



The EALP HIV and AIDS
Baseline Study among Plantation Workers:
Lake Victoria Basin – Tanzania:
A Report.



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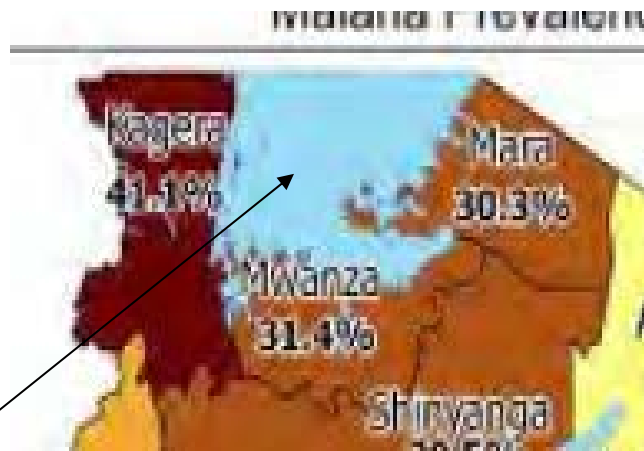
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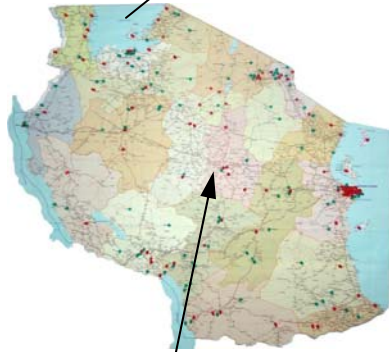
AAU	-	Association of African Universities
AIDS	-	Acquired Immuno-deficiency Syndrome
AMO	-	Assistant Medical Officer
AMREF	-	African Medical Research Foundation
ANC	-	Ante-natal Clinic
ART	-	Anti-Retroviral Treatment
ARVs	-	Anti-Retrovirals
AWSE	-	Association of Women in Science and Engineering
BCC	-	Behavioural Change Communication
BOTI	-	Bank of Tanzania Institute
DALDO	-	District Agricultural and Livestock Development Officer
CBOs	-	Community Based Organizations
CD	-	Council Director
CHAC	-	Council HIV and AIDS Co-ordinator
CSOs	-	Civil Society Organizations
CSWs	-	Commercial Sex Workers
DACC	-	District AIDS Control Co-ordinator
DALDO	-	District Agricultural and Livestock Development Officer
DBS	-	Dry Blood Spots
DC	-	District Commissioner
DED	-	District Executive Director
EAC	-	East Africa Community
EALP	-	EAC/AMREF Lake Victoria Partnership Programme
EIA	-	Enzyme Immunosorbent-linked Assay
ESAMI	-	Eastern and Southern Management Institute
FAO	-	Food and Agricultural Organisation
FGDs	-	Focus Group Discussions
FHI	-	Family Health International
GBV	-	Gender Based Violence
HBC	-	Home Based Care
HCT	-	HIV Counselling and Testing

HIV	-	Human Immunodeficiency Virus
HRH	-	Human Resources for Health
ID	-	Identification Numbers
ICAP	-	International Centre for AIDS Care and Treatment Programmes
KII	-	Key Informant Interview
LGA	-	Local Government Authority
LVB	-	Lake Victoria Basin
LVBC	-	Lake Victoria Basin Commission
MACs	-	Multisectoral AIDS Committees
MARPs	-	Most At Risk Populations
MDAs	-	Ministries, Departments and Agencies
MOCDG&CA	-	Ministry of Community Development, Gender and Children Affairs
MoHSW	-	Ministry of Health and Social Welfare
MoJCA	-	Ministry of Justice and Constitutional Affairs
MSD	-	Medical Stores Department
MTEF	-	Medium Term Expenditure Framework
NACP	-	National AIDS Control Programme
NBS	-	National Bureau of Statistics
NGOs	-	Non-Governmental Organizations
NIMR	-	National Institute for Medical Research
NTT	-	National Technical Team
OIs	-	Opportunistic Infections
PHSDP	-	Primary Health Services Development Programmes
PICT	-	Provider Initiated Counselling and Testing
PLHIV	-	People Living with HIV
PMO-RALG	-	Prime Minister's Office - Regional Administration and Local Government
PMTCT	-	Prevention of Mother to Child Transmission
PPS	-	Probability Proportional to Size
RAs	-	Research Assistants
RACC	-	Regional AIDS Control Co-ordinator
RAS	-	Regional Administrative Secretary
RC	-	Regional Commissioner
RMO	-	Regional Medical Officer

RT	-	Research Team
STIs	-	Sexually Transmitted Infections
SW	-	Sex Workers
TACAIDS	-	Tanzania Commission for AIDS
TANESA	-	Tanzania Essential Strategies Against AIDS
TMAP	-	Tanzania Multisectoral AIDS Programme
ToR	-	Terms of Reference
UNAIDS	-	Joint United Nations HIV and AIDS Programme
USAID	-	United States Agency for International Development
VCT	-	Voluntary Counselling and Testing
WBVHA	-	West Bengal Voluntary Health Association
WHO	-	World Health Organisation
WPP	-	Work Place Programme



Map of Tanzania



Map of Africa

Executive Summary

Introduction, objectives and methodology:

The EAC/AMREF Lake Victoria Partnership Programme (EALP) decided to conduct a baseline study in agricultural plantations in the Lake Victoria basin. The findings were expected to shed light as to what appropriate interventions needed to be implemented in this type of community. The report covers the baseline study for the Tanzania side of the Lake Victoria basin among the large-scale agricultural plantation workers. In the baseline survey, the data was collected focussed on the demographic characteristics of the study population, the HIV sero-prevalence, knowledge, attitude and behavioural risk factors, service availability and utilization. In addition, data was collected on coordination, institutional policies, programmes and structures. The report is divided into five chapters and each chapter into subsections. The introduction describes HIV and AIDS among large-scale plantation workers and contains seven sub-sections on background, HIV sero-prevalence, behavioural risks, service availability and utilisation, co-ordination, institutional policies and structures.

The methodology consisted of the use of four techniques. Questionnaires, Focus Group Discussions, Key Informant Interviews and blood sample collection through filter papers (bloodspots). The blood spots were later taken to NIMR laboratory in Mwanza for HIV testing. The tools developed were used to collect data from plantation workers in Kagera region – the only region of Tanzania surrounding the Lake which has large-scale plantations. Data was collected from plantation workers in Kagera Sugar Estate and Kagera Tea Company. The study was carried out between July - August 2010. The survey attained coverage of 409/425 (92.6%). Out of the total of 409 respondents who were studied, 293 (72%) were men and 116 (28%) were women. The median age for the plantation workers was 31 years while the mean age was 32 years and ranged between 18 – 67 years. The research team was made up of researchers, research assistants and laboratory technicians.

All respondents provided written consent and the protocol had received ethical clearance with certification from the Ethical Review Board of the National Institute for Medical Research/Ministry of Health and Social Welfare.

Main Findings:

The overall result on HIV sero-prevalence in the study population was higher than that of the general population. The overall prevalence being 7.4% which was higher compared to the national prevalence of 5.7%. Women had a higher HIV prevalence than men, at 11.5% against 5.8% respectively. In the study, HIV prevalence in women was twice that of the men. The peak HIV prevalence was in the 35 – 44 years age groups for both sexes.

Establishment of demographic and behavioural risks factors, knowledge and attitudes regarding HIV and STI transmission.

Communities of plantation workers showed that more than 80% knew that HIV can be contracted by having sexual intercourse. Also they knew which other diseases could be contracted through sexual intercourse as well as that a person can appear to look healthy yet be living with the virus. They also knew that HIV is what comes before AIDS. However, the question of misconception has persisted. It was found that about 40% thought that mosquito bites could transmit HIV; casual contact with an infected person could transmit HIV infection and having sex with a virgin could protect one from acquiring HIV.

When probed on whether there had been behaviour change or not, respondents reported that they had changed behaviour mainly in terms of either having only one partner or reduced numbers of sexual partners or started using condoms. Furthermore, while respondents knew that condoms were protective by 80%, yet more than 50% reported that condoms reduced sexual pleasure and also use of condoms denoted that one did not trust sexual partner.

On HIV status disclosure, respondents reported that they would disclose their HIV sero-status mainly to spouse/permanent partner (60%) followed by girlfriend/boyfriend (20%).

Respondents reported to be willing to shake hands, eat from same plate, share work tools, share same toilet or travel in same vehicle with an HIV infected person. They also agreed that an HIV infected person should not be separated from others and such PLHIV deserved compassion. Collaborative evidence that knowledge of HIV and AIDS has helped to minimise stigma was available when respondents were asked as to how they provided care to a PLHIV.

The major ways of care reported were: visiting infected person, provision of food and moral support. Also they stated that they had no fear in providing care or support to a person with HIV and AIDS.

On further probing as to 'ever been abused and type of abuse' approximately 20% of women reported to have either been hit/beaten/slapped/kicked. In addition 30% of women in the study had experienced being sworn at or cursed.

As to when can a women refuse sex even if the one requesting is the spouse, it was stated that during menstruation (70%), during pregnancy (30%) and partner fatigue (50%) were reasons for refusal of sex. It was therefore noted that in this community could only accept sexual refusal from partner mainly during menstruation and not otherwise since the likeliness of violence became likely.

Establishment of the range, breadth, availability and utilization of HIV and AIDS related services.

In terms of HIV and AIDS related services, the researchers had wanted to find out what was available and then see issues of utilisation. Such services were: condom availability, HIV testing services, HIV counselling services and provision of HIV and AIDS health education.

In terms of condom availability, more than two thirds of respondents stated that they obtained condoms from clinics/hospitals, pharmacy and from shops/kiosks. Despite the availability of that service, utilisation appeared to be most likely inadequate as shown by the HIV prevalence in the study population compared to the general public.

Clinics/hospitals were by far the major providers of HIV testing services. The research team probed as to where would be the most preferred place for HIV counselling and testing services to be offered, 30% indicated their own community place while another 30% had no preference.

Determination of the existence and effectiveness of policies, programs and coordination structures on HIV and AIDS.

Existence and effectiveness of HIV and AIDS policies:

EAC level:

There was no HIV and AIDS policy for the EAC but each member state had its own policy. A draft bill awaited ratification by the partner states and therefore its effectiveness cannot be discussed at this material point in time. There was an EAC HIV and AIDS strategic plan whose implementation was to start.

National level:

Effectiveness of policies of partner states was looked at in terms of the Tanzania HIV and AIDS Policy of 2001. It was in the process of being reviewed. While that policy had targeted MARPS, yet the private sector, which was a key stakeholder through its ability of carrying out HIV testing and other HIV and AIDS related services, could not enforce the HIV and AIDS law which had been legislated through the policy. They had no legal power. Therein lay the challenge that such players needed to be empowered to have legal ability to effect the law. It was found out that with regard to PLHIV, only the public sector had done some work because it was expensive for the private sector to do it and even in the private sector, the issue of sustainability remained a major challenge. As to how effective had the policy been, the respondents noted the dichotomy among policy, programmes and practice. The very nature of the basic approach which had been – prevention, care and treatment as well as impact mitigation, the actual practice had placed more emphasis on care and treatment since that intervention was finance-intensive at the expense of the other interventions.

Community level:

The issues that rose with KII and FGDs pointed to the lack of awareness and understanding of the content and context of the national HIV and AIDS policies. That being the case, it was difficult to define effectiveness and even implementation of those policy objectives since some of the CSOs were major implementers in their own rights.

LGAs took up HIV and AIDS activities as an add-on issue and were only active as long as funds were available. Yet such entities, as was occurring in CSOs could have been active in mobilising resources outside official channels.

Existence and effectiveness of HIV and AIDS Programmes:

EAC level:

The inadequacy of staffing has been a major bottleneck. It was reported that permission for the recruitment of new staff has been obtained and are being effected. Since the strategy is in place, the presence of these staff members will enhance its implementation.

National level:

With the Tanzania Government policy of devolution by decentralisation, the national level develops, produces, supervises, carries out monitoring and evaluation as well as build capacity of Local Government Authority (LGA) to be able to advocate, plan, implement, monitor and evaluate and finally co-ordinate HIV and AIDS activities. The performance of the programmes when it comes to the study population was reported to be inadequate. Plantations', being in the private sector, the question of HIV and AIDS infection was not a core activity of the plantation owners. They could easily have dealt with workplace accidents BUT not a chronic disease such as HIV and AIDS.

Community level:

As found out from the both quantitative data and qualitative sources, programme implementation at this level was a joint initiative of both public and private sectors. Hence the need to make sure that the private sector is included in the comprehensive package of HIV and AIDS interventions in a collaborative manner.

Existence and effectiveness of Coordination structures

EAC level:

With the advent of the LVBC, currently co-ordination can take place. The structures to be co-ordinated include NACs, NTTs and umbrella NGOs working in the area of HIV and AIDS. The need to speak as one voice is critical if harmonisation of policies, strategies and best practices has to take place. Furthermore, the opportunities for resource mobilisation could greatly be enhanced if the EAC was to come with one agenda on the epidemic.

National Level:

At this level, as was pointed out during discussions, co-ordination was difficult because all the HIV and AIDS interventions are skills-intensive ones. There is need for co-ordination at inter-Ministerial level let alone departments and agencies. In Tanzania, for example, Ministry of Health is operating at 38% capacity as far as human resources for health go. Performance becomes very problematic. Such co-ordination can only happen with adequate funding which is not the case.

Community level:

One can only co-ordinate what is there. In the plantations, the inadequacy of programmes, resources and other logistics were pointed out many a times. The responsible organ for this activity is supposed to be the LGAs. They are overwhelmed.

Funding of HIV and AIDS activities:

EAC level and Tanzania national levels:

The data obtained at both the EAC and Tanzania Government levels showed that almost over 95% of HIV and AIDS budget was from external sources. Such a scenario is problematic since donor fatigue and the whole question of sustainability can only be addressed with adequate 'own resources'.

Community level:

At this level, the bulk of HIV and AIDS interventions are taking place. Due to the magnitude of the HIV and AIDS epidemic, LGAs are overwhelmed and plantation communities have been marginalised.

Conclusions and recommendations:

HIV prevalence:

The major finding in the study was that plantation workers communities had higher HIV prevalence than the general Tanzania population. Also it was found that women had higher HIV prevalence than the men among plantation workers communities. In addition, the most affected age group was that of 35 -44 year olds.

Recommendation:

Programme implementers should develop interventions that target all plantation workers and focus more on women and the 35 -44 years age group.

HIV awareness and knowledge:

The key finding was that the study populations had higher levels of knowledge on HIV and AIDS. Nevertheless, such levels of knowledge did not translate into changes in HIV prevalence.

Recommendation:

Programmes should focus and intensify on HIV and AIDS education on prevention and care in order to minimise stigma and clear the misconceptions found such as casual contact with an infected person could transmit HIV; sexual intercourse with a virgin is protective against contracting HIV and that mosquito bites can transmit HIV.

Misconception:

It was observed both from quantitative and qualitative sources that blood in urine was a sexually transmitted disease. Furthermore, men reported that having sex with a virgin was a cure or way of not contracting HIV. All these are misconceptions.

Recommendation:

Potential programme implementers should be aware that despite the widespread view that there is adequate knowledge on HIV, many youths are joining the adult age-set annually and have not previously been covered by the HIV education processes which their elders had been given. HIV education should be a continuous process.

Behavioural change:

The study has found that HIV education has been provided by both public sector and civil society organisations to the workers. There was no evidence as to the package of that education in terms of content, number of times given and target audience. In addition, we could not determine whether there were indicators to measure effectiveness of the intervention. In view of the finding, the following recommendation is made. The MoHSW has guidelines and these should be made widely available.

Recommendation:

The plantation management should ensure that existing MoHSW guidelines are available in their health facilities. The potential implementer should design an HIV and AIDS intervention package in such a way as to take into consideration the issues of content, time and measurement of indicators in order to observe the desired impact. Such an intervention package must have a time-line.

HIV testing:

In the study it was found that respondents were more willing to disclose HIV sero-status to spouse/permanent partner and/or girlfriend/boyfriend than to others. In view of the finding, the following recommendation is made.

Recommendation:

Programmes should make sure that HIV testing, while it should follow Tanzania Government guidelines, yet in the study populations it should focus intensely of partner testing (spouse/permanent partner and/or girlfriend, boyfriend).

Condom attitude and utilisation:

It was found that there was negative attitude on condoms i.e. their use leads to reduction of sexual pleasure. Secondly, there was misconception that condom use denotes lack of trust of sexual partner. Condom disposal was said to be problematic. Furthermore, while fifty per cent reported condom use, the results of HIV prevalence was higher in plantation workers than in the general public.

Recommendation:

Programme implementers should ensure more and intense education is delivered to correct the misconception that condom use leads to reduction of sexual pleasure and/or mistrust of sexual partner. In addition that intervention should target on getting people to use condoms correctly and consistently.

Inclusion of other key stakeholders in the provision of HIV and AIDS services:

In the study, it was found that apart from the public sector providing HIV and AIDS services, there were others, such as civil society organisations, which were providing HIV and AIDS services in plantation workers. In view of the finding, the following recommendation is made.

Recommendation:

It is recommended that when interventions are being planned, all stakeholders (especially private service providers) should be included in order to rationalise service provision and avoid undermining the efforts of the intervention.

Site for implementation of community interventions:

Many respondents on being probed as to sites which they would prefer to get services from, 'own community' came out strongly. Similar proportions of respondents had no preference.

Recommendation:

It is recommended that interventions be implemented at 'own community' level. Also, for the plantation workers communities, HIV and AIDS interventions should include the workplace clinic where available e.g. Kagera Sugar Estate.

HIV and AIDS support groups' activities:

While it is understandable that HIV and AIDS prevention, care and support as well as impact mitigation is not a core activity of the management of the plantation owners, yet HIV and AIDS support group activities were found to be inadequate in plantation workers communities. In view of the finding, the following recommendation is made.

Recommendation:

Plantation owners or plantation management should be sensitised to regard HIV and AIDS as a major problem since the nation has declared it to be a 'national disaster' and it affects the production of both sugar and tea. Hence, more and intensive efforts should be put in designing, funding and supporting such an intervention since such an activity has the potential of having a higher coverage of target beneficiaries and the public sector should work closely with the estate managements.

Gender Based Violence:

The magnitude of gender-based violence was found to be significant. The violence experienced ranged from physical and verbal abuse. In view of the finding, the following recommendation is made.

Recommendation:

In any HIV and AIDS interventions being developed for the study populations, gender based violence should be addressed. Communities should be involved right from the beginning.

HIV and AIDS Policies of member states:

It was found out that the five EAC member states have existing HIV and AIDS policies and strategies. There is no linkage even in very clear areas such as plantation workers communities. While the community is meant to be one single entity, when it comes to negotiations with donors, the unifying 'voice' is missing.

Recommendation:

The member state HIV and AIDS policies and strategies should be harmonised to allow for joint development of interventions as well as joint negotiation approaches in the areas of HIV and AIDS among plantation workers populations.

HIV and AIDS programmes

The dislocation between what the policy states and what is happening is a major challenge. Many activities at national and community level cannot be implemented due to inadequacies: human resources, poor co-ordination and poor funding.

Recommendation:

The East African Community (EAC) should speak with one voice and use its muscle for resource mobilisation. Furthermore, 'best practices' should be identified, documented and disseminated.

Kagera Tea Company:

The approach of the company in supporting those who disclose their HIV sero-status was a good move.

Recommendation:

Programme implementers should study this practice in detail, document and disseminate it to other large scale plantation owners so that its benefits can be known and supported.

Chapter 1

Introduction

1.1: Background:

Globally in 2007, people living with HIV were 33 million [30 – 36], new HIV infections were 2.7 million [2.2 – 3.2 million] and deaths due to AIDS were 2.0 million [1.8 – 2.3], (WHO & UNAIDS, 2009). These figures included adults and children. HIV prevalence rates in adults by Region during the same year, to mention some, were Sub-Saharan Africa 5% and Caribbean 1%. Yet the world's average stood at 0.9%, suggesting that Sub-Saharan Africa was the worst affected of all the Regions (WHO & UNAIDS, 2009). Countries within Sub-Saharan Africa are the hardest hit by the HIV and AIDS and East Africa has been no exception. In each of these individual countries which are affected by HIV and AIDS there are certain groups of people or communities which are worst affected by HIV and AIDS. Examples of these groups are plantation workers.

Several studies have been conducted among plantation workers such as the one in the Dominican Republic, where infection levels among sugar cane plantation workers living in communities called “bateyes” averaged 5%, with some groups as high as 12% (USAID, 2008). A study conducted in South Africa reported an extraordinarily high prevalence of HIV among farm workers on commercial farms. An average of 39.5 percent of farm workers tested HIV positive. This was more than twice the UNAIDS estimated national prevalence for South Africa of 18.1 percent. HIV prevalence was significantly higher among women employees with almost half of the women (46.7%) testing positive compared to just under a third (30.9%) of the men workforce (IOM <http://allafrica.com/stories/201011230722.html>). In Zimbabwe, 70 percent of 1995 antenatal patients in the sugar plantation town of Chiredzi were HIV positive (FHI, 2011).

In Kericho, Kenya the overall prevalence of HIV-1 infection among agricultural plantation residents was 9.9% (81/820), with prevalence in women more than twice that in men (17.4% vs 8.0%, $P = 0.001$). (Sateren *et al*, 2006). In many of these plantations or rural farms women usually outnumber men (UNAIDS, 2002).

In another study in Kenya, Human immunodeficiency virus type 1 (HIV-1) epidemiology among residents of rural Kericho, agricultural plantation was studied. The overall, HIV-1 prevalence was 14.3%, and was higher among women (19.1%) than men (11.3%) (G. Foglia et al, 2008).

A cohort study was conducted in a Sugar estate in rural Malawi, HIV prevalence was 24.3% among 1692 men screened in 1994 and 21.0% among 1349 men screened in 1998. HIV incidence was extremely high during 1994 to 1995 (17.1% for that 1-year period) (Kumwenda, Newton I; et al, 2001).

Workers for these plantations come from different places and therefore, separated from socio-cultural norms that regulate behaviour in stable communities (Smith C, 2002). In one study; men reported engaging in more risky sexual behaviour than women, with 60% of currently married men reporting extra-marital affairs compared to 4% of currently married women (Chikovore J & Mbizvo MT, 1999). Another significant source of HIV transmission is sex between men, especially those working and living in predominantly men environments (Global HIV and AIDS Epidemic, 2002).

Plantation workers reside in estates which can be accurately described as closed communities. These communities are therefore, isolated from the mainstream of government HIV and AIDS prevention and awareness campaigns (Roberts, M and Wangombe, J, 1995), illiteracy and with the influx of foreign workers hinder proper dissemination of HIV and AIDS information. These communities do not get exposure to such prevention programmes and therefore, the risk of vulnerability of HIV infection is unknown (Thegaraju MR, 2002). Workers in the plantations are underpaid; live in poor conditions and experience loneliness as they are far from home. They therefore, boost their income by selling sex (PlusNews Global, 2009).

Agricultural workers are also highly vulnerable to HIV infection. Men and women often live together in living quarters called 'labour camps' where conditions are ripe for HIV to be spread quickly. The conditions are poor. The rooms are very small. Poverty is very high and prostitution is a problem (UNAIDS 2006).

In addition, the level of literacy among agricultural workers is very low and use of HIV infection preventive measures such as condom use is extremely poor (Brewer TH *et al*, 1998), allowing misconceptions about HIV to flourish. Sexual abuse is encouraged by poor work organisation such as

isolated work-stations, lonely night shifts and non-transparent practices for recruitment and promotion (UNAIDS 2006).

Despite of the high HIV prevalence in these plantations, there is very little being done to help the workers prevent themselves against HIV and AIDS. A lot of individuals die in these plantations a result of HIV and AIDS infection and yet efforts to combat the situation are not enough (Dominican Republic, 2006).

There is also little concern among plantation managements about the impact of HIV and AIDS on their own business or sector. They have done little to respond to HIV and AIDS and show little interest in taking action in the future (United Nations, 2006).

Despite high awareness about HIV/ AIDS among plantation workers as some studies have elucidated, a big proportion still perceive themselves to be at low risk of infection, and do not consider HIV and AIDS to be a serious problem in the community. Moreover, knowledge of effective HIV prevention measures among the workers is still very low; and there are significant misperceptions about HIV transmission and prevention (Kennedy Nyambuti Ondimu, <http://www.africanbookscollective.com/books/risky-sexual-behaviours-among-migrant-tea-workers-in-kenya>). Such a finding has been augmented by another study in a commercial farm where, despite high sero-prevalence rates in Zimbabwe, many individuals did not perceive themselves at risk (Siziya S. *et al*, 1999).

Mobile populations experience a multitude of risks. Pre-occupied by more immediate challenges of physical survival and financial need, many people on the move regard HIV as a distant risk (Kambou, S.B. (Care International), 2002)).

The impact of the HIV and AIDS on the plantations has not gone unnoticed; production loss due to AIDS on a Malawi tea plantation in 1995/1996 was shown to be 3% of gross profit (UMP, <http://ww2.unhabitat.org/programmes/hiv/documents/UMP-ROA.niche.paper.pdf>).

These agricultural plantation companies also suffer sharp profit losses as a result of the loss of workers and decreased working hours due to illness, death, overwork and stress, attendance at funerals, and home care of ill dependents (Rugalema G., 1999).

In spite of what has been said in the previous paragraphs, people in these plantations are very cooperative and have shown willingness to learn, a potential scenario for interventions (Saterren *et al*, 2006). In India, the West Bengal Voluntary Health Association (WBVHA) introduced an intervention package into tea plantations and it worked well (Poddar DP, 1995).

The Lake Victoria Basin seems to exhibit unique features. It is characterised by high HIV prevalence levels; there is heavy and frequent movement of people within and through the Basin, and in most parts of the Basin, health systems have largely failed to meet the demand for HIV and AIDS services (EAC, 2009).

Despite HIV and AIDS being first confirmed in the Kagera Region within the agricultural plantation communities of Lake Victoria in Tanzania (1983), there has been little evidence of shared experiences among the partner states on how to tackle the problem within a regional context.

There is wide interaction through population mobility among the 30 million people living in the Lake Victoria basin of the partner states of the East African Community (EAC) who are engaged in agricultural plantations. Similarly in the agricultural sector, HIV and AIDS is having a dramatic impact on agricultural production and rural livelihoods. All dimensions of food security—availability, stability, access to, and utilization of food – are affected, particularly where the prevalence of HIV is high (FAO HIV and AIDS Programme, 2003). Emergency situations, especially food emergencies, exacerbate the risk of HIV transmission. Mobile populations are vulnerable to HIV risk. A significant proportion of the populations of the countries most affected by HIV and AIDS depend on agriculture for their subsistence and food security. The agricultural sector therefore, has an important role to play to ensure availability and access to food, as well as to reduce rural households' vulnerability to the long-term effects of the epidemic (Jayne *et. al*, 2005). A successful mitigation strategy must address the diverse impacts of the HIV and AIDS epidemic ranging from illness to food insecurity hence inadequate nutrition.

Sentinel HIV sero-surveillances have been the major technique of collecting data on HIV situation in the country, and informing policy in the country. Few epidemiological cohort studies in the country have provided data on the HIV sero-prevalence in the general populations (ASAP Report, 2008). Recently, the HIV and AIDS trends in Tanzania have been shown to decline in most areas of the country (THMIS, 2007/8). Despite the reported decline of HIV prevalence in the general population in the country, HIV prevalence in the Lake zone regions has remained high. Migrant or seasonal workers are also vulnerable.

It has been found that farm and plantation workers in Iringa and Morogoro for example, have HIV prevalence of about 30%, which is very high, compared to the general population (TACAIDS http://www.tanzania.go.tz/hiv_aids.html).

Based on the above knowledge, the EAC/AMREF Lake Victoria Partnership Programme (EALP) decided to conduct baseline studies in agricultural plantations in the Lake Victoria basin. The findings of the baseline studies will shade light as to what appropriate interventions need to be implemented in these plantation communities.

In order to ensure that the findings of the baseline studies are reliable, valid and widely acceptable within the East African Community (EAC) Partner States, the EALP sought the technical assistance of a lead consultant with an established a team of researchers. That team therefore, developed the research protocols for the HIV sero-prevalence in the agricultural plantation communities as well as the co-ordination element relevant for the study. In addition, the team was responsible for the technical supervision of the study as well as preparation of sector-specific national study reports.

