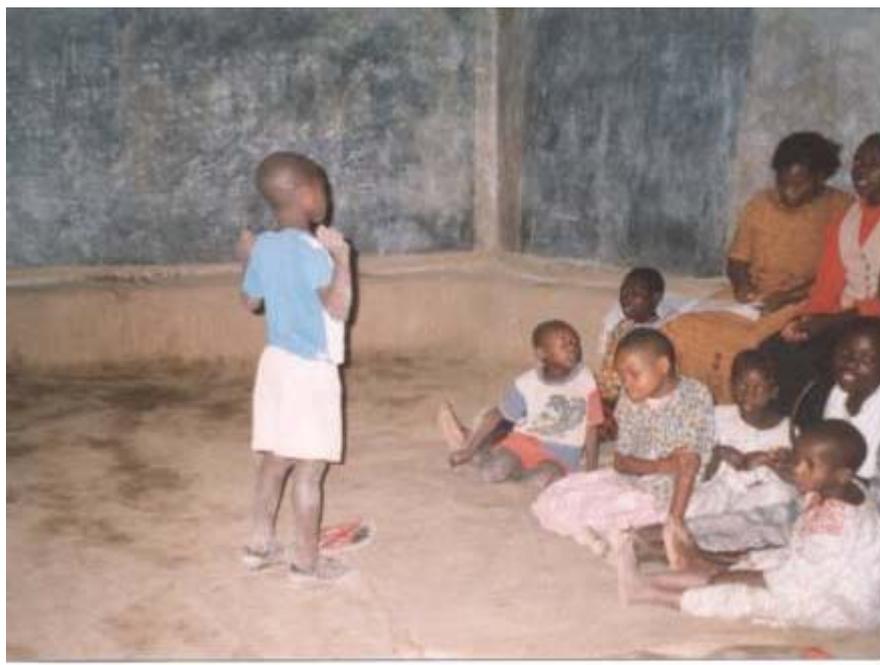


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# **Designing Programs for Orphans and Vulnerable Children in AIDS Affected Areas**

## ***Report of a Needs Assessment in Mbeya Municipality, Tanzania***



**1 June 2002**

Funded by Step Forward of Abbott Laboratories Fund

## **EXECUTIVE SUMMARY**

### **Background**

Tanzania has more than 800,000 AIDS orphans and the numbers are increasing. Tanzania was therefore selected as one of the countries for the Abbott Step Forward Initiative on orphans and vulnerable children in AIDS affected areas (OVC). The Initiative seeks to help orphans in four ways: through addressing orphans' basic needs so that their extended families and communities can care for them; through education and vocational training so that they can become productive members of society; through strengthening the provision of appropriate health care at all levels; and through providing general access to voluntary counseling and testing so the HIV positive parents can plan for the future of their children. Counseling and testing also contributes to preventing the further spread of the virus and thus the creation of more orphans. The OVC project in Tanzania is implemented by Axios.

### **Axios Mobilization Methodology**

The first step in the implementation of the program in Tanzania was to understand the specific problems and resources related to OVC in the selected area. A local team conducted a rapid needs assessment in Mbeya Municipality, Mbeya Region, which is located in the southwestern part of Tanzania.

The Axios Mobilization Methodology (AMM) is an approach that can rapidly identify needs and resources for the solution of a particular problem. The AMM mobilizes relevant stakeholders at the national, regional and district levels for program design and implementation. The AMM encourages the involvement of multiple sectors that will be responsible for implementation of the various aspects of the program from the national to the community level. The team members were representatives from the various ministries at the national and local levels such as education, health, community development and social welfare. Representatives from local NGOs and people with HIV were also part of the team. Some members had qualitative research skills and others medical and pharmacological backgrounds.

The main objective of the assessment was to obtain an in depth understanding of the orphan care issues that were important to people in the community and to identify obstacles to education, health care and voluntary counseling and testing for HIV (VCT). The actions and interventions necessary to establish such a program were subsequently identified and communities, local and national authorities agreed upon an action plan.

The data collection consisted of interviews with prominent members of the community, key government and non-governmental officials, orphans and

their caregivers, teachers, and health providers and also focus group discussions held with community members.

### **Results of the assessment and proposed activities**

It was generally recognized by the communities that the number of orphans was increasing and that the care of the orphans was left in the hands of extended families, in particular grandparents. Tanzanian government policy encourages orphans to remain in extended families within communities, nevertheless there are situations when this is not possible. In Mbeya Municipality, there were a number of community initiatives to provide shelter, food and education to OVC as well as orphanages organized and run by church organizations. It was proposed to aid these community initiatives and encourage the less formalized ones to link with government mechanisms to build sustainable support networks.

### ***Basic needs***

Poverty and the cost of caring for and educating orphans were some of the biggest problems noted by communities. In the municipality, there was a general lack of land for crop cultivation, thus respondents reported an inadequate meal intake with most people eating only one meal a day. Life in the urban areas seemed even more difficult than that of the rural area of Rungwe. Communities noted a lack of local support systems to aid one another. This was due to the problems of AIDS, poverty and caring for OVC which had touched all families leaving very little resources to share. Supporting families caring for orphans with income generating activities (IGA) has been proposed as a means to improve the economic status of the communities as well as providing direct support to families where IGA may not be appropriate.

More than 25% of the orphans interviewed had experienced the effects of inheritance snatching by family members after their parents died. Educating communities on the rights of orphaned children and establishing a system to help orphans retain inheritance rights have been proposed in the action plan.

### ***Education***

Access to education was one of the biggest problems of OVC. Although the Tanzanian Government has recently waived primary school fees, the cost of sending a child to primary school (uniforms, pens, books etc) is estimated at 25,000 TZS (approximately \$28 per year). Given that the gross national income per capita is \$260, even \$28/year/child for primary school is difficult to attain for many families. Some families reported having had to withdraw children from primary school because they could not pay the costs of schooling. Some orphans reported that they had to quit schooling so that they could work to help support the families financial needs.

Of those children fortunate enough to complete primary school, few have the means to afford a secondary school education. Indeed, secondary education costs are expensive ranging from 100,000 TZS to over 335,000 TZS per year (\$112 to over \$370). As there are very few public secondary schools, most families who can afford it, send their children to private secondary schools. Only one of the children interviewed was in secondary school although a total of 6 children had completed primary school.

Caritas Roman Catholic Church is providing support for the primary and secondary education of AIDS orphans in Mbeya Municipality. These activities are funded by the Social Action Trust Fund (SATF), a Tanzanian NGO. Since 1999, Caritas has supported the education needs of 1635 AIDS orphans. In addition to Caritas, there were a number of local NGOs in the municipality such as Kihumbe and SHDEPHA+ who were providing educational support to small numbers of AIDS orphans. The action plan proposes to improve the access to primary school for 2000 OVC in Mbeya Municipality. This is in addition to the provision of a secondary education and vocational training for OVC by strengthening the financial support to local NGOs and church organizations.

There were 6 schools in the assessment area and nearly all were overcrowded and lacking classrooms, toilet stalls and access to water. Overcrowding and poor sanitation in schools can lead to outbreaks of diseases and impede the educational process. The community members of Mbeya have already begun to address this problem by clearing land and preparing bricks, however they need support for furnishing and completing the classrooms. Improving the physical environment of schools by working with communities to increase the number of classrooms and toilet stalls as well as the access to water has been proposed by the assessment team.

Five of the six primary schools have land for a garden but only one uses this space for cultivation. None of the schools are protected by fences and thus have had thieves steal the vegetables during the night. Unfortunately students and staff have been very discouraged and have ceased cultivation. It has been proposed to build fences around each of the schools in the assessment area and encourage schools to begin growing gardens. Children can eat the food from the gardens and excess fruit and vegetables can be sold as an IGA for the school.

### ***Primary health care***

Cost sharing for primary health care was introduced in Tanzania in 1993. In this scheme patients pay a small consultation fee and 50% of drug costs. This small fee is difficult for many people to pay and some community members reported that they skip treatment or seek other treatment options (such as traditional medicine) as a result. Some of the orphans visited said that they did not go to health facilities when they were sick. Overall, child health in the

assessment area was relatively poor and children were frequently afflicted with various infections (including malaria and gastrointestinal infections). Due to the general lack of food and a balanced diet, children were also often malnourished.

Children who become ill while at school must go to the nearest health facility for medical treatment thus missing out on valuable lessons. To help keep children in school and to provide a healthy environment for learning, it has been proposed to strengthen the primary school disease surveillance program. Children will be screened regularly for infectious diseases and 2 teachers at each school will be trained in first aid and be able to treat minor infections with school first aid kits.

### ***Voluntary counseling and testing***

Voluntary counseling and testing (VCT) for HIV is available in 7 centers in Mbeya Municipality (4 government facilities, 2 private and 1 NGO). Most of these centers use ELISA tests carried out at Mbeya Consultant Hospital. Results generally take 3-7 days before reaching health facilities. Only two health centers actually test on-site using rapid tests. Both health professionals and the community members noted that the delay of receiving test results was a problem and discouraged some people from seeking VCT services. Most health professionals noted that demand for services from communities was high and since few health facilities provided VCT services most counselors complained of being overworked.

Although community respondents noted that VCT services are important some reported that they were not yet willing to be tested themselves. Respondents reported their fear of the stigma attached to being HIV positive and many noted the lack of support after testing HIV positive. They suggested that communities would need a great deal of education to emphasize the importance of VCT. Local organizations such as Kihumbe and SHDEPHA+ will play a very important role in community education and mobilization.

It has been proposed that VCT services are expanded to a total of 15 facilities in Mbeya Municipality. This would utilize rapid test technology. This expansion will allow more facilities to offer services and decrease the current burden on counselors. The use of rapid tests will encourage clients to seek services as they know that their results will be immediate.

Kihumbe provides home based care (HBC) services for HIV infected patients. Currently they provide psychological support and some drugs to clients. These drugs, however, were supplied by GTZ (an international NGO) and supply was assured until December 2001 only. Improving home based care services will help to promote VCT seeking behavior as clients will come to know that services are available after testing HIV positive.

## **Conclusion**

The action plan in Annex 1 lists a number of specific interventions that will improve the quality of life for OVC. Multiple Tanzanian ministries, authorities and non-governmental organizations will take responsibility in the implementation of these interventions. With the commitment and enthusiasm already generated from communities and multi-sectoral state institutions, the action plan will be able to address the most important needs of OVC and their communities: basic needs such as adequate nutrition and income, appropriate health care and disease prophylaxis, and assistance in acquiring an education that will improve their chances of becoming productive members of society.

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## **ABBREVIATIONS**

AIDS	Acquired Immune Deficiency Syndrome
AMM	Axios Mobilization Methodology
AZT	Zidovudine
CBO	Community Based Organization
CDO	Community Development Officer
CIDA	Canadian International Development Agency
DoTI	Department of Trade and Industry
DM	Deutsche Marks
DMO	District Medical Officer
EDL	Essential Drug List
FEDA	Finance and Enterprise Development Associates Limited
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit
HBC	Home-Based Care
HIV	Human Immunodeficiency Virus
IGA	Income Generating Activity
KCMC	Kilimanjaro Christian Medical Center
MACC	Municipal AIDS Control Coordinator
MCH	Maternal and Child Health
MEDA	Menonite Economic Development Associates
MEO	Municipal Education Officer
MMOH	Municipal Officer of Health
MOH	Ministry of Health
MSD	Medical Stores Department
NACP	National AIDS Control Program
NGO	Non-Governmental Organization
NORAD	Norwegian Agency for Development Cooperation

OVC	Orphans and Vulnerable Children in AIDS Affected Areas
PHC	Primary Health Care
PLHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission of HIV
PRIDE	Promotion of Rural Initiatives and Development Enterprises
PSLE	Primary School Leaving Exam
RH	Reproductive Health
SATF	Social Action Trust Fund
SIDA	Swedish International Development Cooperation Agency
SIDO	Small Industries Development Organization
SP	Sulfamethoxazole/Pyrimethamine
STG	Standard Treatment Guidelines
SWO	Social Welfare Officer
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
TZS	Tanzanian Shillings
USAID	United States Agency for International Development
UTI	Urinary Tract Infection
VCT	Voluntary Counseling and Testing

## **BACKGROUND**

Tanzania has an estimated population of 31 million people. The country is divided into 20 regions and 113 districts. The average HIV prevalence rate varies not only from region to region but within regions as well. Overall, the HIV prevalence is reported to be 9% among blood donors (8.5% amongst men and 11.5% amongst women donors). The prevalence rate amongst pregnant women in the Mbeya region, one of the worse affected regions in Tanzania, ranges from 15.4% in the rural areas to 24% along the border area. The cumulative number of people living with HIV in Tanzania was estimated to be 1,500,000 at end of 1997.

