The EALP HIV and AIDS Baseline Study in Fishing Communities:

Lake Victoria Basin, Tanzania

A Report:

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CONSULTANTS TEAM:

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<tbody>
<tr>
<td>AAU</td>
<td>Association of African Universities</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immuno-deficiency Syndrome</td>
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<tr>
<td>AMREF</td>
<td>African Medical Research Foundation</td>
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<tr>
<td>ANC</td>
<td>Ante-Natal Clinic</td>
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<tr>
<td>ART</td>
<td>Anti-retroviral Treatment</td>
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<td>ARVs</td>
<td>Anti-retroviral drugs</td>
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<td>AWSE</td>
<td>Association of Women in Science and Engineering</td>
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<td>BMUs</td>
<td>Beach Management Units</td>
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<td>BOTI</td>
<td>Bank of Tanzania Training Institute</td>
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<tr>
<td>CBOs</td>
<td>Community Based Organizations</td>
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<tr>
<td>CHAC</td>
<td>Council HIV and AIDS Co-ordinator</td>
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<td>CHAI</td>
<td>Clinton HIV and AIDS Initiative</td>
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<td>CD</td>
<td>Council Director</td>
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<td>CSOs</td>
<td>Civil Society Organisations</td>
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<td>CSWs</td>
<td>Commercial Sex Workers</td>
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<td>DBS</td>
<td>Dry Blood Spots</td>
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<tr>
<td>DACC</td>
<td>District AIDS Control Co-ordinator</td>
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<tr>
<td>DC</td>
<td>District Commissioner</td>
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<tr>
<td>DMO</td>
<td>District Medical Officer</td>
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<tr>
<td>DPLO</td>
<td>District Planning Officer</td>
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<td>EAC</td>
<td>East Africa Community</td>
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<td>EALP</td>
<td>EAC, AMREF Lake Victoria Project Partners</td>
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<td>EIA</td>
<td>Enzyme Immunosorbent Assay</td>
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<td>FBO</td>
<td>Faith-based Organisation</td>
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<td>FGDs</td>
<td>Focus Group Discussions</td>
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<tr>
<td>HBC</td>
<td>Home Based Care</td>
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<tr>
<td>HCT</td>
<td>HIV Counselling and Testing</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HRH</td>
<td>Human Resources for Health</td>
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<tr>
<td>ID</td>
<td>Identification Numbers</td>
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<tr>
<td>KII</td>
<td>Key Informant Interview</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>LGAs</td>
<td>Local Government Authorities</td>
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<tr>
<td>LVB</td>
<td>Lake Victoria Basin</td>
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<tr>
<td>LVBC</td>
<td>Lake Victoria Basin Commission</td>
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<tr>
<td>LVFO</td>
<td>Lake Victoria Fisheries Organisation</td>
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<tr>
<td>MACs</td>
<td>Multisectoral AIDS Committees</td>
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<td>MARPs</td>
<td>Most At Risk Populations</td>
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<td>MDAs</td>
<td>Ministries, Departments and Agencies</td>
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<tr>
<td>MoHSW</td>
<td>Ministry of Health and Social Welfare</td>
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<td>MoJCA</td>
<td>Ministry of Justice and Constitutional Affairs</td>
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<tr>
<td>MSD</td>
<td>Medical Stores Department</td>
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<tr>
<td>MTEF</td>
<td>Medium Term Expenditure Framework</td>
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<tr>
<td>PMO-RALG</td>
<td>Prime Minister’s Office - Regional Administration and Local Government</td>
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<tr>
<td>NBS</td>
<td>National Bureau of Statistics</td>
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<td>NTT</td>
<td>National Technical Team</td>
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<td>NGOs</td>
<td>Non-Governmental Organisations</td>
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<td>NIMR</td>
<td>National Institute for Medical Research</td>
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<td>OIs</td>
<td>Opportunistic Infections</td>
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<tr>
<td>PICT</td>
<td>Provide - Initiated Counselling and Testing</td>
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<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
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<tr>
<td>PPS</td>
<td>Probability Proportional to Size</td>
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<tr>
<td>QC</td>
<td>Quality Control</td>
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<tr>
<td>RACC</td>
<td>Regional AIDS Control Co-ordinator</td>
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<tr>
<td>RAS</td>
<td>Regional Administrative Secretary</td>
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<tr>
<td>RC</td>
<td>Regional Commissioner</td>
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<tr>
<td>RFO</td>
<td>Regional Fisheries Officer</td>
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<tr>
<td>RMO</td>
<td>Regional Medical Officer</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infections</td>
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<tr>
<td>SSI</td>
<td>Semi-structured Interview</td>
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<tr>
<td>SRS</td>
<td>Simple Random Sampling</td>
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<tr>
<td>SW</td>
<td>Sex Workers</td>
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<tr>
<td>TACAIDS</td>
<td>Tanzania Commission on AIDS</td>
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<tr>
<td>TAFIRI</td>
<td>Tanzania Fisheries Research Institute</td>
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<tr>
<td>TMAP</td>
<td>Tanzania Multi-country AIDS Project</td>
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<td>Acronym</td>
<td>Description</td>
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<tr>
<td>TANESA</td>
<td>Tanzanian Essential Strategies Against AIDS</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on AIDS</td>
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<td>UNDP</td>
<td>United National Development Programme</td>
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<td>UNHCR</td>
<td>United Nations High Commission for Refugees</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
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<tr>
<td>VEO</td>
<td>Village Executive Officer</td>
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<tr>
<td>WEO</td>
<td>Ward Executive Officer</td>
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<td>WPP</td>
<td>Work Place Programme</td>
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Executive Summary

Introduction, objectives and methodology:

The EAC/AMREF Lake Victoria Partnership Programme (EALP) decided to conduct a baseline study in fishing communities in the Lake Victoria basin. The findings of the study were expected to shed light as to what appropriate interventions need to be implemented in these communities. This report covers the baseline study for the Tanzania side of the Lake Victoria basin. In the baseline survey, data collected focused on HIV sero-prevalence, behavioural risks, service availability and utilization. In addition, data was also collected on coordination, institutional policies and structure. The report is divided into 5 chapters and each chapter into subsections. It begins with an introduction explaining the nature of the problem and justification of the study before highlighting the objectives of the study.

The methodology consisted of the use of four techniques. Questionnaires, Focus Group Discussions, Key Informant Interviews and Dry Blood spots. The tools developed were used to collect data from fishing communities in Mara, Mwanza and Kagera regions – the three regions of Tanzania surrounding the Lake including other key stakeholders. Data was collected between July-August 2010.

The sample size was 1120. Of that number only 1064 were interviewed and gave a dry blood spot sample. Thus giving coverage of 95%. There were 769 (72%) men and 295 (28%) women. The median age of the study population among the fishing communities was 33 years while the mean age was 35 years. It ranged between from 16 to 75 years.

The research team was made up of researchers, research assistants and laboratory technicians who were involved in the study. All respondents provided written consent and the protocol had received ethical clearance from the Ethical Review Board of the National Institute for Medical Research/Ministry of Health and Social Welfare.
Main Findings:

The overall HIV sero-prevalence in the study population was higher than that of the general population. The HIV prevalence was 7.4% which was higher than the national prevalence of 5.7%. Women had a higher HIV prevalence at 11.5% compared to 5.8% for men. In this study, the HIV prevalence in women was twice that of men. The peak HIV prevalence was in the 30 – 44 age groups for both sexes. The HIV prevalence was higher in Kagera region for both men and women at 9.7% and 18.6% respectively. The lowest prevalence was in men in Mara region. The Regional HIV prevalence in the fishing communities was lowest in Mara at 6.0%, followed by Mwanza at 7.3% and was highest in Kagera at 12.5%.

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

More than 80% of participants from the fishing communities knew that one of the ways in which HIV can be contracted was through having sexual intercourse. They were also aware of other diseases which can be contracted through sexual intercourse, as well as that a person can look healthy yet can be living with the virus. They also knew that HIV is what comes before AIDS.

However, misconception on HIV transmission also existed. It was found that in fishing communities, about 40% thought that mosquito bites could transmit HIV; casual contact with an infected person could transmit HIV infection; having sex with a virgin could protect one from acquiring HIV. Any interventions which will be developed targeting these populations must take into consideration these misconceptions. When probed on whether there has been behaviour change, fishing communities reported similar results between the sexes. They had reported changed behaviour mainly in terms of either having only one partner, or reduced numbers of sexual partners, or started using condoms. It will be difficult to explain change in behaviour and associate it with prevalence since the change might have started to occur but prevalence can still remain high.

On HIV status disclosure – fishing community respondents reported that they would disclose their HIV sero-status to mainly spouse or permanent partner (60%) followed by girlfriend/boyfriend (20%). Respondents were willing to shake hands, eat from same plate, share work tools, share same toilet or to 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 deserve compassion.
Collaborative evidences 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. These findings suggest that the knowledge of respondents on HIV and AIDS has minimised the magnitude of stigma. 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 survey had experienced being sworn at and/or being cursed.

As to when can a woman refuse to have sex even if the one asking is the spouse, it was reported that menstruation (70%), pregnancy (30%) and partner fatigue (50%) were reasons for refusal of sex. It can therefore be seen that this community would only accept sexual refusal from partner during menstruation and any other reasons would not be accepted and could likely result into forced sex. HIV and AIDS

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 is available and then assess its utilisation. Such services were: condom availability, HIV counselling and testing services, and provision of HIV and AIDS health education. In terms of condom availability, more than two thirds of respondents in the fishing communities stated that they obtained condoms from clinics/hospitals, pharmacy, shops/kiosks. Although condom utilisation alone is not an adequate measure for HIV control, yet estimation of condom utilisation is a challenge. Despite the availability of this service, utilisation of condoms appeared most likely to be inadequate as shown by the HIV prevalence in the study populations.

Clinics/hospitals were by far the major providers of HIV testing services. However, in the fishing communities, private doctors were offering 35% of HIV testing. Private service providers for HIV appear to be more common in fishing communities. One likely explanation is the easy availability of money to pay for services in the fishing communities. Therefore for any intervention targeting this population, private service providers should be addressed.
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. Therefore HIV testing services should focus more at respondents’ communities than other areas.

**Determination of the existence and effectiveness of policies, programs and coordination structures on HIV and AIDS in fishing communities.**

**HIV and AIDS policies:**

**EAC level:**

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

**National level:**

Effectiveness of policies of member states was looked at in terms of the Tanzania HIV and AIDS Policy of 2001. It is in the process of being reviewed. While that policy has targeted MARPS, yet the private sector, which is a key stakeholder through its ability to provide HIV testing and other HIV and AIDS related services, it cannot enforce the HIV and AIDS law which was legislated through the policy. They have no legal power. Therein lays the challenge that such players need to be empowered to have legal ability to enforce the law. It was found out that with regard to PLHIV, only the public sector has done some work because it was expensive for the private sector to implement HIV and AIDS activities. As to how effective has the policy been, the respondents noted the dichotomy between policy, programmes and practice. The very nature of the basic approach which has been –prevention, care and treatment as well as impact mitigation, the actual practice has placed more emphasis on care and treatment since the intervention is finance-intensive.
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.

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 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 very inadequate. The ‘fisherman has been marginalised’ is a quote that was repeated over and over again among the key informants.

Community level:

As found out from the quantitative data, 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.
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 was 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. 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 is concerned. 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 two study populations, 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 fishing communities have been marginalised.

Conclusions and recommendations:

On HIV prevalence:

The major finding in the study was that fishing communities had higher HIV prevalence than the general Tanzania population. Also it was found that women had higher HIV prevalence than the men in fishing communities. In addition, the most affected age group was that of 30-44 year olds.

Recommendation:

It is recommended that EAC should develop harmonised interventions targeting the fishing community specifically and the sub-groups within the community i.e. women and the 30-44 age group in order to control the nodes of infection within the community and the general population at large since these populations are highly mobile.

On 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 HIV prevalence as in the general population.

Recommendation:

Potential Programme implementers (e.g. partner states) should put more emphasis on HIV and AIDS education on prevention, care, treatment and support as well as education campaigns. These should be intensified in order to minimise stigma and 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.
On Behavioural change:

The study has found that HIV education has been provided by both public sector and civil society organisations to the fishing communities. There was no evidence as to the package of that education in terms of content, context, number of times delivered and target audience. In addition, it could not determine whether there were indicators to measure effectiveness of the intervention.

Recommendation:

Sectors and organisations with comparative advantages in the partner states should design HIV and AIDS intervention package in such a way it takes into consideration the issues of content, time and development of indicators in order to monitor and observe the desired impact. Such an intervention package must have a time-line.

On 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.

Recommendation:

HIV testing, while it should follow Tanzania Government guidelines, programme implementers should focus intensely on partner testing (spouse/permanent partner and/or girlfriend, boyfriend).

On Condom attitude and utilisation:

It was reported that there was negative attitude on condoms i.e. their use lead to reduction of sexual pleasure. Secondly the misconception that condom use was due to lack of trust of sexual partner.

Recommendation:

Programme implementers such as CSOs should intensify education to correct the misconception that condom use leads to reduction of sexual pleasure and/or mistrust of sexual partner. In addition the education should target on getting people to use condoms correctly and consistently.
On Inclusion of other key stakeholders in the provision of HIV and AIDS services:

In the study, it was reported 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 fishing communities.

Recommendation:

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

On Site(s) for implementation of community interventions:

Many respondents on being probed as to which sites they would prefer to obtain HIV and AIDS services from, the issue of ‘own community’ came out strongly. Similar proportions of respondents had no preference.

Recommendation:

It is recommended that interventions should be implemented at the BMUs level and the surrounding fishing communities.

On HIV and AIDS Support groups’ activities:

HIV and AIDS support group activities were found to be inadequate in the fishing communities.

Recommendation:

It is recommended that the EAC partner states and programme implementers should intensify efforts in designing, funding and supporting HIV and AIDS support groups’ activities because they have the potential of having a higher coverage of target beneficiaries.
On Gender Based Violence:

The magnitude of gender-based violence was reported to be low. The violence experienced ranged from physical to verbal abuse.

Recommendation:

The EAC partner states and programme implementers should develop HIV and AIDS interventions that addresses gender based violence in the study population.

On HIV and AIDS Policies of partner states:

It was reported that the five EAC partner states do have an HIV and AIDS policies and strategies. However it was reported that there was no linkage even in very clear areas such as MARPs. While the EAC was meant to be one single entity, when it comes to negotiations with donors, the lack of an HIV and AIDS policy becomes a limiting factor during negotiations with other stakeholders.

Recommendation:

It is recommended that the EAC partner states HIV and AIDS policies and strategies be harmonised to allow for joint development of a common HIV and AIDS policy.

On HIV and AIDS programmes

It was reported that there was a dislocation between what the policy states and what is happening which was 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 EAC partner states 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.
National policies and programmes touching the ‘ground floor’

There are national and sectoral policies and programmes which exist on paper and have not been made user friendly to the target beneficiaries’ e.g. Tamko la Sera ya Taifa ya Wavuvi na Mikakati yake, December 1997, Ministry of Natural Resources and Tourism, United Republic of Tanzania.

Recommendation:

The Ministry of Livestock and Fisheries should review the past policy and if need be develop user friendly and culturally acceptable and simplified versions of relevant policies and programme documents and actively disseminate and not only distribute them.

Targeted campaigns:

Fishing communities felt ‘marginalised’ and out of the development mainstream of the general population. Specific campaigns for HIV rarely reach them. It was therefore felt that they should be considered.

Recommended:

The programme implementers should develop a special HIV testing campaigns and documentation for fishing communities.
Chapter 1

1.0: Introduction

1.1: Background

The HIV pandemic is the major public health challenge of the present decade. In Africa, especially in sub-Saharan Africa (WHO & UNAIDS, 2009), HIV infection has mostly affected young adults in the prime of life and has spread predominantly by heterosexual transmission (Piot P, et al 1990).

The number of people living with HIV infection was 33 million worldwide, in the year 2007. Deaths of two million people were attributed to AIDS in the same year (WHO & UNAIDS, 2009).

In sub-Saharan Africa, HIV infection prevalence is already high in the general population. However, there certain categories of individuals who are worst hit by the HIV pandemic and little or nothing is done to safeguard them. Such categories include mobile people for example; truck drivers, plantation workers, miners, refugees, fishing communities etc.

Fishing communities many times have been termed as ‘Most At Risk Populations (MARPs).

Fishing communities have been identified as among the highest-risk groups for HIV infection in countries with high overall rates of HIV and AIDS prevalence. Vulnerability to HIV and AIDS arises as a result of the fishers and fish traders travelling away from home (Sopheab, H, et al 2006), their access to cash income, their demographic profile, the ready availability of commercial sex in landing sites and the sub-cultures of risk taking and hyper-masculinity in fishermen (Seeley & Allison, 2005).