This report covers the baseline study for the Tanzania side of the Lake basin among plantation workers. In the baseline survey, the data collected focussed on HIV sero-prevalence, behavioural risks, service availability and utilization. We also collected data on coordination, institutional policies and structure.

1.2: HIV sero-prevalence:

Given the fact that the sero-prevalence data are mainly obtained from voluntary counselling and testing facilities/services and among few segments of populations' e.g. pregnant women attending MCH services, there is inadequate information on the magnitude of HIV prevalence among groups such as the agricultural plantation communities. The study determined HIV sero-prevalence among people working in plantations and the surrounding communities in the basin of Lake Victoria, Tanzania.

1.3: Behavioural Risks:

In this study behaviour that fuel HIV sero-prevalence in plantation communities in the Lake Victoria basin, in Tanzania was explored.

From socio-epidemiological point of view, people who are highly mobile, those who work or stay away from their spouses for longer periods, and those who are involved in certain job categories (e.g. uniform personnel, sex workers, bar and guest houses attendants, to mention a few, are at increased risk of HIV infections. By the nature of employment, seasonal agricultural plantation workers are known to exhibit short and long term migratory movements in search of lucrative plantations. Specific contexts or environments within which risk sexual practices take place among plantation workers are so far not well explored. There are only generic knowledge on risk behaviour and practices. Behavioural factors or practices which are generally known to increase possibilities to contract HIV, such as the serial casual sexual partnership, types of sexual encounters (intercourse) i.e. oral, anal; intra-vaginal practices, are issues that are not adequately explored among the plantation communities in the Lake Victoria basin in Tanzania. We therefore, explored the demographic and behavioural determinants of HIV infection, sexual behaviour and practices, access to information on HIV, attitudes and beliefs regarding sexually transmitted diseases.

1.4: Service availability and utilization:

Voluntary HIV testing and counselling has been one of the cornerstone for HIV and AIDS control in the country. Such services are readily available in urban settings. Its availability and utility by mobile populations, especially in the remote areas such as the agricultural plantations in Lake Victoria is not well known. The availability and utilization of HIV preventive, care, treatment and support including impact mitigation and coping services were explored.

People who have already sought VCT and found to be HIV-positive and those who are terminally ill from AIDS-related illnesses may be at increased need for medical attention, as well as psycho-social supports. The study established the range and breadth of access, availability and utilization of HIV and AIDS-related services.

In view of the increasing number of people living with AIDS, widow(er) and orphans and the accompanied inadequate capacity of public institutions (including health facilities) to respond to the demands, communities in many societies have initiated or depended on community supporting systems/mechanisms. Little is known with regard to the availability and functioning of such systems in plantation communities. This area was explored in the survey.

The study strove to explore both modern and traditional services and support mechanisms available in the plantation communities in the basins of Lake Victoria.

It has been well established that poverty significantly influences the spread of HIV and AIDS. In many ways poverty creates vulnerability to HIV infection, causes rapid progression of the infection in the individual due to malnutrition and limit access to social and health care services. The study explored household resources to control HIV infection and capacity to deal / cope and mitigate the impact of AIDS.

1.5: Coordination, institutional policies and structures:

The HIV control or AIDS impact mitigation services can only be implemented if an enabling environment exists (e.g. legal framework, political will, effective planning, management and coordination of activities). For example, experiences from neighbouring countries have shown that strong political commitment is necessary in spearheading the fight against AIDS and HIV infection. The study determined the existence of strong political commitments at all levels of leadership, effectiveness of policies, programmes and coordination structures for control of HIV and AIDS in plantation communities.

We also explored whether and how multi-sectoral AIDS response strategies and policies are translated in the actual/local settings. Do the national policies and programmes reach people at the bottom of the ladder such as those in special areas e.g. sugar cane plantation workers?

1.6 Organisation of the report:

The report is divided into five chapters and each chapter into subsections. Chapter 1 contains the introduction which is subdivided into background information, HIV sero-prevalence, behavioural risks, services availability and utilisation. It ends with organisation of the report.

The methodology in chapter 2 gives details of the study objectives, the demographic characteristics on the study populations, study design, sampling procedures and sample size determination. In addition, there is survey mobilisation, preparation for fieldwork, quantitative and qualitative data, staff training, supervision, data management and analysis, ethical considerations and limitations of the study.

Chapter 3 contains the findings of the study for every specific objective. Chapter 4 presents the discussion emanating from the findings given from chapter 3. The discussion is based on the findings of each specific objective. In chapter 5, the recommendations are given as well as specific recommendations for every objective of the study and relevant perspectives. Finally, the report has annexes of references and data collection tools and a scanned Ethical Clearance Certificate.

1.7 Objectives

1.7.1 Broad objective:

The purpose of the baseline survey was to establish the HIV prevalence, the associated drivers of risk and vulnerability and the effectiveness of HIV and AIDS responses for agricultural plantation workers in the Lake Victoria Basin.

1.7.2 Specific objectives of the studies included:

1. To determine HIV sero-prevalence among populations in the agricultural plantation systems in Lake Victoria Basin in Tanzania.
2. To establish the demographic and behavioural risks factors, knowledge and attitudes regarding HIV and STI transmission among plantation workers.
3. To establish the range, breadth, availability and utilization of HIV and AIDS related services.
4. To determine the existence and effectiveness of policies, programs and coordination structures on HIV and AIDS in plantations.

Chapter 2

Methodology:

2.1: Study sites:

The study survey was conducted in sampled sites bordering the Lake Victoria basin. Study sites were identified based on availability of large scale plantation communities. The Research Team conducted surveys in the Kagera Region since it was the only region in the Lake Victoria basin - Tanzania side, which had large-scale agricultural plantations. The farms were in Bukoba Rural district (Kagera Tea Company) and Missenyi district (Kagera Sugar Estate).

2.2: Study design:

This was a baseline cross-sectional study on prevalence of HIV infection, demographic and behavioural risks factors, knowledge and attitudes regarding HIV and STI transmission among plantation workers, establishment of the range, breadth, availability and utilization of HIV and AIDS related services and finally determination of the existence and effectiveness of policies, programs and coordination structures on HIV and AIDS in plantations communities. The study integrated both qualitative and quantitative data collection techniques and tools including quantitative questionnaire survey, secondary sources, focus group discussions, semi-structured interviews, observations and dry blood spots (DBS).

2.3: Sampling

2.3.1: Sampling Framework:

For the two plantations Kagera Sugar Company and Kagera Tea Company, participants were categorized in three groups i.e. permanent workers, seasonal/contractual workers and casual workers. The two plantations were treated as strata. Stratified sampling was deployed to get sample size. Lists of all eligible candidates were obtained from plantation management. Then probability proportion to size (PPS) was applied to the two strata (Plantations in Kagera Sugar and Kagera Tea).

After that process, simple random selection was done within cadres i.e. permanent, seasonal and casual workforces in order to ensure that each cadre was covered. In a preliminary visit carried out to these two plantations, the following data was obtained:

(i): Kagera Sugar Plantation, Missenyi District, Kagera Region, Tanzania:

This was a privately owned plantation and by Tanzania standards, it was very big. While the owner was a Tanzanian of Zanzibari extraction, the management had been outsourced to a management firm which was also then running Mtibwa Sugar Company in Morogoro region. That Management firm was from India. The plantation was more than 8,000 hectares and is still expanding. It had the following human resources:

(ii): Kagera Tea Company, Bukoba Rural District, Kagera Region, Tanzania

The estate has two parts: Maruku and Katoke sites. It is a privately owned plantation and owned by a Tanzanian. It was possible to meet the proprietor during our visit. It had the following permanent human resources:

The majority of the permanent staff lived within the plantation area and only a few had rented accommodation elsewhere. It had the following casual human resources:

The majority of casual labourers stayed in the neighbouring villages and a few were in the labour camps within the plantation. Hence the total manpower (permanent plus casuals) of Kagera Tea Plantation was 717.

Calculation of the sample size, assumed that this mobile population would have similar characteristics as that of the fishing communities with a prevalence of 20%.

2.3.2: Sample size determination:

Sample size was determined by using the formula below:-

$$n = \frac{Z^2_{1-\alpha/2} \times p(1-p)}{d^2}$$

Where:

n is minimum sample size required for our study

$Z^2_{1-\alpha/2}$ is 1.96 Confidence Interval 95%

d^2 Desired Precision

p is expected probability variable of interest (The HIV prevalence in fishing landing site is not known but few studies carried out have given a directive, i.e. 20% prevalence (TANESA/UNDP study, 2005)

Thus the sample size was 425.

2.4: Inclusion and exclusion criteria

2.4.1: Inclusion criteria

- All persons aged 15 years and above working in the plantation.

2.4.2: Exclusion criteria

- Eligible respondents who refused to give consent.

2.5: Mobilisation:

Social mobilization was continuous throughout the study. Channels of communication during the implementation and social mobilisation were from the Lake Victoria Basin Commission (LVBC), member country, and then cascaded to the sub-national levels. Mobilization strategies to allow entry into the community involved four main levels, which were as follows:

1. Regional (EAC): The EAC Secretariat (the Health and HIV and AIDS Programme Officer; the LVBC Secretariat – Kisumu).
2. National level: Ministries, Departments, Agencies which were relevant for the activity; National Officers as part of National Technical Team (NTT), Health, Agriculture, National AIDS Commissions, Research Institution, National laboratories, National Bureau of statistics, Education).
3. Tanzania - Regional level: Regional Commissioner (RC), Regional Administrative Secretary (RAS), TACAIDS Regional HIV and AIDS Focal Point; Regional Medical officer (RMO), Regional AIDS Control Co-ordinator (RACC).
4. District level: Council Directors (CD), District Medical Officer (DMO), CHAC; District AIDS Control Co-ordinator (DACC), Agricultural Departments.
5. Owners of large-scale plantations.

Each of the levels itemised has been described in detailed as to the activities of mobilisation which took place.

East Africa level (EAC):

The EAC secretariat commented on the protocol and the data collection tools. There was also exchange of documents and letters of commitment. Furthermore, there were two meetings one in Nairobi, Lukenya Hotel, and in Jinja in Uganda where the partner state research teams were able to exchange information and share information.

National level:

At National level visits by research team and meetings with respective national public officers were part of sensitization and mobilization approach. Correspondences, exchange of documents and letters of commitment did form part of communication. A meeting was held at La Kairo Hotel in Mwanza City where the research team was able to present the study protocol to the National Technical Team. It was commented upon and the inputs enabled the research team to improve the document.

Regional level:

The research team was able to visit and conduct meetings with Regional stakeholders e.g. the Regional Commissioners (RCs, the Regional Administrative Secretaries (RASs), the Regional Community Development Officers (RDCDOs), Regional AIDS Control Coordinators (RACCs) and the Regional HIV and AIDS Focal Point officers. Highlights of the objectives and approaches of the study were the main focus of these visits.

District level:

Visits and meetings were carried out with the respective officers at the Districts e.g. DC, DED, DALDO, and similarly they were given highlights of the objectives and approaches of the study. Dates, times and name of central meeting places were proposed.

In addition, the following specific activities were carried out during mobilisation strategies:

1. Meeting with farm management including the owners of large scale plantation were carried out, explaining the aim, purpose, objectives and approach of the study.
2. Initially, Kagera sugar management were not cooperative, but after detailed information about the study and second attempt to visit them, they became very interested, cooperative, and even organised a get together function. The same management provided lists of all workers who were working in the factory. These were permanent, seasonal and casual plantation workers.
3. For clarity, easy reference and understanding of the study procedures the research team developed and distributed fliers describing the purpose, procedures, objectives and benefits of the study. Information sheets with details of the study were distributed to all operational factory managers and to eligible participants.
4. Questions and concerns of the participants were answered to their satisfaction

5. For clarification contact address of the lead consultant and the research team was provided to all administrative levels in the study population.

2.6: Quantitative and Qualitative data:

2.6.1: Field Procedures:

The research tools i.e. face to face questionnaire, focus group discussion guides and key informant guides were translated into the national language and re-translated back to English for comparison of consistency. They were then pre-tested to check for the intelligibility, flow and comprehension of the questions among respondents as well as consistency. The final version of the structured questionnaire was then standardized into computer-coded format and designed to include both closed and open-ended questions.

2.6.2: Structured Questionnaire Interview

All eligible participants from selected sites were invited to attend to a central site and were enrolled after being read or after reading the study information sheet and giving informed signed consent. After enrolment, a face to face structured questionnaire was administered by same sex interviewer in a quiet and private environment. Personal characteristics such as age, sex, marital status, occupation, child labour, residence, circumcision status (only for men), mobility and migration, behavioural risks factors such as types/forms of sexual practices and their socio-cultural and economic contexts were sought for.

2.6.3: Focus Group Discussions (FGDs):

Focus group discussions (FGDs) were conducted in groups of 8 to 12 participants each. The groups were aged between 15 years and above, men or women and were led by a facilitator of the same sex. The focus group guides were used to lead the discussions and extract as much information as possible.

The participants gave consent for participating in the FGDs (see Annex1b) before the onset of discussions; they were assured of confidentiality and the safety of the audiotapes used to capture the discussions. Information emanating from those discussions was captured by audio tapes and as back up by physical notes taking.

2.6.4: Key Informant Interviews (KIIs):

Key Informant Interviews were conducted with informants who were meant to be sources of detailed information on HIV and AIDS among the target study populations. An interview guide had been developed, and was used to obtain information (see Annex 4). The participants for the KIIs were identified as follows for plantation workers communities. They were:

- EAC and LVBC professional staff
- National level- Ministries, Departments and Agencies
- Regional/District Agricultural Officers/RACCs
- District Executive/Council Directors
- District Planning Officers (DPLOs)
- District Medical Officers (DMOs)
- Council HIV and AIDS Coordinators (CHACs)
- District HIV and AIDS Coordinators (DACCs)
- Human Relation Officers (Kagera Tea & Kagera Sugar)
- Medical Officers I/C (Kagera Tea & Kagera Sugar)

During the KII, both audio tapes and notes were used to capture the information. Informed consent was obtained before interview.

2.6.5: Field laboratory Procedures and Laboratory Tests

The Guideline of the Ministry of Health and Social Welfare/National AIDS Control Programme (MOH&SW/NACP) on Dry Blood Spots preparation protocol and HIV testing was used. The main features were as follows:

- The study used Dry Blood Sport (DBS) technique using ‘WHATMAN filter paper serial number 903’ and participants, after written consent, were requested to provide blood to be collected using the filter paper.

- Each filter paper was placed with a sticker carrying a unique study number for each participant. A spare sticker was placed on the laboratory submission form for sample tracking and number consistency.
- Having explained to the participant the laboratory procedures and the purpose, the laboratory technician did prick a finger using a sterile pricker and took a filter paper and placed it on the pricked area. The technician allowed the blood to flow naturally until blood was seen on the other side of the filter paper (expected blood volume of 0.5-1.0 ml to be absorbed on the filter paper). The technician was NOT allowed to SQUEEZE the person's finger as this could affect the balance of serum and cells obtained in the sample.
- Once the DBS was taken, the filter paper was placed into a wire mesh slide box. The DBS was left to dry at room temperature until it was completely dry. The DBS was NEVER EXPOSED to direct sunlight because ultra-violet (UV) rays from the sun could destroy the DNA and antibodies contained within the DBS.
- After drying, each DBS was placed in a separate small gas-impermeable grip bag containing a sachet of desiccant and a humidity indicator card.
- At the end of the day the laboratory technician used a sample submission form to prepare a list of that day's DBS collection with their identifier for submission to the laboratory at the NIMR Mwanza Centre.
- The sample submission form had a list of all DBS, date and somewhere for technicians at both ends to sign. It was advised to have a copy of laboratory submission form kept at the field laboratory.
- After preparing the laboratory submission form, all the DBS were placed into one larger grip bag then into the cool box ready for transportation to the NIMR Laboratory. Transportation of the DBS to NIMR Mwanza Laboratory was done by a vehicle on daily basis.

2.6.6: Quality Control Issues:

Three issues were covered for their quality implications. These were: face to face questionnaires; laboratory samples and data entry procedures.

2.6.6.1 Face-to-face questionnaires:

10% of all the questionnaires were repeated on a daily basis to assure quality control. In order to maximise time spent, only sections of the questionnaires were selected and repeated in order to validate consistency.

2.6.6.2: Laboratory samples:

After interview, all eligible consenting participants will be finger-pricked, and a Dry Blood Spot (DBS) was obtained on a dry filter paper. These dry blood spots were kept in sealed plastic envelop which were then placed in a container which had some desiccant material in order to keep it dry until transported to the laboratory. After testing at the central laboratory at NIMR, part of the samples were repeated at the NIMR Centre Laboratory by using different person in order to obtain validation of tests.

2.6.6.3: Data entry quality control:

Data from field were entered into a computer by one data entry clerk. That procedure was repeated using a second data entry clerk. This allowed for verification of entered data in order to ensure consistency.

2.6.7: Field Assistant Training:

The research team developed a training manual for use in the training. The manual contained the following sections/parts. An Introduction to the Manual and HIV and AIDS in Tanzania; Factors fuelling the HIV and AIDS epidemic, the Proposal itself for the work i.e. - The EALP Baseline Studies on HIV and AIDS in Fishing Communities and Agricultural Plantation Sectors in the Lake Victoria Basin, Tanzania, the Tools for data collection, Ethical issues on the study and Consent issues. Initially there was an advertisement for Research Assistants (RAs) which was posted in the TANESA, NIMR Notice Boards and the local stakeholders' notice boards. Four hundred and seventeen (417) applications were received. Sixty (60) applicants were short listed for interviews out of which 35 of them were selected for training which was carried out by the research team at the Bank of Tanzania Institute (BOTI).

2.6.8: Supervision:

Supervision started right from the beginning of the training of RAs and went on throughout the study. The supervision was carried out collaboratively between the research team and the National technical team who participated in the process, starting with the NTT in-country meeting, during training and data collection.

2.6.9: Data management and Analysis

2.6.9.1: Quantitative data:

In the field, data was collected using standardized questionnaire and checklists. Quality control of data was done as described earlier in order to make the necessary corrections and/or re-interview for any omissions or inconsistencies. Then data was entered into computer by two data entry clerks (double entry) using Dbase V computer software for cleaning and validation. Analysis was done with the help of Stata version 10.0 computer software (*Stata Corporation, College Park, Texas*). During the data analysis the biostatistician checked if there were inconsistencies of data that had been collected, and whether there was a problem in data entry and coding.

The statistician ensured that data analysis was done carefully in consideration of the objectives of the study and protocol. Exploration of data was done by using graph techniques such as 4-plot and some statistical classical methods, and if statistical classical methods yielded different conclusions than the graphical analysis, then some effort was invested to explain why.

Data analysis was done by stages: i.e. string with descriptive analysis then followed by univariate, bivariate and multivariate analysis. Numerical data was expressed as means and standard deviations and where needed a student t-test was used. Proportions were compared by using chi –square test or Fishers’ exact test. Multivariate analysis did report odds ratio. P value ≤ 0.05 was considered as statistically significant for all tests.

2.6.9.2: Qualitative data (from FGDs & SSIs):

Investigators independently coded and categorised the transcriptions from FGDs and reports from SSIs and compared notes to minimise inter-coder variations. The coded data was searched for emergent patterns. During that process, a series of validity checks were performed which involved shifting between emic and etic perspectives (Miles and Huberman, 1994). Where cases were found that did not fit with emergent theory, the theory was re-examined and evaluated in the light of those cases (Bernard, 1995). Nvivo version 8.0 (Pty Ltd, Sidney, Australia) qualitative computer software was used to manage and sort out coded segments of transcriptions/reports for interpretable pieces of information. Investigators performed content analysis and data independently and then compared notes so as to find out whether they had more or less assigned the same meaning to the data hence, maximizing inter-investigator reliability.

2.6.10: Ethical clearance:

The research team presented the research protocol to the National ethics committee to be cleared for research work. It was reviewed and comments submitted to the team. Those comments/suggestions were attended to and the final protocol re-submitted.

It received ethical clearance; see Annex 6 for a scanned version of the Clearance certificate.

2.6.11: Challenges of the study:

The survey was carried in parallel with another survey on fishing communities. There were logistical challenges especially on division of the research teams for the two surveys which were running concurrently. Otherwise, we had no challenge concerning the survey in the plantations workers per se.

Chapter 3

Findings

3.1: Introduction:

The section presents the results from the survey in plantations. The survey involved two plantations on the Lake Victoria Basin - Tanzania side. These were the Kagera Sugar Estate in Misenyi District and Kagera Tea Company in Bukoba Rural District both in Kagera Region. Data from the two plantations have been merged so that the total study population could give meaningful results. The findings presented include socio-demographic characteristics, HIV prevalence, knowledge, attitude and behavioural factors, service availability and utilisation and finally availability and effectiveness of policies, programmes as well as coordination issues.

3.2: Description of the Study Population:

The total number of study participants in the plantations was 409, made up of 293 (72%) men and 116 (28%) women. It had been planned to survey a total of 425 individuals but managed to survey the number given i.e. 409, making sure that the agreed sampling frame was strictly followed. Hence the coverage was 409 out of 425 (96.2%). In the sampling frame, we managed to get respondents from all categories of employees as described earlier on. There were more men than women in the study population. Most likely this was due to the nature of the work in the plantations. It is labour intensive and therefore requires young energetic men.

Over two-thirds of the participants were household heads with an average of 4 dependants each among men and women household heads. A household head could either be a man or a woman and most had dependants.

3.2.1: Age profiles of study population:

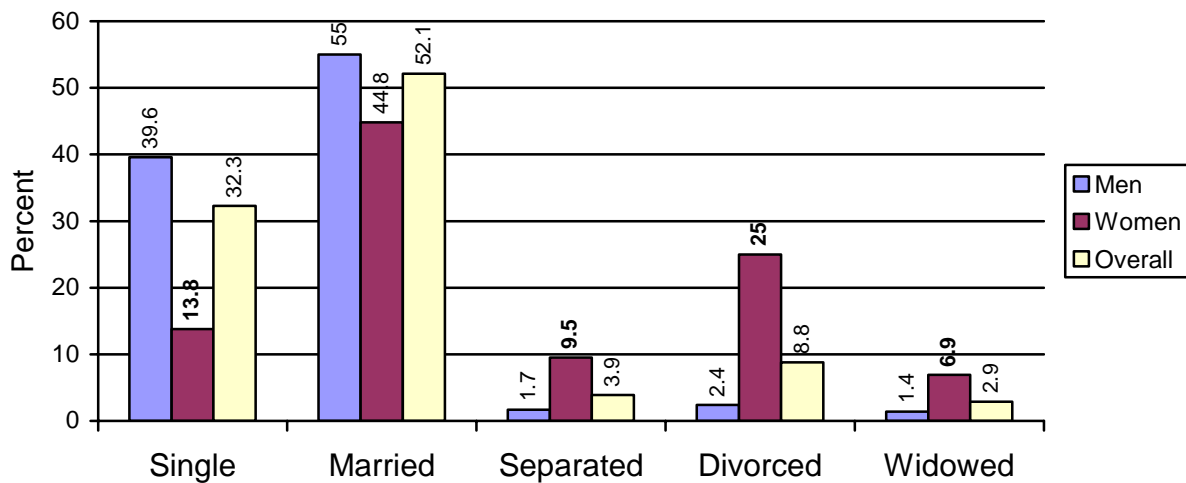
The median age for the plantation workers was 31 years while the mean age was 32 years and it ranged between 18 to 67 years. When the sexes were desegregated, the median age of men was 30 years while for women was 32 years. Their mean ages were 32 (SD 9.5) and 33 (SD 9.0) years for men and women respectively.

The age pattern among plantation respondents did not vary significantly between the sexes. The predominant age-group in both sexes being 25 – 29 years old [68 (23.2%) men, 32 (27.6%) women]. Compared to men, the women interviewed in the plantations were slightly younger. The participants in the plantations were almost of the same age, young and there were no significant difference in age-groups between men and women and comprised mostly young individuals.

3.2.2: Marital status:

Overall over half of the plantations workers were married, mostly the men. A third of the workers were single. About 4% were separated, about 10% were divorced and 3% were widowed. About two-fifths of the men were single compared to just over 10% of the women. The proportions of women who were divorced were a quarter, while women who were separated and widowed were higher than the men (see figure 1).

Figure 1: Marital status among respondents (N=409)



3.2.3: Religious affiliation:

In terms of religious affiliation, overall, most of the plantation workers were Christians 348 (85%), Moslems were 55 (13.5%) and less than 2% had or were of other religions (see table 1).

Table 1: Religious background of respondents: (N=409)

n (%) Plantation communities			
	Men	Women	Total
Christian	243(82.9)	105(90.5)	348 (85.1)
Moslem	45(15.4)	10(8.6)	55(13.4)
Traditional/Pagan	5(1.7)	1(0.9)	6 (1.5)

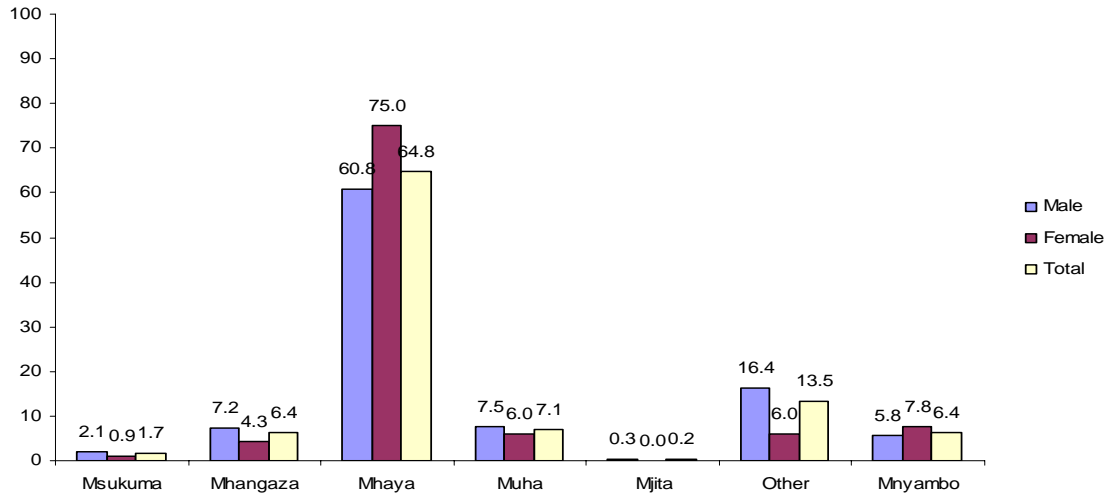
3.2.4: Length of stay in village (N=409):

Overall, two-fifths of the study participants had lived in the village for more than five years. About a third of them having lived between 1 to 4 years and less than a quarter having lived just under one year. Plantation workers could be classified as a fairly unstable population. Despite the finding that majority of plantation workers were 'Wahaya' the ethnic group around the estate, yet the duration of living in the plantation area made it possible to conclude that the population was fairly unstable.

3.2.5: Ethnic composition of labour force:

In terms of the ethnic origin of the study populations, the plantation workers were mainly 'Wahaya' which was the predominant ethnic group of the local area – Kagera region. Overall, more than two-thirds of the respondents in the plantations were of the Wahaya ethnic group. The rest were made up of various other tribes which did not reach one-fifth as shown in figure 2. In the plantations Wahaya outnumbered other tribes because the plantations were situated in Kagera Region whose main ethnic group is Wahaya.