### **Orphan situation in Tanzania**

National data on the magnitude of the orphan problem in Tanzania is not readily available, however the National AIDS Control Program (NACP) of the Ministry of Health estimated that, at the end of 1999, there was a cumulative total of 800,000 AIDS orphans countrywide. This number is expected to rise to 1.5 million by the year 2005.

The main ministries involved in orphan care and support in Tanzania are: The Ministry of Labor and Youth Development, and Sports, The Ministry of Health, The Ministry of Community Development, Women's Affairs and Children, and The Ministry of Education and Culture.

It is of critical importance to create an enabling environment for extended families so they may better cope and care for their orphans and children. Most programs target households which care for orphans and would include all children in the household. In all likelihood, all the children in the extended family have the same basic needs. Selecting only the orphans for special benefits could create social tensions within the family that may harm the orphans.

There is desperate need for action and resources to enable governments and communities to prevent children from becoming orphans and to respond better to the 11 million children who have lost their parents to AIDS. Such action must be tailored to the specific needs of the orphans' society and support existing social structures and institutions.

### **Step Forward for the World's Children**

It is with these issues in mind that the Step Forward for the World's Children program has been created and funded by the Abbott Laboratories Fund. Step Forward aims at building sustainable, community-based responses to the needs of OVC and the communities that support them. The aim of Step Forward is not only to help OVC survive the impact of AIDS but to become

productive members of their communities who may, in turn, become leaders in the fight against AIDS. Step Forward will assist OVC and the communities supporting them through projects in four critical areas: health care, education, voluntary counseling and testing for HIV (VCT) and basic community needs.

## **Axios**

Axios aims to provide people-centered appropriate responses to public health needs with a particular focus on support for individuals and communities affected by AIDS and other diseases. This is accomplished by providing dynamic and innovative approaches to design, implementation and management of healthcare programs related to prevention of mother to child transmission of HIV, VCT, access to care etc. Axios works through the government to develop sustainable health care models that link health systems and communities in productive ways.

Axios is a charter grantee of Step Forward and the implementer of the OVC programs in Tanzania and Burkina Faso.

## **SELECTION OF REGION AND DISTRICTS**

Based on discussions with national authorities and key partners, four districts were selected for field activities for orphans and vulnerable children in AIDS affected areas (OVC); Rungwe District, Mbeya Municipality, Muheza District and Kilosa District.

The selection of districts was based on the following criteria:

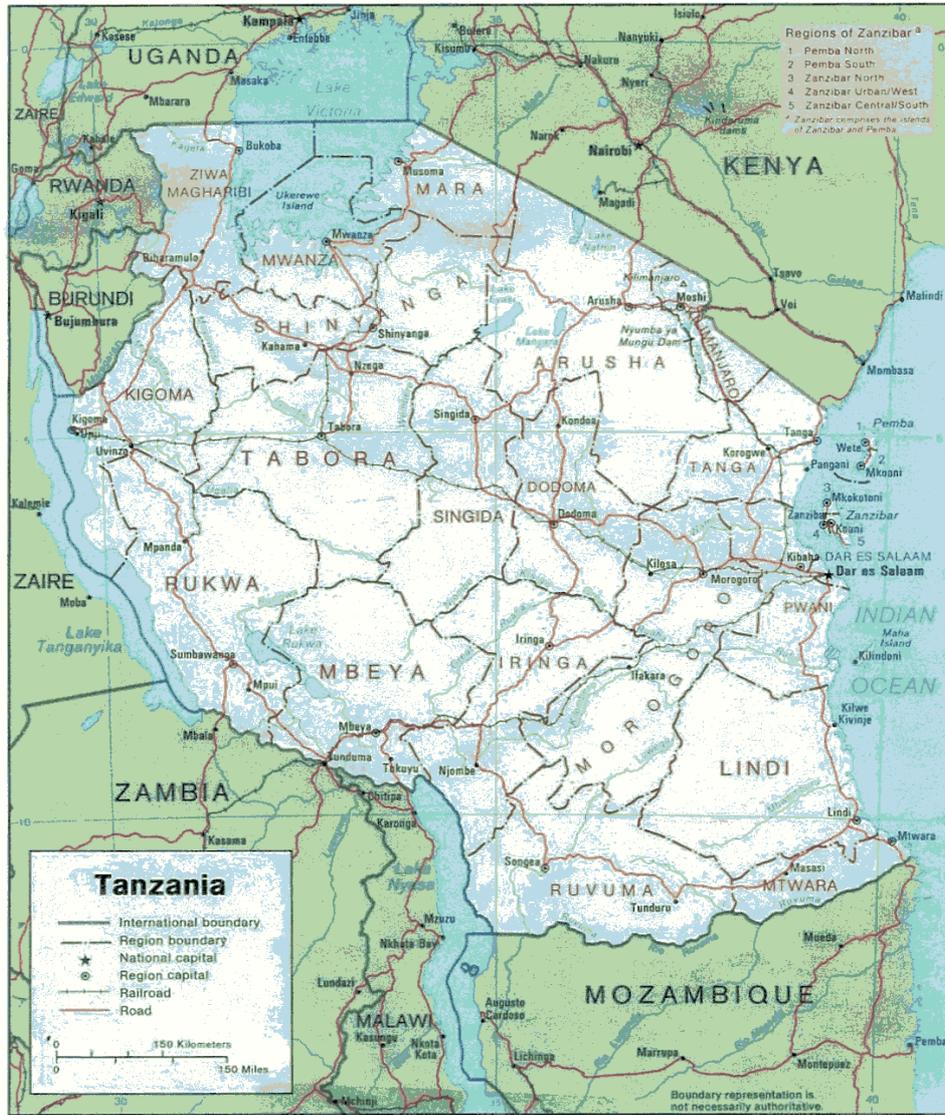
- high estimated number of orphans;
- high HIV/AIDS prevalence;
- limited number of NGOs already active in the district (under-served regions);
- level of district response to other activities (commitment to produce results in a given period).

The OVC program began with a needs assessment in Rungwe District (a rural district of the Mbeya Region) in April/May 2000. This program is now well underway and many interventions have been implemented. Within the Mbeya region, Mbeya Municipality (urban district) was also selected for field assessment and program activities. This report describes the needs assessment and draft action plan of the Mbeya Municipality.

## **Description of selected area**

The Mbeya region is located in the southwestern part of Tanzania and shares borders with Malawi and Zambia. The region is broken into 8 districts: Chunya, Ileje, Kyela, Rungwe, Mbarali, Mbozi, Mbeya rural and Mbeya

Municipality. This region is one of the hardest hit by the HIV/AIDS epidemic. In 1998 prevalence rates among pregnant women attending antenatal clinics ranged between 15.4% and 24% in the border areas. Because of the high HIV prevalence rates it is feared that the number of orphans is increasing at an alarming rate, although the exact magnitude of the orphan situation in the region is not known.



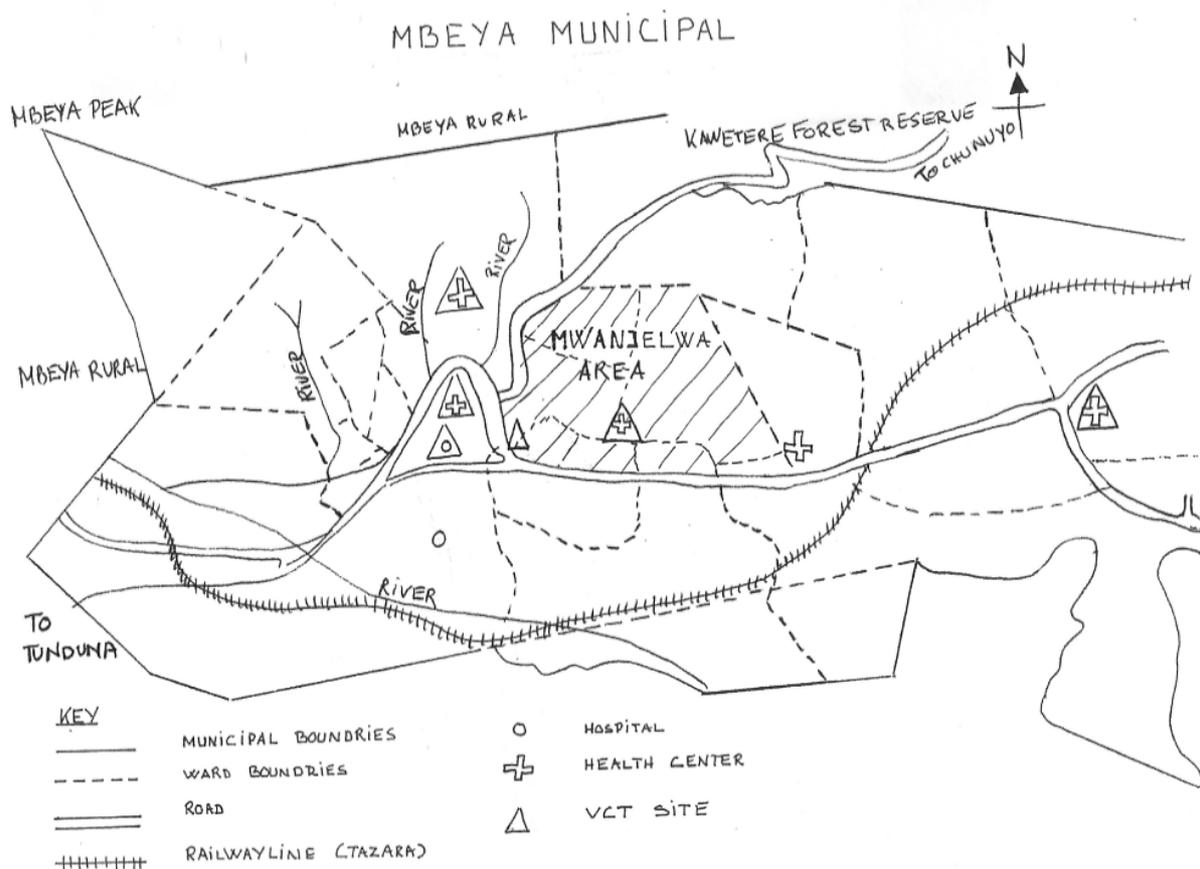
Mbeya district was established in 1935 as a minor settlement. In 1980 the district was given municipality status becoming one of 13 municipalities in Tanzania mainland. Mbeya Municipality is divided administratively into 2 divisions, 36 wards and 180 streets.

Mbeya Municipality covers an area of 214 square kilometers with an estimated population of 352,770 people (57% women and 49% men) based upon the 1998 census. The average population density is 1648 persons per square kilometer. It is estimated that in the municipality there are 14,108 children under the age of one year and 70,554 children under the age of five years. The total fertility rate per woman is 7 children and the infant mortality rate is 81/1,000 based upon institutional data. The under five mortality rate is 18/1,000. Ninety-one percent of population has access to piped water with 22,399 households within 400 meters of piped water and 10,777 households within 1 kilometer of piped water. Toilet coverage is 85%.

Mbeya Municipality is situated at an elevation of 1700 meters above sea level. The climate is influenced by its altitude and receives an average rainfall of 1200 millimeters during November to May and mean temperatures ranging between 11° C and 25° C.

