FEASIBILITY STUDY FOR IMPLEMENTING FAITH-BASED HIV/AIDS VOLUNTARY COUNSELING AND TESTING CENTERS IN TANZANIA

SUMMARY REPORT

In Partnership With
The Christian Council of Tanzania
The Tanzania Episcopal Conference
The National Muslim Council of Tanzania

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EXECUTIVE SUMMARY

BACKGROUND

The fight against HIV/AIDS must be won, but that can only happen through concerted efforts, partnerships and involvement of groups, individuals and institutions such as churches and mosques that are strategically placed and have the moral mandate/obligation to address this global pandemic. The Balm in Gilead and its Tanzania partners – The Tanzania Episcopal Conference (TEC), Christian Council of Tanzania (CCT) and the National Muslim Council of Tanzania (BAKWATA) have for the past four years partnered to build the capacity of faith institutions to intensify their involvement in HIV/AIDS prevention, care and support activities in Tanzania.

According to the UNAIDS/WHO Epidemiological Fact Sheet, the estimated number of people living with HIV/AIDS in Tanzania, at the end of 2003 was 1,500,000. The estimated number of children (under age 17) who have lost one or both parents to AIDS was 1,400,000 by end of 2003. Despite the alarming rates at which the HIV/AIDS pandemic is growing in Tanzania, the faith organizations’ response has been slow and inadequate.

In 2001, The Balm In Gilead received a cooperative agreement from the Centers for Disease Control and Prevention to build the capacity of faith communities within five African countries: Cote d’Ivoire, Nigeria, Kenya, Tanzania, and Zimbabwe. Funding from the Bill and Melinda Foundation further supported The Balm In Gilead’s efforts to build a sustainable health education and service delivery system within Tanzania’s faith community. In partnership with MAP (Medical Assistance Program) International – Kenya office, an International Christian Health Organization, the Balm In Gilead extended its program to include the capacity development of four theological institutions in Tanzania to provide a comprehensive AIDS education curriculum to equip their graduating clergy to address the challenges of the AIDS pandemic within their congregations and communities.

THE STUDY

The Balm In Gilead and its three faith partners, Tanzania Episcopal Conference, Christian Council of Tanzania and the National Muslim Council of Tanzania conducted a feasibility study in three rural communities to determine the factors to be considered in establishing VCT/PMTCT services. The community assessments took place from June-July 2004 in three specific rural locations or sites selected by each national HIV/AIDS faith office:

- Kigoma-Ujiji in Kigoma selected by BAKWATA
- Ludewa in Iringa selected by CCT
- Masasi in Mtwara selected by TEC

Information about the community was gathered using community mapping techniques and interviewing community residents, users of health services, and faith and village leaders. The staff and facilities questionnaire, client interview questionnaire and the community resident questionnaire were adapted from The Faith Organization (TFA) in Partnership with UNICEF Needs Assessment Survey Questionnaire for women in the Congo Area.
Questions asked by the feasibility study included the following:

- What is the need for HIV related services in the specific target area?
- What are the utilization patterns for HIV/AIDS related services?
- How are existing VCT services structured in the existing or nearby locations?
- What services are currently available in the area and how are they structured?
- What is the population’s perceived need for general health-related services?
- What are the facilitators and barriers to service utilization?
- What are attitude/perspectives and common cultural beliefs and practices with respect to HIV/AIDS?

A total of 1,361 individuals participated in this study – 481 from Kigoma-Ujiji; 408 from Ludewa; and 472 from Masasi.

**FINDINGS**

**Community Assessment**

In each site at least 300 community residents, representing different age and gender groupings were interviewed. Some of the major findings include:

- Among women who had ever been pregnant 82% reported receiving prenatal care. However, less than a quarter of these women had received HIV testing and counseling at antenatal clinics.
- The majority of respondents from all sites reported that more health services are needed in their areas; the reported need for health services was highest in Masasi.
- About half the sample (49%; n=1164) believed that HIV was transmitted by mosquitoes and one-quarter agreed that one could become infected from sharing eating utensils.
- Overall, 75% of the sample do not know where to go for HIV counseling and testing or know of only places that are inaccessible to them.
- Fewer than one fifth of all respondent reported ever being tested for HIV/AIDS. Rates vary by geographical area with 27% of Kigoma residents, 17% of Ludewa residents but only 6% of those in Masasi reporting that they had ever had an HIV test.
- The prevalence of HIV testing appears to be low among the broader community in the three areas studied. Only a small percentage (15%) knows of any friends or family members who have been tested for HIV.

**Faith Leaders**

Findings from interviews with fifty-six (56) faith leaders include:

- Almost all (89%) faith leaders interviewed indicated that there was a gap with respect to the supply and demand for general health services in their communities and that the demand was far outstripping the supply.
• Religious leaders seemed to be relatively well informed about HIV but 40-50% in some areas believe that mosquitoes can transmit the virus.

• Support for involving faith communities in the fight against HIV/AIDS was almost universal among faith leaders interviewed

• All but one (96%) agreed that religious organizations should be involved in providing HIV services and the same high proportion indicated that their church or mosque was willing to collaborate with other organizations in fighting HIV.

Clients of VCT Centers

A total of 88 interviews were conducted with clients presenting to health service facilities providing voluntary HIV testing and counseling.

• Approximately two-thirds (66%) of respondents interviewed were first time visitors

• Fewer than half of clients interviewed reported that any of their friends or family members had been tested for HIV although 70% indicated that everyone should get tested for HIV.

• Respondent were asked why they thought that testing was important for everyone. Answers emphasized the importance of knowing one’s health status and acknowledgement of risk behaviors

• Although the majority of VCT clients should have received information about HIV transmission risks, they appear as likely as other community residents (and faith leaders) to incorrectly identify sharing eating utensils and mosquito bites as sources of HIV infection.

Recommendations

The following recommendations are suggested from the findings. First, HIV/AIDS services are needed within a larger context of health services. Situating VCT and other HIV/AIDS related services within the larger health services may reduce the stigma still associated with HIV/AIDS in rural areas. The integration of such services in already existing services requires attention to sensitivity to patient concerns for privacy.

AIDS awareness and education is needed in rural communities and should be an integral component of any health related effort in these areas.

HIV education and testing should be provided as an integral part of prenatal care provided to pregnant women.

Faith leaders should be included in any community mobilization, HIV education and service delivery development in the areas under study. Their position of influence and trust are an invaluable resource in community health promotion and VCT services development.

Community-based participatory research should be employed in endeavors which require broad-based community mobilization particularly on sensitive topics like HIV/AIDS—where community “buy-in” and trust are essential to success of the research endeavor as well as to the success of service programs.
INTRODUCTION

Overview of The Balm In Gilead

The Balm In Gilead™ is a not-for-profit, non-governmental organization with an international mission to improve the health status of people of the African Diaspora by building the capacity of faith communities to address life-threatening diseases, especially HIV/AIDS. Organizational objectives as they specifically relate to HIV/AIDS are to enhance the capacity of faith communities to:

- Provide compassionate leadership in the prevention of HIV;
- Disseminate HIV information;
- Deliver supportive services to those infected and affected.

Over the past 17 years, The Balm In Gilead’s pioneering achievements have enabled thousands of faith institutions to become leaders in preventing HIV by providing comprehensive educational programs and offering compassionate support to encourage those infected to seek and maintain treatment.