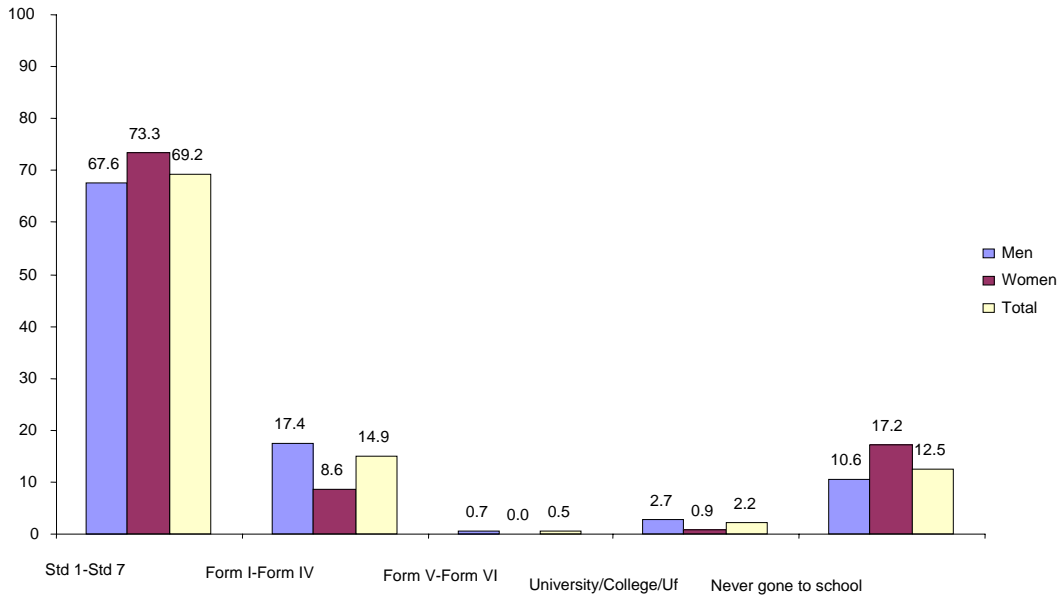
Figure 2: Ethnicity (N=409)



3.2.6: Educational status:

Only 69% of the plantation workers had completed primary education, 15% had completed secondary school education, less than 3% university or college and 12.5% had never gone to school. Women had a higher achievement level for primary education and men had a higher score for secondary education. However, almost a fifth of the women had never gone to school despite government’s position/policy on universal free primary education (see figure 3). Over four-fifths of the plantation workers have never had secondary school education and above. Overall women have had less exposure to education compared to men. The finding of 12.5% who had never gone to school was noted.

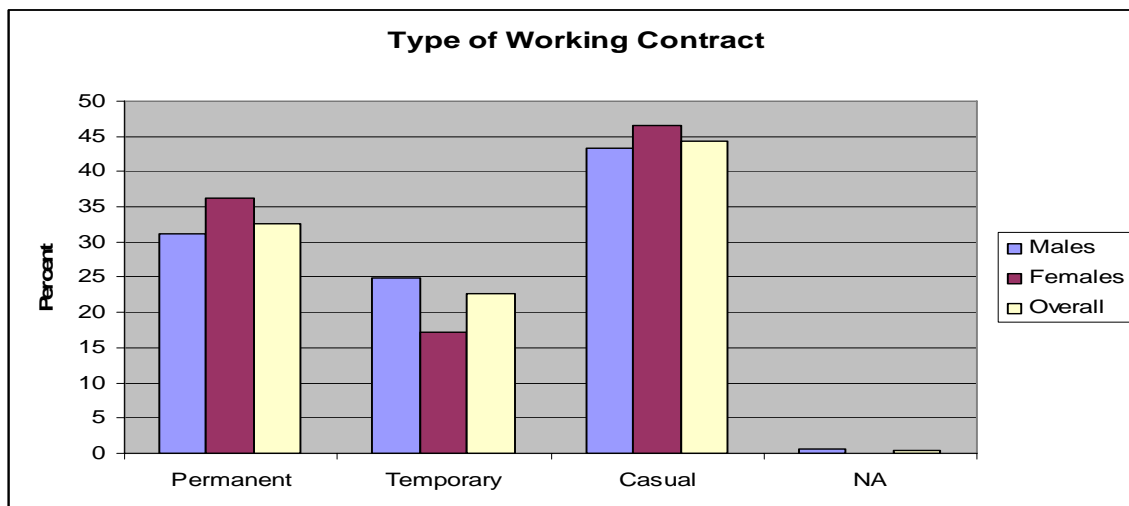
Figure 3: Education status (N=409)



3.2.7: Labour force categories:

In the plantations workers group, labour force was categorised into three working contracts i.e., permanent, casual and seasonal (Figure 4 shows these categories).

Figure 4: Type of working contracts (N=409).



On detailed analysis of the labour force, overall, 181 (i.e. 44.3%) of the plantation workers study population were casual labourers, 133 (32.5%) were permanent and 93 (22.7%) temporary. Fifty three point three per cent (53.3%) i.e. 218 respondents had no access to savings or credit facilities. Over two-thirds of the plantation workers were not employed on permanent basis and therefore, had no access to credit or saving facilities. In the plantations a quarter of the respondents were those who actually tilled the land, a fifth those who plucked tea leaves and approximately another fifth those who worked in the factory (see table 2).

3.2.8: Categories of occupation of plantation workers:

In the plantations workers had been categorised into permanent, seasonal/contractual or temporary and casual. In these categories, among the seasonal and casual, there were more detailed categories as are shown in Table 2. The findings are given for those that were sampled in order to be able to cover all categories.

Table 2: Current occupation (N=409).

Current occupation among plantation workers			
	Men	Women	Total
Professional	22(7.5)	4(3.5)	26(6.4)
Agriculture	74(25.3)	35(30.2)	109(26.7)
Irrigation	19(6.5)	9(7.8)	28(6.9)
Pesticide sprayer	8(2.7)	3(2.6)	11(2.7)
Cane cutter	47(16.0)	5(4.3)	52(12.7)
Tea pluckers	46(15.7)	41(35.3)	87(21.3)
Industry	58(19.8)	19(16.4)	77(18.8)
Factory agent	4(1.4)	0(0.0)	4(1.0)
Driver in industry	13(4.4)	0(0.0)	13(3.2)
Transporter	2(0.7)	0(0.0)	2(0.5)

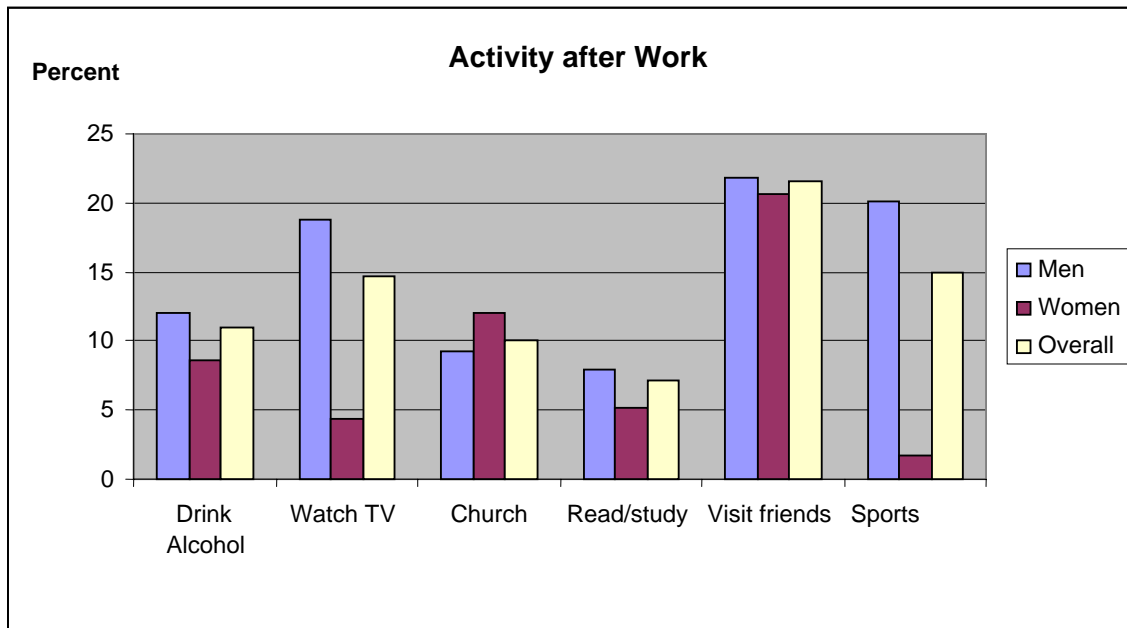
3.2.9: Earning per month (N=409):

Over half of the respondents earned between Tshs 50,000/= and 99,000/= 236 (57.7%) per month, while more than a third of the women earned less than Tshs 50,000/= 41 (35.3%) in a month. It is only 8 (2.0%) of these individuals interviewed who earned above Tshs 500,000/= per month. Individuals working in the plantations have very low earnings; women are the most affected by being the lowest paid.

3.2.10: Activities after work:

About a fifth of the plantation workers either visit friends or engage in sports especially men after day's work. Others watch television, drink alcohol and very few engage themselves with church activity, read or study after work (see figure 5). Various activities are spread across with reading or studying activity being the least and very few women engaging themselves in sports most probably due to cultural reasons.

Figure 5: After work activity (N=409).



3.3: Determination of HIV sero-prevalence among populations in agricultural plantation systems in Lake Victoria Basin in Tanzania.

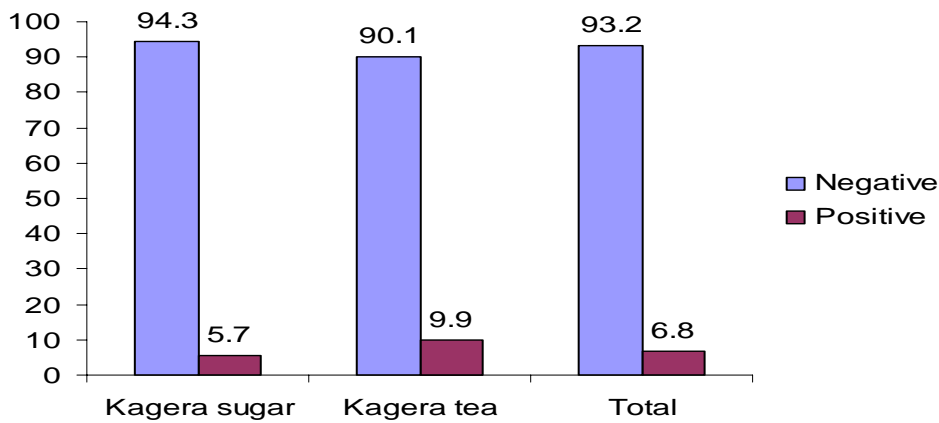
3.3.1: Introduction:

Dry Blood Spots (DBS) from the study respondents were 409 and all could be linked with the face-to-face questionnaires. Thus the HIV prevalence determination was based on the sample size of 409 respondent results of both DBS and their related questionnaires.

3.3.2: HIV Sero-prevalence in the plantations:

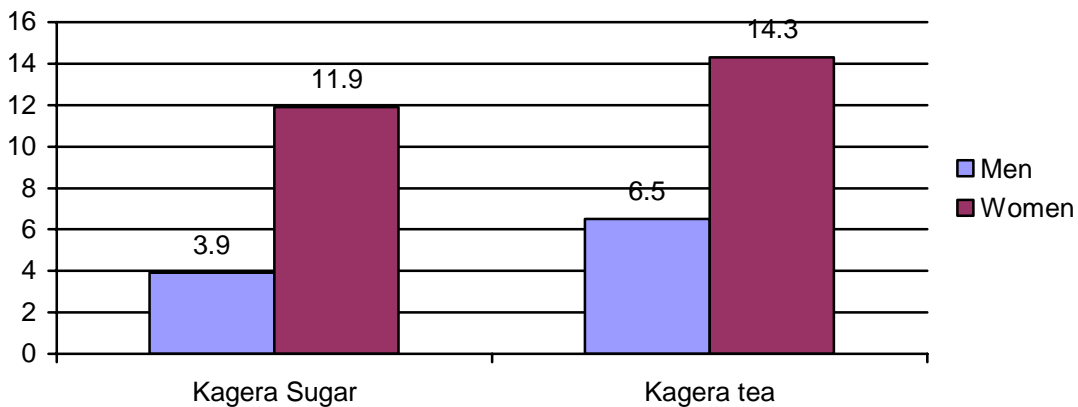
The overall HIV prevalence in the plantations was 28/409 (6.8%), men 13/293 (4.4%) and women 15/116 (12.9%). The overall HIV prevalence was higher than that of the National level (5.7%). There was a significant difference between men and women in HIV prevalence; it was higher in women than in men almost three-fold (p -value = 0.002).

Figure 6a: HIV prevalence (N=409):



The overall HIV prevalence for the plantation workers was 6.8%. Kagera tea had an HIV sero-prevalence of 9.9 % while the large Kagera Sugar Estate had HIV prevalence of 5.7% (see figure 6a). The prevalence of HIV infection in Kagera Tea Estate is higher than that of Kagera Sugar. The difference was not significant (p -value = 0.134).

Figure 6b: HIV prevalence by sex (N=409)

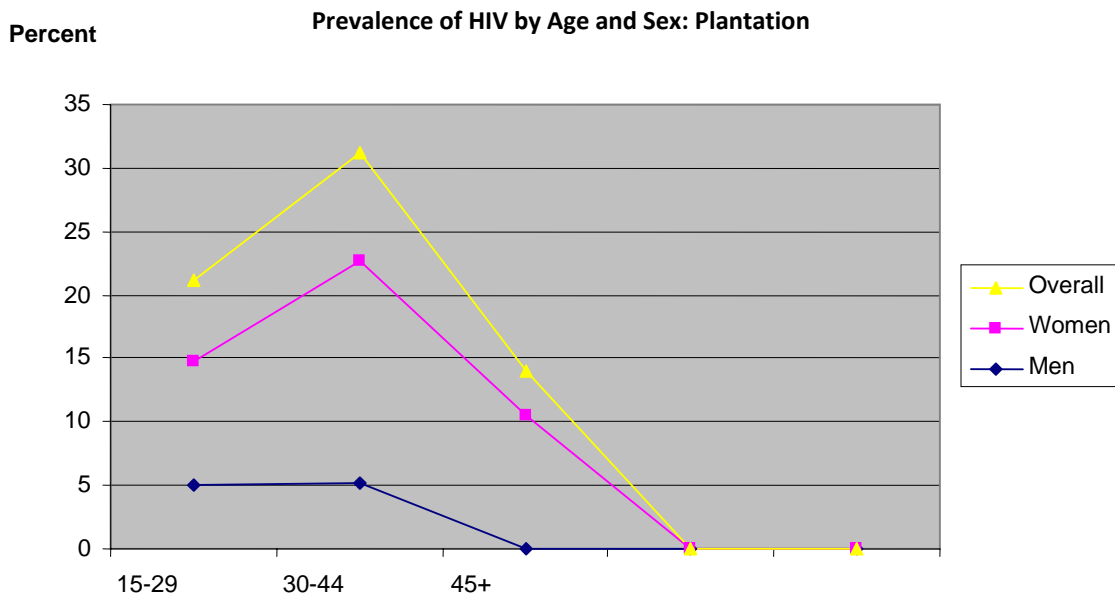


The HIV prevalence for men in Kagera sugar was 3.9%, 6.5% in Kagera tea while that of women was 11.9% in Kagera sugar and 14.3% in Kagera tea (see figure 6b). Among the agricultural plantation workers, women had higher HIV sero-prevalence in both plantations compared to their men counterparts in the same estates. In both cases the difference in the prevalence was more than two-fold.

3.3.3: Prevalence of HIV by Age and Sex:

It was possible to desegregate sero-prevalence data by age and sex of the plantation workers. The findings are shown in figure 6c.

Figure 6c: Prevalence of HIV by Age and Sex (N=409)



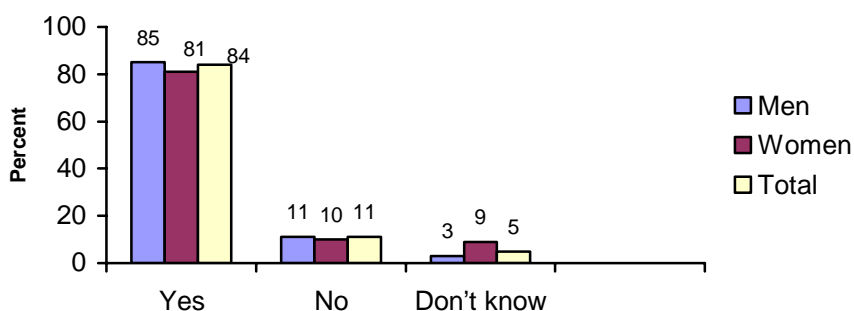
In the plantations, the prevalence of HIV was higher in women than in men at the age-group 15-29 years, it was 5% for men, 15% for women, at 30-44 years it was 5% for men and 23% for women. The age-group 45 years and above, the HIV prevalence started tapering down in both sexes (see figure 6c). Women start getting HIV infection at an earlier age compared to men and the age of mid- thirties it reaches its peak. The differences seen by sex and age was significant (*p-value* = 0.013).

3.4: Establishment of demographic and behavioural risks factors, knowledge and attitudes regarding HIV and STI transmission among plantation workers.

3.4.1: Knowledge regarding HIV and STI transmission:

The plantation workers knew that one could get diseases by having sexual intercourse. More than four-fifths of the respondents in these two areas knew the correct response (see figure 7a). The findings would indicate that there was exposure to knowledge on these diseases.

Figure 7a: Can one get diseases by having sex (N=409)?



Overall, eighty four per cent of all respondents stated that one could get diseases through sexual intercourse. A few (11%) said one could not get diseases through sex while only 5% did not know.

3.4.2: Diseases one can get through sexual intercourse:

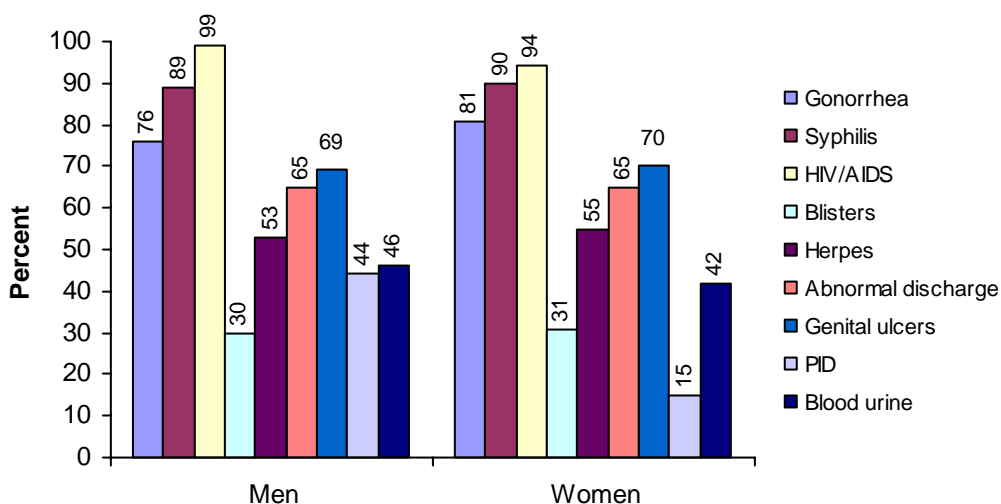
Almost all 274 (98.8%) men, 88 (93.6%) women reported that one could get HIV and AIDS by having sexual intercourse. A third knew of a blister arising as result of sexual intercourse. Almost a half of the respondents knew of herpes and more than two thirds knew of genital ulcer, abnormal genital discharge or itch. About half 109 (43.8) men and 53 (56.4%) women knew of PID (Pelvic Inflammatory Disease) - lower abdominal pain a woman. More than a third 115 (47.0%) men and 39 (41.5%) women said that one could get blood in urine as result of sexual intercourse (see figure 7b). There was high level of knowledge on diseases that are acquired as a result of having sexual intercourse.

However, just about half 109 (43.8) men and 53 (56.4%) women knew of PID (Pelvic Inflammatory Disease) - lower abdominal pain a woman. There was also a misconception that one could get blood in urine as result of sexual intercourse. Between 76% and 90% of the plantation workers mentioned gonorrhoea and syphilis as one of infections.

3.4.3: Type of conditions one can get by having sex:

When probed further as to types of conditions one can get through having sex, the findings are presented in figure7b:

Figure 7b: Type of STIs one can get by having sex (N=344)

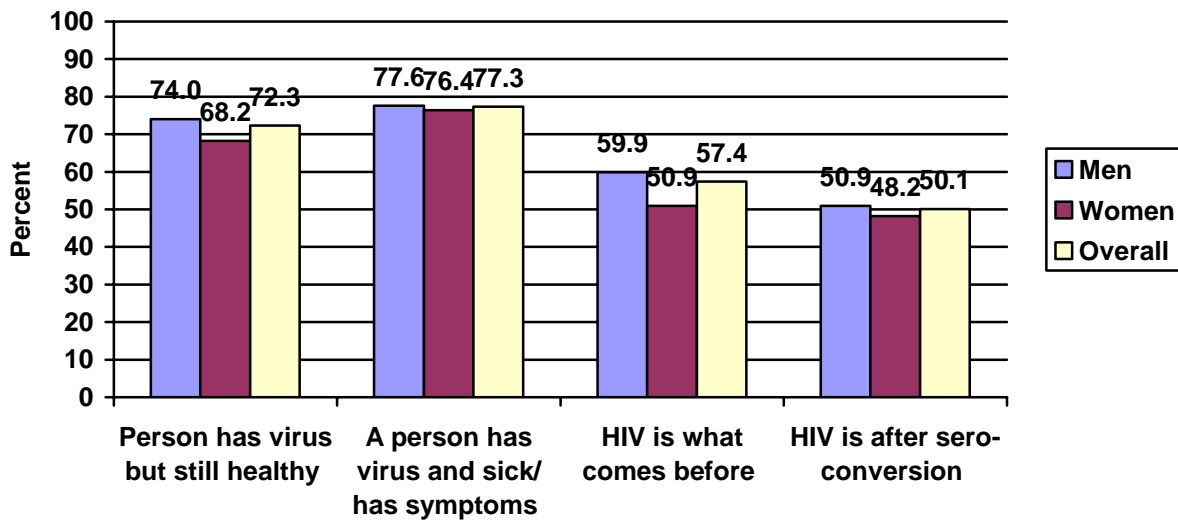


3.4.4: Knowledge on HIV and AIDS:

More than 90% of the participants, 387/409 (94.6%) had ever heard of HIV and AIDS.

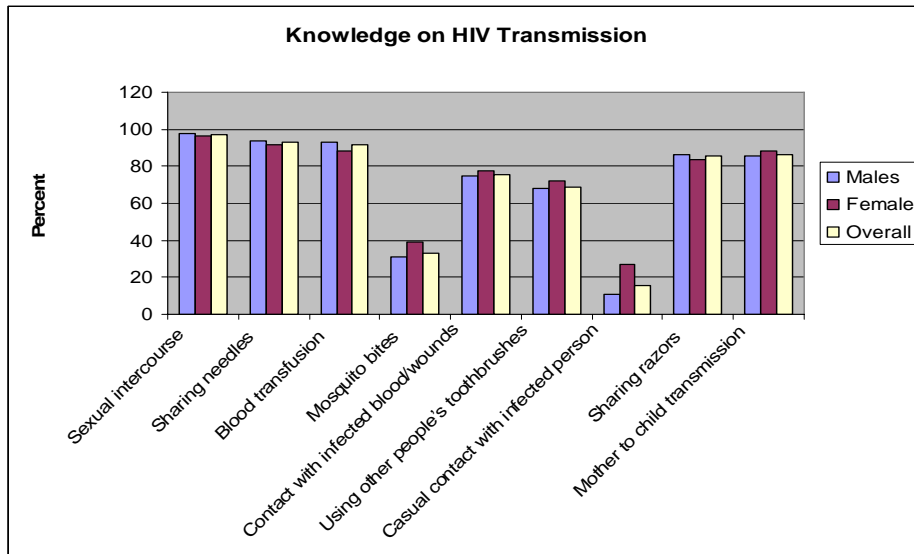
About 280/387 (72%) knew that a person can have HIV infection and still appear healthy and a person can have HIV infection and look sick with symptoms. 222 (57.4%) knew that HIV is what comes before AIDS and 194 (50.1%) said HIV is after sero-conversion (see figure 8a). The level of knowledge on HIV and AIDS is relatively high. However, over half knew that HIV is what comes before AIDS and a half knew about HIV sero-conversion.

Figure 8a: Knowledge on HIV and AIDS (N=387)



More than 90% of the respondents knew that HIV can be transmitted through sexual intercourse, sharing needles and blood transfusion. A third said HIV could be transmitted through mosquito bites. Over 70% knew that contact with infected blood/wounds, using other people’s toothbrushes and sharing razors could transmit HIV. 297 (76.9%) said that casual contact with HIV infected person does not transmit HIV. 238 (85.9%) men and 97 (88.2%) women knew of mother to child transmission of HIV (see figure 8b). Knowledge on HIV transmission is relatively high in the plantation respondents. However, there was a misconception, about 10% of respondents from the plantations said that casual contact with an HIV infected person could transmit HIV and about a third said HIV could be transmitted through mosquito bites.

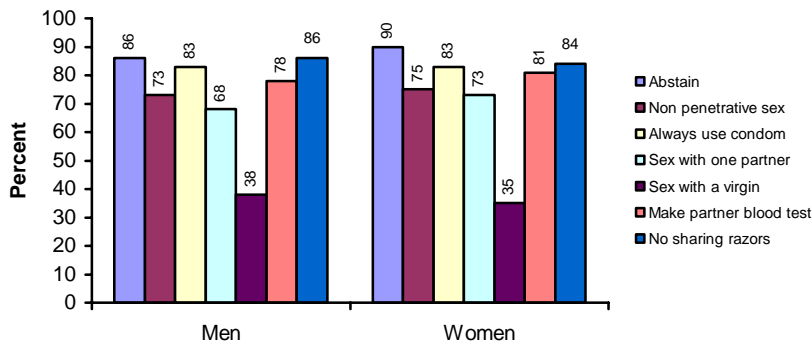
Figure 8b: Knowledge on HIV transmission (N=387)



3.4.5: Knowledge on how one can could protect oneself from HIV infection:

More than two-thirds of the study participants knew that one could protect oneself from HIV infection by abstaining from sex, non penetrative sex/thigh sex, always use of condoms, sexual intercourse with only one partner, not sharing razors and partner taking blood test. More than a third 143 (37.0%) said having sexual intercourse with a virgin is one of the ways of protection against HIV infection (see figure 8c). Knowledge on protection against HIV infection is high among plantation workers. However, there is a misconception that having sexual intercourse with a virgin is one of the ways to protect oneself from HIV infection.

