

**NGORONGORO DISTRICT**  
**HIV/AIDS PROGRAMME FORMULATION**  
**REPORT**

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## List of Acronyms

ABC	Abstain, be faithful, use condom
ACORD	Agency for Cooperation and Research Development
AIDS	Acquired immuno-deficiency syndrome
AMREF	African Medical Research Foundation
ANC	Antenatal care
CBO	Community based organisation
CHMT	Council Health Management Team
C-MAC	Council Multisectoral Aids Committee
CRT	Community Resource Team
ELCT	Evangelical Lutheran Church of Tanzania
FBO	Faith based organisation
FGM	Female genital mutilation
GLIA	Great Lakes Initiative on AIDS
GTZ	German Technical Cooperation
HASAP	HIV/AIDS Support and Advocacy Programme
HIV	Human immunodeficiency virus
KANGO	Kenyan AIDS NGO network
KAP/B-	Knowledge, attitude, practices/behaviours
LADO	Laramatak Development Organisation
MAPADA	Malambo Pastoralist Development Organisation
MDM	Medicos del Mundo
MoH	Ministry of Health
MTCT	Mother to child transmission
NCAA	Ngorongoro Conservation Authority Area
NGO	Non-governmental organisation
NMMU	Northern Maasai Medical Unit
NPP	Ngorongoro Pastoralist Programme
PC	Pastoralist Council
PHC	Primary Health Care
P(H)E	Peer (health) educators
PID	Pelvic inflammatory disease
PINGOS	Pastoralist Network of NGOs
PMTCT	Prevention of mother to child transmission

PRS	Poverty reduction strategy
RFA	Regional facilitating agency
SADA	Salei Development Association
STI	Sexually transmitted infection
SWOT	Strengths, weaknesses, opportunities, threats
TACAIDS	Tanzania Commission for AIDS
TAPHGO	Tanzania Pastoralists, Hunters and Gatherers Organisations
TBA	Traditional birth attendant
T-MAP	Tanzania Multisectoral AIDS Programme
TOT	Training of trainers
UNGASS	United Nations General Assembly Special Session
VCT	Voluntary counselling and testing
V-MAC	Village Multi-sectoral AIDS Committee
W-MAC	Ward Multi-sectoral AIDS Committee

#### List of Maasai and Sonjo words

BIITIA	wasting away illness, term used for AIDS
EMIRIKA/ORMITTA	a disease causing wasting
ENAMURATUNI	a disease cured only by performing circumcision
ENGEYA NAADO	long terminal illness
ENTITO	maasai girl who has not undergone initiation
ESOTO	an evening gathering for warriors and girls
ILLAIGUANAK	age group leaders (pl)
MANYATTA	a settlement for an age group to make rituals
MASE	a night traditional dance for watemi warriors and girls
MBARIMBARI	a seasonal harvest ceremony for dances and songs
MURRAN	maasai warriors
NGUTOT	sub locality at settlement level
OLAIGUANAN	an age group leader
OLOIP	a daytime recreation place for warriors and girls
ORBO	same as oloip
SAJAT	fertility ritual
WANAMIJE	traditional leaders of the Watemi (Sonjo)

## **Executive Summary**

Ngorongoro District is situated in the Arusha Region of Tanzania and covers an area of 14 000 km<sup>2</sup> with a population of 135 000. The pastoralist Maasai make up about 85% of the population, the agro-pastoralist Watemi (Sonjo) about 12% while the remaining 3% belong to various ethnic groups, including a small group of hunter-gatherers, the Hadza.

The Danida supported Ereto Ngorongoro Pastoralist Programme (Ereto-NPP) together with Oxfam Ireland, concerned about the potentially rapid spread of the HIV infection in the district and the projected devastating impact on its people, have commissioned a consultancy to assist the Ngorongoro District Council to develop - through a participatory process- a comprehensive HIV/AIDS programme, appropriate for the predominantly pastoralist communities of the district and in line with the National Multisectoral Strategic Framework for HIV/AIDS. This report reflects the findings and results of the exercise, which was carried out in March-April 2004.

The available data show that the HIV epidemic in Ngorongoro District is in a relatively early stage, with 2.2% of the surveyed women attending antenatal clinics being infected. The HIV prevalence was highest in Salei division (2.9%), intermediate in Loliondo division (2.3%) and lowest in Ngorongoro division (1.1%). When extrapolating these data, there are an estimated 1500 HIV positive people in the district of whom about 150 might have developed AIDS.

Many social, cultural and economic factors contribute to the risk and vulnerability to HIV transmission in the district. The awareness that HIV has started to affect the Maasai population is still low as AIDS is not yet very visible and misconceptions are rampant. Young men are increasingly migrating to urban areas in search of employment, possibly exposing themselves to HIV through sexual intercourse with city women. Condom use is low in the district because of low knowledge and limited availability. Other sexually transmitted infections (STIs) are reported to be common and medical treatment is not readily available or accessed; the presence of an STI facilitates the transmission of HIV. Socio-cultural and sexual practices allow Maasai to engage in sex with a large number of partners, both before and during marriage. Girls become sexually active at a very young age (as early as 9 or 10). Among the Watemi, extensive sexual mixing takes place at ceremonies. Wife inheritance is also practised by the Watemi. Male circumcision using one knife for several boys is still carried out, although campaigns have made the practice of "one boy, one knife" increasingly accepted. Female circumcision is usually carried out on one or a few girls at the time, limiting the risk of HIV transmission. Most deliveries take place at home, assisted by traditional birth attendants (TBAs), without the use of gloves and aprons, and carry some risk of HIV transmission. HIV can also be passed on from an infected mother to her child during delivery and breastfeeding and this is estimated to result in about 46 HIV infected babies per year in the district.

The non-indigenous populations of the district are at high risk because they often come on temporary assignments, leaving their families behind and they are highly mobile and are likely to engage in sex with bar girls and commercial sex workers, especially the tour drivers, guides and hotel workers.

The proposed programme interventions were arrived at through discussions with about 50 key informants, including several traditional leaders, group discussions with men,

women and youth and a two and a half day stakeholder workshop in which 40 representatives from all relevant actors participated.

The core intervention will be a community based campaign to create awareness, improve knowledge about HIV/AIDS and build skills to respond adequately to the epidemic. There is a consensus that the traditional leaders of both men and women who are respected and trusted by the communities, will be crucial actors in this campaign and that they should team up with ward and village chairpersons and secretaries and NGO resource persons to organise information sharing and discussions in each sub-locality (*ngutot*). The sessions should allow men and women to discuss separately first and then come together to develop a consensus on required action. Every sub-locality would select a male and female community based educator who will be trained as permanent resource persons on HIV and STIs in the community. Existing women's meetings and gatherings could be used to discuss HIV/AIDS issues and empower women to bring their grievances related to sexual abuse and rape to the council of elders.

Traditional birth attendants will be actively involved in the campaign and will be trained in safe delivery practices. The role of traditional healers in providing care for HIV related infections will be recognised but the myth that they can cure AIDS will be challenged. Further research into efficacy of traditional herbal treatments for opportunistic infections might be considered in the context of this programme. Traditional healers and circumcisers will be educated on the risk of HIV transmission through sharing of blades and other sharp instruments and will be provided with disposable blades.

School based interventions would use a three pronged approach of training teachers as guardian/counsellors on HIV/AIDS and other reproductive health issues, training peer educators and mobilizing parent-teachers committees for HIV/AIDS interventions.

The youth out of school can best be reached in their areas of recreation and gathering, which can be used as opportunities for education and skills building, including the demonstration and distribution of condoms.

Workplace interventions would be organised in government, NGO and private places of work. Knowledge, attitude, practice and behaviour (KAPB) studies will assist to identify the knowledge and skills gaps and training modules can be obtained from partners with expertise in this area.

Appropriate education materials will need to be developed in the local languages, such as posters, leaflets, songs, poems and videos.

Condom promotion will be part of the awareness campaign, through information, model-aided demonstrations and through establishment of innovative distribution channels and outlets. The acceptability and appropriateness of the female condom will be studied further.

STI syndromic management will be expanded to all the health facilities in the district. It is also proposed to carry out further research to determine the prevalence of STIs and to assess the appropriateness of organizing a one time mass presumptive treatment intervention.

Voluntary counselling and testing (VCT) services will be scaled up from the hospitals to the health centres and dispensaries and eventually into the outreach clinics.

In the interviews with traditional leaders and community groups it was repeatedly argued that the only way to halt the spread of HIV in the Maasai (and also the Watemi) cultural context is to test everyone for HIV at community level and to make the results known in the community. The traditional leaders felt that this is the only way in which those who are not infected can protect themselves and those who are infected can be compelled to use a condom whenever they have sex. This "community confidentiality" is a new concept that warrants careful consideration and will require facilitation of community discussions to ensure that a consensus is reached and that individuals are not subjected

to testing without their consent. The concept could be explored further in the Maasai context and would be an interesting area for operational research. Care and support for HIV infected persons and AIDS patients will be expanded to ensure early and appropriate prevention and treatment of HIV related infections and prevention of further spread of HIV. Antiretrovirals will be acquired to initiate prevention of mother to child transmission (PMTCT) and eventually also triple therapy for eligible AIDS patients. This will require health worker training and upgrading of infrastructure and equipment in a phased way, starting with Wasso hospital and expanding gradually to other hospitals and health facilities and outreach clinics, as appropriate.

Roles and responsibilities of the various stakeholders in the implementation of the programme were allocated during the stakeholder workshop, based on interviews, SWOT (strengths, weaknesses, opportunities and threats) analysis and self-reported interest.

The coordination of all actors and resources and overall responsibility for the implementation and for monitoring and evaluation (M&E) lies with the Council Multi-sectoral AIDS Committee (C-MAC). The C-MAC will finalize the District Multi-sectoral HIV/AIDS Plan and submit it to the Full Council for endorsement as part of the Council Development Plan. The C-MAC will also establish and train the Ward Multi-sectoral AIDS Committees (W-MAC).

The Council Health Department and Council Health Management Team will coordinate the health sector HIV/AIDS interventions (STI, VCT, Care) and will ensure that essential commodities and supplies such as HIV tests, drugs and condoms are available.

The Council Education Department will coordinate and co-fund the school based interventions.

The Council Community Development Department will cooperate with other actors to plan, implement and co-fund the community awareness and mobilization campaign. Ereto-NPP will support the C-MAC to conduct a follow-up meeting to complete the HIV/AIDS Plan and to agree on modalities of implementation. Ereto project staff will be trained to act as HIV/AIDS resource persons in the community, in cooperation with other NGOs and CBOs in the district. Ereto will sub-contract the design and implementation of the community awareness and mobilization campaign to a suitable organisation. Ereto will also commission the production of video and other education materials to suitable organisations. It is proposed that Ereto would commission the proposed research activities to appropriate institutions/consultants (STI prevalence study/ feasibility of mass presumptive treatment and feasibility of community based counselling and testing and community confidentiality).

Oxfam Ireland will play a role in advocacy and support for mainstreaming of HIV/AIDS among NGOs and CBOs (workplace interventions and integration of HIV/AIDS into project activities). Oxfam Ireland will also provide support in monitoring and evaluation of the programme, including organisation of KAPB studies, establishment of a district and community based M&E system and facilitation of the mid-term review and the end of project evaluation. Oxfam Ireland will represent pastoralists' interests at national level and advocate with government and partners for resource allocation to HIV/AIDS interventions among pastoralists. It will also consider providing financial support to selected NGOs and CBOs in the district.

Oxfam GB will be a partner in the community based awareness and mobilization campaign and will also cooperate with the education department in the integration of HIV/AIDS interventions in schools. It is suggested that Oxfam GB would support research activities related to condom promotion and accessibility, including the acceptability of the female condom.

ACORD will be contracted to provide technical expertise and coordination in the implementation of the community awareness and mobilization campaign, including the design of the campaign, the training activities and the community based mobilization. The Catholic Diocese, as the main care providers in the district, will provide STI, VCT and care services. This will include the initiation of PMTCT services and of antiretroviral therapy for AIDS patients. The Diocese will also participate in the community awareness campaign and will consider how the network of outreach clinics can be used to reach remote communities.

Medicos del Mundo will support the health sector to expand STI and VCT services and condom availability and use.

The Pastoralist Council, ELCT-NMMU, LADO, CRT, MAPADA, SADA and Austroproject will all contribute to the implementation of the community awareness campaign. Their project staff will initially be trained to increase their HIV/AIDS knowledge and skills and to be able to facilitate community mobilization for HIV/AIDS.

Other organisations that were not present at the stakeholder workshop should also be contacted and involved. They include: Women's Pastoralist Council, Empuan, KIDUPO. Linkages will need to be made with umbrella organisations such as PINGOS and TAPHGO and with other relevant organisations working in neighbouring districts and in the Arusha region (MWEDO, Afya Bora, UZIMA Centre, UHAI, Life Concern,...).

