The Tanzania AIDS Project: Building Capacity, Saving Lives

The AIDS CAP Response 1993-1997
The Tanzania AIDS Project: Building Capacity, Saving Lives

December 1997

The AIDS Control and Prevention (AIDSCAP) Project was funded by the United States Agency for International Development (USAID) and implemented by Family Health International.
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acronyms</td>
<td>v</td>
</tr>
<tr>
<td>Introduction: A New Model for Prevention and Care</td>
<td>1</td>
</tr>
<tr>
<td>1. The Cluster Strategy</td>
<td>5</td>
</tr>
<tr>
<td>2. Behavior Change Communication: Getting the Message Across</td>
<td>15</td>
</tr>
<tr>
<td>3. Selling Protection: Condom Social Marketing</td>
<td>25</td>
</tr>
<tr>
<td>4. Preventing and Treating Sexually Transmitted Infections</td>
<td>31</td>
</tr>
<tr>
<td>5. Care, Support and Counseling Initiatives</td>
<td>35</td>
</tr>
</tbody>
</table>
# Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDSCAP</td>
<td>AIDS Control and Prevention Project</td>
<td></td>
</tr>
<tr>
<td>AMREF</td>
<td>African Medical and Research Foundation</td>
<td></td>
</tr>
<tr>
<td>BCC</td>
<td>Behavior change communication</td>
<td></td>
</tr>
<tr>
<td>CCBRT</td>
<td>Comprehensive Community-Based Rehabilitation in Tanzania</td>
<td></td>
</tr>
<tr>
<td>FHI</td>
<td>Family Health International</td>
<td></td>
</tr>
<tr>
<td>KIWAKKUKI</td>
<td>Kilimanjaro Women Against AIDS</td>
<td></td>
</tr>
<tr>
<td>MKUKI</td>
<td>Kilimanjaro Project Against AIDS</td>
<td></td>
</tr>
<tr>
<td>NGO</td>
<td>Nongovernmental organization</td>
<td></td>
</tr>
<tr>
<td>OTTU</td>
<td>Organization of Tanzanian Trade Unions</td>
<td></td>
</tr>
<tr>
<td>PASADA</td>
<td>Pastoral Activities and Services for AIDS, Dar es Salaam Archdiocese</td>
<td></td>
</tr>
<tr>
<td>PSI</td>
<td>Population Services International</td>
<td></td>
</tr>
<tr>
<td>PVO</td>
<td>Private voluntary organization</td>
<td></td>
</tr>
<tr>
<td>SHDEPHA+</td>
<td>Service, Health and Development for People Living with HIV/AIDS</td>
<td></td>
</tr>
<tr>
<td>SMU</td>
<td>Social Marketing Unit</td>
<td></td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
<td></td>
</tr>
<tr>
<td>TACOSODE</td>
<td>Tanzania Council for Social Development</td>
<td></td>
</tr>
<tr>
<td>TAP</td>
<td>Tanzania AIDS Project</td>
<td></td>
</tr>
<tr>
<td>TAWG</td>
<td>Tanga AIDS Working Group</td>
<td></td>
</tr>
<tr>
<td>TBA</td>
<td>Traditional birth attendant</td>
<td></td>
</tr>
<tr>
<td>TH</td>
<td>Traditional healer</td>
<td></td>
</tr>
<tr>
<td>UMATI</td>
<td>Family Planning Association of Tanzania</td>
<td></td>
</tr>
<tr>
<td>USAID</td>
<td>U.S. Agency for International Development</td>
<td></td>
</tr>
</tbody>
</table>
he East African nation of Tanzania would appear to have many strikes against it in the battle against HIV/AIDS. With its western provinces located within the historical African epicenter of the epidemic, Tanzania has struggled since the mid-1980s with some of the highest HIV infection rates in the world, and AIDS is now the leading cause of death among Tanzanian adults. Data on HIV seroprevalence among pregnant women attending antenatal clinics—a globally accepted measure of how far HIV infection has spread through the general population—show national averages of more than 13 percent, with rates higher than 30 percent in one district. At clinics in high-risk areas such as towns on transportation routes, that figure can rise to 50 percent or more. The country’s National AIDS Control Program predicts that up to 2.4 million Tanzanians will be infected by the year 2000.

Other HIV/AIDS-related health projections for Tanzania are equally discouraging. By the year 2010, given current national trends in HIV infection rates, life expectancy for Tanzanians will drop from 65.2 years to 36.5 years. Child mortality rates for 2010—primarily due to mother-child transmission—will rise from 95.8 to 166.1 per thousand. The number of children orphaned by AIDS could exceed 850,000 by 2000, an enormous economic burden on the country’s health and welfare systems and a terrible psychosocial blow to the generation upon whom the country’s future rests.

Greatly exacerbating the crisis is the fact that Tanzania is also one of the most poverty-stricken countries in the world. With a per capita income of only $90 per year—and many other health and development demands on its national budget—Tanzania has few resources to devote to curbing the epidemic. Able to spend only about $4 per capita annually on public health expenditures, the government health system lacks the funds to cover the most basic of health care needs for its population, much less treat most cases of opportunistic infections caused by HIV. The expensive new protease inhibitors and other antiretroviral medications that have had such an impact on the course of the disease in wealthier countries are unaffordable for a country such as Tanzania, where the costs of offering them to all those suffering from AIDS would exceed 50 percent of the entire gross national product.

The point is often made that HIV/AIDS is as much a development crisis for impoverished countries as it is a health problem. The gradual and modest gains that Tanzania has achieved over the last few decades in economic and social development are indeed threatened by the demands the epidemic makes on the
country’s limited resources. The high costs of treatment, the diversion of funds from other pressing health and social needs, and the strain of providing care for hundreds of thousands of orphans and support to bereaved, impoverished families are only part of the picture. Perhaps the biggest sacrifice the country makes to the epidemic is the loss of its farmers, factory workers, teachers, parents, small businesspeople, community leaders—citizens from all walks of life in their most productive years, who drive the economy, grow the nation’s food and raise the next generation. The toll is high, and the effects are immediate. The death of some 8,000 farm workers per year due to AIDS, for example, has had a serious impact on a nation that is deeply dependent on internal agricultural production.

Yet it is also this threatened human capital from which HIV/AIDS prevention and care efforts draw strength. For decades, Tanzanians have lived within a political culture that stresses cooperative action in solving their nation’s problems. One result has been the growth of strong, committed nongovernmental service and advocacy organizations that seek to improve their communities and further public interests in health, social welfare, and policy reform.

Within this setting has flourished an innovative approach to HIV/AIDS prevention and care called the “cluster” strategy. Developed by the Tanzania AIDS Project (TAP), which is funded by the U.S. Agency for International Development and was managed by the AIDS Control and Prevention (AIDSCAP) Project from 1993 to 1997, the cluster concept maximizes the effectiveness of indigenous service organizations that once worked separately to curb the epidemic—NGOs, PVOs, medical and public health institutions, government agencies, religious and political organizations—by bringing them together to work in regional
“clusters.” (TAP continues through 1998 under a cooperative agreement between USAID/Tanzania and Family Health International.)

This collaborative approach guarantees sharing of scarce regional resources, eliminates competition for funds and duplication of efforts, and encourages a rich cross-fertilization of ideas. Such strengthening of regional prevention and care NGOs has led to the effective decentralization of HIV/AIDS programming, as TAP put planning and decision making into local hands, creating solutions that are deeply rooted in each community and much more responsive to local and regional needs.

TAP’s nine regional clusters—made up of more than 180 community-based organizations—have since the project’s beginning in 1993 maintained a comprehensive program of integrated prevention strategies, including behavior change communication, condom social marketing, prevention of sexually transmitted infections, policy advocacy, and workplace programs, with special efforts to reach youth and other population sectors at risk. Each of the clusters is also involved in providing basic care, counseling and support for those already infected, for local families impoverished by the death of a breadwinner to AIDS and for some of the many thousands of Tanzanian children orphaned by the epidemic.

The Tanzanian cluster system—the only such national endeavor of its kind in the world—has the potential to serve as a global model for bringing about significant behavior change and for building capacity and sustainability in resource-poor settings. This report takes a look at this national success story in prevention, an encouraging and refreshing challenge to traditional perspectives on HIV/AIDS prevention programming.
The Cluster Strategy

Around a large table in a storefront—an AIDS information center—in the bustling Kariakoo market area of Dar es Salaam, an animated discussion is taking place among a dozen people involved in the Tanzania AIDS Project (TAP). The subject is the upcoming International AIDS Candlelight Memorial, an annual event held each spring to commemorate those who have died of AIDS, support those who are HIV-positive and raise awareness around the world of the need for united action.

This global event provides an opportunity for HIV/AIDS organizations to promote prevention in their communities, and the meeting participants—each representing an NGO, government or city agency, or other organization working in the capital—have many ideas on how best to get the message out. Should there be a rally or a march? Which important public figures should be recruited to speak? Who will organize the banners, and what should they say? The exchange sometimes gets heated, but eventually an action plan, including tasks for each participant to fulfill, comes together.

What is unusual about their discussion is that it is not simply a once-a-year meeting to organize a single special event. Such gatherings of NGO representatives occur regularly in Dar es Salaam and in eight other regions of the country to plan and organize all major aspects of TAP’s HIV/AIDS prevention activities in each area. This kind of cooperation, in fact, exemplifies a core strategy for TAP: coordinated decision making and action among a broad variety of NGOs and other local and regional entities that have united against the epidemic.