The HIV seroprevalence in Mbeya Municipality is estimated at 13.4%. Among blood donors tested in 1999/2000, 13% were HIV positive. The incidence of STDs is estimated at 11.3%. Factors contributing to high HIV prevalence include unsafe sexual behavior brought on by excessive consumption of alcohol, misconception regarding condom usage, peer pressure and lack of education on safe sex.

The needs assessment was conducted in the Mwanjelwa area of the Mbeya Municipality. This area was deliberately chosen for its high HIV prevalence and thus presumed high number of OVC. There is also a lack of basic services and support and care activities for orphans and their families.



## THE AXIOS MOBILIZATION METHODOLOGY

The Axios Mobilization Methodology (AMM) was designed in response to the need for an approach that could rapidly identify needs and resources for the solution of a particular problem. The AMM has been field tested in different technical areas. It has also been adapted and improved after each application. The methodology's basic principles are that the people who assess a problem and define the solutions should be the ones to implement them. The AMM mobilizes relevant stakeholders for the program design and implementation. The methodology aims at designing and implementing programs at the district level but representatives of the national level are involved to ensure appropriate links to the policy level and the methodology's replication in other districts. The approach creates linkages and alliances between different sectors of governments, NGOs, private sector and communities in order to achieve sustainable solutions. The resulting program is based upon the local priorities and it defines clearly the roles and responsibilities of the national level, district authorities, NGOs and communities.

## **THE OVC ASSESSMENT**

### **The team**

The role and composition of the assessment team is very important. The team members represented the various ministries and sectors that were relevant to the implementation of interventions arising from the assessment. There were two groups of people included in the assessment team. One group consisted of those from the national level who formed a core group to ensure policy linkages and replication of the assessment in other districts. The other group consisted of relevant individuals recruited at the municipality and regional levels. The district and regional personnel will change according to the district of assessment. New members of the assessment team will be trained by the national team members and Axios.

At the regional and municipality levels, the team members were those who will take part in the implementation of the program. The national team was recruited from the relevant ministries: Ministry of Labor, Youth Development and Sports, Ministry of Health, Ministry of Education and Culture, and Ministry of Community Development, Women's Affairs and Children. In addition, it was relevant to include the Regional Reproductive and Child Health Coordinator. At the municipality level, the team members consisted of the Acting Medical Officer of Health, the Acting Municipal Planning Officer, the Municipal AIDS Control Coordinator, the Municipal Social Welfare Officer, the Municipal Education Officer, and the Municipal Community Development Officer. Representatives from two local non-governmental organizations (NGOs) active in HIV were also included in the team. The team members were:

### **District Level**

Mr. Kuhenga	Acting Municipal Medical Officer of Health
Mr. Luvanda	Municipal AIDS Control Coordinator
Ms. Siriwa	Municipal Community Development Officer
Mr. Msandagila	Municipal Social Welfare Officer
Mr. Ngonyani	Municipal Education Officer
Mr. Mwaijonga	Municipal Acting Planning Officer
Ms. Mwakanyamale	Coordinator of Kihumbe (NGO for home based care for people with HIV)
Ms. Mahenge	Chairwoman of SHDEPHA+ (NGO for people living with HIV/AIDS)

### **Regional Level**

Mrs. Nyalusi Regional Reproductive and Child Health Coordinator

### **National Level**

Mr. Charwe National OVC Coordinator and Assistant Commissioner of Social Welfare, Ministry of Labor, Youth Development and Sports

Ms. Ndunguru Hospital Counselor, National AIDS Control Program

Mr. Tarimo Head of Community Based Health Care, Ministry of Health

Mrs. Kimario School Health Coordinator, Ministry of Education and Culture

Mr. Chipata Senior Officer Women's Desk Issues, Ministry of Community Development, Women's Affairs and Children

Mr. Magalla OVC Project Coordinator, Axios Foundation

The team was assisted by two consultants from Axios International, Mrs. Kabondo and Dr. Houlihan.



## **The assessment process**

Within the municipality, a number of wards were chosen for data collection. In these wards the data collection sought information on the care and support of orphans and vulnerable children, the accessibility and quality of health services and the extent to which these respond to the needs of users. The qualitative approach used for the communities was horizontal, that is, it aimed at obtaining a broad view of the orphan care issues important to people in the community. The health system approach was vertical but bottom up. It started with identifying specific childhood disease problems as well as drug-related problems of health centers in communities. It then pursued the causes of these problems upwards through the system from community level to regional level. The aim of the project was to ascertain the actions needed (and the level at which they were needed) to improve the linkages between health systems and communities with respect to orphan care.

## **Data collection tools**

### **Community tools**

For the community the methodology consisted of a set of instruments that aimed to capture a comprehensive picture of treatment and care in the community. The aim was to understand how people perceived problems of orphan care and support and how they responded to them within the community. The nature of the data collected included the indirect and direct costs of caring for orphans and how families coped with the care burden. Additionally, in-depth interviews with open-ended questions were conducted with orphans who had been identified by key informants in the communities. The caregivers of these orphans were also interviewed (separately) about the care burden and its impact on their families. Key people in the community were interviewed about their perceptions of orphan problems in the context of other community problems and focus group discussions addressed the same issues.

A comprehensive range of providers in the community were interviewed on the services they provided to the community and specifically to children. This resulted in health workers, traditional healers, traditional birth attendants, drug sellers, community-based organizations and NGOs being consulted on their present and potential role in primary health care and the extent to which they collaborated with other providers in giving this care.

### **Health systems tools**

The health systems tools assessed all aspects relating to drug supply, management and use in the formal public and private health services. As it was impossible to check all drugs, a number of primary health care-related marker drugs were selected from the essential drugs list. These drugs then

became the focus of the enquiry in the health system. This resulted in the investigation of stocks and records of marker drugs and the rationality of prescription requests. Health personnel including pharmacists were interviewed on their training levels and issues relating to treatment of childhood illnesses.

The data collection yielded data on the appropriateness of the drugs that were available and accessible in the health centers, the regularity of their supply, the rationality of their use and the adequacy of existing stock management systems for drugs. Any problems that were identified at the community level of health services were traced upwards within the system in order to pinpoint the cause of the problems. This resulted in the process of enquiry within the public health system proceeding from health center to hospital. Investigations continued from the municipal level to regional medical stores and regional hospitals. At the national level, the Ministry of Health and the Central Medical Stores, were ultimately involved, especially if problems in drug supply and use were due to drug policies or specific disease control programs.

The private sector, including mission hospitals and private pharmacies, was also investigated at municipal, regional and national levels in terms of their role in ensuring the accessibility and availability of essential drugs for primary health care.

Patients leaving health centers and other providers were also interviewed on the type and quality of treatment that they had received.

Annex 2 describes the specific tools and the number of interviews conducted.

## **Analysis**

The community data were analyzed using triangulation to check its validity. Qualitative information was analyzed and discussed in terms of patterns and causal relationships. Where relevant, the information was quantified. The quantitative data were analyzed from a spreadsheet. Conclusions on community and health systems data were discussed in the group, as were the suggested interventions. It is worth noting that the process of analysis and discussion required as much time as the process of data collection.

## **RESULTS OF THE ASSESSMENT**

### **Community problems and needs**

#### **Social and economic situation**

Although the Mbeya Region is rich in terms of agricultural production, the situation in the Mbeya Municipality is quite different. A lack of income generation is a problem for communities in this urban area. There is little land for crop cultivation so many people must purchase basic food items such as fruit and vegetables rather than growing them themselves. The most common occupations in the district are businesses such as small shops (34%), the informal sector such as petty traders (32%) and agriculture (13%). Subsistence farming is practiced in only 27 of the 36 wards in the district.

Communities noted that there have been lifestyle changes in recent years. Overall, incomes were lower. This has been attributed to the fact that much of the land has been inhabited or exhausted with sequential crop growing leaving low agricultural yields. Communities also said that due to inflation the Tanzanian currency had lost its value and thus lowered purchasing power. Some key informants noted that high business taxes had caused them to cease trading. Economic problems have increased the presence of the commercial sex trade and thus increasing the transmission of HIV.

The lack of overall income of the community members has further compounded the problems of caring for orphans. Most caregivers are so poor that they are unable to meet their own basic needs let alone those of the OVC. As a result many orphans are becoming involved in child labor or are turning to life on the streets stealing or begging for money.

Communities also noted that in the past when families had difficulties, neighbors and other community members would assist one another. Due to the fact that most families are faced with similar situations of poverty and caring for OVC those community support systems seem to be disappearing leaving families to fend for themselves.

#### **Impact of HIV/AIDS**

The community members observed an increase in deaths compared to ten years ago. These deaths were mainly attributed to AIDS or AIDS-related diseases such as upper respiratory tract infections, pneumonia, and diarrhea. Deaths from malaria, typhoid and malnutrition were also common in this area. These diseases account for the high mortality rate amongst children, youth and middle-aged people reported by the community. On average respondents noted that there were 2-3 deaths daily within communities. In health centers there had been an increase in the health facility admission rates with those admitted often being couples that were suffering from the same illness.

Communities in general were willing to discuss the impact that HIV has had on them. The deaths of community members due to HIV/AIDS has left behind many orphaned children to be cared for by extended families - usually elderly grandparents. Most of the extended families which formerly provided a safety net for orphans are now overstretched due to the increasing numbers of orphaned and vulnerable children. Some orphaned children are now even finding themselves responsible for providing care and support to their younger siblings.

## **Education**

### ***Primary schools***

There are 52 primary schools in the municipality of which 49 are government run and 3 privately run. The government of Tanzania recently waived fees for all primary school children. This has increased the numbers of students in classrooms leading to overcrowding in many schools. In the assessment area, there were 6 government primary schools serving a population of 82,634. All six primary schools were overcrowded and in need of between 3 and 26 additional classrooms per school.

Of the six primary schools in the assessment area, only three had access to piped water (sometimes only twice a week) and all lacked toilet stalls. Each school is supposed to have toilets at 1 stall/20 females and 1 stall/25 males. Currently the ratio of toilets in this municipality's schools is 1 stall/91 students.

#### ***Primary schools classroom and toilet needs***

	<b><i>Number of students</i></b>	<b><i>Number of classrooms needed</i></b>	<b><i>Number of toilet stalls needed</i></b>
<b>Sinde</b>	1724	12	67
<b>Iganzo</b>	435	3	9
<b>Ilemi</b>	2025	26	56
<b>Mwenge</b>	1574	12	51
<b>Manga</b>	1414	15	45
<b>Isanga</b>	2105	18	73

Five of the primary schools had garden space but currently only Iganzo uses the space as a garden. The main reason for this is that the schools or gardens are not fenced and vegetables are often stolen by thieves at night. This has discouraged school staff and students from garden cultivation.

## ***Secondary schools***

Approximately 5000 students take the primary school leaving exam (PSLE) each year. The municipality selects about 360 students each year for secondary education in government schools based upon their performance on the PSLE. The other students that have passed the PSLE and have the means to pay for secondary education go to private schools.

There are 12 secondary schools in the municipality of which 3 are government and 9 are privately run. The fees alone for government secondary schools are between 40,000 – 70,000 TZS/student/year (\$45 - \$78). For private secondary schools this is between 105,000 – 275,000 TZS/student/year (\$117 – \$305). In addition to school fees, parents must pay around 30,000 TZS/year (\$33) for contributions and all the material costs of the student (uniforms, books, etc).

## **Needs of orphans and caregivers**

### ***Identification and definition of orphans and vulnerable children***

Overall, people in the community defined orphans and vulnerable children in many different ways. Out of 50 responses the vast majority (over 90%) reported that they define orphans as those children who have lost both parents. The age that a child was no longer classified as an orphan ranged from 15 years to 18 years. Other respondents commented that an orphan is always an orphan no matter what age. Only 4 respondents said that a child is an orphan even if they have lost only one parent.

