# UZIKWASA
# Training Guide



# For Village and Ward
# Multisectoral HIV/AIDS Committees

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# ACKNOWLEDGEMENTS

# LIST OF ACRONYMS

| | |
|---|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| ARVs | Anti-retroviral drugs |
| CBO | Community Based Organisation |
| CMAC | Council Multisectoral AIDS Committee |
| FBO | Faith Based Organisation |
| MAC | Multisectoral AIDS Committee |
| NACP | National AIDS Control Programme |
| NGO | Non-Government Organisation |
| NMSF | National Multisectoral Strategic Framework |
| PLHA | People living with HIV/AIDS |
| PMTCT | Prevention of Mother to Child Transmission |
| STI | Sexually Transmitted Infections |
| TACAIDS | Tanzania Commission of AIDS |
| TCMP | Tanzania Coastal Management Partnership |
| TFD | Theatre for Development |
| UZIKWASA | Uzima kwa Sanaa |
| VCT | Voluntary Counselling and Testing |
| VMAC | Village Multisectoral AIDS Committee |
| WHO | World Health Organisation |
| WMAC | Ward Multisectoral AIDS Committee |
| WEO | Ward Executive Officer |

# INTRODUCTION

In Tanzania, like other developing countries, taking a multisectoral approach has become a keystone of the National AIDS control strategy. This means including all sectors, public, private, voluntary and faith-based institutions, and most importantly, local communities.

The National Multisectoral Strategic Framework on HIV and AIDS (2003-2007), puts emphasizes a community-based response to HIV and AIDS, which means fully involving communities in the planning, implementation, monitoring and evaluation of their own HIV and AIDS-control activities. In 2003, structures for the co-ordination of local responses to HIV/AIDS were formed from the council level down to the village level.

While Council Multisectoral AIDS Committees (CMACs) were strengthened nationwide through an extensive training programme, lower level multisectoral AIDS committees in the wards (WMACs) and villages (VMACs) are yet to be trained on their new roles.

A major challenge therefore is the need for them to co-ordinate their local responses to HIV and AIDS. This requires a proper understanding of the pandemic itself as well as sound knowledge of their roles and responsibilities.

The present training guide is primarily based on the TACAIDS training modules for Council Multisectoral AIDS Committees. These modules were modified and shortened in order to suit the particular training needs of lower level multisectoral AIDS Committees.

Furthermore, the guide puts particular attention on the gender dimensions of the escalating HIV and AIDS situation. In our own experiences from working with grass roots communities, gender issues are prominent among the socio-cultural factors that inhibit HIV-prevention and control efforts.

Other key topics in HIV/AIDS control covered include basic facts on HIV and AIDS, national guidelines, composition, roles and responsibilities of multisectoral AIDS committees, participatory HIV and AIDS planning and report writing.

The user of this training guide is expected to be innovative and regard it as a simple guide rather than a document that possesses all the answers. One is advised to consult other sources as well.

UZIKWASA invites any user to provide feed back and suggestions for future improvements.

# UNIT 1. BASIC FACTS AND THE STATUS OF HIV/AIDS IN TANZANIA

## UNIT OVERVIEW

This unit is intended to provide basic facts on HIV and AIDS to Multisectoral AIDS Committee (MAC) members and update them on emerging issues related to the epidemic. It aims to create positive attitudes towards people affected by HIV and AIDS, thus counteracting stigma in communities.

## UNIT SESSIONS

1.1     Basic facts on HIV and AIDS
1.2     HIV and AIDS Situation in Tanzania

## TRAINING METHODOLOGY

- Lecture
- Group discussions
- Plenary

## TRAINING MATERIALS

- Overhead Projector
- Transparencies
- Flip charts (or chalkboard)
- Masking tape
- Marker pens (or chalk)
- Pieces of paper
- Video Projector
- Video Film on Sexually Transmitted Infections (STIs) and HIV and AIDS

## SESSION 1.1     BASIC FACTS ON HIV AND AIDS

### SESSION OBJECTIVES:

By the end of the session, the participant should be able to:
1. Explain the differences between HIV and AIDS
2. Describe the modes of HIV transmission
3. Describe signs and symptoms of HIV and AIDS
4. Describe the natural history of AIDS (stages)
5. Describe preventive measures against HIV transmission
6. Describe anti-retroviral therapy.
7. Discuss stigma and discrimination

### SESSION ACTIVITIES

1. Start the session by introducing the topic and explaining the objectives. Ask the participants in a plenary session:
   - What is HIV and how is it transmitted?
   - What is AIDS?

2. *Divide the participants into groups.* Each group member should reflect on a behaviour that could put them at risk of contracting HIV and suggest ways of avoiding such behaviour. These should be listed under the heading: "possible risky behaviours".
   Let each group discuss:
   ▪ Risk factors of HIV transmission, particularly in their respective communities.
   ▪ HIV-prevention methods which they know.
3. Summarize the answers, give the model answers, correct misconceptions if any and agree on the model answers.
4. Inform participants and arrange for a video show on Sexually Transmitted Infections and HIV and AIDS.
5. Share with participants their observations, reflections and lessons from the video show. Make sure that you watch the Video film before showing it to the participants. Use probing questions during discussion. Make sure you have answers to these questions as well. Some examples of probing questions are:
▪ What did you see and hear?
▪ What symptoms/signs have been shown/ explained?
▪ How does one contract HIV or STIs?
▪ What can we do to prevent it?
▪ What recommendations do we have to the local authorities with regard to the fight against HIV in our community
6. After some brainstorming on the natural history of HIV and AIDS make a brief presentation on the subject.
7. Ask the participants a few questions (brainstorming) to find out what they know about anti-retroviral drugs (ARVs). Then make a presentation on the subject.
8. Ask participants to explain how they understand the terms "stigma" and "discrimination"
9. Discuss their responses, clarify gaps, and summarize.
10. Design a role-play portraying how People Living with HIV/AIDS (PLHA) are stigmatized and discriminated.