THE CLUSTER CONCEPT

The idea of bringing NGOs together into regional “clusters” first emerged as an effective and cost-saving means for TAP to deliver training and technical assistance to NGO staff from several organizations at once. The non-financial advantages of joint training soon became evident, as NGOs brought together in workshops experienced the immediate benefits of cross-fertilization of ideas, networking and learning from each other’s programmatic strengths.

Soon the concept of working together as groups of NGOs rather than individually evolved into a far broader strategy for TAP that provided an opportunity for organizations that once operated in isolation from each other, duplicating local efforts and competing for limited donor funds, to create a united front with a far more powerful impact on the epidemic in their communities.

TAP’s cluster strategy was also developed as a response to the Tanzanian National AIDS Control Pro-
program's second Medium-Term Plan (1992-96), which called for decentralization and capacity building to strengthen HIV/AIDS programming at the local and regional levels. The plan represented the Ministry of Health's recognition of the need to deepen the impact of HIV/AIDS programming at the community level by tapping grassroots resources and networks and empowering them to act.

But what has evolved during TAP's five years of existence is far greater than enhanced networking. The successes of programming through clusters point to a new global model for community mobilization that harnesses a powerful national response driven not by a single national vision of HIV/AIDS prevention but rather by the specific needs of each community—a bottom-up rather than top-down form of implementation.

The building blocks of this new model are the NGOs themselves. When TAP first began in 1993, its staff conducted a national institutional needs assessment to determine who in the country was conducting HIV/AIDS prevention and care programs. What they found was a wide range of NGOs—religious, political, community-based, occupational, youth-oriented, tiny village-based groups and larger urban organizations—with strong and longstanding ties to their communities and constituencies.

A MIX OF TALENTS

This diversity is part of the strength of the clusters. Each NGO brings its experiences and strengths to the
mix, be they medical or counseling skills, management and accounting ability, extensive experience in reaching a specific audience or strong relationships with local leaders, and every other NGO involved in the cluster benefits as a result—as does TAP.

"TAP really walks on ground already paved with the experiences and community connections of these NGOs," said Dr. Justin Nguma, FHI’s resident advisor for TAP. "The activities they had already begun and the community linkages they’ve built represented a real head start for the national program."

What also strengthens each cluster is the participation of important local gatekeepers and organizations with national or regional stature: the district and regional AIDS control coordinators from the Ministry of Health, local branches of powerful national organizations such as labor unions and trade associations, professional groups such as the Family Planning Association of Tanzania and the Tanzania Home Economics Association, and church leaders. The cluster formations thus represent a rare opportunity to knit together Tanzania’s breadth of human resources in HIV/AIDS prevention, giving smaller organizations access to more powerful ones while exposing larger NGOs to the community-based perspectives and concerns of the smaller ones. Given the devastation that the epidemic has already brought to Tanzania and the threat it continues to pose, the process of uniting the nation’s diverse forces in HIV/AIDS prevention into cohesive teams has been critically important.
Much of the Kilimanjaro region is as beautiful as the majestic mountain that dominates its landscape. Although only a few degrees from the equator the high-altitude area often enjoys relatively cool weather and, for much of the year, abundant rainfall and lush vegetation. Green gardens and bountiful plantations cover much of the rural terrain.

Yet despite its beauty, the region struggles with HIV/AIDS. Seroprevalence rates in Kilimanjaro are the fifth highest of the nation's 20 regions. At the Kenyan border only a few miles to the north, trucks cross the frontier along a well-traveled highway, and high rates of STI and HIV infection plague some of the towns en route. The limited number of local jobs forces many men to leave their families behind to seek work or pursue entrepreneurial opportunities in other parts of the country—and when they return to visit, they sometimes bring HIV back with them. Workers in the region's plantations and mines, also separated from home and family may find it difficult to resist high-risk behaviors in the settlements where they live. Such conditions contribute to the high rates of HIV infection in Kilimanjaro's rural Hai district, where AIDS is responsible for 29 percent of all adult deaths. And the city of Moshi—the fourth largest in the nation—suffers from many of the same urban ills that raise vulnerability to HIV in cities around the world.

Within this context operates TAP's dynamic Kilimanjaro cluster. The cluster—which decentralized in 1996 into the Moshi and Hai districts—is involved in a broad range of prevention and care activities across the region. Its 37 member organizations are extremely diverse, an indication that TAP and the cluster have done a good job of recruiting the most important elements of community leadership in Kilimanjaro. The cluster's lead NGO, Women Against AIDS in Kilimanjaro (KIWAKKUKI), is one of several women-led organizations in the cluster, helping to ensure gender sensitivity in programming. Local chapters of prominent national organizations, such as the Red Cross, the Family Planning Association of Tanzania (UMATI) and the Tanzania Home Economics Association, also play a big role in the cluster. Several regional branches of national unions—among them the Tanzania Plantation and Agricultural Workers Union, the Union of Government and Health Employees and the Teachers Trade Union—are members, as are such key employers as the Tanganyika Planting Company. The religious community is well represented by the Moshi Diocese of the Roman Catholic Church, the Lutheran Church, the Anglican Church and BAKWATA, the Muslim Association. Such representation is extremely important in a region where religious institutions are powerful members of society and important arbiters of community norms.

Together, these community leaders, with TAP support, have created a comprehensive regional prevention and care project that has wide impact throughout the region. Among its most important activities are peer education and behavioral change communication activities, prevention and treatment of STIs and an extensive care, counseling and orphan support program.

**REACHING INTO THE COMMUNITY**

During the day, Moshi's AIDS Information Center, which also serves as the Kilimanjaro cluster's office, is seldom empty. Located on a busy

"Tanzania was lucky to be the guinea pig of the cluster system experiment," said Dr. Nguma. "We now have a model for all developing nations that have the human energy but need focus in the fight against AIDS."

All nine clusters are involved in the same program areas, including behavior change communication, prevention and treatment of sexually transmitted infections, condom social marketing, policy advocacy and care, and support and counseling for those already infected and their families. Each cluster, though, tends to develop and become known for certain projects, based on member strengths and local needs.

Clusters also share a basic operational structure. Each has a steering committee, elected by participating NGOs, that meets at least monthly and is responsible for planning and monitoring the cluster's activities. Early on, each steering committee chooses a "lead" NGO with the management skills and financial capacity to oversee contractual obligations and coordinate funding with TAP. Steering committees also help hire full-time staff—a project manager, an accountant and sometimes other support staff—to manage day-to-day operations. All clusters operate at least one local HIV/AIDS information center where the public can come for information and counseling and where cluster activities and meetings can take place.

**BUILDING CAPACITY**

Capacity building was a primary goal of all AIDSCAP programs around the world, and the innovations of the
commercial street in the city's downtown, its front door is always open, and passersby—workers, shoppers, street vendors, unemployed and out-of-school youth, even schoolchildren—don't hesitate to come inside, curious about the activity within. Often a video drama on HIV/AIDS prevention is showing, and the room is hushed as the audience concentrates on the dialogue. Afterward, a center staffer—a member of one of the cluster's NGOs—starts a discussion about the issues raised during the showing and how to reduce risk-taking behaviors to protect oneself from HIV/AIDS.

At other times, classes and counseling sessions are scheduled. Training in peer education—a fundamental prevention activity for Kilimanjaro and all the other clusters—occurs regularly. Crafts production and other income-generation activities for HIV-positive people who have joined the cluster's new "body positive" group, Kikundi na Matumaini, take place in a back workroom. Sometimes, when the activity slows a bit, a staffer simply walks out into the street for a minute, soon to return with a ragged, barefoot street child by the hand, for some one-on-one counseling.

In fact, reaching young people of all kinds is one of the Kilimanjaro cluster's programmatic strengths, and its successes have inspired other clusters to expand their own youth interventions. The cluster has even been able to penetrate the region's schools with youthful peer educators, who are trained to engage their cohorts in various behavior change communication activities about a wide range of issues relating to HIV/AIDS, sexually transmitted infections, sexuality and relationships, all in a language designed to reach a young audience.

Initially, though, bringing sex education into the schools wasn't an easy sell. The cluster's lead NGO, KIWAKKILI, encountered resistance from the school district when it first began to develop a sexual health education manual for science teachers. Now, however, school officials have been convinced by the cluster leadership and by prominent political leaders in the region—sensitized by the cluster's workshops for policy makers—of the importance of youth education efforts. They are distributing the manual and signing up their teachers for training in how to conduct sexual health classes with sensitivity and tact.

The cluster also established a wide-reaching peer education program for behavior change among out-of-school youth in every district of the region. Young people are recruited from organizations such as football clubs and church groups to attend training-of-trainers sessions in HIV prevention, STI health-seeking behavior, condom use, delaying sexual debut and other issues. The training—which is used to train other youth and thereby multiply the effects throughout the region—helps out-of-school girls learn how to handle sexually coercive situations, how to avoid pressure from older men to exchange sex for money, and what the dangers of female circumcision are.

Adults in Kilimanjaro are also the beneficiaries of the cluster's peer education efforts. During the AIDSCAP project, more than 60,000 adults received prevention education for HIV/AIDS and STIs from more than 350 family planning counselors trained by UMATT, a prominent cluster member. Adult drama groups were recruited and trained to reach sexually active adults in bars and in other places where they seek entertainment. And new cluster education initiatives will include women who work in the commercial sector.

TAP model presents new potential in this regard. By strengthening community-based organizations, government agencies and other entities through training, technical assistance, coordination and support, TAP helps build a permanent, multiskilled and confident team able to design and carry out cutting-edge interventions against the epidemic far into the future. TAP's cluster structure—built upon grassroots participation and coordinated action—promises a high probability of program success that can be sustained.