In Cambodian fishermen have been described as being a highly mobile population and regularly visit sex workers (SW) in port cities. The prevalence of HIV infection among fishermen was reported to be 16% (Po et al, 2002).

As fishermen become more integrated into the global economy and labour market, the probability increases that mobile fisher-folk become a “bridge” population, linking areas of high and low HIV prevalence (Allison and Seeley, 2004).
In Walvis Bay, Namibia, for example, visiting Asian and European fishermen, most of whom have received little advice on sexual health risks, frequently establish relationships with Namibian sex workers, or become involved in other forms of “transactional sex” (Keulder, 2006).

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 throughout the Basin, and in most parts of the Basin, health systems are either unavailable or have largely failed to meet the demand for HIV and AIDS services (EAC, 2009; TANESA, 2007). There is relative lack of knowledge on HIV and AIDS in fishing communities (Sheikh, NS et al, 2003). However, this is an area where some researchers think that the use of peer educators would work best (Balyagati, D, et al 1995).

The vulnerability of fishing communities to HIV and AIDS has been widely overlooked by health organisations. Consequently, they have not received the prevention, care and treatment programmes that have been available to the rest of the population. This is having devastating impacts on these communities (FAO, 2005).

The use of condoms in fishing communities is very poor (Setiawan, IM and Pattern, JH, 2010). In addition, fishermen have no or limited access to health services, which means they have been largely excluded from HIV and AIDS intervention programmes and research. As a result, these communities suffer from high rates of HIV infection, putting the local fisheries industry and the surrounding communities under serious threat (EDCTP, 2009).

People in the fishing communities are difficult to reach with anti-retroviral therapy (ART) and even continued prevention efforts. It is therefore fair to conclude from the available evidence that fisher folk will be among those untouched by planned initiatives to increase access ART in the coming years (Seeley & Allison 2005).

The fisheries sector is an important contributor to development and to national economies. Fisheries have links with services and other industries and make a substantial contribution to gross domestic productivity (GDP), employment, nutrition and revenue generation (FAO, 2006).
The profitability of the fishery business notwithstanding, poverty remains at a high 60% with HIV and AIDS ravaging the fishing communities despite recent national gains in controlling the scourge. Fishing districts report HIV infection rates being five times higher than that of inland districts. For example while the national HIV prevalence for 2006 in Kenya stood at 5.8%; Suba fishing district was at 21% with a life expectancy of 37 years. National life expectancy rates for the same period stood at 43 years for men and 44 years for women. Lakeshore districts in Uganda and Tanzania reported similarly ominous scenario (ELCI, 2009).

The fishing communities along the Lake Victoria’s shores have remained the poorest throughout the Region with particularly high HIV infection rates than the rest of the population.

Women engage in trade of “sex for fish” while the fishermen usually use their money to lure young women especially school girls and women in lakeside communities (Mojola, 2011). It has also been established that women trade “sex for fish” purely on economic purposes because of poverty (Merten, S and Haller, 2007). Women are forced to exploit peripheral economies, such as the small-scale fish trade, where they must compete against (men) buyers and the fish factories. Women often use sex as a means of developing relationships between fishermen, and by so doing thus securing a steady supply of fish (Bene and Merten, 2008). While women devote all or most of their income to their children, men have different spending priorities, such as investing in their fishing capacity, drinking and prostitution (Appleton, J., 2000). Fishermen are a high-risk group for HIV and STIs thus making them suitable for HIV prevention trials (Zachary A. et al, 2010).

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

Sentinel HIV sero-surveillances have been the major technique of collecting data on HIV situation in the country which can be used to inform policy. Few epidemiological cohort studies in the country have provided data on the HIV incidence 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. Policies need to be developed to enhance the resilience of fishing communities to deal with the threat of HIV and AIDS (New Agriculturist, November 2005).

Based on the above knowledge, the EAC/AMREF Lake Victoria Partnership Programme (EALP) decided to conduct baseline studies in fishing communities 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 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 team of researchers. That team therefore, developed the research protocols for HIV sero-prevalence in the fishing communities as well as the co-ordination elements 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. The report covers the baseline study for the Tanzania side of the Lake Victoria basin within the fishing communities.

In the baseline survey, the data collected focussed on HIV sero-prevalence, behavioural risks, service availability and utilization. The research team also collected data on coordination, institutional policies and structure.

1.2: HIV sero-prevalence:

However, 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, blood donors and others, there is inadequate information on the magnitude of HIV prevalence among groups such as the fishing communities. The study determined HIV sero-prevalence among fishing communities (all cadres) and the surrounding communities around the landing sites in the basin of Lake Victoria, Tanzania.

1.3: Behavioural Risks:

In the current study the research team explored risk behaviour that fuel HIV sero-prevalence in the fishing communities in the Lake Victoria basin, in Tanzania.
From the 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, long distance truck drivers, just to mention a few, are at an increased risk of HIV infections. By the nature of such working conditions, fishermen are known to exhibit short and long term migratory movements in search of lucrative fish catches. Specific contexts or the environments within which risk sexual practices takes place among fishermen has so far not been well explored nor documented. There are only anecdotal 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 fishing communities in the Lake Victoria basin in Tanzania. The research team 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 (STDs).

1.4: Service availability and utilization:

Voluntary HIV testing and counselling (VCT) has been one of the cornerstones 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 fishing islands in Lake Victoria is not well known at best and mostly very inadequate. The availability and utilization of HIV preventive, care, treatment and support including impact mitigation and coping services were thus explored during the survey.

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 ART, 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 HIV (PLHIV), widow(er) and orphans and the concurrent 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/structures. Little is known with regard to the availability and functioning of such systems in fishing communities. This area was explored in the survey.
The study strove to explore both modern and traditional services and support mechanisms available in the fishing 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 also 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 advocacy, planning, implementation, management and coordination of activities). For example, experiences from some of the neighbouring countries have shown that strong political commitment is necessary in spearheading the fight against HIV and AIDS. 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 fishing communities.

The research team 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 the mobile fishermen?

1.6 **Organisation of the report:**

This report is divided into six 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 gives the organisation of the report and ends with the objectives of the study.

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 collection, 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 above. The discussion is based on the findings of each specific objective. In chapter 5 recommendations are given as well as specific sectoral recommendations. Finally, the report has annexes of references and data collection tools.

1.7: **Broad objective:**

The purpose of the baseline survey was to establish the HIV sero-prevalence, the associated drivers of risk and vulnerability and the effectiveness of HIV and AIDS responses for fishing communities in the Lake Victoria Basin in Tanzania.

1.7.1: **Specific objectives of the study:**

2. To establish the demographic and behavioural risk factors, knowledge and attitudes regarding HIV and STIs transmission among fishing communities.
3. To establish the range, breadth, availability and utilization of HIV and AIDS related services.
4. To determine the existence and effectiveness of policies, programmes and coordination structures on HIV among fishing communities.
Chapter 2

2.0: Methodology

2.1: Study sites:

The survey was conducted in sampled sites of the three regions of Tanzania bordering the Lake Victoria basin. Study sites were identified based on availability of fishing communities. The Research Team conducted surveys in three Regions namely, Mwanza, Kagera and Mara. In each region, districts bordering the Lake were selected Sengerema, Ilemela, Magu, Ukerewe, Geita and Missungwi districts were selected for Mwanza region. In Kagera Region, Muleba, Bukoba Rural and Chato Districts were surveyed while in Mara Region, Bunda, Rorya, and Musoma Rural Districts were selected.

2.2: Study design:

This was a baseline cross-sectional study on prevalence of HIV infection, demographic and behavioural risk factors, knowledge and attitudes regarding HIV and STIs transmission in fishing communities, 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 among fishing communities. The study used both qualitative and quantitative data collection techniques and tools including face to face questionnaires, secondary sources, focus group discussions guides, semi-structured interview schedules and observations.

2.3: Sampling procedure and sample size determination:

2.3.1: Sampling Framework:

Beach Management Units (BMUs) were used as clusters (the smallest sampling unit). They were categorised into large, medium and small based on the numbers of fishing boats anchored on the beach. In each cluster the following cadres were included: boat crew, boat owners, managers/ supervisors, chatterers, fish processors, fish mongers, local fish gear makers and repairs and fish dealers.
Apart from those directly involved in the fish industry, other service providers e.g. food vendors, bar owners, bar maids and hotel owners were also included in the study. List of all eligible candidates were obtained from BMU authority. PPS was applied in all cluster selected and SRS was used in each selected cluster and all cadres from each selected cluster was included.

2.3.2: Sample size determination:

Sample size was determined by using the formula below:-

\[ N = \text{DEFF} \times \frac{Z^2_{1-\alpha/2} \times p(1-p)}{d^2} \]

where:
N is minimum sample size required for our study
DEFF is design effect=2
\( Z^2_{1-\alpha/2} \) 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 20% prevalence (TANESA/UNDP study, 2005)

Therefore our sample size was 683 people
Assuming that 30% was for non-responders for any reason then sample size required was 888.
Assuming 10% of questionnaires were incomplete then sample size required was 1066

Number of participants interviewed per cluster depended on the number of clusters selected as shown in Table 1:-

Table 1: Number of clusters and number of participants per cluster:

<table>
<thead>
<tr>
<th>No of clusters</th>
<th>No. of participant per cluster</th>
</tr>
</thead>
<tbody>
<tr>
<td>40</td>
<td>27</td>
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<tr>
<td>50</td>
<td>21</td>
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<tr>
<td>60</td>
<td>18</td>
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<td>70</td>
<td>16</td>
</tr>
<tr>
<td>80</td>
<td>13</td>
</tr>
</tbody>
</table>
Since there were 584 landing sites in total, the research team would have required to visit 70 and interviewed 16 participants from each cluster giving a total of 1,120 participants.

2.4: **Sampling procedure:**

Fishing communities’ landing sites (BMUs) were considered as the clusters. Beach Management Units (BMUs) provided the number of people who have been registered in their registry books, with help of TAFIRI-Mwanza. BMUs were updated through their registry books which included all people aged 10 years (for observation only use 10-14 years) and above who were involved in daily fishing activities and/or living within fishing landing sites. The co-operation of the village government where the BMUs were located was available. That approach supported the sampling of the non-core fishing communities e.g. shop keepers, bar workers, hotel owners’ etc. The study covered the age groups 15 years and above.

Probability proportion to size in all landing sites was applied to obtain clusters (small, medium and large landing sites) and samples for the study. Clusters were determined based on the number of fishing boats which dock at the landing site. With the help of the National Technical Team (NTT), it was discussed and agreed that the study unit was all those living within the BMU/village surrounding the fishing industry.

From each selected cluster (landing site) it was possible to categorized cadres to represent the following: Boat crew, boat owners, Managers/Supervisors, boat charterers, fish processors, fishmongers, local gear makers (repairers), fish dealers, fishing gear shop owners, fish transporters, traders (shopkeepers, bar owners, food vendors and children). Simple random selection was applied to these entire cadres to recruit participants who were the study clients.

2.5: **Inclusion and exclusion criteria**

2.5.1: **Inclusion criteria:**

- All persons aged 15 years and above living or working in the landing sites. Those aged 10-14 years who were found around the landing sites were observed but not included in the study respondents.
2.5.2: Exclusion criteria

- Those who refused to give consent

2.6: Mobilisation:

Social mobilization was continuous throughout the study. The channels of communications during the implementation and social mobilization were from EAC organs to the National and sub-national levels in Tanzania. They are presented separately.

2.6.1: EAC Level:

Meetings were held where the protocol for the research was presented and commented upon. In addition the data collection tools were presented and commented upon. Those comments were used to improve the quality of the tools. Furthermore during the pre-test, this was carried out at the BMU at Nyakasenge in Nyanguge ward of Magu district. The choice was such that the site was not one of the sampled study areas. A special flier had been developed and commented upon by this level. It was both in English and then translated into Swahili for use at the national and sub-national level.

2.6.2: National level:

There were several Ministries, Departments and Agencies of the Tanzania Government who were involved in the mobilisation. These were Permanent Secretaries, relevant Directors; Chief Executive officers of Agencies and the National Officers as part of National Technical Team (NTT) (Fisheries, Health, National AIDS Commissions, Research Institution, National laboratories, Education. Mobilisation involved presentation of the research protocol to the NTT during a meeting held at La Kairo Hotel in Mwanza, comments on the data collection tools and exchange of documentation. A special flier had been developed, commented upon and improved at this level. It was both in English and then translated into Swahili for use at the national and sub-national level. In summary At National level visits and meetings with respective officers were part of sensitization and mobilization approach. Correspondences, exchange of documents and letters of commitment did form part of communication.
2.6.3: Tanzania - Regional level:

There were several people involved in the mobilisation effort. These were Regional Commissioners (RC) and Regional Administrative Secretaries (RAS) in the three regions bordering the lake in Tanzania i.e. Mara, Mwanza and Kagera, TACAIDS Regional HIV and AIDS Focal Point; Regional Medical offices (RMOs), Regional Fisheries Officers (RFOs), Regional AIDS Control Co-ordinators (RACCs). A special flier had been developed and commented upon by this level. It was both in English and then translated into Swahili for use at the national and sub - national level. The flier identified the objectives of the survey and the potential benefits of the study. In summary and with the help of National EALP focal supervisors the research team was able to visit and conduct meetings with Regional stakeholders. Highlights of the objectives and approaches of the study were the main focus of these visits.

2.6.4: Tanzania - District level:

At this level, the following key people were involved in the mobilisation. These were: Council Directors (CD), District Medical Officer (DMO), Council HIV and AIDS Control Co-ordinator (CHAC); District AIDS Control Co-ordinator (DACC), and Fishing Departments; Beach Management Unit (BMU) level: Village government where the BMU were located and the BMU leadership and members. The BMUs had been categorized into Core BMU (e.g. BMU Manager, boat owners, fish traders, chatterers, fish processors, fish gear traders; crews (wajeshi), transporters) members and Non-Core BMU (e.g. food vendors, bar owners, bar maids, hotel owners, village leadership) members. Presence and activities of children under 15 years of age were observed. Each cluster was represented in the sampling frame. Visits and meetings were carried out with the respective officers at the Districts and similarly they were given highlights of the objectives and approaches of the study.

2.6.5: Beach Management Unit (BMU) level:

The research team did conduct meetings with BMU committees assisted by sub-Village leaders, Village leaders, fisheries and public health officers. Efforts were made and where possible, meetings were conducted with the study population. During such meetings, participants were informed of the purpose, procedures and benefits of the proposed study. Dates, times and name of central meeting places during the survey were given to them.
Questions and concerns that were raised were answered to their satisfaction. In addition, the study population was given information sheets containing all the details on the proposed study.

2.6.6: Community mobilization:

Sub-village leaders or Beach Management Unit (BMU) leaders of the selected landing sites were informed of the study objectives and requested to make a list of all individuals aged 15 years old and above who derived livelihood in the fishing sector using the stated groups agreed upon earlier. All eligible participants were invited to attend at a central site and be enrolled after reading the study information sheet and giving informed signed consent. After enrolment, personal characteristics and history of STIs were obtained through a structured questionnaire, in confidential face to face interview.

2.6.7: Other specific activities carried out during community mobilization:

The research team finally developed and distributed the flier that containing detailed information concerning the proposed study i.e. purpose, objectives, procedures, approaches, eligible participants and benefits of the proposed study. The flier distributed to all the BMU leaders’, eligible participants and to the management of all levels as indicated earlier. In case of any further questions, comments or clarification concerning the study the contact address and telephone numbers were provided to all leaders at various levels and to the eligible participants.

2.7: Quantitative and Qualitative data:

2.7.1: 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, Kiswahili, and back translated 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 close and open-ended questions. Piloting of the research tools was done at Nyakasenje landing site in Nyanguge Ward in Magu District, Mwanza Region.
2.7.2: **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, residence, mobility and migration, behavioural risks factors such as types/forms of sexual practices and their socio-cultural and economic contexts were captured.

2.7.3: **Focus Group Discussions (FGDs):**

Focus group discussions (FGDs) were conducted in groups of 8 to 12 participants each. The FGD participants were aged 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. Participants in FGDs were not part of those who had earlier been interviewed. BMU leadership supported the process of selection of the representatives from different cadres other than those who had been identified in the face-to-face interviews.

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 taking notes.

2.7.4: **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. Such KII were categorised into two groups – those from the EAC and the National and sub-national levels. A guide had been developed for each group. See Annex 4a and 4b below, and was used to obtain the information. The participants for the KIIs were identified as follows for fishing communities.
They were:

- EAC, LVBC
- National Level
- Regional/District Fisheries 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)
- Tanzania Fisheries Research Institute (TAFIRI), Mwanza
- Beach Management Units (BMUs)
- Ward Executive Officers (WEOs)
- Village Executive Officers (VEOs)
- Influential People in landing sites (i.e. Clinical Officers, Village health workers, others)

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

2.7.5: Field laboratory Procedures and Laboratory Tests:

The Guideline of the Ministry of Health and Social Welfare/National AIDS Control Programme (MoHSW/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 disposable 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 the UV light 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 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 space 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 DBSs 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. For the landing sites that where far from NIMR Mwanza, DBS where stored in the refrigerator of a near health facility until when where transported to NIMR Mwanza laboratory.