In the United States, The Balm In Gilead has been endorsed by more than 13 national church denominations and caucuses. The Balm In Gilead spearheads a dynamic response to the AIDS crisis in Black communities. The Balm In Gilead has established and continues to develop educational and training programs specifically designed to meet the unique needs of Black churches that strive to become community centers for AIDS education, compassion and care.

In response to the devastation HIV/AIDS is having on the African continent, The Balm In Gilead, through a cooperative agreement awarded by the US Centers for Disease Control and Prevention in 2001, expanded its services to five African countries: Cote d’Ivoire, Kenya, Nigeria, Tanzania and Zimbabwe.

The Africa HIV/ AIDS Faith Initiative

Building upon its seventeen-year history of domestic mobilization of African American faith communities to respond to HIV/AIDS, The Balm In Gilead has gone ‘from the villages of Harlem into the villages of Africa’ to build the capacity of faith communities within five African countries to address the AIDS epidemic. Through a cooperative agreement with the US Centers for Disease Control and Prevention, The Balm In Gilead established its Africa HIV/AIDS Faith Initiative. This initiative is designed to build a sustainable health education and service delivery system throughout African faith communities. The goal of the Africa HIV/AIDS Faith Initiative is to increase the capacity of faith communities to become an effective force in the fight against the AIDS pandemic in Cote d’ Ivoire, Kenya, Nigeria, Tanzania and Zimbabwe.

As a key partner in the Centers for Disease Control and Prevention’s Global AIDS Project, (CDC-GAP), the Balm In Gilead’s Africa HIV/AIDS Faith Initiative seeks to enhance the capacity of faith organizations to establish sustainable systems of HIV/AIDS prevention and service delivery through the provision of: infrastructure development, capacity building, community mobilization, training and technical assistance, assessment and program evaluation, and communications/media support.
Specifically, the Africa HIV/AIDS Faith Initiative aims to enhance the capacity of African communities of faith to:

- Speak out against the stigma of AIDS;
- Educate people about AIDS;
- Support & provide interventions that prevent mother-to-child transmission of HIV;
- Support & provide faith-based voluntary counseling and testing;
- Provide effective HIV prevention education to adolescents and youth;
- Develop interventions that support low-risk behaviors and sero-negative status;
- Provide long-term care & support for people living with HIV/AIDS and orphans; and
- Advocate for people living with HIV/AIDS, including the rights of women, widows and orphans.

**Goals, Objectives and Activities**

The HIV/AIDS Faith Initiative in Tanzania was initiated with two major religious partners, the Christian Council of Tanzania (CCT) and the Tanzania Episcopal Conference (TEC). The mutual agreement to work with The Balm In Gilead and yet not with each other was arrived at after major discussions with both organizations. The Balm In Gilead respected the decision made by both religious bodies and, moved forward with the establishment of two national HIV/AIDS offices in Tanzania.

The work of the Balm In Gilead’s Africa HIV/AIDS Faith Initiative attracted the interest of the Muslim community and with additional support from the Tanzania office of the Centers for Disease Control and Prevention, The Balm In Gilead expanded its service to include capacity building of the national headquarters of the National Muslim Council of Tanzania (BAKWATA).

As a result of the Balm In Gilead’s Africa HIV/AIDS Faith Initiative in each of the three largest religious organizations in Tanzania, CCT, TEC and BAKWATA have developed the infrastructure and capacity to coordinate HIV/AIDS services through the structure of their national HIV/AIDS offices. As a result of the collaboration and partnership between the three national HIV/AIDS offices, the feasibility study for implementing faith-based HIV voluntary counseling and testing centers in Tanzania was undertaken.

The feasibility study was part of a broader set of collaborative activities designed to: 1) Build the capacity of an HIV/AIDS office within the national headquarters of both the Christian Council of Churches, The Tanzania Episcopal Conference and the National Muslim Council of Tanzania (BAKWATA) to effectively design and support the delivery of HIV intervention services through the local churches in urban and rural communities; 2) Build and strengthen the capacity of four theological institutions in Tanzania to provide a comprehensive AIDS education curriculum to equip their graduating clergy to address the challenges of the AIDS pandemic within their congregations and communities; 3) Conduct a series of in-country skills-building training programs to build and support a strong HIV service delivery network via local church communities; and 4) Develop and reproduce effective, culturally appropriate, HIV education materials for mass distribution throughout each country’s faith community.
**Tanzanian Faith Partners**

*Christian Council of Tanzania (CCT)* was established in 1934 as the umbrella organization for 14 Christian Protestant mainline denominations including, Lutherans, Anglicans, Methodist, Baptist, United Church of Christ, African Inland, Mennonite, Presbyterian, Moravian, Evangelistic and All Africa Churches. The membership of CCT is also comprised of 10 Christian affiliated societies such as the YWCA, YMCA, Good Samaritan, and Tanganyika Refugee Services. The organization is governed by a council of 60 Diocesan Bishops with a membership of approximately 7,000,000 Protestants living in Tanzania mainland and Zanzibar. CCT’s headquarters is in Dodoma, the political capital of Tanzania.

*Tanzania Episcopal Conference (TEC)* was established in 1956 as the administrative office of the entire Catholic Church movement in Tanzania. The Tanzania Episcopal Conference is comprised of 30 dioceses and numerous parishes throughout the country. With approximately 30 bishops appointed by the Pope as overseer of each diocese, this assembly of bishops governs the affairs of The Tanzania Episcopal Conference. This body is the decision making body on all critical issues in the entire Catholic Church, which includes addressing HIV/AIDS and a partnership with The Balm In Gilead. Tanzania Episcopal Conference is considered one of the largest faith organizations in Tanzania. The Catholic Church in Tanzania has a membership of about 9,000,000 believers - about a quarter of the population of Tanzania.

*The National Muslim Council of Tanzania (BAKWATA)* has represented the national interests of the Islamic community in Tanzania since it’s formation in 1968. It is estimated that the Islamic community in Tanzania is around 40% of the population and BAKWATA coordinates Muslim activities throughout the country. BAKWATA’s structure is linked from the headquarters office to the street level Mosque in the following way. The structure starts with the Mufti, followed by the Cleric Committee (Ulamaa Committee), Executive Committee then National Secretary. Next is the regional level. There is a BAKWATA office in every region of Tanzania with a Regional Sheikh and Regional Secretary. At the District level there is a District Sheikh and District Secretary, and finally, a Street level and Mosque level.

BAKWATA’s National HIV/AIDS Program is abbreviated as BAK-AIDS. The mission of BAK-AIDS is to mobilize the faith leaders in the Muslim Community to speak out with knowledge about HIV/AIDS, stigma and discrimination in order to reduce and prevent the rate of HIV/AIDS in the Muslim Community in Tanzania. The vision of BAK-AIDS is to reduce and stop the spread of HIV/AIDS and create a healthy Muslim Community.

**Feasibility Study Goals**

At the end of the second year of the initiative, the three partner organizations began the development of the infrastructure that would allow for the provision of HIV/Health services at the community level in the rural areas. The development of VCT/PMTCT services was identified as a critical component of HIV/Health service delivery needed in rural communities. A feasibility study was undertaken in three rural communities to determine the factors to be considered in establishing VCT/PMTCT services.
Questions to be answered by the feasibility study include the following:

- What is the need for HIV related services in the specific target area?
- What are the utilization patterns for HIV/AIDS related services?
- How are existing VCT services structured in the existing or nearby locations?
- What services are currently available in the area and how are they structured?
- What is the population’s perceived need for general health-related services?
- What are the facilitators and barriers to service utilization?
- What are attitude/perspectives and common cultural beliefs and practices with respect to HIV/AIDS?