The relationship of TAP's central office to its clusters also reflects the importance of capacity building. TAP does not direct operations from Dar es Salaam, nor does it set goals or design projects for the clusters to carry out. Once the cluster structure was created, TAP's job evolved into coordination and program support for the clusters. The clusters themselves formulate their response to community needs, and TAP's role is to provide the training and technical support needed to achieve cluster goals. Over time, this division of responsibilities has led to successful decentralization of the project and a strong feeling of local "ownership" on the part of cluster members. Decentralization is also an effective way to deal with the logistical problems that a nation like Tanzania presents.

"To some extent, the decentralization aspect of the cluster concept is a way of dealing with the geographical monster that is Tanzania, where communication is difficult and roads are sometimes impassable," said Dr. Nguma. "The clusters are the machinery that
can run the show in the regions, while the TAP office in Dar provides the technical support to help them do that work."

This kind of structure is a new experience for NGOs in Tanzania. Independent NGOs often carry out interventions in isolation, while other community-based organizations receive direction from the government, the churches or some other controlling entity. The cluster model is thus helping to redefine what NGOs are and what they do throughout Tanzanian society.

"The TAP experience has helped bring Tanzanian NGOs into the limelight," Dr. Nguma said. "Because the cluster system has been so successful in increasing the effectiveness of NGOs doing HIV/AIDS work, the government now takes NGOs much more seriously and sees them as an independent force to deploy in the battle against AIDS."

The great challenge is now the question of sustainability. Can the program continue even after USAID support ends in 1998? The training and technical assistance that TAP has provided to NGOs have built impressive technical and management capacity, and the cluster structure has strengthened NGO confidence and working relationships in each region while increasing effectiveness and efficiency. But funding is essential, too, and TAP is beginning to explore new mechanisms the clusters can use to generate income. Perhaps the most promising possibilities lie with the workplace programs directed by the African Medical and Research Foundation (AMREF) and supported by TAP: the companies where the programs are based are so convinced of their value that they now pay half the costs. Other income-generating ideas will undoubtedly take longer to develop in a nation with such grinding poverty.

**COMPREHENSIVE TRAINING**

Building skills is fundamental to building capacity, and training is one of the most important functions that TAP fulfills for the clusters and other organizations involved in TAP programming. For all of TAP's management and technical emphases—from financial accounting to peer education to STI treatment—training activities strengthen the ability of the clusters and their component NGOs to design and perform key prevention and care activities, with goals and expectations clearly defined.

To set the administrative groundwork for sound cluster and project management from the start, several different workshops provided management skills. As clusters were formed, their project managers, steering committee members, coordinating NGO leaders and accountants participated in leadership workshops; cluster accountants also enrolled in project accounting workshops. Management skills building workshops were offered as needed to various clusters. Proposal writing workshops helped cluster and NGO leaders develop proposals for funding. These critical management and fund-raising skills ultimately benefit not only the clusters but individual NGOs, as their leaders apply what they've learned to strengthen the management and financial structures of their own organizations.
Already overcrowded Tanzanian hospitals find it hard to cope with an increased patient load due to AIDS.
To multiply the benefits of training in program-based skills, TAP uses a training-of-trainers methodology for many of its workshops. This means that participants learn not only how to perform prevention and care tasks and assess their effectiveness but also how to train others in those skills. In developing countries, the training-of-trainers approach is an important way to build sustainability into program efforts, as those who learn train others, creating an invaluable pool of human resources for the nation’s future.

The basic programmatic skills strengthened by TAP’s training-of-trainers workshops include:

- Community-based behavior change communication (BCC), focusing on appropriate and creative means of conveying prevention messages to reach specific community audiences.

- Peer education involving a wide variety of cluster and non-cluster participants—young people, village-based health workers and traditional healers, workplace representatives and more—to ensure broad community coverage in educating a diverse public about the dangers of HIV/AIDS.

- Home-based care and counseling for those living with HIV/AIDS and support to their families.

- Cost-recovery strategies for clusters, including such topics as marketing, accounting, production, sales and fund raising.

- Gender issues and HIV/AIDS, designed to raise participants’ awareness of the different ways in which the epidemic affects men and women and of the need for gender sensitivity in programming.

**A WIDE-RANGING DIVERSITY**

TAP’s nine clusters—in Arusha, Kilimanjaro, Iringa, Dodoma, Shinyanga, Dar es Salaam, Tanga, Morogoro and Tabora—are all located in regions with populations of a million or more. HIV/AIDS has had varying impact on each of the regions—Dar es Salaam ranks fourth among the nation’s 20 regions for cumulative AIDS cases, while Dodoma ranks 20th—but each region is threatened with the potential of the epidemic’s growth, particularly into new populations and among young people reaching the age of sexual experimentation.

**A Tireless Activist, A Pioneering Organization**

Walking through the city of Moshi with Margaret Mshana is like taking a stroll with an incumbent mayor during an election campaign. Everyone knows her. Every other person stops to confer with her. There doesn’t seem to be a community issue or activity in Moshi that she’s not involved in.

Mshana’s popularity is hardly surprising. The 65-year-old grandmother has been a community activist in Moshi for decades. Five feet tall with a shock of grey hair, she’s a tiny but very visible—and vocal—presence at most civic gatherings and conferences and rallies. Involved since youth with the Lutheran Church, which sent her to nursing school in Germany for five years, she’s has long played a leadership role in a wide variety of social welfare and public health campaigns.

For the last several years, though, Mshana has devoted much of her considerable energy to the problem of HIV/AIDS in the Kilimanjaro region. As coordinator of Kilimanjaro Women Against AIDS (KIWAKKUKI), the lead NGO for TAP’s regional cluster, she has a schedule filled with cluster activities, visits to orphans and home care clients, meetings with local leaders and special events.

“It’s a busy life because AIDS never takes a rest,” she said.

Mshana was one of the founders of KIWAKKUKI. Formed in 1989 as a small ad hoc committee of professional women that organized to publicize World AIDS Day, the pioneering group’s educational activities were probably the earliest sustained responses to HIV/AIDS in Moshi. That year, the group also produced the region’s first HIV/AIDS prevention posters and literature in Swahili. Ever since then, KIWAKKUKI has continued to break new ground—and sometimes break-old rules—in HIV/AIDS prevention.

By the time KIWAKKUKI formally incorporated as an NGO in 1991, it had developed an organizational outlook recognizing the connection between women’s risk of HIV infection and their social and economic status in Tanzanian society—at the time, a bold new perspective on HIV/AIDS, especially in Kilimanjaro. Since then, the group has incorporated that gender-sensitive approach into much of its work in community education, especially with young people. The initially controversial sexual health education manual for youth that the group developed for secondary school science teachers (see p. 9, sidebar) includes sections on relations between young men and women, recognizing coercive sexual advances, understanding the dangers of gender stereotyping and improving communication skills.

“When you’re young, you
can still learn how to change your approach to the opposite sex," said Mshana. "And reaching youth early is important—before they become infected."

KIWAKKUKI was also one of the first NGOs in the region to develop counseling and home-based care for local people living with HIV and their families. With training from the Tanzanian-Norwegian AIDS Project (MUTAN), the group identified affected families and individuals and provided much-needed social, psychological and health care support that had not been available before. Members also set up the area’s first self-support group for HIV-positive people. For the many AIDS orphans in the community, KIWAKKUKI initiated some of the earliest efforts to create support and vocational training programs.

"When we began, there was such a need in the whole region for support to people with AIDS and to orphans, because the epidemic had already hit us so hard," said Mshana. "Our work in prevention has always been important, but we felt we weren't taking care of community needs unless we also helped those already infected."

It’s the experience of innovative and energetic cluster members such as KIWAKKUKI that have made the Kilimanjaro cluster so dynamic and well-rooted in the region. TAP itself—built upon the groundwork of the many NGOs that make up its nine clusters—continues to benefit from the insight of these grassroots organizations, whose understanding of their communities’ needs helps ensure ongoing program success.

The clusters face many of the same challenges in combating the epidemic within their regions. The poverty that is endemic to much of Tanzanian society raises vulnerability, particularly among women and girls, who are often dependent on men for their survival and cannot demand such safer sex practices as condom use to protect themselves. Out-of-school youth, usually unemployed, can be prone to higher-risk behaviors. Illiteracy and lack of education among some sectors of the population limit the ways in which prevention messages can be effectively disseminated. The generation gap between parent and child—especially when it comes to the once-traditional duty of teaching young people about sexuality—has widened throughout Tanzanian society, and many youth find themselves with nowhere to turn with their questions. And—as is the case in nations around the world—even people who know that HIV infection will kill them are often reluctant to change deeply entrenched sexual behaviors.

But populations and circumstances also vary widely across the country, and clusters—empowered by the structural autonomy of the cluster system—are able to respond to the special conditions and challenges they encounter within their regions. In agriculturally fertile regions, for example, clusters have developed prevention interventions targeting plantation workers, who live far away from their families in cramped company quarters. In regions where mining is an important industry, similar programs exist for those living in mining settlements. Major highways cross some cluster regions, connecting the Dar es Salaam port to distant parts of the country and to Zambia and Kenya. High levels of HIV and STI infection are found in the towns and villages along the routes that serve the truckers, requiring specially targeted behavior change and STI treatment interventions.