2.7.6: Quality Control Issues:

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

Ten per cent (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.

**Laboratory samples:**

After interview, all eligible consenting participants were finger-pricked, and a Dry Blood Spot (DBS) was obtained on a dry filter paper, Whatman filter paper, serial number 903. These dry blood spots were kept in sealed plastic envelops which were then placed in a container which had some desiccant material in order to keep them dry until transported to the laboratory. After testing at the central laboratory at NIMR, a sub-sample of DBS was selected randomly and repeat-tested at the NIMR Centre Laboratory by a different laboratory technologist person for quality control (QC) purposes. The number of samples re-tested for QC was 106 samples. The results of tests were consistent between the two tests.

**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.

**2.7.7:  Field Assistant training:**

The research Team developed a training manual for use during 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 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) were short listed for interviews
out of which 40 of them were selected for training which was carried out by the research Team at the Bank of Tanzania Institute (BOTI).

2.7.8: 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 supervising the RAs during training and data collection as well as the National technical team who participated in the process starting with the NTT in-country meeting, during training, during data collection.

2.7.9: Data Management and Analysis:

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 IV 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 \( \leq 0.05 \) was considered as statistically significant for all tests.
**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 interpretation 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.

**2.7.10: Ethical clearance:**

The research team presented the research protocol to the National ethics committee for consideration 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 number NIMR/HQ/R.8a/Vol.IX/902; see Annex 6 for a scanned version of the Clearance certificate.

**2.7.11: Challenges of the study:**

Tanzania occupies close to 49% of the Lake Victoria water surface. There were three regions bordering the Lake i.e. Mara, Mwanza and Kagera. As such there were long distances to be covered and very many and varied communities particularly in the fishing islands and fishing sites along the lake shores. The research team was challenged to get all the data needed. The main challenges were inaccessibility of some of sampled areas where the RV Jumuiya, a research vessel owned by the EAC, could not dock in the islands since it needed deep water to dock. Fibre boats were therefore hired to ferry the research
team to the site. In some islands, where distances were too far, they were replaced by similar sized islands having the same characteristics. It happened only once.
Chapter 3

3. Findings

3.1: Coverage of study population:

The sample size of the study population was 1120. Of those, it was possible to interview 1064 giving coverage of study population of 95%. It was that population which was interviewed and requested to provide a dry blood spot (DBS).

3.1.1: Overview:

The section presents the results from the fishing community survey. It had been planned to survey 70 landing sites but managed to survey 69 landing sites which covered the fishing communities in Kagera, Mara and Mwanza regions in Tanzania. The missing site was not surveyed due to its being geographically inaccessible.

The findings presented include socio-demographic characteristics of the men and women who took part in the survey. Also the study present findings on prevalence of HIV infection, behavioural risk factors, knowledge and attitudes regarding HIV and STI transmission among fishing communities, establishment of the range, breadth, availability and utilization of HIV and AIDS related services and finally determination of the existence and effectiveness of policies and programmes.

3.2: Detailed Description of the Study Population:

The overall number of study participants in the fishing communities was 1064. Of those 769 out of 1064 i.e. 72% were men and 295 out of 1064 i.e. 28% were women.
Figure 1: Sexual profile of study population. (N = 1064)

![Sexual profile of study population](image)

295 (28%)  
769 (72%)

3.2.1: Age profiles of study population:

The median age of the study population among the fishing communities was 33 years while the mean age was 35 years. Overall it ranged from 16 to 75 years. When the sexes were desegregated, the mean age among the men was 35 years (range from 16 to 75 years with a SD 10.6) while for women it was 33 years ranging from 16 to 60 years. In the current study population men were significantly older than women (t-test: *p*-value=0.02).

Of the 1064 respondents who had provided information through the face to face questionnaires and the DBS, it was possible to get data on marital status from all of them. Overall more than two-thirds of the respondents were married, mostly men (69%), about a fifth were single, less than 5% were separated or widowed and about 7% divorced. The proportions of men divorced (2.6%) was very small compared to women (19%). (See figure 2).
Figure 2: Marital status of respondents (N = 1064)

A quarter of the men were single, this was a young energetic labour force. There was a higher proportion of women who were divorced or widowed in the fishing community compared to men. See figure 2.

3.2.2: Religious beliefs among respondents:

Table 12 gives the breakdown on religious beliefs of the respondents. When broken down, it can be seen that the majority were of the Christian faith i.e. 82.1%. Moslems were 143 (13.4%) and 4.2% were practising traditional/paganism and very few had no religion at all.

Table 2: Religious background of respondents, (N = 1064)

<table>
<thead>
<tr>
<th></th>
<th>Fishing communities</th>
</tr>
</thead>
<tbody>
<tr>
<td>n (%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Men</td>
</tr>
<tr>
<td>Christian</td>
<td>645 (83.88)</td>
</tr>
<tr>
<td>Moslem</td>
<td>86 (11.1)</td>
</tr>
<tr>
<td>Traditional/Pagan</td>
<td>37 (4.8)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>1 (0.1)</td>
</tr>
<tr>
<td>Total</td>
<td>769</td>
</tr>
</tbody>
</table>
3.2.2.1: Duration of stay and number of dependants:

Over two-thirds of these participants were household heads in fishing communities with an average of 6 dependants each among men and women. While men had an average of 7 dependants, women had five (5) dependants. A household leader could either be a man or a woman and men had more dependants than women. Overall, approximately two-thirds 630 (59.2%) of study participants had lived in the Village for more than five years, about a quarter have lived in the village for 1 to 4 years and 171 (16%) having lived just under one year. Fishing communities in Tanzania could be classified as a fairly unstable population. Almost 40% had lived in the area for periods of 1-4 years only.

3.2.3: Ethnicity:

There were twelve different ethnic groups among the fishing populations. In the fishing community about a quarter of the respondents belonged to the Wasukuma ethnic group and a fifth were Wajita, the rest were many various tribes e.g. the Magomeni, Mbembe, Wachaga, Wafipa, Wahangaza, Waikizu, Wajaluo etc. Almost all of them were less 1%. That ethnic mixture denotes mobility as well since some of the ethnic groups were from distant areas from the locality in search of lucrative fish catches.

Table 3: Ethnic groups of respondents, N=1064

<table>
<thead>
<tr>
<th>DETAILS</th>
<th>Men (%)</th>
<th>Women (%)</th>
<th>TOTAL (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wasukuma</td>
<td>202(26.3)</td>
<td>78(26.4)</td>
<td>280(26.3)</td>
</tr>
<tr>
<td>Wakerewe</td>
<td>71(9.2)</td>
<td>26(8.8)</td>
<td>97(9.1)</td>
</tr>
<tr>
<td>Wazinza</td>
<td>27(3.5)</td>
<td>6(2.0)</td>
<td>33(3.1)</td>
</tr>
<tr>
<td>Wahaya</td>
<td>47(6.1)</td>
<td>36(12.2)</td>
<td>83(7.8)</td>
</tr>
<tr>
<td>Wakurya</td>
<td>38(4.9)</td>
<td>12(4.1)</td>
<td>50(4.7)</td>
</tr>
<tr>
<td>Wajita</td>
<td>147(19.1)</td>
<td>55(18.6)</td>
<td>202(19.0)</td>
</tr>
<tr>
<td>Other</td>
<td>131(17.0)</td>
<td>45(15.3)</td>
<td>176(16.5)</td>
</tr>
<tr>
<td>DK</td>
<td>4(0.5)</td>
<td>0(0.0)</td>
<td>4(0.4)</td>
</tr>
<tr>
<td>Waha</td>
<td>28(3.6)</td>
<td>14(4.8)</td>
<td>42(4.0)</td>
</tr>
<tr>
<td>Wazanaki</td>
<td>7(0.9)</td>
<td>2(0.7)</td>
<td>9(0.9)</td>
</tr>
<tr>
<td>Waruli</td>
<td>22(2.9)</td>
<td>7(2.4)</td>
<td>29(2.7)</td>
</tr>
<tr>
<td>Wanyamwezi</td>
<td>10(1.3)</td>
<td>3(1.0)</td>
<td>13(1.2)</td>
</tr>
<tr>
<td>Wakwaya</td>
<td>20(2.6)</td>
<td>10(3.4)</td>
<td>30(2.8)</td>
</tr>
<tr>
<td>Wakara</td>
<td>15(2.0)</td>
<td>1(0.3)</td>
<td>16(1.5)</td>
</tr>
</tbody>
</table>
3.2.3: **Educational status:**

Eighty one per cent of the study participants in the fishing communities had completed primary school education, 12% secondary education, 7% have never gone to school and less than 1% have ever been to high school, college or university (see figure 3). Therefore, women had a higher score on primary education compared to men while men had a slightly high score in secondary education versus the woman counterparts. It was noticeable that 7% of fishing community respondents had never gone to school despite government’s position/policy on universal free primary education.

**Figure 3: Educational background among respondents, (N = 1064)**

Table 4 below shows the current occupation among respondents in the fishing communities. In the fishing community more than two-fifths were boat crew members followed by fishmongers 143 (13.4%) and food vendors 123 (11.6%). Majority of the respondents in the fishing communities worked as boat crew 467 (44%) the rest of the working cadres were widely distributed in small proportions. This was the group which did the actual fishing.
Table 4: Current occupation of respondents (N = 1064)

<table>
<thead>
<tr>
<th>Fishing communities (%)</th>
<th>Men</th>
<th>Women</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional</td>
<td>44(5.7)</td>
<td>6(2.0)</td>
<td>50(4.7)</td>
</tr>
<tr>
<td>Trader</td>
<td>14(1.8)</td>
<td>2(0.7)</td>
<td>16(1.5)</td>
</tr>
<tr>
<td>Boat owner</td>
<td>59(7.7)</td>
<td>4(1.4)</td>
<td>63(5.9)</td>
</tr>
<tr>
<td>Fish processor</td>
<td>13(1.7)</td>
<td>18(6.1)</td>
<td>31(2.9)</td>
</tr>
<tr>
<td>Boat crew</td>
<td>455(59.1)</td>
<td>12(4.1)</td>
<td>467(43.9)</td>
</tr>
<tr>
<td>Fishmonger</td>
<td>80(10.4)</td>
<td>63(21.4)</td>
<td>143(13.4)</td>
</tr>
<tr>
<td>Food vendor</td>
<td>17(2.2)</td>
<td>106(35.9)</td>
<td>123(11.6)</td>
</tr>
<tr>
<td>Bar maid</td>
<td>10(1.3)</td>
<td>36(12.2)</td>
<td>46(4.3)</td>
</tr>
<tr>
<td>Bar owner</td>
<td>15(2.0)</td>
<td>15(5.1)</td>
<td>30(2.8)</td>
</tr>
<tr>
<td>Shop keeper</td>
<td>44(5.7)</td>
<td>31(10.5)</td>
<td>75(7.1)</td>
</tr>
<tr>
<td>Industry Agent</td>
<td>4(0.5)</td>
<td>0(0.0)</td>
<td>4(0.4)</td>
</tr>
<tr>
<td>Transporters</td>
<td>5(0.7)</td>
<td>1(0.3)</td>
<td>6(0.6)</td>
</tr>
<tr>
<td>Other</td>
<td>9(1.2)</td>
<td>1(0.3)</td>
<td>10(0.9)</td>
</tr>
</tbody>
</table>

3.2.4: Earning per month:

In the fishing sector, in a month many of the respondents 456(43%) earned less than 50,000/=, a quarter earned between Tshs 50,000/= and 99,000/=; 113 (10.6%) earned between Tshs 100,000/= and 149,000/= and only 36 (3.4%) earned 500,000/= and above. Generally, men earned more than women; for example; more than two-thirds of women earned less than Tshs 50,000/= compared to a third of men (see table 5). Individuals in the fishing communities are lowly paid and the most affected are the women. Boat crew members had better income compared to other groups.
Table 5: Earnings per month, (N = 1064)

<table>
<thead>
<tr>
<th>Earnings per month</th>
<th>Men</th>
<th>Women</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than Tshs 50000</td>
<td>281(36.5)</td>
<td>175(59.3)</td>
<td>456(42.9)</td>
</tr>
<tr>
<td>Tshs 50000/= to 99000/=</td>
<td>205(26.7)</td>
<td>66(22.4)</td>
<td>271(25.5)</td>
</tr>
<tr>
<td>Tshs 100000-149000/=</td>
<td>89(11.6)</td>
<td>24(8.1)</td>
<td>113(10.6)</td>
</tr>
<tr>
<td>Tshs 150 000/= to 190000/=</td>
<td>47(6.1)</td>
<td>5(1.7)</td>
<td>52(4.9)</td>
</tr>
<tr>
<td>Tshs 200000/= to 299000/=</td>
<td>49(6.4)</td>
<td>7(2.4)</td>
<td>56(5.3)</td>
</tr>
<tr>
<td>Tshs 300000 to 399000/=</td>
<td>47(6.1)</td>
<td>3(1.0)</td>
<td>50(4.7)</td>
</tr>
<tr>
<td>Tshs 400000/= to 499000/=</td>
<td>9(1.2)</td>
<td>0(0.0)</td>
<td>9(0.9)</td>
</tr>
<tr>
<td>Tshs 500000/= and above</td>
<td>29(3.8)</td>
<td>7(2.4)</td>
<td>36(3.4)</td>
</tr>
<tr>
<td>Don't know</td>
<td>13(1.7)</td>
<td>8(2.7)</td>
<td>21(2.0)</td>
</tr>
</tbody>
</table>

3.3: Determination of HIV sero-prevalence

3.3.1: Introduction:

It was possible to obtain only 1064 samples of dry blood spots (DBS) which could be linked with the face-to-face questionnaires and hence able to be interpreted. Thus the HIV prevalence determination was based on the sample size of 1064 respondent results of both DBS and questionnaires. This part presents the HIV infection sero-prevalence.

The overall HIV infection prevalence in the fishing communities was 80/1064 (7.6%), having a higher women HIV prevalence at 32/295 (11%) compared to that of the men at 48/769 (6.3%). The overall HIV prevalence was higher than that of the National level (5.7%). There was a significant difference in HIV prevalence between men and women (from $X^2$, $p$-value = 0.01).
3.3.2: HIV prevalence by Region:

The study was carried out along the Lake Victoria basin-Tanzania side. There are three regions bordering the Lake i.e. Kagera, Mara and Mwanza. When data was analysed among the fishing communities per region, figure 4a below gives the following findings.

Figure 4a: HIV prevalence by region (N = 1064)

Kagera region had the highest HIV prevalence (12.5%) followed by Mwanza at 7.3% and then Mara at 6%. When that data was further analysed to get sex differentials per region, figure 3b below gives the findings. Women in all the three regions had higher prevalence compared to their men counterparts. The differences seen in the Regional HIV infection prevalence is significant (p-value = 0.05).
Thus for the fishing community, HIV prevalence in women in Kagera was highest at 18.6%, followed by those in Mara region (9.8%) and the least was Mwanza at 9.6%. Such prevalence can be considered against the THMIS 2007/08 survey results. Table 6 gives a summary of those findings:

**Table 6: Prevalence (%) between current study and THMIS 2007/08:**

<table>
<thead>
<tr>
<th>Region</th>
<th>Current study 2010/11</th>
<th>THMIS 2007/08</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fishing Communities</td>
<td>General population</td>
</tr>
<tr>
<td>Mara</td>
<td>9.8%</td>
<td>7.7%</td>
</tr>
<tr>
<td>Mwanza</td>
<td>9.6%</td>
<td>5.6%</td>
</tr>
<tr>
<td>Kagera</td>
<td>18.6%</td>
<td>3.5%</td>
</tr>
</tbody>
</table>

Four years down the line, the prevalence in the fishing population and the general community in Tanzania are different. The ones in the fishing communities remain higher.
3.3.3: HIV prevalence by age groups and sex:
The HIV prevalence increased with age in both sexes being 5% and 15% for men and women respectively for the age-group 15-29 years. The HIV prevalence was highest at 7.5% and 20% for men and women respectively for those aged 30-44 years (figure 4c). The prevalence of HIV was higher in women than men in all age groups.

Figure 4c: HIV prevalence by age and sex (N = 1064)

3.3.3.1: HIV prevalence by marital status, age and number of times ever suffered from STI:

It was possible to examine the link between HIV sero-status and marital status. The total number of respondents among those HIV positive was 80. There were 48 men and 32 women. Table 7 shows the findings.