This report will present a brief outline of the implementation and selected findings from this feasibility study.
METHODOLOGY

The study used a multi-level multi-method approach for identifying and salient factors to be considered in establishing VCT in 3 rural sites in Tanzania. The underlying principle in this study was the acknowledgement that equitable partnership was vital to the planning and implementation of the project. Thus, the National HIV/AIDS Office of each partner organization, the Christian Council of Churches, The Tanzania Episcopal Conference and the National Muslim Council of Tanzania (BAKWATA) selected the sites and were active decision makers at every stage of the research.

The National HIV/AIDS Office staff engaged in extensive training to become trainers and supervisors of the study’s field operations for the study. They were responsible for recruitment of staff supervising and monitoring the field effort, data entry and analysis support. A critical responsibility of the national offices was establishing support and permission for the study from their own national religious advisory councils as well as local authorities and leaders in the rural sites.

Community Entry

Community entry served two purposes, gaining entry, securing permissions, developing rapport and mobilizing the community for involvement in the study. Securing permission to collect information from the communities in each of these areas was an important process that took considerable time and steps to complete. In each area there were multiple levels of leadership and authority from which permission had to be sought and received.

The National HIV/AIDS Office staff met with the appropriate district, ward and village level authorities to gain permission for the study. The study protocols and instruments were reviewed and approved by local leaders individually and through council meetings (see Appendices 1-7 for data collection instruments). These leaders were instrumental in assisting field staff with enumeration of the residents as well as with recruitment strategies. Without their assistance and cooperation before and during the data collection process, the study could not have been done.

A series of procedural steps were initiated by the National HIV/AIDS Office staff to prepare each site for the study. The complete protocol is included in Appendix 13.

Data Collection

It is important to note that the data collection activity was a large and vital component of this entire process and required much coordination. Comprehensive protocols and forms covering each phase of activity were given to the field supervisors by the trainers from The Balm in Gilead. Please see Appendices 8-12 for these.

Field work was designed using a rapid community assessment approach (WHO/AIDS 2003). All field work was completed in a six-week period. There was a high level of community participation and involvement in the study. At every stage of implementation community leaders of all types were involved and this resulted in significant levels of cooperation and high response rates. The lack of transportation and the need to travel long distances to reach respondents and to survey the community was the main challenge experienced in this effort.
**Selection and Training of Field Staff**

Training was conducted in a number of phases in order for field staff to gain competency in each type of data collection activity. National HIV/Office staff of each partner organization were trained by the Balm in Gilead on the study protocols and procedures as well as in field management and monitoring. Previously appointed Evaluation Coordinators who were working in each national office were also trained in data collection, data editing and data entry.

The training of the Evaluation Coordinators was especially important as they assisted in facilitating the training of thirty (30) assessors – ten for each area. The Evaluation Coordinators were the field supervisors overseeing the work of the assessors in the field. Language was the other issue. As most of the assessor group spoke only Swahili, and the trainers were English-speaking, the Evaluation Coordinators served as translators during the period of assessor training.

Approximately 10 assessors (interviewers) were selected from each locale where VCT/PMTCT services were to be established. Consequently a total of 30 assessors were trained over a 5-day period (June 7 – 11, 2004) in a residential setting. Assessors were selected who were able to speak Swahili and English fluently, had good interpersonal skills, had completed secondary school or the equivalent, and, if possible, had some interviewing experience.

**Data Sources**

1. **Community Mapping**

Community mapping was the first exercise undertaken and this required the involvement of all ten assessors in each of the site for approximately one week. Because of the differences in geographical terrain, each group of assessors were divided differently. For example in Masasi, there were ten village areas, whereas in Kigoma-Ujiji the area was relatively spread out across several areas in two main towns. This was a cooperative exercise as assessors had to report their findings each day to their supervisor and in all cases a collective map of the entire areas were drawn by the assessor team.

2. **Community Resident Interviews**

In each site at least 300 persons, representing different age and gender groupings were interviewed. The minimum age for respondents was 14 years. In addition to age and gender, geographic location of the residents was also taken into account to ensure that there were respondents from different locations within each community.

In all three sites, samples of residents were selected using the same methodology designed to ensure broad representation of all sectors of each community. A stratified sampling procedure was used, recruiting equal numbers of women and men, and equal representation in four differing age groups, from among the constituent geographic sections (wards, villages or sub-villages) of each study site. Comprehensive lists of all community residents obtained from the community leaders in each respective area, and the lists of community residents were divided to reflect these 8 (gender and age groupings. Within each of these groups, residents were randomly selected for interviewing. Approximately 400 residents were interviewed in each area.
3. Faith Leader Interviews

Faith leaders from both the Christian and Muslim faith were interviewed in each of the three communities. These were face-to-face individual interviews that were conducted by the Program Coordinators with leaders of identified faith organizations. Different methods of sampling were employed in each of the three sites. In Kigoma-Ujiji a listing was made of all faith leaders in the area. From the community mapping exercise, some 48 churches and mosques were identified. In the attempt to ensure representation from the major denominations or sects in the area, leaders from 5 churches and 10 mosques were selected for interview. Christian faith organizations represented include Anglican, Moravian, Catholic and Pentecostal. Three types of Muslim sects were represented: Sunni Wal Jamaa, Sunni Shafi and Ahswan Sunna. All of the faith leaders approached participated in the survey.

In Ludewa, a predominantly Christian area, 10 churches and one mosque were identified as faith organizations. Anglicans, Pentecostals, Lutherans and Catholics were represented among the Christian faith organizations. Nine of eleven faith leaders approached agreed to be interviewed.

A listing was made of all the faith organizations in each of the 10 villages of the Lisekese ward comprising the Masasi site. Thirty-two faith organizations were found, representing six faith traditions: Muslim, Anglican, Catholic, Pentecostal, Baptist and Seventh Day Adventist. Representatives from each of the faith organizations identified were interviewed.
4. VCT Client Interviews

The approach to sampling VCT clients followed from information generated by the community mapping exercise. In each site, a task of the mapping exercise was to identify health related facilities and specifically VCT services. A goal was to conduct interviews with users of VCT services (whether in free standing VCT centers or within health service facilities). The interviews were scheduled to take place during a one week period. Based on the information collected, a quota sampling was to be generated in order to ensure client representation from each facility offering VCT services. However, findings indicated that there were very few facilities offering VCT services and equally small number of clients presenting for services during the period scheduled for data collection. Therefore, the strategy was adapted to reflect the field situation. Time for recruitment of clients was extended to include the entire study period in order to an attempt to include at least 30 clients from each facility. In that period, a total of eighty-eight ($n=88$) clients were interviewed from two sites, Ludewa and Kigoma-Ujiji.