Cultural diversity can add greatly to the special challenges facing clusters. In the Arusha region, for example, many members of the Maasai tribe still live deep in the countryside, where they graze their livestock. Isolation and language barriers make it difficult to reach many Maasai with prevention programming, although the threat of HIV to the tribe has increased greatly in recent years. As growing poverty drives more
and more Maasai men from rural areas to work or trade in towns and cities, they become vulnerable to HIV infection. When they return to visit their communities, they may pass the virus to others who—if they’re even aware of the existence of HIV/AIDS—are unlikely to suspect that a fellow Maasai might be infected with an “outsider’s” disease.

The danger is increased by the high level of acceptance among the Maasai of extramarital and premarital sex. Maasai circumcision ceremonies for both young men and women also pose special risks because traditionally the same knife or razor is used to circumcise a whole age cohort at one time, with the possibility of HIV infection passing from one person to the next through tainted blood. The Arusha cluster—which includes two NGOs with predominately Maasai membership, based in Maasai villages—has developed special interventions to approach this difficult-to-reach community and has enlisted key Maasai community leaders in curbing HIV infection among their people. Because for many years the Maasai have experienced pressure from the government, mainstream religion and society at large to change their cultural practices, the Arusha cluster always approaches the community with sensitivity and seeks ways to propose prevention solutions that respect Maasai beliefs and traditions.

Other clusters have developed special initiatives that reflect the circumstances and needs of their communities. In Tanga, for example, the cluster became involved in programs to train traditional healers and traditional birth attendants in HIV/AIDS counseling and to develop linkages between these traditional practitioners and the biomedical community (see page 17). In this region, where many people consult traditional healers when they’re ill and rarely find their way to clinics or hospitals, recruiting these healers to the cause of fighting HIV/AIDS is an important prevention intervention.

Clusters get the opportunity to learn from each other’s strengths and experiences through intercluster meetings and evaluation/study tours coordinated by TAP. The evaluations bring together cluster project managers, steering committee chairs and National AIDS Control Program coordinators from every cluster to examine and evaluate each other’s activities. The gathering critiques the cluster’s organizational operations, its linkages with the community, its relationship to local leaders and to regional government agencies, the effectiveness of its projects and other issues. When the group finishes analyzing these complex questions, each cluster’s team uses these lessons learned to prepare a plan of action to improve their own programming and operations.
Behavior Change Communication: Getting the Message Across

Three boats are afloat in the rising tide. Each bears a different name: Abstinence, Fidelity, Condom. People adrift in the deluge are being urged to board the boat of their choice and save themselves from drowning in the dangerous seas of HIV infection.

In Tanzania, this extended metaphor has become one of the most popular and effective ways to get the message across that individuals have options in how they protect themselves from HIV/AIDS—but that they must act before the waters of the epidemic close over their heads. It was created by a Catholic priest in a rural Tanzanian parish who was concerned that his congregants were caught between religious dictates and condom social marketing, and fearful that the friction might paralyze them rather than prompt them to assess their own risks and avoid infection.

Since its first appearance, the “Fleet of Hope” has been used to reach every sector of the population with the message of HIV/AIDS prevention. It has become the theme for a video, a popular calendar, a radio program, posters, a behavior change communication (BCC) handbook and other materials and has been adapted for similar use in Rwanda, Ethiopia and Haiti. This simple, inclusive concept has also bridged what had been a widening gap between Tanzania’s religious leadership—many of whom do not approve of condoms—and standard prevention programming, which strongly promotes condom use.

“The ‘Fleet of Hope’ has worked miracles,” said Anne Kamande, TAP BCC specialist. “It has allowed community leaders who disagree strongly with each other to find a way to unite in promoting prevention.”

Expressing Community Needs

The success of the “Fleet of Hope” is a solid confirmation of one of the most important observations TAP staff have made about BCC: that messages and materials that are culturally sensitive expressions of real community needs and conflicts are the most effective ways to influence people. TAP thus supports local involvement in BCC activities and materials production by tapping the energies and creativity of the clusters, which have long been involved in their communities at the grassroots level.

A powerful example is the drama groups that all nine clusters train and support. Each group devises plays to meet the information needs of specific local audiences—secondary school students, high-risk populations that frequent bars and nightclubs, unemployed youth, agricultural workers—and arranges to present them in appropriate and convenient settings, or at such well-attended public events as World AIDS Day and
International Women’s Day. Local issues often take the spotlight. In Dodoma, for example, where polygamy is widespread, the cluster’s highly acclaimed theater group created a drama about the risks of the practice. One of the Arusha cluster’s NGOs, DOHOCE, produced prevention dramas in the Maasai language dealing with high-risk practices that prevail among youth in that tribal group.

“These groups present real situations to their audiences,” said Kamande. “Drama is so powerful because people are able to participate emotionally by relating their everyday lives to what they see played out in front of them.”

To support these efforts, TAP holds training-of-trainers workshops that focus on drama and other folk media. The project also sent a drama consultant from Dar es Salaam to work with cluster drama groups on polishing their communication, scriptwriting and acting skills to more effectively get their messages across.

Clusters are also deeply involved in TAP’s production of such BCC materials as posters, brochures and other written and visual materials. Cluster members participate in BCC training-of-trainers activities led by TAP staff and are asked for their input in creating appropriate and relevant messages that will have meaning for the people in their regions. These sessions simultaneously shape TAP’s BCC campaign to better reach its audience as they raise the BCC skill level of cluster members.

**Training for Prevention**

An even more widespread community-based BCC effort involves peer educators, who engage audiences of their peers—fellow workers, young people, commercial sex workers and much more—in education and discussion about the epidemic and how to reduce personal risk of HIV and other STIs. Because they themselves belong to the groups to which they speak, peer educators are able to tailor the contents of their educational sessions and direct discussions to the issues that are most relevant to their audiences. All clusters are deeply involved in training peer educators and in deploying them throughout the community. For example, the Kilimanjaro cluster, which aggressively recruits peer educators to reach a wide variety of audiences within the region, has trained nearly 400 peer educators, who have provided more than 133,000 people with prevention education.

The peer education model works especially well for young people, who are less likely to feel inhibited about expressing their concerns and asking potentially embarrassing questions when the peer educator leading the discussion is about the same age they are. The Tanga cluster’s diverse team of peer educators includes 20 out-
of-school youth and 20 youth from church groups. The Kilimanjaro cluster devotes a great deal of resources to both school-based and non-school-based peer education activities using peer educators selected from school and community groups.

Several clusters have also embarked on recruiting and training traditional healers (THs) and traditional birth attendants (TBAs) in HIV/AIDS and STI education skills. In many parts of the country, these traditional practitioners are widely consulted by the local population and can have an enormous impact on the health of their communities. The training has two goals: first, to encourage safer clinical practices—such as use of gloves during deliveries or when blood is present—to protect both practitioner and client, and second, to make it possible for practitioners to offer sound advice on HIV/STIs to their patients. The Dodoma cluster provides special educational sessions to THs and TBAs in the region, and the Arusha cluster conducts workshops in the Maasai language for traditional practitioners from that tribal community.

In the western part of Arusha, traditional Maasai birth attendants in Monduli—who are also revered female village leaders—have been inspired by their workshop training to take on even broader prevention issues in the community. Maasai youth—young men who have undergone circumcision rites and girls as young as 12 or 13—participate in traditional nighttime dances that often turn into sexual sprees. Rather than offend the rest of the community by acting to ban the practice altogether, these women are now working to educate youth about HIV/AIDS and how to avoid infection, so that the dances can continue but with less high-risk behavior.

“We want to keep the young people healthy, and they will listen to us,” said Mama Mbelc, a 60-year-old Monduli TBA who participated in a TAP workshop. “But tradition is hard to change, so we look for ways to make change acceptable.”

The Tanga cluster’s lead NGO—the Tanga AIDS Working Group—received special funding from TAP for a project that not only trains traditional practitioners in HIV/AIDS prevention and caregiving but also builds supportive partnerships between traditional healers and the biomedical community. Armed with a greater understanding of each other’s healing practices, these two medical traditions—normally at odds—now work together to improve the health of the region, prevent HIV/STIs and provide effective care to those already infected. The THs and TBAs can recognize potential symptoms of HIV and STI infection and refer patients to local clinics, and clinicians have clinically tested several traditional herbal remedies and found them to be beneficial in treating certain AIDS-related symptoms.

**Workplace Initiatives**

Because HIV/AIDS strikes hardest at those between 15 and 49—the sector of the population in its most economically productive years—the epidemic has had a serious impact on the workforce, especially in high-prevalence countries like Tanzania. A 1995 TAP study of Dar es Salaam businesses with more than 100 employees found that 18 percent of those surveyed had
Youth Newspaper Tells It Like It Is on AIDS and STIs

Dear Doctor: Which is more dangerous—having sex without or with a condom? I have heard that a condom can get stuck inside a lady and then she dies.

Dear Doctor: If I have sex with a girl who is not a virgin and she has no bruises, can I get AIDS?

Dear Doctor: Why don't mosquitoes transmit HIV?

The letters that come in from all over Tanzania to the offices of Straight Talk Sema Wazi Wazi, the bilingual youth newspaper published by the Tanzania AIDS Project, could not cover a broader range of topics. From the emotional difficulties of discussing faithfulness with a boyfriend to the mechanics of condom use, from specific STI symptoms to locations of HIV testing sites, Straight Talk staff have learned to expect anything and everything from their thousands of readers.