During the stakeholder workshop, a list of 8 objectives and several outputs for each objective were proposed by the consultants. The workshop participants worked in groups to formulate activities and sub-activities for the objectives and outputs.

The report includes a logframe, elaborating further on each activity. The proposed indicators, time frame, responsible organisation and budget are only indicative. Further fine-tuning of the logframe is required as well as consensus building around the exact modalities of implementation and allocation of responsibilities.

## **1. Introduction**

### **1.1 Background to the consultancy**

This report reflects the results of a consultancy carried out from 1<sup>st</sup> March to 8 April 2004 in Ngorongoro District, with the aim to formulate a comprehensive HIV/AIDS programme for the predominantly pastoralist population of the district. The report also recommends specifically how the sponsoring agencies, Ereto-Ngorongoro Pastoralist Project and Oxfam, can integrate HIV/AIDS into their ongoing programmes and can make a significant contribution to the response to the epidemic, in line with their comparative advantage.

The Ereto Ngorongoro Pastoralist Programme (Ereto-NPP), funded by Danida, is presently into its second phase (2003-2008). Ereto-NPP is livelihood oriented, focusing on key elements of pastoral livelihoods systems such as livestock, pastures and water. Ereto-I commissioned a major study in 2002, looking into HIV/AIDS in Ngorongoro District. The study underlined once again that HIV/AIDS could potentially have a devastating effect on the communities in the Maasai land and their production systems. Knowledge about HIV/AIDS among the Maasai at present is very limited. Campaigns used to address this huge knowledge gap have to be culturally appropriate in order to be effective and to generate the desired behavioural changes.

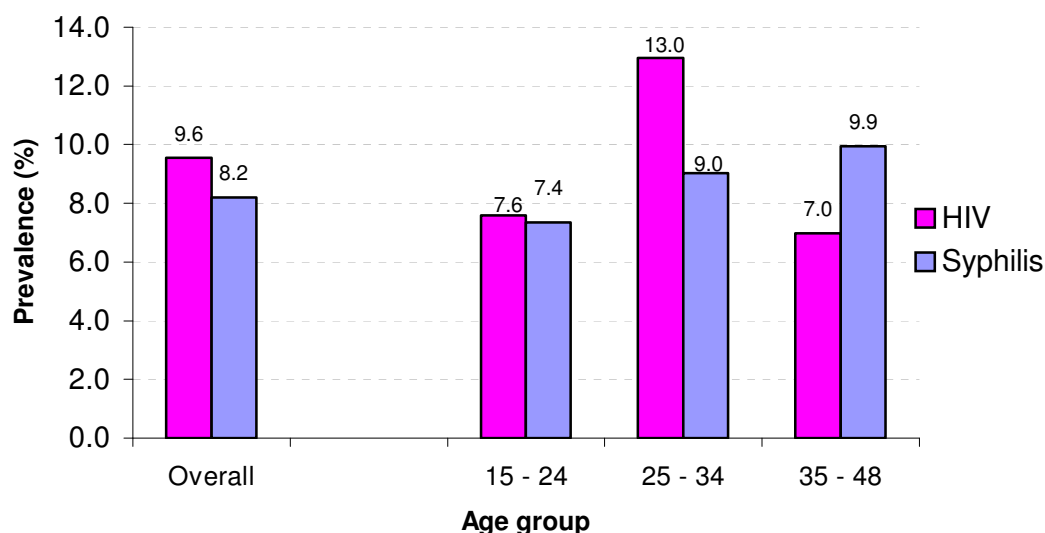
Oxfam has been working with pastoralists in and around Ngorongoro District for many years through a number of civil society organisations. Oxfam is committed to mainstreaming HIV/AIDS across all its programming in Tanzania. The three Oxfam affiliates working in Tanzania, Oxfam Ireland, Oxfam GB and Novib, have prioritised livelihoods as the focus for their external mainstreaming work from 2003-2005, with pastoralism the specific priority focus. These choices were made using the findings of two complementary studies on HIV/AIDS, a situation analysis and a mainstreaming study undertaken in the first half of 2003. Oxfam Ireland is managing an HIV/AIDS programme in Tanzania which is focused on specialist HIV/AIDS work i.e. embracing prevention, mitigation, care and support.

ACORD (Agency for Cooperation and Research in Development) has been invited to be part of the programme development process as it has experience in facilitating a broader HIV/AIDS response through capacity building for HIV prevention, care and support. ACORD has experience in working with pastoralists and runs an HIV/AIDS Support and Advocacy Programme (HASAP), based in Kampala, that supports HIV/AIDS components in 17 country programmes in Sub-Saharan Africa.

Ereto and Oxfam decided to jointly sponsor the development of a district-wide, comprehensive, community based HIV/AIDS programme for Ngorongoro District, in line with the National Multi-sectoral Strategic Framework for HIV/AIDS and with specific consideration of the socio-cultural context of the pastoralist population in the district. The programme will serve as the basis for the Council Multi-sectoral HIV/AIDS Plan, that will be further developed by the Council Multi-sectoral AIDS Committee (C-MAC) and submitted to the full Council for ratification. It will also serve as the basis for Ereto-NPP to develop its HIV/AIDS component in phase II of the project. Oxfam will be provided with ideas around mainstreaming of HIV/AIDS and ACORD will be able to use the document to develop its own programme focussing on supporting communities to become AIDS-competent and to develop their own responses.

## 1.2 The context: National situation and response to HIV/AIDS in Tanzania

**Figure 3: Prevalence of HIV and syphilis by age group among ANC attendees, Tanzania, 2001 - 2002**



According to the latest available epidemiological data, the HIV prevalence among pregnant women attending Antenatal clinics in Tanzania is estimated at 9.6%, while the prevalence of syphilis is 8.2%. New infections occur mainly in the younger (15 to 24) age group where 7.6% are already HIV-infected.

The national response has been spearheaded by the health sector since the beginning of the epidemic in 1983 and has mainly focused on prevention of HIV transmission through awareness creation and control of other sexually transmitted infections. The establishment of the Tanzania AIDS Commission (TACAIDS) in 2001 has seen an acceleration of the response with involvement of other key sectors and other partners. A National Policy on HIV/AIDS and a National Multi-sectoral Strategic Framework (2003-2007) have been developed. HIV/AIDS has been recognized as a development issue and has been integrated into national instruments such as Poverty Reduction Strategy (PRS). The health sector has started to shift its emphasis from prevention to voluntary counseling and testing (VCT) and to care, including provision of anti-retroviral treatment. At district and community level, capacity to respond has been very limited and intervention have been fragmented, largely depending on the support by externally funded projects initiated by development partners and NGO's. In 2003, Council Multi-sectoral AIDS Committees have been established and country-wide training of the committees has been done in early 2004. Their role is to coordinate all the HIV/AIDS interventions through a Council Multi-sectoral HIV/AIDS Plan, jointly formulated by all stakeholders and endorsed by the Council.

### **1.3 Methodology used for the consultancy**

Available documents were studied, including reports of studies commissioned by Ereto and Oxfam, district annual reports, activity reports of NGOs and CBOs and project proposals. Selected literature related to HIV/AIDS among pastoralist communities was also consulted.

Interviews were held with about 50 key informants from Government (national, regional, district, ward and village), Church organizations, NGOs, CBO's and networks. The list of organisations and persons met is found in Annex 1.

Interviews with three traditional leaders were held in Kimaasai and recorded on video; they were used as inputs during the Stakeholder workshop. Group discussions were held with 3 women's groups, 1 group of men and 1 youth group.

A two and a half day stakeholder workshop was held from 6 to 8 April, in which 40 representatives from all relevant actors participated (District Council (3), Key government departments (5), Ngorongoro Conservation Area Authority (2), Pastoralist Council (3), Wasso and Endulen hospital (4), Ereto-NPP (7), Oxfam (4), ACORD (1), Medicos del Mundo (3) and other NGO's working in the district (6).

The objectives of the workshop included: to present and discuss the findings of the situation and response analysis and to receive inputs from the stakeholders.

During the first group-work session the participants analyzed the strengths, weaknesses, opportunities and threats of the different stakeholders and presented the results in the plenary for discussion. The video recorded interviews with 2 traditional leaders were shown, translated and discussed. During the second group-work session, participants critically considered and revised the proposed objectives and outputs for a comprehensive district HIV/AIDS plan, as they were presented by the consultants. The groups also developed activities and indicators for each objective. The last day of the workshop was dedicated to presenting and discussing the work of the groups and to charting the roles of different stakeholders in implementation, coordination, technical backstopping and/or funding of parts of the programme. Finally, a number of agreements were reached on the next steps to complete the programme and to strengthen the Council Multi-sectoral AIDS Committee

## **2. Summary of the HIV/AIDS situation in Ngorongoro District**

### **2.1 Demographic profile of Ngorogoro District**

Ngorongoro district has a population of about 135 000, according to the 2002 Population Census. 85% of the population is Maasai, 12% belongs to the Watemi group (Sonjo) and 3% are a mixture of other ethnic groups.

### **2.2 Epidemiological data on HIV/AIDS and other STI's**

A study by Dr. Moke Magoma et al. is ongoing in Ngorongoro district, to document the patterns, causes and prevalence of maternal morbidity and mortality and to assess efficacy of syphilis treatment with one instead of three doses of penicillin.

In the context of this study blood samples were taken from nearly 2500 antenatal clinic attendees in 70 clinic sites (two hospital sites and 68 outreach sites), distributed in the

three divisions of Loliondo, Ngorongoro and Salei. Testing for syphilis was performed and treatment was provided. Anonymous, unlinked testing for HIV was performed on the left-over blood. Preliminary findings show that the overall HIV prevalence in the district is 2.1% and the syphilis prevalence 4.5%. The prevalence is highest in Salei division (2.9%), followed by Loliondo (2.3%) and Ngorongoro division (1.1%). The data are presented in table 1.

*Table 1: HIV and Syphilis infection among pregnant women, Ngorongoro District*

Division	Number tested	HIV infection		Syphilis infection		HIV and syphilis infection	
		Nr	%	Nr	%	Nr	%
Loliondo	861	20	2.3	42	4.9	5	0.6
Ngorongoro	889	10	1.1	54	6.1	1	0.1
Salei	747	22	2.9	16	2.1	5	0.7
Total Ngorongoro District	2497	52	2.1	112	4.5	11	0.4

When extrapolating these prevalence figures to the entire population of the district, there are an estimated 1500 HIV positive adults in the district. Every year about 46 infants would acquire HIV from their mother at birth or through breastfeeding.

Morbidity and mortality data from Wasso hospital show that 6 out of 602 (1%) of adult admissions in the second half of 2003 were diagnosed as AIDS related complications and one out of 6 hospital deaths was attributed to AIDS. Out of 38 patients tested for HIV in the same period, 19 were found to be HIV positive (based on only one rapid test). Other available data are difficult to interpret as testing of blood donors and of patients were not reported separately

### **2.3 Factors that contribute to risk and vulnerability to HIV transmission in Ngorongoro district**

Based on available studies of documents, interviews and discussions during the stakeholder workshop, the main factors underlying the risk and vulnerability to HIV transmission can be summarized as follows:

#### **2.3.1 Awareness that HIV has started to affect the Maasai population is low**

Although the limited surveys show that most people have heard about HIV/AIDS, the perception that it is a "Swahili" disease is widespread. Maasai men believe that they are only vulnerable when they engage in sexual intercourse with non-Maasai women in towns. The fact that most posters and videos used in education sessions are in Swahili and depict non-Maasai, reinforces this belief. Visibility of the disease is low as few Maasai have actually developed full-blown AIDS or have died of AIDS. To date there is no known person living openly with HIV among the Maasai in the district.

### 2.3.2 Misconceptions about HIV and AIDS are common

Even among those who have heard about HIV and AIDS, the understanding of what the infection is might differ as indicated by the variety of Maasai names with different meanings that are used: *bitia*, *engeeya naado* (a long terminal illness), *enamuratuni* (a disease that can be cured by circumcision), *emirika/ormitta* (a disease causing wasting). The belief that HIV/AIDS is an “ordinary”, known disease and that it is curable with traditional herbs is also widespread. The education about HIV/AIDS has so far mainly been organized by the primary health care team of the 2 hospital, Wasso and Endulen and has mainly reached women in outreach clinics. A few seminars have been organized for traditional leaders, workers of the district council and the NCAA and for traditional birth attendants and village health workers. Knowledge about HIV/AIDS is therefore likely to be superficial and insufficient to allow for rational decisions about behavioral change.

### 2.3.3 Migration by young men to the cities and mining areas might lead to high risk sexual interaction

Male pastoralists in Ngorongoro district are frequently traveling to neighboring cities in Tanzania and Kenya to sell cattle but there is no information on the extend to which sexual interaction takes place during those trips. Migration out of Ngorongoro to seek employment (mainly as watchmen) in Arusha, Shinyanga, Mwanza, Bukoba, Mererani and Kenya is reported to be increasingly frequent among young Maasai. A recent study by Ernestina Coast however found that 41% of unmarried rural-urban migrants in Arusha reported no sex in the 12 months preceding the interview, probably due to the perceived risk of acquiring HIV infection in towns.