## FACILITATOR'S NOTES

### 1. The difference between HIV and AIDS

*What is HIV?*

"HIV" is the short form for "Human Immunodeficiency Virus". It is the name of the virus that destroys the body's immune system (the defence mechanism that fights diseases). HIV infection occurs when a person contracts the virus (HIV) in his/her body. He/She has

> *H - Human*
> *I - Immunodeficiency*
> *V - Virus*

not yet developed the disease. This person looks healthy but is highly infectious and capable of transmitting the virus to another person.

*What is AIDS?*

"AIDS" is the short form for "Acquired Immune Deficiency Syndrome". This is the disease resulting from the HIV infection (the virus) that destroys the body's immune system. At this stage, a person with AIDS has symptoms and signs of AIDS-related diseases.

> *A - Acquired*
> *I - Immune*
> *D - Deficiency*
> *S - Syndrome*

### 2. Modes of transmission of HIV

The main types of HIV transmission are:

- Through unprotected sexual intercourse with an infected partner
- From an infected mother to her child during
  - Pregnancy
  - Birth
  - Breast-feeding.
- Through transfusion of contaminated (infected) blood and blood products.
- Through contaminated needles by intravenous drug users.
- Through sharing contaminated sharp skin piercing instruments, e.g. group circumcision, tattooing etc.

## 3. Signs and symptoms of AIDS

As the immune system weakens the infected person starts to experience health problems. The World Health Organization (WHO) has produced a clinical case definition of AIDS for Africa where the symptoms are divided into major and minor. AIDS is diagnosed by the existence of at least two major and one minor symptom. Children have to present at least two major signs and two minor signs.

*Major Symptoms*

- Body weight loss of 10% or more within a short period
- Chronic diarrhoea persisting for more than one month
- Persistent fever lasting for more than one month

*Minor Signs*

- Persistent cough for more than a month
- Skin infection (fungal infection)
- Recurrent herpes zoster (Shingle's)
- Oral candidiasis or thrush
- Swelling of lymph nodes
- Chronic or persistent herpes simplex

**NOTE:** *The above signs and symptoms are not necessarily used to conclude that someone is HIV infected. This is because there are other health conditions which present with similar signs and symptoms. For confirmation purposes, laboratory tests should be carried out.*

## 4. Natural History of HIV

The natural history of HIV refers to the diseases progression in the human body and its outcome. Once infected the person passes through the following stages:

*Window period:*

The window period is the time between becoming infected with HIV to the time when the body responds by producing antibodies. The person is free of symptoms and **appears negative when tested** but is capable of passing the virus to other persons. The window period is from 3 weeks to 6 months.

*Dormant period:*

This is the period when a person is HIV positive but the virus is still "dormant" which means somehow sleeping. Therefore there are no signs of illness. However, a test will show HIV+ if the person is tested.

*AIDS-Related Complex (ARC):*

This is the stage of onset of clinical illness with non-specific symptoms/signs i.e. swelling of the lymph nodes, nausea, chronic diarrhoea, weight loss, fever and fatigue.

*Full-blown AIDS*

This is the stage when a patient presents obvious symptoms and signs of AIDS. The symptoms of AIDS are those of opportunistic infections that take advantage of the damaged immune system. Full blown AIDS refers to only the last fatal stage of HIV infection. Without treatment at this stage the patient will die after a short time.

## 5. HIV Preventive Measures

There are many ways to prevent HIV infection. These ways depend on the risk and vulnerability factors associated with them. Common measures are:
- Abstinence (This gives you 100% protection)
- Faithfulness to one uninfected partner
- Practicing safer sex: Consistent and correct use of male or female condom when having sex.
- Practicing sex without penetration such as kissing, masturbation etc.
- Taking universal precaution when touching blood or body fluids. Always wearing gloves when dealing with blood related procedures.
- Ensuring blood safety measures are undertaken prior to blood transfusion.
- Early and complete treatment of STIs for both couples.
- Male circumcision has been proved to be protective, but for men only.
- Encouraging voluntary counselling and testing for all, particularly for expecting mothers or women who plan to get pregnant.
- Providing anti-retroviral drugs to HIV-positive pregnant women to prevent transmission to the unborn child.
- Countering harmful gender norms that lead to the sexual coercion and exploitation of women and girls[1].
- Countering harmful cultural practices such as widow inheritance (unless both partners are tested and found HIV negative), dry sex, Female Genital Mutilation (FGM) and many others.
- Preventing HIV among drug users including drug dependency treatment, rehabilitation, education, psychosocial support and access to clean needles and syringes.
- Giving information on HIV and AIDS and life skills to young people to reduce their vulnerability to HIV infection.
- Fighting poverty and unemployment.

## 6. Anti-retroviral therapy

Antiretroviral drugs have been available since 1998. This does not mean that a cure for the HIV infection was found. However, drugs do exist that can improve the quality of life of PLHA and prolong their lives by supporting the immune system, reducing the viral load and, through that, minimize the symptoms. But we do not yet know how long people will continue to live under such treatment,

In order for patients to use ARV treatment effectively they need
- proper medical consultation

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[1] See also Unit 4 on Gender

- counselling on how to use a combination of drugs properly
- to understand that they might need a lifelong treatment
- regular clinical and laboratory check ups
- strictly adhere to the treatment plan
- know that these drugs can have severe side effects

## 7. Stigma and discrimination

*Definition of Stigma*

Stigma can be defined as the act of identifying, labelling or attributing undesirable qualities targeted towards those who are perceived as being shamefully different and deviant from the social norm.