The deluge of questions is hardly surprising, just as young Tanzanians reach an age when they begin to experience changing emotions and growing sexual feelings, they also become aware that a deadly disease that can be transmitted sexually is killing people in their community. The need to know more is overwhelming—yet there are few places they can turn to for information without feeling shame, embarrassment or even fear.

The tabloid-style Straight Talk, designed specifically for the information and behavior change communication needs of youth, has since 1994 answered these questions with sensitivity and honesty, in approach while adapting the style and contents for a young Tanzanian audience. Articles discuss what happens when one is tested for HIV, lost an average of 23 employees each to AIDS. As these workers sicken and die, the investment that employers made in their training is lost, as is the valuable work experience they’ve accrued over the years. Time taken from work to go to the doctor, to recover from AIDS-related opportunistic infections or to attend family funerals is costly, as are the employees’ medical and funeral expenses and other costs that employers traditionally pay. Individual firms suffer as a result, as does the economy overall. A recent World Bank report predicts that over the next 15 years, the Tanzanian economy could shrink by 14 to 24 percent because of the epidemic’s effect on the workforce and the financial pressure it puts on businesses.

Bringing prevention education directly into the workplace has been the mission of several TAP-supported projects in Tanzania. Two of them—conducted by the Organization of Tanzanian Trade Unions (OTTU) and the Tanzania Council for Social Development (TACOSODE)—focus on worksite peer education of workers. (TAP funding has ended for both projects, which now receive support from other donors.) AMREF has directed two other major workplace projects: one in high-risk transmission areas along trucking routes, and a second at workplaces in different regions of the country.

All three organizations recruit workers to receive peer education training so they can engage their fellow workers in small-group discussions, after video presentations and one-on-one in the office, in the lunchroom or on the shop floor. Drama groups are sometimes invited to perform for workplace audiences. Peer educators also sell Salama condoms to their co-workers. Because these organizations cultivate strong relation-
STI symptoms and the long-term damage that can be done if they're left untreated, how the body changes during puberty, how young women and men can learn to treat each other with more respect and how to talk to parents about sex. There are also profiles of youth peer educators and of popular film stars who have spoken out about HIV/AIDS.

The need couldn't be greater for this kind of resource for young people. A 1994 survey revealed that in Tanzania the average age at first intercourse for both males and females is 17 years. Data from the same survey indicate that 26 percent of girls 15 to 19 have already given birth or are pregnant with their first child; more than half (53 percent) of 19-year-old girls have begun childbearing. According to the National AIDS Control Program, HIV prevalence is increasing rapidly within the 15- to 24-year-old age group.

At the heart of Straight Talk are the speak-out columns and question-and-answer segments to which readers themselves contribute. In addition to the “Dear Doctor” section, there's “Dear Auntie Wazi Wazi,” which answers questions about both relationships and the dangers of HIV/AIDS, a letters-to-the-editor column that prints the photos as well as the comments of young readers; and short articles sent in by youth organizations that concentrate on educating their peers about HIV/AIDS and STIs.

“This is an interactive paper,” said Semkae Kilonzo, Straight Talk's 25-year-old editor. “Because we receive so much feedback from our readers, we know what's on their minds, and what we print really reflects what they're concerned about.”

More than 352 secondary schools in every region of the country receive bundles of Straight Talk for free distribution—and Kilonzo estimates that hundreds of students per school read each issue. The paper is also inserted into regional newspapers around the country, and into a Sunday sports paper, Dimba, that's read by many young men.

A testament to Straight Talk's impact on Tanzania's young people is that it has inspired the creation of Straight Talk clubs in several of the schools where the paper is distributed. One club at the Bungu Secondary School in Mwanza has 35 members. Under the guidance of a popular teacher, the members meet each Friday to discuss HIV/AIDS and relationships. The newly created Chimala Secondary School Straight Talk Club in Mbeya has 12 members, with more expected to join.

“These young people are forming clubs because they consider Straight Talk to be their paper; so we try to give them long-distance support and report positively on what they're doing,” said Kilonzo. “When they're right here in Dar es Salaam, our staff will sometimes send speakers or go meet the students ourselves.”

Population Services International, which directs TAP's condom social marketing unit, takes over publication of Straight Talk in 1998. Because of its popularity, the paper is slated to become a monthly and expand distribution even more broadly.

ships with managers who enthusiastically support efforts to curb infection within their companies, peer educators are able to perform their duties during work hours and to attend planning meetings as needed while they receive their regular pay. Together, OTTU, TACOSODE and AMREF developed and field tested a “Model Worksite Intervention Guide” to help TAP's clusters expand prevention programming into worksites on a regional basis.

During its workplace project, which ended in April 1997, AMREF worked with 18 companies to create comprehensive behavior change interventions on-site, including peer education, video showings and condom social marketing. Because of the success of AMREF's efforts to sensitize top management to the threat the epidemic poses to their workforces, each participating company created a company AIDS committee and committed itself to contributing 50 percent of program costs—important factors in the potential sustainability of these workplace efforts.

A BROADER AUDIENCE
The mass media also provide TAP with important venues for spreading prevention education to a wide audience. While broadcast messages on HIV/AIDS may be less personal and immediate than peer education or drama, consistent use of the airwaves reinforces what viewers and listeners have learned about HIV/AIDS and risk taking and helps build an environment where the message of prevention is pervasive.

But even mass media can be interactive, and TAP media interventions have been especially creative in transforming the public's role from passive listener to engaged participant. For example, TAP collaborates with one of the country's biggest national radio networks, Radio Tanzania, to produce a weekly show that
investigates all aspects of the epidemic and how it affects individuals and their families. “AIDS in the Community” has been enormously successful in personalizing HIV/AIDS by inviting HIV-positive people and their families to tell their own stories on the air about the stigmatization, illness, poverty and fear that grip their lives. Interspersed with prevention information and facts about the epidemic’s effect on Tanzania, these riveting accounts helped the program win a significant base of listeners around the country, who call and write in with questions and comments and request that specific topics be covered in coming weeks.

“Radio has a big role to play in AIDS prevention,” said Edda Sanga, who produces the show for Radio Tanzania. “Because it reaches everywhere, it helps drive a growing national discussion about HIV/AIDS at the same time that it dashes myths and rumors about the epidemic.”

The Dodoma and Morogoro clusters also produce well-received community-based radio shows at local affiliates of national networks. These successes—national and regional—have confirmed the value of radio as popular, affordable and widely accessible, and TAP intends to expand its work in the medium.

Television has been available only since 1994, and, apart from residents of big cities like Dar es Salaam that have local stations, relatively few Tanzanians have TV sets. Filming and purchasing air time for television programs are also quite expensive. For these reasons, TAP has done limited programming for television. Post-test evaluation of several TAP-produced television programs aired early in the project showed that, while the broadcasts were well received, they did not have much lasting impact because—unlike the radio shows—they could not be sustained long enough to build a regular audience.

TAP also moved its media campaign into print. The AIDSWATCH Column, written by TAP’s BCC staff, appears in various local newspapers. It examines issues surrounding HIV/AIDS and STIs and relates the experiences of those who are infected and their families. TAP also publishes two quarterly periodicals targeted to specific audiences. Written for adults, Tuzungumze—“Let’s Talk” in Swahili—takes a close look at issues such as communication with sexual partners and personal risk assessment. And Straight Talk/Sema Wazi Wazi, a bilingual quarterly, is designed to reach young people in a frank and engaging way.

While there is as yet no comprehensive evaluation of the program’s BCC interventions, one study suggests that TAP’s efforts have been effective in influencing sexual behaviors. A 1996 knowledge, attitudes, behavior and practices study conducted by TAP in four of its target regions reveals higher rates of condom use with nonregular partners than among the general population. In the four TAP regions, 38 percent of women reported condom use with their last nonregular partner, as opposed to 17 percent in the general population. For men, the TAP figure was 46 percent, as opposed to 35 percent generally. These higher rates indicate that BCC interventions in regions with TAP programs are influencing more people to protect themselves from HIV/AIDS.

ENGAGING THE DECISION MAKERS
Educating Tanzania’s leaders about the epidemic is another important BCC activity that all TAP clusters undertake. Policy makers—from national legislators and cabinet members to regional governors to village mayors—and other community gatekeepers such as clergy,
traditional healers, and business and labor leaders who are aware of the dangers of HIV/AIDS can ensure that resources are available for prevention efforts. Legislation favorable to prevention and care initiatives is passed and that the issue of HIV/AIDS becomes a national and regional priority. Leaders can also influence public opinion by lending their voices directly to
the cause, speaking out about the epidemic at meetings, at the pulpit or at public events.

To recruit the nation’s decision makers, each cluster sponsors periodic “sensitization” workshops to which they invite local and regional leaders. Cluster members who lead the workshops present basic facts about the virus and explain how the epidemic threatens both the region and the nation. The group then discusses how leaders can act as policy advocates and public spokespeople for prevention. Throughout the clusters, hundreds of leaders have participated in these workshops, many of whom now give invaluable support to cluster activities.

Last spring, for example, the Kilimanjaro cluster held a sensitization workshop in Moshi for about 20 regional leaders. The participants included local labor union presidents, ward and village leaders, a minister from the Seventh Day Adventist church and Moshi Mayor Dennis Chuwa. After an animated discussion, several of these leaders became involved in cluster preparations for the upcoming International AIDS Candlelight Memorial celebrations.

“I learned many things I hadn’t known about the dangers of AIDS to my constituency,” said Mayor Chuwa. “Leaders must take responsibility for helping their communities fight this epidemic.”