Table 7: HIV prevalence by marital status (N = 80)

<table>
<thead>
<tr>
<th>DETAILS</th>
<th>TOTAL</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>% prevalence</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>10</td>
<td>4.4</td>
</tr>
<tr>
<td>Married</td>
<td>49</td>
<td>7.0</td>
</tr>
<tr>
<td>Separated/Divorced/Widowed</td>
<td>21</td>
<td>16.5</td>
</tr>
</tbody>
</table>
Among those who were single and married, more women than men were HIV positive. However, when those who were separated, divorced or widowed, were placed together, despite their numbers being small, prevalence of HIV infection was much higher than among the single and married.

Table 8: HIV prevalence by type of Age group (N= 70)

<table>
<thead>
<tr>
<th>DETAILS</th>
<th>MEN</th>
<th>WOMEN</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Age group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-24</td>
<td>3</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>25-34</td>
<td>18</td>
<td>11</td>
<td>29</td>
</tr>
<tr>
<td>35-44</td>
<td>19</td>
<td>13</td>
<td>32</td>
</tr>
<tr>
<td>45+</td>
<td>8</td>
<td>4</td>
<td>12</td>
</tr>
</tbody>
</table>

When HIV infection was looked at against the age groups of the respondents among the 80 HIV positive individuals, as seen in Table 8, it was found that the prevalence increased gradually from the 15-24 year olds and peaked at the 35-44 year before dropping after the 45+ year’s age group. However, the numbers in the 45+ age group were only 12 therefore not adequate to interpret.

3.3.3.2: HIV prevalence by level of education and type of activity in the fishing community:

When HIV prevalence was examined versus the educational level and type of activity in the fishing community, it was found that between primary education and secondary education, the HIV prevalence was higher among primary school (7.6%) against those with secondary education (5.7%).

Also among the fishing community, there were those dealing directly with fish e.g. traders, boat owners, crew, fishmongers and the ones who were providing services to the fishing community e.g. food vendors, bar maids, bar owners etc. Those directly involved in fish, it was found that boat crew had the highest HIV prevalence (6.7%) and those service providers when considered as a group, the prevalence was 9.1%. As found earlier, the prevalence’s found were above the national levels as determined during the THMIS 2007/08 survey.
3.4: Establishment of demographic and behavioural risks factors, knowledge and attitudes regarding HIV and STI transmission.

3.4.1: Knowledge on sexually transmitted infections

Respondents in fishing communities knew that one could get STIs by having sexual intercourse. More than 95% of the respondents knew the correct response (see figure 4a). The knowledge about STIs was high among fishing communities. When respondents were probed on which diseases one can get by having sex, the responses are shown in figure 5a:

Figure 5a: Can one get STIs through sexual intercourse (N = 1064)

Respondents were asked as to the type(s) of STIs one could contract through sexual intercourse. 1024 out of 1064 (96.2%) in the fishing communities stated that one could get STI through sexual intercourse. On further probing, respondents were asked as to the types of STIs one could get through sexual intercourse. The responses were as follows. Gonorrhoea and syphilis were mentioned by many respondents. Also, almost all men (98%) and women (99%) respondents said that one could get HIV and AIDS by having sexual intercourse. A third knew of a blister arising as result of sexual intercourse.
About half knew of herpes and more than four-fifths knew of genital ulcer, abnormal genital discharge or itch. Almost three quarters 72% of men and 75% women knew of Pelvic Inflammatory Disease (PID). More than half of men (52.0%) and about two thirds of women (62.0%) said that one could get blood in urine as result of sexual intercourse (see figure 4b). On further probing as to which diseases one can get through having sex, details of the findings are given on Figure 5b for both men and women.

**Figure 5b: Type of STIs one can get by having sex (N = 1024)**

There is high level of knowledge on diseases that are acquired as a result of having sexual intercourse. However, there was a misconception of blood in urine as one of the sexually transmitted infections. Respondents were probed on sexual behaviour; a third of respondents in this community had ever suffered from sexually transmitted infections (STIs). Another third had had more than one episode of STIs. Also with regard to men having sex with men, and having anal sex with women, the key finding was that STI infections and men having anal sex with women were common. The two findings are co-factors in facilitating HIV transmission. Any planned intervention should take that fact on board.

**3.4.2: Knowledge on HIV and AIDS:**

More than 90% of the participants from the fishing community had ever heard of HIV AND AIDS. About 70% knew that a person can have HIV infection and still look healthy and while 80% thought a person can have HIV infection and look sick with symptoms.
About 50% knew that HIV is what comes before AIDS and said HIV is after sero-conversion (see figure 6a). The total number of respondents adds to more than 100% because each response was a stand-alone. The level of knowledge on HIV AND AIDS is very high. However, knowledge that HIV comes before AIDS and HIV sero-conversion is not as high.

Figure 6a: Knowledge on HIV and AIDS (N= 1037)

Almost all, 1023/1064 (99%) of the respondents knew that HIV can be transmitted through sexual intercourse, more than 93% mentioned sharing needles and blood transfusion. Respondents who knew that contact with infected blood/wounds, using other people’s toothbrushes and sharing razors could transmit HIV were more than 80%, two-thirds and more than 90% respectively. However, 672 (65%) individuals said that casual contact with HIV infected person does not transmit HIV. A total of 701 (93.3%) men and 259 (90.6%) women were aware of mother to child transmission of HIV. Three hundred and seven (29.6%) of respondents from the fishing community said that casual contact with an HIV infected person could transmit HIV A total of 380 (36.6%) respondents thought one could catch HIV through mosquito bites (see figure 6b).
Thus overall knowledge on HIV transmission was high in the fishing community respondents. However, there were some misconceptions, about third of respondents said that casual contact with an HIV infected person could transmit HIV and more than a third said HIV could be transmitted through mosquito bites.

Figure 6b: Knowledge on HIV transmission (N = 1037)

3.4.4: How can people be protected from contracting HIV:

Respondents were asked on how one can be protected from contracting HIV infection. Overall the majority (71% to 93%) of the study participants knew the right responses. The responses obtained ranged from: abstention from sex, practising non-penetrative sex, always using condoms during sexual intercourse, having sex with only one partner, having sex with a virgin, having sex with a partner who has tested for HIV and non-sharing of sharps. Thus, knowledge on protection against HIV infection is high among fishing community members. However, there is a misconception that having sexual intercourse with a virgin is one of the ways to protect oneself from HIV infection (see figure 6c).
Approximately, 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. See Figure 5d. About a half said problems caused by HIV and AIDS included absenteeism from work, stress and overcrowded hospitals. In general, the study respondents had a fair knowledge on the impact of HIV and AIDS to the community.
Over four-fifths of the respondents from the fishing communities agreed that condoms protect oneself against HIV infection; about a half agreed that condoms reduce pleasure and about two-thirds agreed that using condoms is a sign of not trusting your partner (see figure 6d). 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.

3.4.4.1: Attitude towards condom use among respondents:

Over four-fifths of the respondents from the fishing communities agreed that condoms protect oneself against HIV infection; about a half agreed that condoms reduce pleasure and about two-thirds agreed that using condoms is a sign of not trusting your partner (see Table 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.

Table 9: Attitude towards condom use among respondents (N = 1037)

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Condoms protect you from HIV</td>
<td>Condoms protect you from HIV</td>
</tr>
<tr>
<td></td>
<td>Using a condom reduces sexual pleasure</td>
<td>Using a condom reduces sexual pleasure</td>
</tr>
<tr>
<td></td>
<td>Using a condom is a sign of not trusting</td>
<td>Using a condom is a sign of not trusting your</td>
</tr>
<tr>
<td></td>
<td>your partner</td>
<td>partner</td>
</tr>
<tr>
<td>True</td>
<td>627 (83.5)</td>
<td>228 (79.7)</td>
</tr>
<tr>
<td>False</td>
<td>102 (13.6)</td>
<td>37 (12.9)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>22 (2.9)</td>
<td>21 (7.3)</td>
</tr>
</tbody>
</table>

Slightly more men (50.1%) compared to women (43.7%) stated that using a condom reduces sexual pleasure. The percentage of those who did not know that condoms were protective from HIV infection among men and women was 3% (men) and 7.3% (women). Such a situation should not be observed after such a long period with the HIV epidemic.
3.4.4.2: Behaviour change after knowing about HIV and AIDS:

Overall almost 90% of participants in the fishing community reported to have changed behaviour to avoid being infected after hearing about HIV and AIDS. Approximately, 10% reported to have stopped completely all activities related to sex, about half started using condoms, over two-thirds restricted themselves to one partner, two-fifths reduced their number of sexual partners, a fifth stopped using injections and another fifth requested their sexual partners to be faithful. Therefore the responses from respondents suggest that there was a change in risk behaviour. See figure 7.

Fig. 7: Behaviour change after knowing about HIV and AIDS (N = 958)

3.4.4.3: Risk perception of acquiring HIV and AIDS in the next 12 months

Overall about 18% of the respondents in the fishing community perceived themselves to be at a greater risk of being infected with HIV. Overall, a third of the respondents perceived themselves as not being at risk, and a fifth did not know whether they were at risk or not (see figure 8).

Very few individuals in the fishing communities perceived themselves to be at risk of acquiring HIV infection in the next twelve months, a period which was considered as reasonable for predicting future events/actions or occurrences.
More than 70% of the fishing community respondents 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 9). Majority of the participants in the fishing communities do not drink alcohol and then engage into sexual intercourse.

3.4.4.5: Alcohol intake and sexual intercourse:

More than 70% of respondents 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 9). Majority of the participants in the fishing communities do not drink alcohol and then engage into sexual intercourse.
Figure 9: Alcohol intake and sexual intercourse (N = 971)

In the fishing communities a third of the respondents had ever suffered from sexually transmitted infections (STIs), and another third had suffered from STIs more than once. When asked about sexual behaviour in their community, about 10% of the respondents said that men have sex with men and a third said that men have anal sex with women in their community. Eighteen (2.3%) men admitted having ever had anal sex with another man and 55 (7.1%) of the men admitted having ever had anal sex with a woman (see figure 10). Sexually transmitted infections are common in the fishing communities and anal sex is being practised in this community. Approximately, 5% of the men have actually either had anal sex with a man or a woman.

3.4.4.6: Sexual behaviour among respondents

In the fishing communities a third of the respondents had ever suffered from sexually transmitted infections (STIs), and another third had suffered from STIs more than once. When asked about sexual behaviour in their community, about 10% of the respondents said that men have sex with men and a third said that men have anal sex with women in their community. Eighteen (2.3%) men admitted having ever had anal sex with another man and 55 out of 769 (7.1%) men admitted having ever had anal sex with a woman (see figure 10). Out of them only 4 (7.3%) were HIV positive.
3.4.4.7: Condom use and non-regular sexual partners

Just over 10% of the study participants in the fishing community reported always using condoms with non-regular partners, about 8% use condom most of the time, 4% sometimes, a fifth use condoms once in a while with non-regular partners and about half never use condoms (see figure 11). Use of condoms during sexual intercourse with a non-regular partner is very poor in the fishing communities.

Fig 11: Condom use and non-regular sexual partners (N = 971)
3.4.5: **Stigma and disclosure:**

On stigma several aspects 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 fishing community respondents said that if a member of the family became infected with HIV it should remain a secret. About 10% said the first person to be informed if they became HIV positive was girlfriend/boyfriend, almost two-thirds said spouse/permanent partner, less than 5% colleague, social worker, counsellor, friend (see figure 12). HIV infection status disclosure is poor in the fishing communities; very few participants would be ready to disclose their HIV status. Disclosure appears to be limited to spouse/permanent partner and to some extent boyfriend/girlfriend.

3.4.5.1: **Person to be informed after testing HIV positive (+ve):**

About 70-90% of the participants in the fishing community said that they were comfortable in shaking hands, eating from the same plate, sharing working tools, sharing toilet and travelling in the same vehicle with a person who was HIV positive. About 18% of the respondents said that people with HIV infection should be separated and do not deserve compassion (see figure 12). Stigmatisation in the fishing communities appears to be minimal; participants seem to be comfortable in many ways with an HIV infected person. However, there are few, about 18% who harbour the feeling that HIV infected people should be separated and do not deserve compassion.
Figure 12: Person to be informed after testing HIV positive N = 1064)

About 70-90% of the participants in the fishing community said that they were comfortable in shaking hands, eating from the same plate, sharing working tools, sharing toilet and travelling in the same vehicle with a person who was HIV positive. About 18% of the respondents said that people with HIV infection should be separated and do not deserve compassion (see figure 14).

Stigmatisation in the fishing communities appears to be minimal; participants seem to be comfortable in many ways with an HIV infected person. However, there are few, about 18% who harbour the feeling that HIV infected people should be separated and do not deserve compassion.

3.4.5.2: Interaction with PLHIV

Participants in the fishing community were asked what kinds of bad treatment people living with HIV and AIDS and /or their families face about 70% said isolation, two-fifth said verbal abuse, about 15% said physical abuse/violence, two-fifth said rumours/gossips, a fifth said rejection, 10% ejection from home, below 5% rejection by insurance (see figure 13).

Isolation appears to be the most common kind of bad treatment people living with HIV and AIDS (PLHIV) face in the fishing communities. Other bad treatments which are common are verbal abuse and rumours or gossips.
Figure 13: Kinds of bad treatment PLHIV or their families face (N = 1064)

3.4.5.4: Sources of stigmatisation:

50% of the respondents said people living with HIV and AIDS and /or their families were treated badly by family members, approximately two-fifth mentioned neighbours, about half mentioned community members, about 8% health workers, 8% young people, 5% everyone, about 2% religious groups and 9% colleagues (see figure 14). Common sources of stigmatisation in the fishing community are community members, family members and neighbours.
3.4.6: Care and support:

Approximately, half of the study individuals have provided care to a family member or neighbour who was HIV positive. Approximately two-thirds of participants provided care by visiting the infected person, more than 70% provided food, about half talked to the person, about a fifth cleaned the person’s house, another fifth helped the person wash, another fifth linked the person to clinics and about 6% encouraged disclosure (see fig. 15). Care to people living with HIV and AIDS (PLHIV) is provided mainly through visiting, provision of food, talking to the infected person and to some extent cleaning the person’s house.
3.4.7: Care and Support to PLHIV:

Two thirds of the fishing community study participants said they had no fear/worries in providing care or support to a person who has HIV and AIDS, about 10% said they were worried of being infected, 5% were worried of rejection by people, less than 5% were worried of being labelled and 5% were worried that they lacked care skills. (See figure 16). There was low level of stigmatisation and fair knowledge of HIV and AIDS.
3.4.8: **Relationship with partner:**

About four-fifths of the individuals reported their relationship with their partners as friendly/happy, over two-fifths respectful, one-third caring, 5% unfriendly/unhappy, about 1% non respectful, uncaring and abusive (see figure 17). Most of the relationships in the fishing community appear to be friendly/happy, respectful and caring.

**Figure 17: Relationship with partner (N = 971)**

![Relationship with Partner as reported by Fishermen](image)

3.4.9: **Gender Based Violence:**

Ten per cent of the respondents reported their partners having hit/beat/slap/kicked them, about 7% forced them to have sex, 5% forced them into sex without condom, 2% denied them food, 2% threatened them with a weapon, 2% locked them out, about a fifth swore/cursed them, about 7% refused to answer them and around 10% did nothing unusual (see figure 20). There is gender violence in the fishing communities. Swearing and cursing appear to be the most common type of gender violence though beating/slapping/kicking is also practised.
Figure 18: Gender Based Violence (GBV) (N = 971)

3.4.10: Refusal to have sex:

Three-quarters of the individuals from the fishing communities reported that circumstances acceptable for a woman to refuse sex with her partner is during menstruation, a third during pregnancy, about a fifth partner unfaithful, a fifth partner recently given birth, 10% fear of being infected with HIV, about half partner being tired, 10% partner being drunk and approximately 1% did not know (see figure 19). In these communities it is acceptable for a woman to refuse having sex with her partner only when she is menstruating, tired and to some extent when pregnant or having recently given birth.
3.5: Establishment of the range, breadth, availability and utilization of HIV and AIDS related services.

3.5.1: Availability of condoms:

Individuals from the fishing community reported that when they wanted condoms they were available at certain points. Majority 913 (85.8%) mentioned shop/kiosk, followed by hospital/clinic 504 (78.5%), approximately two-thirds 626 (58.8%) mentioned pharmacy, 137 (12.9%) supermarket, 47 (4.4%) mentioned workplace and 22 (2.1%) did not know (see figure 20). People from the fishing community get most of their condoms from shops/kiosks, health facilities and pharmacies.


**Figure 20: Condom availability (N = 1064)**

![Condom availability chart]

### 3.5.2: HIV testing services:

Individuals from fishing communities were asked about places that offer HIV testing services, 47 (4.4%) mentioned workplace clinic, 412 (38.7%) clinic, more than two-thirds 697 (65.5%) mentioned hospital, 356 (33.5%) private doctor, 89 (8.4%) NGO/CBO and 40 (3.8%) did not know (see figure 21a).