*Definition of Discrimination*

Discrimination refers to some action based on stigma and directed towards people infected or affected by HIV/AIDS. Such actions might involve:
- refusal to grant (justice rights etc)
- refusal to acknowledge
- disownment of responsibility or disassociation from the truth
- refuse somebody something requested or a specific service

   ***NOTE:*** *Stigma is the attitude and discrimination is the act*

*Causes of stigma and discrimination*

- Misinformation about HIV transmission
- Fear of contracting HIV
- Religious beliefs about sexual practices and certain preventive methods.
- Cultural norms that cause silence regarding sexual practice preferences and desires.
- Shocking pictures or words used by media (e.g. television, radio and magazines) when discussing HIV and AIDS.

*How is stigma created?*

*HIV positive people may cause self-stigmatisation due to:*
- Fear of isolating themselves (being misunderstood, abandoned, dead)
- Fear of not being accepted anymore by family and community

*The media*
- Calling HIV positive persons negative names, such as "Marehemu mtarajiwa" ("the future dead").
- Sensationalized reporting of HIV-related negative outcomes
- Journalistic reporting may be gender biased " hela zamponza" (money has put her into trouble)

*The work place*
- You are only employed if you are tested HIV negative
- We can not share with you if you are polluted (HIV positive)
- You should leave employment if your are HIV positive

*The health profession*
- Training based on fear of death due to HIV (pollution disease)

- Fear due to shortages of medical supplies and the fear of being infected
- Test people for HIV without their consent

*The educational system*
- Children who have serious health problems are stigmatized.

*Effects of stigma and discrimination*

- Continued marginalization and denial of people's rights and services
- Further spread of HIV
- People living with HIV and AIDS hide their condition
- Clients miss opportunities for care provision and behaviour change interventions
- Sometimes people may not be considered for promotions or further studies.


## SESSION 1.2      HIV/AIDS SITUATION IN TANZANIA

### SESSION OBJECTIVES

By the end of the session the participant should be able to:
1. Describe the HIV and AIDS situation in Tanzania
2. Describe the local HIV and AIDS situation in their own communities
3. Describe the contributing factors in the transmission of HIV in their local areas.

### SESSIONS ACTIVITIES:

1. Make a presentation on the national HIV/AIDS situation

2. Ask participants to get into groups according to their Wards/Villages
   - Let each group discuss:
     - The magnitude of the epidemic in their own Ward/Village
     - The main factors contributing to HIV transmission in their areas
   - Let each group present their finding to the plenary for discussion
   - Clarify gaps in the discussion and summarize


### FACILITATOR'S NOTES:


**1. National HIV and AIDS situation**

Since the first AIDS cases in Tanzania were reported in the Kagera region in 1983, the HIV epidemic has progressed differently among various population groups. Early in the epidemic, the urban population and communities located along highways were most affected. In 1997, more than 10% of women attending antenatal clinics situated in some rural areas were found to be HIV infected. Recent projections suggest that by 2010 the number of new infections in rural areas could be twice as high as in urban areas (UNAIDS, 2006).

Most of those infected are between15-49 years of age, which is the most productive age. Infected women tend to be younger than men because young girls often get married to or have their sexual debut with older men.

Although the reported prevalence in Tanzania has declined from 8.1% in 1995 to 6.5% in 2004 (Somi et al, 2006) there was an estimated 1.4 million (between 1.3 and 1.6 million) adults and children living with HIV in Tanzania at the end of 2005, making Tanzania one of the most affected countries in the world (UNAIDS, 2006). As a consequence, life expectancy is falling and in 2001, Tanzanians lived on average until they were 43 years old (UNDP Human Development Report, 2003). Caution in interpreting these results is recommended since the NACP estimates that only 1 out of 5 AIDS cases are reported due to under utilization of health services, under diagnosis, under reporting and delays in reporting (http://www.tanzania.go.tz/hiv _aidsf.html). .

Youth and the women have been the most affected groups because of economic, socio-cultural, biological and anatomical reasons. Poverty, is also an important determinant. Mobile population groups have also been categorized as vulnerable to HIV infection as their occupation forces them into high-risk sexual behaviour. The mobile population groups include commercial sex workers, petty traders, migrant workers, military personnel and long-distance truck drivers.

Determinants of the epidemic have been identified and grouped into societal, behavioural and biological ones. The HIV and AIDS epidemic has had a serious impact on the country's economy. It has affected agricultural and industrial production as well as socio-demographic parameters such as life expectancy. AIDS orphans have been increasing while families, communities, and the Government cannot come up with the resources needed to cater to their needs.

**2. Examples of socio-cultural and behavioural factors contributing in the transmission of HIV in their own communities:**

- Excessive drinking of alcohol and use of illicit drugs
- Market days
- Gender inequality e.g. limited or no access to income by women/girls (sex as a source of income)
- Sexual violence including individual and collective rapes
- Sexual exploitation of young women and girls by older men
- Traditional dances especially during the night (initiation ceremony)
- Inheritance of widows
- Female Genital Mutilation (FGM)
- Early marriage of young girls to elderly men
- Burial rites
- Traditional healing
- Working or trading away from home for long periods
- Beliefs about witchcraft, for example the belief that having sex with a virgin cleanses or contributes to better business or that AIDS is caused by witchcraft.

# UNIT 2.   NATIONAL GUIDELINES ON HIV AND AIDS

## UNIT OVERVIEW

The HIV and AIDS epidemic needs to be addressed in a multisectoral, comprehensive, and holistic manner. The unit introduces the participants to the national policy and national framework that guide stakeholders and partners in their efforts to control the epidemic.

## UNIT SESSIONS:

    2.1. National HIV and AIDS Policy
    2.2. National Multisectoral Strategic Framework

## SESSION 2.1       NATIONAL HIV/AIDS POLICY

### SESSION OBJECTIVES

By the end of this session the participants should be able to:
1.  Define what a policy is
2.  Explain the overall goal of the National HIV/AIDS Policy
3.  Describe some of the guiding principles of the National HIV/AIDS Policy

### SESSIONS ACTIVITIES

1.  Ask participants what they understand by the term "policy". Discuss the responses and come out with an agreed definition "policy".
2.  Make a presentation of the overall goals and guiding principles of the National HIV and AIDS Policy.
3.  Clarify any issues which have not been properly understood.