The study by Magoma et al. also collected information about the mobility of the partners of the pregnant women in the study and tried to correlate this factor with the prevalence of HIV. The results show that the male partners are reported to be significantly more mobile in Salei division (20.5%) than in the other divisions (Loliondo (3.5%) and Ngorongoro (6.5%)). It is possible that this signifies a higher mobility among the Watemi, who live in Salei division (and mainly migrate to Kenya) than among the Maasai. Overall the HIV prevalence was almost 3 times higher in women with a migrating partner than in women without migrating partner (See table 2).

*Table 2: HIV infection among pregnant women according to partner's mobility status*

Division	Number tested	Women with migrating partner		HIV infection among women with migrating partner		HIV infection among women without migrating partner	
		Nr	%	Nr	%	Nr	%
Loliondo	861	30	3.5	2	6.7	18	2.2
Ngorongoro	889	58	6.5	1	1.7	9	1.1
Salei	747	153	20.5	10	6.5	12	2.0
Total Ngorongoro District	2497	241	9.7	13	5.4	39	1.7

### 2.3.4 High prevalence of STIs facilitates transmission of HIV

The presence of another STI, especially a genital ulcer, increases the risk of HIV transmission during unprotected sexual intercourse.

Several sources report that prevalence of STIs in Ngorongoro district is high, but the data in table 1 suggest that syphilis prevalence is relatively low (4.5%) compared to the

national estimate of 8.2% (see figure 1). Data for Wasso hospital (for the period of July to December 2003) show that among 4139 adult outpatient diagnoses, 181(4.4%) were STIs, which were further divided into: pelvic inflammatory disease (PID): 66, genital discharge: 56, genital ulcer: 32, other STI: 26. It is possible that genital discharge syndrome is relatively common among the Maasai, but additional epidemiological studies are needed to confirm this. The proportion of patients with STIs who seek medical treatment is probably low, as STIs are commonly perceived as “normal” among the Maasai and traditional herbs are believed to be effective. Partner tracing is difficult and re-infection is therefore likely to be common.

### **2.3.5 Socio-cultural practices increase the risk of sexual transmission of HIV**

Sexual mixing among Maasai is extensive both before and during marriage. The social structure among the Maasai, based on the age set system, determines the acceptable sexual partners for a member of an age set. “Illegal” sexual relations, for example between warriors (*murran*) and married women, also take place. Young uncircumcised girls (*entito*) from age 9-10 upwards are expected to engage in sex with *murran* and extensive sexual mixing takes place at youth gatherings (*Esoto, Orbo/oloip, Manyattas*). It is believed that semen helps the girl to mature physically. It is reported that a *murran* can have 10 or more partners in one week.

An “elder” is expected to marry and can accumulate as many wives as he can afford. When old men marry young girls, it is common practice for these girls to have “lovers” for sexual satisfaction. Husbands are expected to share their wives with their age set mates. Guests commonly sleep in the house of the wife of an age mate.

Other cultural practices, such as fertility rituals (*Sajat*), specially organized to impregnate barren women through having sex with as many men as possible in a given time-period, carry a high risk of HIV transmission

Among the Watemi, girls also become sexually active at an early age and virginity is not valued. Sexual mixing takes place at ceremonies such as *Mase, Mbarimbari* and weddings. Polygamy is less common than among Maasai.

Women belong to their husband and wife selling (together with the children) is sometimes practiced. Wife inheritance by a brother of the deceased husband is common, a practice that is not found among the Maasai.

Both societies are patriarchal and men are making decisions about sex; women often cannot refuse sex. While sexual violence and rape are not condoned and are punishable, exerting pressure and using threats to force a woman into having sex is reported to occur.

### **2.3.6 The non-indigenous populations of the district (civil servants, NGO staff, hotel workers, NCAA staff and business owners) are also at high risk**

Because of the remoteness and relative lack of services and housing in the district, a large proportion of workers regard their assignment as short term and don't bring their families; this increases the risk of engaging in sex with commercial sex workers, bar girls and each other. Civil servants and NGO workers frequently travel to Karatu and Arusha for business and official duties and stay overnight in guest houses there.

A particularly high risk group is the tour drivers, guides and tourist camp workers who move in and out of the district, spending the night at guest houses and looking for sex partners.

### **2.3.7 Sharing of potentially contaminated sharp instruments**

Male circumcision is universally practiced among Maasai, often using one knife for several boys to symbolize the bonding within the age set. Campaigns have recently been organized to advocate for “one boy, one knife” practice, reportedly with some success.

Female circumcision is usually carried out on 1 or few girls at the same time, limiting the risk of HIV transmission. The anti-FGM campaign also emphasizes the importance of using one knife per girl.

Other possible transmission routes include scarifications, tattooing, piercing and sharing of razor blades for shaving.

### **2.3.8 Most deliveries take place at home and are assisted by TBAs**

Home deliveries by TBAs carry a risk of infecting the TBA if the mother is HIV-positive, since deliveries are generally carried out without the use of gloves and aprons. It has also been reported that there is a ritual in which women who are not able to conceive, handle the placenta and other birth products as a fertility enhancing measure.

### **2.3.9 Condom use is low**

Promotion and demonstration of condom use has not been widely done; it is estimated that about 50 000 condoms were distributed in 2003 through the health sector (less than one condom per sexually active person per year).

Many Maasai don't like condoms and some find it difficult to put on the male condom because in the Maasai circumcision, the foreskin is partially excised but remains attached and forms a potential hindrance when unrolling the condom over the penis. Condoms are so far mainly used in town, due to the widespread misconception that the risk of HIV transmission only exists when having sex in towns.

Availability of condoms is limited to health facilities (free condoms distributed by the Ministry of Health) and shops in larger towns (Salama condoms for sale through social marketing).

Female condoms have so far not been widely available. A few samples have been provided by Oxfam and Medicos del Mundo for demonstration purposes.

### **2.3.10 Transmission from mother to child (MTCT) is likely to be high**

Transmission of HIV from mother to child during pregnancy, delivery and breastfeeding carries a risk of about 40%, in the absence of interventions. Traditionally there is a long period of breastfeeding and mixed feeding, which might increase the risk further. So far, interventions to reduce transmission from mother to child are not in place yet in the district. With a district population of 135 000, a birth rate of 4% and an HIV- prevalence of 2.1%, about 114 HIV-positive women are estimated to become pregnant per year and about 46 babies would become infected through MTCT (mother to child transmission).

The practice of abstinence during pregnancy and breastfeeding might reduce the risk of new infections among women, but there are indications that this practice is no longer followed strictly, as shown by frequent new pregnancies found within the first 9 months after delivery (study by Magoma et al.).

### **3. Scale of the response required**

Although the HIV prevalence in Ngorongoro district is still relatively low compared to the national estimate, the infection could potentially spread very rapidly, due to prevailing sexual mixing patterns and low use of condoms. According to the prevalence data, all three divisions in the district have similar infection rates, although in Salei division the HIV-prevalence is relatively slightly higher, possibly due to higher migration rates among men. The proposed interventions should therefore cover all three divisions.

There is agreement among the key informants and workshop participants that awareness creation about HIV at the village and hamlet level is a priority intervention at this stage. It is proposed that this would be done in the form of an intensive campaign spread over a number of months with involvement of stakeholders from traditional leadership, government and NGOs to cover all the traditional sub-localities (*ngutot*) of the Maasai and sub-villages of the Sonjo area.

Specific groups that are at risk and should be targeted for awareness creation are workers in government, NGOs and the private sector, school children and youth out of school.

For these interventions to be effective there will be a need to produce education material such as videos/DVDs, posters and leaflets in local languages and to ensure that condoms are available in sufficient quantities and through accessible and acceptable outlets.

STI syndromic management needs to be expanded to all existing health facilities in the district in order to reach an increasing proportion of symptomatic patients with effective treatment. It is proposed to organize research to assess the prevalence of STIs and explore the appropriateness of “mass presumptive treatment” of the sexually active population, if the prevalence is confirmed to be high.

Voluntary counseling and testing for HIV has so far not been offered in the district. It is therefore difficult to predict the number of clients that will come forward when services have started. It is proposed that services would be initiated in the 3 hospitals (Wasso, Endulen and NCAA) immediately and that they would be gradually expanded to all health facilities.

During interviews and group discussions, community leaders and members suggested that everyone should be tested at community level, as the only effective way to halt the spread of HIV in the Maasai community. After extensive discussions in the stakeholder workshop, it was agreed that the concept of community counseling and community confidentiality should be further explored and possibly implemented in villages that have reached consensus on the approach. The extent to which this intervention might be expanded will depend on community readiness and acceptance and on experiences from initial pilots.

Extrapolating from the HIV-prevalence rate among pregnant women, there are an estimated 1500 HIV-infected persons among the sexually active population in the district. Of these, about 300 (20%) would be expected to have become symptomatic or developed AIDS. Care and support services for the HIV infected will need to be expanded to the 3 hospitals and partially to other health facilities, as more people are

tested and more HIV infected individuals are identified. Home based care services should be started as well.

It is also proposed that all pregnant women attending antenatal care, both in health facilities and outreach clinics, are offered counseling and HIV testing as a routine ANC service. HIV-positive women would be offered appropriate interventions to reduce the risk of transmission to the baby. According to the HIV-prevalence rate and birth rate, about 114 HIV positive women are estimated to become pregnant per year in the district.

#### **4. Nature of the response required**

##### **4.1 Awareness creation, knowledge and skills building and community mobilization**

*At community level:*

The aim of the community based awareness campaign would be to make communities accept that Maasai have become infected and that the infection is no longer confined to those who have migrated to towns but is also spreading within villages. The concept that everyone who is sexually active is at risk and could potentially already be infected is not easy to make clear in communities that have merely heard about HIV and have not been confronted with AIDS patients. It is therefore important that the information is brought in a culturally appropriate way, ensuring that the messages are understood by all. There is consensus that in the Maasai community the most effective way of disseminating information is in Kimaasai through the traditional leaders (*Iliaiguanak*) of both men and women, who are respected and trusted by the community.

It is proposed to organize initial meetings in each division with traditional leaders, traditional healers and birth attendants, ward and village chairpersons and secretaries, to educate them about HIV/AIDS in a two to three day seminar. An initial questionnaire based KAPB study will help to define level of knowledge and help to design the content of the training. Bringing traditional leaders together with ward and village level administrators offers the best platform to ensure that the issues are taken seriously by the community and at the same time that they are included in the village and ward development plans and receive higher level support and funding where required. Healers/herbalists are important actors in community health, as most Maasai consult them when they are ill. It is important to recognise their role in providing care for HIV related infections, where the traditional cures and herbs might be effective, while challenging the myth that they can cure AIDS. The possibility of conducting further research into the efficacy of herbal cures for opportunistic infections could be explored, in cooperation with an appropriate research institute.

Traditional birth attendants are also respected community members, who not only assist at deliveries but also advise women on fertility issues, healthy living during pregnancy and care of the baby. They can play an important role in educating women about HIV/AIDS and should be trained in use of protective gear during deliveries. However, traditionally these birth attendants are very old women and might not be receptive to new ideas and change. It is therefore also important to discuss with the community how younger women could take over their role and receive training as birth attendants and possibly also as community educators/counsellors.

There are some socio-cultural differences between the Kisongo (mainly living in Ngorongoro division), Sale (mainly in Salei division) and the Purko, Loita and Laitayok (mainly in Loliondo), that need to be considered when deciding whether or not the

leaders of these groups can be brought together for the initial seminar. The traditional leaders of the Watemi (*Wanamije*) might need to be trained separately or can be brought together with the leadership of the Maasai in Salei division.

The most important traditional leaders are the main locality leaders for the three active age groups: leaders of the present active warriors, of the retired warriors (junior elders) and of the senior elders. The leadership of women is not as formally structured but mechanisms exist to elect representatives for specific activities. Traditional leaders safeguard what is agreed as a consensus by the elders and the maasai community in general adhere to the decisions and consider them as laws and rules to live by. Through the mechanism and network of their assistants (*ngopir olaiguanani*) in the respective sub localities (*ngutot*), they will spread the message to the communities in their areas.

Teams of traditional leaders and their assistants, local administrators (village and hamlet chairpersons), supported by resource persons (NGO staff), will then visit each sub-locality (*ngutot*) and organize information sharing and discussions in the community. It is important to initially allow men and women to discuss issues separately, as women would not be able to talk freely in front of men. Also delicate issues related to sexual practices and fertility rituals could not easily be brought up in a mixed group. There should be an opportunity to bring the groups together at a later stage and allow for each group to present their ideas and perspectives on how the community can best deal with the problem. Possible action at community level could include to abolish, reduce or transform practices that contribute to the transmission of HIV transmission (building houses for guests, discourage marriage of young girls to old men, use youth gatherings for education). Decisions might have to be consolidated into bye laws and ratified by the Council.