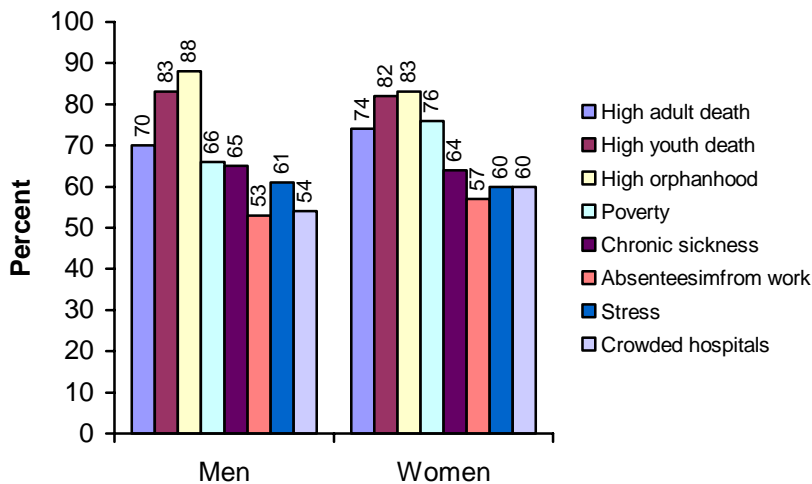
Figure 8c: How can people be protected from HIV infection? (N=387)



3.4.6: Problems caused by AIDS:

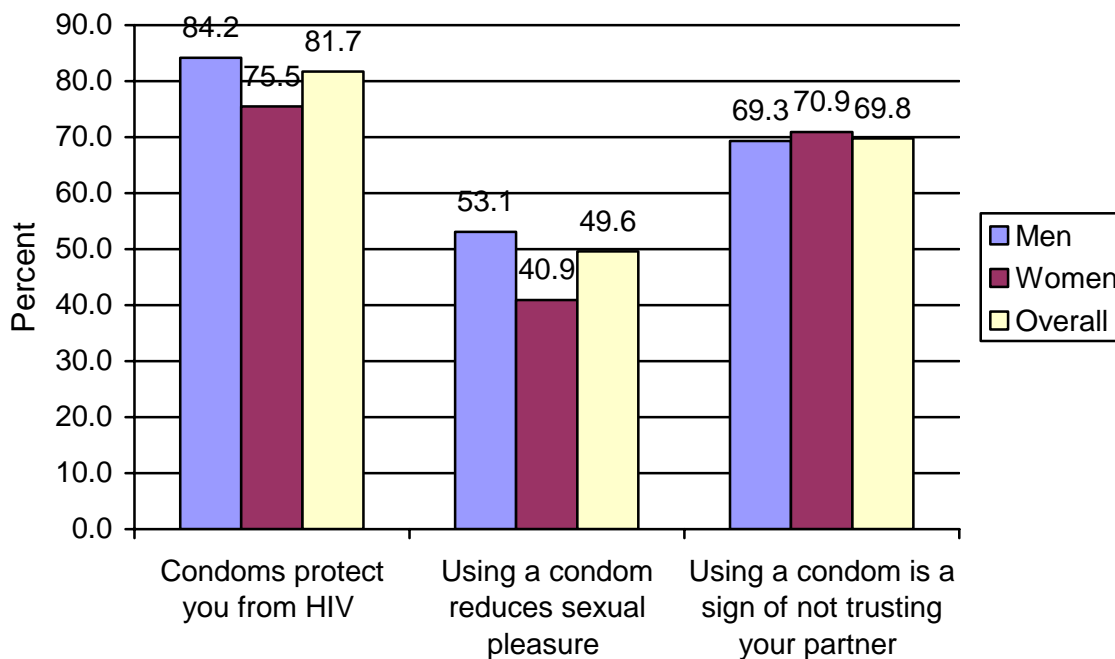
From the findings on how one can protect oneself from getting infected by HIV, respondents were further probed on what problems can be caused by HIV. More than two-thirds of the participants knew that problems caused by HIV and AIDS included high adult deaths, high youth deaths, high level of orphan hood, poverty and chronic illness. About a half said problems caused by HIV and AIDS included absenteeism from work, stress and overcrowded hospitals. Generally, the study respondents had a fair knowledge on the impact of HIV and AIDS to the community.

Figure 8d: Problems caused by AIDS (N=387).



Over three quarters of the respondents agreed that condoms protect you from HIV infection; about a half agreed that condoms reduce pleasure and about a third agreed that using condoms is a sign of not trusting your partner (see figure 9). There is a good knowledge on the purpose of condoms but there are negative attitudes towards condoms in terms of sexual pleasure and partner trust.

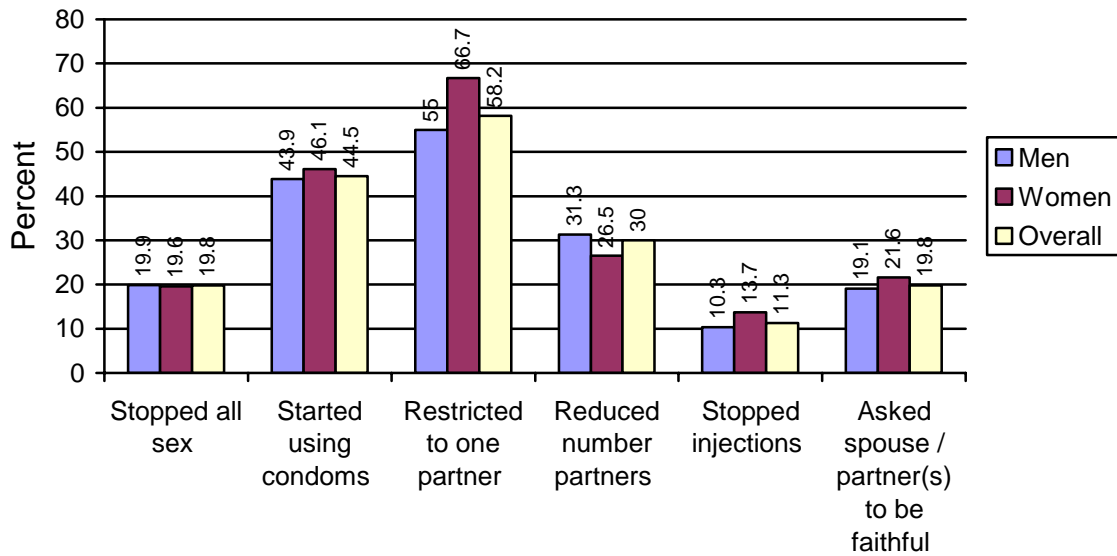
Figure 9: Attitude towards condom use (N=387)



3.4.7: Steps taken after being aware of HIV and AIDS:

When asked on what was steps were taken after being aware of HIV and AIDS, respondents stated that after hearing of HIV and AIDS; 262 (89.4%) men and 102 (87.9%) women said that they changed their behaviour to avoid being infected. About a fifth reported to have stopped completely all activities related to sex, 162 (44.5%) started using condoms, over half restricted themselves to one partner, a third reduced their number of sexual partners, 41 (11.3%) stopped using injections and about a fifth requested their sexual partners to be faithful (see figure 10). Use of condoms and partner relationship are likely to effect behaviour change in the plantation workers in relations to other markers.

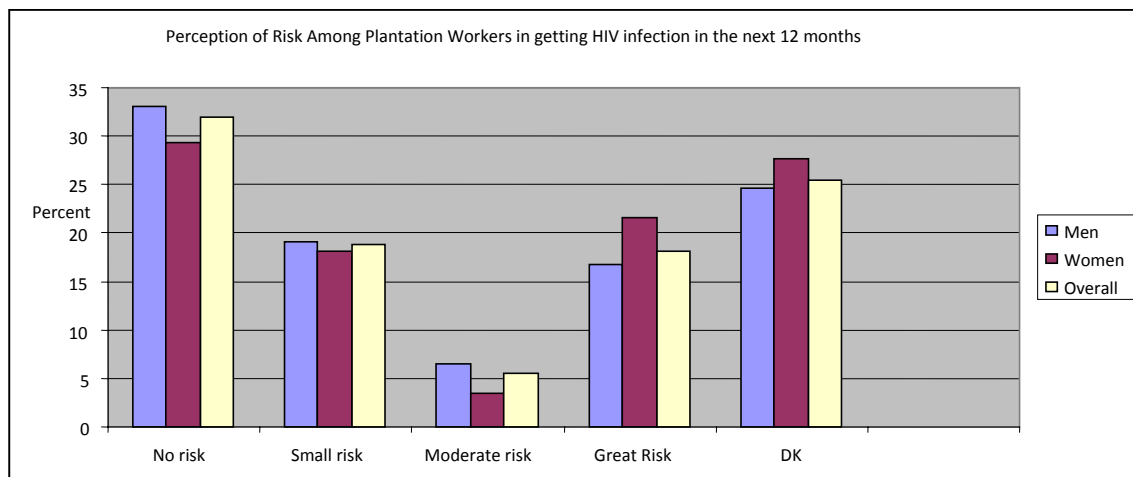
Figure 10: Behaviour change after knowing about HIV and AIDS (N=409)



3.4.8: Perceived risk of being infected with HIV:

More than a fifth of the women perceived themselves to be at a greater risk of being infected with HIV in the next 12 months. Overall, a third of the respondents perceived themselves as not being at risk, and a quarter did not know whether they were at risk or not (see figure 11). Very few individuals in the plantations perceive themselves to be at risk of acquiring HIV infection in the next twelve months.

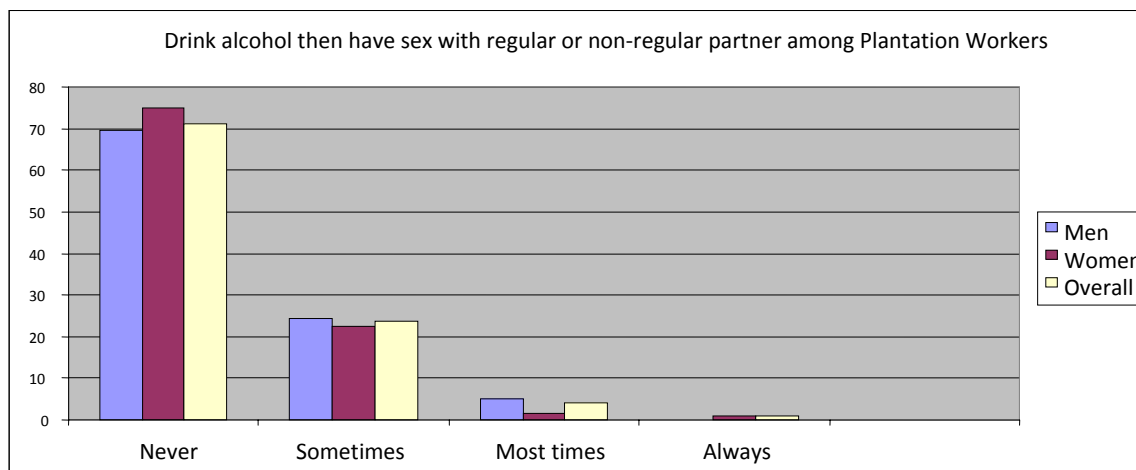
Figure 11: Risk perception among. (N=409)



3.4.9: Alcohol intake and sex:

About 70% of the plantation workers reported of never having drunk alcohol and then engage in sexual intercourse with either regular or non-regular partner. A fifth said they do so sometimes, 5% most of the time and about 1% did so always (see figure 12). Drinking alcohol and then engage into sexual intercourse was not a major issue.

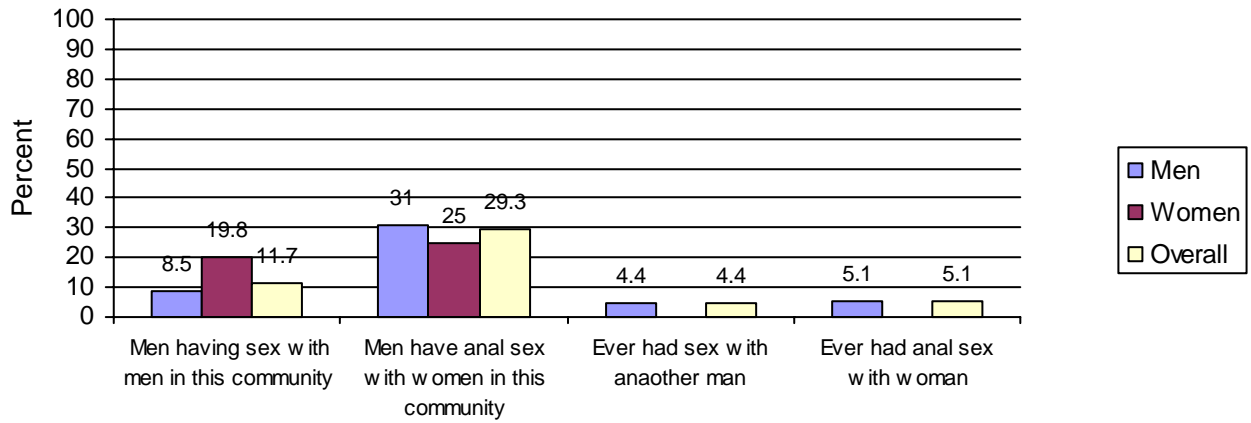
Figure 12: Alcohol intake and sexual intercourse with different categories/types of sexual partners. (N=409)



3.4.10: Sexual behaviour:

In the plantations 15% of the respondents had ever suffered from sexually transmitted infections, and about 8% had suffered more than once. When asked about sexual behaviour in their plantation community, 25 (8.6%) men and 23 (19.8%) women said that men have sex with men in their community. 91 (31.0%) men and 29 (25.0%) women said that men have anal sex with women in their community. 13 (4.4%) of the men admitted having ever had anal sex with another man and 15 (5.1%) of the men admitted having ever had anal sex with a woman. Sexually transmitted infections are a problem in the plantations; anal sex practise is taking place in this community. 5% of the men have actually either had anal sex with a man or a woman.

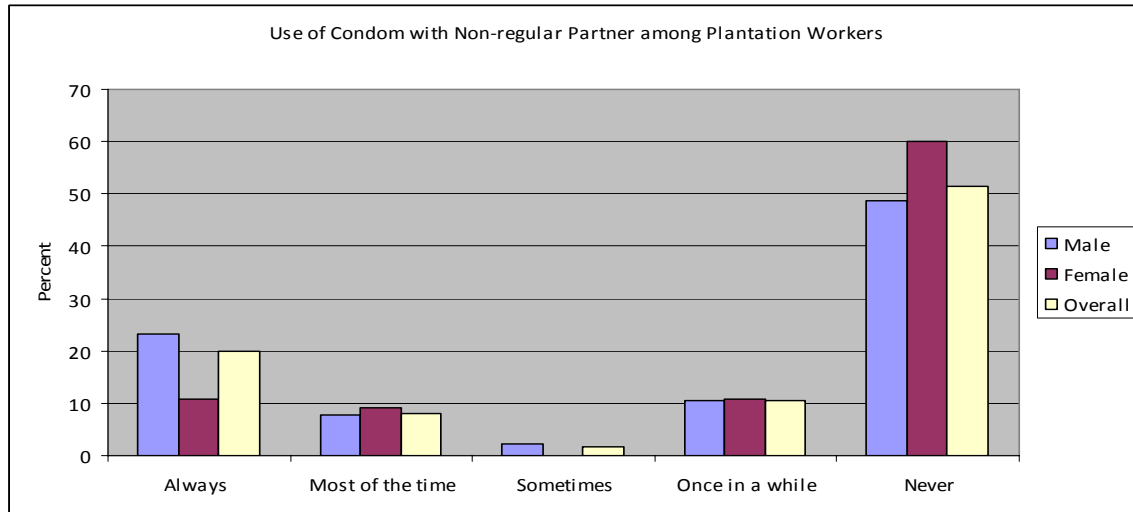
Figure 13: Sexual behaviour. (N=409)



3.4.11: Condom use:

Forty-nine (19.9%) of the study individuals reported always using condoms with non-regular partners, 20 (8.1%) using most of the time, 4 (1.6%) sometimes, 26 (10.6%) use condoms once in a while with non-regular partners and 127 (51.6%) never. Use of condoms during sexual intercourse with a non-regular partner was very poor among plantation workers (see figure 14).

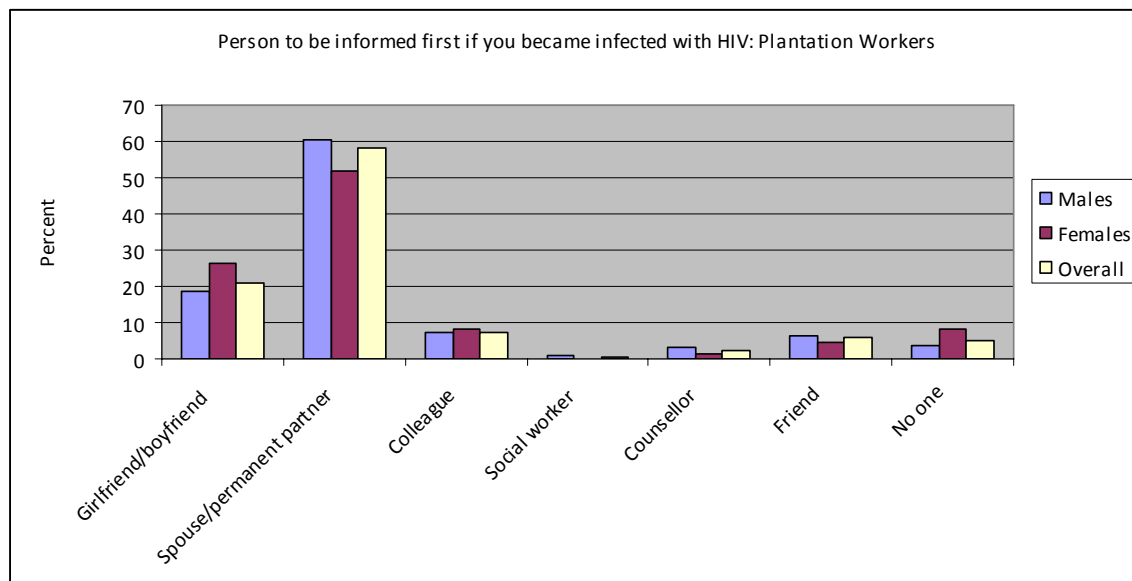
Figure 14: Condom use and non-regular sexual partners. (N=246)



3.4.12: Stigma and disclosure:

Several aspects of stigma were examined. They included person to be informed of HIV test results, interactions with PLHIV, bad treatment and sources of such treatment. The results are presented. More than two-thirds of the respondents said that if a member of the family became infected with HIV it should remain a secret. About a fifth said the first person to be informed if they became HIV positive would be girlfriend/boyfriend, almost two-thirds said spouse/permanent partner, 24 (7.4%) colleague, 2 (0.6%) social worker, 8 (2.5%) counsellor, 19 (5.9%) friend and 16 (4.9%) no one (see figure 15). HIV infection status disclosure is a problem among plantation workers. Disclosure appears to be limited to spouse/permanent partner and to some extent boyfriend/girlfriend.

Figure 15: Person to be informed in case of HIV infection. (N=324)

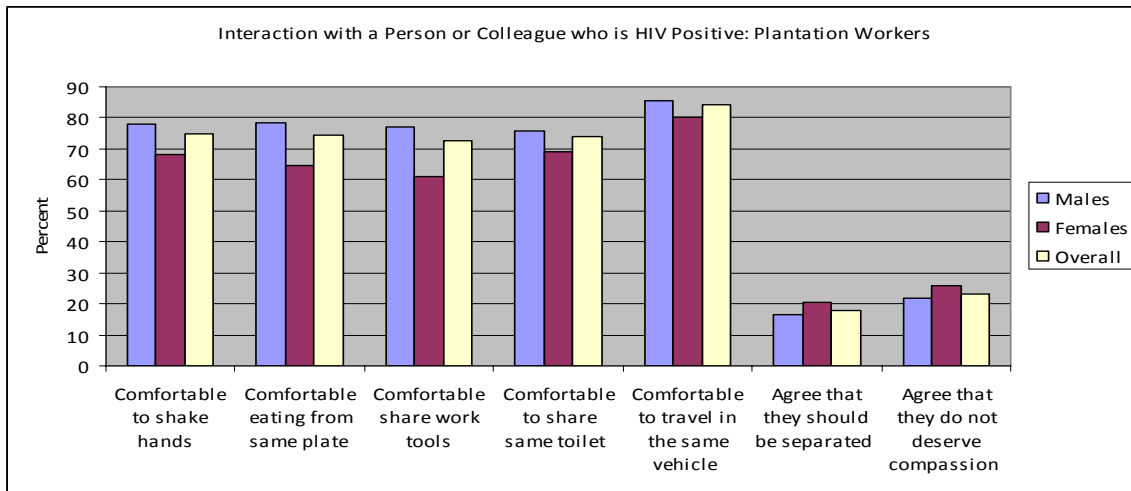


Three quarters of the study participants said that they would be comfortable to shake hands with colleague/someone who is HIV positive, 94 (23.0%) said they would not be comfortable, 2 (0.5%) somewhat comfortable and 6 (1.5%) did not know. Almost three-quarters of the study participants said that they would be comfortable to eat from same plate with colleague/someone who is HIV positive, 97 (23.7%) said they would not be comfortable, 4 (1.0%) somewhat comfortable and 4 (1.0%) did not know. Two hundred and ninety seven out of 409 (i.e. 72.6%) of the study participants said that they would be comfortable to share work tools with colleague/someone who is HIV positive, a quarter said they would not be comfortable, 5 (1.2%) somewhat comfortable and 7 (1.7%) did not know. Three hundred and two out of four hundred and two (73.8%) of the study participants said that they would be comfortable to share same toilet with colleague/someone who is HIV positive, approximately a quarter said they would not be comfortable, 1 (0.2%) somewhat comfortable and 8 (2.0%) did not know.

More than four-fifths of the study participants said that they would be comfortable to travel in the same vehicle with colleague/someone who is HIV positive, 56 (13.7%) said they would not be comfortable, 4 (1.0%) somewhat comfortable and 5 (1.2%) did not know(see figure 16).

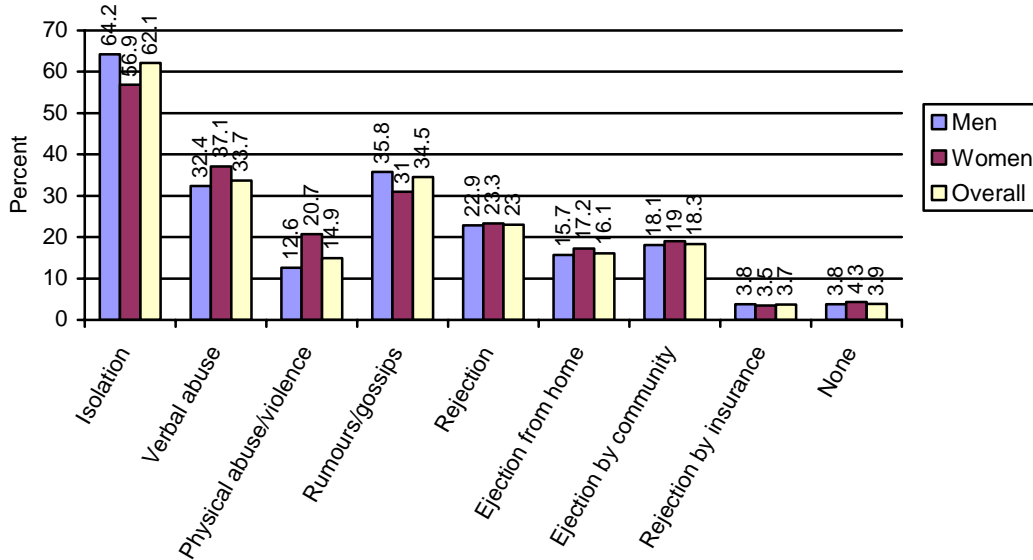
Stigmatisation in the plantations seems to be well addressed; participants appear to be comfortable in many ways with an HIV infected person. However, there are few, about 20% who harbour the feeling that HIV infected people should be separated and do not deserve compassion.

Figure 16: Interaction with PLHIV. (N=409)



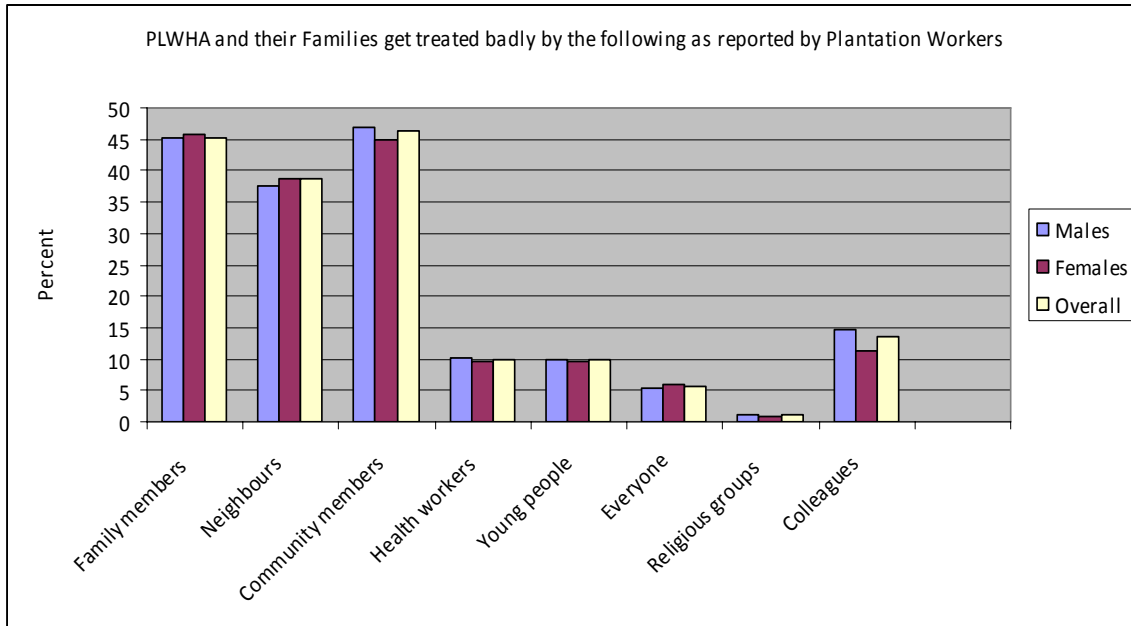
When the study participants in the plantations were asked kinds of bad treatment people living with HIV and AIDS and /or their families face two-thirds said isolation, just over a third said verbal abuse, 61 (14.9%) said physical abuse/violence, over a third rumours/gossips, 94 (23.0%) rejection, 66 (16.1%) ejection from home, 15 (3.7%) rejection by insurance and 16 (3.9%) said none (see figure 17). Isolation appears to be the most common kind of bad treatment PLHIV face in the plantation workers community. Other bad treatments which are common are verbal abuse and rumours or gossips.

Figure 17: Bad treatment. (N=409)



Forty-five per cent (45%) of the study individuals said people living with HIV and AIDS and /or their families were treated badly by family members, approximately two-fifth mentioned neighbours, around 46% community members, 10% health workers, 10% young people, 5% everyone, about 1% religious groups and colleagues (see figure 18). Common sources of stigmatisation in the plantation community are community members and family members.

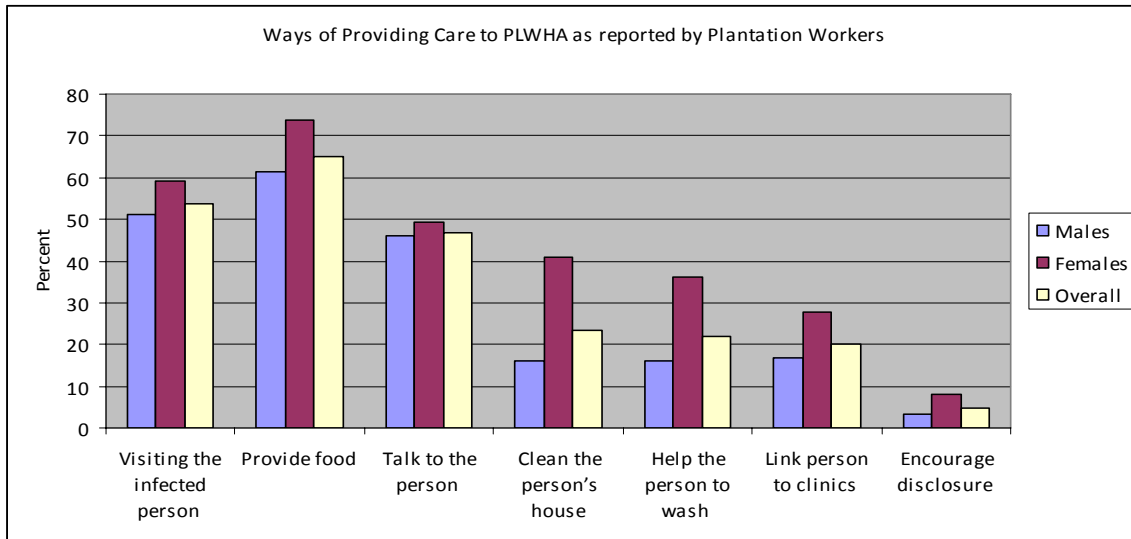
Figure 18: Sources of bad treatment to PLHIV. (N=409)



3.4.13: Care and support:

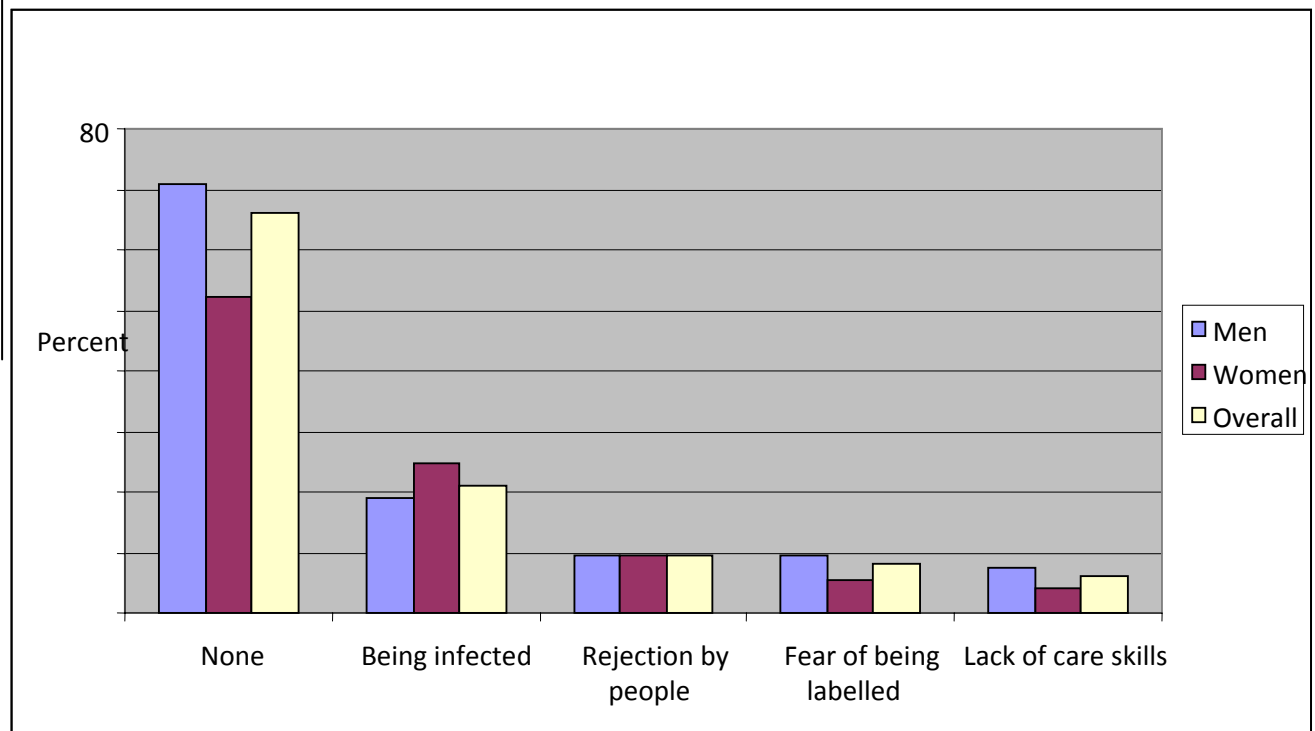
Approximately, half of the study individuals had provided care to family member or neighbour who was HIV positive. One hundred and twelve (53.6%) participants provided care by visiting the infected person, more than two-thirds provided food, 98 (46.9%) talked to the person, 49 (23.4%) cleaned the person’s house, about a fifth helped the person wash, another fifth linked the person to clinics and 10 (4.8%) encouraged disclosure (see figure 19). Care to people living with HIV and AIDS (PLHIV) in the plantations is provided mainly through visiting, provision of food and talking to the infected person.