### FACILITATOR'S NOTES

**1. Definition of policy**

A policy is a binding guideline or framework that describes commitment to a course of action. The National Policy on HIV/AIDS is defined as a general framework for our collective and individual response to the pandemic. The policy outlines among other things a strategy for preventing HIV and AIDS through sexual transmission, principles for counselling and testing, the rights of people living with HIV/AIDS, and the mandate and functions of the TACAIDS in the national response to the pandemic.

**2. Overall goal of the National HIV/AIDS Policy**

The overall goal of the National Policy on HIV/AIDS is to provide a general framework for leadership and coordination of the national multisectoral response to the HIV/AIDS pandemic. This includes:
- Formulation by all sectors of relevant interventions which will be effective in preventing HIV and AIDS and other sexually transmitted infections.
- Protecting and supporting vulnerable groups
- Mitigating the social and economic impact of HIV and AIDS

- Strengthening the institutions, communities and individuals in all sectors to stop the spread of the pandemic

The local government councils are the focal points for involving and co-ordinating public and private sectors, NGOs, FBOs and CBOs in planning and implementing HIV/AIDS interventions particularly at community level.

## *SESSION 2.2 NATIONAL MULTISECTORAL STRATEGIC FRAMEWORK (2003-2007)*

### SESSION OBJECTIVES

By the end of this session the participants should be able to:
1. Explain the meaning and purpose of the National Multisectoral Strategic Framework
2. Describe he main thematic areas of the National Multisectoral Strategic Framework

### SESSIONS ACTIVITIES

1. Make a presentation on the meaning, purpose of the National Multisectoral Strategic Framework.
2. Explain the main thematic areas of the National Multisectoral Strategic Framework.
3. Clarify any points that have not been well understood.

### FACILITATOR'S NOTES

**1. Meaning and purpose of the National Multisectoral Strategic Framework (NMSF)**

The NMSF is a document developed to guide various sectors in the planning and implementation of HIV/AIDS interventions. The NMSF attempts to translate the National HIV/AIDS policy into practice. It guides stakeholders on how to respond to the pandemic, by:
- Putting the problem of HIV/AIDS in the context of national development.
- Drawing on lessons learned from the first 16 years of HIV/AIDS prevention and control.
- Stating the mission, main values, and guiding principles
- Identifying priority areas and strategies for action and indicators of success.
- Creating a management, financial, and monitoring and evaluation framework.

Local government at all levels is required to respond to the HIV/AIDS pandemic in line with the NMSF.

**2. Main thematic areas of the National Multisectoral Strategic Framework**

*Thematic area 1: Cross cutting issues*

- Advocacy
- Fighting stigma and discrimination
- Community response
- Mainstreaming HIV and AIDS
- Development and poverty reduction policies

*Thematic area 2: Prevention.*

- Control of sexually transmitted infections (STIs)

- Condom promotion and distribution
- Voluntary Counselling and Testing (VCT)
- Prevention of Mother-to-Child transmission (PMTCT)
- Health promotion
- School based prevention (primary and secondary schools)
- Health promotion for vulnerable population groups.
- Workplace interventions
- Safety of blood, safety in the healthcare setting

*Thematic area 3: Care and support.*

- Treatment for common opportunistic
- Antiretroviral treatment
- Home and community - based care and support

*Thematic area 4: Social and economic impact mitigation.*

- Economic and social support for persons families and communities
- Support to orphans and other vulnerable children, especially those under five.

# UNIT 3. COMPOSITION, ROLES, AND RESPONSIBILITIES OF HIV/AIDS MULTISECTORAL COMMITTEES

## UNIT OVERVIEW

A clear understanding of the composition, roles and responsibilities of the MACs is crucial to the effective implementation of the HIV and AIDS prevention and control activities. This Unit introduces the MAC members to the areas of the guidelines that directly concern them.

## UNIT SESSIONS

3.1    Composition of Multisectoral AIDS Committees
3.2    Roles and responsibilities of Multisectoral HIV/AIDS Committees


## SESSION 3.1        COMPOSITION OF MULTISECTORAL HIV/AIDS COMMITTEES

### SESSION OBJECTIVE

By the end of the session the participant should be able to describe the composition of MACs in the local government at the district, ward, village, and hamlet levels.

### SESSIONS ACTIVITIES:

1. Let participants work in groups and ask them to list the composition of the multisectoral committees at district, village and ward levels.
2. Discuss the responses and agree on the correct composition of the MACs.


### FACILITATOR'S NOTES

**1. Composition of Multisectoral AIDS Committees**

*Council Multisectoral AIDS Committee (CMAC)*

- District Council Deputy Chairperson –Chair Person
- District Executive Director - secretary
- Elected members of Parliament from constituencies within the district
- Ward Councillors selected by the District Council (one woman and one man)
- One AIDS Coordinator
- Religious representatives (one Muslim and one Christian)
- Youth representatives (one girl and one boy)
- Representatives from PLHA (one woman and one man)
- One representative from a network of NGOs involved in AIDS control activities
- Representatives from other relevant sectors

*Ward Multisectoral AIDS Committee (WMAC)*

- Hon. Councillor of the Ward - Chairperson
- Ward Executive Officer - Secretary
- 2 Representatives from WDC must include one Community Development Officer
- Religious representatives (one Muslim and one Christian)

- Youth representatives (one girl and one boy)
- Influential person in WDC (one woman and one man)
- Representatives from PLHA (one woman and one man)
- One representative from a network of NGOs involved in AIDS control activities
- Representatives from other relevant sectors

### *Village Multisectoral AIDS Committee (VMAC)*

- Chairperson of the Village Government –Chairperson
- Village Executive Officer- Secretary
- 1 representative from each Hamlet (Kitongoji)
- 2 Representatives from the Village Council
- 1 teacher representing all school within the Village area.
- 2 influential persons from Village Council (one woman and one man)
- 2 Youth representatives (one girl and one boy)
- 2 Religious representatives (one Muslim and one Christian)
- Sector experts working within the Village area
- Representatives from PLHA (one woman and one man)
- 1 Representative from a network of NGOs involved in AIDS control activities