Community based educators/counselors (one male and one female) from every sub-locality will be selected in a participatory way and will subsequently be trained as permanent resource persons for HIV/AIDS issues in the sub-locality.

#### *Workplace interventions:*

Workplace interventions have so far not systematically been organized and it is proposed that government, NGOs and private sectors employers would be assisted to organize awareness seminars for their employees. It might be useful to conduct a KAP study to assess training needs before the training is organized. Training modules for this purpose have been developed in Tanzania (a.o. by AMREF) and could be made use of. The Government is the largest employer in the district with about 450 employees. NCAA is also an important employer. Both could make their own resources available to organize these interventions but might require technical assistance. The tourist hotels have their own clinics and could organize and finance their own interventions, as some have already done. High risk groups which have so far been neglected and should be specifically targeted are bar workers and tour drivers who stay overnight in Ngorongoro.

#### *Children in school:*

As children in Maasailand commonly become sexually active at ages 9-10, children in both primary and secondary schools are an important risk group. The schools in the district could play an important role in creating awareness and imparting knowledge and skills on HIV/AIDS and other reproductive health issues. There are 54 schools in the district and it is proposed to train one male and one female teacher from each school as a guardian/counselor for STI/HIV/AIDS and sexual/reproductive health. Several projects in Tanzania (GTZ, Tanesa) have used peer education as an approach for school based education and have developed modules and training materials. It is proposed that this

combined approach of guardian/counselors supported by peer educators would be used in the district.

*Youth out of school:*

In the Maasai community the youth have special areas of recreation and gatherings for both male and female. The contact of both genders is accepted and encouraged by the community, giving them an opportunity for discussions, dancing, playing, composing songs and also for sexual interaction. *Oloip, orbo, esoto* and other ceremonies are meeting opportunities for recreation, exchange and sharing. These youth gatherings could be transformed into educational forums. Peer educators should be trained who will guide discussions on HIV/AIDS, assist to compose songs on HIV/AIDS, distribute condoms and demonstrate their proper use.

*Gender issues:*

Adolescence among the Maasai is considered a time of freedom and sexual exploration for both genders. Warriors can make sexual advances towards girls they like as much as girls can towards the warriors they fancy. Girls make decorations for someone they love and admire, to express their interest. They even send messages to invite the admired men from wherever they are. *Esoto/orbo* gatherings for youths do not limit or confine girls to any individual man. Since girls become sexually active at a very young age of 8 or 9, the immature reproductive tract is easily traumatized and therefore risk of transmission of STIs, including HIV, if a partner is infected, is very high. Virginity is not expected at the time of marriage and the newly-wed husband of a virgin even has the right to take his wife back to her mother's house because she is regarded as a child.

Sexual faithfulness within marriage is a foreign concept to the Maasai culture, as men of the husband's age group will come to the house and the woman is the major host with final decision on what happens when it comes to sexual advances from any side. The husband will spend the night somewhere else leaving the woman with the guest. When hosting an age mate it is not automatic that sex is a part of hosting. The sexual advances are usually there and the woman has the final control over the situation and is not obliged to have sex with the guest. In a community meeting in Handeni district, women however complained that when age mates make advances and are refused, they sometimes threaten the woman that they will throw a curse on the children and on the family. The women complained that they are "forced" into sex in this way. The general consensus of the meeting regarded this as rape and advised that this should be reported by women as they would report any other forced sex or rape. Forced sex and rape is considered a punishable offence according to the traditions, which may be punished by refusing the culprit the normal traditional hospitality and other fines.

It is customary that married women have one or several lovers; they make poems of praise for their lovers and everybody in the community knows about this, including the husband. However, women have been severely punished when found with a man younger than her husband's age group, which is considered a serious transgression. Women are the guardians of culture. They play an important role in passing knowledge to all children aged 1-6 of both genders. Women have day time meeting fora, like *oloip* where they meet for a chat, repair calabashes, make decorations, discuss things and gossip. It is here that poems, songs and songs of praise are made. This is where girls are taught "women things" and anything else they should know while they are girls and when they grow up. Women also have ceremonies and rituals during child birth.

During the community mobilization meetings, it is important that women are given enough time to discuss issues separately, in the presence of female leaders and

resource persons. The female community educators/counsellors that will be identified and trained in every sub-locality should be sensitised to use the opportunities of existing meetings and gatherings to introduce HIV/AIDS into the discussions, poems and songs.

*Appropriate education materials and messages:*

Maasai exchange of news and information is mainly oral. Poems and songs are the most important recreational way of delivering messages to the youth who go to the evening and ceremonial dances. Theatre and drama is not very common in the Maasai culture. Radio in the local language would be an appropriate medium for communication on HIV/AIDS. The Voice of Kenya broadcasts in Maasai language at certain times, and sometimes talks about HIV/AIDS. However, very few Maasai listen to radios and owning a radio is rare in the district. Setting up a radio station would be beyond the scope of this programme.

Video materials in Maasai language and other local languages should be developed for use during the community mobilization campaign. Other educational materials such as posters and leaflets need to be carefully designed in a participatory way and field-tested to ensure that intended messages are understood.

It has been recognized that in the widely used “ABC” prevention message (abstinence, being faithful to one partner and condom use) both “a” and “b” are not very feasible in the Maasai community, and would require drastic cultural changes, which are unlikely to take place in the short term. Messages will have to focus on reinforcing those traditions that are protective against HIV transmission (such as abstinence during pregnancy and breastfeeding) and discouraging those that contribute to the transmission. Young people should be encouraged to delay sexual debut, condom use should be promoted and the benefits of knowing your HIV status through testing should be emphasized.

#### **4.2 Condom promotion and distribution**

Condoms are reported to be used by Maasai, especially in towns. The reported limited use of condoms cannot be attributed to resistance only but is also due to lack of awareness and knowledge of their use and limited condom availability. There is a need to increase knowledge about condoms, including model-aided demonstrations on proper use. New distribution channels and outlets closer to potential users, such as peer educators at village level, in schools and workplaces need to be explored. The acceptability and appropriateness of female condoms also needs to be studied further.

#### **4.3 STI syndromic management**

The priority intervention in this area is to expand the STI syndromic management to all health facilities in the district and to ensure that drugs are regularly supplied to provide the services. Promotion of proper health care seeking in case of a symptomatic STI needs to be a part of all education activities.

It is also proposed that research is carried out to assess the prevalence of STIs in the Maasai community. If the prevalence is confirmed to be very high, it might be scientifically sound to organize a mass presumptive treatment intervention (directly observed home based antibiotic treatment for everyone who is sexually active, regardless of symptoms and signs). A study could be carried out to assess the appropriateness and effectiveness of this approach and to develop modalities to organize a mass treatment campaign. Additional external funding would be required to carry out the intervention.

#### **4.4 Reduction of HIV-transmission through invasive procedures**

Traditional circumcisers and TBAs should be trained to avoid HIV transmission in their own practices and provided with protective gear and disposable blades. Female circumcision does not carry a high risk of HIV transmission since it is usually carried out on one girl at the time. It seems wise not to combine HIV and anti-FGM messages, as resistance to the anti-FGM campaign is considerable among the Maasai and this might discredit the HIV efforts. The message of using a separate knife for each boy during the male circumcision ceremonies needs to be further emphasized and communities need to discuss how this can be reinforced. Education in the community should also emphasize that body piercing, scarifications and shaving should all be performed with new disposable instruments, which could be made available through the health facilities or at community level.

#### **4.5 Voluntary counseling and testing (VCT)**

Although 14 health workers have recently been trained as counselors in the district, services had not started by early April 2004 as tests were not available. The priority is therefore to provide the required two rapid tests, initially to the three hospitals (Wasso, Endulen and NCAA) and to start VCT, in line with the national protocol. Based on the initial experiences, health workers in other health facilities could be trained and services could be further expanded, possibly also to outreach clinics organized by Wasso and Endulen PHC-teams.

In most of the interviews with community leaders and community groups, it was argued that the only effective way to halt the spread of HIV in the Maasai cultural context is to have everyone tested at community level. Some interviewees mentioned that it would be best to make the results known to the community, so that those who are not infected can protect themselves. An intervention of this nature needs very careful consideration, as it is not only novel but might have serious ethical implications. The process would require facilitation of discussions at community level to ensure that there is a consensus about the approach and that individuals are not subjected to testing without their consent or results are not shared without explicit permission. There is a danger that women might not have sufficient power to make their own decision and mechanisms should be built in to ensure that their opinion is respected. The issue of potential discrimination and rejection of HIV positive people should be openly discussed and the community should agree on mechanisms to safeguard the rights of the infected. According to national and global guidelines, HIV counseling has to be voluntary and results should be confidential (i.e. shared with the client only, unless the client gives explicit permission to share with others). There is however a growing recognition that individual confidentiality might not be appropriate in societies where the interest of the group or community prevails over individual interests. The new concept of "community confidentiality", where results are shared within the community, with the explicit consent of the person(s) tested, could be explored further in selected Maasai communities of Ngorongoro and might become an area for operational research. Lessons learned from this experience could be shared with other districts were communities express an interest in doing community-based HIV-testing and community sharing of results.

#### **4.6 Care and support for HIV infected persons**

As more HIV testing is carried out, the health facilities have to increase their readiness to provide care and support for the HIV positive clients from the early stages of the infection onwards, in order to maintain optimal quality of life and prevent further spread of the infection.

This requires training of health workers and provision of additional drugs and supplies. National guidelines on prevention of opportunistic and other infection through Cotrimoxazole prophylaxis need to be implemented.

The catholic diocese has applied for donation of Nevirapine to start prevention of mother to child transmission (PMTCT) interventions. It is suggested that HIV testing is offered as a routine part of antenatal care, using a group pre-test counseling approach and individual post-test counseling with special attention for those who are HIV positive. This service could initially be integrated in the hospital antenatal clinics and later expanded to other health facilities and outreach clinics. Additional staff would be required to cope with the increased workload.

It is also proposed that Wasso hospital would apply for accreditation as an AIDS treatment center and would initiate fundraising to acquire the necessary laboratory equipment to monitor HIV-positive patients on anti-retroviral drugs. Other hospitals (Endulen and NCAA) could become involved at a later stage, depending on the experiences of Wasso.

#### **4.7 Mainstreaming of HIV/AIDS**

During the stakeholder workshop it was decided that the newly established C-MAC needs to review its membership to ensure legitimate representation of the stakeholders. The guidelines, issued by the Government, define the composition and the procedures to elect the members and need to be followed. Members can be co-opted as deemed necessary to strengthen the capacity of the C-MAC.

The C-MAC will advocate with the key sectors to ensure that all government departments include HIV/AIDS into their annual plans and budgets. Education of the workforce is a first step, but each department will have to consider which routine sector activities constitute opportunities to improve awareness and knowledge about HIV/AIDS in specific target groups.

Projects, NGOs and CBO in the district have established a network which can be used to share experiences on mainstreaming of HIV/AIDS and to learn from each other. All staff needs to be trained on HIV/AIDS, so that they can integrate HIV/AIDS education into their project activities.

#### **4.8 Linkages beyond Ngorongoro district**

As a large proportion of Maasai from the district -mainly young men- migrate to the cities for employment purposes, it is important to link up with the respective C-MACs and with organization that are working on HIV/AIDS and/or with pastoralist migrants in these urban areas. Existing gatherings of Maasai in the cities could be utilized to create awareness and promote safe sexual behaviour and HIV-testing among the migrants. The educational materials in Maasai language could be made available to partner organisations in the urban areas. Traditional leaders from the home area could be brought in to participate in the initial meetings, to share the discussions and experiences from the communities in Ngorongoro district and to facilitate appropriate decision making among the migrants.

Through existing pastoralist umbrella organizations, such as PINGOS and TAPHGO, experiences on culturally appropriate HIV/AIDS programmes could be shared with other districts with pastoralist populations and joint trainings and production of educational material could be organized.

Purko and Loita sections of the Maasai in Ngorongoro district extend across the border to Narok district in Kenya. The border is an administration boundary but does not separate the section members on either side. Seasonal movement for livestock grazing, inter-marriages, rituals and social visits and interaction take place. It is therefore important to link with government authorities, health facilities and NGOs/CBOs in Narok district to share information on the prevalence and on existing HIV/AIDS programmes and actors. Potential partners could be identified through the Kenyan AIDS NGO network (KANGO) and some form of cross-border collaboration could be initiated. The World Bank supported Great Lakes Initiative on AIDS (GLIA) might be approached for technical assistance and possible funding of a cross-border project.