Twenty-two out of 45 responses defined a vulnerable child as one whose parents' income is very small and does not meet the basic needs of the child. Other respondents said that a vulnerable child was one who has been neglected by its parents and wanders the streets begging for food, or alternatively has lost one parent.

### ***Sources of care***

In total, 26 OVC between the ages of 7 and 17 years were interviewed. Interviews were also conducted with caregivers of 20 of these children (77%) and an additional 5 caregivers. In general the households where OVC lived were very poor. Most of the houses were made of mud bricks, uncemented floors and unplastered walls, however these observations were not limited to the households caring for orphans. The living conditions seemed similar in most households where interviews were conducted.

OVC generally lived with their relatives and in most cases the orphans had been distributed among family members. Of a total of 25 caregivers interviewed, seven of these caregivers were actually widows who were taking care of their own children. Six of the caregivers were maternal grandparents and 3 were paternal grandparents. Three caregivers were sisters of deceased

mothers and four were brothers of deceased fathers, though in this case the care of children was mainly left in the hands of their wives. Two of the caregivers were in fact orphans who were heading the household.

The age of caregivers ranged from 14 to 85 years. Only five of the caregivers were below the age of 35 (including the two children who were head of their household) with most caregivers above the age of 56 years. The main source of income among caregivers was fetching and selling firewood as well as making local beer. The area of assessment was over populated with very little land for crop cultivation.

Household size ranged from 3 to 14 people. In most cases the female caregivers were responsible for caring for children from more than one family. One caregiver in particular was looking after orphans left behind from her 9 children. Although discussions with this caregiver lead the interviewer to believe that many of her children died from AIDS the caregiver did not explicitly say so. AIDS deaths of parents were mentioned as the main cause of OVC by nearly all respondents (with the exception of caregivers).<sup>3</sup>



### ***Burden of care for caregivers***

Life among caregivers was hard with a very large burden of care. Most of the caregivers had very little to give the children. One of the caregivers said, “I do not know what we will eat tomorrow, we eat what we will find that day. Sometimes I send the children to go to the hills to fetch firewood so we sell

that and buy food.” Food was one of the biggest problems in the study area even though the region is rich in terms of food. There was plenty of food in the market places but hardly any in the homes visited. This was because most families did not have enough money to buy food.

Caregivers also complained about the cost of health services. Under a national cost sharing program in Tanzania, patients must pay a small fee for medical visits and usually 50% of drug costs. Even this small fee was difficult for many caregivers to meet, thus some reported that they sought other treatment sources.

Caregivers reported that they received little or no help in caring for their children from other community members except for two caregivers who said that neighbors brought food and clothing once in a while. Despite the lack of help, caregivers generally agreed that there was little, if any, discrimination of orphans in the communities. Most households that inherited orphans did not inherit any property left by the orphans parents except in a few circumstances when the children were cared for by paternal relatives.

Almost all caregivers defined good quality care as access to food, education, medical services and provision of clothing. However most caregivers were unable to provide such care due to their poor economic status. Caregivers said that their priority problems were food and education for the orphans. Caregivers in local businesses suggested business loans as a means to improve their economic status.

### ***Problems affecting orphaned children***

#### ***Inadequate food***

All of the orphans complained of having an inadequate supply of food, most children ate only one meal per day. Children reported that this meal usually consisted of ugali (local corn meal porridge) and beans. In the urban areas land for subsistence crop cultivation is scarce and few urban dwellers have access to land.

#### ***Access to education***

Another problem reported by orphans was the lack of support for educational needs. This complaint was noted in all interviews regardless of the recent efforts by the government to alleviate this problem by waiving schools fees for primary school education (Standard I – VII). Standard I starting age is usually 7 years old. Most caregivers could not even afford to pay for materials such as uniforms and books or other school contributions. The highest level of education among orphans was Standard VII with the exception of one of the children who was in the third year of secondary school.

Of the 26 orphans interviewed, 18 were currently in school (69%) although most children were in Standard I or II despite the fact that they were over the age of 10 years. Five of the orphans had completed primary school (through Standard VII) but had not been selected for government secondary school. Access to government secondary schools is limited in Tanzania and on a merit basis only. There are very few government secondary schools in Tanzania (only 3 in Mbeya Municipality) hence more able families opt for private education. For those students with limited funds such as the orphans interviewed, Standard VII is their highest level of education. Three of the orphans (11.5%) interviewed have dropped out of school since their parents have died; two of these orphans blamed the educational system for their dropout. These two orphans stated that the system for transferring schools when they moved to live with their grandparents was lengthy and difficult.

Most of the siblings of the orphans interviewed have also dropped out of school. One of the orphans noted that his brother has dropped out of school and is now on the streets stealing to support himself. Some of the orphans interviewed as well as their siblings are involved in child labor activities.

#### *Lack of money*

Most orphans were involved in normal household chores such as fetching water. Some of these children were also involved in income generating activities such as fetching and selling firewood and selling of fruits, vegetables and charcoal. Others even reported involvement in the making of local beer. In most cases these activities were done in order to supplement household income and to support their siblings as well as to obtain money for school materials and contributions. (see case study1).

#### **Case study 1**

*J is an orphan who has lost both parents. We visited her home and this is what she had to say to us: "My name is J and I am 14 years old. I used to live in Kawetere with my parents and everything was fine. My parents had a farm and they used to grow all kinds of food and we could go to school. Unfortunately my father died in 1996 then my mother followed in 2001. Then our life changed. There was no one to take care of us. We were there alone in the house that our parents left. Our aunt felt pity for us and she brought us here to live with her family. Her husband has three wives but none of the wives has seen him in 2 years. No one knows where he his. The only problem now is that our aunt is frequently sick and she can not support us even though she is trying. She used to sell firewood but now due to her health she cannot do it. So now I am responsible for earning money for us. I go to the hills to collect firewood but it is not easy for me. I frequently have chest pains but I guess it is because I carry very heavy logs. Unfortunately I have no way out. My*

*younger brother has a job shepherding goats and he earns 2000 TZS/month (\$2.20). I have another sibling who is living with my grandmother but we are better off here than she is. Neither my brother nor I go to school. I failed to get a transfer letter when I moved in order to change schools. They said that I had already received 2 transfer letters so the head teacher refused to give me another.*

#### **Access to health care**

Another common problem reported by the orphans was a lack of money to pay for medical treatment as well as consultation fees for providers. Most of the orphans said that they were not taken to health facilities when they got sick. One of the orphans who was 14 years old and looked after her two younger siblings said that although the youngest child was frequently sick she did not have the money to take her for treatment. (see case study 2)

#### **Inheritance snatching**

Though the view of the community was that most people in the area were poor and had no property to leave behind when they died, more than 25% (7 of 26) of the orphans interviewed said that the property left behind by their parents had been distributed or snatched by relatives. Two of these orphans reported that although the properties were in their own names, they were being controlled by their relatives who misused the income. (see case study 2).

#### **Case study 2**

*K is a girl aged 14 years who has lost both of her parents. She told us the following story: "My father died in 1997 and my mother died this year. I was living in Rungwe where I was going to school but after the death of my mother I had to come back to Mbeya to look after my two younger siblings. I also have two older sisters who are married. My parents left behind this house where we are living which has five bedrooms. They also left behind a guesthouse but neither of these properties are under my control. My uncle controls the guesthouse and my older sisters control this house. Three of the rooms in this house are rented at a cost of 3,000 TZS/month (\$3.33). My sister collects the rent money every month and buys us a little food but not enough to last the month. My uncle who controls the guesthouse gives us nothing even when I ask for help. My brother who is 12 years old goes to school but I cannot. My little sister has not been well since my mother's death. She has frequent skin rashes and fevers but I cannot do anything as I have no money for doctor visits or medicine. When I ask my older sisters for money they tell me that it has all been used to buy us food. When they are*

*here they don't even touch my little sister, they are afraid that she will infect them. Life is tough. It has changed from the way it was when my parents were alive when we had love, food, clothes, and everything we needed. Now we have nothing. I am supposed to look after my brother and sister but I have no resources since the properties are not under my control. I wish that the government had plans to provide free treatment to orphans."*

## **Common childhood illnesses**

From the information obtained in the study area, the leading cause of illness of children is malaria. All respondents mentioned malaria as the most common illness attacking children followed by diarrhea. Other diseases mentioned included fever, headache, stomach pain and pneumonia. However diarrhea is a very common disease in infants and young children below the age of five years and is due to poor hygiene and environmental sanitation.

Other illnesses affecting children are skin diseases including scabies, worms, malnutrition, HIV/AIDS, typhoid, influenza, tuberculosis, coughing measles, epilepsy, urinary tract infections, anemia, fungal disease, dehydration, cholera, chest pain and asthma. The government health policy of cost sharing has changed people's treatment patterns. Most respondents said they were using traditional healers more often instead of public or private facilities that were very costly.

## **Health care provision**

### ***Modern health provision***

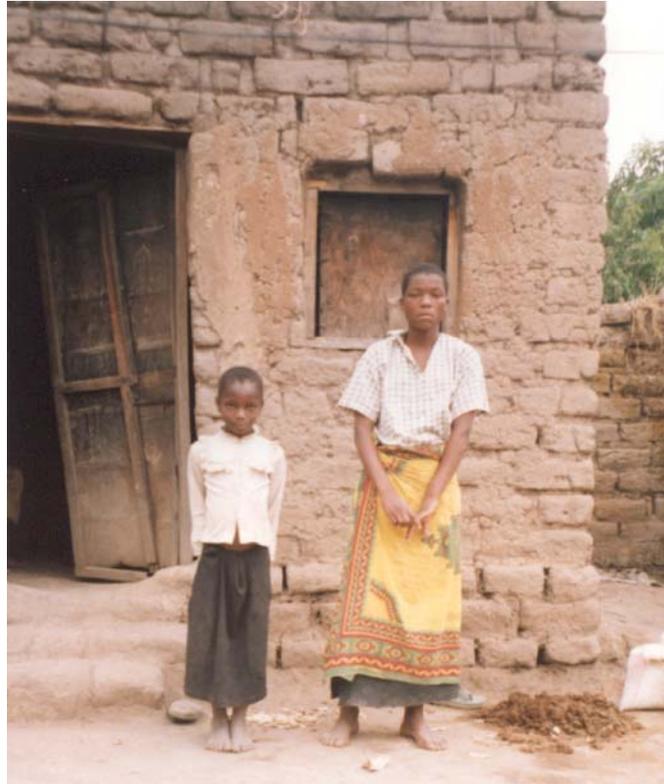
There are a total of three hospitals in the municipality, Mbeya Consultant Hospital, K's Hospital and Uyole Hospital. Mbeya Consultant Hospital is a government hospital while K's Hospital and Uyole Hospital are privately run.

A regional hospital for Mbeya is currently in constructed. Outpatient service provision began in early 2002. It is anticipated that the hospital will near completion around December 2002 or sometime in 2003. Meanwhile Mbeya Consultant Hospital functions as the regional hospital for inpatient stays and surgery.

There are 5 health centers in the municipality. These include 3 government run health centers (Ruanda Health Center, Kiwanjampaka Health Center and Igawilo Health Center), and 2 health centers run by religious organizations (Uhai Baptist Health Center and Aga Khan Health Center). There are 40 dispensaries in the municipality: 10 governmental, 3 run by religious organizations, 4 run by parastatals and 23 private dispensaries.

Dispensaries generally provide basic primary health care such as immunizations and mother and child health services. Health centers provide

similar services and function as a referral mechanism to the local consultant or regional hospital when necessary. A referral system is practiced within the regional health network or outside the region to specialized hospitals such as Muhimbili National Hospital or Aga Khan Hospital in Dar es Salaam and Kilimanjaro Christian Medical Center (KCMC) in Moshi.



### ***Traditional healers and traditional birth attendants***

In addition to the modern health care providers in dispensaries, health centers and hospitals there were a large number of traditional healers in the municipality. Traditional healers are quite active and serve as a valuable treatment source for the people of Mbeya. Traditional healers treat a large number of diseases including malaria, diabetes, hypertension, infertility, pregnancy related problems, including hemorrhoids, using traditional medicine.