### *Hamlet Multisectoral AIDS Committee*

- Hamlet Chairperson – Chairperson
- Hamlet Secretary – Secretary
- 3 Members, two female and one male
- 2 Religious representatives (one Muslim and one Christian)
- 2 Youth representatives (one girl and one boy)
- 2 Representatives from PLHA (one woman and one man)
- 1 influential persons from Village Council (one woman and one man)

## *SESSION 3.2     ROLES AND RESPONSIBILITIES OF MULTISECTORAL HIV/AIDS COMMITTEES*

### SESSION OBJECTIVES

By the end of the session the participant should be able to describe the roles and responsibilities of Multisectoral AIDS Committees.

### SESSIONS ACTIVITIES:

1. Let the participants form groups.
2. Assign each group the task of describing the roles and responsibilities of MACs and then let the groups present their responses.
3. Summarize by providing the correct roles and responsibilities of MACs.

## FACILITATOR'S NOTES

### 1. Responsibilities of Multisectoral AIDS committees

1. To involve various stakeholders from the concerned areas to increase input of ideas and/or resources, supervision, coordination and implementation of TACAIDS activities
2. To oversee/supervise formation of AIDS committees at all levels
3. To analyse AIDS situation plans and plan for how to implement them
4. To evaluate the state of AIDS within the respective areas:
   - The number of affected persons - sick, orphans, and widows
   - Rate of infection
   - Special environmental factors that contribute towards spreading the infection and people's attitudes toward the epidemic
5. To evaluate different stakeholders' AIDS control activities
   - NGO's (capabilities and interests)
   - Faith Based Organizations (capabilities and interests)
   - Government Organization (capabilities and interests)
   - International Organizations (capabilities and interests)
6. To involve the community and other stakeholders in plans for
   - The fight against the AIDS epidemic
   - Increase people's awareness of AIDS
   - Collect and keep records related to the state of the AIDS epidemic and the economic status of those affected by AIDS
7. To coordinate/document, follow up, monitor, and evaluate the implementation process of the respective plans
   - To secure resources for implementation
   - To provide advice on bylaws and policies concerned with AIDS control at different levels.

# UNIT 4.   GENDER ISSUES IN RELATION TO HIV/AIDS

## UNIT OVERVIEW

In most Tanzanian communities gender relations are characterized by unbalanced power between men and women. Women usually have limited rights and access to socio-economic opportunities and social services. Poverty, cultural beliefs, and practices such as gender-based violence are major causative factors to these inequalities. In the context of HIV/AIDS, gender imbalances contribute considerably to women's increased vulnerability for contracting HIV. Therefore it is not possible to adequately deal with the various aspects of HIV/AIDS control unless gender issues are thoroughly addressed. Although national lawmakers have made progress toward providing a legal framework for gender equality, practices that make women more vulnerable to HIV/AIDS are still common, particularly at the community level where customary law prevails. At this level, socio-cultural practices do not provide enough attention to gender imbalances and constraints.

This unit helps the participants acquire a basic understanding of gender as an important determinant of the burden of HIV/AIDS among Tanzanian communities.

## SESSION UNITS

4.1 Gender issues in HIV/AIDS
4.2 Response to gender issues in HIV/AIDS

## SESSION 4.1      GENDER ISSUES IN HIV/AIDS

### SESSION OBJECTIVES

By the end of the session the participants should be able to:

1. Explain the meaning of gender and other related concepts (e.g. explain the difference between gender and sex).
2. Identify key gender issues and highlight the linkages between gender inequalities and the HIV and AIDS situation in their communities.

### SESSIONS ACTIVITIES:

1.   *Let the participants get into groups and assign each groups the task of defining key gender concepts:*

   a) Gender
   b) Sex
   c) Sexuality
   d) Gender equality
   e) Gender bias and discrimination
   f) Gender division of labour
   g) Masculinity ("mfumo dume")
   h) Women's empowerment
   i) Rearing girls and boys in the society (socialization).

Let the groups present their responses to the plenary for discussion. Clarify gaps and agree on the correct definitions.

*2.        Divide the participants get into groups again and let them*

- a) List gender related problems in their communities
- b) Discuss women's and men's socio-economic positions and roles in their communities and how this affects HIV and AIDS control activities in their villages.

They can discuss the linkages by using the following framework:

- *Transmission of HIV* (e.g. socio-cultural and economic factors and biological factors enhancing transmission)
- *Prevention* (e.g. socio-economic factors inhibiting prevention efforts)
- *VCT* (e.g. how gender inequalities affect counselling and testing)
- *PMTCT* (e.g. how gender inequalities affect health seeking behaviour)
- *Care and treatment* (e.g. the lack of participation of men and boys in caring for the sick)

Conduct a plenary discussion of the groups' findings. Summarize and conclude.

*3.        Final group work.*

Let the groups work out solutions to the gender related problems that they have discussed before, including the relationship between gender inequalities and HIV/AIDS control. Invite them to present their findings to the plenary for discussion and conclusion.

## FACILITATOR'S NOTES

### 1. Definition of terms

*Gender:*

Gender defines the relationship and interactions between men and women in the society. These differences are reflected in roles, responsibilities, access to resources, constraints, opportunities, needs, perceptions and views held by both women and men. In a society, the formation of gender roles and relationships start early in childhood. Male and female children are brought up in a way that they receive different norms and values. For example, while it is normal for young girls to do household duties and serve male family members, boys often are exempted from such duties.

Gender equality is a primary goal of all areas of social and economic development. Gender specific interventions can target women exclusively, as well as men and women together.

*Sex*

The term sex refers to biological differences between women and men. These properties distinguish human beings on the basis of their physical appearance and their reproductive and sexual organs.