## **5. Role of stakeholders in the programme implementation**

In the following section, roles and responsibilities are allocated to stakeholders, based on interviews, the SWOT analysis of stakeholders and the self-reported interests of the participants in the workshop. The overview of roles of stakeholders in implementation, coordination, technical backstopping and funding, as expressed in the workshop, is found in Annex 2.

**C-MAC** will play a central role in coordination of the entire programme and of all actors, according to its official mandate. As it is a newly established body, which has undergone some basic training only, it is important that it recognizes its limitations and seeks advice/ co-opts resource persons from NGOs and church organizations with relevant experience in planning and implementation of HIV interventions. The C-MAC will finalize the formulation of the multi-sectoral AIDS plan and will ensure that the plan is endorsed by the Council as an integral part of the Council Development Plan. It should advocate for mainstreaming of HIV/AIDS into all departments and ensure that Council own resources are made available to fund a large part of the plan. The C-MAC is also expected to organize training of Ward Multi-sectoral AIDS Committees in all the wards.

**The Council Health Department** (Council Health Management Team-CHMT) will coordinate all health sector HIV/AIDS activities and liaise with the principal actors in the sector: the Catholic Diocese (Wasso, Endulen, Digodigo), ELCT/NMMU, MDM, the NCAA health department and the private clinics in the tourism sector. The training of health workers in STI, VCT and AIDS care will be coordinated by the CHMT and co-funded by interested partners as indicated below. The DMO will lobby with the Council to allocate 5% of the Council health budget to HIV/AIDS and will ensure that essential commodities and supplies such as condoms, HIV tests, drugs for STI and for opportunistic infections are obtained regularly and in sufficient quantities. The DMO will liaise with other heads of departments to organize education of civil servants on HIV/AIDS and will identify resource persons for these trainings.

**The Council Education Department** (DEO's office) will coordinate the education sector activities and ensure that funds are available to conduct training of teachers as guardians and training of students as peer educators.

**The Council Community Development Department** (DCDO's office) will cooperate with the proposed coordinators (Ereto with NCAA and PC in Ngorongoro division, LADO with Erato in Salei division and Erato in Loliondo division) and with the technical experts

(ACORD) to plan, implement and co-fund the community awareness and mobilization campaign.

**Ereto-NPP**, as the principal initiator of the formulation of the comprehensive district HIV/AIDS programme, will provide support for the C-MAC to organize a follow-up stakeholder workshop to complete the HIV/AIDS plan and to agree on implementation modalities and responsibilities.

The project staff members of Ereto-NPP need to be trained in HIV/AIDS, in order to be able to function as resource persons and facilitators on HIV/AIDS at community level. Since many other NGOs working in the district (LADO, Oxfam GB, Austroproject, MAPADA, SADA and CRT) also identified lack of capacity among their staff to deal with HIV/AIDS as a major weakness, it would be most effective to organize a joint intervention to carry out a KAPB survey among NGO staff, assess training needs and organize one week training workshops for all staff. ACORD has technical expertise in carrying out this intervention and could involve one of its partners experienced with NGO staff training (AMREF, TANESA). Ereto and Oxfam are proposed to jointly take the lead in organizing and funding this intervention.

Ereto-NPP will coordinate the design and implementation of the community based awareness campaign, initially in Ngorongoro division and later in Loliondo and Salei divisions. It is proposed that Ereto-NPP subcontracts ACORD to design the campaign, to carry out the trainings of leadership and of community based educators/counsellors and to support the facilitation of discussions and action at community level.

Ereto-NPP will commission the production of a video, to be used for community based awareness creation. It is suggested that this activity could be subcontracted to Maweni Farms, Ltd, a Tanzania based organization with extensive experience in participatory video production. They have developed a concept and scenario for a half hour video to address common myths about Maasai being immune to HIV and about the existence of effective traditional cures for the infection. Already Maasai living with HIV/AIDS have been recruited to tell their stories as part of the film.

Ereto-NPP will also commission and fund the proposed research activities:

- to assess the STI prevalence and the feasibility/appropriateness of a mass presumptive STI treatment campaign. This study needs to be commissioned to an appropriate research institute.
- to explore the appropriateness and feasibility of community based counselling and testing and the modalities of implementation. The study needs to be commissioned to a team of an international expert in community counselling and a local expert familiar with the socio-cultural context of the Maasai in Tanzania.

### **Oxfam Ireland**

Oxfam Ireland will be a new partner in Ngorongoro district and will mainly play a role in advocacy, support for mainstreaming of HIV/AIDS, facilitation of networking among NGOs/CBOs and funding of partner organisations.

Oxfam Ireland has extensive experience in mainstreaming of HIV/AIDS, with a focus on livelihood and pastoralism, and is therefore best placed to take the lead in building capacity of other NGOs and CBOs to identify opportunities and entry points for mainstreaming of HIV/AIDS into their projects and to explore how best to do this. The

existing NGO network can be used as a platform for capacity building and exchange of experiences. Oxfam Ireland has already organized training events for internal mainstreaming (workplace), in which some NGOs and CBOs of Ngorongoro district have participated, and could cooperate with Ereto and ACORD to cover all relevant organisations in the district.

In association with Oxfam GB and with ACORD, Oxfam Ireland will support co-ordination and networking among NGOs/CBOs around HIV/AIDS. This could be done through the existing NGO network in Ngorongoro.

Oxfam will also provide support and technical assistance in monitoring and evaluation of the programme. This will include the implementation at district and community level of the national M&E system for HIV/AIDS as well as organisation KAPB studies, the mid-term review and the end of project evaluation.

Oxfam Ireland will also consider providing financial support to selected NGOs/CBOs in the district. While ACORD and Oxfam GB are the most likely partners to benefit, the partnership could be extended to other actors in the district.

Beyond Ngorongoro district, Oxfam Ireland is well placed to represent pastoralists' interests at national level and to advocate with government and development partners to increase technical support and resources for appropriate HIV/AIDS interventions among pastoralists. Through its partnership with pastoralists umbrella organisations, such as TAPHGO and PINGOS, co-ordination on HIV/AIDS beyond Ngorongoro district will be promoted. Oxfam International in Tanzania will focus on pastoralism as the main theme for HIV/AIDS mainstreaming and will establish linkages with other initiatives and experiences on HIV/AIDS in pastoral communities, both nationally and regionally.

**Oxfam GB** will need to build capacity of its project field staff, as suggested for Ereto-NPP (see above).

Oxfam GB will be a partner in the implementation of the community awareness campaign in Loliondo division, in partnership with Ereto-NPP and other NGOs and with technical guidance from ACORD.

Oxfam GB has already integrated HIV/AIDS into the syllabus of the adult education programme in the context of the Ngorongoro Adult Literacy Programme. It is proposed that Oxfam would support the education department to initiate school based HIV/AIDS interventions. The education sector has recognized the need to start STI/HIV/AIDS and reproductive health education in both primary and secondary schools. The primary health care teams of Wasso and Endulen hospital have taken the initiative to give talks on HIV/AIDS in some schools in the past, and would be good partners to involve in initial planning. It is suggested that other partners with extensive experience in school based HIV/AIDS interventions are approached to provide training materials and training of trainers for both the guardian/counselor and the peer education component. AMREF, TANESA and GTZ all have experience in this area.

It is also suggested that Oxfam supports research activities related to condom promotion and accessibility:

- to assess how condom availability can be improved through alternative distribution channels and outlets at village level, in schools and in workplaces
- to explore the usefulness and acceptability of female condoms in the Maasai society

**ACORD** will be contracted to provide technical expertise for the community based awareness and mobilization campaign. It will provide the overall design of the campaign, organize the training of traditional leaders and village administration, organize training of village based educators/counselors and facilitate the community based awareness creation and mobilization activities. Organizations with experience of community based mobilization should be brought on board as partners for the implementation of this campaign. They include: the Pastoralist Council, LADO, MAPADA, SADA, the catholic diocese and ELCT/NMMU. Coordination of all involved partners will be a major challenge.

ACORD will also provide technical expertise to train NGO/CBO and project staff in HIV/AIDS and will work with Oxfam Ireland on building capacity for mainstreaming among NGOs/CBOs and projects and on documenting experiences.

**The Catholic Diocese** (Wasso hospital, Endulen hospital and Digodigo health centre) provides the bulk of health care services in the district. They will be partners in the community awareness campaign and will consider how the existing network of outreach clinics can be used as an entry point to reach remote communities.

The health facilities under the diocese will start VCT services as soon as tests are available. Antenatal care clients will be offered VCT and PMTCT when supplies of Nevirapine are secured, initially in the health facilities only and later in the outreach clinics.

Wasso hospital will initiate procedures to apply for accreditation as an AIDS treatment centre and will request assistance with funding from the private sector to acquire CD4 counting equipment and other essential laboratory upgrading.

**Medicos del Mundo** will support the health sector to expand STI syndromic management services and VCT services to additional health facilities. It will support training, supplies of drug kits, condoms and tests and monitoring/evaluation.

MDM will also support the health sector to initiate PMTCT interventions in selected health facilities.

**The Pastoralist Council, ELCT-NMMU, LADO, CRT, MAPADA, SADA and Austroproject** will all contribute as implementers in the community awareness and mobilization campaign. They all have staff who are working at community level and speak the local language. Most of the staff will initially require knowledge on HIV/AIDS and skills in facilitation of community discussions on sexuality and HIV/AIDS.

## **6. Coordination mechanisms**

Effective coordination of a complex programme with many actors will be a crucial element in successful implementation.

The **Council Multi-sectoral AIDS Committee (C-MAC)** has a mandate to plan, coordinate and monitor all HIV/AIDS activities in the district. The overall district HIV/AIDS programme will be coordinated by this body and there is therefore no need to set up a steering committee or additional coordinating body. The first task of the C-MAC will be to finalize the Council Multi-sectoral AIDS plan and submit it to the Full Council. As was agreed in the workshop, the composition of the C-MAC needs to be revised in order to ensure that the different constituencies are represented by a capable and experienced member, who will ensure two-way communication between the C-MAC and the respective constituency. This applies particularly to the NGO's and CBO's, who can use the NGO-network as a forum to elect their representative(s) and to maintain communication. The catholic diocese has so far been the initiator and implementer of a large proportion of the HIV/AIDS interventions in the district (education in hospital, outreach clinics and schools, STI services, blood screening, care for PLHAs) and would be the most appropriate representative of the Christian faith based organizations (FBOs) in the C-MAC.

The C-MAC is expected to establish and train a **Ward Multi-sectoral AIDS Committee (W-MAC)** in each ward. These committees will co-organize the community awareness creation, discussions and decision making on community responses and will coordinate the different actors who implement HIV/AIDS activities in the ward. In turn the W-MAC will establish and train a **Village Multi-sectoral AIDS Committee (V-MAC)** in each village to plan and implement village specific activities. The W-MACs will compile the village HIV/AIDS plans and submit them to the C-MAC for approval and funding.

It was agreed in the Stakeholder workshop that a follow-up workshop of stakeholders should be called within the next 3 months to review the final district HIV/AIDS plan prepared by the C-MAC and to discuss and agree upon implementation arrangements and funding. This forum could become institutionalized as a "**stakeholder forum**" which could meet quarterly to exchange information on ongoing activities and interventions and to monitor progress.

Under the World Bank supported Tanzania Multi-sectoral AIDS Program (T-MAP), **Regional Facilitating Agencies (RFAs)** will be appointed to manage the Community Response Fund component of the T-MAP. The RFA will closely cooperate with the C-MAC to identify potential implementing partners at district and community level, to assess and build capacity of NGOs and CBOs and to approve and fund proposals generated at community level. Both proposals from NGOs/CBOs and from villages/sub-villages can be considered for funding. The RFA will also be in charge of programmatic and financial monitoring of the funded projects.

## **7. Monitoring and evaluation**

TACAIDS is currently developing an M&E system for HIV/AIDS interventions at Council and Ward level. The selected indicators of this system are largely taken from the National Multisectoral Strategic Framework and are consistent with the indicators developed at global level during the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS. Tools and formats have also been developed and are being field-tested to collect information at the district, sub-district and institutional level and to report to regional and national level. It is suggested that these same indicators would be used for this programme as much as possible. The indicator-set is comprehensive and is designed to monitor inputs, processes and outputs.

In the draft logframe in chapter 9, a number of indicators/milestones have been suggested at activity and sub-activity level. The C-MAC will have to decide which of these will be retained or adapted for the final plan.

It is suggested that baseline KAPB-studies are carried out among specific groups (traditional leaders, youth in school, youth out of school, workers) to assess the learning needs and design appropriate educational interventions. These studies should be repeated at the end of the 3 year programme to evaluate progress. The results would form an important input for the end of programme joint evaluation.

It is recommended that a mid-term internal review would take place after 18 months, organized by the C-MAC with full participation of all the stakeholders. This will provide an opportunity to assess progress made and to reorient the programme. New development in the national response, such as availability of anti-retroviral drugs will need to be taken into account. The findings of feasibility studies and experiences from pilots should be considered to redirect the programme where necessary.