Hospitals and clinics were by far the most common facilities that offer HIV testing in fishing communities. Private sector and NGO/CBO also offers some of the testing.
3.5.3: Preference for HIV testing:

In the Fishing community there were 370 (34.5%) who identified their own community as a place they would prefer for HIV testing, while 19 (1.8%) opted not to respond, 58 (5.5%) chose workplace clinics, while 53 (5.0%) wanted testing in another community, 33 (3.1 %) chose testing by a private doctor, while 443 (41.6%) had no preference and 8 (0.8%) said they did not know (see figure 21b). Therefore, the majority wanted or preferred to be tested in their own communities, while others stated that it did not matter where they were tested (i.e. no specific site preference).
3.5.4: Individuals/Groups offering HIV and AIDS education.

When members of the fishing community were asked for places that offer education on HIV and AIDS prevention and care, 75 (7.0%) mentioned workplace clinic, 257 (24.1%) clinic, about two-thirds 494 (46.4%) mentioned hospital, 321(30.2) NGO/CBO, 201 (18.9%) community and 75 (7.0%) did not know (see figure 22a). Individuals or groups offering education on HIV and AIDS prevention and care in fishing communities are hospitals, NGO/CBO and clinics.
3.5.5: Preferred places for HIV and AIDS education:

Overall, two-fifths of the participants in the fishing community said that they would prefer to get HIV and AIDS education on prevention and care in their community and another two-fifths had no preference. Less than 5% said that they would not participate, another 5% said they would prefer getting their education in another community (see figure 22b). Fishermen would like education on HIV and AIDS prevention and care, it does not matter where but they would be comfortable getting it within their community.
3.5.6: Preferred places to participate in supporting groups dealing with PLHIV:

Two-thirds of the individuals in the fishing community said that they would prefer to participate in supporting groups dealing with people living with HIV and AIDS (PLHIV) in their community; another fifth said they had no preference. Fishermen would like to support HIV and AIDS activities taking place in their community. It is only a few who would like to support HIV and AIDS activities taking place anywhere (see figure 23a).
3.5.7: Reasons for preference of places to participate in supporting groups dealing with PLHIV:

More than half of the participants gave the reasons for preference as close proximity and easy accessibility. Other reasons given were, by a third provision of good health services, less than a fifth organise support groups and about 10% confidentiality (see figure 23b). Accessibility to places where the HIV and AIDS education on prevention and care are going to be conducted is important and should be given a priority.
3.5.8: Services dealing with HIV and AIDS activities ever used or attended by respondents:

Over half of the respondents in the fishing community have used or attended services dealing with HIV and AIDS prevention and care. About half have attended educational sessions, two-thirds counselling, approximately 70% HIV testing and 10% HIV and AIDS support groups (see figure 24).
3.5.9: Knowledge of someone’s HIV results:

In the fishermen community about 70% of their wives or partners knew the HIV test result of the other. Approximately 10% told no-one their test result, less than 5% told their girlfriends or boyfriends and friends (see figure 25). In the fishing community it appears it is easy to tell HIV test results to husbands, wives or partners in relation to other categories of associates.

Figure 25: Knowledge of someone’s HIV results (N = 1064)

3.5.10: Influence on behaviour after attending HIV and AIDS services:

The survey team wanted to know what behavioural effect was gained after attending HIV and AIDS services. About two-fifths of the respondents in the fishing community reported to have changed behaviour to one partner only, a third to use of condoms, about a fifth to have reduced their number of sexual partners.

Approximately 10% to have abstained from sex and about 5% said that they have not changed their behaviour despite attending these services (see figure 26). Services on HIV and AIDS prevention and care are important in the change of sexual behaviour.
Figure 26: Influence on behaviour after attending HIV and AIDS services (N = 1064)

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

3.6.1: Introduction:

Information on the existence and effectiveness of policies, programs and coordination structures on HIV and AIDS in fishing communities was obtained from several sources. A key informant interview tool was developed targeting at policy and programme managers at the EALP level as well as the national and sub-national levels – within Tanzania. The results are presented in such a format to allow an easy grasp of the report.

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

Professional staff competencies:

Top level professional officers at the EAC headquarters, the Lake Victoria Fisheries Organisation (LVFO) and the Lake Victoria Basin Commission (LVBC) were interviewed. It was found out that the staff in general was very highly qualified, knew their responsibilities and had a broad wealth of experience on HIV and AIDS and other relevant areas.
For example, the Executive Secretary and his deputy at the LVFO had held very senior positions in the same sector in their countries (Uganda and Kenya) while at the LVBC the two officers met had a wealth of experience in the area. One of them having worked as Director at Maseno University HIV/IDS Programme; also as a representative of the Association of African Universities (AAU) on HIV, representative at Association of African Women in Science and Engineering (AWSE); and also has worked for UNHCR – HIV and AIDS Programme in Ethiopia and Eritrea – refugees camps and 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. At the EAC Secretariat, the Principal Health Officer has been in position since 2003, a Medical Doctor by training and having specialised in Paediatrics and Child Health, Immunology and Public Health.

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

The EAC had no HIV policy of its own. However all member states had National HIV and AIDS Policies and Tanzania had a policy. It was elaborated in 2001 and was followed by the first Multi-sectoral Strategic Framework (NMSF) 2003 - 2007 and 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. However, until now the community has not addressed the issue of HIV and AIDS with one voice. The EAC is making efforts to harmonise the policies of the five-member countries on HIV and AIDS. There is already a draft bill on HIV and AIDS which needs to be approved by the Council of Ministers. The East African Law Society (EALS) and the East African Legislative Assembly (EALA) will need to have their inputs and then the bill to get approval of the Council of Ministers.

The harmonisation of 1st and 2nd line AIDS treatment so that people in the partner states can have same/similar access was also an on-going activity. Harmonisation started since 2005 targeting branded versus generic ARVs. It has been advocated that ARVs harmonisation among partner states would be the best option. Since such move on harmonisation would ensure consistence of quality drugs among first line and second line ARVs users, adherence and avoidance of unnecessary side effects due to change of different types of ARVs in the same category.
Workplace Policy was being discussed and found to be accepted by all member states. Furthermore, within the Sexual and Reproductive Health Plan of Action, the EAC is trying to integrate HIV and AIDS and gender.

With regard to existence of ART, HBC, PMTCT/VCT/PICT programmes, the EAC will depend on what is going on in partner states and discuss the challenges being met and how to harmonise best practices by sharing information being made available among the member states. There is need to document these programmes and came out with an assessment which allows how to determine best performance.

- Challenges:

The main challenges were inadequate staff. The EAC Health Directorate had been permitted to recruit 14 professionals. These will fall under the Directorate of Health which is made up of: HIV and AIDS Unit, Medicines and Food Safety, Disease prevention and Control, Health Systems, health research and Health Policies and Sexual and reproductive Health, Child Health, Adolescent Health and Nutrition.

*Financing and sources:*

Contribution from donors was good while that of partner states was very low. The Budget for health in general, donor contribution equalled 99% while that of partner states was 1%. Its breakdown was given as shown on Table 6.

Table 10: Contribution from donors to EAC:

<table>
<thead>
<tr>
<th>Donor</th>
<th>Area</th>
<th>Amount (mil. US $)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sida/Sweden/Irish AID</td>
<td>HIV and AIDS</td>
<td>7.0</td>
</tr>
<tr>
<td>EU</td>
<td>Reproductive and Adolescent Health</td>
<td>2.2</td>
</tr>
<tr>
<td>Rockefeller Foundation</td>
<td>Disease Surveillance</td>
<td>0.5</td>
</tr>
<tr>
<td>World Bank (WB)</td>
<td>Public Health Laboratories</td>
<td>1.3</td>
</tr>
<tr>
<td></td>
<td>Networking implemented through National levels</td>
<td>(Total fund 66 million US$)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NB: Grant to Rwanda and loans to Kenya (25 million), Uganda10 million and Tanzania (15 million), while Burundi did not qualify).</td>
</tr>
</tbody>
</table>
In January 2011, the EAC expected to be funded 10 million US dollars from the Bill and Melinda Gates; DFID and World Bank. The funds were to be utilised for the Medicines regulation and Harmonisation project. In addition, the African Development Bank would make available 26 million US $ for a ‘Health, Climate Change and Environment’. That project was still being negotiated.

*Co-ordination structures and mechanisms at EAC:*

Before the launch of the Lake Victoria Basin Commission (LVBC) it was found that all HIV and AIDS activities within the partner states were uncoordinated. The main purpose of EALP programme was to lower HIV prevalence in the Lake basin. The actors who formed the EALP partner forum were: East African Law Society; East African Business Council, GLIA, USAID-EA and the German Foundation for World Population.

At national level the main coordinating structure was the National Technical Teams (NTT). It was made up of the following sectors/institutions: education; health; TACAIDS; Fisheries; Community development, Gender and children affairs and NIMR. Best practice models on coordination of how things were done in the various partner states needed identification, documentation and active dissemination. The main challenges were along the lines of advocacy at several levels: policy, management and users/beneficiary levels.

To elaborate, these can be described in details as follows:

- **Policy** – each country has own policy and strategy. Any 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. For advocacy can the partner states agree that the fishing community is at risk?

- **Management level:** Among the fisheries and Universities main challenge is DENIAL. These are private enterprise: they have many employees who are casual labourers. Furthermore, Universities need money for research and continued funding from different funding agencies which needed justification for continuity.
- Users: beneficiaries’ knowledge on HIV and AIDS/STIs was very low and therefore difficulty in understanding and accepting interventions.

3.6.3: 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. These were the Ministries of health and Social welfare, Community Development, Gender and Children Affairs; Livestock and Fisheries; as well as the Tanzania Commission of AIDS (TACAIDS). The highlights of the discussions are summarised according to each area of study.

_Fishing communities – a perspective from NACP/MoHSW:_

- **Burden of disease:**

  Among drug users, CSWs, mobile populations - in all these sub-group we already had information on them. We knew the prevalence was high among them than in the general population. It was reported that the current study findings will most likely confirm what was already known and also be able to allow key stakeholders to chart out the progress of the prevalence.

- **Service availability:**

  Most HIV and AIDS/STI services are static. Even if these populations were to want to use them, those static services cannot help. There was need to study these groups and give them user-friendly services according to their needs and lifestyles.

  Within the Ministry of Health, there was the ‘Health Sector Strategy’ which was the overall roadmap for the Ministry in terms of policy and programmatic directives on services. Yet District Councils are the implementers of those guidelines. The challenge was the dichotomy between policy and practice.
• Policies and Programme:

There are huge variances between policies, programmes and practice. While the policy places emphasis on HIV prevention, yet a review at the expenditure on the HIV and AIDS programme showed that expenditure is on ‘CARE’, specifically funding for ARVs. It was also reported that for every one case on ARVs, there was 2 more untreated clients. (1:2).

• Expenditure:

It was reported that as of September 2010, the Tanzania Government’s contribution to HIV and AIDS was 6.3 million US $ and by October 2011, it had come down to 5 million US $. However, from Global Fund with the following main contributors: US Government and Clinton HIV and AIDS Initiative (CHAI), as had contributed to HIV and AIDS funding US 220 million US $ specifically covering 1st line drugs, Laboratory services and human resources for health.

• Coordination:

Co-ordination is difficult. All the HIV and AIDS interventions are skill-intensive interventions. They all need re-training. We are operating at 38% human capacity level. Most of the target population e.g. PLHIV, are very well informed of their rights and needs.
We therefore need to train expert teams; concentrate on issues of quality such as follow up; issues of logistics e.g. drugs at CMS; availability of drugs to be in the pipeline; prescribers don’t know how to prescribe and call while MSD don’t respond quickly.

• Challenges:

Most challenges were ‘systems’ issues, for example Human Resources for Health (HRH); Medical Stores Departments (MSD); Logistics. In addition there were challenges for the role of the Pharmacist. There were no examples to learn from. HIV and AIDS was the only disease demanding a team approach made of a prescriber, a nurse, a nurse-counsellor, a pharmacist, a laboratory technologist and a nutritionist.
Documentation in the management of HIV and AIDS services was paper based in terms of record keeping which was a nightmare. Longitudinal analysis could not be done. The HIV prevalence had gone down from 10 to 5.7%. PLHIV clients 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 had been done. Actual implementation is awaiting. It was further reported that the Global Fund accepts inter-country HIV and AIDS proposals.

3.6.4: Tanzania Commission for AIDS (TACAIDS)

Burden of Disease:

Mobile populations are more affected. They leave their families behind. Such populations are fishing communities, small scale miners (in Geita, Arusha, Mara and Mwanza). They have a high HIV prevalence and that prevalence in that community may have the potential to spread to the rest of the population.

Services availability:

It was reported that services were inadequate in terms of quality of the services, human resources and confidentiality is an issue.

Policy on HIV and AIDS:

HIV and AIDS policies have targeted MARPS. Yet the private sector carry out HIV testing but cannot enforce, 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.

Co-ordination:

All co-ordination was done through the “Medium Term Expenditure Framework, MTEF’. Yet there was no MTEF that specifically focuses on MARPS. The terms of reference of the CHACs were a problem. The functionality of the MACs was reported to be questionable and people were asking themselves what needed to be done to make MACs work?
3.6.5: Ministry of Livestock and Fisheries:

Burden of disease for HIV and AIDS:

Fish for sex was a major problem in the fish sector. The arrival of ARVs had made it possible to have PLHIV look very well and hence the misconception that fishermen can get sick, get treated and recover and then comeback. Therefore, the misconception that there was no HIV infection. Fishermen have low education, there are many and frequent accidental deaths in the Lake (boats capsizing, strong winds and huge waves many times). There is no life insurance and therefore people live a very reckless life.

3.6.6: Ministry of Community Development, Gender and Children Affairs;

Burden of Disease:

Burden of disease for HIV and AIDS is huge particularly on shores and the islands. People move alone without wives or husbands. In addition, once they reach there, the practice becomes that of ‘mob psychology – i.e. do what the others are doing’. Fishing is done at night and therefore some can fake that they are going fishing while not true! The mind set was on work while recreation was missing. They come from hard labour and go straight into relaxation/recreation.

Services availability:

Available services were few, for example, VCT, CD4 estimation and ARVs. In the Lake there were inadequate services. There was inadequate transport to access services.

Policy and Programmes:

In the 2000s, a strategic plan was developed with the technical support of ESAMI. There was no Mkukuta, yet when Mkukuta came, it came from above. There were 35 areas of high priority to work with but no funds were available. There is a Community Development Policy ‘Sera ya Maendelao ya Jamii’.
Co-ordination:

Local Government Authorities (LGAs) did not have to report to Ministries. But from 2009, they had to start to do so. It will be in their TOR and they will be answerable.

- Information from Focus Group Discussion among Fishing Communities:

Burden of Disease:

HIV and AIDS was reported to be major problem in the fishing communities and was being fuelled by poverty and greed. In addition there were many women who had lost husbands and had come to fishing sites for livelihoods through sex. In the community, there were more men than women and those few women were being approached by many men for sex. It had been stated that “Mtandao ni kweli, kinachotusumbua ni tamaa. Hawa wenzetu wasichana wamekuja kibiashara, ukimwingiza chumbani, vyumba vyetu havina siri, ataweka madoido ili wengine wasikie na watu wanataka kujua nani katoa single nzuri hivi na watu humfuata” When women come to the fishing places it was reported that they are not shy to demonstrate how good they are in bed and due to lack of privacy in our rooms many people want to know and test the lady who had given that special single i.e. the love noises made during sexual intercourse.

Source of HIV and AIDS information:

There were various sources of information but not reliable. ‘Taarifa kutoka kwanye vijiwe vya vijana’ Most information was obtained from jobless corners patronised by the youth. Some information had also been obtained from the dispensary. Others reported getting information through the radio, newspaper and counsellors and the TV. The most preferred means were radios and newspapers. “Huku visiwani matamasha hamna”. There were no HIV campaigns in the islands.
HIV Service availability:

Condoms were available from kiosks, shops and when one goes to the hospital. Misconceptions were noted i.e. condoms contaminated with HIV and use reduced sexual pleasure. Prices were reported to range 100 shillings to 1000 shillings. There were dispensaries for testing and HIV. Discussants reported lack of confidentiality. ‘Watu wako tayari kupima lakini wanaogopa uvujaji wa taarifa ila wakija wageni watu tutajitokeza zaidi kupima’. People are willing to test but lack of confidentiality discourages them. Discussants advocated for services to be within the community.

3.7: Qualitative data from KII at community levels:

3.7.1: Burden of HIV and AIDS:

HIV and AIDS was reported to be a big problem. There were many factors fuelling the spread of HIV which included mobile community from small Islands of Lake Victoria to the mainland and vice versa, leisure fare attitude towards HIV and AIDS, alcoholism and pornographic videos.