### Difference between gender and sex

Sex is a biological make up of individuals. While sex is biological and unchangeable, gender is a changeable social construct, based on the values and norms of a society.

**Examples to use in the exercise**
Breastfeeding **(S)**
Women washing the dishes **(G)**
Having a beard **(S)**
Having a bald head **(S)**
Men are the breadwinners **(G)**
Girls can not study mathematics **(G)**
Women must prepare the family's food **(G)**
Men feeding a baby **(G)**
Women breastfeeding a baby **(S)**
Men carrying a baby **(G)**

S – Sex
G – Gender

### Sexuality

Involves giving and receiving sexual pleasure, as well as enabling reproduction. Sexuality is a sensory experience, involving the whole mind and body—not just the genitals. Sexuality is shaped by a person's values, attitudes, behaviours, physical appearance, beliefs, emotions, personality, likes and dislikes, and spiritual selves, as well as all the ways in which one has been socialized.

### Gender equality

It is the state of people, men and women, being equal in terms of opportunities to develop and reach their full potential irrespective of their sex.

### Gender bias and discrimination

Decisions and prejudicial treatment of a person based on gender stereotypes, for example, depriving women of acquiring positions which are commonly reserved for men.

### Gender division of labour

This refers to the types of work that men and women are assigned. The divisions are made based on supposedly essential differences between men and women (e.g. it is believed that a woman can not be a hunter or airline pilot, or that men are not supposed to wash dishes).

### Masculinity

Behaving in ways considered typical for men in a given society

### Women's empowerment

This is the process by which women and men achieve the skills, confidence and support to determine their own lives and make their own choices. It it's the state in which people have access to the resources and opportunities to control their own future.

*Rearing boys and girls in the society (Socialisation)*

This is the process whereby individuals learn, from early childhood, to conform to the moral standards, codes of conduct, role expectations, and role performances in a specific society.

## 2. Gender issues and how they influence the HIV/AIDS situation in communities.

*A. Transmission and prevention*

The following factors contribute to making women more vulnerable to HIV infection.

*Biological factors:*
- Women are four times more likely to become HIV infected than men. This is because women have a much larger mucosal surface than men and because there is more virus in sperm than in vaginal secretions. Infection normally happens through micro-lesions which can occur during intercourse. Very young women are more vulnerable to infection.
- The presence of an untreated STI is a major risk factor for HIV. In cases where they do not have any symptoms, women may not be aware that they have an STI. These women are more likely not to seek early treatment for the STI, makes them even more vulnerable to attracting HIV.
- Forced sex (rape) increases the risk of micro-lesions.

*Economic factors:*
- Financial or material dependence on men means that women have a harder time negotiating safe sex. Women are denied a lot of rights which contribute to their lack of financial power. For example:
  - *Land ownership:* Given the fact that the livelihood of about 80% of the population depends on land, and that women are more likely to use the land for income generating activities, land is an essential resource and asset to women. Traditionally women could use, but not own land.
  - *Income generating activities:* Women are often denied by their husbands to engage in income generating activities, thus depending entirely on their male partners. Since women usually do not participate in decisions concerning household budgets, they often do not even have pocket money for buying small household items.

The result of all this is that women often have to engage in sex with various partners in order to secure their and their children's basic needs.

*Socio-cultural factors:*
- Cultural norms and attitudes are believed to increase the likelihood of HIV transmission in rural villages*. For example:*
  - Women do not have control over their own sexual behaviour, because their male partners usually decide. Women do not have the negotiation power to use protection because of their unequal relationship with their partners.
  - Women who request to use condoms are often considered promiscuous and untrustworthy. If they insist on condom use they risk abuse or even divorce.
  - In African societies a woman is often blamed for not bearing children even if she is not the cause of the problem. As a consequence, women are desperately looking for a child even if it means having (unprotected) sex with many men outside their marriage.
  - Marital rape is accepted and puts women and risk
  - Wife inheritance: if a women's husband dies she is forced to get married to her late husband's brother.

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- Society accepts and sometimes demands to have multiple sex partners as an expression of male sexuality and masculinity.
- Women are expected to have relations with or marry older men who are more likely to be infected.
- Power relations: older men sometimes abuse girls under their charge (pupils, house girls, other female employees, and even female relatives) Sexual based abuse cases often go unnoticed because of the perception that they are "private or family matters")
- Men are seeking younger and younger partners to avoid infection and in the false belief that sex with a virgin cures AIDS and other diseases.

*B. HIV&AIDS preventive services*

*Voluntary HIV counselling and testing (VCT) and Prevention of Mother to Child Transmission (PMTCT):*
- Women usually do not notify their partners when they find out that they are HIV infected, because they are likely to face violence when disclosing their positive status to their male partners.
  - Because of heavy social pressure, couples are expected to have children, regardless of their HIV status,.
  - Male partners usually do not have access to educational sessions conducted in antenatal clinics, and hence they miss important information regarding prevention of mother to child transmission.
  - The majority of women deliver in villages and lack access to PMTCT services
  - Women face discrimination when trying to follow preventive measures such as discontinuing breast feeding.

*C. Care, support and treatment*

- The burden of caring for the sick affect women and girls disproportionately. Access to support and treatment services are limited to women whose movements outside the home are restricted.
- Young girls often drop out of school to assist their mothers caring for sick household members.
- Preoccupation with domestic work makes it difficult for women to access information and services related to reproductive health, including those related to HIV and AIDS prevention and control
- Discriminatory inheritance practices: the majority of inheritance and property is often taken unlawfully by a deceased husband's family. If the few possessions left by a husband are taken away, the wife is left economically powerless and has live a completely dependent life.
- If a woman is first tested positive with the disease she is normally given the blame for being the source of infection

## *SESSION 4.2    RESPONSE TO GENDER ISSUES IN HIV&AIDS*

### SESSION OBJECTIVES

By the end of the session the participants should be able to suggest strategies to overcome gender challenges in the community.

