |
| 5. Improving food and nutritional security | |
| 6. Strengthen social community support | |
| 7. Prevention of poverty grabbing | |
| 8. Action-oriented impact and mitigation research | |

3. Which is the preferred medium for disseminating HIV/AIDS information to your community? and why?
- 4 (a) What constraints access to schooling in your community? Even with free primary education, most children do not access education. Why?
(b) How has HIV/AIDS constraints children attending school on a regular basis? Have the school enrolment increased/Decreased? Is the answer attributable to HIV/AIDS?

5. What coping strategies/safety nets exist in your community that could cushion against impacts of HIV/AIDS?
6. Who in your community constitute high-risk group and why?
7. Food security:
 - a) How is the food situation in HIV/AIDS affected households? (Comparatively with non-affected households)
 - b) How dependent are households affected by HIV/AIDS on livestock sales for food? (comparatively with non-affected households).
8. HIV/AIDS risks:
 - (a) How does prolonged ill health as a result of HIV/AIDS contribute to loss in household productivity?
 - (b) What active responses existing within your community could enable individuals and their household to avoid the worst impacts of HIV/AIDS?

Focus Group Discussion

- 1 How has HIV/AIDS affected your community's participation in community-based organizations, associations and other social support networks?
- 2 Are the local political and government leadership available and accessible for consultation with the community on wider development issues including HIV/AIDS?
- 3 Which organization operates services in this area and what nature of services do they provide?
- 4 Has there been a reduction or increased in the incidence of child labour in your community?
- 5 What factors and situations in your community contribute to risk of being infected with HIV? (Cultural practices, poverty etc).
6. Reproductive rights:
 - a) Do more women have access to contraceptive services?
 - b) Do women in your community negotiate/have a say on safe sex?
 - c) Are more women allowed to use contraception?
 - d) Have there been changes in cultural practices including FGM, early marriages, and rights of the girl child to education?