In Ludewa, there is only one VCT facility. All clients presenting to the center over a four-week period of the study were approached for interviews. Prior approval was obtained from center authorities. Thirty of the 42 clients approached agreed to be interviewed ($n=30$). Two VCT centers were identified in the Kigoma-Ujiji area and arrangements were made with the VCT authorities to conduct interviews with clients at both facilities. The aim was to interview a total of 60 VCT clients (30 from each site). Sixty people presented for services and were approached for recruitment. A total of 58 persons agreed to complete the survey ($N=58$).

It is important to note that the Masasi site had no VCT or health related facilities within its geographic area. The nearest facility was several hours walk away. Community residents and village officials mentioned the engagement of traditional healers who serve as an alternative to health care providers within the villages.

5. Facilities Staff Informant Interviews

Informant interviews were conducted with staff from all organizations providing health services in each geographic area, as identified through the community mapping exercise. The goal of this component of the study was to identify and describe the organizations present and services offered, the population groups being served, and linkages between service providers. There was a focus on both government sponsored and non-governmental organizations offering health and HIV-related services.

In Kigoma-Ujiji 8 such organizations were identified, and in Ludewa there were 7 organizations. However, in the ten villages comprising the Masasi site, no health facilities existed; the existing NGOs were mainly political parties and other small groups with limited formal structure, and no focus on health issues. Consequently, the nearest health facilities were selected for study. The 9 organizations surveyed were located in Masasi town, approximately 7 miles from the nearest of the 10 villages comprising the site of the feasibility study.

All facilities located participated in the project; a member of the upper administrative staff of the organization, or the person responsible for coordinating health activities was chosen for interview. Because there were no health facilities in Masasi, a decision was taken to interview all 22 of the traditional healers in that area.
6. Village Leader Interviews

Subsequent to the initiation of data collection, The Balm in Gilead staff made site visits to Kigoma-Ujiji and Masasi in order to monitor the fieldwork activities. During this time, village leaders from both locations were interviewed in order to ascertain their perceptions of the resources, the challenges and the needs of the villagers.

Data Preparation and Analysis

Because all instruments, except for the faith leaders questionnaires were also in Swahili, data from open-ended questions had to be translated from Swahili to English. This was done by a group of high school graduates and University students. Reliability checks were instituted to ensure high levels of accuracy.

Data were entered in SPSS and subsequently analyzed, looking for patterns and trends in the data for the sample overall, as well within geographic region, and for the community resident survey, by gender and age group of survey participants. Answers to open-ended questions were recorded verbatim and entered into a computer database. Development of coding categories and qualitative analysis was conducted with the assistance of Tanzanian staff.

| Number of Study Participants and Type of Data Collected |
|-----------------|--------|--------|--------|--------|
| Kigoma          | Ludwe | Masasi | All Sites |
| Community Resident Survey     | 398  | 362  | 404  | 1164 |
| VCT Client Interviews      | 58   | 30   | Na¹  | 88   |
| Faith Leaders Interviews    | 15   | 9    | 32    | 56   |
| Facility Staff Interviews   | 8    | 7    | 9     | 24   |
| Village Leaders Interviews  | 2    | 0    | 5     | 7    |
| Traditional Healer Interviews² | 0   | 0    | 22    | 22   |

¹ There were no VCT centers or any health facilities in this area.
² With no health facilities in the area, traditional healers were most informed about local health issues.

Table 1. Number of Study Participants and Type of Data Collected
DESCRIPTION OF STUDY SITES

Kigoma - Ujiji

The Kigoma region is located in western Tanzania and borders the Democratic Republic of Congo and Burundi. The region is divided into three administrative districts: Kigoma, Kasulu and Kibondo. The district local government authorities in the region include: Kasulu district council, Kibondo district council, Kigoma district council and Kigoma/Ujiji town council. As is the case with all other regions in the Tanzania mainland, the district is further divided into successively smaller administrative units known as divisions, wards and finally villages. In the case of Kigoma, it is divided into 18 divisions, 81 wards and 220 villages. Economic activity is primarily agriculture in nature. Major crops grown include maize, beans, cassava, bananas, groundnuts, palm oil, coffee, cotton and tobacco. There are no factories in the region. There are a number of game parks which serve as tourist attractions.

Kigoma Urban is one of the four local authorities of Kigoma Region. The district capital - Kigoma-Ujiji - was the site selected for the feasibility study. This area is comprised of 13 wards: Buhanda Businde, Gungu, Machinjioni, Majengo, Mwanga Kusini, Kigoma Bangwe and Mwanga Kaskazini in the Kigoma zone and Rubuga, Kitongoni, Rusimbi, Kagera, Kasimbu, Kasingirima in the Ujiji zone. The population of Kigoma-Ujiji township is approximately 144,000.

The first case of HIV/AIDS in the region was discovered in 1985. HIV testing results from the VCT center in the Maweni regional government hospital indicate that HIV rates of HIV infection are especially high for women in the area. For the years 2001-2002, of 483 females tested 142 (29.4%) were HIV positive, whereas only 185 males were found to be positive from a total of 2948 (6.3%) who underwent testing. In May 2004, Kigoma/Ujiji Town Council in collaboration with AMREF (African Medical and Research Foundation) opened a VCT known as ANGAZA.

Kigoma-Ujiji was selected to be a study area due to its remoteness in the far western area of Tanzania and the presence of multiple, transient subpopulations. The area is located at the border with the Democratic Republic of Congo and Burundi. Many refugees from Rwanda, Burundi and Democratic Republic of Congo come as a result of war and unrest. In addition, people are moving in from Zambia, Rwanda, Burundi and Democratic Republic of Congo for business and other activities due to presence of the Kigoma port. Fishing activities on Lake Tanganyika also attract a lot of people from different areas of the Region.

Ludewa

Ludewa is one of the six administrative districts of the Iringa region located in the Southern Highlands of Tanzania. It has a population of 233,687 (2002 census). Ludewa town, the district headquarters, has four divisions, twenty wards and fifty villages. The feasibility study was conducted in Ludewa town and Ludewa Village. Ludewa town has following hamlets: Mkondachi, Nyamapinda, Mdambanyafu, Kanisa A, Kanisa B, Kilimahewa, Majengo, Ibani, Kiyombo and Kimabila. Ludewa Village has the following hamlets: Ngongano, Likelulilo Mataala Makorongoni, Ngalawale, Ndongome. All together these areas have a population of approximately 13,000 people. The main economic activity is peasant farming – crops and
livestock. Crops such as maize, rice, potatoes, wheat, beans, tomatoes, onions and cassava are grown.

Ludewa has some of the highest rates in the country of major health conditions affecting the population. These include: malaria, diarrhea, pneumonia, eye infections, skin infections, acute respiratory infections (ARI), anemia, internal worms and emergency oral care. The infant mortality rate is 11/1000; and maternal mortality rate is 135/100,000. (Source: Ludewa District Development Planning Office report: 2003). There are several indicators that the prevalence of HIV infection is high in Ludewa. For example, in 2002 Ludewa district had the highest prevalence of HIV among blood donors compared to other districts (NACP Report). Ludewa town has an inadequate supply of water from two streams situated 11 kilometers away. Only 60% of the daily water demand is met, and the lack of reliable water source likely contributes to many health conditions and the difficulties of providing health care.

Ludewa was selected to be a study area due to the following reasons: Rates of HIV infection are already high. In addition, Ludewa is a rural district which is now being developed and thus is attracting many migrants. In addition to in-migrants who plan to stay, iron ore and coal mining in the area are expanding and high rates of migrant labor from the neighboring area of Makete are expected. Makete is a district which has one of the highest rates of HIV infection in the country. Ludewa is also a border region, adjacent to Zambia and Malawi, and interactions with outsiders might present increased risk. Finally, there has not been any serious intervention by faith organizations in Ludewa.