## TRAINER /TRAINEE ACTIVITIES

- Ask participants to break up into groups and ask them to go through the list of issues identified under section 4.1. Ask them to suggest responses to each of the issues.
- Facilitate a discussion around their responses and conclude by coming up with a list of agreed strategies to be adopted to respond to the issues.


## FACILITATOR'S NOTES

Examples of possible strategies:
- Promote a caring attitude among men towards protecting their female partners from becoming infected with HIV or other sexually transmitted diseases. Promote supportive attitudes among men to empower women to negotiate condom use, refuse unsafe sex, and access HIV and AIDS information and services.
- Promote the rights of women within the community to control their own lives—particularly their sexual relations. This implies a profound shift in social and economic power relations between men and women.
- Empower women to expose acts of sexual violence committed on them and promote support among the village leadership for implementing existing laws against such acts.
- Improve access to economic resources among women to reduce dependence on men and thus to improve their power to negotiate their sexual life.
- Advocate communities to review customary laws regarding land and property ownership and allow women to exercise the right to own land and other property.
- Encourage and support women to make use of existing statutory laws to gain the right to own land.
- Sensitize communities around existing legislations concerning sexual offences and violence[2] and promote their implementation.
- Promote policies in favour of girls' and women's rights to education
- Promote prosecution of those who obstruct girls' education.
- Discourage cultural practices, such as forced and early marriages.
- Sensitize communities around the need to expose incidences of sexual exploitation of school girls (and boys), house girls and other dependents by those who are taking charge of them (teachers, employers, relatives etc.). Promote prosecution of such incidences.
- Protect women from sexual violence in and outside their marriage.
- Address traditional norms of masculinity that place men and their partners at risk of HIV
- Address norms that make it less likely for men to seek health care information and services
- Streamline legislations that contradict each other (e.g. that a girl can be legally married at 16, but not vote until she is 18 years old).
- Mainstream a gender perspective in all sectors of society by addressing women's and men's concerns alike in the planning, implementation monitoring and evaluation of policies and development programmes. This would promote gender equality by ensuring that women and men benefit equally.

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[2] Sexual Offences Special Provisions Act (SOSPA, 1998)

# UNIT 5.    PARTICIPATORY HIV AND AIDS PLANNING

## UNIT OVERVIEW

The implementation of HIV/AIDS control activities at hamlet, village, and ward level must start with planning that involves all stakeholders. This unit introduces the concept and methods of participatory community HIV/AIDS planning.

## SESSION UNITS

5.1 Basic concepts of participatory planning
5.2 Steps in the planning process
5.3 Resource mapping

## SESSION 5.1    BASIC CONCEPTS OF PARTICIPATORY PLANNING

### SESSION OBJECTIVES:

By the end of the session the participant should be able to:
1. Define "planning"
2. Define participatory planning and explain its advantages
3. Identify the roles of WMAC and VMAC in planning
4. Explain different planning approaches

### SESSION ACTIVITIES:

1. Ask the participants what types of planning they undertake as part of their daily lives. Let them elaborate on their examples by describing what steps they took in the planning process. Discuss the various responses given and come up with some agreed definition of planning.
2. Divide the participants into groups of not more than 5 people. Let each group define "participatory planning" and describe its advantages. Allow the groups to present and discuss their responses in plenary. Clarify gaps and conclude.
3. Ask the participants to brainstorm around what their roles as VMACs are in the planning process. Collect as many responses as possible and note them on flipchart for plenary discussion. Clarify gaps and summarize.
4. Ask the participants about the different planning approaches that they know. Let them provide individual responses and note them on flipcharts for plenary discussion. Clarify gaps and conclude.

### FACILITATOR'S NOTES

**Definition of planning**

Planning involves conceiving ideas about how to best carry out an activity and arranging for implementing the activity. Planning is a management function, just like assessing, organizing, implementing, monitoring, and evaluating.

**Definition of participatory planning and its advantages:**

Participatory planning means involving all stakeholders to be part of the process of formulating future actions.
The advantages of participatory planning are:

- It motivates and leads to ownership.
- It fosters a sense of responsibility and accountability
- It provides the opportunity to share ideas and resources.
- It ensures that the real needs of stakeholders are met.

**Roles of WMACs and VMACS**

- Provide community data to understand the magnitude of HIV and AIDS
- Partner with organizations addressing HIV/AIDS in their respective communities (e.g. existing services and community support programmes).
- Coordinate the planning process by actively involving stakeholders such as
  - Community members
  - Health service providers
  - CBOs,
  - FBOs,
  - Local mobilizers such as theatre groups and extension workers from various sectors (agriculture, education etc).
- Ensure equal representation of community members in the planning process (women, men, schoolchildren, youth)
- Ensure that the village HIV and AIDS action plans are linked to the overall comprehensive village development plans.
- Monitor and evaluate the implementation of the village HIV and AIDS action plans.

**Different planning approaches**

- **Strategic plans:** these are long-term plans (5-10 years) which aim at implementing the long term goals of a program.
- **Short term (or medium term) plans**: These are one to two year plans that call for immediate implementation.
- **Top down approach**: Starts from the central level (for example the headquarters of a ministry or organization). It usually does not involve community-level stakeholders, who at best might be asked to implement the plan.
- **Bottom–up approach**: This approach is participatory and starts within the community. It is <u>for</u> the community and formulated <u>by</u> the community. The community is involved throughout the planning process from the initial assessments to the final evaluation.

## *SESSION 5.2*    *STEPS IN THE PARTICIPATORY PLANNING PROCESS*

### SESSION OBJECTIVE

By the end of the session the participant should be able to describe the steps involved in a participatory planning process.

### SESSION ACTIVITIES

2. Revisit the basic definition of planning through a brief question and answer session**.**

3. Form groups of 4-5 people and ask each group to list and describe the steps in the participatory planning processes.
   - Let the groups present their responses for plenary discussion.
   - Clarify gaps and conclude.