Figure 19: Care provision to PLHIV (N=209)



Two thirds 215/326 (66%) of the plantation study participants said they had no fear/worries in providing care or support to a person who has HIV and AIDS, a fifth said they were worried of being infected, 20/210 (9.5%) were worried of rejection by people, 17/210 (8.1%) worried of being labelled and 13/210 (6.2%) were worried that they lacked care skills (see figure 20). There is low level of stigmatisation and fair knowledge of HIV and AIDS.

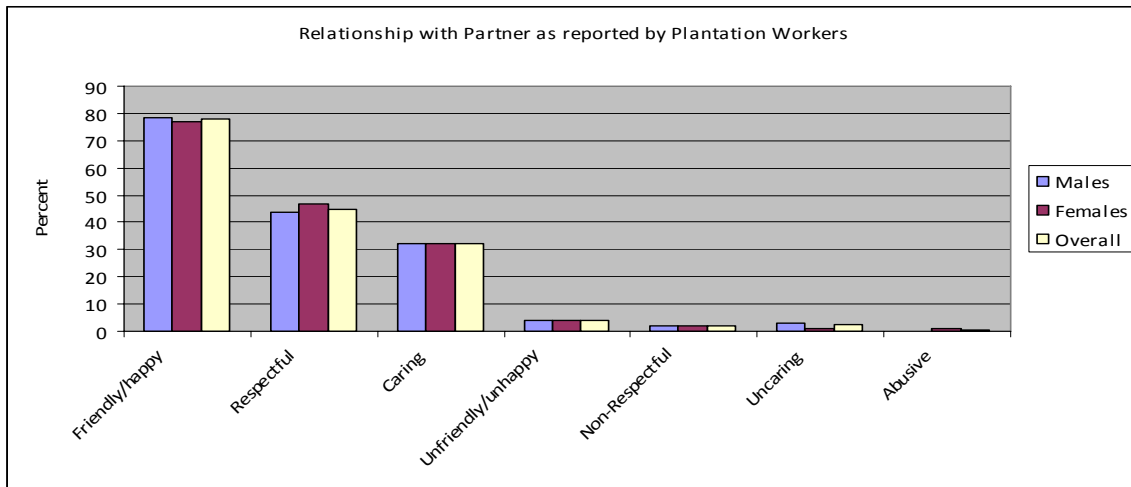
Figure 20: Care and Support to PLHIV. (N=210)



3.4.14: Gender Based Violence:

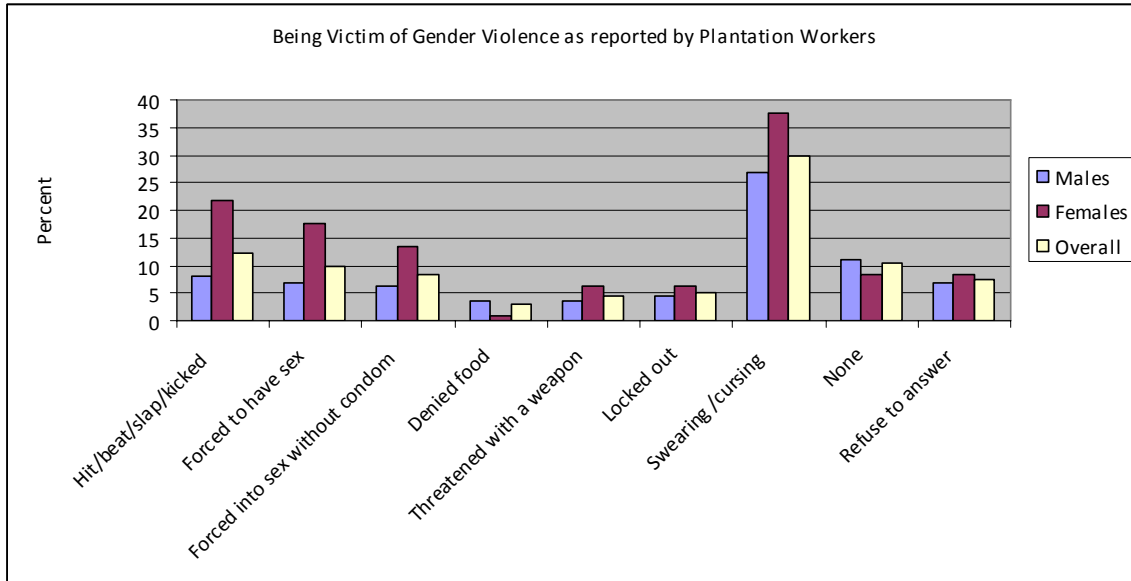
The participants reported their relationship with their partners as friendly/happy 264 (77.9%), respectful 151 (44.5%), caring 109 (32.2%), unfriendly/unhappy 14 (4.1%), non respectful 7 (2.1%), uncaring 8 (2.4%) and abusive 1 (0.3%). (See figure 21). Most of the relationships in the plantation community appear to be friendly/happy, respectful and caring.

Figure 21: Relationship with partner (N=339)



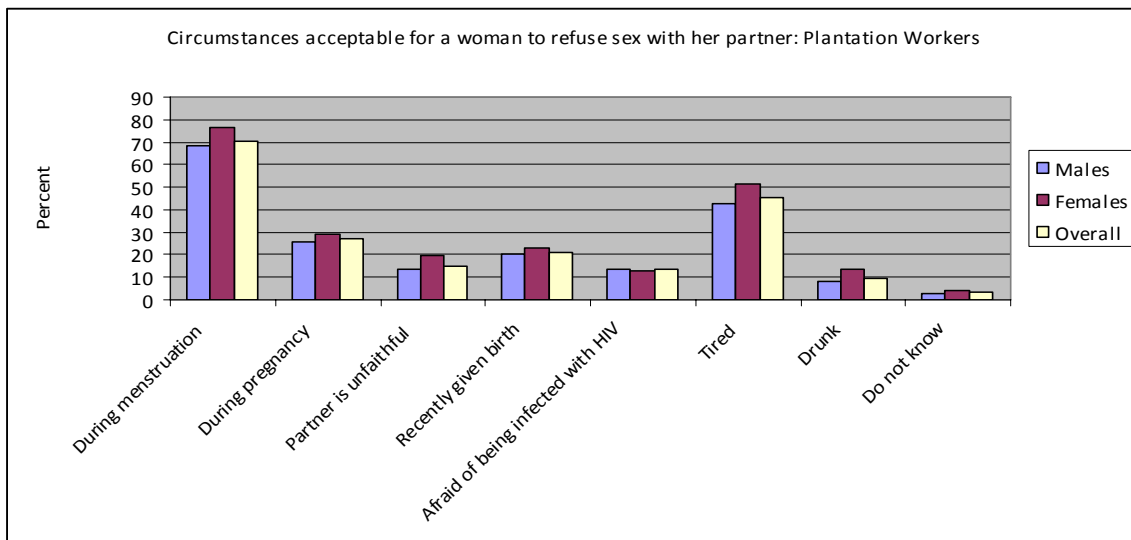
Forty one out of 339 (12.1%) of the respondents reported that their partners having hit/beat/slap/kicked them i.e. gender based violence (GBV), while 34 (10.0%) forced them to have sex, 28 (8.3%) forced them into sex without condom, 10 (3.0%) denied them food, 15 (4.4%) threatened them with a weapon, 17 (5.0%) locked them out, 101 (29.8%) swore/cursed them, 25 (7.4%) refused to answer them and 35 (10.3%) did nothing unusual (see figure 22). There was gender violence in the plantation communities though at low levels. Swearing and cursing appear to be the most common type of gender violence though beating/slapping/kicking is also practised.

Figure 22: Gender-Based Violence (GBV) (N=339)



Two hundred and eighty nine (70.7%) of the participants in the plantations reported that circumstances acceptable for a woman to refuse sex with her partner is during menstruation, 110 (26.9%) during pregnancy, 62 (25.2%) partner unfaithful, 87 (21.3%) partner recently given birth, 54 (13.2%) fear of being infected with HIV, 185 (45.2%) partner being tired, 39 (9.5%) partner being drunk and 13 (3.2%) did not know (see figure 23). In the plantation community it is acceptable for a woman to refuse sex with her partner only when she is menstruating or tired and to some extent when pregnant.

Figure 23: Refusal of sex (N=409)

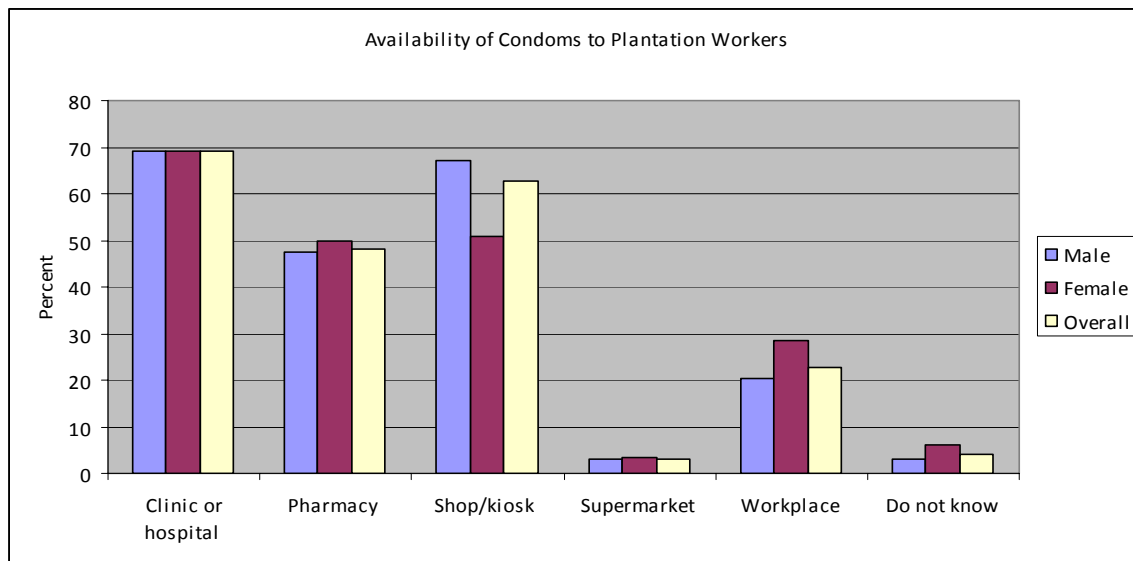


3.5: Establishment of the range, breadth, availability and utilization of HIV and AIDS related services.

3.5.1: Availability of condoms

The plantation workers when asked on the availability of condoms, 203 (69.3%) men and 80 (69.0%) women mentioned hospital/clinic, approximately a half said pharmacy, two-thirds shop/kiosk, about a fifth mentioned workplace, 13 (3.2%) supermarket and 13 (3.2%) did not know (see figure 24). Most individuals from the plantations also get condoms from hospitals or clinics, pharmacy and some from place of work.

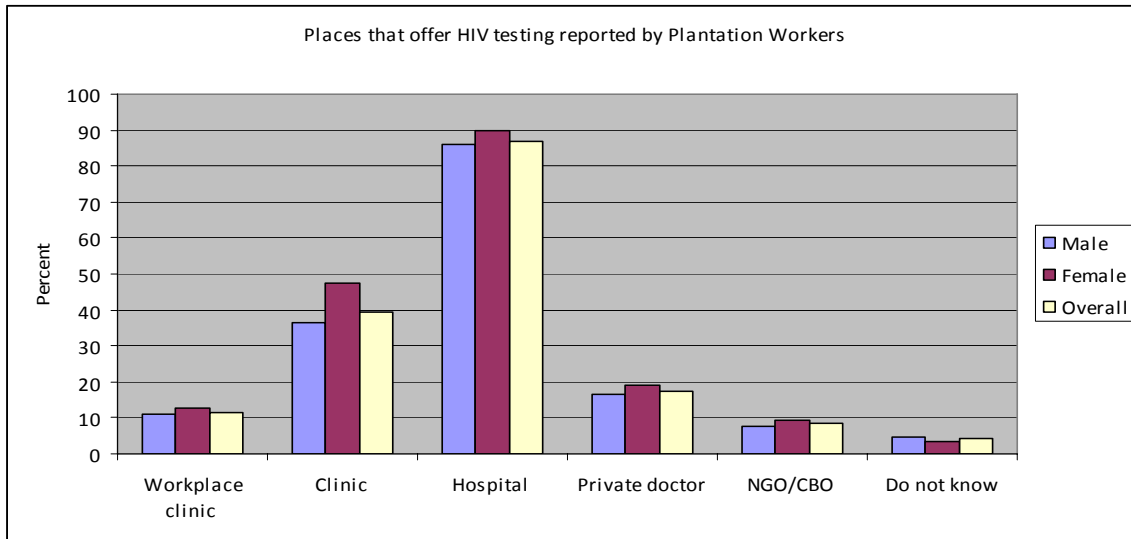
Figure 24: Condom availability. (N=409)



3.5.2: HIV testing services:

When asked places that offer HIV testing services, the respondents 47 (11.5%) mentioned workplace clinic, 162 (39.6%) clinic, more than four-fifth mentioned hospital, 71 (17.4%) private doctor, 34 (8.3%) NGO/CBO and 18 (4.4%) did not know (see figure 25). Hospitals and clinics are by far the facilities that offer HIV testing in plantation communities. In the plantations workplace clinic also offers some of the HIV testing.

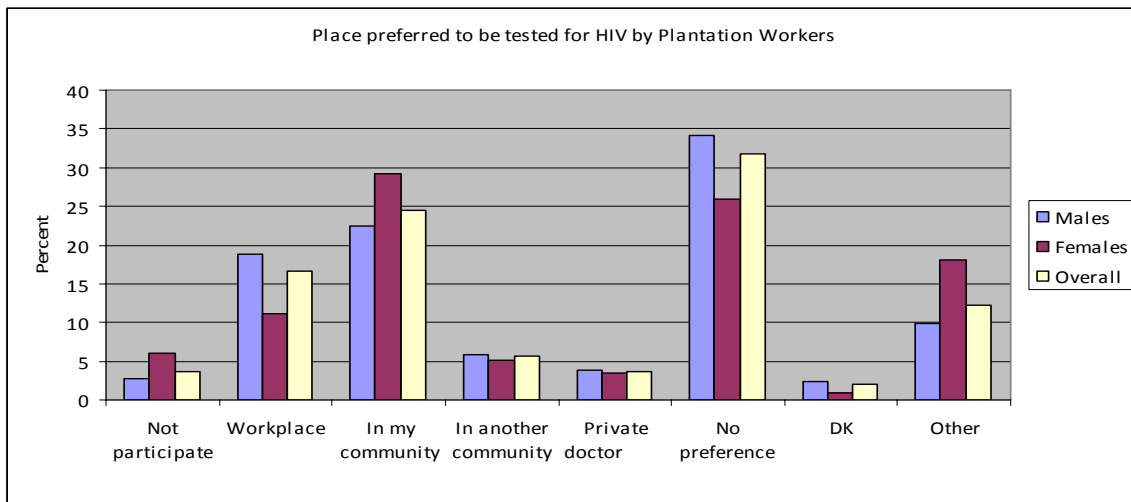
Figure 25: Services for HIV testing (N=409)



3.5.3: Preference for HIV testing:

In the Plantations places preferred by the participants to be for HIV testing were 68 (16.6%) workplace clinic, 100 (24.5%) in their community, 23 (5.6%) in another community, 15 (3.7%) by private doctor, 130 (31.8%) had no preference, 15 (3.7%) opted not participate, and 8 (2.0%) did not know (see fig. 33a). Respondents preferred to be tested in their own communities and working place. More than a quarter of the respondents had no preference meaning that they could fit anywhere.

Figure 26: Preferred places for HIV services (N=409)

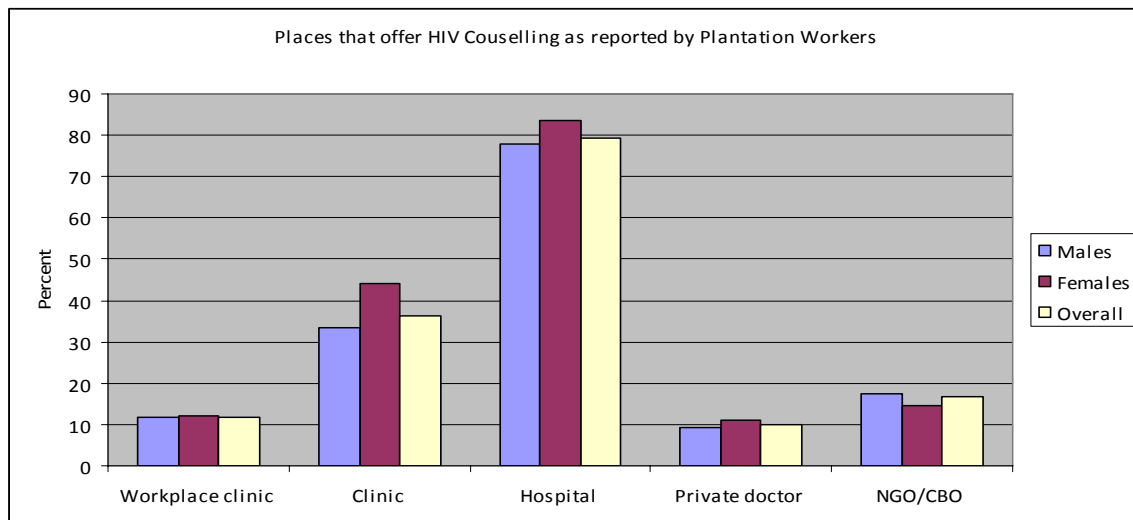


About four-fifths of the participants in plantations mentioned places that offer HIV counselling services as hospital, 48 (11.7%) mentioned workplace clinic, 149 (36.4%) clinic, 40 (9.8%) private doctor and 68 (16.6%) mentioned NGO/CBO (see figure 27). Most of the HIV counselling in the plantation communities is offered by hospitals and clinics. Some HIV counselling is also offered at their workplace clinic.

3.5.4: Services for HIV Counselling:

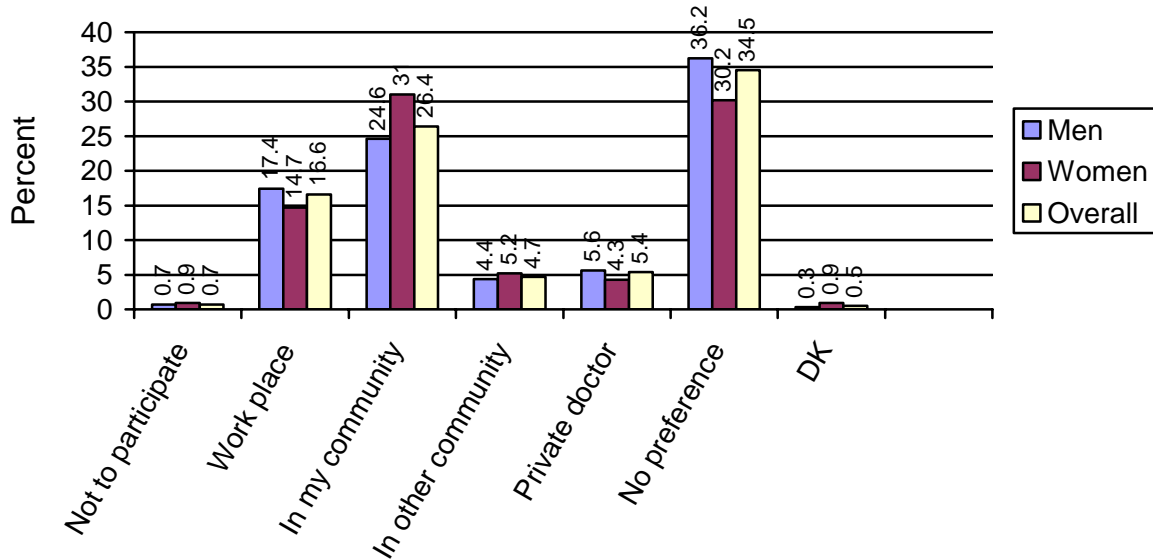
When respondents were probed as to where they get HIV counselling services, the findings obtained are presented:

Figure 27: Services for HIV Counselling (N=409)



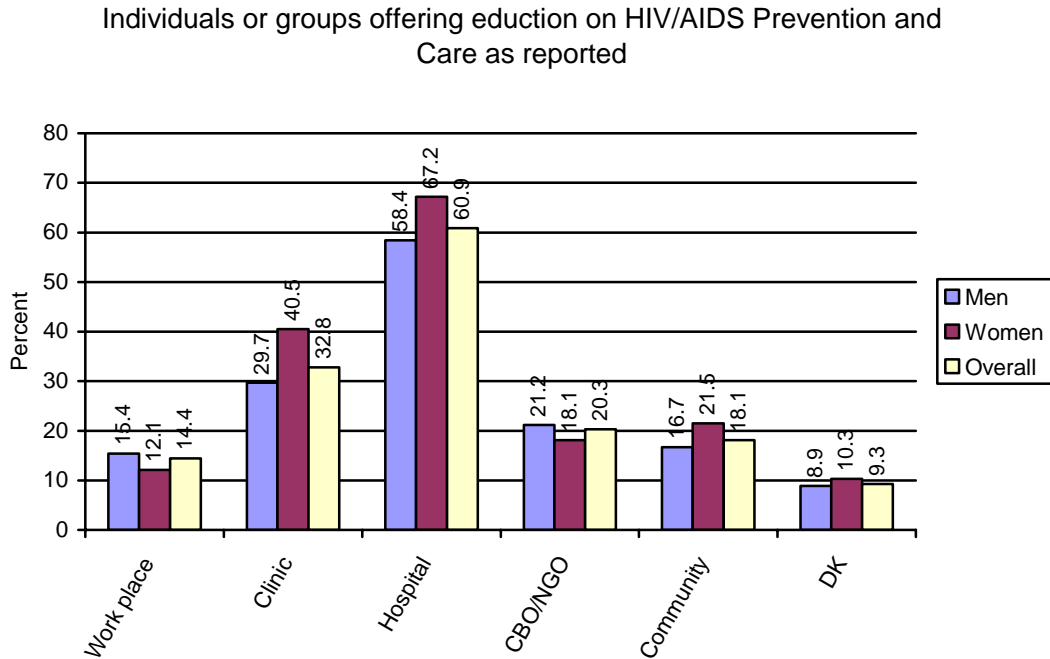
Places preferred to be for HIV counselling by the plantation participants were 68 (16.6%) workplace clinic, 108 (26.4%) their community, 19 (4.7%) another community, 22 (5.4%) private doctor, 141 (34.5%) no preference, 3 (0.7%) not participate and 2 (0.5%) did not know (see figure 28). Approximately a quarter of the plantation workers prefer to be HIV counselled in their communities. A third of the plantation workers had no preference meaning that they could be counselled anywhere.

Figure 28: Preferred places for HIV Counselling. (N=409)



When asked for places that offer education on HIV and AIDS prevention and care 59 (14.4%) mentioned workplace clinic, 134 (32.8%) clinic, about two-thirds of the plantation workers mentioned hospital, a fifth NGO/CBO, 74 (18.1%) community and 38 (9.3%) did not know(see figure 29). Individuals or groups offering education on HIV and AIDS prevention and care in the plantation communities are hospitals, a response given by two-thirds of the participants. Some of the education on HIV and AIDS care and prevention is also provided by the community and workplace clinic.

Figure 29: Individuals/Groups who offer HIV and AIDS education. (N=409)



3.6: Determination of existence and effectiveness of policies, programs and coordination structures on HIV and AIDS.

3.6.1: Introduction:

Information on existence and effectiveness of policies, programs and coordination structures on HIV and AIDS in plantations was obtained from several sources. A key informant interview tool was developed targeting policy and programme managers at the EALP level, National and sub-National levels. Key Informants (KIs) were identified at all levels. The results are presented in such a format to allow an easy grasp of the report. Findings have been provided as captured at the different levels: the EALP level; national level and sub-national levels.

3.6.2: Overall perspective of the EALP and the HIV epidemic at EAC and its organs:

EAC Professional staff competencies:

Top level professional staffs at the EAC headquarters and the Lake Victoria Basin Commission were interviewed. At the LVBC in Kisumu, it was found that the two relevant staff was of very highly qualified, knew their responsibilities and had a broad wealth of experience on HIV and AIDS and other relevant areas. For example, at the LVBC the two officers who were met had a wealth of experience in their area of responsibilities. One of them having worked as a Director of HIV and AIDS Programme at Maseno University; representative of the Association of African Universities (AAU) on HIV and AIDS representative at Association of African Women in Science and Engineering (AWSE); worked for UNHCR in the HIV and AIDS Programme in Ethiopia and Eritrea in refugee camps, finally in the Red Cross in Kenya- HIV peer education programme in 2 regions of Western Kenya. She is currently the HIV and AIDS Technical Specialist at LVBC and Regional Co-ordinator for EALP (EAC/AMREF/LVFO).

The other senior staff member was a specialist in Monitoring and Evaluation.

At the EAC Secretariat in Arusha, the Principal Health Officer has been in position since 2003. He is a Medical Doctor, Specialist in Paediatrics and Child Health, Immunology and Public Health.

3.6.3: Policies, programmes and co-ordination structures on HIV and AIDS services:

The EAC has no HIV policy of its own. However, all member states have their own National HIV and AIDS Policies. The Tanzania AIDS Policy was developed in 2001 which resulted into the first Multi-sectoral Strategic Framework (NMSF) 2003 - 2007 and has been updated to the present one 2008 – 2012. The EAC has developed a strategic plan (SP) for HIV and AIDS 2008 – 2012, which has objective 8 focussing on mobile populations and objective 4 on data generation and management. The implementation of the SP has yet to take off. It was reported that implementation is supposed to be done by the member states in the five countries.