Masasi

Mtwara, one of 21 regions in mainland Tanzania, is situated in the southern region of the country. Masasi is one of 5 districts in that region. The district has 7 divisions and 33 wards. The Lisekese ward is part of the Masasi district and contains the 10 villages which were identified as the site of the feasibility study. The villages included in the study were: Sululu, Mpekeso, Matawale, Mkapunda, Mwenge Mtapika, Mbonde, Tukaewote, Nangose, Temeke and Mtandi. These 10 villages have a population of approximately 30,102 persons. Four ethnic tribes -Makua, Makonde, Yao and Mwera - occupy the area. Their main economic activities are peasant farming. Cashew is the main cash crop. The carvings done by the Makonde tribesmen is also a source of income.


Although the villages in Lisekese ward are accessible by roads, public transportation is in short supply and the majority of the populace travel on foot or by bicycle. Although the Tanzania National Electricity Supply Company supplies electricity to the Masasi district, few individuals in the villages have access to this service. Potable water is also in short supply and a single water source can serve up to 4,000 individuals.

The Lisekese Ward in Masasi District was chosen as a study site for many reasons. It is a rural area which has had a close relationship with both Christian and Muslim faith groups, and Tanzania Episcopal Conference in-country partner organization had some existing connections via services provided through the Catholic Diocese of Tunduru Masasi. The structure of local
government facilitated access and permission to conduct study activities. All the villages had viable village governments with minimal hierarchical organization and prior experience working with other organizations to address community issues – e.g. improving agriculture, fisheries and animal husbandry.
FINDINGS - COMMUNITY MAPPING

Community mapping was the first exercise undertaken and it required the involvement of all ten assessors in each of the sites for approximately one week. Because of the differences in geographical terrain, each group of assessors was organized differently. For example, in Masasi there were ten village areas whereas in Kigoma-Ujiji the area was relatively spread out across several areas in two main towns. This was a cooperative exercise. The assessors reported their findings each day to their field supervisor and in all cases a collective map of the entire site areas were drawn by the assessor team and verified by the field supervisor.

The community mapping exercise served multiple purposes; 1) topographical depiction of the area 2) identification, and enumeration of residential areas, businesses, schools, health and government operations 3) visibility to the study and familiarity with the study’s field staff and 4) most importantly an opportunity to build rapport and collaboration with local residents and government officials. For instance, local residents helped with identification and discussion of businesses and focal points in their community. The exercise resulted in colorful detailed maps of each site and generated the invaluable information needed for the other data gathering tasks of the study. Following are brief summaries of data generated by the mapping exercise.

KIGOMA-UJJII

The exercise could not have been doing without the close collaboration of the staff of the BAKWATA HIV/AIDS faith office and the local leaders - Town Council officials, Ward Executive officers and community leaders of Gungu, Mwanga Kaskazini, Mwanga Kusini, Rusimbi, Rubuga, Kasimbu, Kigoma/Bangwe, Kasingirima, Kitongoni and Kibirizi. These areas were selected with the involvement of these local leaders in order to ensure that the community mapping was representative of all the areas of Kigoma/Ujiji.

From the community mapping exercise, the study team found that the Kigoma Bangwe area had a large number of businesses (48), government organizations (35), schools (36) and NGOs (19). This was not surprising as this area is a business center in which a number of services and amenities (catering to both the local and international organizations) are located. It should be noted that Kigoma ANGAZA VCT center is located in this area as well. Business activities included wholesale and retail sales for building materials, food, clothes, and restaurants. This area is also very famous for the wholesale and retail selling of sardines. The Rusimbi area contained locations for regional government offices, the Maweni Regional Hospital and the Kigoma/Ujiji Town Council office. Generally Kigoma/Ujiji has a large number of religious institutions (48) including mosques, theological schools like Madrasa (Junior Islamic Seminary) and churches. There are 21 organizations concerned with health issues, discussed in more detail below (See Table 2 in Appendix).

LUDEWA

In order to conduct the mapping exercise, the area was divided into two sections: Ludewa town and Ludewa village (both located in Ludewa ward). Each contain a number of smaller hamlets. The following observations were made. Ludewa Town is a small growing town in which all business activities (such as markets, small shops and small restaurants) are concentrated at the center. All government offices are located in one place which is some distance from the town center, about half a kilometer. There are 66 businesses and 10 governmental organizations in this area. The remaining area is residential. There is no
apparent residential separation for the people of different economic statuses. In Ludewa village, few services or commercial establishments are available. For example, there are only 4 businesses which are small scale, selling food, charcoal, oil, chicken, clothes, or stationery, and one governmental organization. Services are obtained are from Ludewa town which is about 15 km away. There are 8 religious organizations and 8 schools in Ludewa town, and 2 each religious organizations and schools in Ludewa Village (See Table 3A and 3B in Appendix).

**MASASI**

The community mapping was done in each of the 10 villages selected. A total of 50 businesses were found. The main types of business were retail shops, pharmacies, milling machines (for grain), markets, and butchers. Each village had at least one governmental office (total =14). The Government organizations in nine of the villages represent the Village government offices. In Mbonde Village - capital of Lisekese ward - there is a Primary Court, Airport Office, Ward Government Office and Village Government office.

There were a total of 39 religious organizations in the villages which include the Anglican Church, Lutheran Church, Catholic Church, Pentecost Holiness Mission, Baptist Church, New Apostolic Church, Evangelical Assemblies of God, Seventh Day Adventist, and Christ Church as well as many mosques. The 17 schools are mainly primary schools which also serve as centres for adult education. There are pre-primary schools and secondary school in Mbonde village. Colleges for the Blind are to be found in Mtandi and Mbonde villages.

There are no health facilities in the 10 villages and people rely heavily on traditional healers for the services. If the patients are in a critical state they are forced to go to Mkomaindo Government Hospital located at Mkomaindo village in Masasi town. NGOs operating in the villages are mainly political parties (See Table 4 in Appendix).
Findings - Community Resident Interviews

Demographic Characteristics of the Community Residents

In the overall sample (n=1164) and in the sub-samples from each of the areas, there was adequate representation across age and gender groups. Males and females were equally represented and the percentages of individuals in each of the four age groups (14-19 years, 20-35 years, 36-49 years and over 50 years) were consistent across the sites – approximately 25% in each age grouping. Respondents from all 3 sites were more likely to be married than to be not. The majority of the respondents in each area had little schooling, with only 32% having more than primary education. The majority of both men and women were parents. ¹

General Health Services

When asked about their use of general health services, the majority (91%) of respondents (from all sites) knew where to get health services. Far fewer (58%) reported that it was easy to use health services. Barriers included long travel and lack of transportation to reach services, the cost of services, and provider factors such as differential treatment and lack of appropriate medicines. It should be noted that respondents from Masasi were less likely than those from the other two sites to report that it is easy to use health services and less likely to have used any health services in the past 12 months. ² Generally, youth were as likely as older residents to know where to go for health services but less likely to have had any health care visits in the past 12 months. ³ Among women who had ever been pregnant 82% reported receiving prenatal care. However, fewer than a quarter of these women had received HIV testing and counseling at antenatal clinics. The majority of respondents from all sites reported that more health services are needed in their areas; the reported need for health services was highest in Masasi. ⁴