## FACILITATOR'S NOTES

**Requirements for preparing community participatory HIV and AIDS action plans**

In order to prepare such a plan you need:
- Information on HIV/AIDS prevention and control activities in the community.
- A list of all stakeholders to be involved.
- National policy documents (e.g. National AIDS Policy, National Multisectoral Strategic Framework, Guidelines for District Planning)
- Socio-economic, demographic and health data
- Data on the HIV and AIDS situation in the community such as:
  - number of orphans,
  - number of PLHAs,
  - number of child headed households,
  - High transmission areas (e.g. market places, bars and guesthouses)
  - common risk taking behaviours

*NOTE: It is important to collect this data by fully involving the various community groups (women, men, school girls and boys, and female and male youth).*

Commonly used participatory data collection methods are:
  - Focus group discussions
  - Household interviews
  - Community mapping
  - Transect walk

**Steps in planning:**

Step 1.      Data collection
Step 2.      Data analysis and prioritization of issues and problems identified.
Step 3.      Identification of main objectives, opportunities and obstacles for
             HIV&AIDS control in the respective community.
Step 4.      Identification of solution to the problems
Step 5.      Formulation of activities to achieve objectives
Step 6.      Identification of resources
Step 7.      Preparing the budget for the implementation of the action plan
Step 8.      Monitoring and Evaluation of Implementation of action plan

The following planning matrix will be used:

| Objective | Opportunity | Obstacle | Solution | Activity | Resources required | Indicator | Responsible |
|-----------|-------------|----------|----------|----------|--------------------|-----------|-------------|
|           |             |          |          |          |                    |           |             |

**NOTE:** *In order to achieve a high level of community ownership of the HIV and AIDS action plan, it is desirable to give the villagers a chance to discuss the prioritized issues and problems and suggest solutions. This can be done through a General Village Assembly or similar events. For example, an innovative participatory HIV and AIDS planning approach recently piloted, involved using the Theatre for Development Methodology during a Village Theatre Festival, to serve as a forum to present identified risk taking behaviours that are common in the villages.*

# UNIT 6.   REPORT WRITING

## UNIT OVERVIEW

VMAC members as a committee or as individual actors are expected to document their activities in HIV/AIDS prevention and control. The reports are important records of the status of implementation and are essential for evaluation purposes.

This unit introduces VMAC members to the techniques of documenting their activities in a clear concise and readable manner.

## SESSION 6.1      REPORT WRITING

### SESSION OBJECTIVES

By the end of the session the participants should be able to:
1. Describe the main components of an activity implementation report
2. Produce a draft report of the training activity that he/she is currently undergoing and just completing – i.e the present workshop.

### SESSION ACTIVITIES

1. Through questions and answers ask participants if they have ever written any reports. Ask what type of report it was and what it was required for.
2. Divide the participants into groups of no more than 5 participants. Ask each group to explain the importance of report writing and list and describe the main components of an activity implementation report. Let them describe the main aspects of each component.
3. Let the groups present their responses to the plenary for discussion. Then clarify gaps and agree on the main components of a report described under "Facilitator's notes".

### FACILITATOR'S NOTES

It is very important for implemented activities to be documented. For example, a VMAC report may be required by the village government (village council) for their own planning, monitoring and evaluation purposes and for disseminating to other stakeholders.

**Components of a report**

There are as many formats of a report as there are requirements, activities, or supervisory bodies. However, despite the different formats, there are some basic requirements which any report is expected to have. The main basic components which any activity implementation are:

- Title
- Table of contents
- Acknowledgements
- Executive summary
- Introduction
- The "body" or major issues
- Recommendations

- Conclusion
- Annexes

## *Title*

The title describes what the report is about. It also states who wrote the report and indicates where the activity took place and when

The title should be brief. If it is not possible to make it brief enough, a subtitle can be used together with the main title

The title should be in capital letters (upper case). Another option is to capitalize the first letter in each word.

## *Table of contents*

This is a list of major items in the report. It is normally written after the report has been drafted—that is after the main topics and sub-topics of the report are known. It is important that each item in the table of contents corresponds correctly with the page on which the item appears in the report.

## *Acknowledgements*

This section of the report credits the individuals who in one way or another have contributed to the completion of the report. This could even include data collectors and typists who offered secretarial service. On another level it includes the organizations that have funded the program, activity, and report.

## *Executive summary*

This is a synopsis of the contents of the report. Some of the people for whom the report is intended may not have the time to read the whole report. For them, the summary can provide a quick outline of the main points of the report.

The executive summary contains in a nutshell the background, methodology, outcomes, outputs, and recommendations related to the activity described in the report.

## *Introduction*

The actual report starts with the introduction, which describes what the report is about, for whom it is written, and how it is intended to be used.

## *The "body" or major issues of the report*

The report body describes the objectives, methodology, processes, outcomes, and outputs. It ends with the lessons learnt, challenges, recommendations, and conclusions. This is the main and most important component of the report.

## *The Annexes:*

The annexes, sometimes known as "appendices", consist of attachments and "evidences" of various types that verifies some of the statements made in the main report. Examples of evidences that might be listed in appendices are: list of activity participants, glossary of uncommon terms, and references tables or samples of checklists.

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# About UZIKWASA and this Training Guide

UZIKWASA (Uzima Kwa Sanaa) is an independent not-for-profit and non-governmental organization, located in Pangani, Tanzania. Its founding members are experts with a proven track record in education, culture, art, organizational development, and reproductive health at the district, regional and national level. A major incentive for establishing UZIKWASA was the founding members' concern over the lack of HIV/AIDS interventions that actually reach the communities in Tanzania.

In response to this need, UZIKWASA promotes HIV/AIDS control at the community level through theatre for development and other participatory methodologies. This training guide is one of the tools developed by UZIKWASA to help local leaders understand the pandemic and to assist them in coordinating their local responses to HIV and AIDS.