At the end of three years an external evaluation will be commissioned by the funders of the programme.

## **8. List of objectives, outputs and activities**

### **Objective 1: Improve awareness, knowledge and skills among communities, groups and individuals in order to empower them to respond appropriately to HIV and AIDS**

- Output 1.1: Awareness, knowledge and skills improved among communities
  - Act. 1.1.1: Assess training needs of traditional leaders, elders, leaders of women, youth leaders (ngopir,bekoran), traditional midwives, circumcisors (mumuradi,ngariba), Illoibonok/Wanamije
  - Act. 1.1.2: Organize training of Ilaiguanak so that they can use their authority with the leadership of youth and women to educate the community on:
    - the presence of HIV/AIDS, emphasizing that there is no cure and medicine and that HIV does not discriminate
    - all ways in which HIV can be transmitted
    - how to protect against and prevent HIV infection
  - Act. 1.1.3: Organize training of TBAs and circumcisors on proper use of their equipments for circumcision and delivery, emphasizing:
    - to boil razor blades and knives before use or use disposable blades and knives for one person only - “each youth should have own knife”
    - proper use of gloves and general hygiene/body cleanliness
  - Act. 1.1.4: Organize a community mobilization campaign:
    - Act 1.1.4.1: Train important people of both genders from every settlement
    - Act 1.1.4.2: Produce videos in the language of the local people like Maasai, Barbaig and Watemi
    - Act 1.1.4.3: Produce posters/leaflets in the local language and make traditional dances on the HIV/AIDS theme
    - Act 1.1.4.4: Educate the community at the level of the hamlet by mobilising community groups of both genders through meetings, songs and olamal
- Output 1.2: Awareness, knowledge and skills improved among workers in government, NGOs, FBO's and private sector
  - Act. 1.2.1: Identify key staff in government, NGOs, FBO's, CBO's and private sector
  - Act. 1.2.2: Conduct a baseline survey on awareness, knowledge and skills
  - Act. 1.2.3: Conduct training needs assessment
  - Act. 1.2.4: Design appropriate training modules
  - Act. 1.2.5: Train key staff through workshops, seminars, exchange visits, etc.
  - Act. 1.2.6: Conduct monitoring, evaluation and systematic review
- Output 1.3: Awareness, knowledge and skills improved among school children
  - Act. 1.3.1: Train facilitators and peer educators
    - Act. 1.3.1.1: Assess training needs
    - Act. 1.3.1.2: Correspond with/involve district authorities
    - Act. 1.3.1.3: Identify and formulate peer groups
    - Act. 1.3.1.4: Organize and conduct peer educator training
  - Act. 1.3.2: Train teachers as guardians/counselors on STI/HIV/AIDS and sexual/reproductive health

- Act. 1.3.2.1: Identify and train TOT's
- Act. 1.3.2.1: Identify and train 108 school teachers
- Act. 1.3.3: Organize school health screening
  - Act 1.3.3.1: Procure medical supplies and drugs for school health
  - Act 1.3.3.2: Train health workers in reproductive health service provision for school pupils
- Act. 1.3.4: Conduct advocacy for user-friendly adolescent sexual and reproductive health services
  - Act. 1.3.4.1: Conduct review meeting with MoEC on policy and strategy for sexual/reproductive health education and services for pupils
  - Act. 1.3.4.2: Address issues of premarital sex, pregnant school girls etc
- Output 1.4: Awareness, knowledge and skills improved among youth/ morani
  - Act. 1.4.1: Conduct KAPB study
  - Act. 1.4.2: Identify peer health educators
  - Act. 1.4.3: Conduct training needs assessment of peer educators
  - Act. 1.4.4: Organize and conduct peer educator training
  - Act. 1.4.5: Organize and conduct M&E

**Objective 2: Reduce or eradicate cultural practices that are harmful and reinforce good practice**

- Output 2.1: Practices that contribute to the spread of HIV reduced or eradicated
  - Act 2.1.1: Organize education sessions/discussions with both gender groups and encourage groups to give feedback on cultural practices such as oloip/orbo, esoto, night dances, esajare (fertility rituals), embatatare (rape), mbarimbari, mase, kirimo, ghorou (faith rituals))
  - Act 2.1.2: Assess existing bye laws and change or improve taking the situation of HIV into account
  - Act 2.1.3: Support the traditional courts to discuss and eradicate traditions that contribute to the spread of HIV/AIDS
  - Act 2.1.4: Advocate with the government to recognize the importance of traditional leadership courts and to include them in policy documents
- Output 2.2: Practices that contribute to the spread of HIV transformed into good practices
  - Act. 2.2.1: Use traditional gatherings to educate community to fight against/protect against HIV/AIDS
  - Act. 2.2.2: Mobilize the concerned age group to use esoto/orbo as a place for education
  - Act. 2.2.3: Transform night dances into daytime dances and develop songs, poetry and different kinds of dances that educate about AIDS
  - Act 2.2.4: Encourage the community to build houses for guests
  - Act 2.2.5: Educate women on ways to prevent infertility and seek expert help rather than participating in fertility rituals

### **Objective 3: Promote condom use and improve access to male and female condoms**

- Output 3.1: Appropriate educational materials developed for condom promotion and demonstration
  - Act. 3.1.1: Obtain/procure female and male condoms
  - Act. 3.1.2: Obtain penile models and female models
  - Act. 3.1.3: Obtain/develop posters, leaflets and videos
- Output 3.2: Acceptability and feasibility of female condoms explored and promotion/demonstration done if appropriate
  - Act. 3.2.1: Organize research on acceptability and feasibility of female condoms in the Maasai culture
  - Act. 3.2.2: Train health workers on promotion and proper use of female condoms
- Output 3.3: Availability and acceptability of condoms improved
  - Act. 3.3.1: Explore alternative distribution channels and outlets for condoms (schools, workplaces, youth centers)
- Output 3.4: Condoms regularly obtained/procured and distributed
  - Act. 3.4.1: Ensure sufficient condoms in stock and distributed

### **Objective 4: Intensify and expand STI prevention and management**

- Output 4.1: All health workers trained in STI syndromic management and guidelines available in all health facilities
  - Act 4.1.1: Identify trainers
  - Act 4.1.2: Develop/acquire training package
  - Act 4.1.3: Train health providers in all facilities on STI syndromic management
  - Act 4.1.4: Ensure guidelines availability in all health facilities by procuring and distribution
- Output 4.2: Feasibility of organizing a mass treatment campaign explored and campaign implemented if appropriate
  - Act. 4.2.1: Develop terms of reference
  - Act. 4.2.2: Engage expertise to undertake feasibility study
  - Act. 4.2.3: Decide to organize mass campaign based on expert report
- Output 4.3: Drugs and supplies regularly procured and distributed
  - Act 4.3.1: Establish a drug list based on standardized treatment regimen
  - Act 4.3.2: Regularly procure essential drugs for treatment of STI's
- Output 4.4: Supervision and monitoring of STI management integrated in routing supervision and in MTUHA
  - Act. 4.4.1: Establish monitoring system to assess impact of prevention and management of STI's
  - Act. 4.4.2: Document process and results

## **Objective 5: Promote and expand counseling and testing of individuals, couples and communities**

- Output 5.1: More counselors trained in health facilities (and stand-alone centers)
  - Act 5.1.1: Organize and run training for counselors
  - Act 5.1.2: Provide counselors with education materials (condoms, models)
- Output 5.2: Community counselors trained in every village/sub-village
  - Act 5.2.1: Identify candidates for training in a participatory way
  - Act 5.2.2: Identify and contract specialized institution/expert to develop training package in the local language
  - Act 5.2.3: Organize and conduct training
  - Act 5.2.4: Provide relevant materials (condoms, posters,...)
- Output 5.3: Rapid test kits available at VCT centres
  - Act 5.3.1: Procure and distribute rapid test kits (both first and second test) regularly
- Output 5.4: Community voluntary counseling and testing organized in villages that have build consensus and agreed on community counseling and testing
  - Act 5.4.1: Identify traditional leaders of different age sets who can be used in the entire process of organizing the community and dialoguing with them on community counseling and testing
  - Act 5.4.2: Organize community level meetings to agree on procedures for undertaking community counseling and testing
  - Act 5.4.3: Undertake community VCT with the technical backstopping from specialists/consultants
  - Act 5.4.4: Capture and document the process
  - Act 5.4.5: Institute a monitoring and feed backing mechanism to assess impact

## **Objective 6: Improve provision of care and treatment for people with HIV/AIDS**

- Output 6.1: HIV-positive persons registered and monitored regularly at hospital level
  - Act 6.1.1: Create a functioning patient register with important identification for proper follow-up during treatment
  - Act 6.1.2: Monitor patients for any opportunistic infections and treat them appropriately
  - Act 6.1.3: Manage stocks of all the relevant drugs such as Cotrimoxazole, pentamidine, ausiclovit, Fluconazole, Ampotericin B, pain killers, multivitamins, nystatin oral drops etc.
- Output 6.2: Improve staff capacity for management of HIV/AIDS, including PMTCT and home based care
  - Act 6.2.1: Train clinicians on the management of HIV/AIDS including PMTCT
  - Act 6.2.2: Train laboratory staff in the monitoring of people on ARV treatment e.g. CD4 count, LFT, etc.
  - Act 6.2.3: Train health workers and community volunteers in home based care

- Output 6.3: Cotrimoxazole prophylaxis given to all HIV+ve children and all symptomatic HIV+ve adults
  - Act 6.3.1: Procure and provide cotrimoxazole as appropriate to HIV+ve people (according to the national guideline)
- Output 6.4: All pregnant HIV+ve women enrolled in PMTCT programme
  - Act 6.4.1: Increase antenatal coverage and encourage regular ANC attendances
  - Act 6.4.2: Offer VCT to all antenatal women using at least two rapid tests
  - Act 6.4.3: Provide nevirapine for all HIV +ve antenatal mothers when labour starts and to the baby within 72 hours after delivery
  - Act 6.4.4: Discourage antenatal activities which may increase the risk of MTCT of HIV, such as external cephalic version
  - Act 6.4.5: Treat infections in pregnant women such as malaria appropriately
  - Act 6.4.6: Provide iron and folic acid supplements to avoid antenatal anaemia
  - Act 6.4.7: Counsel HIV positive mothers on exclusive breastfeeding and rapid weaning
  - Act 6.4.8: Follow-up children born to HIV positive mothers and care for the HIV-infected women and children
- Output 6.5: ARV treatment started in Wasso and Endulen Hospital
  - Act 6.5.1: Apply for accreditation as AIDS treatment center for Wasso and Endulen hospital (and NCAA clinic at a later stage)
  - Act 6.5.2: Improve laboratory services for the diagnosis and monitoring of HIV/AIDS patients at Wasso and Endulen hospital
    - Act 6.5.2.1: Procure CD4 count machines for Wasso and Endulen hospitals
    - Act 6.5.2.2: Procure HIV ELISA machine for Wasso and Endulen hospitals
    - Act 6.5.2.3: Improve laboratory capacity to perform important monitoring parameters such as liver function tests, electrolytes, blood sugar levels, renal functions tests, etc
  - Act 6.5.3: Procure/obtain appropriate ARV and start treatment as per national guidelines for clinical management of HIV/AIDS.