¹ Table 5-Demographic Information
² Table 6- General Health Services By Site
³ Table 7- General Health Services By Age
⁴ Table 1 and Table 8-General Health Services by Gender
HIV Knowledge of Community Residents

The six-point knowledge scale contained questions on HIV transmission. The average score was 4.09 from a possible high score of 6.0. However, most respondents were unable to distinguish between HIV and AIDS, and many held false beliefs about HIV transmission. About half the sample (49%) believed that HIV was transmitted by mosquitoes and one-quarter agreed that one could become infected from sharing eating utensils.5 Youth (less than 24 years) were more likely to hold false beliefs about HIV transmission than older individuals.6

On the other hand, high proportions (90 %+) of survey participants among all sub-populations were aware that HIV can be transmitted by infusion of infected blood or by the sharing of infected needles. On average males tended to score higher than females on the index of HIV knowledge (4.2 as against 3.9).7

Figure 1: Community Resident’s Lack of HIV Transmission Knowledge

5 Table 9- HIV/ AIDS Knowledge by Site
6 Table 10-HIV/AIDS Knowledge by Age
7 Table 11-HIV/AIDS Knowledge by Gender
**Perception of HIV-infected Persons**

Community views on person with HIV were mixed. Both positive and negative perspectives were held in almost equal proportions by the residents interviewed. Advocates indicated that persons infected with HIV should be supported in tangible ways through the provision of services and advice and not stigmatized. Those with more negative views held that such persons should be isolated and/or feared. Some community members mentioned that HIV-infected persons may experience despair and hopelessness as a result of their condition. Many others were either not aware of such persons in their community or did not seem knowledgeable enough to have an opinion.

**Awareness and Access to HIV Testing**

There are significant differences by site with regard to awareness of and access to HIV voluntary counseling and testing services (VCT). Only 38% of respondents from Masasi knew where to obtain VCT services compared to over 60% of residents of Kigoma and Ludewa. As with general health services, many persons who know of such services, reported that these services are nonetheless inaccessible to them. Respondents from Ludewa were more likely than others to report that VCT facilities are accessible to their residence, but rates are still low. Overall, 75% of the sample do not know where to go for HIV counseling and testing or know of only places that are inaccessible to them.

![Awareness and Access to VCT](image)

**Figure 2: Community Residents Awareness and Access to VCT**

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8 Table 12-Views and Experience with HIV/AIDS by Site
The low rates of awareness and accessibility in Masasi are most likely a reflection of the fact that no VCT, or health facilities are located within their geographic area. The nearest health services and VCT are approximately several hours walk from their area and located in Masasi town. In both Ludewa and Kigoma there is a hospital-based VCT center. In addition, at the time of the survey, Kigoma also had a newly established VCT center with a special emphasis on youth participation. The most established services for these areas were the hospital based VCT services.

**Interest and Experience with HIV Testing**

Fewer than one fifth of all respondents reported ever being tested for HIV/AIDS. Rates vary by geographic area with 27% of Kigoma residents, 17% of Ludewa residents but only 6% of those in Masai reporting that they had ever had an HIV test. Among persons never tested for HIV, fewer than half (40%) have considered being tested for HIV. About half of the sample have never been tested for HIV and have not considered being tested.⁹

Reasons given for not considering testing include perceived lack of risk for HIV infection, sometimes referring to their own good conduct or lifestyle practices or that of their spouse. Another common reason was the lack of symptoms: “Because I haven’t gotten sick.” Some respondents acknowledged fear of learning a positive test result: “I am fearing to be laughed at and isolated if I will be diagnosed as HIV positive.” Others provided no explanation for their conviction that they are not HIV positive and thus no testing is needed. Some respondents indicated that the lack of counselors and/or receiving any advice about testing was a factor for their not considering it. Almost all survey participants (91%) indicated that they wanted to know more about VCT.

⁹ Table 12- Views and Experiences with VCT by Site
The prevalence of HIV testing appears to be low among the broader community in the three areas studied. Only a small percentage (15%) know of any friends or family members who have been tested for HIV.\textsuperscript{10}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{hiv_test_experience.png}
\caption{Community Interest and Experience with HIV Testing}
\end{figure}

**Perceived Risk for HIV**

The majority of survey participants in all areas reported that it is very possible or at least they are not sure that they will get HIV. Residents of Masasi were the most likely to report that they might be at risk for HIV; only 20% said that it was not possible.\textsuperscript{11} Answers to open-ended questions provide some insight into AIDS awareness among the population studied. Many respondents emphasized that there were “too many ways” of contracting HIV, although as we have seen, perceptions of sources of risk were not always accurate. Some individuals acknowledged multiple sexual partners and/or the lack of confidence that their spouse or partner has been faithful. Relatively few mentioned taking steps to protect against HIV transmission. Slightly more than half of respondents who answered that it is ‘very possible’ that they have HIV report that they have considered being tested for HIV.

\textsuperscript{10} Table 12 - Views and Experiences with HIV testing by Site
\textsuperscript{11} Table 12 - Views and Experiences with HIV Testing by Site
Figure 4. Community Resident Perceptions of Risk for HIV Infection
FINDINGS - FAITH LEADER INTERVIEWS

Demographic Characteristics of Faith Leaders

A total of fifty-six (56) faith leaders – all male - were interviewed. The majority (57%) were from Masasi with a quarter of the group from Kigoma-Ujiji. The respondents were relatively young with the majority (69%) being less than 49 years old. Two-thirds of the sample were Christian and one third Muslim. There were differences by area, reflecting the presence of different faith traditions locally. In Kigoma, Muslim leaders comprised the majority (66%) of the respondent group, but Christian ministers were in the majority in Masasi (75%) and especially in Ludewa (89%).  

There was wide variation in the length of time that these leaders had been involved with their respective faith organizations. Leaders in all areas had been with their current organizations for an average of 11 years; however the sample is a mixture of faith leaders who were relative neophytes (in their position one year or less) and many who were seasoned veterans (more than 30 years leading their community).

Availability of Health Services

Almost all (89%) faith leaders interviewed indicated that there was a gap with respect to the supply and demand for general health services in their communities and that the demand was outstripping the supply. With respect to HIV related services the situation was similar as only 2% of the respondents indicating that HIV-related services were sufficient for the needs of their communities.

HIV Knowledge of Faith Leaders

On a six-point HIV knowledge scale, religious leaders seemed to be relatively well informed and scored an average of 4.3 points. They all knew that HIV could be transmitted by transfusion of infected blood or through sharing infected needles. Faith Leaders may need further training in 2 areas – distinguishing between HIV and AIDS (75% answered that they were the same) and correcting the misinformation that a person can be infected with HIV/AIDS by sharing eating utensils or by mosquitoes. Ludewa and Masasi, 44% and 56%, respectively, of religious leaders in these areas believe that mosquitoes can transmit. Faith leaders in Kigoma appear to be better informed regarding HIV transmission.
Figure 5: Lack of HIV Transmission Knowledge among Faith Leaders

The Role of Faith Communities and HIV

Support for involving faith communities in the fight against HIV/AIDS was almost universal among faith leaders interviewed. All but one respondent (96%) agreed that religious organizations should be involved in providing HIV services and the same high proportion indicated that their church or mosque was willing to collaborate with other organizations in fighting HIV.  