Of all the clusters, perhaps Iringa has devoted the most effort to educating and developing working relationships with regional leaders. The cluster has systematically invited hundreds of leaders from the regional, district, ward and village levels throughout Iringa to sensitization seminars. To maintain these contacts and encourage ongoing participation, the cluster schedules quarterly meetings to update leaders about HIV/AIDS developments and cluster activities.

Close collaboration between the cluster and the regional power structure has been the outcome. These leaders have made office space available for information
and counseling centers, contributed funds to training and special events organized by the cluster, helped find markets for orphan income-generation efforts and loaned vehicles to the cluster so it can carry out its far-flung regional activities. Peer educators and drama group participants who work for ward and village leaders are regularly excused to carry out their prevention duties. And HIV/AIDS is now a permanent agenda item for meetings of village and ward development committees, which have made such decisions as limiting local alcohol consumption hours to cut down on high-risk behaviors.

“We’ve had a lot of success because these leaders are so involved they now see this as their own project,” said Lediana Mafuru, an Iringa cluster activist who leads sensitization workshops. “Developing their leadership in HIV/AIDS means program sustainability.”

In a country such as Tanzania, religious leaders are often as influential as political ones. All clusters include religious organizations and attempt to engage the support of the local religious leadership. Inspired by their involvement in various cluster activities, the diverse religious community in Dodoma created its own ecumenical coalition to promote a united front against the epidemic, and—contrary to earlier positions by individual members—came out in support of condom promotion.

On a national level, TAP is also involved in raising awareness about HIV/AIDS among legislators and other prominent leaders. When the national parliament convened for the 1997 session, TAP and the National AIDS Control Program conducted a full-day sensitization workshop for the delegates. The issues discussed included the impact of the epidemic on the national health care system, social welfare and the economy. Throughout the presentations, TAP stressed the important role that these legislators can play in developing policy, backing national and regional prevention and care initiatives, and supporting the human rights of those living with HIV/AIDS.
CHAPTER 3

Selling Protection: Condom Social Marketing

Post offices throughout Tanzania are selling a controversial new set of four stamps whose purpose is to promote HIV/AIDS prevention. One focuses on the growing population of AIDS orphans that the epidemic has created, while another encourages national solidarity in the response to the epidemic. A third points out that everyone is vulnerable in its message, "AIDS has no barrier."

But it's the fourth stamp that has captured the most notice. It pictures a Salama condom—the brand promoted by TAP—and carries the message, "Condoms prevent transmission of HIV." Although some conservative and religious groups have objected to the stamps, the Post Office and the National AIDS Control Program, whose support TAP recruited as the stamps were developed, have stood firmly behind the campaign.

Bold and creative initiatives such as this are a hallmark of TAP's Social Marketing Unit (SMU), which is directed by an AIDSCAP partner, the U.S.-based, non-profit Population Services International (PSI). PSI is a global leader in social marketing, which uses commercial marketing techniques to promote and expand interest in and use of socially beneficial products such as condoms. Through advertising, public service notices, product launches, use of media outlets, special events promotion and expansion of distribution networks—all standard product marketing methods used in the business world—social marketing has raised public awareness about using condoms to prevent HIV infection and greatly increased the numbers of condoms sold in developing countries throughout the world. In many places, social marketing's promotional efforts have turned around negative public attitudes about condoms, enhancing their desirability not only for health and contraceptive reasons but as symbols of sophistication or a sign of emotional commitment to a partner.

MAKING CONDOMS DESIRABLE—AND AFFORDABLE

The point of marketing products is to increase sales, and the concept is no different for social marketing of condoms. While hundreds of millions of condoms have been distributed free of charge throughout the developing world since the HIV/AIDS epidemic began, social marketing is built upon the concept of promoting the value—and thus increasing the use—of products such as condoms by charging a price for them. Customers are making an investment in their health when they buy condoms and are much more likely to use a product that they've paid for.

In countries as impoverished as Tanzania, though, a key strategy is to set condom prices that even low-income people can afford to pay. Salama condoms cost only $.03 apiece, about a fifth the price of the next low-
est socially marketed brand and a tiny fraction of the cost of some imported commercial condoms with price tags of $1.00 to $3.00 each. This level of pricing, which is possible because all of the condoms are given to the project by international donors, allows most adults convinced through promotion of the value of condom use to purchase them consistently.

And many Tanzanians have indeed been convinced. From December 1993 to the end of its original contract in June 1997, TAP’s SMU has overseen sales of 30 million condoms—far exceeding the original project goal of 6 million. Salama now claims more than 90 percent of the country’s market share. Health surveys also reveal that, since the start-up of Salama sales, a significant percentage of Tanzanian adults have come to understand the importance of condom use in HIV prevention and have heard of the Salama brand name, evidence of the impact of Salama advertising and promotional activities.
MAKING THE PITCH

In fact, it is the advertising and promotional aspects of social marketing that can have the broadest impact on how society responds to the epidemic, since the prevention messages they convey reach everyone, not just those prepared to buy condoms. Pitching a brand name is only part of the process; convincing the public that HIV/AIDS threatens their lives and that they must act to protect themselves is what drives promotional efforts. TAP's SMU thus invests considerable time and effort in planning promotional activities because of their importance as behavior change communication tools.

One particularly valuable promotion strategy has been the use of mobile video vans in each of four vast regional sales zones. These 3.5-ton vans—built to negotiate rutted rural roads—contain complete mobile video units. In coordination with local health officials who organize and announce the vans' arrival, sales teams set up a huge screen in a soccer field or town square to present videos on behavior change and condom use. After each video showing they lead audience discussions, distribute promotional materials and tell viewers where they can buy condoms in their communities. In a nation where only a tiny minority of the population have television sets and entertainment opportunities are few, the vans often attract audiences in the thousands. In 1994, more than 2 million people attended 457 video showings throughout the country.

Another major promotional success was the popular “Je?” poster and newspaper advertisement series—Tanzania's first advertising campaign dealing with HIV/AIDS—which ran throughout the entire second year of the project. Designed for the general population, the ads and posters portrayed a single hapless character in comic but dangerous situations: putting his head in a crocodile's jaws, teasing a lion, dancing in front of a commuter bus with no brakes, sleeping on railway tracks. The messages throughout the campaign compared such activities to the dangers of having unprotected sex and promoted the use of Salama condoms.

"The 'Je?' campaign was a huge success," said Tim Manchester, PSI Tanzania project manager. "Everything that people had seen about AIDS before this had been
a speech or a sermon or a newspaper story that was all gloom and doom. We made the character a bit comical so you’d remember him, and kept the story coming so we could build anticipation about what he would do next. To this day [two years later], people are still talking about his exploits.”

Other poster campaigns targeted urban women, portraying them as taking charge of their lives by warning their partners that without Salama condoms there would be no sex. The “Je?” character was also portrayed in a poster series promoting the ABCs of safe sex (Abstinence, Be faithful, or use a Condom). More than 46,000 posters, 95,000 promotional calendars and tens of thousands of other materials such as T-shirts and stickers have been distributed since the beginning of the project.

The SMU produced four popular TV commercials for Salama, including a remake of a clever ad that originated in South Africa showing a karate superstar coming out of a movie screen to give a Salama condom to a passionate couple in the back row of the theater. For radio, the project created a series of public service announcements using the Salama theme song in the background and a voiceover with HIV/AIDS prevention messages.

The SMU has also promoted Salama by sponsoring 418 public events such as sports competitions, concerts and beauty pageants. During half time at soccer matches and breaks in other events, staff reach a captive audience with educational presentations and roving condom salespeople. Sometimes theater groups present prevention dramas.

Such promotional activities are key to increasing demand for condoms. And this demand has helped SMU expand sales outlets throughout many regions of the country, making condoms available in places where they had never been sold before.

**GETTING CONDOMS TO CUSTOMERS**

Getting Salama to market has not been a simple task. Tanzania is the largest country in East Africa—about the same size as Texas and New Mexico put together—and it remains fractured geographically by an inadequate transportation infrastructure and underdeveloped commercial distribution networks. The nation’s limited tele-
phone and other communications systems also make it difficult to build the kind of commercial network that would allow sustained growth in condom distribution.

Despite these logistical constraints, TAP’s SMU has been able to dramatically improve access to condoms throughout its sales zones, which cover nearly all of the country’s 20 regions and include more than half of the national population. Four of those zones are operated directly by SMU and include a network of nearly a thousand retail sales points. In addition to the more traditional outlets such as pharmacies and over-the-counter drugstores, these venues include grocery stores, bars, night clubs, guesthouses, hair salons, photo studios and gas stations—enabling people seeking protection from HIV/AIDS to buy condoms where they live, work and seek entertainment, during many more hours of the day.

The nine TAP clusters also incorporate Salama condom sales and promotion into many of their own prevention activities, including training of peer educators. The Tabora cluster, for example, has developed a particularly successful social marketing component. The cluster has trained hundreds of community-based educators and independent vendors as sales promoters and retail agents and has opened eight new wholesale outlets and 126 retail outlets throughout the region.

A fifth zone—which includes Dar es Salaam—is covered by a commercial distributor, Kay’s Hygiene. In addition, 10 pharmaceutical wholesalers and 38 consumer goods wholesalers are now marketing Salama. The project has worked hard to encourage the growing participation of the commercial sector in Salama’s distribution, which it sees as a sign of sustainability.