### **Objective 7: Reduce transmission of HIV through delivery and invasive procedures**

- Output 7.1: TBA's knowledge and skills in safe delivery improved
  - Act 7.1.1: Identify TBAs and train them on safe delivery
  - Act 7.1.2: Provide protective gears like gloves, aprons to all TBAs
  - Act 7.1.3: Promote hospital delivery of all HIV+ve mothers while maintaining confidentiality.
- Output 7.2: Safe blood transfusion and safe medical procedures in place in health facilities
  - Act 7.2.1: Develop strict blood transfusion criteria for all health facilities and share experience among them
  - Act 7.2.2: Maintain the provision of safe blood to all patients and provide reagents for donor screening

- Act 7.2.3: Establish a community network of safe blood donors such that all units have a stand-by blood supply for transfusion in case of an emergency.
- Output 7.3: Traditional invasive practices (shaving, tattooing, piercing) discouraged or made safe
  - Act 7.3.1: Organize health education to the community on the dangers of sharing razor blades, tattooing, body piercing instruments using the existing health education teams including VHWs
- Output 7.4: Hospital and health unit staff trained in safe procedures including how to avoid unnecessary invasive procedures
  - Act 7.4.1: Ensure sufficient supply of gloves, disposable syringes and needles and equipment for sterilization in health facilities
  - Act 7.4.2: Train health workers on avoiding episiotomies, use of separate blades/scissors for mother and baby and delay in rupture of membranes

**Objective 8: Mainstream HIV/AIDS in the activities of the district through C-MAC, Projects/Programmes, NGO's, FBO's, CBO's and private sector in order to develop a sustainable HIV/AIDS response**

- Output 8.1: HIV/AIDS mainstreaming initiated and implemented within district, projects/programmes, NGO's, CBO's, FBO's and private sector
  - Act. 8.1.1: Identify and prioritize key social and economic issues that impact on or are impacted by HIV/AIDS in the district
  - Act. 8.1.2: Train staff on mainstreaming of HIV/AIDS into projects and activities (institutional strengthening and capacity building)
  - Act. 8.1.3: Design appropriate interventions for mainstreaming HIV/AIDS in all sectors at district and community level (agriculture, education, health, community development, livelihood, gender, governance and basic rights)
  - Act. 8.1.4: Conduct participatory monitoring and evaluation and provide feedback
- Output 8.2: Advocacy strategy developed based on successful mainstreaming of HIV/AIDS
  - Act. 8.2.1: Document good practice and disseminate to influence policy
  - Act. 8.2.2: Lobby for replication of good practice in other districts and regions

## 9. Draft Logical Framework

**Objective 1: Improve awareness, knowledge and skills among communities, groups and individuals in order to empower them to respond appropriately to HIV and AIDS**

Output	Activities	Indicators	TIMETABLE												Responsible Organisation	Indicative Budget (US\$)		
			Year 1				Year 2				Year 3							
			1	2	3	4	1	2	3	4	1	2	3	4				
<b>Output 1.1: Awareness, knowledge and skills improved among communities</b>	Act. 1.1.1: Assess training needs of traditional leaders, elders, leaders of women, youth leaders (ngopir,bekoran), traditional midwives, circumcisors (mumuradi,ngariba), Illoibonok/Wanamije	Need assessment report available	x														ERETO, OXFAM, ACORD	KAPB study and training needs assessment 3000
	Act. 1.1.2: Organize training of Illaiguanak so that they can use their authority with the leadership of youth and women to educate the community on: -the presence of HIV/AIDS, emphasizing that there is no cure and medicine and that HIV does not discriminate -all ways in which HIV can be transmitted -how to protect against and prevent HIV infection	Number of traditional leaders trained		x													ERETO, OXFAM ACORD	3 x 3 day meetings for traditional leaders (M&F), administrators, healers, circumcisors and TBAs Transport, food, venue, facilitators: 9000

Act. 1.1.3: Organize training of TBAs and circumcisors on proper use of their equipments for circumcision and delivery, emphasizing: -to boil razor blades and knives before use or use disposable blades and knives for one person only - “each youth should have own knife” -proper use of gloves and general hygiene/body cleanliness	Number of TBAs and circumcisors trained			x											ERETO, OXFAM, ACORD	Covered under 1.1.2 and 7.1
Act. 1.1.4: Organize a community mobilization campaign:	Number of hamlets that discussed HIV/AIDS and developed their own responses			x	x	x	x	x	x	x					ERETO, OXFAM, ACORD	
<i>Act 1.1.4.1: Train important people of both genders from every settlement</i>	Number of community educators/co unsellors identified and trained			x	x										ERETO, OXFAM, ACORD	6 trainings for 40 community educators/ counsellors 18000
<i>Act 1.1.4.2: Produce videos in the language of the local people like Maasai, Barbaig and Sonjo</i>	Video in local language available			x											ERETO, OXFAM, ACORD, Consultant (Maweni Farm)	Contract with professional producer 40000
<i>Act 1.1.4.3: Produce posters/ leaflets in the local language and make traditional dances/songs on the HIV/AIDS theme</i>	IEC materials available			x											ERETO, OXFAM, ACORD	Contract 10000

	<i>Act 1.1.4.4: Educate the community at the level of the hamlet by mobilising community groups of both genders through meetings, songs and olamal</i>	Number of hamlets that held facilitated discussions on HIV/AIDS and developed their own responses			X	X	X	X	X	X						ERETO, OXFAM, ACORD MAPADA, LADO, DIOCESE NDC. NMMU MDM, NCAA, PC	Contract with NGOs  2 vehicles 2 video projectors, 2 generator, transport, allowances  130000
<b>Output 1.2: Awareness, knowledge and skills improved among workers in government, NGOs, FBO's and private sector</b>	Act. 1.2.1: Identify key staff in government, NGOs, FBO's, CBO's and private sector to be trained	List of staff to be trained available	X													ERETO, OXFAM MAPADA, LADO, DIOCESE, NDC. NMMU, MDM, NCAA, NDC	
	Act. 1.2.2: Conduct a baseline survey on, knowledge and skills	KAPB study/ baseline survey report		X												ACORD	KAPB study and training needs assessment 3000
	Act. 1.2.3: Conduct training needs	Staff training needs assessment report			X											ACORD with AMREF	See under 1.2.2
	Act. 1.2.4: Design/ obtain appropriate training modules	Modules available			X											ACORD with AMREF	Covered under 1.2.5
	Act. 1.2.5: Train key staff through workshops, seminars, exchange visits etc.	Number of staff trained in workplaces				X	X	X								ACORD with AMREF	5 training of 20 workers each for 5 days 12000
	Act. 1.2.6: Conduct monitoring, evaluation and systematic review	M/E report of workplace intervention							X					X		ACORD with AMREF	Contract 2000

<b>Output 1.3: Awareness, knowledge and skills improved among school children</b>	Act. 1.3.1: Train facilitators and peer educators	Number of facilitators and peer educators trained																	Education department, OXFAM, consultant (TANESA)		
	<i>Act. 1.3.1.1: Assess training needs</i>				X															KABP study and needs assessment 2000	
	<i>Act. 1.3.1.2: Correspond with/involve district education authorities</i>				X																
	<i>Act. 1.3.1.3: Identify school children for peer educator training</i>				X																
	<i>Act. 1.3.1.4: Organize and conduct peer educator training</i>					X					X							X		Training of 8 PE per year per school 3000	
	Act. 1.3.2: Train teachers as guardians/counsellors on STI/HIV/AIDS and sexual/reproductive health	Number of teachers trained as guardian/counselors (target 108))																		Education department, OXFAM, consultant (TANESA)	
	<i>Act. 1.3.2.1: Identify and train TOT's</i>		X																		Contract for TOT training 2000
	<i>Act. 1.3.2.2: Identify and train 108 school teachers</i>			X	X																4 trainings of 27 teachers for 1 week each 12000

	Act. 1.3.3: Organize school health screening	Number of school children with STI s identified and treated														Education department, Health Department, Diocese	
	<i>Act 1.3.3.1: Procure medical supplies and drugs for school health</i>			x		x			x			x				DMO, Diocese	Covered under 4.3.2
	<i>Act 1.3.3.2: Train health workers in reproductive health service provision for school pupils</i>	Number of health workers trained		x												DMO, Diocese	Covered under 4.1.3
	Act. 1.3.4: Conduct advocacy for user-friendly adolescent sexual and reproductive health services	Number of advocacy meetings held														OXFAM, Diocese	Advocacy meetings 500
	<i>Act. 1.3.4.1: Conduct review meeting with MoEC on policy and strategy for sexual/reproductive health education and services for pupils</i>	Report of meeting available		x					x							OXFAM, Diocese	2 meetings for 1 day each 500
	<i>Act. 1.3.4.2: Address issues of premarital sex, pregnant school girls etc</i>	Data available on pregnancy among school girls		x	x	x	x	x	x	x	x	x	x	x		OXFAM, Diocese	Covered under 1.3.4.1
<b>Output 1.4: awareness, knowledge and skills improved among youth/ morani</b>	Act. 1.4.1: Conduct KAPB study	Report of KAPB study among youth available	x													ERETO, OXFAM ACORD	KAPB study and training needs assessment 2000
	Act. 1.4.2: Identify peer educators among youth out of school	List of PE available		x												“	



	Act 2.1.3: Support the traditional courts to discuss and eradicate traditions that contribute to the spread of HIV/AIDS	Reports of discussions in traditional courts available			x	x	x	x	x	x				Community leaders	Covered under 1.1.4.4
	Act 2.1.4: Advocate with the government to recognize the importance of leadership courts and to include them in policy documents									x	x	x		ACORD	Covered under 1.1.4.4
<b>Output 2.2: Practices that contribute to the spread of HIV transformed into good practices</b>	Act. 2.2.1: Use traditional gatherings to educate community to fight against/protect against HIV/AIDS	Number of gatherings where HIV/AIDS was discussed			x	x	x	x	x	x				Community leaders, Community educators/ counsellors	Covered under 1.1.4.4
	Act. 2.2.2: Mobilize the concerned age group to use esoto/orbo as a place for education	Number of education sessions organised during esoto/orbo			x	x	x	x	x	x				Community leaders, community educators/ counsellors	Covered under 1.1.4.4
	Act. 2.2.3: Transform night dances into daytime dances and develop songs, poetry and different kinds of dances that educate about AIDS	Decreasing number of night time dances			x	x	x	x	x	x	x			Community leaders, community educators/ counsellors	Covered under 1.1.4.4
	Act 2.2.4: Encourage the community to build houses for guests	Number of settlements with guesthouses			x	x	x	x	x	x				Community leaders, Community educators/ counsellors	Covered under 1.1.4.4
	Act 2.2.5: Educate women on ways to prevent infertility and seek expert help rather than participating in fertility rituals				x	x	x	x	x	x				Community leaders, Community educators/ counsellors	Covered under 1.1.4.4

### Objective 3: Promote condom use and improve access to male and female condoms

<b>Output 3.1: Appropriate educational materials developed for condom promotion and demonstration</b>	Act. 3.1.1: Obtain/procure female and male condoms	Numbers of male and female condoms available for demonstration	x	x	x	x	x	x	x	x	x	x	x	x	x	DMO, MDM	Female condoms 500
	Act. 3.1.2: Obtain penile models and female models	Models available	x	x												DMO, MDM, OXFAM	Local production of models 500
	Act. 3.1.3: Obtain/develop posters, leaflets and videos	IEC materials in local languages available			x											DMO, MDM, OXFAM	Contract with video producer 10 000
<b>Output 3.2: Acceptability and feasibility of female condoms explored and promotion/demonstration done if appropriate</b>	Act 3.2.1: Organise research on acceptability and feasibility of female condoms in the Maasai culture	Research report available				x										OXFAM, DMO, MDM	Consultancy contract 5000
	Act. 3.2.2: Train health workers on promotion and proper use of female condoms	Number of health workers trained in female condom promotion	x	x												OXFAM, DMO, MDM	Included in STI training
<b>Output 3.3: Availability and acceptability of condoms improved</b>	Act. 3.3.1: Explore alternative distribution channels and outlets for condoms (schools, workplaces, youth centers)	Increasing number of condom outlets														OXFAM, DMO, MDM	Covered under same consultancy contract as 3.2.1
<b>Output 3.4: Condoms regularly obtained/procured and distributed</b>	Act. 3.4.1: Ensure sufficient stock of condoms in store and distributed	Number of condoms distributed					x		x		x		x			OXFAM, DMO, MDM	Male condoms from MoH female condoms according to



<b>regularly procured and distributed</b>	Act 4.3.2: Regularly procure essential drugs for treatment of STI's	No stock-out of STI drugs		x		x		x		x		x		x	DMO, MDM, Diocese, NCAA clinic	In health budget
<b>Output 4.4: Supervision and monitoring of STI management integrated in routing supervision and in MTUHA</b>	Act. 4.4.1: Establish monitoring system to assess impact of prevention and management of STI's	STI report available and data included in MTUHA		x											DMO, MDM, Diocese	In routine supervision budget
	Act. 4.4.2: Document process and results	Report available						x						x	DMO, MDM, Diocese	Consultancy for mid-term review and end of project evaluation 6000
<b>Total budget for Objective 4</b>																<b>31000</b>

### Objective 5: Promote and expand counseling and testing of individuals, couples and communities

<b>Output 5.1: More counselors trained in health facilities (and stand-alone centers)</b>	Act 5.1.1: Organize and run training for counsellors	Number of counsellors trained		x				x							DMO, MDM	2 trainings of 20 counsellors for 2 weeks 20000
	Act 5.1.2: Provide counsellors with education materials (condoms, models)	IEC material available in health facilities		x				x							DMO, MDM	Covered under 3.1
<b>Output 5.2: Community counselors trained in every village/sub-village</b>	Act 5.2.1: Identify candidates for training in a participatory way	List of community counsellors available			x	x	x								Ereto, OXFAM, ACORD	Covered under 1.1.4.4
	Act 5.2.2: Identify and contract specialized institution/expert to develop training package in the local language	Training package available						x							Ereto, OXFAM, ACORD	Contract for training 3000