Traditional birth attendants (TBAs) assist deliveries in the community. There were approximately 144 trained TBAs in the municipality. It is estimated that 52% of deliveries in Mbeya Region take place outside health facilities. The cost for such service provision is not predetermined and payment is generally

in-kind rather than cash. Small gifts to the TBA often include items like soap or cooking oil.

Traditional healers and TBAs stated that they referred clients to other providers when necessary. TBAs noted that they referred women to primary health care for immunizations or management of complicated cases of childbirth. Traditional healers commented that they sometimes referred patients to other traditional healers but generally did not refer patients to primary health facilities unless in an emergency. It seemed that there was little or no collaboration between traditional healers and primary health facilities. Traditional healers responded that in general they felt that modern practitioners ignored them and their role in health service provision.

### ***Cost of treatment***

Health care at government facilities is generally less expensive than at private facilities. The government of Tanzania introduced a cost-sharing program in 1993 whereby patients pay a small consultation fee and 50% of prescription drug costs. All pregnant women, children under 5 years of age, elderly persons over 60 years of age, and people with AIDS or TB are exempt from fees including drug costs. One of the problems with the cost-sharing program experienced by health facilities, was that many of their patients are exempt from paying fees. This means that funds that are normally used for programs such as VCT have been reduced.

About 80% of patients attending public health services reported that they were able to obtain all the treatment and drugs that they required. Of those patients attending private facilities, most said that as long as they were able to meet the cost, required drugs and treatment were generally available. Out of two private facilities visited, only one had a policy to provide free treatment to those who were poor and unable to meet the costs of treatment and medicines. One of the five traditional healers interviewed said that they provide free treatment (or significantly reduced charges) to orphans depending on the economic status of caregivers.

Aga Khan Health Center charges between 3,000 and 13,000 TZS (\$3.33 and \$14.44) for diagnosis and treatment of malaria (range depends on severity of the disease). Mbeya Consultant Hospital charges between 1,500 and 4,500 TZS (\$1.66 and \$5) for diagnosis and treatment of the same disease. Traditional healers reported that they charge between 2,000 to 3,000 TZS (\$2.22 and \$3.33) for treatment of malaria. In contrast, if patients self-diagnose themselves with malaria, the cost of obtaining the necessary drugs from drug outlets or pharmacies is about 400 TZS (\$0.44).

## Cost of diagnosis and treatment of malaria

	Cost
Aga Khan Health Center	3,000 to 13,000 TZS (\$3.33 to 14.44)
Mbeya Consultant Hospital	1,500 to 4,500 TZS (\$1.66 to 5.00)
Traditional Healer	2,000 to 3,000 TZS (\$2.22 to 3.33)
Self diagnosis and drug purchase from pharmacy	400 TZS (\$0.44)

### ***Satisfaction with health service provision***

Upon exiting primary health facilities, nine people were asked about the treatment and services received. When asked about the level of satisfaction with the health service just provided, only one client expressed dissatisfaction. This was due to the fact that he did not receive an injection. Interestingly, three clients exiting private facilities stated that they chose private facilities because they had good services and drugs in stock. One client took the time to describe to the interviewers his unhappiness with the services generally provided by the local government hospital particularly the cost of services. Hence he often visited private health facilities such as the one he was exiting the day of the interview.

### **Drugs and medical supplies**

#### ***Availability of Drugs***

As it is not possible to look at the availability of all drugs in health facilities, a number of drugs relevant to primary health care were selected as marker drugs. These drugs included: cotrimoxazole, amoxicillin, nalidixic acid, tetracycline, erythromycin, ciprofloxacin, sulfadoxazine/pyrimethamine, penicillin, gentamicin, quinine, paracetamol, mebendazole, iron/folic acid supplements, oral rehydration salts, diazepam, and gentian violet paint or povidone iodine solution.

At the time of assessment, the MSD was out of stock of three items on the marker list – cotrimoxazole, nalidixic acid and sulfadoxine/pyrimethamine (SP). The MSD did note that they expected a shipment the same day to arrive with stocks of cotrimoxazole and nalidixic acid but SP availability was currently a problem. SP has recently replaced (as of June 2001) chloroquine as the drug of choice for malaria treatment. Unfortunately, there have been some adverse reactions with SP thought to be drug batch related. The Tanzania Board of Pharmacy had removed this batch from stocks approximately 2 weeks before the needs assessment began and the MSD was awaiting a new shipment of SP.

There are 13 private drug stores (Duka La Madawa) and 12 pharmacies in Mbeya Municipality. Pharmacies differ from Duka La Madawas in that they must have a pharmacist and can sell any drugs. Duka La Madawas generally do not employ a pharmacist and sell drugs for the treatment of minor illnesses including pain, fever, malaria, worms, cough, dermatological irritation etc.

Three pharmacies and three drug stores were visited during the needs assessment. The number of clients purchasing drugs in pharmacies ranged between 140 to 500 clients per week while the number in drug outlets ranged between 70 to 140 during the same time period. This implies that more clients seek services at pharmacies where they are assured of accessing drugs compared to drug outlets that have restrictions on drugs they can carry.

### ***Procurement and distribution***

The main supplier of drugs and medical supplies to Tanzania's public health system is the Medical Stores Department (MSD). All government facilities have an account at MSD into which the Government Treasury deposits money. Health facilities use these funds to purchase drugs and supplies and are not allowed to use suppliers other than the MSD unless under special circumstances. It should be noted that the MSD only stocks items on the national Essential Drug List (EDL). Users wishing to purchase items not on the EDL must procure them from private wholesalers.

Primary health care facilities do not purchase their drugs and medical supplies according to need. They receive from the MSD a fixed amount of drugs once a month in the form of a kit. The same kit is standard for all facilities of the same level regardless of variations in patient load and disease profile. Because of the kit system, the facilities do not have a system to estimate their actual needs for their medicines and medical supplies.

The zonal MSD, located in Mbeya Municipality, serves two regions (Mbeya and Rukwa) and 12 districts. At the time of assessment, it was noted that the essential drug kits are currently being distributed from the MSD in Iringa due to a lack of transport at the MSD Mbeya. This issue is expected to be solved before the end of 2001 when MSD Mbeya receives a truck from MSD

Headquarters. In addition to distribution of drug kits, MSD also sells drugs and medical supplies to clients such as government facilities, voluntary/religious organizations, parastatal organizations and private organizations that have been pre-approved by the Ministry of Health. Government facilities can procure drugs from the MSD using funds collected through cost-sharing programs with patients.

There are a number of private drug and medical supply wholesalers in Mbeya Municipality. The clients of these facilities are private dispensaries, health centers, hospitals and government facilities. Private wholesalers procure and distribute drugs and medical supplies outside of the essential drug list including antiretrovirals. Two private wholesalers, Bojani and Msafiri, were interviewed during the needs assessment.

Bojani stocks approximately 5000 items and have a yearly drug and medical supply procurement of over \$200,000. Records are kept using stock cards although computerized record keeping is planned for the near future. At the time of assessment they had all marker drugs and noted no problems procuring items for their clients. Special order items (such as recent orders for anticancer drugs, growth hormone etc) are generally received within 3-7 days depending on source of the item.

Msafiri is a wholesale drug and medical supplier that was established in Mbeya in 1999. The facility has 50 permanent wholesale customers throughout the region. At the time of assessment they had all marker drugs and noted no problems procuring items for their clients. Msafiri records stock manually using bin cards.

### ***Drug management system***

Proper drug recording is an essential component in tracking the flow of drug sales, and monitoring expiration dates, as well as identifying common diseases in the area and determining relevant interventions. Record keeping enables the establishment of an efficient stock management system. Although all six pharmacy and drug outlets noted that they kept records of drug stocks using ledger books or bin cards, they did not have a proper record of drug sales. For example one pharmacy recorded only 236 customers during the entire year of 2000 (less than 1 client per day). This seems to be related to payment of taxes. Under recording and non-recording of sales shields profits and decreases the amount of taxes that must be paid to government authorities.

Although by law, drug outlets must not have items such as antibiotics for human consumption, 2 of the 3 drug outlets had various antibiotics in stock. Only two of the six outlets visited had copies of the national EDL and standard treatment guidelines (STG) while three additional facilities had a copy of the STG only. It should be noted that the cost of drugs was very similar between

facilities and did not differ significantly between drug outlets and pharmacies. There were no expired drugs found in any of the facilities visited.

### **Voluntary counseling and testing**

VCT services are available in 8 centers in Mbeya Municipality. These centers include Mbeya Consultant Hospital, Mbeya Regional Hospital, Ruanda Health Center, Kiwanjampaka Health Center, Igawilo Health Center, Uhai Baptist Health Center, Aga Khan Health Center and Kihumbe. SHDEPHA+ provides pretest counseling and supportive counseling as well but does not undertake testing.

Testing for all facilities (with the exception of Aga Khan Health Center, Uhai Baptist Health Center and Mbeya Regional Hospital) is carried out at Mbeya Consultant Hospital using ELISA tests. A member of the facility (usually a counselor) takes samples daily to Mbeya Consultant Hospital for testing. Public transport is the most commonly used means to deposit samples and to collect test results. Most facilities noted that this was expensive (200 to 400 TZS/trip - \$0.22 to \$0.44) and time consuming. There is a time lag between 3-7 days for receiving results.

Rapid tests for VCT are used in only two facilities (Uhai Baptist Health Center and Aga Khan Health Center) in the municipality. Both facilities use Capillus™ tests procured from Mbeya MSD. Testing of clients from the outpatient department of Mbeya Regional Hospital is carried out using ELISA tests in the onsite laboratory.

Most public facilities observed a shortage of basic supplies such as gloves and cotton wool for conducting tests. These items are generally purchased from the funds generated by cost sharing programs within government facilities. Due to the various exemptions, funds collected are not enough to satisfy all procurement needs. One facility commented that they have had to ask people who seek VCT services to bring to gloves with them when they are tested.

Most respondents (55%) from the community were in favor of counseling but 59% were not ready to be tested themselves. Many respondents were concerned with the stigma of finding out they are HIV positive and the fear that they would suffer psychologically. Furthermore, respondents complained that there was a general lack of assistance in terms of drug availability or material support for those testing HIV positive.

Detailed information regarding each of the facilities currently providing VCT can be found in Annex 3.

## Community suggestions for solutions

The informants gave a number of suggestions on how to deal with some of the problems identified during the needs assessment. These suggestions were taken into account when the action plan was prepared.

Most respondents stated that the government should find ways of helping orphans and their families meet basic needs such as food, education, clothing and health care. They suggested that scholarships be available so that orphans have access to secondary school education as well as vocational training. Unless the government intervenes, orphans will not have a proper education since most caregivers are too old and poor to provide quality care.

Most respondents welcomed the idea of expanding VCT services though they recognized that it would not be easy to encourage people to seek testing. In this respect they suggested that there should be a great deal of education about the importance of VCT and to bring the services closer to the communities.

There were some informants who suggested that VCT should be incorporated into the existing health system and 17% of respondents said that making VCT services free would encourage people to be tested. In fact, most respondents suggested that the government should waive all fees and cost-sharing that exist in the health delivery system. In addition, the community requested that the government build more dispensaries and health centers in their areas.



### **3 Institutional responses**

#### **Role of the government**

Up until now, orphan support programs in Tanzania are few. The extended family and communities continue to take care of orphans, as has traditionally been the case. However, the growing numbers of orphans makes it increasingly difficult for families and communities to cope with the needs of orphans. Many households in Tanzania are now economically constrained while modernization and the rural-urban influx has disrupted the traditional extended family system.

The Tanzanian Government has taken deliberate steps in an attempt to alleviate the orphan situation but due to limited funding this has focused mainly on the provision of foster care services, adoption services and the registering of children's homes (orphanages). Currently there are 52 registered children's homes around the country catering for about 3500 orphans and other children in need of special protection measures such as the abandoned and neglected. All, except one of the orphanages, are run by NGOs or religious organizations.