Despite the willingness to collaborate, however, some areas had very few links of any type with other religious, governmental, or nongovernmental organizations. Percentages were highest in Kigoma (67%) and lowest in Masasi (9%). Overall most collaboration occurs with other religious organizations or with governmental agencies. Few (7% overall) had any relations with any international organizations. 

Provision or Support of HIV/AIDS Activities

The great majority of all respondents indicated that their organizations were involved in HIV/AIDS activities. This went from a high of 93% among those faith leaders in Kigoma-Ujiji, to 81% in Masasi and a low of 67% in Ludewa. 

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15 Table 16- Faith Leader Attitudes Regarding Faith Communities and HIV
16 Table 17- Extent to which Faith Organizations Collaborate with Other Organizations
17 Table 18-Provision or Support of HIV/AIDS Related Services by Site
Figure 6. Faith Leader Report of HIV/AIDS Activities Conducted by their Church or Mosque
What were the activities most frequently provided or supported by the faith leaders interviewed? Not surprisingly, the most frequently mentioned (73%) activity was spiritual counseling. Bereavement support (59%), HIV prevention education and (57%) and outreach services (54%) were also provided by more than half of the faith organizations. Fewer organizations but at least several in each region provided tangible non-medical assistance such as AIDS orphan support services and meal programs for persons with HIV. Only 3 faith organizations among the 56 represented in the study provided any HIV related medical care.18

There was a dearth of HIV testing and counseling services in all three areas. Less than 10% of all participating faith organizations provided referrals to testing sites or did outreach specifically promoting HIV testing. Faith organizations in Ludewa were most active in these two areas with 22% and 33% of organizations (respectively) providing these services. No organizations actually provided HIV testing and none were involved with condom distribution.19

Of the three sites, faith organizations in Kigoma-Ujiji seemed most active in the provision or support of HIV related services, while Masasi was the least active in this regard.

Services needed in the area

Faith leaders in all regions were uniform in reporting the great need for HIV related services in their areas. Services rated as ‘highly needed’ by 90% of the sample included HIV counseling, HIV testing, HIV prevention education outreach, medical treatment for persons with HIV/AIDS, and the care of children orphaned by AIDS. Faith leaders also supported the need for treatment of other sexually transmitted diseases, and for the provision of concrete services such as food, clothing, housing, and employment services for persons with HIV. The only service area not defined as a critical need was condom distribution which was endorsed by only one in ten (11%) of respondents.20

Barriers to service provision

Faith leader reported the same set of barriers to the provision of HIV prevention and education services as well as provision of HIV testing and counseling services. Lack of knowledge as well as lack of resources (financial, staff) and the belief that only Government agencies should perform these activities are the major barriers to implementing or expanding HIV services through their organizations cited by leaders of faith organizations in each of the three sites studied.21

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18 Table 18-Provision or Support of HIV/AIDS Related Services by Site
19 Table 19- HIV Testing and Counseling Services Provided by Site
20 Table 20- Faith Leader Report of Level of Service Need in the Area
21 Table 21- Faith Leader Report of Barriers to Establishing HIV Testing and Counseling and Table 22- Barriers to Establishing HIV Education and Prevention Programs
Barriers to HIV Testing and Counseling Programs

Lack financial resources
Don’t know how
Not enough staff
Only Govt agencies can do it

Figure 7. Faith Leaders Report of Barriers to HIV Testing and Counseling Programs
FINDINGS - VCT CLIENT INTERVIEWS

Demographic Characteristics

A total of 88 interviews were conducted with clients presenting to health service facilities providing voluntary HIV testing and counseling in Kigoma-Ujiji and Ludewa. Males and females were almost equally represented. Respondents tended to be older, with 56% reporting being 25 years or older. The majority of respondents reported being single and never having children. Over half (59%) had a primary education or no formal education. A majority (80%) of women who had ever been pregnant reported receiving prenatal care. Among women who had been pregnant, slightly more than half had received HIV counseling and testing as part of their antenatal care. It should be noted that those in Kigoma-Ujiji were more than twice as likely to receive these services as women in Ludewa.  

VCT Service Utilization

Approximately two thirds (66%) of respondents interviewed were first time visitors. The majority of clients were there to get tested for HIV (74%) and the remainder was equally divided between those who came to get the results of a prior HIV test or to get other services.

Fewer than half of clients interviewed reported that any of their friends or family members had been tested for HIV although 70% indicated that everyone should get tested for HIV. Respondents were asked why they thought that testing was important for everyone. Answers emphasized the importance of knowing one’s health status. A secondary theme was the voluntary nature of testing - the importance of individually deciding to be tested for HIV.

Need for HIV Services

Four of every five clients interviewed reported that there were not enough HIV services in their areas. Respondents visiting clinics in Kigoma were more likely than others to emphasize the lack of accessible HIV services. Only 10% clients felt that there were alternative services for treating HIV other than clinic based medicine.

HIV Knowledge of VCT Clients

Although the majority of VCT clients should have received information about HIV transmission risks, they appear as likely as other community residents (and faith leaders) to incorrectly identify sharing eating utensils and mosquito bites as sources of HIV infection. Two-thirds answer that HIV infection is the same as having AIDS.
Figure 8: VCT Clients’ Lack of Knowledge of HIV Transmission

Figure 9: Perceived Risk for HIV Infection among VCT Clients
Perceived Risk for HIV

With regards to perception of risk for HIV, three-quarters of all VCT clients interviewed indicated that it was very possible or somewhat possible that they would get HIV. There were no differences in perceived risk for HIV infection by gender or by age group. Heightened awareness of HIV risk may of course been a motivating factor for clients to access VCT services. However, 25% of clients interviewed claimed that it was impossible for them to get HIV.26

Reasons given for perceived heightened risk for HIV include many references to distrust of partners and having multiple partners. However themes of ‘many ways to get HIV’ and thus limited ability to protect oneself against infection were also often expressed.

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26 Tables 27, 28, 29 - Views and Experiences with VCT Services
FINDINGS - FACILITY STAFF INTERVIEWS

Description of Facilities

Of the 24 organizations found to be providing health and related services, the majority were NGOs in both Kigoma (5 of 8) and Ludewa (5 of 7). This was not the case in the Masasi region where 4 of the 9 facilities located were private, for profit organizations. Each of the three area had 2 government operated facilities, about one-quarter of all facilities present.

With regard to organizational focus, health was the major focus for 70% of the organizations. For the remainder, economic and human development and general social welfare concerns were also important. HIV was a central focus for 15 of the 24 organizations located and surveyed.27

Organizational Funding Sources

Organizations were funded from a variety of sources with governmental and international agencies playing significant roles in their upkeep. Fees for services provided less than half of operational funds. There were differences by study site. Governmental funding provided the major support for 7 of the 8 organizations in Kigoma but only 1 of the 8 organizations in Ludewa and 2 among the 9 found in the Masasi region. At least half of organizations in each region received some funding from international organizations. Other sources of support included income generating projects, contributions from the community and from religious organizations.28

Collaborative Relationships with Other Organizations

The organizations surveyed had collaborative relationships with several types of other organizations. Although government funding was not common in all regions, at least half of health related organizations in each study site had some collaborative relations with governmental agencies or organizations. Other types of inter-organizational relationships varied by geographic region. While many organizations in Kigoma-Ujiji and Ludewa seem to have developed relationships with international and religious organizations, this was not the case in Masasi. Organizations providing health services were often linked with community development organizations in Kigoma but much less often in the other two areas.