“This is good news,” said Tim Manchester, PSI Tanzania project manager. “It means that a substantial quantity of the product is now moving through commercial distribution channels without the project’s direct involvement.”
Preventing and Treating Sexually Transmitted Infections

In 1995, the global HIV/AIDS prevention community was electrified by the publication of the results of a research project on sexually transmitted infections (STIs) that had been conducted in Mwanza, in western Tanzania. The project, conducted by AMREF, the London School of Hygiene and Tropical Medicine and several other investigators, was designed to discover whether improved treatment of STIs could lower the number of new HIV infections.

Because STIs that cause ulcers or inflammation of the genital tract are known to raise vulnerability to HIV infection as much as tenfold, the study called for improving STI management at six health centers for two years, then comparing the incidence of HIV infections to that of another cohort that had not received treatment. The findings: consistent and correct STI treatment reduced new infections by a stunning 42 percent.

Because STIs are so widespread in developing countries such as Tanzania, the results offer real hope for an effective public health solution—comprehensive STI diagnosis and treatment programs—to curbing HIV infection. But the study confirmed something perhaps equally important: how to actually accomplish this ambitious and potentially costly goal with limited resources through the use of a technique called syndromic management.

**An Effective, Affordable Approach**

Syndromic management of STIs—the diagnosis and treatment methodology used for the Mwanza study—has long been a cornerstone of prevention for AIDSCAP programs, including TAP. This approach, first developed by the World Health Organization, allows primary health care workers to diagnose and treat most STIs without expensive (and often unavailable) lab tests or lengthy and complex medical training.

Using easy-to-follow diagnostic guidelines designed for each region’s STI prevalence and antibiotic resistance patterns, practitioners of syndromic management assess their patients’ symptoms and prescribe medication for all possible STIs that cause those symptoms. Since full treatment and counseling are completed during the first visit, patients usually don’t need to return for follow-up. In addition to diagnosis and treatment, patients also receive advice on condom use and other prevention methods and are encouraged to refer partners who may also be infected, a way to help identify women whose asymptomatic STIs would not prompt them to seek treatment.

Recognizing the value for Tanzania of this cost-saving alternative approach to STI treatment, TAP has been in the forefront of syndromic management training for all levels of health professionals in regions throughout the nation. Early in the project, TAP contracted with three primary health care training institutes—the
Centre for Educational Development in Health in Arusha, the Primary Health Care Institute in Iringa and the Infectious Disease Centre in Dar es Salaam—to provide training in syndromic management to private sector health clinics and hospitals throughout TAP’s nine cluster regions. All clusters are asked to identify local private health care centers that serve their communities and to help select the individual health practitioners from each facility who will receive training.

But cluster support is critically important in a more fundamental way: cluster-trained peer educators use every opportunity to discuss STIs with their audiences and explain the importance of seeking immediate and appropriate treatment. Peer educators in the Iringa and Tanga clusters in particular are prepared to refer clients who suspect they may have an STI to local clinics.

**BUILDING CAPACITY IN STI TREATMENT**

Since the beginning of TAP, 788 medical personnel have received extensive training from the three training institutions—10 days of workshops, including two days of supervised, hands-on "practicals"—and have enthusiastically taken what they’ve learned back to their home facilities.

“Working through these prominent national training centers has been critical for sustainability,” said Richard Steen, AIDSCAP’s Africa Region STI officer. “This training now has an institutional basis that remains even after the project ends.”

A limited analysis of the effectiveness of these efforts was conducted using patient encounter forms filled out by trainees after diagnosing each STI case using syndromic management. They revealed that more than 93 percent of the patients had received the proper diagnosis, based on the STI symptoms each presented to the practitioner. Seventy percent of the patients received the recommended drugs for their symptoms. And more than 97 percent of 250 patients who returned to the clinic for follow-up reported either cure or improvement in their conditions. These figures stand in sharp contrast to baseline data collected in 1994 before training began, which showed that patients received correct STI treatment less than 10 percent of the time.

“These numbers are an impressive indicator of the success of this training,” said Steen. “Another, ‘softer’ indicator of success is the high demand—all the TAP clusters say they have health workers clamoring to participate, and the training centers can barely keep up.”
Two other TAP syndromic management training efforts have targeted specific kinds of health care workers. One project, directed by AMREF, was designed to train clinicians working with women along Tanzania’s trucking routes, where STIs are rampant and HIV seroprevalence rates are considerably higher than among the general population. A second, smaller-scale training effort in Dar es Salaam early in the project, conducted by Muhimbili University, trained pharmacists—the only health professionals that many Tanzanians suffering from STIs consult—to use syndromic management techniques to evaluate their customers’ symptoms and dispense effective medications. An assessment of the pharmacists’ accuracy in diagnosis post training revealed that their skills improved significantly.
During the rainy season, the leaking tin roof on John Mwita’s home in a small village west of Moshi forces him and his three tiny children to move their beds into dry corners. Mwita has been unable to fix the roof himself; in 1994, he lost his right arm in an industrial accident and, with no prosthesis to help him function, he can do only the simplest chores. He also cannot afford to hire anyone to do the work for him. Although his employer gave him a desk job after he recovered from the accident, he was let go several months later during a general layoff and has been unable since then to find work.

Unfortunately, Mwita’s crippling injury, joblessness and consequent poverty were just the beginning of his difficulties. Two years ago, his wife—who had since the accident supported the family by selling in the marketplace—became too sick to work and was diagnosed with AIDS. Mwita then asked for a test and discovered that he is also HIV-positive. She has since died, leaving him alone to care for their children and survive any way he can until he, too, becomes ill.

Mwita’s is only one of many thousands of tragic stories that HIV/AIDS has written in Tanzania. Because the epidemic is at an advanced stage, the impoverished country is struggling to cope with the growing psychological, financial and health care needs of its HIV-positive citizens and their families. Hospitals in many regions of the country are overflowing with AIDS patients. With limited resources already stretched thin to meet the demands of other social, development and health problems, Tanzania’s government agencies and health care facilities are hard-pressed to provide sufficient support to those affected by the epidemic. And—especially given the deep poverty in which many Tanzanians live—traditional and family networks upon which people could once rely as the final safety net are themselves overwhelmed by the needs of HIV-positive people and AIDS orphans.

Until recently, little international funding was earmarked for support and care initiatives in countries like Tanzania. While care and support have long been part of the mission of charitable organizations and some community-based NGOs in developing countries, most international donors have focused exclusively on prevention and behavior change efforts. The argument was that funding should be devoted to stemming the spread of the epidemic and ultimately freeing nations to undertake other important development initiatives. This has begun to change, as programmers increasingly perceive the social stress and economic burden caused by the burgeoning population of those who are ill and have been impoverished by the disease, or who, like the
thousands of AIDS orphans in every region of the country, need significant and ongoing support to survive and to eventually lead useful and self-sufficient lives.

INTEGRATING CARE WITH PREVENTION

What has also changed is that many HIV/AIDS programmers no longer see an artificial divide between prevention and care. First, those who are already infected need to learn how to avoid infecting others—and are more likely to take the responsibility seriously if their own needs are being met. Second, rather than seeing those who are already infected as beyond help and therefore as “charity cases,” many in the prevention community now understand that HIV-positive people and their families can articulate some of the most powerful prevention messages to their communities. Third, developing the capacity for caring for AIDS patients at home through initiatives that teach nursing skills to family members relieves some of the enormous burden upon hospitals and clinics barely able to cope with patient loads. And fourth, in countries like Tanzania with high rates of infection, HIV/AIDS prevention programs that ignore the needs of those already ill risk undermining their credibility within the communities they are trying to reach.

Because many of the NGOs that joined TAP clusters had long been involved in support, care and counseling, TAP integrated care initiatives into its prevention programming from the beginning. All nine clusters provide a combination of care and counseling services and sometimes material support to HIV-positive community members and their families and to children orphaned by the epidemic. Whenever possible, they also involve them in public prevention activities. At the same time, TAP peer education and BCC prevention activities for the public include sensitization to ease the stigmatization of HIV-positive people. This holistic approach to prevention and care benefits the entire community as it helps people with HIV and AIDS find acceptance among their neighbors.

The Iringa cluster of 41 NGOs carries out extensive counseling and home care activities. Hundreds of HIV-positive individuals and their families throughout the region have received counseling, and more than 358 home care visits have provided assistance and counseling to those too ill to leave their homes. The cluster—known for taking advantage of public events and celebrations to get out the prevention message—asked some of the HIV-positive people they have helped to speak before the thousands who attended the 1997 International AIDS Candlelight Memorial. Their
riveting accounts of the pain, fear and insecurity they have suffered as HIV-positive people and as the orphaned children of parents who died of AIDS had an enormous impact on the large audience and on the many community leaders with whom they shared the platform.

In the Dar es Salaam cluster, the religious NGO PASADA (Pastoral Activities and Services for AIDS, Dar es Salaam Archdiocese) used supplementary funding from TAP to expand the ability of its own community and health centers to reach more HIV-positive clients with counseling and home-based care. Hundreds of patients have received assistance, including visits from mobile teams offering basic care and treatment to patients who cannot leave home.

Another member of the Dar es Salaam cluster, Comprehensive Community-Based Rehabilitation in Tanzania (CCBRT), provides legal counseling and support for low-income clients living with HIV/AIDS, including will writing and representation in court for inheritance, adoption and workplace discrimination cases. The Tanzanian legal system is very complex, and people struggling with the death of a spouse from AIDS or with their own illness who also face legal difficulties benefit greatly from expert advice. Widows in particular are often victimized by traditional inheritance practices that leave the dead husband’s possessions— even the house itself—to his brothers. CCBRT’s clients learn how to write wills to avoid leaving family survivors penniless and homeless.