One of the guiding principles in orphan support is that the children should, as far as possible, be brought up in either their own families or the families of close relatives. As such, most babies cared for in orphanages are returned to their relatives or put up for adoption as soon as they are two years of age. The government has taken an active role in identifying and locating relatives of children in orphanages so that children can be placed in families when appropriate.

#### **National initiatives**

Social Action Trust Fund (SATF) is a non-governmental organization financed by the United States Agency for International Development (USAID). SATF invests in financially viable and environmentally friendly projects having a developmental value to the economy. Investments can take the form of loans, shareholdings or a combination of both options. The earnings from the interest and investments are used for grants to NGOs registered in Tanzania to assist the educational needs of AIDS orphans.

Grants for the year 2000 totaled 195 million TZS (\$216,667) provided support to 10,621 orphans in various primary schools in 12 regions in Tanzania including the Mbeya Region. Grants for 2001 totaled 300 million TZS (\$333,333) and extended support to include primary and secondary education. In 2001, over 12,000 orphans in 14 regions received support through SATF.

## **Institutional support for orphans**

There are three orphanages/orphan centers in Mbeya Municipality, two of which are community initiatives to provide a home for orphaned and abandoned children. Currently none of the institutions are registered or recognized by the National Social Welfare Department.

### ***Iwambi Orphanage***

Iwambi Orphanage is located along the road to Zambia approximately 10 kilometers from Mbeya town. Iwambi is supported by the Lutheran Church and other sponsors. The orphanage currently supports 42 children between the ages of 6 and 18 years. Thirty five children are in primary school and 7 are in secondary school. The orphanage is currently at maximum capacity and have requests to take more children.

All children have “foster parents” who contribute 15,000 TZS/month or 44 DM (\$17) toward the costs of raising the children. All children have lost both parents and some of them were living on the streets before coming to the orphanage. When children are sick they are treated at the church dispensary located in Mbeya town. Iwambi has two gardens for growing food for the children; in addition they have 2 dairy cattle to provide drinking milk for the children. Any extra food or milk is sold to provide funds for orphanage expenses.

### ***Simike Orphan Center***

Simike Orphan Center is a non-registered center located in the Simike Ward of the municipality. The center is the private home of a women who is a primary school teacher. This center currently houses approximately 45 orphans between the ages of 6 months and 25 years. The house is very basic with dirt floors and mud walls. Few children sleep on beds, most sleep on mats on the floor. All children of primary school age are currently attending school with the exception of a blind girl who is 10 years of age.

The caregiver stated that she is in need of support to provide food and other basic needs for the children, as sometimes they do not know where their next meal will come from. Most of the children who have come to this center were abandoned as infants and very few of the children can describe their life before coming to live at Simike. All children call the caregiver “mother” and most have no idea that they are not her biological children.

### ***Nuru Orphan Center***

Nuru Orphan Center is located in the Uyole Ward of Mbeya Municipality. Nuru is not officially registered as an orphan center but it is well known in the community. Nuru is a private household that is currently caring for 4 orphans. Nuru Orphan Center is currently in the process of trying to become registered but is finding the process long and expensive because based upon

government policy orphan homes can not be registered if they are a private home.

These orphans lost both of their parents and were either living on the street or with grandparents too old and poor to care for them. The orphans range between 2 to 10 years of age. One child currently goes to primary school and another will begin in January 2002. The owners of Nuru have a lot of land and grow many things. They also have dairy cattle that provide milk for the children. Money for school materials and uniforms remains a problem for the caregivers.

## **Orphan outreach initiatives**

### ***Caritas***

Caritas is an international Catholic NGO active in the Mbeya Region. The organization is responsible for rural and urban community development. Caritas receives funds from SATF to support the educational needs of AIDS orphans. Orphans are provided support for school fees, stationery, shoes and medical treatment.

Currently the orphan program operates in 23 centers in the region, 4 of which are located in Mbeya Municipality. These centers include Uyole, Mwanjelwa, Mbeya Town, and Nzovye. A regional support network has been established linking the 23 centers to ensure correct distribution of funds and no duplication of disbursements. Since 1999, Caritas has supported 1635 AIDS orphans in the entire Mbeya Region with a total expenditure of 36,288,000 TZS (\$40,320).

Caritas has experienced a number of constraints with their orphan support programs. A lack of clear and established criteria for identification makes it difficult to identify and aid needy orphans. Communities do not always regard orphan problems as their responsibility thus depending on the church as a relief organization. In addition, it was noted that the region lacks an established body to oversee and coordinate care and support to orphans.

### ***Kihumbe***

Kihumbe is a local NGO providing care and support to people infected and affected by HIV. The organization initially began to provide home-based care (HBC) to people living with HIV/AIDS. Kihumbe quickly realized that many of their HBC patients who died were leaving orphans behind. Kihumbe currently have registered 204 orphans (100 children between 0-5 years and 104 between 6-18 years). Seventeen children are currently being supported by German foster families who provide financial support for school fees, uniforms, materials, blankets and bedding, food, soap and any other basic needs of the orphan. These children have been supported continuously for three years. Unfortunately, Kihumbe is currently unable to support the needs

of the 187 other remaining registered orphans due to a lack of financial assistance.

### ***Morovian Church***

The Morovian Church women's group is currently supporting orphans identified in their communities. Orphans are identified using criteria defined by the women's group. Currently 12 children (11 orphans having lost both parents and 1 child with mentally ill parents) are being supported with basic needs and educational needs. These children have been continuously supported for three years. Funds for these activities are raised by contributions from the church and women's group. Children who have lost both parents and who are under the age of 2 are referred to the Morovian Church orphanage located in Mbozi (approximately 30 kilometers from Mbeya town).

The Morovian Church determined that there was a need for an orphanage in Mbeya and are currently constructing an orphanage for children above the age of 3 years in the Nsalage Ward. The orphanage is expected to be completed in February 2002 and will have a bed capacity of 20. The orphanage will be supported by the Bishop of the Morovian Church and other church members.

The women's group also supports other needy orphans in the communities with small things such as a bag of rice or bar of soap if resources are available.

### ***Lutheran Church***

The women's group in the Lutheran Church in Mbeya is supporting orphans in their communities. Local pastors and area leaders identify orphans needing support. These orphans are provided with basic needs such as clothes and food, as well as school fees. The church does not have a proper reporting system, so they do not know the exact number of orphans being supported but they estimate the number to be around 100. Funds for orphan activities are collected from church members, contributions from the women's group and donations from visitors. The church also supports sick HIV positive patients and widows depending on available resources.

### ***SHDEPHA+***

SHDEPHA+ is a national NGO involved in the support for people living with HIV/AIDS. The SHDEPHA+ branch in Mbeya Municipality has identified 36 orphans from their clients who have died. Four of these children have also tested positive for HIV. SHDEPHA+ provides some small educational support to the orphans in the form of schoolbooks, pens and pencils. The funds for this activity generally come from the personal resources of SHDEPHA+ members.

## **Financial institutions**

As poverty was cited as a major constraint in providing care and support to OVC, it was necessary to investigate the options for loan/credit in the area. In Mbeya Municipality there are a number of financial institutions providing seed funds in the form of grants for income generating activities (IGA) or small business loans. All of these organizations expect repayment of loans with interest.

### ***FEDA***

Finance and Enterprise Development Associates Limited (FEDA), a project established with support from USAID, was set up to assist small businesses through the introduction of market oriented approaches to business development. FEDA is currently managing a \$2,000,000 risk management and profit sharing fund (RMPS). RMPS is geared to support businesses with loans between \$300 and \$100,000.

FEDA's head office is in Dar es Salaam with zonal offices in Mbeya, Tanga and Mwanza. Activities began in Mbeya in 1999 with poverty alleviation programs in the districts of Mbeya Rural and Chunya (Mbeya Region) and Njombe and Ludewa (Iringa Region).

### ***PRIDE***

Promotion of Rural Initiatives and Development Enterprises (PRIDE) was established in 1996 with headquarters in Arusha. Two branches have been operating in Mbeya since 1997. PRIDE provides working capital to solidarity groups and loans to the informal sector. PRIDE working capital is 800,000,000 TZS (\$888,889). PRIDE operates 5 kilometers from Mbeya town. Lending is done based on inter-group appraisal with loan repayment of 100% and interest of 30%.

About 2450 people have been reached through PRIDE loans of which 49% are female and 51% are male. Major businesses include cereal/grain selling, food street vendors, carpentry, kiosks and gardening. PRIDE receives its funding from the Norwegian Agency for Development Cooperation (NORAD) and the Swedish International Development Cooperation Agency (SIDA).

### ***MEDA***

The Menonite Economic Development Associates (MEDA) is a credit facility established in 1994 with offices in Dar es Salaam and Mbeya. MEDA receives funding from the Canadian International Development Agency (CIDA). MEDA provides loans and business training to community members in the Mbeya Region. It has a portfolio size of 295,000,000 TZS (\$327,778) and operates 8 satellite offices in the region - of which 4 sites are located in Mbeya Municipality.

MEDA operates within a community network involving ward, village/street leaders and religious leaders. Loans ranging between 2,500 to 75,000 TZS (\$2.80 to \$83.34) are available to individuals, groups and market associations including petty traders. Loans are repaid with a monthly interest rate between 2.5-4%. About 3,800 clients have benefited from MEDA loans of which 45% are female and 55% male.

## **HIV/AIDS activities**

### ***Barmaid program***

An interventional program targeting female barworkers is currently ongoing in the Mbeya Region. The intervention is taking place in high HIV transmission areas in the region which are generally along the highways where truck drivers stop for the night. Four of the 20 intervention sites are located in Mbeya town. The intervention addresses a number of criteria including behavioral changes related to HIV, a drug trial for syphilis and other STI studies. The cohort of 600 barmaids (of which approximately 68% were HIV positive at the beginning of the program) will be followed for 2½ years. This project is being carried out by the Regional AIDS Control Program and is supported by the University of Munich.

### ***Prevention of mother to child transmission of HIV***

Currently interventions for the prevention of mother to child transmission (PMTCT) of HIV are available at two sites in Mbeya: Meta Hospital (labor and delivery wing of Mbeya Consultant Hospital) and Ruanda Health Center. Interventions will be expanded to Igawilo Health Center in 2002 after the labor and delivery unit has been completed.

These sites are part of the national PMTCT program sponsored by GTZ. Zidovudine (AZT) is administered to mothers from 34 weeks gestation until delivery. No antiretroviral drugs are administered to the child or mother after delivery. Women are also counseled on the various infant-feeding options and children are followed up by a pediatrician for 15 to 18 months after which they are tested for HIV.

### ***Local efforts against HIV/AIDS***

Communities themselves have already recognized the problem of AIDS and the resulting numbers of orphans and have taken steps to set up local support groups. There are a number of community based organizations (CBOs) such as Kihumbe and SHDEPHA+ as well as youth drama groups and church home based care groups active in the municipality. These groups provide community education and mobilization for HIV/AIDS and some even provide support to orphans.

The government in collaboration with GTZ has been providing HIV/AIDS education to the community, advocacy and AIDS awareness meetings. In addition, sexually transmitted infection (STI) syndromic management programs and voluntary counseling and testing (VCT) services have been implemented in the municipality. Other efforts include school AIDS programs, condom promotion and HIV interventions in high-risk work places (such as bars).



## **CONCLUSION**

Life in the urban area of Mbeya Municipality is very difficult. Communities seemed very poor and were not able to rely on the other community members for assistance. The problem of HIV/AIDS has significantly impacted on these communities. The traditional family unit is overburdened and OVC are left in the care of the extended family. This is usually elderly grandparents, who find it difficult to make ends meet for themselves let alone a houseful of grandchildren. The burden of care among caregivers was great. Most caregivers said that they had very little to give to children including food, medical care or education.