Services Offered

Many organizations concerned with health issues address a range of issues including nutrition and food security, substance use/abuse, family planning, support for families, especially orphans, affected by HIV. The table below shows the number of organizations actually providing any health care services, those providing any HIV related services both medical and non-medical, and facilities offering HIV testing. As evident from the community resident and faith leader surveys, the need for health services, especially HIV related services, far outpaces the capacity of existing service providers.

27 Table 33 – Focus Areas of Organizations Surveyed
28 Table 34- Funding Sources of Organizations Surveyed
Health and HIV-related services offered by organizations in Kigoma-Ujiji include: medical services (treatment of cholera patients, maternal and child health), HIV counseling and testing, training in HIV/AIDS, counseling and support of orphans. NGOs in the area offered HIV/AIDS education, counseling, drug abuse prevention, HIV testing and counseling and orphan care and support services. Only two organizations (one governmental and one NGO) offered voluntary HIV counseling and testing. Both offered the full range of services including: pre and post test counseling, on-going counseling, HIV testing and group counseling. Testing is done and processed on site. The organizations also indicate that quality control measures with checks from external sources are in place. Approximately 75,000 persons are in the area served by the government facility while the NGO services an area with about 26,000 persons. Approximately 100 persons attend each site each month.

Although both organizations give and receive referrals from a variety of health-related and other organizations, the VCT attached to the hospital facility gives and receives many more referrals. This could be due to the fact that it has been in the community for approximately 8 years versus the recently established (2 month old) private VCT center. Most referrals for HIV services are made to NGOs and other institutions that provide social, economic, spiritual and moral support and treatment. Problems with the referral system included the fact that some clients did not want to disclose their HIV status to the organizations to which they were referred and some referral locations did not provide feedback so that the originating agency would know whether the client had follow-up on referral. Both organizations offering VCT services in Kigoma-Ujiji felt that their current referral systems were inadequate.
Other problems include shortage of working facilities and resources, great demand for VCT services but minimal capacity of the VCT unit and transportation problems with respect to doing outreach counseling. Despite these challenges, both organizations providing testing services reported positive outcomes: client confidence is increasing through the on-going process of counseling; there has been an increase in the number of clients attending for VCT services; more couples now choosing to opt for HIV testing before marriage.

**Ludewa Health Facilities**

Of the 7 organizations surveyed in Ludewa, health and HIV-related services were offered by two government organizations and services included a range of medical care and education services. Among the four NGOs surveyed HIV/AIDS education, orphan care and support, counseling and construction services were among their offerings.

Only one organization in Ludewa offers VCT counseling - the Ludewa District Hospital. This organization serves the entire district of Ludewa with a population of approximately 128,000 individuals. The hospital-based center provides the full range of VCT services, pre and post counseling, on-going counseling, HIV testing and group counseling. There is an appointment system in place; however, individuals without an appointment are always seen on the same day. Approximately 30-60 persons per month are seen for testing.

Referrals from other organizations are received by the VCT center occasionally but the hospital-based VCT center seems not to refer clients to any other organization. Staff reported that medical personnel at times forced individuals to participate in HIV testing which created a variety of problems. Although outreach efforts were constrained by transportation problems, there has been some success in increasing the number of individuals attending the VCT center.

**Masasi Health Facilities**

The organizations surveyed in Masasi Town were for the most part focused on health issues and included district and mission hospitals, dispensaries, and (three) NGOs focusing on a broad range of community concerns including health related issues such as nutrition and food security. Of the 9 organizations surveyed, 6 offered health related services 4 of these offered HIV-related services. Of the four, only three offered HIV testing services. However, one facility was a laboratory and it was unclear whether individual clients could go there for a test or whether they just provided testing for patients seen at other facilities.

The Masasi site was comprised of 10 villages (of the Lisekese ward). Results of the community mapping confirmed that there, there were no health facilities within any of the villages. Villagers found health facilities located in Masasi town highly inaccessible – involving several hours of walking from their residence to the nearest health care facility. The population of the 10 villages which are the focus of the current report is 27,102. There are an estimated 430,000 persons living in the broader Masasi region which includes Masasi Town where the above described HIV related services are located.
SUMMARY AND RECOMMENDATIONS

Summary

Findings from the feasibility study illuminated several key issues for consideration in establishing VCT. Community residents and faith leaders reported that HIV/AIDS related services are woefully inadequate and inaccessible in these locales. Not surprisingly only a small proportion of residents had ever been tested for HIV but, the overwhelming majority (91%) want to know more about HIV testing. The implication here is that community residents would be receptive to mobilization efforts which would couple HIV/AIDS education with counseling and testing.

Faith leaders are key opinion leaders in the locales under study. Their views and opinions are influential among their membership and the broader community. Most leaders reported providing some type of HIV/AIDS related support. However, few provide services such as HIV testing although they reportedly felt these services were seriously needed. These leaders cited lack of knowledge as well as lack of resources as major reasons for not providing these services. Their responses suggest a readiness to support an HIV/AIDS faith initiative which potentially provides both education and resources for establishing and expanding VCT and HIV/AIDS related services.

A consistent finding from these communities was a general awareness of HIV/AIDS but a lack of consistent understanding about transmission of the virus. For instance some respondents and faith leaders thought the virus was passed through sharing eating utensils and mosquitoes. Thus, AIDS awareness and education should be an essential component of establishing any programs in these areas.

Another consistent finding was the community’s need for general health and related services. Respondents called for VCT and HIV/AIDS related services to be structured within the broader array of health care services needed in these areas.

While the majority of women who have ever been pregnant receive prenatal care, only a small sub-set of this group participate in HIV testing. This is obviously a missed opportunity as this would be a good time to introduce HIV testing as part of the health care of these women and possibly prevent the transmission of HIV/AIDS to their newborns.

In summary, the feasibility study has provided the opportunity to examine a broad range of factors to be considered in establishing VCT in 3 rural areas. The findings point to a need for general health and HIV/AIDS education and related services including VCT. Faith leaders, community residents and leaders appear to be receptive and supportive of these services to be established in their geographic areas.

Recommendations

The following recommendations are suggested based on the findings of the feasibility study. First, HIV/AIDS services are needed within a larger context of health services. Situating VCT and other HIV/AIDS related services within larger health services facilities will reduce the stigma still associated with HIV/AIDS in rural areas. The integration of such services in already existing services requires attention and sensitivity to patient concerns for privacy.
AIDS awareness and education are desperately needed in rural communities in Tanzania and should be an integral component of any health related effort in these areas.

HIV education and testing should be provided as an integral part of prenatal care provided to pregnant women.

Faith leaders should be included in any community mobilization, HIV education and service delivery development in the areas under study. Their position of influence and trust are an invaluable resource for any community health promotion effort as well as the development of VCT services.

Community-based participatory research should be employed in any endeavor which requires broad-based community mobilization, particularly to address sensitive topics like HIV/AIDS—where community “buy-in” and trust are essential to success of the research endeavor as well as to the success of services and programs that can be better informed by the research.