Financing and sources:

Contribution from donors is doing well while that of partner states is very low. The Budget for health in general, donor contribution equals 99% while that of member states is 1%. Its breakdown was given as shown in Table 6:

Table 3: Contribution from donors to EAC:

<u>Donor</u>	<u>Area</u>	<u>Amount (mil. US \$)</u>
Sida/Sweden/Irish AID	HIV and AIDS	7.0
EU	Reproductive and Adolescent Health	2.2
Rockefeller Foundation	Disease Surveillance	0.5
World Bank (WB)	Public Health Laboratories	1.3
	Networking implemented through National levels	(Total fund 66 million US\$) NB: Grant to Rwanda and loans to Kenya (25 million), Uganda 10 million) and Tanzania (15 million), while Burundi did not qualify).

In January 2011, the EAC expects to be funded 10 million US dollars from the Bill and Melinda Gates; DFiD; World Bank. The funds will be used for the Medicines regulation and Harmonisation project. In addition, the African Development Bank may make available 26 million US \$ for a 'health, Climate changes and Environment. This project is still being negotiated.

Co-ordination structures and mechanisms at EAC:

Before the launch of the Lake Victoria basin Commission (LVBC, 2009/2010) it was found that all HIV and AIDS activities within the member states were poorly coordinated. There was little exchange of information. The main purpose of EALP HIV and AIDS programme through LVBC is to lower HIV infection prevalence in the LVB. Identified actors at the EAC level are EALP partner forums (e.g. East African Law Society; East African Business Council, GLIA, USAID-EA, German Foundation for World Population).

At the national level, such actors included the National Technical Teams (NTTs), for example the one for Tanzania, which was made up of the following sectors/institutions - Education; Health and Social Welfare; TACAIDS; Livestock and Fisheries; Community Development, Gender and Children Affairs; NIMR and Agriculture and Food Security. Detailed findings included:

Policy – each country has its own policy and strategy. Any EAC regional advocacy strategy will need to convince all the 5 countries. One will have to overcome issues of bureaucracy; procedures; plus the fact that HIV and AIDS policies have not been harmonised. At least for advocacy - can they agree that mobile populations and specifically plantation workers are at risk? There are many such ‘Most at Risk Populations, (MARPs)’ and they have a spill-over effect on the rest of the communities since they are not permanently isolated communities!

Management level - Among the Plantations and Universities main challenges is DENIAL. These are private enterprise –employees are casual labourers. Universities- need money for research.

Users – Beneficiaries’ knowledge was very low. The target populations being addressed here being the plantation workers.

3.6.4: HIV and AIDS at National level

In discussions with key actors at National level, it was possible to get a perspective of the situation on the ground from them. The actors included Programme managers, Directors, heads of departments and institutions who were active in the area and who had previously been identified as being good sources of information. Thus Ministries of health and Social welfare, Community Development, Gender and Children Affairs; Agriculture and Food Security as well as the Tanzania Commission of AIDS (TACAIDS). The highlights of the discussions are summarised below according to each area of study.

Burden of disease:

It was reported that among drug users, CSWs, mobile population’s information on HIV prevalence was available. It was known that the prevalence was high among them than in the general population. In the

current survey/study, what is needed is confirmation of what was already known so as to institute appropriate interventions.

Service availability:

Most HIV and AIDS/STIs services are static and most often were inadequate. Within the Ministry of Health and Social Welfare, there is the 'Health Sector Strategy' – this is an overall roadmap for the Ministry. The Central Government has developed the 'Primary Health Services Development Programme (PHSDP) or Mpango wa Maendeleo wa Afya ya Msingi (MMAM) 2007 -2017 thus establishing the roadmap for the long-term commitment of the Government for the provision of quality social services, health being one of them.

Programme and Policies:

There are huge variances among policies, programmes and practice. While the policy places emphasis HIV prevention, a review at the expenditure on the HIV and AIDS programme shows that expenditure is on 'Care, treatment and Support' – particularly on ARVs expenditure. It is also known that for every one case on ARVs, there are 2 more untreated. It was reported that as of June 2010, there were 'ever been' 345,000 clients on ARVs while those enrolled on care (both on ARVs and being followed up) were 660,000 clients. The challenge is therefore, available data does not allow knowing those actually on ARVs. In addition, by July 1 – to September 30th, 2010, two per cent (2%) of all clients were on 2nd line ARV drugs BUT for all facilities i.e. Referral and Regional health facilities, 5% of patients were on 2nd line ARV drugs.

Expenditure:

The findings at this level were that there was heavy donor dependency on care, treatment and support on HIV and AIDS.

Coordination:

Co-ordination is difficult. All the HIV and AIDS interventions are skilled-intensive. They all need re-training. The system is operating at 38% capacity.

3.6.5: Tanzania Commission for AIDS (TACAIDS)

Burden of Disease:

Mobile populations are more affected by HIV infection than the general population. When they move they tend to leave their families behind. Such populations are plantation communities, small scale miners etc; (in Geita, Arusha, Mara and Mwanza). Apart from the large plantations found in the LVB in Tanzania, there are other areas with similar agricultural profiles e.g. Mufindi in Iringa, Kilombero and Mtibwa in Morogoro and Amani in Tanga.

Services availability:

Services are not targeted and are inadequate. Quality of the services was a challenge. Inadequate personnel, poor services and confidentiality were issues.

Policy on HIV and AIDS:

HIV and AIDS policies have targeted MARPS. Yet the private sector carries out HIV testing but cannot enforce the details of the testing because they have no legal power. With regard to PLHIV, only the public sector has done some work. It was expensive and was funded through TMAP which has since expired.

Co-ordination:

All co-ordination is supposed to be done through the "Medium Term Expenditure Framework, MTEF" but it is not well articulated. The terms of reference of the CHACs is a problem and currently, it is being challenged if the Multi-sectoral AIDS Committees (MACs) are alive or not at Council, Ward and Village.

3.6.6: Ministry of Agriculture and Food security:

Burden of Disease:

The Ministry has both a sectoral policy and strategy. There is a committee at Ministerial level which is coordinating HIV and AIDS issues. There are funds from TACAIDS and a situation analysis has been done. HIV and AIDS is a problem because it is decimating labour force in the Ministry. Work Place programme (WPP) has done sensitization in 2008 and 2009. It has covered many Training institutions e.g. Ilonga, Mlingano, Ukiriguru, Tumbi, Uyole, Seliani, Hombolo and Naliendebe. They promoted the idea of putting condoms in toilets and peer health education in work place.

There was poor linkage between plantation estates owners and the Ministry concerned.

3.6.7: Ministry of Community Development, Women Affairs and Children;

Burden of Disease:

Burden of disease for HIV and AIDS is huge particularly in plantations. People move alone without wives or husbands.

Services availability:

There are few services on VCT, CD4 estimation and ARVs. In the Lake, there are no services. Even in Dar-es-Salaam, the capital city of the nation, there are problems. One can 'hide' in Dar while in the villages there is no hiding places. Transport is inadequate to access services. When these people loose hope, they can be very dangerous and purposely be infectious. With the low education on the disease, it is recipe for disaster particularly with few experts available.

Programmes and Policy:

The sector has developed 'Community-based framework to the protection of Women and children against HIV and AIDS. Community has been defined as any group – farmers; women or children. Little is being done. WPP is there and is being implemented. MTEF should also plan for PLHIV.

In the 2000s, a strategic plan for the Ministry was developed with the technical support of ESAMI. There was no Mkukuta, yet when Mkukuta came, it came from above. There are thirty five (35) areas in the current MKUKUTA (II) to work but with inadequate funding for implementation. There is a community development policy 'Sera ya Maendelao ya jamii'.

Co-ordination:

Local Government Authorities (LGAs) do not have to report to us (Ministries). From 2009, they will start to do so. It will be in their terms of reference (ToR) and then they can answer. The Ministry has 64 training institutions.

Support and participation in EAC activities:

The Ministry of Community Development, Gender and Children Affairs (CDG&CA) participate in meetings. Challenge is how to co-ordinate social sectors. Social policies are approached in a compartmentalized form.

Information from Focus Group Discussions (FGDs):

Burden of Disease:

These are results of FGDs of different groups. In all of the groups it was stated that HIV and AIDS was a big problem in the plantation workers community because it had reduced the work force of the company resulting in loss of productivity. 'Watu wanakufa'. Many people have died. There were many widows and in addition, children were left alone with no one to care for them and sometimes stigmatised because they were born HIV positive. Health education is obtained from radio programmes, TV, newspapers; billboards were everywhere, different seminars, meetings, fliers and HIV counselling facilities are available. Others were of the opinion that many times they teach themselves on the disease. Problems experienced were lack of teaching tools and non-availability of providers of HIV testing services unless one goes to the hospital. It was reported that people go for testing but do not go to collect results. Excessive alcohol intake result into men taking casual sex partners without knowing their social/sexual backgrounds. Discussants knew that HIV is transmitted through sex, injections and multiple sexual partners.

There was a style of sex known as 'katerero' which was done by the man holding the penis and stroking the clitoris. Each group accused the other as being more in favour of the style. Condoms cannot be used in such type of sex thus posing a route for HIV transmission through risky sex. Participants knew of mother-to-child transmission and transmission of HIV infection during breastfeeding.

It was disclosed that parents do not care and do sex while children were aware of what was going on. In addition, parents did not care when children came home late. It was stated that pornographic videos were rampant both in public and private homes. People from different background, the 'rainbow' among plantation workers-there is such a mix of all sorts of people everyone with his/her own culture and outlook towards life.

Participants suggested that, information on the epidemic should be frequently shown on TV, newspapers, radio and photographs of infected people should be shown so that people can fear taking unnecessary sexual risks. Also those PLHIV should be encouraged to come out. '*Waliopimwa na kukutwa wameathirika wahamasishwe wajitangaze*' Mobile cinema shows were recommended as well as sports venues for youths where HIV information and testing could also be made available. People with HIV should not be blamed since they did not intentionally infect themselves and sex is unavoidable.

When discussing on inter-personal relationships, it was stated that there are many tempting opportunities for sexual encounters. There are many women from Uganda who frequent the plantation estates '*na ni wachokozi wa kimapenzi na wanatongoza wanaume*'. They are sexually aggressive and can even seduce men. Such women are aggressive to senior people but are also available to the lower cadres! There are more men than women and particularly during paydays, men take women and do not use condoms and such relationships are never permanent. Women wear sexually suggestive dresses to attract men into sex for money to the extent that men neglect their families. When one finds s/he is HIV positive, they intentionally spread the disease and it is worse when men target secondary school girls.

There are cases where sugar cane is used as an exchange gift for sex such that supervisors prefer young girls as workers so that sex can continue. There are cases where a man can get a salary increase so that he stops having an affair with a girl whom a senior person has targeted and women stated that they are sometimes offered sugar and other stuff at the truck-shop and the man pays for it in the evening. When probed as to why such a situation should occur, the issue of poverty and greed for material things came up.

It was mentioned that salaries are low! Those with contracts were singled out as being more promiscuous. Sex in exchange for employment is commonly practised in the plantations. *'Ukikosa moyo wa subira, na watoto hawajala kama wiki moja, unapokea fedha au sukari au miwa'*. If you are not patient and your children have not eaten for a week, you engage in sex. In men hostels, 4 people stay in one room and a young girl can unknowingly be taken in the room and sex is done and it seems normal and she will bring her friends next time.

Parents encourage girls to ask for lifts in passing vehicles when going to school. Sometimes the girls, the distances to schools contribute to what can be seen as sexual contacts/opportunities for sexual negotiations. In some camps (e.g. number 6 in KSE) there are many children – both primary and secondary school kids. Teachers and parents should give sex education and such children should be tested for HIV infection since they are sexually active. The temptation of pornographic videos and pictures is another problem. During FGDs, it was noted that incidence like the one *'natoka kambi namba 5 naambiwa kuna msichana mpya kambi namba 4 nikamwone. Hii hasa inatokea kwa madereva'* I am from Camp number 5 and I am told there is a new girl in camp number 4. I will have to go and see her. Then there are the young boys, popularly known as 'serengeti' loosely translated as energetic young men in the vein of the national Under-17 football team. Older women go for such boys, not necessarily under-17 BUT much younger than those ladies. In the farms, senior people, men or women, they take lower cadres for lovers. People have multiple lovers be it men or women.

Has knowledge led to behaviour change?

It was reported that it appeared that knowledge had not led to behaviour change because very few (only 20%) had changed behaviour. On further probing as to why change had not happened, it was stated that they had taken HIV to be similar to malaria. *'Anayekufa na UKIMWI kafa kiume'* When one died of AIDS he had died like a real man.

Prevention:

'Siku hizi watoto nao wako kama wakubwa' – nowadays children are like adults. They should be taught on HIV and AIDS right from the start. There is death and parents should educate their children. It was informative when some parents were told that their kids are engaging in sexual activities, they retorted back that 'they are learning!'

Parents ask their daughters to bring soap and food yet they don't give them money. That girl knows then if she has to bring those items she has to ask money from a man! Women condoms were requested as well as trainers on how to use them. Men said they forget to carry men condoms so women ones should be made available. It was said that people fear their HIV testing results hence the need for education. In the past people died very often but now they understand and are using medicines and living longer. The government should spread service coverage for example people in Kakungwe have no facility they have to come to the district hospital. HIV counselling and testing should come from outside our community in order to reduce stigmatisation

Special requests:

The estates should reduce the workload of PLHIV and not discontinue them. Some die on the farms. Also the government should build another hospital in the estate since those with money are favoured when it comes to treatment compared to the poor ones. On further probing, some said PLHIV should be given special services such as food, milk, green vegetables and seeds should be given to them so that can do it themselves. Starter funds should be provided as loans to community.

HIV and AIDS and related services:

Condoms are available in the plantation areas; others are using them while others are not. The reasons for not using include misconception among plantation staff. These condoms are available and sold in the shops. Those from Uganda were more costly and of good quality too. Free condoms were available at the dispensary/hospitals.

The issue of health facility in the plantation area confirmed that the Kagera Sugar Company were providing VCT to the company workers and their families though the services were inadequate with shortage of staff, shortage of drugs, low salaries, and no confidentiality. On the other hand, workers insisted that the company should ensure availability of women condoms. Health services are available as well as VCT though are not adequate. At the Kagera Tea Company, services were obtained from the Regional Hospital in Bukoba and Mugana Mission hospital.

On further probing, it was said that condoms are available from shops, clinic/hospital. Whether they are used is the question. There are many HIV infected women and some are pregnant. Salama condoms are sold at lower prices compared to those from Uganda which are expensive.' *Kuna aina ya Tatu Bomba'*- there are three super varieties. Even when they are used they are thrown carelessly. HIV testing services are available at the district hospital and people are willing to be tested but some do not come to collect results even during rapid testing. They disappear when told to wait for the results within a very short time. Home based care is available but there is need for that service to be provided for both men and women since mainly women are the ones being tested when they become pregnant. It was stated that testing was useful since when one knows his/her HIV status, one can take care of himself/herself and be able to look after the family and can remain healthy. Also various services should be made available to those found to be HIV positive.

It was mentioned that there are negative issues on testing. One can loose his/her job as well as being stigmatised by society and even divorce/separation can occur. ARVs were mentioned but not in detail.

On how services should be improved, the groups stated that people should do a self introspection that they are needed by their families and not to think of sex all the time. Let us be faithful to one partner. People should practise their religion and let them use condoms and they should know their HIV status.

Out of work activities:

Discussants stated that after work they rest. Men visited beer halls while women washed clothes, did small businesses and cook for family members

On Disclosure:

Discussants agreed that spouse is the best choice for disclosure. It was agreed that it was not good to tell everyone but others thought people should disclose so that people know who is infected. On further probing if such disclosure could result in PLHIV receiving support, then it was beneficial.

Stigma:

In both quantitative data sources as well as the qualitative ones, information was obtained on who needs to know. It was agreed that spouse was first choice. On type of bad treatment met by PLHIV, it was pointed to be 'isolation' and sources of stigmatisation was from community members and family. Definitely HIV health education should target at the issue of stigma in several dimensions i.e. community members, family and the in-school youth so that the topic is laid open up-front.

3.6.8: KII with Plantation Management:

Burden of HIV and AIDS:

Two drivers in the Department of Administration have died due to HIV and AIDS. One of them was sent home and died of AIDS. At the supervisory level in this department (Agric.) which has 100 -150 people, none has died of AIDS. Section Managers are mostly University graduates and number 100 – 150. The Labourers who are daily paid and the company had no way of following them up.

It was reported that the Kagera war fought between May – October 1978 made it impossible to work and the factory closed after workers ran away. It was re-started in March 1979. There were a lot of foreign investors and a lot of people came in and out of the factory. There was free sex. People fell sick with symptoms of coughing, had diarrhoea and loss of body weight. Business people were more affected than other cadres. This led to increased blame on 'witchcraft'. A police woman contracted the disease and people flocked to have a look at her. Research showed that it was not witchcraft but an infection. A lot of people died. Of those whom the respondent started work with in 1978, three quarters had died due to the disease. At that time all staff were permanent i.e. in 1979 – 1992. The alarm was then raised and people started getting education on HIV infection. Those were the days when one driver said 'one can't eat a sweet with its cover'. That driver is dead and six women who had relations with him died also.

At Kagera Tea Estate, it was found that the estate owner personally supports PLHIV who have disclosed their HIV sero-status by providing them with 50,000/- per month in addition to their salaries in order to improve their nutritional status. There were 5 such PLHIV at our time of visit. They were on ARVs and their sick sheets were kept at the Human Resources Department.

Support from Collaborators:

There have been little activities with the EAC or Government on support on HIV and AIDS. Only the Tanzania Sugar Producers Association – had formed a committee which discussed how to improve varieties of sugar cane and nothing on HIV or AIDS. Lake Victoria Basin Commission Secretariat of Lake Victoria basin Commission had visited them and discussed HIV and AIDS.

This research was the first input on HIV and AIDS on them. HIV and AIDS is not an issue at Management meetings of Kagera Sugar Estate (KSE).

HIV and AIDS and other health services:

The company hospital is independent. It serves all (company and non-company clients). Non-company clients pay a fee for services while employees are treated at a token fee. HIV and AIDS clients are given free services regardless of where they come from. Behaviour change communication (BCC) is provided by hospital. There is no strategic plan for HIV and AIDS in the company (Kagera Sugar Estate).

Policy on health Service delivery:

Company employees and the surrounding community are given services there. The hospital also attracts clients from Uganda, Minziro, Mutukura and Katoro. Company employees pay a token fee of 500/- while non-company employees pay 1,000/- for Out-patient department (OPD) and 5,000/- for admissions. There is a fee for surgical procedures.

There are 72 beds in the hospital divided as follows: 28 maternity beds; 12 paediatric beds, the rest are equally divided between men and women in-patients.

Specific HIV and AIDS Services:

Provider initiated Counselling and testing (PICT) provide 50-60% of hospital attendees. VCT, CTC and PMTCT are offered and staff trained. The hospital provides out-reach health services once a month to the surrounding areas. It is a very successful service. ICAP, a USA NGO supports the hospital in HIV and AIDS services in terms of facilitating 1 computer and pays the salaries of: a laboratory technician; a pharmacist; 2 nurses and a data clerk.

ICAP funds are channelled through company and levels of pay are rationalized along company pay policies and therefore staff cannot get the actual levels paid by ICAP! It was an issue that raised concern from those employees who needed discussing by the responsible officers and other key stakeholders particularly in view of the staff drain being experienced at the hospital.

Hospital Staffing:

Due to better remuneration in the public sector recently, 15 (mostly Enrolled Nurses) hospital employees have left for greener pastures to Missenyi District Council Health Services. The hospital has been able to recruit only 3 enrolled nurses after announcing the positions in newspapers with a poor response. Majority of employees are Nursing Assistants. There are only 5 Nurse-Midwives. Total staff compliment at present is 10 enrolled nurses, 1 Medical officer and 1 Assistant Medical Officer (AMO).

- Major Challenge:

The company strategy is to persistently increase sugar production. The issue of HIV and AIDS is perceived by most senior company staff as unimportant and extra-burden activity and should not be borne by the company.

Chapter 4

Discussion

4.1: Coverage of the study population:

From the calculated sample size of 425 respondents, the study team managed to collect data from 409 individuals giving coverage of 96.2%. That coverage was adequate to provide meaningful information from the study to be able to address the specific objectives. The results obtained indicated the study population was mobile because the average length of stay in the plantation for the majority of them was between 1 - 4 years only. Such duration of residence was similar to other plantation populations (e.g. Foglia et al, 2008). During FGDs it was reported that plantation workers had originated from far off places such as Morogoro and Iringa although majority came from the nearby ethnic group.

4.2: Socio-demographic profile of the study population:

The study population was a young population by age the majority being men. Since the plantation activities were energy intensive, it was not surprising for this observation, i.e. men being stronger than women and freer in mobility (Plus News Global Kenya 2009).

4.3: Determination of HIV sero-prevalence:

The overall result of the HIV sero-prevalence in the study population of agricultural plantation workers communities was higher than that of the general population. The prevalence being 6.8% which is higher compared to the national prevalence of 5.7% (THMIS 2007/8). That prevalence is also higher than the one for sub-Saharan Africa which was 5.0%, (WHO and UNAIDS, 2009). When the different sexes were examined, men had a prevalence of 4.4% while that of the women was 12.9% being almost three-fold. The peak HIV prevalence was in the 30 – 44 year age group for both sexes. Such an age group would be in line with a sexually active and a young labour force characterising the plantation workers that was surveyed. Qualitative data obtained from FGDs reported frequent illnesses, many widows and orphans as well as frequent deaths.

HIV prevalence based on marital status as well as the employment categories i.e. permanent, seasonal/temporary and casual could not be analysed due to numbers being too small in these categories.

4.4: Establishment of demographic and behavioural risks factors, knowledge and attitudes regarding HIV and STI transmission.

In the current study, it was found that agricultural plantation workers had high knowledge on HIV and AIDS unlike other reported similar studies (Kennedy Nyambuti Ondimu, <http://www.africanbookscollective.com/books/risky-sexual-behaviours-among-migrant-tea-workers-in-kenya>, 2011). Such knowledge included – e.g. condom use, restriction to one sexual partner, reduced number of sexual partners, stoppage of sharing injections and fidelity/faithfulness in sexual relations. However, despite respondents having such high knowledge useful in HIV prevention, that population had higher HIV prevalence than the general population possibly implying that either knowledge was not protective/functional from infection protection or prevention services from public health providers was inadequate or inaccessible.

Furthermore, despite the evidence of high knowledge, the question of misconception persisted. It seemed most likely that knowledge of condoms being protective alone is inadequate since the issue of condom use causing reduction in sexual pleasure could counterbalance the knowledge benefits. Such an observation gets additional support from the finding obtained when the issue of ‘condom use’ with a non-regular partner was investigated and it was found that only fifty per cent of the respondents reported having never used a condom even with a non-regular partner.

In our study population the issue of disclosure was addressed and the finding was that they would disclose their HIV sero-status to mainly spouse/permanent partner followed by girlfriend/boyfriend. Therefore any intervention should be planned in such a way as to target those two groups in HIV testing and home-based care education.

When stigma was probed, it was reported to be a problem and types of stigma were revealed. Hence more efforts should be put in attempting to reduce/reverse the situation on stigma among PLHIV and their families.

There was a discrepancy in the finding on the influence of alcohol on sex. While quantitatively it was reported that alcohol played a minor role in influencing sex, during focus group discussions it was reported that excessive alcohol drove men to have casual sex with partners whose social background was unknown thus having the potential of predisposing them to HIV/STI infections. That later observation (qualitatively) was consistent with the studies done elsewhere (Poddar, D.P., 1995).

With regard to attitude of community members towards PLHIV, it was reported that it consisted of visiting infected person, giving moral support and provision of food. That was a positive attitude and should be encouraged. A similar example was reported by Kagera Tea Company management that they gave extra incentives to workers who disclose their HIV sero-status. Other studies have shown that there is a rift between employees and employers on HIV sero-status disclosure (Roberts, M and Wangombe J, 1995).

In this survey, gender based violence (GBV) was reported by 12% of respondents. We believe that there was under reporting of the GBV. Twelve percent is still high, when perceived in a scope where it should be less than 1%. It is important that gender based violence is addressed during intervention in these communities so that the issue is contained.

Box 1:

Gender and Human Right issues :

The information on the gender and human rights issues in relation to HIV and AIDS national initiatives were not fully explored in this study. Hence the need for appropriate integrated interventions addressing human rights and gender equalities.

4.5: Establishment of the range, breadth, availability and utilization of HIV and AIDS related services:

The range of services has been described. They were mainly in regard to HIV testing and counselling, condoms and health education. In the study carried out, the Kagera Sugar Estate had such services and even more. For example they had inpatients services, maternity including PMTCT services etc. Yet in Kagera tea Estate such services were not available at the site and could only be accessed through referral to Kagera regional Hospital and Mugana Catholic Church Hospital.

The ideal situation would have been the availability of a comprehensive work place programme (WPP) which would have included the following: VCT, STI control and management, condom distribution, peer health education, financial support to those affected and infected, burial benefits as well as family support for employees who have died and left behind dependants (Roberts M and Wangombe J. 1995). There was no WPP in the two plantations studied.

In terms of service utilisation, Kagera Sugar Estate allowed non-company employees to access health facilities for an affordable nominal fee. Such a developments need to be strongly acknowledged and supported by the Local Government Authority in the area where the estate is located.

FGD information confirmed the observation that while services were available, there was need for more focussed and intensive provision and utilisation. Clients needed to be encouraged to not only go for VCT but also collect results in order to allow for meaningful care, treatment and support.

Furthermore, while a private company owner would have preferred to deal with direct health outcomes in relation to its core production activities e.g. sugar cane production, yet the issue of HIV and AIDS is a special case. HIV and AIDS would fall outside such category. However, HIV negative health workers are better producers than those infected. Thus HIV and AIDS should be considered a production issue and company owners need to be sensitised and mobilised to acknowledge it as an important subject. In addition, the presence of public organs/structures such as the Council Multisectoral AIDS Committees and those at the Ward and Village level should be involved in case such companies are within their areas of jurisdiction.

4.6: Determination of the existence and effectiveness of policies, programmes and co-ordination structures on HIV and AIDS:

4.6.1: Existence and effectiveness of HIV and AIDS Policies, programmes and co-ordination structures on HIV and AIDS services:

The study found that the EAC had no HIV and AIDS policy of its own but has left each partner to go its way with regard to HIV and AIDS policies. That has therefore meant that to date there is no common approach to fight the epidemic in the partner states.

They also do not have a common strategy on resource mobilisation from development partners. Yet the pandemic is one of the major health problem not only in the partner states but the whole of sub-Saharan Africa (WHO and UNAIDS, 2009). Therefore, urgent efforts should be made to harmonise the policies of the partner states. For example the draft HIV and AIDS bill on HIV and AIDS should be fast-tracked to allow for its implementation.

The harmonisation of 1st and 2nd line AIDS treatment for HIV and AIDS clients is one major example of the need for harmonisation such that any movement of beneficiaries to the drugs should not be compromised through differing quality of services. Another topic requiring similar attention within the partner states is the whole question of the work place programme package. Its content as well as approach has to be harmonised.

In each partner state, there are HIV and AIDS interventions being carried out/implemented. In some of the countries it is possible that such interventions are being done better. Yet due to inadequate/poor information sharing it has been difficult to document such best practices interventions and disseminate them in order to harmonise and utilise them in region-wide approach. Such a method should be broadened to cover other critical areas in the pandemic.

The question of human resources for health is a common problem across the board. The HIV and AIDS Unit in the EAC is one such affected entity. The finding that it has now been approved to recruit additional professional staff was a welcome development. It is being argued that the recruitment be fast tracked and monitored.

4.6.2: Co-ordination structures and mechanisms at EAC:

When the HIV and AIDS pandemic was taken up by the EAC, it was felt that there was need for co-ordination of relevant structures/organs which impact on plantation workers. Such entities include National AIDS Commissions; National AIDS Control Programmes (NACP); both small and large-scale plantations owners; key Sectoral organs such as Agriculture and Food security and Community Development, Gender and Children Affairs. In addition, Civil Society Organisations (CSOs) should be brought on board. All the identified stakeholders should be players in the fight against the pandemic. The major problem observed was that while NGOs had access to most of the local communities, yet they seemed not to be very active on plantation workers.