	Act 6.4.5: Treat infections in pregnant women such as malaria appropriately		x	x	x	x	x	x	x	x	x	x	x	x	x	DMO, Diocese	In health budget
	Act 6.4.6: Provide iron and folic acid supplements to avoid antenatal anaemia		x	x	x	x	x	x	x	x	x	x	x	x	x	DMO, Diocese	In health budget
	Act 6.4.7: Counsel HIV positive mothers on exclusive breastfeeding and rapid weaning	Number of HIV positive women counseled	x	x	x	x	x	x	x	x	x	x	x	x	x	DMO, Diocese, MDM	
	Act 6.4.8: Follow-up children born to HIV positive mothers and care for the HIV-infected women and children	Number of babies born to HIV positive mothers followed up	x	x	x	x	x	x	x	x	x	x	x	x	x	DMO, Diocese, MDM	Covered under 6.4.3
<b>Output 6.5: ARV treatment started in Wasso and Endulen Hospital</b>	Act 6.5.1: Apply for accreditation as AIDS treatment center for Wasso and Endulen hospital (and NCAA clinic at a later stage)	Accreditation application submitted			x											Diocese	
	Act 6.5.2: Improve laboratory services for the diagnosis and monitoring of HIV/AIDS patients at Wasso and Endulen hospital															Diocese, MOH	
	<i>Act 6.5.2.1: Procure CD4 count machines for Wasso and Endulen hospitals</i>	CD4 count machine available in Wasso and Endulen				x					x					Diocese, MOH, donors	Fund raising
	<i>Act 6.5.2.2: Procure HIV ELISA machine for Wasso and Endulen hospitals</i>	ELISA machine in place				x					x					Diocese, MOH, donors	3000
	<i>Act 6.5.2.3: Improve laboratory capacity to perform important monitoring parameters such as liver function tests, electrolytes, blood sugar levels, renal functions tests, etc</i>	Number of lab technicians trained				x										Diocese, MOH	5000

	Act 6.5.3: Procure/obtain appropriate ARV and start treatment as per national guidelines for clinical management of HIV/AIDS.	Number of HIV patients started on ARVs					x	x	x	x	x	x	x	x	x	Diocese, MOH	Donation
<b>Total budget for Objective 6</b>																	<b>43200</b>

### Objective 7: Reduce transmission of HIV through delivery and invasive procedures

<b>Output 7.1: TBA's knowledge and skills in safe delivery improved</b>	Act 7.1.1: Identify TBAs and train them on safe delivery	Number of trained TBAs		x	x	x										DMO, Diocese	5 trainings of 20 TBAs for 3 days 10000
	Act 7.1.2: Provide protective gears like gloves, aprons to all TBAs	Number of TBAs equipped														DMO, Diocese	1500
	Act 7.1.3: Promote hospital delivery of all HIV+ve mothers while maintaining confidentiality	Number of HIV positive women delivering in hospital	x	x	x	x	x	x	x	x	x	x	x	x	x	DMO, Diocese	
<b>Output 7.2: Safe blood transfusion and safe medical procedures in place in health facilities</b>	Act 7.2.1: Develop strict blood transfusion criteria for all health facilities and share experience among them	Guidelines available			x											DMO, Diocese,	Printed Guidelines 200
	Act 7.2.2: Maintain the provision of safe blood to all patients and provide reagents for donor screening	Sufficient HIV tests available for donor screening	x	x	x	x	x	x	x	x	x	x	x	x	DMO, Diocese,	500 tests per year at US\$1.2 1800	
	Act 7.2.3: Establish a community network of safe blood donors such that all units have a stand-by blood supply for transfusion in case of an emergency	Proportion of blood supply originating from regular safe donors					x								DMO, Diocese, PHC teams	Posters, leaflets 300	
<b>Output 7.3:</b>	Act 7.3.1: Organize health	Reports of health			x	x	x	x	x	x					ERETO,	Covered	





## Annex 1: Programme of meetings and visits

### Week 1

Date/Time	Place	Organisation	Person(s) met
Mo 1/3 09:00	DSM	TACAIDS	Dir. of District and Community Responses, Rustica Tembele
11:00		Oxfam	Programme Coordinator, John Plastow; Programme Co-ordinator Ngorongoro, Godfrey Leylya
14:00		UNAIDS	UNAIDS Country Coordinator, Bernadette Olowo-Freers
Tu 2/3 09:00	DSM	Embassy of Denmark	Vera Mugitu
10:30		Oxfam	HIV/AIDS Coordinator, Dan Maina
We 3/3 10:00	Arusha	UHAI Centre	Sr. Greta Mwashu, Coordinator
11:00		EANNASO	Lucy N'gang'a, Esther Mzava, Julius Sabuni, Olive Mumba
14:00		PINGOS	Edward Porokwa, William Ole Naasha
Th 4/3 09:00	Arusha	Regional AIDS Coordinator	Christopher Mremi
11:00		Maasai Women Development Organisation (MWEDO)	Ndinini Kimeresa
13:00		Catholic Diocese	Joyce Sagala, Health Coordinator
15:00		Afya Bora	Mr. Brown, Coordinator
Fr 5/3 08:30	Arusha	Selian Hospital	Dr. Marc Jacobson, MO in charge
10:00		Regional Medical Officer	Dr. Ole Kin'gori
11:00		Mt Meru Hospital, VCT and STI clinic	Mrs Haule, VCT Counsellor
13:00		TAPHGO	Moses Sangale, Esau Losioki
15:00		St Elisabeth Hospital	Dr. Magoma, Consultant, Gyn and Obs
Sa 6/3 11:00	Arusha	Life Concern	Nsiima Advera Susan Mallya, programme Coordinator
13:00		Uzima Centre and Angaza	John Laiser

**Week 2**

<b>Date</b>	<b>Place</b>	<b>Organisation</b>	<b>Person(s) met</b>
Mo 8/3 09:00	Ngorongoro	Ereto	Samuel Ole Saiguran, Project Manager; Rob Sillevs, Adviser; Simon Loishiye, Gender and Community Participation Coordinator
15:00		NCAA	Mr. Shaluwa, Human Resources Manager Dr. Kundi, MO in charge of NCAA HC; Mr. Mbwambo, CO
Tu 9/3 09:00	Ngorongoro	Visit to NCAA clinic	Dr. Kundi, MO in charge of NCAA HC Mr. Mbwambo, CO
18:00	Loliondo	District Medical Officer	Dr. John Lukumay
20:30		Local bar in Wasso	8 bar customers
We 10/3 09:00	Loliondo	Oxfam staff	Angelindis Mtana, Raymond, Mr. Mwaisela
14:00		Wasso Hospital	Dr. Nicholas Kisyeri, MO in charge; Suzanna Koillah, PHC coordinator
17:00		Women's group in Loliondo	Mrs. Timan (Councillor) and 2 women
Th 11/3 08:30	Loliondo	LADO	Michael Tipap, Administrative Secretary; Paulo Shomet
11:00		Community Resource Team (CRT)	Witness
12:30		North Maasai Medical Unit	Richard Ole Nkambi, Coordinator
15:00		District Commissioner (i.a.)	Mr. Muhindi
16:00		Loliondo secondary school	Mr. Ochieng, Principal (i.a.)

**Week 3**

<b>Date</b>	<b>Place</b>	<b>Organisation</b>	<b>Person(s) met</b>
Mo 15/3 09:00	Arusha	ACORD	Donald Kasenga, Country Coordinator Tanzania Dennis Nduhura, Programme Manager, Kampala
14:00		Community Resource Team (Hilde)	Dismas Ole Meitaya Edward Ole Parmelo
		Inyuat e Maa (Rafael, Dennis and Donald)	Jacob Porokwa

16:00		Serena Hotels Crater Lodg Sopa Lodges	Maria Lugwe, Reservations Manager Gary Lotter, Operations Director Louis Okech, Reservations Manager
Tu 16/3 11:00	Karatu	Medicos Del Mundo	Geraldine Gaillot, Coordinator; Joseph Bairo, Administrator-Logistician
13:00		TACAIDS Facilitators for C-MAC training	E. Mbwambo E. Sizya Grace Makenya
13:30		Ngorongoro District Council Multisectoral AIDS Committee	Metui Ole Shaudo, Vice Chair of the Council Ibrahimu Sakay Councillor for Pinyinyi Juliana Bhayo, Councillor for Endulen Evaristo Ntibuhera, District Community Development Officer Jonathan Nzuma, Minister Pentecostal Church Suleiman Rubeya, Sheikh Elisabeth Kimaro, youth Wilfred Lotha, youth Venans Joseph, youth Mallya Laurence, AFNET (NGO) Dorcas Nzuna, MAHAO, (NGO) Nurdin Msangi, District Agriculture and Livestock Officer Asha Kivaju, teacher, representing District Education Officer Dr. Longishu, representing District Medical Officer
We 17/3 11:00	Endulen	Endulen Hospital	Dr. Simon Megiroo Harriet Monah, PHC Team
14:00		Catholic mission	Father Ned Augustino Pakaay, Village Chairman
Th 18/3 09:00	Ngorongoro	NCAA	Vincent Mbiriki, Public Relations
11:00	Irmisigiyo	Village leader	Mzee Nathait Ole Lerug, Olaiquanani
14:00	Makorombwa	Grinding mill women's group	Chairwoman: Nanyamal Enlengot; Secretary: Meruoyoene Papaii; 7 members
		Nyora Food cooking women's group	Chairwoman: Somoine Wasso; Secretary: Namurruw Nfkarato
Fr 19/3 08:00	Endulen	Oloibon and Advisers	MzeeMbirikaa Kasuma Birika Dismas Soombe
Sa 20/3 16:00	Loliondo	District Commissioner	Captain Aseri Msangi
Su 21/3 11:00	Soit Sambu	LOSADI/Austroproject	Francis Shomet Ole Nain'gisa, Planning Advisor

**Week 4**

<b>Date</b>	<b>Place</b>	<b>Organisation</b>	<b>Person(s) met</b>
Mo 22/3 09:00	Loliondo	Ngorongoro District Council	Mohammed Noro, Acting Manpower Management Officer Muna Munjori Mbuga, Teacher Service Department
15:00	Digodigo	Digodigo dispensary	Francis Lisso, Clinical Officer Mwirei Mtunguja, Nurse/midwife Charse Kivambe, Lab Assistant Namjgo Batanisha, PHC Coordinator
17:00		Wanamije	Peter Dudui
Tu 23/3 08:00	Malambo	MAPADA	Paulo Parkipuni, Chairman Paulina Labbi, Secretary Bertha Marco Mohe, Transport manager Elisha Ole Moita, Member
11:00		Olaiguanani and Village Chairman	Lawrence Ngorisa Daniel Oloj
Th 25/3 12:00	Arusha	Flying Medical Service	Pat Patten
Fr 26/3 08:30	Arusha	Help for the Maasai	Sister Angelika

**Week 5**

<b>Date</b>	<b>Place</b>	<b>Organisation</b>	<b>Person(s) met</b>
Mo 29/3 10:00	DSM	TACAIDS	Rustica Tembele, Director District and Community Responses
We 31/3 9:30	DSM	Oxfam	John Plastow, Programme Coordinator Tanzania Aodh O'Connor, Livelihood Programme Coordinator, Ireland Moses Mwangi, Land and Pastoralist Specialist

## Annex 2: Implementing agencies, coordinators and funding per objective

OBJECTIVE	OUTPUT	IMPLEMENTATION	COORDINATION	TECHNICAL BACKSTOPPING	FUNDING
<b>OBJECTIVE 1</b>	Output 1. 1.	MAPADA, ERETO, PC, LADO, ELCT/NMMU, Diocese NDC, MDM, NCAA, Oxfam	Ngorongoro: PC, NCAA, ERETO Sale: LADO Loliondo: ERETO	ACORD	ERETO, PC, NCAA, Diocese, N District Council
<b>OBJECTIVE 2</b>	All outputs				
<b>OBJECTIVE 1</b>	Output 1.2	ALL, Unions, hotel owners association TATO, CMAC, NCAA	ACORD, Oxfam, ERETO,	ACORD, Oxfam, ERETO	N District Council, NCAA
<b>OBJECTIVE 8</b>	All outputs				
<b>OBJECTIVE 1</b>	Output 1.3	DEO, Diocese, Oxfam	DEO	Oxfam	N District Council
<b>OBJECTIVE 3&amp;4</b>	All outputs	DMO, MDM, Diocese, NCAA Clinic	DMO		N District Council, NACP, Diocese, MDM, ERETO (feasibility study for STI mass treatment), ALL (condoms), Oxfam (female condoms)
<b>OBJECTIVE 5</b>	All outputs	Diocese, DMO, NCAA clinic, MDM, ELCT	DMO		N District Council, MDM, Diocese ERETO (feasibility study on Community VCT) PC (community counselling in Ngorongoro)
<b>OBJECTIVE 6&amp;7</b>	All outputs	DMO, Diocese, MDM (PMTCT) ELCT (CHBC Support) NCAA clinic	DMO		N District Council, MDM, NCAA, Diocese Resource mobilization from private sector for CD4 count machine

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