3.7.2: HIV and AIDS and related services:

During key informant interviews, respondents stated that HIV/AIDS and related services were poor, mainly provided by faith-based organisation such as Anglican Church. There was inadequate access to services which were mainly located on the mainland. Availability of condoms was a problem and the free ones provided by the public sector hardly reached them.

3.7.3: Policies, Programs and Coordination structures on HIV and AIDS services:

The National HIV and AIDS Policy and the Multisectoral Strategic Plan (NMSP) which was all inclusive for the Tanzania population including the fishing communities were reported to be in place but communities were not very clear on it. Council HIV and AIDS Co-ordinators (CHAC) and District AIDS Control Co-ordinators (DACC) were there at district council but were not felt by the fishing communities. Coordination structures for HIV and AIDS services were Beach Management Units (BMU), Council Multisectoral AIDS Committees (CMACs) in collaboration with Wards Multisectoral AIDS Committees (WMACs) and Village Multisectoral AIDS Committees (VMACs) had been established in the early 2003.
Their functionality was another issue. Clear evidence was needed in terms of LGA reports regarding regularity of meetings and annual plans of actions. Policies were there. *Tamko la Sera ya Taifa ya Wavuvi na Mikakati yake, December 1997, Ministry of Natural Resources and Tourism, United republic of Tanzania.* However, the Ministry has been reorganised many times and one wonders whether the newly created structures do follow up.

**3.7.4: Quality of services:**

Health services were available as well as VCT though they were inadequate compared to the population density. NGO’s such CRS were facilitating prevention programmes, HBC services and palliative care to PLHIV. BMUs leaders were invited to participate in community sensitization meetings. However, in other areas, Health facilities and services were observed to be very limited or not available at all. The groups were satisfied with services although insisted on getting more prevention programmes so as to focus community response at large. Orphans and widows should have special interventions. People requested for in-depth information on services and scaling up of their availability.
Chapter 4

4. Discussion

It is assumed that findings reported in the study were representative of the population since the coverage was high.

4.1: Determination of HIV sero-prevalence among populations in fishing communities:

The overall HIV sero-prevalence in the study population was higher than that of the general population. The prevalence at 7.6% was higher compared to the national prevalence of 5.7% (THMIS 2007/8). The prevalence was also higher than for sub-Saharan Africa, 5.0%, (WHO and UNAIDS, 2009). Such a finding was consistent with the available data on most at risk populations such as the one we have studied i.e. fishing communities who are known to be very mobile (Po S. et. al 2002).

Furthermore, when the data was desegregated by sex, it was found that women had a higher HIV prevalence than men, at 11.0% against 6.3% respectively. Such a finding was again in line with the national profile whereby women had a higher prevalence compared to men. In this study, the women prevalence was twice that of men.

In the fishing communities the peak HIV prevalence was in the 30 – 44 year age group. Such an age group would be in line with the labour-intensive activities as are found in fishing work.

It was also possible to desegregate the data among the fishing population by regions. The three regions bordering Lake Victoria in Tanzania are Mara, Mwanza and Kagera. The HIV prevalence was higher in Kagera region in both men and women at 9.7% and 18.6% respectively. The lowest prevalence was in men in Mara region. It will be remembered that Kagera region was the epicentre of the HIV epidemic in Tanzania right from the start in 1983 when the first three cases were diagnosed.
The regional HIV prevalence in the fishing communities within the three regions was 6.0% for Mara, 7.3% for Mwanza and 12.5% for Kagera. When these proportions are compared with those obtained in the THMIS 2007/8 for the general populations it was found that Mara was 7.7%, Mwanza 5.6% and finally Kagera 3.4%. It must be remembered that the survey was for 15-49 years old and did not single out fishing communities. (THMIS, 2007/8)

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

While respondents had knowledge on HIV and AIDS, despite that knowledge, the same population had higher HIV prevalence than the general population implying that knowledge was not translated into behaviour change. Twenty eight years since the first case of AIDS was identified in Kagera and the continued HIV and AIDS education which had been provided to the communities were inadequate to control the misconception. The research team observed that communities still thought that mosquito bites could transmit HIV; casual contact with an infected person could also transmit HIV infection; and having sex with a virgin could protect one from acquiring HIV and use the use of condoms reduced sexual pleasure and were unsafe for HIV protection. Any interventions which will be developed targeting these populations must take into consideration the misconceptions mentioned above.

The research team wanted to find out whether ‘hearing about HIV and AIDS had led to behaviour change’. It is argued that behaviour change is difficult to measure and the indicator used i.e. ‘hearing’ was inadequate. Behaviour change takes time and that any change cannot be attributed to a single one line intervention. However 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.

It seemed most likely that knowledge of condoms being protective alone was inadequate since the issue of sexual pleasure counterbalances 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 found low condom use with non-regular partners.

It was noted that disclosure remains a challenge. It needed to be worked upon in terms of increasing knowledge of the benefits of disclosure as well as the need for widespread HIV counselling and testing with the added move towards the newer approach of provider initiated counselling and testing.
It could be possible that people are unwilling to disclose their HIV-sero status because of fear of stigma. Although in the study the issue of stigma appeared low yet it needs to be addressed in order to lower stigma levels even further.

Under ideal situation one would expect that there should be no gender based violence at all. However that situation is dependent on communities and socio-cultural values. In the study population GBV was reported to be low. Yet, even that low level is difficult to justify. Any intervention addressing that area should target at having a free GBV.

4.2.1: Specific issues:

One specific issue was anal sex. Anal sex in terms of men having sex with men (MSM) and men having anal sex with women. The research team found disconnection, while respondents admitted to the issue being present in the community, yet few reported to having personally experienced it. It is known that anal sex is a co-factor in HIV transmission. Hence the research team would like to see the subject addressed in-depth and preferably in a longitudinal study using different research techniques or interventions due to the sensitivity of the subject area.

<table>
<thead>
<tr>
<th>Box 1</th>
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<tr>
<td><strong>10-14 year olds:</strong></td>
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<td>During the entire study period, 10 - 14 years old were not part of the study and therefore were not interviewed but only observed. That was in line with the ethical clearance. Boys and girls were being used as child labour – removing fish scales and cleaning of boats. Through our observation many young girls were roaming around instead of being in school. It was reported that young girls were engaging in sexual activities with older men because of money. Married women complained of being ‘robbed’ of their husbands by these young girls who were already sexually active despite their young age.</td>
</tr>
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Box 2

Sanitation problems along the Lake shores:

During both the pre-test and survey, the research team observed major sanitation challenges along the Lake shores. Beaches in the mainland and islands were used as sources for drinking water, bathing and for toilet services. The knowledge of the sanitation situation was poor. It appeared that the deeper one went into the lake, the cleaner the water would be and hence good for drinking and the issue of fecal contamination was not a problem. At Nyakasenge, the Village leadership reported a number of recent deaths whose cause was not well explained. When contacted, the DMO stated that such recent deaths was a problem along all the beaches and the diagnosis was from cholera to dysentery. Furthermore toilets were a rare site in the beaches.

Hence the need for innovative interventions to be carried out to address this problem
4.3: Establishment of the range, breadth, availability and utilization of HIV and AIDS related services.

The range of services were condom availability, HIV testing services, HIV counselling services and provision of HIV and AIDS health education. There was inadequacy of ARV provision. While in the mainland such efforts are much better yet the fishing population in the islands are worse off in comparison. It is argued that efforts to enhance the range, breadth and availability of such services which are going on in the mainland along the lake shores should also be addressed towards the fishing communities in the inaccessible areas particularly the far off island.

Furthermore, clients on 2nd line ARVs and all those in need of referral services can only access them by travelling long distances to the static public health facilities. There is need therefore to make those services available even to the hard to reach fishing communities for all ARVs services as well as the general care and treatment services specifcally CD4 monitoring and follow up.

In the fishing communities, private service providers were offering HIV testing and would appear to be stronger and present in fishing communities. Therefore, for any intervention targeting this sub-group, those service providers should be addressed and furthermore HIV testing services should focus more at respondents’ own communities than other areas because these were the preferred places by the respondents.

Box 3:

VCT Services and responses:

In order for the survey to be user friendly and provide benefits to the study population it was planned that those people who wished to be tested for HIV would be provided such a service. Furthermore, those found HIV positive were referred to nearby public facilities offering care, treatment and support services. Tanzania Government Guidelines on VCT were used. The response was overwhelming. Many people wanted to be tested and this challenged the supply of test kits. VCT testing was free.

Though the eligible survey participants were given priority because these services were taken concurrently with the DBS, the demand was very high even for those outside the survey. In every visited study site/area the reagents were not enough to cover the demand. Many people wanted to know their HIV status because sero-status results were available within a very short time and on the same day.
4.4: Determination of the existence and effectiveness of policies, programs and coordination structures on HIV and AIDS.

4.4.1: Existence and effectiveness of HIV and AIDS policies:

**EAC level:**

The challenge at this point is the speed with which the EAC can come up with a common HIV and AIDS policy and harmonisation of interventions e.g. 1\textsuperscript{st} and 2\textsuperscript{nd} line ARV drugs. It needs the consensus of five different countries each with its own national agenda. The National HIV and AIDS policies of partner states have not been harmonised and therefore a bottleneck to regional implementation in the absence of a harmonised approach.

**National level:**

While that National Policy on AIDS has targeted MARPS, yet the private sector, which is a key stakeholder through its ability of carrying out HIV testing and other HIV and AIDS related services cannot enforce the HIV and AIDS law which was legislated through the policy because they have no legal power. Therein lays the challenge that such players need to be empowered to have legal ability to effect the law. On effectiveness of the policy, it was reported that there was dichotomy regarding policy, programmes and practice. The very nature of the basic approach has been mainly on prevention, care and treatment as well as impact mitigation. The actual practice has placed more emphasis on care and treatment since this intervention is finance-intensive.

**Community level:**

It was difficult to define effectiveness and even implementation of policy objectives. One possible explanation of the situation could be the lack of specific terms of reference of CHACs and DACCs to work on full time basis on HIV and AIDS. At present time such officers were addressing HIV and AIDS issues only when funding had been made available. The existence of MACs at district level has had little impact due to lack of a coherence funding modality and functions.
4.4.2: HIV and AIDS Programmes:

National level:

Under ideal condition policy formulation and policy implementation should be carried out by the same entity. At present policies are supervised by the central government and district councils are implementers at the local level. Furthermore, a multisectoral approach is advocated at all levels i.e. central and local government. The reality is not ideal. Hence the inadequacy of performance in terms of translating policy into interventions and comprehensive approach. Such an approach would have placed major emphasis on advocacy, planning, implementation, monitoring an evaluation and finally coordination. It has remained a challenge. Funding has been a major bottleneck although policy makers insist that there is a lot of money in HIV and AIDS. There is the need to make sure that the private sector is included in the comprehensive package of HIV and AIDS interventions.

4.4.3: Funding of HIV and AIDS activities

It was reported that the EAC has no HIV and AIDS policy. If the policy was available, it would enhance the quality of the existing EAC HIV and AIDS strategic plan. Such a plan with costs for its activities would make it easy for the EAC to have a common approach on resource mobilisation. In fact it could also strategise such mobilisation in terms of identification of personalities with a wide network of potential funding organisations including names of key stakeholders in those entities.
Chapter 5:

5. Conclusions and recommendations:

5.1: On HIV prevalence:

The major finding in the study was that fishing communities had higher HIV prevalence than the general Tanzania population. Also it was found that women had higher HIV prevalence than the men in fishing communities. In addition, the most affected age group was that of 30-44 year olds.

Recommendation:

It is recommended that EAC should develop harmonised interventions targeting the fishing community specifically and the sub-groups within the community i.e. women and the 30-44 age group in order to control the nodes of infection within the community and the general population at large since these populations are highly mobile.

5.2: On 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 HIV prevalence as in the general population.

Recommendation:

Potential Programme implementers (e.g. partner states) should put more emphasis on HIV and AIDS education on prevention, care, treatment and support as well as education campaigns. These should be intensified in order to minimise stigma and 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: On Behavioural change:

The study has found that HIV education has been provided by both public sector and civil society organisations to the fishing communities. There was no evidence as to the package of that education in terms of content, context, number of times delivered and target audience. In addition, it could not determine whether there were indicators to measure effectiveness of the intervention.

Recommendation:

Sectors and organisations with comparative advantages in the partner states should design HIV and AIDS intervention package in such a way it takes into consideration the issues of content, time and development of indicators in order to monitor and observe the desired impact. Such an intervention package must have a time-line.

5.4: On 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.

Recommendation:

HIV testing, while it should follow Tanzania Government guidelines, programme implementers should focus intensely on partner testing (spouse/permanent partner and/or girlfriend, boyfriend).

5.5: On Condom attitude and utilisation:

It was reported that there was negative attitude on condoms i.e. their use lead to reduction of sexual pleasure. Secondly the misconception that condom use was due to lack of trust of sexual partner.

Recommendation:

Programme implementers such as CSOs should intensify education to correct the misconception that condom use leads to reduction of sexual pleasure and/or mistrust of sexual partner. In addition the education should target on getting people to use condoms correctly and consistently.
5.6: On Inclusion of other key stakeholders in the provision of HIV and AIDS services:

In the study, it was reported 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 fishing communities.

Recommendation:

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

5.7: On Site(s) for implementation of community interventions:

Many respondents on being probed as to which sites they would prefer to obtain HIV and AIDS services from, the issue of ‘own community’ came out strongly. Similar proportions of respondents had no preference.

Recommendation:

It is recommended that interventions should be implemented at the BMUs level and the surrounding fishing communities.

5.8: On HIV and AIDS Support groups’ activities:

HIV and AIDS support group activities were found to be inadequate in the fishing communities.

Recommendation:

It is recommended that the EAC partner states and programme implementers should intensify efforts in designing, funding and supporting HIV and AIDS support groups’ activities because they have the potential of having a higher coverage of target beneficiaries.
5.9: On Gender Based Violence:

The magnitude of gender-based violence was reported to be low. The violence experienced ranged from physical to verbal abuse.

Recommendation:

The EAC partner states and programme implementers should develop HIV and AIDS interventions that addresses gender based violence in the study population.

5.10: On HIV and AIDS Policies of partner states:

It was reported that the five EAC partner states do have an HIV and AIDS policies and strategies. However it was reported that there was no linkage even in very clear areas such as MARPs. While the EAC was meant to be one single entity, when it comes to negotiations with donors, the lack of an HIV and AIDS policy becomes a limiting factor during negotiations with other stakeholders.

Recommendation:

It is recommended that the EAC partner states HIV and AIDS policies and strategies be harmonised to allow for joint development of a common HIV and AIDS policy.

5.11: On HIV and AIDS programmes

It was reported that there was a dislocation between what the policy states and what is happening which was 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 EAC partner states 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.
5.12: National policies and programmes touching the ‘ground floor’

There are national and sectoral policies and programmes which exist on paper and have not been made user friendly to the target beneficiaries’ e.g. Tamko la Sera ya Taifa ya Wavuvi na Mikakati yake, December 1997, Ministry of Natural Resources and Tourism, United Republic of Tanzania.

Recommendation:

The Ministry of Livestock and Fisheries should review the past policy and if need be develop user friendly and culturally acceptable and simplified versions of relevant policies and programme documents and actively disseminate and not only distribute them.

5.13: Targeted campaigns:

Fishing communities felt ‘marginalised’ and out of the development mainstream of the general population. Specific campaigns for HIV rarely reach them. It was therefore felt that they should be considered.

Recommended:

The programme implementers should develop a special HIV testing campaigns and documentation for fishing communities.
6. References


ASAP Report, 2008: The HIV epidemic in Tanzania Mainland: where have we come from, where is it going and how are we responding?


Bernard, 1995


EDCTP - European & Developing Countries Clinical Trials Partnership. Fisher folk study involves those that are most affected by HIV and AIDS. Published on 18 May 2009.


ELCI: ELCI is based at ICIPE Campus, Nairobi Kenya. (http://www.jaboya.org/, 21st October 2009). - Jaboya is a project of the Environment Liaison Center International (ELCI).


Miles and Huberman, 1994


Pty Ltd, Sidney, Australia


Stata Corporation, College Park, Texas


THMIS – Tanzania HIV and AIDS and Malaria Indicator Survey 2007 – 08.