The care and support to OVC presents many problems for families. Although primary school fees have been waived for all children in Tanzania, the cost of

basic materials such as uniforms, pens, and books can be prohibitive. For those children fortunate enough to complete primary school very few OVC are able to attain secondary education. Only 1 child interviewed during the needs assessment (of the 6 that had passed primary education) was in secondary school. Some of the children not in school were involved in IGA to earn money for the family and to support the educational needs of siblings. Strategies for increasing income should be enhanced, although these activities would be unlikely to help the old or frail caregivers. Further interventions for children who are heads of household should be addressed.

Promotion of VCT services and expanding the access to services at community level will allow families to plan their future and that of their children. Expansion of services can be done by utilizing rapid tests. Rapid tests have now been validated as safe and effective by international organizations such as WHO and UNICEF. They do not require laboratory equipment and little training is needed to administer them. They can therefore be delivered in health facilities. Supervision, quality assurance and quality control should be conducted by the responsible laboratories.

The support systems for people who test HIV positive should be strengthened. There are a number of local NGOs in Mbeya Municipality already providing HBC services for people with HIV. Improving the service provision and the treatment options to those testing positive will increase the numbers of people seeking VCT services.

The action plan, located in Annex 1, was developed as a result of the needs assessment. The strategies and activities described are those deemed necessary to implement a program to help OVC in the Mwanjelwa area (comprising of 5 wards) of Mbeya Municipality, Tanzania. These initial recommendations aim at improving care of OVC, strengthening the ability of families to cope and improving access to schooling and primary healthcare. This should lead to a substantial improvement in the quality of life of orphans and their families. It is worth noting that some of the interventions are costly and cannot be easily met with the limited resources available. It would be necessary in this case to focus priority to needs that directly affect OVC and address others subsequently.

A project document has also been developed separately from this report. The document is based upon the findings from the needs assessment and the activities listed in the action plan. The project document justifies the activities and describes the roles and contributions of each of the actors in project implementation.

## **ANNEXES**

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## Annex 1 – Draft action plan

### OBJECTIVE 1: TO IMPROVE THE FULFILLMENT OF BASIC NEEDS

<b>STRATEGIES</b>	<b>ACTIVITIES</b>	<b>RESPONSIBLE</b>	<b>INDICATORS</b>
1. Create a system of supporting orphans and caregivers by the year 2003	1.1 Notify responsible government offices, NGOs and community leaders about the program	Social Welfare Officer	Relevant people notified and aware of program
	1.2 Conduct a workshop to develop criteria for choosing most needy orphans	Social Welfare Officer	Criteria developed Workshop report
	1.3 Conduct a mapping exercise to identify orphans and their needs	Social Welfare Officer	Mapping exercise report
	1.4 Print and distribute registers at street leader level and teach them how to fill them in	Social Welfare Officer	Registers distributed
	1.5 Compile comprehensive registers at ward and district levels	Social Welfare Officer	Registers completed
	1.6 Sensitize communities to register deaths and OVC with street leaders	Social Welfare Officer, NGOs	Sensitization completed
	1.7 Visit and verify information in registers with caregivers of OVC	Social Welfare Officer	Number of orphans identified & registered
2. Improve the economic status of households, especially those caring for orphans	2.1 Obtain a list of orphans and caregivers and sensitize them and communities to the different types of IGAs	Community Development Officer (CDO), NGOs	List obtained
	2.2 Create IGA revolving fund by collaborating with SIDO or other groups	Dept of Trade and Industry, NGOs	IGA revolving funds established
	2.3 Form groups of people with similar IGA interests	Community Development Officer, NGOs	Groups formed

<b>STRATEGIES</b>	<b>ACTIVITIES</b>	<b>RESPONSIBLE</b>	<b>INDICATORS</b>
	2.4 Train 12 groups, each consisting of 5 members, in IGA skills within a period of 2 years	Community Development Officer, Dept of Trade and Industry, NGOs	Groups trained
	2.5 Provide loans and materials needed by each IGA group	Community Development Officer, Dept of Trade and Industry, NGOs	Groups receiving loans
	2.6 Collect debts from IGA groups in specified time intervals	Community Development Officer, Dept of Trade and Industry, NGOs	Debts collected
3a Support existing community initiatives already caring for OVC	3.1 Facilitate registration of Simike and Nuru Orphan Centers	Social Welfare Officer	Centers registered
3b. Improve existing day care centers	3.2 Provide educational materials to Nuru Orphan Center	Education Officer	Educational materials provided
	3.3 Renovate Simike Center to provide proper accommodation for children	Social Welfare Officer	Center renovated
	3.4 Provide beds and bedding for Simike Center	Social Welfare Officer	Beds/bedding provided
	3.5 Improve sanitation by providing water, kitchen and toilets at Simike Center	Social Welfare Officer	Water, kitchen and toilets installed
	3.6 Provide food and clothes as well as educational needs for Simike children	Social Welfare Officer	Food, clothes and educational materials provided
	3.7 Establish IGAs for Simike Center such as maize mill or day center	Social Welfare Officer, Dept of Trade and Industry, Community Development Officer	Day care center established

<b>STRATEGIES</b>	<b>ACTIVITIES</b>	<b>RESPONSIBLE</b>	<b>INDICATORS</b>
	3.8 Build community interest in the ownership of Simike for sustainability purposes	Social Welfare Officer, Community Development Officer	Ownership and awareness created
	3.9 Identify existing day centers in the ward and assess their needs	Community Development Officer	Center visited and report of needs undertaken
	3.10 Facilitate registration of day centers	Community Development Officer	Centers registered
	3.11 Renovate 1 day center in the assessment area	Community Development Officer	Center renovated
4. Raise awareness among the community regarding widow and orphan inheritance rights	4.1 Educate communities in the rights of widows and their children to inherit property	Social Welfare Officer, NGOs	Communities sensitized
	4.2 Facilitate widow's and children's consultation with lawyers if inheritance is "grabbed" by family	Social Welfare Officer	Number of widows and children helped
5. Empower local NGOs who are working with OVC	5.1 Provide training for 5 artists at Bagamoyo drama and training school	NGOs	Training provided
	5.2 Provide equipment for acrobatics and musical instruments	NGOs	Equipment and instruments provided
	5.3 Provide drama group with costumes	NGOs	Costumes provided
	5.4 Provide Kihumbe office with a video & TV for educating people on HIV and orphan issues	NGOs	Video & TV provided Number of educational sessions

<b>STRATEGIES</b>	<b>ACTIVITIES</b>	<b>RESPONSIBLE</b>	<b>INDICATORS</b>
	5.5 Purchase a computer and printer for Kihumbe for information storage and report writing	NGOs	Reports submitted
	5.6 Purchase 5 bicycles for Kihumbe outreach services	NGO	Increased number of outreach services

**OBJECTIVE 2: TO IMPROVE ACCESS TO EDUCATION**

<b>STRATEGIES</b>	<b>ACTIVITIES</b>	<b>RESPONSIBLE</b>	<b>INDICATORS</b>
1. Provide material and financial support to cover school costs for OVC	1.1 Identify the numbers of OVC in school and assess their needs	Municipal Education Officer (MEO), Municipal Director (MD)	Numbers of OVCs identified and needs assessed Report provided
	1.2 Improve capacity development of caregivers	Municipal Education Officer, Municipal Director	Sensitization session completed
	1.3 Provide basic school materials to 2000 OVC in school within 2 years	Municipal Education Officer, Municipal Director	Materials provided
	1.4 Provide sponsorship to 32 OVC in secondary schools	Municipal Education Officer, Municipal Director	Sponsorship provided
	1.5 Provide vocational training for 16 OVC not in school	Municipal Education Officer, Municipal Director	Training provided
	1.6 Establish out-of-school training program for OVC who are caregivers/dropouts	Municipal Education Officer, Municipal Director	Training program established Number of OVC trained
	1.7 Recruit and train teachers for learning centers	Municipal Education Officer, Municipal Director	Number of teachers trained
	1.8 Improve guidance and counseling services in schools	Municipal Education Officer, Municipal Director	Services provided in schools

<b>STRATEGIES</b>	<b>ACTIVITIES</b>	<b>RESPONSIBLE</b>	<b>INDICATORS</b>
2. Improve water and sanitation services in primary schools	2.1 Identify schools with poor sanitation in the assessment area	Municipal Education Officer, Municipal Director	School needs identified
	2.2 Construct toilet stalls in 6 primary schools in the assessment area	Municipal Education Officer, Municipal Director	Toilet stalls constructed
	2.3 Install piped water in 3 existing primary schools	Municipal Education Officer, Municipal Director	Piped water available
	2.4 Construct additional classrooms to reduce congestion in 6 schools	Municipal Education Officer, Municipal Director	Classrooms built
	2.5 Construct walls around 6 schools	Municipal Education Officer, Municipal Director	Walls built Number of schools with new gardens

### OBJECTIVE 3: IMPROVE ACCESS TO PRIMARY HEALTH CARE

<b>STRATEGIES</b>	<b>ACTIVITIES</b>	<b>RESPONSIBLE</b>	<b>INDICATORS</b>
1. Provide basic health services at schools	1.1 Strengthen school health surveillance programs	Municipal Officer of Health, Municipal Director, Municipal Education Officer	Health surveillance program established
	1.2 Provide first aid kits in schools	Municipal Officer of Health, Municipal Director, Municipal Education Officer	First aid kits established
2. Reduce malaria morbidity among children	2.1 Purchase and distribute 5000 impregnated bed nets to OVC	Municipal Officer of Health	Bed nets distributed
	2.2 Conduct dialogue meeting with caregivers and communities on malaria prevention and treatment	Municipal Officer of Health	Meeting conducted
	2.3 Identify permanent and temporary mosquito breeding sites	Municipal Officer of Health	Sites identified
	2.4 Conduct community mobilization to take action against breeding sites	Municipal Officer of Health, NGOs	Mobilization conducted Number of sites reduced
	2.5 Procure malaria drugs and equipment	Municipal Officer of Health	Drugs and equipment procured Number of sites reduced
	2.6 Repair one truck for mosquito source reduction	Municipal Officer of Health	Truck repaired

#### OBJECTIVE 4: TO IMPROVE ACCESS TO VCT AND HIV RELATED SERVICES

<b>STRATEGIES</b>	<b>ACTIVITIES</b>	<b>RESPONSIBLE</b>	<b>INDICATORS</b>
1. Promote the use of simple and rapid HIV tests in Mbeya Municipality by establishing more VCT centers and outreach services in the communities	1.1 Renovate 15 structures to provide VCT services	Municipal AIDS Control Coordinator, Municipal Officer of Health	Structures renovated Number of clients receiving services
	1.2 Procure office equipment and furniture	Municipal AIDS Control Coordinator, Municipal Officer of Health	Equipment procured
	1.3 Procure stationery	Municipal AIDS Control Coordinator, Municipal Officer of Health	Stationery procured
	1.4 Procure HIV tests and relevant equipment	Municipal AIDS Control Coordinator, Municipal Officer of Health	Kits procured Kits used
	1.5 Identify 45 people for counseling skill training	Municipal AIDS Control Coordinator, Municipal Officer of Health	People identified
	1.6 Prepare training program	Municipal AIDS Control Coordinator, NGOs, Municipal Officer of Health	Training program prepared
	1.7 Prepare VCT training materials	Municipal AIDS Control Coordinator, Municipal Officer of Health, NGOs	Training materials prepared
	1.8 Conduct training of counselors	Municipal AIDS Control Coordinator, Municipal Officer of Health, NGOs	Training conducted Number of counselors