It was further reported in KIIs/FGDs that some communities have set up 'own HIV and AIDS responses' which can be utilised. For example mobile telephones have been used for reminding clients when to take ARVs. You telephone 5 then those five telephone another 5. There are issues of funding. Can we have a special fund for mobile populations who are hard to reach with currently available services? Even when services are provided as is the case with plantation workers, there still is a problem.

There is need to know what works in these communities and what does not work. There was a discussion about 'electronic health services - e-health services. There are structures in place at LGA levels. The LGA structures are not reaching the plantation workers since they are considered as belonging to the owners of the plantations.

- The Future:

Most of the challenges found were 'systems' issues – Human Resources for Health (HRH); Medical Stores department (MSD) and Logistics such as transport, cold chain etc. There are challenges for example, for the role of pharmacist: There were no examples to learn from. HIV and AIDS is the only disease demanding a team approach of e.g. prescriber, pharmacist, laboratory technologist, VCT and Nutritional Counselling. Yet the experience of the different partner states needs to be documented, discussed and preferably harmonised. Furthermore the issue of 'Records' – a paper – based record system is a nightmare. Longitudinal analysis is not done. The HIV prevalence has come down from 10%; 8%; 7% to 5.7%. However, those PLHIV are there, they are on ARVs, living much longer, hence more patients due to better 'Care and Treatment'. It was stated that THERE was no forum for discussion of views, except some few. Harmonisation of treatment guidelines has been done. Not actual implementation. Global Fund accepts inter-country proposals. As far as plantations go; we should think of Iringa and Morogoro with regard to large-scale plantations in Tanzania.

4.6.3: What should be done to make MACs work?

In some partner states, multi-sectoral AIDS Committees were established at various levels in order to empower communities in responding to the HIV and AIDS response e.g. district, ward and village levels. It is important that their functionality is revisited.

4.6.4: Community Concerns from FGDs:

- I. There is need for mass sensitization particularly to the Management of the Estate
- II. Since majority of employees are at risk of contracting HIV and AIDS, casual labourers are preferred.
- III. There is need to support on-going activities on HIV and AIDS, hence a strong need for a CD4 counting machine.

At the time of our visit, samples for CD4 were being sent to Bukoba Regional Hospital and Mugana Hospital. There is a good flow of ARVs. Hospital is getting reagents for rapid HIV testing from the District AIDS Control Coordinator (DACC)/ICAP. For scaling up provider initiated counselling and testing, there is need to train all service providers.

It is said there are ARV drugs which cure HIV. Is there a danger that when people know about it, they will go back to their previous risky behaviour? Also Information is freely flowing through Fema/Femina Radio and TV are there. They are educating people but other TV/Radio programmes are also providing dangerous information. What can be done? It was reported that in Wa-Haya culture it is taboo to discuss sex with ones' daughter. Only the aunt is allowed. What happens when the aunt is not there?

What needs to be done on HIV and AIDS?

The respondents had the opinion that what was needed to be done was for campaigns to educate them all on HIV and AIDS so that they can say it easily and openly. They needed audio-visual equipment with a big screen. There needs to be training for women health providers at the clinic and more HIV and AIDS posters all along the camps and fliers. In one office visited there was one toilet, no condoms and no peer educators in the company.

Although male circumcision was not part of the study, it should be included in HV and AIDS campaign.

Box 2:

Circumcision Campaigns:

Male Circumcision strategy has been taken up as one of the prevention measures against HIV infection in Tanzania. Yet, male circumcision practices were not part of this study. However, there were pockets of populations where the practice was carried out e.g. among the Moslems.

It has been confirmed that male circumcision if performed before sexual debut has 60% protection against HIV infection in circumcised men. (Tanzania National Multisectoral HIV prevention Strategy, 2009.)

Chapter 5:

Conclusions and Recommendations

5.1: HIV prevalence:

The major finding in the study was that plantation workers communities had higher HIV prevalence than the general Tanzania population. Also it was found that women had higher HIV prevalence than the men among plantation workers communities. In addition, the most affected age group was that of 35 -44 year olds. In view of this finding, the following recommendation can be made:

Recommendation:

Programme implementers should develop interventions that target all plantation workers and special attention should be given to women and the 35 -44 years age group.

5.2: HIV awareness and knowledge:

The key finding was that the study populations had higher levels of knowledge on HIV and AIDS. Nevertheless, such levels of knowledge did not translate into changes in HIV prevalence. In view of this finding, the following recommendation can be made:

Recommendation:

Programmes should focus and intensify on HIV and AIDS education on prevention and care in order to minimise stigma and clear the misconceptions found such as casual contact with an infected person could transmit HIV; sexual intercourse with a virgin is protective against contracting HIV and that mosquito bites can transmit HIV.

5.3: Behavioural change:

The study has found that HIV education has been provided by both public sector and civil society organisations to the workers. There was no evidence as to the package of that education in terms of content, number of times given and target audience. In addition, we could not determine whether there were indicators to measure effectiveness of the intervention. In view of the finding, the following recommendation is made. The MOH&SW has guidelines and these should be made available

Recommendation:

The plantation management should ensure that existing MOH&SW guidelines are available in their health facilities. The potential implementer should design an HIV and AIDS intervention package in such a way as to take into consideration the issues of content, time and measurement of indicators in order to observe the desired impact. Such an intervention package must have a time-line.

5.4: HIV testing:

In the study it was found that respondents were more willing to disclose HIV sero-status to spouse/permanent partner and/or girlfriend/boyfriend than to others. In view of the finding, the following recommendation is made.

Recommendation:

Programmes should make sure that HIV testing, while following Tanzania Government guidelines, yet in the study populations it should focus intensely of partner testing (spouse/permanent partner and/or girlfriend, boyfriend).

5.5: Condom attitude and utilisation:

It was found that there was negative attitude on condoms i.e. their use leads to reduction of sexual pleasure. Secondly, there was misconception that condom use was due to lack of trust of sexual partner. Condom disposal was said to be problematic. Furthermore while fifty per cent reported

condom use, the results of HIV prevalence was higher in plantation workers than in the general public. In view of the finding, the following recommendation is made.

Recommendation:

Programme implementers should ensure more and intense education is delivered to correct the misconception that condom use leads to reduction of sexual pleasure and/or mistrust of sexual partner. In addition that intervention should target on getting people to use condoms correctly, consistently and disposal.

5.6: Stigma:

Available data shows a significant amount of stigmatisation of PLHIV and is reflected in the issues such as disclosure, isolation and who are the main perpetrators of the stigma acts. Definitely there is need for in-depth HIV education to both community members and the families of PLHIVs. In the light of the above the following recommendation is made:

Recommendation:

It is recommended that systematic HIV education targeting on stigma reduction be mounted in the plantation workers community. The benefits of disclosure should be highlighted and workers should not be dismissed when found to be HIV positive.

5.7: Inclusion of other key stakeholders in the provision of HIV and AIDS services:

In the study, it was found that apart from the public sector providing HIV and AIDS services, there were others, such as civil society organisations, which were providing HIV and AIDS services in plantation workers. In view of the finding, the following recommendation is made.

Recommendation:

It is recommended that when interventions are being planned, all stakeholders (especially private service providers) be included in order to rationalise service provision and avoid undermining the efforts of the intervention.

5.8: Site for implementation of community interventions:

Many respondents on being probed as to sites which they would prefer to get services from, 'own community' came out strongly. Similar proportions of respondents had no preference. In view of the finding, the following recommendation is made.

Recommendation:

It is recommended that interventions in the plantations should be implemented at 'own community' level. Also, HIV and AIDS interventions should include the workplace clinic where available e.g. Kagera Sugar Estate.

5.9: HIV and AIDS support groups activities:

While it is understandable that HIV and AIDS prevention, care and support as well as impact mitigation is not a core activity of the management of the plantation owners, yet HIV and AIDS support group activities were found to be inadequate in plantation workers communities. In view of the finding, the following recommendation is made.

Recommendation:

Plantation owners or plantation management should be sensitised to regard HIV and AIDS as a major problem since the nation has declared it to be a 'national disaster' and it affects the production of both sugar and tea. Hence, more and intensive efforts should be put in designing, funding and supporting such an intervention since such an activity has the potential of having a higher coverage of target beneficiaries and the public sector should work closely with the estate managements.

5.10: Gender Based Violence:

The magnitude of gender-based violence was found to be significant. The violence experienced ranged from physical and verbal abuse. In view of the finding, the following recommendation is made.

Recommendation:

In any HIV and AIDS interventions being developed for the study populations, gender based violence should be addressed. Communities should be involved right from the beginning.

5.11: HIV and AIDS policies of member states:

It was found out that the five EAC member states have existing HIV and AIDS policies and strategies. There is no linkage even in very clear areas such as plantation workers communities. While the community is meant to be one single entity, when it comes to negotiations with donors, the unifying 'voice' is missing.

Recommendation:

The member state HIV and AIDS policies and strategies should be harmonised to allow for joint development of interventions as well as joint negotiation approaches in the areas of HIV and AIDS among plantation workers populations.

5.12: HIV and AIDS programmes

The dislocation between what the policy states and what is happening through HIV and AIDS programmes is a major challenge. Many activities at national and community level cannot be implemented due to inadequacies: human resources, poor co-ordination and poor funding.

Recommendation:

The East African Community (EAC) should speak with one voice and use its muscle for resource mobilisation. Furthermore, 'best practices' should be identified and documented so that they can be disseminated.

5.13: Participation of plantation workers in HIV and AIDS workplace programmes:

There was no evidence of components of HIV and AIDS workplace programme activities in the plantations such as: peer educators, STI control and treatment, condom supply, etc. The guidelines for the programme are available through the public sector and they should be adapted to fit the context of the large-scale plantations. The following recommendation is made:

Recommendation:

An HIV and AIDS workplace programme should be introduced in the plantations for the benefit of all staff irrespective of category.

5.14: Kagera Tea Company:

The approach of the company in supporting those who were willing to disclose their HIV sero-status was a good move and exemplary.

Recommendation:

Programme implementers should study this practice in detail, document and disseminate it to other large scale plantation owners so that its benefits can be known and supported.

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ANNEXES:

Annex 1a: Information sheet for study participants:

Information Sheet for HIV and AIDS Baseline Studies in Agricultural Plantations in the Lake Victoria Basin, Tanzania

Background

The East African Lake Victoria Partnership (EALP) is a programme of the East African Community, coordinated by the Lake Victoria Basin Commission (LVBC) and managed by the African Medical and Research Foundation (AMREF). The LVBC is an organ of the EAC charged with the socio-economic development of the Lake Victoria Basin region of East Africa. It is a three-year (2007-2010) programme, with funding from Swedish/Norwegian Governments through SIDA.

The EALP aims at establishing a framework for improving the effectiveness of the HIV and AIDS responses for mobile populations within the Lake Victoria Basin region. This will be achieved through policy and practice harmonization, strengthening the coordination capacity of key regional institutions, and strengthening the capacity of select networks and organizations of mobile populations within the Basin. A major aspect of the program is strengthening the capacity of the East African Community (EAC) to effectively coordinate regional HIV and AIDS responses generally, but specifically those responses targeting mobile populations within the Lake Victoria Basin (LVB).

The Lake Victoria Fisheries Organisation (The East African Community), East African Community Lake Victoria Basin Commission and TANESA in collaboration with the Ministry of Health and Social Welfare (MOH&SW) are carrying out HIV and AIDS baseline studies in fisheries and agricultural plantations in the Lake Victoria basin with the overall objective to establish the HIV prevalence, the associated drivers of risk and vulnerability and the effectiveness of HIV and AIDS responses for agricultural plantation workers and fisher folk in the Lake Victoria Basin. Specific objectives of the studies include: to determine HIV sero-prevalence among populations in fishing communities and agricultural plantation systems in Lake Victoria Basin in Kenya, Uganda and Tanzania, to establish the demographic and behavioural risks factors, knowledge and attitudes regarding HIV and STI transmission among plantation workers and fishing communities, to establish the range, breadth, availability and utilization of HIV and AIDS related

services, and to determine the existence and effectiveness of policies, programs and coordination structures on HIV and AIDS in plantations and among fishing communities.

Procedures

During the study survey, all eligible participants from selected sites will be invited to attend at a central site and be enrolled after giving informed signed consent. After enrolment, personal characteristics and history of sexually transmitted diseases will be obtained through a structured questionnaire, in a confidential face to face interview.

After the face to face interview, the participants will undergo counselling and testing for HIV. They will be subjected to a painless finger-prick which will be put on to a filter paper to obtain a dried blood spot (DBS) for HIV testing at the National Institute for Medical Research, Mwanza Centre.

Some of the individuals from face to face interview will be asked to participate in focus group discussions (FGDs), while others will attend semi-structured interviews (SSIs).

Confidentiality

All data and results from every participant will be kept secret.

Participation

We hope that every eligible individual will agree to participate in this important research. However if any person does not want participate, we will not tell anyone and he/she will continue with work as usual. If any person agrees to participate now, he/she has a right to withdraw from the research at any time in future.

If any person has any questions about this project or what it means, please don't hesitate to contact any TANESA staff. A meeting will be held at the working premises. At that time they can ask any question about the research.

Everyone is encouraged to feel free to discuss this information sheet with anyone with whom they want to discuss it or to consult.

Annex 1b: Consent form for survey participants

Consent Form for Survey Participants

HIV and AIDS Baseline Studies in Fisheries and Agricultural Plantations in the Lake Victoria Basin, Tanzania

Background:

The East African Lake Victoria Partnership (EALP) is a programme of the East African Community, coordinated by the Lake Victoria Basin Commission (LVBC) and managed by the African Medical and Research Foundation (AMREF). The LVBC is an organ of the EAC charged with the socio-economic development of the Lake Victoria Basin region of East Africa. It is a three-year (2007-2010) programme, with funding from Swedish/Norwegian Governments through SIDA.

The EALP aims at establishing a framework for improving the effectiveness of the HIV and AIDS responses for mobile populations within the Lake Victoria Basin region. This will be achieved through policy and practice harmonization, strengthening the coordination capacity of key regional institutions, and strengthening the capacity of select networks and organizations of mobile populations within the Basin. A major aspect of the program is strengthening the capacity of the East African Community (EAC) to effectively coordinate regional HIV and AIDS responses generally, but specifically those responses targeting mobile populations within the Lake Victoria Basin (LVB).

Research purpose:

The Lake Victoria Fisheries Organisation (The East African Community), East African Community Lake Victoria Basin Commission and TANESA in collaboration with the Ministry of Health and Social Welfare (MOH&SW) are carrying out HIV and AIDS baseline studies in fisheries and agricultural plantations in the Lake Victoria basin with the overall objective to establish the HIV prevalence, the associated drivers of risk and vulnerability and the effectiveness of HIV and AIDS responses for agricultural plantation workers and fisher folk in the Lake Victoria Basin.

Procedures:

During the study survey, all eligible participants from selected sites will be invited to attend at a central site and be enrolled after giving informed signed consent. After enrolment, personal characteristics and history

of sexually transmitted diseases will be obtained through a structured questionnaire, in a confidential face to face interview.

After the face to face interview, the participants will undergo counselling and testing for HIV. They will be subjected to a painless finger-prick which will be put on to a filter paper to obtain a dried blood spot (DBS) for HIV testing at the National Institute for Medical Research, Mwanza Centre.

Some of the individuals from face to face interview will be asked to participate in focus group discussions (FGDs), while others will attend semi-structured interviews (SSIs).

Risk/Discomforts:

Some of the questions in the questionnaire may be embarrassing for you, but you are free to decline to answer any questions you do not wish to answer at any time. You are also free to stop the interview at any time without giving an explanation. Your refusal to participate or to withdrawal from the interview, will not affect your job in any way.

Benefits:

There is no direct benefit to you from taking part in this study, but the results of this study will help to strengthen the capacity of the East African Community (EAC) to effectively coordinate regional HIV and AIDS responses generally, but specifically those responses targeting mobile populations within the Lake Victoria Basin (LVB).

Also participants wanting to know their HIV status will be able to do so through this study.

Costs:

There are no extra costs to you for taking part in this study, except for giving up the time to participate in the interview.

Confidentiality:

If you decide to answer questions, the interview will be conducted in a private setting where no one else can hear your answers to the questions. Your information will be kept as confidential as possible. No individual identities will be used in any reports or publications resulting from this study. Only senior researchers may see your information, and will be unable to link that information to you.

Right to refuse or withdraw:

It is your choice to be in this study and you can choose not to participate in this study without giving a reason. If you decide not to take part in this study, it will not affect your job and will not affect on the care you receive in the clinics and health centers you have been attending.

Questions and person to contact:

The interviewers will answer any questions that you may have to your satisfaction. If you have further questions or concerns after the research team has left your community, please address them to study consultant, TANESA, P. O. Box 434, Isamilo Road, NIMR building, Mwanza, Tanzania. Telephone Official +255(0)28 2500236 or you may write to DIRECTOR, TANESA, Box 434, MWANZA, or you may call +255 (0)28 2502644.

Consent:

I have read this consent form. I have talked about what it says with the research staff. I had a chance to ask questions and my questions were answered satisfactorily. I agree to be in the study.

Name of participant: _____

Signature / Thumb print: _____ Date: ____/____/____

Name of person taking consent: _____

Signature: _____ Date: ____/____/____

Annex 2: Participant face to face questionnaire :

TANESA/LVFO/LVB/AMREF/Sida/EAC

KNOWLEDGE ATTITUDE AND PRACTICES ON HIV AND AIDS AMONG AGRICULTURAL PLANTATION WORKERS IN THE LAKE VICTORIA BASIN, TANZANIA



Sticker

Section A: 1. Respondent's ID

1.1	ID No.	_ _ _ _	ID
1.3	Date of interview	_ _ _ / _ _ _ /20 _ _ _	IntDate
1.4	Interviewer's staff code	_ _ _	IntCode

Section B: 2. Demographic Information

2.1	Sex of respondent.	1=Men	_	Sex
2.2	What is your tribe?	1=Sukuma; 2=Kerewe; 3=Zinza; 4=Haya; 5=Kurya; 6=Gita; 9=NK; 7=Other _____	_	Tribe
2.3	How old were you at your last birthday?	Age in years 99= Don't know	_ _ _	Age
2.4	What is the highest level of education/schooling that you have completed?	1= Class 1 to Standard 7; 2=Form I to IV; 3=Form V to VI; 4=University/College/Tech; 5= Never been to school; 6=Other (specify) _____	_	Education
2.5	Marital status	1=Single; 2=Married; 3=Separated; 4=Divorced; 5=Widowed;	_	Maristatus
2.6	What is your religion?	1=Roman Catholic; 2=Other Christian; 3=Moslem; 4=Other Religion (including traditional/pagan); 5=No religion; 9=NK	_	Tribe
2.7	Are you the head of the household?	1=Yes; 2=No; 9=NK <i>If No, write 88 to Q2.8</i>	_	HHead

2.8	<i>If yes, to Q2.7</i> How many people depend on you? _ _	HDepend
2.9	How long have you lived in the village which you are living in now? 0=Less than 1 year; 1=1 yr; 2= 2-4 yrs; 3= ≥5yrs; 8=NA; 9=NK _	VilDuration
2.10	What is your main current occupation? 1=Professional; 2=Trader; 3=Plantation worker; 4=Agriculture; 6=Fishing; 7=Unemployed/retired/housework; 8=Mining; 9= NK _	Occupation
2.11	<i>If Occupation is Plantation worker, What type of contract do you have?</i> 1=Permanent; 2=Temporary;3=Casual 4=Other (specify)_____ _	Contract
2.12	How long have you been working for this plantation? Number of months; 99=Nk _ _ _	Workdurat
2.13	What kinds of activities do you and your colleagues engage in after work? Do not prompt 1= Mentioned; 2= Not mentioned; 8= NA	Workactiv
2.13.1	Drinking _	Workactiv1
2.13.2	Watching TV _	Workactiv2
2.13.3	Church activities _	Workactiv3
2.13.4	Reading/studying _	Workactiv4
2.13.5	Visiting friends _	Workactiv5
2.13.6	Sports _	Workactiv6
2.13.7	Other (specify)_____ _	Workactiv7

Section C: 3. Knowledge and Attitudes.

3.1	Are there any diseases that one can get by having sex? <i>If No or NK, enter 8s for Q3.1.2</i> 1=Yes; 2=No; 9=NK _	DisSex
3.2	Please name as many as you can: Do not prompt 1= Mentioned; 2= Not mentioned; 8= NA	
3.2.1	Gonorrhoea _	STISGon
3.2.2	Syphilis _	STISyph
3.2.3	HIV AND AIDS _	STISHIV
3.2.4	Herpes _	STISHerp
3.2.5	Abnormal genital discharge or itch _	STISGDS

3.2.6	Genital ulcer	_	STISGUS
3.2.7	PID/lower abdominal pain in a woman	_	STISPID
3.2.8	Bloody urine	_	STISBlood
3.3	Have you ever heard of HIV or AIDS? 1=Yes; 2=No	_	
3.4	What is an HIV Infection? Do not prompt; 1=Mentioned 2=Not mentioned; 8=NA		
3.4.1	A person has virus but still healthy	_	HIVheard 1
3.4.2	A person has virus and is sick /has symptoms	_	HIVheard 2
3.4.3	HIV is what comes before AIDS	_	HIVheard 3
3.4.4	HIV is after sero-conversion	_	HIVheard 4
3.4.5	Other (specify)_____	_	HIVheard 5
3.5	In what ways do you believe a person can be infected with HIV? Please mention as many as you can: Do not prompt; 1=Mentioned 2=Not mentioned; 8=NA		HIVInf
3.5.1	Sexual intercourse	_	HIVInf1
3.5.2	Sharing needles	_	HIVInf2
3.5.3	Blood transfusions	_	HIVInf3
3.5.4	Mosquito bites	_	HIVInf4
3.5.5	Contact with infected blood/wounds	_	HIVInf5
3.5.6	Using other people's toothbrushes	_	HIVInf6
3.5.7	Casual contact with infected person	_	HIVInf7
3.5.8	Sharing razors	_	HIVInf8
3.5.9	Don't know	_	HIVInf9
3.5.10	Other (specify) _____	_	HIVInf10
3.6	How can people protect themselves against being infected with HIV? Please mention as many as you can: Do not prompt 1=Mentioned 2=Not mentioned; 8=NA		HIVPrev

3.6.1	Abstain from sex	__	HIVPrev1
3.6.2	Non penetrative sex/thigh sex	__	HIVPrev2
3.6.3	Always use condom	__	HIVPrev3
3.6.4	Have sex with only one partner	__	HIVPrev4
3.6.5	Have sex with a virgin	__	HIVPrev5
3.6.6	Make partner take blood test	__	HIVPrev6
3.6.7	Not sharing razors	__	HIVPrev7
3.6.8	Don't know	__	HIVPrev8
3.6.9	Other (specify) _____	__	HIVPrev9
3.7	What are some of the problems caused by AIDS? Please mention as many as you can: Do not prompt 1=Mentioned 2=Not mentioned; 8=NA		AIDSProb
3.7.1	High adult deaths	__	AIDSProb 1
3.7.2	High youth deaths	__	AIDSProb 2
3.7.3	High orphan hood	__	AIDSProb 3
3.7.4	<i>Poverty</i>	__	AIDSProb 4
3.7.5	Chronic sicknesses	__	AIDSProb 5
3.7.6	Absenteeism from work	__	AIDSProb 6
3.7.7	Stress	__	AIDSProb 7
3.7.8	Crowded hospitals	__	AIDSProb 8
3.7.9	Don't know	__	AIDSProb 9
3.7.10	Other (specify) _____	__	AIDSProb 10

3.8	Can you catch HIV and AIDS by having sex with someone? 1=Yes; 2=No; 9=NK	<input type="checkbox"/> <input type="checkbox"/>	HIVTran
3.9	Can you catch HIV and AIDS by sharing a plate of food with an HIV positive person? 1=Yes; 2=No; 9=NK	<input type="checkbox"/> <input type="checkbox"/>	HIVPlate
3.10	Can a person who looks healthy have HIV and AIDS? 1=Yes; 2=No; 9=NK	<input type="checkbox"/> <input type="checkbox"/>	HIVLook
Now I will read a list of statements. Please tell me whether the statement is "True" or "False."			
3.11	A healthy person who is HIV positive cannot transmit HIV. 1=True; 2=False; 9=NK	<input type="checkbox"/> <input type="checkbox"/>	HIVtrans1
3.12	HIV can be transmitted from a mother to her baby 1=True; 2=False; 9=NK	<input type="checkbox"/> <input type="checkbox"/>	HIVtrans2
3.13	A fat person can have HIV infection? 1=True; 2=False; 9=NK	<input type="checkbox"/> <input type="checkbox"/>	HIVfat
3.14	A person can have HIV and not feel sick 1=True; 2=False; 9=NK	<input type="checkbox"/> <input type="checkbox"/>	HIVsick
3.15	HIV is mainly transmitted by sexual intercourse 1=True; 2=False; 9=NK	<input type="checkbox"/> <input type="checkbox"/>	HIVtrans3
3.16	There is a test you can take which tells you if you have HIV 1=True; 2=False; 9=NK	<input type="checkbox"/> <input type="checkbox"/>	HIVtest
3.17	Women are more likely to have HIV than men. 1=True; 2=False; 9=NK	<input type="checkbox"/> <input type="checkbox"/>	HIVWomen
3.18	Condoms protect you from HIV. 1=True; 2=False; 9=NK	<input type="checkbox"/> <input type="checkbox"/>	Condom
3.19	Using a condom reduces sexual pleasure. 1=True; 2=False; 9=NK	<input type="checkbox"/> <input type="checkbox"/>	Condom1
3.20	Using a condom is a sign of not trusting your partner. 1=True; 2=False; 9=NK	<input type="checkbox"/> <input type="checkbox"/>	Condom2

Section D: 4. Risks and Sexual Practices

Now I'm going to ask you a few questions about your experiences. Some of these may be sensitive. Please remember that these questions are totally confidential and no-one will know how you answer			
4.1	How many times have you travelled away from this village in the last 4 weeks?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Travel
4.2	What was the longest duration in one of those travels? 1=<5 days; 2= 1 week; 3= 1 to 2 Weeks; 4= 2-3 weeks; 5= above 4 weeks; 8=NA; 9=NK	<input type="checkbox"/> <input type="checkbox"/>	Tduration
4.3	Did you have sexual intercourse while on transit/travel? 1=Yes; 2=No	<input type="checkbox"/> <input type="checkbox"/>	Sextravel
4.3.1	If Yes, was it with a 1=Regular partner; 2=Casual contact; 3=CSW; 4=Other(Specify) _____	<input type="checkbox"/> <input type="checkbox"/>	Sexpartn

4.3.2	Did you use condom during the sexual intercourse? 1=Yes; 2=No 8=NA; 9=NK	__	Sexcond
4.4	I now want you to think of the first time you had sex: How old were you at that time? Enter number 88=Never had sex; 99=NK	__ __	Sexdebut
4.5	Have you ever suffered from sexually transmitted diseases? 1=Yes, once; 2=Yes, more than once; 3=No	__	STISever
4.5.1	If Yes, the last time you had STIs, did you get treatment? 1=Yes; 2=No; 8=NA	__	STIStrat
4.5.2	If Yes, where did you get treatment 1=Pharmacy; 2=Govt HC; 3=Private HC; 4=Tradition healers 5=Others (specify) _____ ; 8=NA;	__	STIStrat1
4.5.3	Was the partner treated for sexually transmitted diseases? 1=Yes; 2=No; 9=DK; 8=NA;	__	Treatpart n
4.6	Do men have sex with men in this community? 1=Yes; 2=No; 9=DK	__	Msm
4.7	Do men have anal sex with women in this community? 1=Yes; 2=No; 9=DK	__	Sexanal
4.8	Have you ever had sex with a man? 1=Yes; 2=No; 9=DK	__	Msmever
4.9	Have you ever had anal sex with a woman? 1=Yes; 2=No; 9=DK	__	AnalEver
4.10	Since you heard of HIV and AIDS, have you changed your behaviour to avoid being infected? 1=Yes; 2=No; 9=NK.	__	Prev1
4.11	In what ways have you changed your behaviour to avoid being infected? Do not prompt; 1=Mentioned 2=Not mentioned; 8=NA		
4.11.1	Stopped all sex	__	Prev2
4.11.2	Started using condoms	__	Prev3
4.11.2.3	Restricted to one partner	__	Prev4
4.11.4	Reduced number of partners	__	Prev5
4.11.5	Stopped injections	__	Prev6
4.11.6	Asked spouse / partner(s) to be faithful	__	Prev7
4.11.7	Other (specify) _____	__	Prev8
4.12	What level of risk do you think you have in getting the HIV Virus in the next 12 months? 1=No risk; 2=Small risk; 3=Moderate Risk; 4=Great risk; 9=NK	__	HIVrisk

4.13	Have you shared needles or syringes with someone else for any reason? 1=Yes; 2=No; 9=NK	__	HIVsyring e
4.14	How frequently do you drink alcohol and then have sexual intercourse with regular and non-regular partners? 1=Never; 2=Sometimes; 3=Most times; 4=Always	__	Sexalcoh
4.15	If you wanted condoms, where would you get them? 1=Clinic or hospital; 2=Pharmacy; 3=Shop/Kiosk; 4=Supermarket; 5=Workplace; 9=NK; 6=Other (specify) _____ ?	__	Condavail
4.16	How many sexual partners have you had in the last 12 months (including spouse/permanent partners)? Enter number; 99=NK;	__ __	Part12mt h
Now I will ask you some questions about your <u>regular sexual partner</u>. By regular I mean the person you have a consistent sexual relationship with.			
4.17	Have you ever discussed using condoms with your regular sexual partner? 1=Yes; 2=No; 9=NK	__	Cond1
4.18	Was it easy or difficult to discuss condoms with your regular partner? 1=Very easy; 2=Easy; 3=Difficult; 4=Very difficult; 9=NK	__	Cond2
4.19	Would you like to use a condom with your regular sexual partner? 1=Yes; 2=No; 9=NK	__	Cond3
4.20	How confident are you that you could convince your regular partner that a condom should be used if you wanted to use one? 1=Not at all confident; 2=Somewhat confident; 3=Confident; 4=Very confident; 9=NK	__	Cond4
4.21	How often do you use a condom with your regular partner? 1=Always; 2=Most of the time; 3=Sometimes; 4=Once in a while; 5=Never; 9=NK	__	Cond5
4.22	<i>Did you use a condom with your regular partner the last time you had sexual intercourse? 1=Yes; 2=No; 9=NK</i>	__	Cond6
4.23	<i>Did you drink alcohol prior to having sex with your regular partner, the last time you had sex with them? 1=Yes; 2=No; 9=NK</i>	__	Cond7
Now I would like to ask you some questions about <u>non-regular</u> sexual partners. By non-regular I mean a person you have had a sexual experience with only once, or very rarely, or a commercial sex worker.			