ANNEXES:

Annex 1a: Information sheet for study participants

2.1. Information Sheet for HIV&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&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&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

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&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&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&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 the care you receive in the clinics and health centres 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: Face to face questionnaire for study participants

KNOWLEDGE ATTITUDE AND PRACTICES ON HIV & AIDS AMONG FISHERMEN IN THE LAKE VICTORIA BASIN, TANZANIA

<table>
<thead>
<tr>
<th>1. Section A: 1. Respondent’s ID</th>
<th>STICKER</th>
<th>Sticker</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 ID No.</td>
<td></td>
<td>ID</td>
</tr>
<tr>
<td>1.3 Date of interview</td>
<td></td>
<td>IntDate</td>
</tr>
<tr>
<td>1.4 Interviewer’s staff code</td>
<td></td>
<td>IntCode</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Section B: 2. Demographic Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Sex of respondent.</td>
<td>1=Male</td>
</tr>
<tr>
<td>2.2 What is your tribe?</td>
<td>1=Sukuma; 2=Kerewe; 3=Zinza; 4=Haya; 5=Kurya; 6=Gita; 9=NK; 7=Other__</td>
</tr>
<tr>
<td>2.3 How old were you at your last birthday?</td>
<td>Age in years 99= Don’t know</td>
</tr>
<tr>
<td>2.4 What is the highest level of education/schooling that you have completed?</td>
<td>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)__</td>
</tr>
<tr>
<td>2.5 Marital status</td>
<td>1=Single; 2=Married; 3=Separated; 4=Divorced; 5=Widowed;</td>
</tr>
<tr>
<td>2.6 What is your religion?</td>
<td>1=Roman Catholic; 2=Other Christian; 3=Moslem; 4=Other Religion (including traditional/pagan); 5=No religion; 9=NK</td>
</tr>
<tr>
<td>2.7 Are you the head of the household?</td>
<td>1=Yes; 2=No; 9=NK</td>
</tr>
<tr>
<td>If No, write 88 to Q2.8</td>
<td></td>
</tr>
<tr>
<td>If yes, to Q2.7</td>
<td></td>
</tr>
<tr>
<td>How many people depend on you?</td>
<td>HDepend</td>
</tr>
<tr>
<td>How long have you lived in the village which you are living in now?</td>
<td></td>
</tr>
</tbody>
</table>
2.9.1 What is your main current occupation?
1=Professional; 2=Trader; 3=Boat owner; 4=Crew; 5=Agriculture; 6=Artisanal processor; 7=Fishing; 8=Fishmonger; 9=Factory agent; 10=Transporter; 99=NK

2.9.2 If Occupation is fishing, What type of fish do you mainly catch?
1=Nile perch; 2=Tilapia; 3=Sardines; 8=NA; 9=NK

3. Section C: 3. Knowledge and Attitudes.

3.1 Are there any diseases that one can get by having sex?
If No or NK, enter 8s for Q3.1.2
1=Yes; 2=No; 9=NK

3.2 Please name as many as you can: Do not prompt 1=Mentioned; 2=Not mentioned; 8=NA

3.2.1 Gonorrhoea
3.2.2 Syphilis
3.2.3 HIV and AIDS
3.2.4 Herpes
3.2.5 Abnormal genital discharge or itch
3.2.6 Genital ulcer
3.2.7 PID/lower abdominal pain in a woman
3.2.8 Bloody urine
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
3.4.2 A person has virus and is sick /has symptoms
3.4.3 HIV is what comes before AIDS
<table>
<thead>
<tr>
<th>3.4.4</th>
<th>HIV is after sero-conversion</th>
<th>HIVheard 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.4.5</td>
<td>Other (specify)_______________</td>
<td>HIVheard 5</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>3.5.1</th>
<th>Sexual intercourse</th>
<th>HIVInf1</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.5.2</td>
<td>Sharing needles</td>
<td>HIVInf2</td>
</tr>
<tr>
<td>3.5.3</td>
<td>Blood transfusions</td>
<td>HIVInf3</td>
</tr>
<tr>
<td>3.5.4</td>
<td>Mosquito bites</td>
<td>HIVInf4</td>
</tr>
<tr>
<td>3.5.5</td>
<td>Contact with infected blood/wounds</td>
<td>HIVInf5</td>
</tr>
<tr>
<td>3.5.6</td>
<td>Using other people’s toothbrushes</td>
<td>HIVInf6</td>
</tr>
<tr>
<td>3.5.7</td>
<td>Casual contact with infected person</td>
<td>HIVInf7</td>
</tr>
<tr>
<td>3.5.8</td>
<td>Sharing razors</td>
<td>HIVInf8</td>
</tr>
<tr>
<td>3.5.9</td>
<td>Don’t know</td>
<td>HIVInf9</td>
</tr>
<tr>
<td>3.5.10</td>
<td>Other (specify)___________________</td>
<td>HIVInf10</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>3.6.1</th>
<th>Abstain from sex</th>
<th>HIVPrev1</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.6.2</td>
<td>Non penetrative sex/thigh sex</td>
<td>HIVPrev2</td>
</tr>
<tr>
<td>3.6.3</td>
<td>Always use condom</td>
<td>HIVPrev3</td>
</tr>
<tr>
<td>3.6.4</td>
<td>Have sex with only one partner</td>
<td>HIVPrev4</td>
</tr>
<tr>
<td>3.6.5</td>
<td>Have sex with a virgin</td>
<td>HIVPrev5</td>
</tr>
<tr>
<td>3.6.6</td>
<td>Make partner take blood test</td>
<td>HIVPrev6</td>
</tr>
<tr>
<td>3.6.7</td>
<td>Not sharing razors</td>
<td>HIVPrev7</td>
</tr>
<tr>
<td>3.6.8</td>
<td>Don’t know</td>
<td>HIVPrev8</td>
</tr>
<tr>
<td>3.6.9</td>
<td>Other (specify)___________________</td>
<td>HIVPrev9</td>
</tr>
</tbody>
</table>

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

| 3.7    | What are some of the problems caused by AIDS? | 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  | Poverty | 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

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

3.10 Can a person who looks healthy have HIV and AIDS? 1=Yes; 2=No; 9=NK

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=Yes; 2=No; 9=NK

3.12 HIV can be transmitted from a mother to her baby 1=Yes; 2=No; 9=NK

3.13 A fat person can have HIV infection? 1=Yes; 2=No; 9=NK
### 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.

<table>
<thead>
<tr>
<th>No.</th>
<th>Question</th>
<th>Options</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>How many times have you travelled away from this village in the last 4 weeks?</td>
<td>1=1 to 2 Weeks; 2=2-3 weeks; 3=above 4 weeks; 8=NA; 9=NK</td>
<td></td>
</tr>
<tr>
<td>4.2</td>
<td>What was the longest duration in one of those travels?</td>
<td>1=&lt;5 days; 2=1 week; 3=1 to 2 Weeks; 4=2-3 weeks; 5=above 4 weeks; 8=NA; 9=NK</td>
<td></td>
</tr>
<tr>
<td>4.3</td>
<td>Did you have sexual intercourse while on transit/travel?</td>
<td>1=Yes; 2=No</td>
<td></td>
</tr>
<tr>
<td>4.3.1</td>
<td>If Yes, was it with a 1=Regular partner; 2=Casual contact; 3=CSW; 4=Other (Specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.3.2</td>
<td>Did you use condom during the sexual intercourse?</td>
<td>1=Yes; 2=No 8=NA; 9=NK</td>
<td></td>
</tr>
<tr>
<td>4.4</td>
<td>I now want you to think of the first time you had sex: How old were you at that time? Enter number</td>
<td>88=Never had sex; 99=NK</td>
<td></td>
</tr>
<tr>
<td>4.5</td>
<td>Have you ever suffered from sexually transmitted diseases?</td>
<td>1=Yes, once; 2=Yes, more than once; 3=No</td>
<td></td>
</tr>
<tr>
<td>4.5.1</td>
<td>If Yes, the last time you had STIs, did you get treatment?</td>
<td>1=Yes; 2=No; 8=NA</td>
<td></td>
</tr>
<tr>
<td>4.5.2</td>
<td>If Yes, where did you get treatment</td>
<td>1=Pharmacy; 2=Govt HC; 3=Private HC; 4=Tradition healers 5=Others (specify)</td>
<td></td>
</tr>
</tbody>
</table>

### Table: 3.14-3.20

<table>
<thead>
<tr>
<th>No.</th>
<th>Question</th>
<th>Options</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.14</td>
<td>A person can have HIV and not feel sick</td>
<td>1=True; 2=False; 9=NK</td>
<td></td>
</tr>
<tr>
<td>3.15</td>
<td>HIV is mainly transmitted by sexual intercourse</td>
<td>1=True; 2=False; 9=NK</td>
<td></td>
</tr>
<tr>
<td>3.16</td>
<td>There is a test you can take which tells you if you have HIV</td>
<td>1=True; 2=False; 9=NK</td>
<td></td>
</tr>
<tr>
<td>3.17</td>
<td>Women are more likely to have HIV than men.</td>
<td>1=True; 2=False; 9=NK</td>
<td></td>
</tr>
<tr>
<td>3.18</td>
<td>Condoms protect you from HIV.</td>
<td>1=True; 2=False; 9=NK</td>
<td></td>
</tr>
<tr>
<td>3.19</td>
<td>Using a condom reduces sexual pleasure.</td>
<td>1=True; 2=False; 9=NK</td>
<td></td>
</tr>
<tr>
<td>3.20</td>
<td>Using a condom is a sign of not trusting your partner.</td>
<td>1=True; 2=False; 9=NK</td>
<td></td>
</tr>
<tr>
<td>4.5.3</td>
<td>Was the partner treated for sexually transmitted diseases?</td>
<td>Treatpartn</td>
<td></td>
</tr>
<tr>
<td>1=Yes; 2=No; 9=DK; 8=NA;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.6</td>
<td>Do men have sex with men in this community? 1=Yes; 2=No; 9=DK</td>
<td>Msm</td>
<td></td>
</tr>
<tr>
<td>4.7</td>
<td>Do men have anal sex with women in this community? 1=Yes; 2=No; 9=DK</td>
<td>Sexanal</td>
<td></td>
</tr>
<tr>
<td>4.8</td>
<td>Have you ever had sex with a man? 1=Yes; 2=No; 9=DK</td>
<td>Msmever</td>
<td></td>
</tr>
<tr>
<td>4.9</td>
<td>Have you ever had anal sex with a woman? 1=Yes; 2=No; 9=DK</td>
<td>AnalEver</td>
<td></td>
</tr>
<tr>
<td>4.10</td>
<td>Since you heard of HIV and AIDS, have you changed your behaviour to avoid being infected? 1=Yes; 2=No; 9=NK.</td>
<td>Prev1</td>
<td></td>
</tr>
<tr>
<td>4.11</td>
<td>In what ways have you changed your behaviour to avoid being infected?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do not prompt; 1=Mentioned 2=Not mentioned; 8=NA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.11.1</td>
<td>Stopped all sex</td>
<td>Prev2</td>
<td></td>
</tr>
<tr>
<td>4.11.2</td>
<td>Started using condoms</td>
<td>Prev3</td>
<td></td>
</tr>
<tr>
<td>4.11.2.3</td>
<td>Restricted to one partner</td>
<td>Prev4</td>
<td></td>
</tr>
<tr>
<td>4.11.4</td>
<td>Reduced number of partners</td>
<td>Prev5</td>
<td></td>
</tr>
<tr>
<td>4.11.5</td>
<td>Stopped injections</td>
<td>Prev6</td>
<td></td>
</tr>
<tr>
<td>4.11.6</td>
<td>Asked spouse / partner(s) to be faithful</td>
<td>Prev7</td>
<td></td>
</tr>
<tr>
<td>4.11.7</td>
<td>Other (specify)____________________</td>
<td>Prev8</td>
<td></td>
</tr>
<tr>
<td>4.12</td>
<td>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</td>
<td>HIVrisk</td>
<td></td>
</tr>
<tr>
<td>4.13</td>
<td>Have you shared needles or syringes with someone else for any reason? 1=Yes; 2=No; 9=NK</td>
<td>HIVsyringe</td>
<td></td>
</tr>
<tr>
<td>4.14</td>
<td>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</td>
<td>Sexalcoh</td>
<td></td>
</tr>
<tr>
<td>4.15</td>
<td>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)____________________?</td>
<td>Condavail</td>
<td></td>
</tr>
<tr>
<td>4.16</td>
<td>How many sexual partners have you had in the last 12 months (including spouse/permanent partners)? Enter number; 99=NK;</td>
<td>Part12mt</td>
<td></td>
</tr>
</tbody>
</table>
Now I will ask you some questions about your **regular sexual partner**. By regular I mean the person you have a consistent sexual relationship with.

<table>
<thead>
<tr>
<th>Question</th>
<th>Response Options</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.17 Have you ever discussed using condoms with your regular sexual partner?</td>
<td>1=Yes; 2=No; 9=NK</td>
<td>Cond1</td>
</tr>
<tr>
<td>4.18 Was it easy or difficult to discuss condoms with your regular partner?</td>
<td>1=Very easy; 2=Easy; 3=Difficult; 4=Very difficult; 9=NK</td>
<td>Cond2</td>
</tr>
<tr>
<td>4.19 Would you like to use a condom with your regular sexual partner?</td>
<td>1=Yes; 2=No; 9=NK</td>
<td>Cond3</td>
</tr>
<tr>
<td>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?</td>
<td>1=Not at all confident; 2=Somewhat confident; 3=Confident; 4=Very confident; 9=NK</td>
<td>Cond4</td>
</tr>
<tr>
<td>4.21 How often do you use a condom with your regular partner?</td>
<td>1=Always; 2=Most of the time; 3=Sometimes; 4=Once in a while; 5=Never; 9=NK</td>
<td>Cond5</td>
</tr>
<tr>
<td>4.22 Did you use a condom with your regular partner the last time you had sexual intercourse?</td>
<td>1=Yes; 2=No; 9=NK</td>
<td>Cond6</td>
</tr>
<tr>
<td>4.23 Did you drink alcohol prior to having sex with your regular partner, the last time you had sex with them?</td>
<td>1=Yes; 2=No; 9=NK</td>
<td>Cond7</td>
</tr>
</tbody>
</table>

Now I would like to ask you some questions about **non-regular** 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.

<table>
<thead>
<tr>
<th>Question</th>
<th>Response Options</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.24 Have you had sexual intercourse with a non-regular in the last 12 months?</td>
<td>1=Yes; 2=No; 9=NK</td>
<td>NonReg1</td>
</tr>
<tr>
<td>4.25 Have you ever discussed using a condom with your non-regular partner?</td>
<td>1=Yes; 2=No; 9=NK</td>
<td>NonReg1</td>
</tr>
<tr>
<td>4.26 Was it easy or difficult to discuss condoms with your non-regular partner?</td>
<td>1=Very easy; 2=Easy; 3=Difficult; 4=Very difficult; 9=NK</td>
<td>NonReg1</td>
</tr>
<tr>
<td>4.27 Would you like to use condoms with your non-regular partner?</td>
<td>1=Yes; 2=No; 9=NK</td>
<td>NonReg1</td>
</tr>
<tr>
<td>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?</td>
<td>1=Not at all confident; 2=Somewhat confident; 3=Confident; 4=Very confident; 9=NK</td>
<td>NonReg1</td>
</tr>
<tr>
<td>4.29 How often do you use condoms with your non-regular partner?</td>
<td>1=Always; 2=Most of the time; 3=Sometimes; 4=Once in a while; 5=Never; 9=NK</td>
<td>NonReg1</td>
</tr>
</tbody>
</table>
### Section E: 5. Access to HIV & AIDS, VCT Services and Utilisation

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

<table>
<thead>
<tr>
<th>5.1</th>
<th>What places offer HIV testing services? Do not prompt</th>
<th>VCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1.1</td>
<td>Workplace clinic</td>
<td>__</td>
</tr>
<tr>
<td>5.1.2</td>
<td>Clinic</td>
<td>__</td>
</tr>
<tr>
<td>5.1.3</td>
<td>Hospital</td>
<td>__</td>
</tr>
<tr>
<td>5.1.4</td>
<td>NGO /CBO</td>
<td>__</td>
</tr>
<tr>
<td>5.1.5</td>
<td>Private Doctor</td>
<td>__</td>
</tr>
<tr>
<td>5.1.6</td>
<td>Don’t know</td>
<td>__</td>
</tr>
<tr>
<td>5.1.7</td>
<td>Other (specify)____________________________</td>
<td>__</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5.2</th>
<th>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 (specify)____________________________</th>
<th>Place</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.2.1</td>
<td>What places offer counselling for HIV and AIDS? Do not prompt</td>
<td>Place1</td>
</tr>
<tr>
<td>5.2.2</td>
<td>Workplace</td>
<td>__</td>
</tr>
<tr>
<td>5.2.3</td>
<td>Clinic</td>
<td>__</td>
</tr>
<tr>
<td>5.2.4</td>
<td>Hospital</td>
<td>__</td>
</tr>
<tr>
<td>5.2.5</td>
<td>Community organization</td>
<td>__</td>
</tr>
<tr>
<td>5.2.6</td>
<td>Private Doctors</td>
<td>__</td>
</tr>
<tr>
<td>5.2.7</td>
<td>Don’t know</td>
<td>__</td>
</tr>
</tbody>
</table>
### 5.2.8
Other (specify)_____________________

### 5.3
Where would you prefer to be counselled?
1= I don’t want to be counselled; 2= Workplace; 3= In my community; 4= In another community; 5= Private Doctor; 6= I have no preference; 7= I do not know; 8= Other (specify)_____________________