REACHING DEEP INTO THE COMMUNITY

TAP also funded the Tanga AIDS Working Group (TAWG), the lead NGO of the Tanga cluster, to implement HIV/AIDS community- and home-based counseling and care services, with the aim of reducing hospital patient loads. A special innovation of this project has been the involvement of traditional healers in the care network and the creation of partnerships between the healers and the biomedical community (see page 17). TAWG has enlisted the help of long-term AIDS survivors in counseling those newly infected, to help them cope with social stigmatization, anticipate future...
In 1992, one year after his wife died of AIDS and he learned from his workplace doctor that he too was HIV-positive, Joseph Katto was forced out of his job with a large Tanzanian oil company. Although it's illegal in Tanzania for businesses to fire employees because of their serostatus, some firms find ways to bring spurious complaints against HIV-positive workers, who have few avenues for appeal. Despite 11 years of exemplary service, Katto—aware that word had spread about his infection and that finding another job in the oil industry would be nearly impossible—saw little choice but to accept the end of his career. With children to raise and the future of his good health uncertain, he spent the next year living frugally on severance pay, uncertain of what to do next.

"I was afraid that I would experience the same kind of treatment wherever I looked for work," he said.

In June 1993, he and three friends decided it was time to do something about the injustices, stigmatization and lack of services and support to which HIV-positive individuals were vulnerable. Together they created a blueprint for one of the country's first self-support organizations for HIV-infected people. Soon, the new NGO, Service, Health and Development for People Living with HIV/AIDS (SHDEPHA+), had 15 founding members and a mandate to serve, empower and advocate for HIV-positive community members and their families. From that small core has grown an influential national organization with 160 members in Dar es Salaam and branches in Kagera, Tanga, and Arusha, with more expected to open in the next few years. The Dar es Salaam central office is an important member of TAP's regional cluster, one of two created especially for HIV-positive people.

The organization's guiding principle has been "Live Positively"—and its members and all those its services reach are encouraged to believe in their own dignity as human beings and to defend their rights as citizens. One important way members of the group do this is by voluntarily "coming out" as HIV-positive to relatives, neighbors and co-workers, to help the community around them reassess their prejudices and understand the need to offer support and understanding to its infected members.

"Eventually all SHDEPHA+ members go public," said Katto. "We feel that hiding the truth just perpetuates the artificial division between those who are infected and those who aren't."

Counseling and home-based care are at the heart of SHDEPHA+ service activities. For several hours every Saturday, volunteer counselors at the NGO's large office in a busy part of Dar es Salaam lead a group session for HIV-positive people on specific themes: learning to accept their status, changing sexual behaviors so the infection doesn't spread further, being aware of physical changes that could signal the beginning of an opportunistic infection, cooking nutritious meals, avoiding stress and so on. Participants get a chance to raise any concerns, talk about their own experiences and offer support and comfort to one another. Counselors also present videos on HIV/AIDS and STI prevention and report on the condition of regular counseling participants who are hospitalized or ill at home. An average of 35 to 40 people attend each group counseling session.

SHDEPHA+ volunteers also offer individual counseling for those uncomfortable with a group setting or whose problems are too complex to counsel adequately in a group meeting. Home counseling and home-based care for those too ill to come to the SHDEPHA+ center are available, serving anywhere from 15 to 50

needs and develop a positive attitude about life despite their serostatus. Many hundreds have taken advantage of TAWG's wide-ranging services since the project began.

The TAWG program served as a study site for a six-month AIDSCAP research project to determine the effect care and support have on sexual behavior among those newly diagnosed as HIV-positive—one of the first to examine the linkages between care and prevention. Two groups of about 150 people each who had recently learned of their HIV-positive status enrolled in the study. While the control group received basic pre- and post-test counseling, the experimental group received consistent home- and center-based care and counseling—at least once per month—that included ongoing discussion about such issues as disclosure of HIV-positive status to family members, reducing risk plans for the future, changing feelings about the diagnosis, family planning, condom use and health concerns. Participants in both groups were then asked whether they were practicing risk reduction. The research team expects to complete its analysis of the results in early 1998.

"What we hope to determine is whether enhanced counseling and care decrease sexual risk taking," said Dr. Joan MacNeil of AIDSCAP, who designed
The group’s current funding makes it possible to provide some medicine and food to poorer home-based care clients.

Outreach to the public is the NGO’s second mission. Some 30 members have received special training in communication skills to speak at meetings and workshops and to youth and school groups about their HIV-positive status, overcoming stereotypical attitudes about people with HIV and AIDS, sexual behavior change to lower risk and other issues. SHDEPHA+ activists also collaborate with the mass media to more widely disseminate information on HIV/AIDS prevention and to create a more accepting social environment for Tanzanians who are infected. Members appear on live TV and radio broadcasts and contact the print media regularly to offer ideas for stories or to volunteer to be interviewed.

SHDEPHA+ has helped raise awareness about the lives of HIV-positive people even among some of the most knowledgeable and committed HIV/AIDS activists in the country. The group’s input during the planning of the cluster’s counseling and support components has helped improve the delivery and quality of those services. Other members of the cluster refer HIV-positive clients to SHDEPHA+ and frequently seek the advice of the NGO’s leaders about how best to approach and support people living with HIV/AIDS.

“SHDEPHA+’s leaders and counselors pose with Gilbert Lutwaza, TAP’s NGO program officer (far left), at the NGO’s office in Dar es Salaam.”

The Kilimanjaro cluster has provided community- and hospital-based support and counseling to hundreds in the region, and has more than 60 deeply committed home-based care providers who have helped 320 AIDS patients manage their AIDS-related illnesses. Cluster staff have developed a special relationship with John Mwitaa, who receives ongoing counseling and support but does not yet require medical care at home. Because the cluster has no extra funds set aside to provide basic material support—even in a case as dire as Mwitaa’s—his counselors work to identify other sources, such as church groups and charities, that can supply him with food and clothing for himself and his children and may eventually help him fix his ramshackle house. The cluster does have a small fund for school fees, and this year his six-year-old daughter was able to begin school.

Once too ashamed to admit he was HIV-positive, Mwitaa has been transformed into an activist and a powerful public speaker, who is often invited to address audiences and to speak on radio shows. His appearance at a leadership sensitization seminar in Moshi in April 1997 prompted many of the community leaders present to commit themselves to helping local citizens struggling with the infection.
This 15-year-old lived on the street until he found a place at a special home in Singida. Many homeless children in Tanzania are AIDS orphans.

“I don’t want to hide my face any more,” said Mwita. “I want to help those who have helped me and tell my neighbors how to avoid the struggle that is now my life.”

**A “LOST GENERATION”**

Throughout Tanzania, the impact of the HIV/AIDS epidemic will be felt far into the next generation, by the thousands of children who lose parents to the virus. Young people orphaned by HIV/AIDS become victims of stigmatization, depression and loss of identity. Because traditional family and community networks are increasingly less able to absorb and provide for the growing number of orphaned children, many are also vulnerable to disinheritance, impoverishment, homelessness and malnutrition. Without support, few will have the funds for school fees and will grow up disadvantaged by their lack of education and less able to support themselves adequately. As many as 850,000 young Tanzanians under the age of 15 may be orphaned by AIDS by the year 2000, a “lost generation” unable to contribute to the country’s program for future development.

Many of the NGOs that have joined TAP clusters have long been involved in providing support for AIDS orphans, and their experience has helped build TAP’s ability to shape a response to this growing crisis. On average, each cluster is able to provide some support for 50 orphans—unfortunately, only a tiny percentage of those who need help.

An important support strategy for many of the clusters is providing vocational training to older children to ensure their ability to make a living and, in many cases, support their younger siblings as head of the family. The Morogoro cluster, in collaboration with various government agencies, created an extensive vocational training program for local orphans. The cluster works with the Agriculture Ministry to offer training in garden and crop cultivation skills and with the Social Welfare Ministry to provide scholarships for orphans in existing vocational programs. Other clusters, including Arusha and Iringa, set up such activities as crafts and furniture production to provide orphans with a protected workplace and income.

The Kilimanjaro cluster provides vocational training for some 250 orphans through two programs within the region that call upon assistance from members of the community and thus help raise citizens’ consciousness of the growing problem of orphans in their midst. One, led by cluster member Kilimanjaro
Project Against AIDS (MKUKI), provides training in carpentry, cooking, sewing and agriculture for older orphans. The cluster supplies all necessary materials for these workshops, while the community provides classroom space and farming plots. Some of the cost of the program is covered by sales of items produced in the workshops. A second training effort, led by KIWAKKUKI, helps orphans find internships with local craftspeople, including shoemakers and tailors.

One 21-year-old who received a shoemaking internship became the sole support for his younger siblings after both parents died of AIDS. The children had been left with no inheritance; what little savings the parents had after they became too ill to work were used to buy medicine and food. The training has been invaluable for him because he is partially disabled from severe scoliosis and a club foot and had been unable to find other work. In addition to placing him in his internship, the cluster solicited outside funds to build a sturdy house for the family and helped the children plant and learn to maintain a garden plot with corn and beans to provide nutritious meals. KIWAKKUKI members also convinced an uncle who had not offered help to give the children a few chickens to add eggs to their diet. Once threatened with homelessness, the family has been able to stay together and survive.
Cover photo: Margaret Dadian/AIDSCAP
This family of AIDS orphans stands in front of a house that the Tanzania AIDS Project’s Kilimanjaro cluster built for them with donations.