<b>STRATEGIES</b>	<b>ACTIVITIES</b>	<b>RESPONSIBLE</b>	<b>INDICATORS</b>
	1.9 Conduct weekly outreach services	Municipal AIDS Control Coordinator, Municipal Officer of Health, NGOs	Outreach services provided
	1.10 Disseminate IEC materials	Municipal AIDS Control Coordinator, Municipal Officer of Health	Materials disseminated
	1.11 Purchase one 4-wheel drive vehicle for video shows with public address system	Municipal AIDS Control Coordinator, Municipal Officer of Health	Vehicle procured Number of shows
2. Promote VCT seeking behavior in Mbeya Municipality by December 2002	2.1 Conduct VCT community dialogue meetings in all 36 wards of municipality	Municipal AIDS Control Coordinator, Municipal Officer of Health, NGOs	Meetings conducted % clients seeking services
	2.2 Conduct risk mapping on social and cultural behaviors associated with HIV transmission	Municipal AIDS Control Coordinator, Municipal Officer of Health	Mapping completed
	2.3 Disseminate risk mapping information to community members and leaders	Municipal AIDS Control Coordinator, Municipal Officer of Health	Mapping disseminated
	2.4 Conduct VCT dialogue meetings for in- and out-of-school youth	Municipal AIDS Control Coordinator, Municipal Officer of Health, NGOs	Meeting conducted
	2.5 Train community resource persons to enhance VCT seeking behavior	Municipal AIDS Control Coordinator, Municipal Officer of Health, NGOs	Persons trained and active
	2.6 Establish social clubs for people living positively with HIV for promoting psychosocial support	Municipal AIDS Control Coordinator, Municipal Officer of Health, NGOs	Social club established

<b>STRATEGIES</b>	<b>ACTIVITIES</b>	<b>RESPONSIBLE</b>	<b>INDICATORS</b>
3. Improve home based care (HBC) services in 6 wards by December 2002	3.1 Identify 90 HBC providers	Municipal AIDS Control Coordinator, Municipal Officer of Health, NGOs	Providers identified
	3.2 Train 90 HBC providers	Municipal AIDS Control Coordinator, Municipal Officer of Health, NGOs	Providers trained
	3.3 Procure 90 HBC kits	Municipal AIDS Control Coordinator, Municipal Officer of Health	Kits procured Kits used
	3.4 Purchase 90 bicycles	Municipal AIDS Control Coordinator, Municipal Officer of Health	Bicycles procured Number of HBC visits
4. Create database for project information management	4.1 Conduct workshop to review and refine existing tools for information management system and identify gaps	Municipal AIDS Control Coordinator, Municipal Officer of Health	Workshop conducted Tools available
	4.2 Train service providers in using developed tools	Municipal AIDS Control Coordinator, Municipal Officer of Health	Providers trained
	4.3 Procure necessary equipment for documentation and data management	Municipal AIDS Control Coordinator, Municipal Officer of Health	Equipment procured Report provided
	4.4 Establish system for supervision and monitoring	Municipal AIDS Control Coordinator, Municipal Officer of Health	System established
5. Improve HIV awareness in communities	5.1 Conduct HIV/AIDS life skill training to 120 OVC to prevent HIV transmission	Municipal AIDS Control Coordinator, Municipal Officer of Health, NGOs	Training provided

<b>STRATEGIES</b>	<b>ACTIVITIES</b>	<b>RESPONSIBLE</b>	<b>INDICATORS</b>
	5.2 Train 25 peer health educators in the identification of OVC in the community needing life skills training	Municipal AIDS Control Coordinator, Municipal Officer of Health, NGOs	Training provided
	5.3 Procure motorcycle for surveillance	Municipal AIDS Control Coordinator, Municipal Officer of Health	Motorcycle procured

## Annex 2 – Data collection tools

<i>Type of respondent</i>	<i>Method of data collection</i>	<i>Objective of tool</i>	<i>Sample size</i>
Key informants such as village chiefs, traditional healers, religious leaders, representatives of local NGOs and respected village elders	In-depth interview	To identify the problems of the communities and give an overview of care situation in the community	12
Orphaned children	In-depth interview	To identify at first hand, care, education and primary health care problems of orphans	26
Caregivers of orphaned children	In-depth interview	To understand the burden of care of caregivers of orphans. Validating the information obtained from interviews with orphans	25
Community members	Focus group discussion	To rank major problems of orphans and vulnerable children and to map sources of care and support	6
Community members	Focus group discussion	To identify the importance of collaborating with local groups and institutions in the community	5
Orphan care centers and support groups	In-depth interview	To identify the various groups and sources of care for orphans and vulnerable children	5
Teachers	In-depth interview	To understand the problems that orphans and vulnerable children face in schools	10

<b><i>Type of respondent</i></b>	<b><i>Method of data collection</i></b>	<b><i>Objective of tool</i></b>	<b><i>Sample size</i></b>
Drug stores	In-depth interview	To provide information on drug and medical supply procurement, distribution, availability and accessibility at the wholesale level	3
Drug outlets	In-depth interview	To provide information on drug and medical supply procurement, distribution, availability and accessibility at the community level	6
Child health, AIDS support and diagnostic services	In-depth interview	To provide information on general child health, VCT service provision, and diagnostic services	8
Health care providers	In-depth interview	To determine the availability of drugs and treatment options in the community	11
Exit interviews	Exit interview	To determine the quality of care and service provision for children in health facilities	9

## **Annex 3 – VCT services in Mbeya Municipality**

### ***Mbeya Consultant Hospital***

Mbeya Consultant Hospital has been providing VCT services since 1994. Service provision began with two counselors who were trained for 4 weeks at Iringa Primary Health Care Institute. Due to the death of one of the counselors last year, there is now only one trained counselor. The laboratory at the hospital has the capacity to conduct ELISA tests for VCT clients and Capillus™ tests for blood donors.

During 2000, Mbeya Consultant Hospital counseled 3882 clients and tested 3055 (averaging 250 clients per month). One thousand seven hundred and two clients were found to be HIV positive (55%) of which 802 were female (47%) and 900 were male (53%). The cost of VCT is 1000 TZS/test (\$1.11). HIV positive clients are referred to Kihumbe for HBC and social support.

VCT is also conducted at Meta Hospital (the labor and delivery section of Mbeya Consultant Hospital) as part of the PMTCT interventions.

### ***Mbeya Regional Hospital***

Mbeya Regional Hospital is currently being constructed although the outpatient department services having begun in January 2002. The hospital has one trained counselor who is providing counseling for VCT through the outpatient department. Testing is carried out onsite in the hospital laboratory using ELISA tests. The cost of VCT is 1000 TZS/test (\$1.11). Clients who test positive for HIV are referred to SHDEPHA+ or Kihumbe for HBC and social support.

### ***Ruanda Health Center***

Ruanda Health Center is a government health center that provides VCT services. There are 3 counselors trained by GTZ of which two have been trained in PMTCT interventions. Approximately 8 clients are tested each day. All VCT services as well as PMTCT interventions are free. Counselors also provide HBC services but recognize that lack of transport is a common problem. Blood samples are sent to Mbeya Consultant Hospital for ELISA testing.

VCT services began at Ruanda Health Center in September 2000. Since then, 269 people have been counseled and tested of which 68 (25%) were HIV positive. Of the 269 clients undergoing VCT, 185 were pregnant women (69%) of which 41 pregnant women (22%) were found to be HIV positive. HIV positive pregnant women receive AZT at Ruanda Health Center for PMTCT.

### ***Kiwanjampaka Health Center***

Kiwanjampaka is a government health center located in Mbeya town center. Kiwanjampaka has two counselors who have been trained by GTZ. There is no charge for VCT services at Kiwanjampaka. Blood samples are sent to Mbeya Consultant Hospital for ELISA testing.

Since January 2001, 98 patients have been tested for HIV (29 males and 71 females) of which 47 clients were found to be HIV positive (48%). Of the 47 clients who were HIV positive, 36 were female (77%) and 11 male (23%). Over half of the clients (53 of 98) requested testing voluntarily while the remainder were referred by a doctor.

Since September 2001, Kiwanjampaka has been targeting pregnant women with VCT messages. Eight pregnant women have been counseled, 6 have been tested, 2 refused and 1 tested positive for HIV. Pregnant women who test positive for HIV are referred to Meta Hospital or Ruanda Health Center for PMTCT interventions.

### ***Igawilo Health Center***

Igawilo is a government health center located approximately 30 kilometers from Mbeya town at the border of the Mbeya Municipality and Mbeya rural district. Formal VCT services began at Igawilo Health Center in February 2001. Igawilo has 2 counselors who have been trained by GTZ. VCT services are provided free for all clients. Blood samples are sent to Mbeya Consultant Hospital for ELISA testing.

The health center provides health education and recommends VCT to clients and especially pregnant women. Igawilo counselors plan to initiate HBC services for HIV positive patients but have not yet done so due to a lack of transport.

Since February, they have tested a total of 134 non-pregnant clients of which 46 were positive for HIV (34%). In addition, 167 pregnant women have been tested of which 34 were positive for HIV (20%). Pregnant women who test positive for HIV are referred to Meta Hospital (Mbeya Consultant Hospital) or Ruanda Health Center for participation in the PMTCT program. The counselors noted that although HIV positive pregnant women were interested in the PMTCT program they were discouraged from participating due to the travel distance to Meta or Ruanda and the concern with confidentiality. Many pregnant women have requested that PMTCT services be available to them at Igawilo Health Center.

### ***Uhai Baptist Health Center***

Uhai Baptist Health Center is run by the Baptist Church and is located in the Ruanda Ward of Mbeya Municipality. It provides general health care services as well as VCT services. Seven members of the health staff provide VCT in addition to their normal duties although none have been specifically trained on counseling skills. During 2000, 63 clients were tested for HIV of which 51 were HIV positive (81%). Clients include those seeking VCT (i.e. before marriage) and those sick and suspected to be HIV positive. VCT is performed at the health center using Capillus™ rapid tests and costs 1000 TZS/test (\$1.11) for

all clients except those sick in the hospital. VCT is provided free of charge to hospitalized patients.

### ***Aga Khan Health Center***

Aga Khan is a private health center located in Mbeya town. VCT services are provided by three counselors of which only two have received training in counseling. The health center uses Capillus™ rapid tests. Tests cost 3000 TZS/test (\$3.34). In 2001, 166 people received counseling and were tested. 88 (53%) of these were HIV positive (65% female and 35% male).

### ***Kihumbe***

Kihumbe is a local NGO providing HBC and other services to people affected by HIV. VCT services began slowly in 1991. Kihumbe has three counselors who have been trained by GTZ and 30 volunteer counselors who work in the communities. VCT services are free for suspected HIV patients or partners of HIV positive people. Other people seeking VCT services (i.e. testing before marriage) pay 1000 TZS (\$1.11). Blood samples are sent to Mbeya Consultant Hospital for ELISA testing.

For the first 6 months of 2001 only, a total of 447 clients were counseled and 231 clients agreed to be tested. Of those clients tested, 92 clients (40%) were found to be HIV positive.

Kihumbe provides some drugs through their HBC program to patients with HIV with the support of GTZ. The current drug supply is estimated to last through December 2001 but it is unknown where funding for the next drug supply will come from.

### ***SHDEPHA+***

SHDEPHA+ is a national NGO for people living with HIV/AIDS. The name SHDEPHA+ is an acronym for Service, Health and Development for People Living with HIV/AIDS. The organization has 21 branches in Tanzania with the headquarters in Dar es Salaam. The Mbeya Branch was established in 2000 and currently has 29 members. In addition to the Mbeya Branch there are also newly created branches in Rungwe District with 26 members and Mbozi District with 16 members making a total of 66 members in the region.

According to the rules and regulations of the organization, members must be HIV positive and pay annual membership fees of 1000 TZS (\$1.11). Fees are used to support SHDEPHA+'s activities. SHDEPHA+ is involved in community mobilization and sensitization to HIV in the Mbeya Municipality and Rungwe District. SHDEPHA+ plans to expand these activities to the districts of Chunya and Mbozi next year.

SHDEPHA+'s main activity is to provide HBC and continuous supportive counseling to people with HIV. SHDEPHA+ teaches families and caregivers

about adequate treatment, nutrition and care for people with HIV/AIDS. Unfortunately the provision of HBC is currently limited and the demand is greater than the service provision due to a lack of financial resources. SHDEPHA+ also provide pretest counseling and refer clients to Mbeya Consultant Hospital for HIV testing.