### 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

| 5.4.1 Workplace |  
| 5.4.2 Clinic |  
| 5.4.3 Hospital |  
| 5.4.4 NGO/CBO |  
| 5.4.5 Community |  
| 5.4.6 Don’t know |  
| 5.4.7 Other (specify)_____________________

### 5.5
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; 7= I do not know; 8= Other (specify)_____________________

### 5.6
Where does one find any support groups for people who have AIDS or their families?
1= Mentioned 2= Not mentioned; 8= NA

| 5.6.1 Workplace |  
| 5.6.2 Clinic |  
| 5.6.3 Hospital |  
| 5.6.4 NGO/CBO |  
| 5.6.5 Church |  
| 5.6.6 Community |  
| 5.6.7 Don’t know |  
| 5.6.8 Other (specify)_____________________

### 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; 6= I do not know; 7= Other (specify)_____________________

### Place7

### Counsel

### HIVEd

### HIVEd1

### HIVEd2

### HIVEd3

### HIVEd4

### HIVEd5

### HIVEd6

### HIVEd7

### PartEd

### Grps

### Grps1

### Grps2

### Grps3

### Grps4

### Grps5

### Grps6

### Grps7

### Grps8

### 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 Proximity | __ | Reas2
5.7.4 Easily accessible | __ | Reas3
5.7.5 Provide good health services | __ | Reas4
5.7.6 Organise support groups | __ | Reas5
5.7.7 Confidentiality | __ | 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 Educational sessions | __ | HIVact1
5.8.2 Counselling | __ | HIVact2
5.8.3 HIV Testing | __ | HIVact3
5.8.4 HIV and AIDS support group | __ | HIVact4
5.8.5 None of the above | __ | 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. 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 | __ | 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
<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.10.8 Refuse to answer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.10.9 Other (specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.11 Would you like to be tested for HIV and AIDS in the future?</td>
<td>1=Yes; 2=No; 9=NK</td>
<td>Testfut</td>
</tr>
<tr>
<td>5.12 Why would you want to be tested?</td>
<td>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</td>
<td>Testre1</td>
</tr>
<tr>
<td>5.13 Why would you not want to be tested?</td>
<td>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</td>
<td>Testre2</td>
</tr>
<tr>
<td>Section F: 6. Stigma and Disclosure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.0 Do you know of anyone who has had a blood test for HIV and AIDS and is POSITIVE?</td>
<td>1=Yes; 2=No; 9=NK</td>
<td>HIVpost</td>
</tr>
<tr>
<td>6.1 Do you think that it is advisable for people to tell others their HIV and AIDS status?</td>
<td>1=Yes; 2=No; 9=NK</td>
<td>HIVtell</td>
</tr>
<tr>
<td>6.2 Who would be the most appropriate person/people to be informed of someone’s HIV and AIDS status?</td>
<td>1= Spouse / permanent partner; 2=Girlfriend/Boyfriend; 3=Parents; 4=Close Friend; 5=Colleague; 6=Neighbour; 7=Social worker; 8=Counsellor; 10=Other (specify)</td>
<td>Tellpers</td>
</tr>
<tr>
<td>6.3 If a member of your family got infected with HIV and AIDS, would you want it to remain a secret?</td>
<td>1=Yes; 2=No; 9=NK</td>
<td>HIVfami</td>
</tr>
<tr>
<td>6.4 Who would you tell first if you were infected with HIV?</td>
<td>1=Girlfriend/Boyfriend; 2=Spouse; 3=Colleague; 4=Social worker; 5=Counsellor; 6=Friend; 7=No-one; 8=Other(specify)</td>
<td>Firsttell</td>
</tr>
<tr>
<td>6.5 How would you go about telling this person about your HIV status?</td>
<td>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</td>
<td>Howtell</td>
</tr>
</tbody>
</table>
6.6 Would you feel comfortable to shake hands with a colleague/person whom you know has HIV and AIDS?  1=Yes; 2=No; 3=Somewhat

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

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

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

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

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

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

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

6.13.2 Verbal abuse

6.13.3 Physical abuse/violence

6.13.4 Rumours/gossips

6.13.5 Rejection

6.13.6 Ejection from home

6.13.7 Rejection by community

6.13.8 Rejection by insurance

6.13.9 None

6.13.10 Other (specify) ________________

6.14 Who treats them badly? Do not prompt; 1=Mentioned 2=Not mentioned; 8=NA

6.14.1 Family members

6.14.2 Neighbours

6.14.3 Community members

6.14.4 Health workers

6.14.5 Young people
| 6.14.6 | Everyone | Stigma22 |
| 6.14.7 | Religious groups | Stigma23 |
| 6.14.8 | Colleagues | 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=Female treated better; 2=Female treated same; 3=Female treated worse; 9=Don’t know. | Stigma29 |

**Section G: 7. Care and Support**

<p>| 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 | Help the person to wash | 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? | Fear |
| 7.2.1 | None | Fear |</p>
<table>
<thead>
<tr>
<th>Section</th>
<th>Question</th>
<th>Code</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.2.2</td>
<td>Fear of being infected</td>
<td>Fear1</td>
<td></td>
</tr>
<tr>
<td>7.2.3</td>
<td>Rejection by people</td>
<td>Fear2</td>
<td></td>
</tr>
<tr>
<td>7.2.4</td>
<td>Fear of being labelled</td>
<td>Fear3</td>
<td></td>
</tr>
<tr>
<td>7.2.5</td>
<td>Lack of care skills</td>
<td>Fear4</td>
<td></td>
</tr>
<tr>
<td>7.2.6</td>
<td>Other (specify)</td>
<td>Fear5</td>
<td></td>
</tr>
<tr>
<td>7.3</td>
<td>Do you encourage others to provide care and support for PLHA? 1=Yes; 2=No; 9=NK</td>
<td>CareEnco</td>
<td></td>
</tr>
<tr>
<td>7.4</td>
<td>Do you think that PLHA have access to adequate care and support services? 1=Yes; 2=No; 9=NK</td>
<td>CareAcce</td>
<td></td>
</tr>
<tr>
<td>7.5</td>
<td>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</td>
<td>TypePe</td>
<td></td>
</tr>
<tr>
<td>7.5.1</td>
<td>Family members</td>
<td>TypePe1</td>
<td></td>
</tr>
<tr>
<td>7.5.2</td>
<td>Neighbours</td>
<td>TypePe2</td>
<td></td>
</tr>
<tr>
<td>7.5.3</td>
<td>Church members</td>
<td>TypePe3</td>
<td></td>
</tr>
<tr>
<td>7.5.4</td>
<td>In-patients in clinic/hospital</td>
<td>TypePe4</td>
<td></td>
</tr>
<tr>
<td>7.5.5</td>
<td>Peers</td>
<td>TypePe5</td>
<td></td>
</tr>
<tr>
<td>7.5.6</td>
<td>Other (specify)</td>
<td>TypePe6</td>
<td></td>
</tr>
<tr>
<td>7.6</td>
<td>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</td>
<td>BestCar</td>
<td></td>
</tr>
<tr>
<td>7.6.1</td>
<td>Home</td>
<td>BestCar1</td>
<td></td>
</tr>
<tr>
<td>7.6.2</td>
<td>Clinic/hospital</td>
<td>BestCar2</td>
<td></td>
</tr>
<tr>
<td>7.6.3</td>
<td>Community</td>
<td>BestCar3</td>
<td></td>
</tr>
<tr>
<td>7.6.4</td>
<td>Traditional healer’s house</td>
<td>BestCar4</td>
<td></td>
</tr>
<tr>
<td>7.6.5</td>
<td>School environment</td>
<td>BestCar5</td>
<td></td>
</tr>
<tr>
<td>7.6.6</td>
<td>Other (specify)</td>
<td>BestCar6</td>
<td></td>
</tr>
<tr>
<td>Section H</td>
<td>8. Socio–Cultural Practices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.0</td>
<td>Have you ever taken alcohol? 1=Yes; 2=No;</td>
<td>AlcoEver</td>
<td></td>
</tr>
<tr>
<td>8.1</td>
<td>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</td>
<td>AlcoPast</td>
<td></td>
</tr>
<tr>
<td>8.2</td>
<td>Have you ever taken drugs? 1=Yes; 2=No;</td>
<td>DrugEver</td>
<td></td>
</tr>
<tr>
<td>8.3</td>
<td>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</td>
<td>DrugPast</td>
<td></td>
</tr>
</tbody>
</table>
### 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**

<table>
<thead>
<tr>
<th>9.1</th>
<th>Friendly/happy</th>
<th>1</th>
<th>9.1.1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Respectful</td>
<td>1</td>
<td>9.1.2</td>
</tr>
<tr>
<td></td>
<td>Caring</td>
<td>1</td>
<td>9.1.3</td>
</tr>
<tr>
<td></td>
<td>Unfriendly/unhappy</td>
<td>1</td>
<td>9.1.4</td>
</tr>
<tr>
<td></td>
<td>Non respectful</td>
<td>1</td>
<td>9.1.5</td>
</tr>
<tr>
<td></td>
<td>Uncaring</td>
<td>1</td>
<td>9.1.6</td>
</tr>
<tr>
<td></td>
<td>Abusive</td>
<td>1</td>
<td>9.1.7</td>
</tr>
<tr>
<td></td>
<td>Other (specify)</td>
<td>1</td>
<td>9.1.8</td>
</tr>
</tbody>
</table>

#### 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**

<table>
<thead>
<tr>
<th>9.2</th>
<th>Hit/beat/slap/kicked</th>
<th>1</th>
<th>9.2.1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Forced to have sex</td>
<td>1</td>
<td>9.2.2</td>
</tr>
<tr>
<td></td>
<td>Forced into sex without condom</td>
<td>1</td>
<td>9.2.3</td>
</tr>
<tr>
<td></td>
<td>Denied food</td>
<td>1</td>
<td>9.2.4</td>
</tr>
<tr>
<td></td>
<td>Threatened with a weapon</td>
<td>1</td>
<td>9.2.5</td>
</tr>
<tr>
<td></td>
<td>Locked out</td>
<td>1</td>
<td>9.2.6</td>
</tr>
<tr>
<td></td>
<td>Swearing/cursing</td>
<td>1</td>
<td>9.2.7</td>
</tr>
<tr>
<td></td>
<td>None</td>
<td>1</td>
<td>9.2.8</td>
</tr>
<tr>
<td></td>
<td><em>Refuse to answer</em></td>
<td>1</td>
<td>9.2.9</td>
</tr>
<tr>
<td></td>
<td>Other (specify)</td>
<td>1</td>
<td>9.2.10</td>
</tr>
</tbody>
</table>

#### 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**

<table>
<thead>
<tr>
<th>9.3</th>
<th>Hit/beat/slap/kicked</th>
<th>1</th>
<th>9.3.1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Forced to have sex</td>
<td>1</td>
<td>9.3.2</td>
</tr>
<tr>
<td></td>
<td>Forced into sex without condom</td>
<td>1</td>
<td>9.3.3</td>
</tr>
<tr>
<td></td>
<td>Denied food</td>
<td>1</td>
<td>9.3.4</td>
</tr>
<tr>
<td></td>
<td>Threatened with a weapon</td>
<td>1</td>
<td>9.3.5</td>
</tr>
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<td>Description</td>
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<td>---------</td>
<td>--------------------------------------------------</td>
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<td></td>
</tr>
<tr>
<td>9.3.6</td>
<td>Locked out</td>
<td>DoneLast6</td>
<td></td>
</tr>
<tr>
<td>9.3.7</td>
<td>Swearing/cursing</td>
<td>DoneLast7</td>
<td></td>
</tr>
<tr>
<td>9.3.8</td>
<td>None</td>
<td>DoneLast8</td>
<td></td>
</tr>
<tr>
<td>9.3.9</td>
<td>Refuse to answer</td>
<td>DoneLast9</td>
<td></td>
</tr>
<tr>
<td>9.3.10</td>
<td>Other (specify)__________________________</td>
<td>DoneLast1</td>
<td></td>
</tr>
<tr>
<td>9.4</td>
<td>Do you agree or disagree that a man should have a final say in sexual matters? 1=Agree; 2=Disagree; 9=Don’t know</td>
<td>Finalsay</td>
<td></td>
</tr>
<tr>
<td>9.5</td>
<td>Do you agree or disagree that a woman has the right to refuse sex? 1=Agree; 2=Disagree; 9=Don’t know</td>
<td>Sexref</td>
<td></td>
</tr>
<tr>
<td>9.6</td>
<td>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</td>
<td>SexViolenc</td>
<td></td>
</tr>
<tr>
<td>9.7</td>
<td>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</td>
<td>WomanRe</td>
<td></td>
</tr>
<tr>
<td>9.7.1</td>
<td>During menstruation</td>
<td>WomanRe 1</td>
<td></td>
</tr>
<tr>
<td>9.7.2</td>
<td>During pregnancy</td>
<td>WomanRe 2</td>
<td></td>
</tr>
<tr>
<td>9.7.3</td>
<td>Partner is unfaithful</td>
<td>WomanRe 3</td>
<td></td>
</tr>
<tr>
<td>9.7.4</td>
<td>Recently given birth</td>
<td>WomanRe 4</td>
<td></td>
</tr>
<tr>
<td>9.7.5</td>
<td>Afraid of being infected with HIV</td>
<td>WomanRe 5</td>
<td></td>
</tr>
<tr>
<td>9.7.6</td>
<td>Tired</td>
<td>WomanRe 6</td>
<td></td>
</tr>
<tr>
<td>9.7.7</td>
<td>Drunk</td>
<td>WomanRe 7</td>
<td></td>
</tr>
<tr>
<td>9.7.8</td>
<td>Don’t know</td>
<td>WomanRe 8</td>
<td></td>
</tr>
<tr>
<td>9.7.9</td>
<td>Other (specify)_______________________</td>
<td>__</td>
<td>WomanRe9</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>9.8</td>
<td>Under what circumstances is it acceptable for a man to refuse sex with his partner? <strong>Do not prompt; 1=Mentioned 2=Not mentioned; 8=NA</strong></td>
<td></td>
<td>ManRef</td>
</tr>
<tr>
<td>9.8.1</td>
<td>During menstruation</td>
<td>__</td>
<td>ManRef1</td>
</tr>
<tr>
<td>9.8.2</td>
<td>During pregnancy</td>
<td>__</td>
<td>ManRef2</td>
</tr>
<tr>
<td>9.8.3</td>
<td>Partner is unfaithful</td>
<td>__</td>
<td>ManRef3</td>
</tr>
<tr>
<td>9.8.4</td>
<td>Recently given birth</td>
<td>__</td>
<td>ManRef4</td>
</tr>
<tr>
<td>9.8.5</td>
<td>Afraid of being infected with HIV</td>
<td>__</td>
<td>ManRef5</td>
</tr>
<tr>
<td>9.8.6</td>
<td>Tired</td>
<td>__</td>
<td>ManRef6</td>
</tr>
<tr>
<td>9.8.7</td>
<td>Drunk</td>
<td>__</td>
<td>ManRef7</td>
</tr>
<tr>
<td>9.8.8</td>
<td>Don’t know</td>
<td>__</td>
<td>ManRef8</td>
</tr>
<tr>
<td>9.8.9</td>
<td>Other (specify)_______________________</td>
<td>__</td>
<td>ManRef9</td>
</tr>
<tr>
<td>9.9</td>
<td>Do you agree or disagree that people should be forced into having sex even if they don’t want to? <strong>1=Agree; 2=Disagree; 9=Don’t know</strong></td>
<td></td>
<td>Forcesex</td>
</tr>
<tr>
<td>9.10</td>
<td>Are forced to provide sex in exchange for employment: <strong>1=Agree; 2=Disagree; 9=Don’t know</strong></td>
<td></td>
<td>SexEmpl</td>
</tr>
</tbody>
</table>
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 (MoHSW) 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: Fisheries/Plantations

- Regional/District Fisheries Offices/RACC
- District Executive/Council Directors
- District Planning Offices (DPLO)
- District Medical Officer (DMO)
- Council HIV&AIDS Coordinators (CHAC)
- District HIV&AIDS Coordinator (DACC)
- Tanzania Fisheries Research Institute (TAFIRI)
- Human Relation Officers (Kagera Tea & Kagera Sugar)
- Beach Management Unit (BMU)
- Medical Officer I/C (Kagera Tea & Kagera Sugar)
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&AIDS:**
   a. In your own assessment, how big a problem is HIV&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&AIDS related services:**
   a. Are HIV&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&AIDS service in plantations:**

3.1. **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?
3.2. **Coordination Issue:**

f. What coordination structures for HIV&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

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 behaviours 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 center 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

CC: RMO DMO

Name: Dr Deo M Mwasiwa

Signature

CHIEF MEDICAL OFFICER MINISTRY OF HEALTH, SOCIAL WELFARE