4.24	Have you had sexual intercourse with a non-regular in the last 12 months? 1=Yes; 2=No; 9=NK	__	NonReg1
4.25	Have you ever discussed using a condom with your non-regular partner? 1=Yes; 2=No; 9=NK	__	NonReg1
4.26	Was it easy or difficult to discuss condoms with your non-regular partner? 1=Very easy; 2=Easy; 3=Difficult; 4=Very difficult; 9=NK	__	NonReg1
4.27	Would you like to use condoms with your non-regular partner? 1=Yes; 2=No; 9=NK	__	NonReg1
4.28	How confident are you that you could convince your non-regular partner that a condom should be used if you wanted to use one? 1=Not at all confident; 2=Somewhat confident; 3=Confident; 4=Very confident; 9=NK	__	NonReg1
4.29	How often do you use condoms with your non-regular partner? 1=Always; 2=Most of the time; 3=Sometimes; 4=Once in a while; 5=Never; 9=NK	__	NonReg1
4.30	<i>Did you use a condom with your non-regular partner the last time you had sexual intercourse?</i> 1=Yes; 2=No; 9=NK	__	NonReg1

Section E: 5. Access to HIV and AIDS, VCT Services and Utilisation

I would now like to ask you some questions about access to HIV and AIDS and Voluntary Counseling & testing Services (VCT).

5.1	What places offer HIV testing services? Do not prompt 1=Mentioned 2=Not mentioned; 8=NA		VCT
5.1.1	<i>Workplace clinic</i>	__	VCT1
5.1.2	Clinic	__	VCT2
5.1.3	Hospital	__	VCT3
5.1.4	NGO /CBO	__	VCT4
5.1.5	Private Doctor	__	VCT5
5.1.6	Don't know	__	VCT6
5.1.7	Other (specify)_____	__	VCT7
5.2	<i>Where would you prefer to be tested for HIV? 1=I don't like to be tested; 2=Workplace; 3=In my community; 4=In another community; 5=Private Doctor; 6=I have no preference; 9=Don't know; 10=Other</i>	__	Place

	<i>(specify)</i> _____		
5.2.1	What places offer counselling for HIV and AIDS? Do not prompt 1=Mentioned 2=Not mentioned; 8=NA		
5.2.2	<i>Workplace</i>	__	Place1
5.2.3	Clinic	__	Place2
5.2.4	Hospital	__	Place3
5.2.5	Community organization	__	Place4
5.2.6	<i>Private Doctors</i>	__	Place5
5.2.7	<i>Don't know</i>	__	Place6
5.2.8	<i>Other (specify)</i> _____	__	Place7
5.3	Where would you prefer to be counselled? 1= I don't want to be counseled; 2= Workplace; 3=In my community; 4=In another community; 5=Private Doctor; 6=I have no preference; 9=Don't know; 10=Other (specify) _____	__	Counsel
5.4	Where does one find individuals or groups offering education on HIV and AIDS prevention and care? 1=Mentioned 2=Not mentioned; 8=NA		HIVEd
5.4.1	<i>Workplace</i>	__	HIVEd1
5.4.2	Clinic	__	HIVEd2
5.4.3	Hospital	__	HIVEd3
5.4.4	NGO/CBO	__	HIVEd4
5.4.5	Community	__	HIVEd5
5.4.6	Don't know	__	HIVEd6
5.4.7	Other (specify)_____	__	HIVEd7
5.5	<i>Where would you prefer to participate in educational sessions? 1=I don't want to participate; 2=Workplace; 3=In my community; 4=In another community; 5=Private Doctor;6=I have no preference; 9=Don't know; 10=Other (specify)</i> _____	__	PartEd
5.6	Where does one find any support groups for people who have AIDS or their families? 1=Mentioned 2=Not mentioned; 8=NA	__	Grps
5.6.1	<i>Workplace</i>	__	Grps1
5.6.2	Clinic	__	Grps2
5.6.3	Hospital	__	Grps3

5.6.4	NGO/CBO	__	Grps4
5.6.5	Church	__	Grps5
5.6.6	Community	__	Grps6
5.6.7	Don't know	__	Grps7
5.6.8	Other (specify)_____	__	Grps8
5.7	Where would you prefer to participate in a support group activity? 1=I don't want to participate; 2=Workplace;3=In my community; 4=In another community; 5=I have no preference; 9=Don't know; 10=Other (specify)_____	__	Grpactv
5.7.1	Would you prefer services such as education, testing and counselling or support groups in the workplace or community? 1= Workplace; 2=Community; 3=Both; 4=Neither; 9=Don't Know.	__	Service
5.7.2	What are the reasons for your preference? 1=Mentioned 2=Not mentioned; 8=NA Do not prompt:	__	Reas1
5.7.3	<i>Proximity</i>	__	Reas2
5.7.4	<i>Easily accessible</i>	__	Reas3
5.7.5	<i>Provide good health services</i>	__	Reas4
5.7.6	<i>Organise support groups</i>	__	Reas5
5.7.7	<i>Confidentiality</i>	__	Reas6
5.7.8	Other (specify)_____	__	Reas7
5.8	Have you ever used any of the following services or attended any of these activities for HIV and AIDS? READ LIST AND INDICATE 1=YES; 2=NO;		HIVact
5.8.1	<i>Educational sessions</i>	__	HIVact1
5.8.2	<i>Counseling</i>	__	HIVact2
5.8.3	<i>HIV Testing</i>	__	HIVact3
5.8.4	<i>HIV and AIDS support group</i>	__	HIVact4
5.8.5	<i>None of the above</i>	__	HIVact5
5.9	I do not want to know the results of your test. I would like to ask whether you told anyone else your results and if so whom? 1=Told no-one; 2=Told wife/partner; 3=Told girlfriend/boyfriend; 4=Told family member; 5=Told friend; 6=Other (specify)_____	__	Testres

5.10.	<i>Has taking part in any of these services influenced your sexual behaviour in any way and if so how? Do not prompt; 1=Mentioned 2=Not mentioned; 8=NA</i>	__	Infbeh
5.10.1	No	__	Infbeh1
5.10.2	Abstained from sex	__	Infbeh2
5.10.3	Used condoms	__	Infbeh3
5.10.4	Reduced number of partners	__	Infbeh4
5.10.5	Discussed HIV with partner	__	Infbeh5
5.10.6	Have only one partner	__	Infbeh6
5.10.7	Don't know	__	Infbeh7
5.10.8	Refuse to answer	__	Infbeh8
5.10.9	Other (specify)_____	__	Infbeh9
5.11	Would you like to be tested for HIV and AIDS in the future? 1=Yes; 2=No; 9=NK	__	Testfut
5.12	Why would you want to be tested? 1=I think I may be positive;2=It is important to know your status; 3=To get advice on how to stay healthy; 4=To get information on nutrition; 5=So I do not spread it; 6=To plan for the future 7=Other (specify)_____	__	Testre1
5.13	Why would you not want to be tested? 1=There is no need to know; 2=There is nothing to be done; 3=The stress would kill me; 4=I would kill myself 5=Other (specify)_____	__	Testre2

Section F: 6. Stigma and Disclosure			
6.0	Do you know of anyone who has had a blood test for HIV and AIDS and is POSITIVE ?	__	HIVpost
	1=Yes; 2=No; 9=NK		
6.1	Do you think that it is advisable for people to tell others their HIV and AIDS status?	__	HIVtell
	1=Yes; 2=No; 9=NK		
6.2	Who would be the most appropriate person/people to be informed of someone's HIV and AIDS status? 1= Spouse / permanent partner; 2=Girlfriend/Boyfriend; 3=Parents; 4=Close Friend; 5=Colleague; 6=Neighbour;7=Social worker; 8=Counsellor; 10=Other (specify) _____	__	Tellpers

6.3	If a member of your family got infected with HIV and AIDS, would you want it to remain a secret? 1=Yes; 2=No; 9=NK	__	HIVfami
6.4	Who would you tell first if you were infected with HIV? 1=Girlfriend/Boyfriend; 2=Spouse; 3=Colleague; 4=Social worker; 5=Counsellor; 6=Friend; 7=No-one; 8=Other(specify)_____	__	Firsttell
6.5	How would you go about telling this person about your HIV status? 1=Take him/her to a VCT; 2=Take him/her to a support group; 3=Show him/her your results; 4=Encourage that both of you tested; 9=Don't know 5=Other (specify)_____	__	Howtell
6.6	<i>Would you feel comfortable to shake hands with a colleague /person whom you know has HIV and AIDS? 1=Yes; 2=No; 3=Somewhat</i>	__	Stigma
6.7	Would you feel comfortable eating from the same plate with a colleague /person whom you know has HIV and AIDS? 1=Yes; 2=No; 3=Somewhat	__	Stigma1
6.8	Would you feel comfortable to share work tools with a colleague /person whom you know has HIV and AIDS? 1=Yes; 2=No; 3=Somewhat	__	Stigma2
6.9	Would you feel comfortable to share the same toilet with a colleague /person whom you know has HIV and AIDS? 1=Yes; 2=No; 3=Somewhat	__	Stigma3
6.10	Would you feel comfortable to travel in the same vehicle with a colleague /person whom you know has HIV and AIDS? 1=Yes; 2=No; 3=Somewhat	__	Stigma4
6.11	Do you agree or disagree that colleagues/people with HIV and AIDS should be separated from others? 1=Agree; 2=Disagree; 9=Don't know	__	Stigma5
6.12	Do you agree, or disagree, that people who have HIV and AIDS do not deserve compassion or support? 1=Agree; 2=Disagree; 9=Don't know	__	Stigma6
6.13	What kinds of bad treatment do People Living with HIV and AIDS (PLHA) and/or their families face? Do not prompt; 1=Mentioned 2=Not mentioned; 8=NA		
6.13.1	Isolation	__	Stigma7
6.13.2	Verbal abuse	__	Stigma8
6.13.3	Physical abuse/violence	__	Stigma9
6.13.4	Rumours/gossips	__	Stigma10
6.13.5	Rejection	__	Stigma11
6.13.6	Ejection from home	__	Stigma12

6.13.7	Rejection by community	__	Stigma13
6.13.8	Rejection by insurance	__	Stigma14
6.13.9	None	__	Stigma15
6.13.10	Other (specify) _____	__	Stigma16
6.14	Who treats them badly? Do not prompt; 1=Mentioned 2=Not mentioned; 8=NA		
6.14.1	Family members	__	Stigma17
6.14.2	Neighbours	__	Stigma18
6.14.3	Community members	__	Stigma19
6.14.4	Health workers	__	Stigma20
6.14.5	Young people	__	Stigma21
6.14.6	Everyone	__	Stigma22
6.14.7	<i>Religious groups</i>	__	Stigma23
6.14.8	<i>Colleagues</i>	__	Stigma24
6.14.9	Other (specify) _____	__	Stigma25
6.15	Are families who have lost members to AIDS treated worse, the same, or better than those who have lost a member to other causes? 1=Treated worse; 2=Treated same; 3=Treated better; 9=Don't know	__	Stigma26
6.16	Do you think People Living With HIV and AIDS should get the same, more or less health care than someone with another chronic disease/illness? 1=Same; 2=More; 3=Less; 9=Don't know.	__	Stigma27
6.17	If a colleague is found to be infected with HIV and AIDS should he or she continue working? 1=Yes; 2=No; 9=Don't know.	__	Stigma28
6.18	Is a woman infected with HIV treated better, same, or worse than an infected man? 1=Women treated better; 2=Women treated same; 3=Women treated worse; 9=Don't know.	__	Stigma29

Section G: 7. Care and Support			
7.0	Have you provided care or support to a family member, friend or neighbour with HIV and AIDS? 1=Yes; 2=No; 9=NK	__	Care
7.1	In what ways did you provide care? ? Do not prompt; 1=Mentioned 2=Not mentioned; 8=NA	__	Care1
7.1.1	Visiting the person infected	__	Care2

7.1.2	Provide food	__	Care3
7.1.3	Talk to the person	__	Care4
7.1.4	Clean the person's house	__	Care5
7.1.5	<i>Help the person to wash</i>	__	Care6
7.1.6	Link person to clinics	__	Care7
7.1.7	Encourage disclosure	__	Care8
7.1.8	Other (specify) _____	__	Care9
7.2	What fears/worries do you have about providing care or support to a person who has HIV and AIDS?		
7.2.1	None	__	Fear
7.2.2	Fear of being infected	__	Fear1
7.2.3	Rejection by people	__	Fear2
7.2.4	Fear of being labelled	__	Fear3
7.2.5	Lack of care skills	__	Fear4
7.2.6	Other (specify) _____	__	Fear5
7.3	Do you encourage others to provide care and support for PLHA? 1=Yes; 2=No; 9=NK	__	CareEnco
7.4	Do you think that PLHA have access to adequate care and support services? 1=Yes; 2=No; 9=NK	__	CareAcce
7.5	What types of people should provide care and support to people living with HIV and AIDS? Do not prompt; 1=Mentioned 2=Not mentioned; 8=NA		
7.5.1	Family members	__	TypePe
7.5.2	Neighbours	__	TypePe1
7.5.3	Church members	__	TypePe2
7.5.4	In-patients in clinic/hospital	__	TypePe3
7.5.5	Peers	__	TypePe4
7.5.6	Other (specify) _____	__	TypePe5
7.6	In what places do people living with HIV and AIDS get the best care/support? Do not prompt; 1=Mentioned 2=Not mentioned; 8=NA	__	BestCar
7.6.1	Home	__	BestCar1
7.6.2	Clinic/hospital	__	BestCar2
7.6.3	Community	__	BestCar3

7.6.4	Traditional healer's house	__	BestCar4
7.6.5	School environment	__	BestCar5
7.6.6	Other (specify) _____	__	BestCar6

Section H: 8. Socio-Cultural Practices			
8.0	Have you ever taken alcohol? 1=Yes; 2=No;	__	AlcoEver
8.1	If Yes, How many episodes of alcohol taken in the past 4 weeks? 1=Not taken; 2=Daily; 3=Weekly; 3=Less than a week; 4=Once to twice	__	AlcoPast
8.2	Have you ever taken drugs? 1=Yes; 2=No;	__	DrugEver
8.3	If Yes, How many episodes of drugs taken in the past 4 weeks? 1=Not taken; 2=Daily; 3=Weekly; 3=Less than a week; 4=Once to twice	__	DrugPast
8.4	Men only: Are you circumcised? 1=Yes; 2=No; 9=Don't know	__	Circum

Section I: 9. Gender and Associated Violence			
9.1	How is your relationship with your partner? Do not prompt; 1=Mentioned 2=Not mentioned; 8=NA	__	Relat
9.1.1	Friendly/happy	__	Relat1
9.1.2	Respectful	__	Relat2
9.1.3	Caring	__	Relat3
9.1.4	Unfriendly/unhappy	__	Relat4
9.1.5	Non respectful	__	Relat5
9.1.6	Uncaring	__	Relat6
9.1.7	Abusive	__	Relat7
9.1.8	Other (specify _____)	__	Relat8
9.2	Has your partner ever done any of the following to you in the past one year? READ OUT 1=Yes; 2=No; 9=NK		Everdon
9.2.1	Hit/beat/slap/kicked	__	Everdon1
9.2.2	Forced to have sex	__	Everdon2
9.2.3	Forced into sex without condom	__	Everdon3
9.2.4	Denied food	__	Everdon4
9.2.5	Threatened with a weapon	__	Everdon5
9.2.6	Locked out	__	Everdon6

9.2.7	Swearing/cursing	__	Everdon7
9.2.8	None	__	Everdon8
9.2.9	<i>Refuse to answer</i>	__	Everdon9
9.2.10	<i>Other (specify)</i> _____	__	Everdon10
9.3	Have you done any of the following to your partner in the past one year? READ OUT 1=Yes; 2=No; 9=NK		DoneLast
9.3.1	Hit/beat/slap/kicked	__	DoneLast1
9.3.2	Forced to have sex	__	DoneLast2
9.3.3	Forced into sex without condom	__	DoneLast3
9.3.4	Denied food	__	DoneLast4
9.3.5	Threatened with a weapon	__	DoneLast5
9.3.6	Locked out	__	DoneLast6
9.3.7	Swearing/cursing	__	DoneLast7
9.3.8	None	__	DoneLast8
9.3.9	<i>Refuse to answer</i>	__	DoneLast9
9.3.10	<i>Other (specify)</i> _____	__	DoneLast10
9.4	Do you agree or disagree that a man should have a final say in sexual matters? 1=Agree; 2=Disagree; 9=Don't know	__	Finalsay
9.5	Do you agree or disagree that a woman has the right to refuse sex? 1=Agree; 2=Disagree; 9=Don't know	__	Sexref

9.6	Do you agree or disagree that a partner is justified to use violence against the other partner when s/he refuses to have sex? 1=Agree; 2=Disagree; 9=Don't know	__	SexViolenc
9.7	Under what circumstances is it acceptable for a woman to refuse sex with her partner? Do not prompt; 1=Mentioned 2=Not mentioned; 8=NA		WomanRe
9.7.1	During menstruation	__	WomanRe1
9.7.2	During pregnancy	__	WomanRe2
9.7.3	Partner is unfaithful	__	WomanRe3
9.7.4	Recently given birth	__	WomanRe4
9.7.5	Afraid of being infected with HIV	__	WomanRe5
9.7.6	Tired	__	WomanRe6
9.7.7	Drunk	__	WomanRe7
9.7.8	Don't know	__	WomanRe8
9.7.9	Other (specify)_____	__	WomanRe9
9.8	Under what circumstances is it acceptable for a man to refuse sex with his partner? Do not prompt; 1=Mentioned 2=Not mentioned; 8=NA		ManRef
9.8.1	During menstruation	__	ManRef1
9.8.2	During pregnancy	__	ManRef2
9.8.3	Partner is unfaithful	__	ManRef3
9.8.4	Recently given birth	__	ManRef4
9.8.5	Afraid of being infected with HIV	__	ManRef5

9.8.6	Tired	_	ManRef6
9.8.7	Drunk	_	ManRef7
9.8.8	Don't know	_	ManRef8
9.8.9	Other (specify)_____	_	ManRef9
9.9	Do you agree or disagree that people should be forced into having sex even if they don't want to? 1=Agree; 2=Disagree; 9=Don't know	_	Forcesex
9.10	Are forced to provide sex in exchange for employment: ? 1=Agree; 2=Disagree; 9=Don't know	_	SexEmpl

Annex 3: KEY INFORMANT INTERVIEW SCHEDULE (KIIS)

KEY INFORMANT INTERVIEW SCHEDULE (KIIS)

Introduction:

The Lake Victoria Fisheries Organisation (LVFO) (The East African Community), East African Community Lake Victoria Basin Commission and TANESA as Consultant of EALP in collaboration with the Ministry of Health and Social Welfare (MOH&SW) are carrying out HIV and AIDS baseline studies in fisheries and agricultural plantations in the Lake Victoria basin with the overall objective to establish the HIV prevalence, the associated drivers of risk and vulnerability and the effectiveness of HIV and AIDS responses for agricultural plantation workers and fisher folk in the Lake Victoria Basin.

Specific objectives of the studies include:

- To determine HIV sero-prevalence among populations in fishing communities and agricultural plantation systems in Lake Victoria Basin in Tanzania.
- To establish the demographic and behavioural risks factors, knowledge and attitudes regarding HIV and STI transmission among plantation workers and fishing communities.
- To establish the range, breadth, availability and utilization of HIV and AIDS related services.
- And to determine the existence and effectiveness of policies, programs and coordination structures on HIV and AIDS in plantations and among fishing communities.

Target:

/Plantations

- National Ministries, Departments and Agencies
- Regional/District Agricultural Offices/RACC
- District Executive/Council Directors
- District Planning Offices (DPLO)
- District Medical Officer (DMO)
- Council HIV and AIDS Coordinators (CHAC)
- District HIV and AIDS Coordinator (DACC)
- Human Relation Officers (Kagera Tea & Kagera Sugar)

- Medical Officer I/C (Kagera Tea & Kagera Sugar)
- Ward Executive Officers (WEO)
- Village Executive Officers (VEO)

Thank you for accepting to be interviewed by my team. The interview is going to focus on the following topics:

1. The views you have on how big a problem is HIV and AIDS in plantations and among fishing communities.
2. The range, breadth, availability and utilization of HIV and AIDS related services in AIDS in plantations and among fishing communities.
3. The existence and effectiveness of policies, programs and coordination structures on HIV and AIDS services in AIDS in plantations and among fishing communities.
4. Any suggestions on how services for HIV prevention and care can be improved in your community.

I would now like to go over them one by one.

1. Burden of HIV and AIDS:

- a. In your own assessment, how big a problem is HIV and AIDS in plantations and among fishing communities?
- b. If it is a big problem, what are the factors that promote the spread of HIV infection in the community?

2. HIV and AIDS related services:

- a. Are HIV and AIDS related services available in this community?
- b. If yes, what services are available, can you enumerate them?
- c. Are these services being used?

3. Policies, programs and coordination structures on HIV and AIDS service in plantations:

1.1. Policy Issues:

- a. Are there specific policies for HIV in your organization?
- b. Is HIV testing a requirement before a worker is employed in your organization?
- c. How do you handle a worker who is found to have HIV infection?
- d. Is he/she allowed to continue working?
- e. Does the company pay for treatment of people found to suffer from AIDS?

1.2. Coordination Issue:

- f. What coordination structures for HIV and AIDS services are there?
- g. Are there HIV-related CSOs (NGOs/CBOs/FBOs) in this area?
- h. How do you collaborate with them?

i. Quality of services:

- j. Are you satisfied with what is being done on HIV prevention and care in this area?
- k. What specific activities are being carried out for OVCs and widows?
- l. If not, could you please make suggestions on how services can be improved

Thank you

Annex 4: Guide for Focus Group Discussions

1. Do you think HIV and AIDS is a problem in your community? Explain
 - a. What are the main channels of communication from which you obtain health information in this community?
 - b. What is the preferred source?
2. How do people in your community spend their free time?
3. Mention any risky sexual behaviour in your community and explain the influencing factors?
4. Can we discuss sexual networking in this community?
5. Are there any people involved in exchanging sex for money or sex for fish or sugar in your community? If yes what influences them?
 - a. Do you think there are girls and boys under 18 years in your community who are involved in sexual intercourse? If yes what influences them?
 - b. Do these boys and girls sometimes get multiple partners?
 - c. Do these boys and girls sometimes get partners who are 10 years (or more) older than them?
6. Are condoms available? And used? Discuss
7. Source
8. Prices
9. Promotion and distribution etc.
10. Should children aged 12-14 be taught about HIV and AIDS? Where? By whom?

11. How do you think HIV is transmitted in your community?
12. What are the key routes of HIV transmission?
13. What about in the community?
 - a. Is there a centre in this community where one would go if he/she wanted to test for HIV?
 14. b. (IF THERE IS NO CENTER) Do you think people would be willing to go for HIV testing services if such a centre is opened in this community?
 15. c. Would it be a good idea if a trained counsellor went home to home to offer people with free HIV counselling and doing the HIV testing from people's homes?
16. In your opinion, do you think if someone tested positive for HIV he/she should disclose the result to the following:
 - i. Spouse/partner
 - ii. Family member
 - iii. Community
17. What benefits can such a person expect after disclosure?
18. What problem can s/he face?
19. a. Do you think there is a general change in behaviour of people in your community because of fear of getting HIV and AIDS?
20. b. If yes, what are these changes that you have noticed?
- m. If no why do you think there are no such changes?
21. Do you agree or disagree that people with the AIDS virus should be blamed for bringing the disease into the community.
 - a. Can the virus that causes AIDS be transmitted from a mother to child? If Yes at what stages

b. Have you heard of any special drugs that people infected with the AIDS virus can take to help them live longer? If yes mention such drugs.

22. If a community member was found having AIDS, are there places in this community (or in a distance of 5 kilometres) where he/she can be taken to have care? If yes what are these places?

23. What should the BMU/Village government do to help such people?

24. What should the plantation management do to help people who are HIV +ve?

25. What comments do you have on the availability, adequacy and quality of HIV and AIDS services in this area?

26. Do you have any suggestions on how services for HIV prevention and care can be improved in your community?

Thank you.

Annex 5: Clearance Certificate for Conducting Medical Research in Tanzania



THE UNITED REPUBLIC OF
TANZANIA



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10th December 2009

Prof Gabriel Mwaluko
TANESA Programme
P O Box 434
MWANZA

**CLEARANCE CERTIFICATE FOR CONDUCTING
MEDICAL RESEARCH IN TANZANIA**

This is to certify that the research entitled: Baseline study in fishing communities and agricultural plantation sectors in Lake Victoria Basin - Tanzania, (Mwaluko G *et al*), has been granted ethics clearance to be conducted in Tanzania.

The Principal Investigator of the study must ensure that the following conditions are fulfilled:

1. Progress report is submitted to the Ministry of Health and the National Institute for Medical Research, Regional and District Medical Officers after every six months.
2. Permission to publish the results is obtained from National Institute for Medical Research.
3. Copies of final publications are made available to the Ministry of Health & Social Welfare and the National Institute for Medical Research.
4. Any researcher, who contravenes or fails to comply with these conditions, shall be guilty of an offence and shall be liable on conviction to a fine: NIMR Act No. 23 of 1979, PART III Section 10(2).
5. Approval is for one year: 10th December 2009 to 09th December 2010.

Name: Dr Mwelecele N Malecela

Signature

ACTING CHAIRPERSON
MEDICAL RESEARCH
COORDINATING COMMITTEE

Name: Dr Deo M Mtasiwa

Signature

CHIEF MEDICAL OFFICER
MINISTRY OF HEALTH, SOCIAL
WELFARE

CC: RMO
DMO