

**DETERMINANTS OF COMMUNITY PARTICIPATION IN PLANNING HIV
AND AIDS INTERVENTIONS UNDER NATIONAL MULTISECTORAL
STRATEGIC FRAMEWORK IN MTWARA REGION, TANZANIA.**

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ABSTRACT

For over a decade, the central government of Tanzania has increasingly been pushing for responsibility for planning HIV and AIDS interventions to communities, and it has developed three phases of National Multisectoral Strategic Framework to date in an attempt to involve them in the planning process. Yet, many obstacles stand in the way of participation in the planning process. Drawing on 192 respondents, 12 focus group discussions and 16 key informants, this research sought to assess determinants of community participation in planning HIV and AIDS interventions under NMSF in Mtwara Region. A cross-sectional study was conducted between September 2014 and February 2015. The findings indicated that the majority of the surveyed people (69.0%) were not aware of NMSF interventions while 77.0% had unfavourable attitude towards HIV and AIDS interventions under NMSF. It was also found that 81.8% did not participate in planning HIV and AIDS interventions. Furthermore, using ordinal logistic regression, it was found that community awareness of ($p \leq 0.001$) and attitude towards HIV and AIDS interventions ($p \leq 0.005$), access to planning information ($p \leq 0.001$), education level ($p \leq 0.05$), and community satisfaction with involvement in planning ($p \leq 0.001$) were the factors observed to have significant impacts on the chances of participating highly in planning of HIV and AIDS interventions. In conclusion, community participation in planning HIV and AIDS interventions in Mtwara region is low despite the government efforts to involve the participation. Considering the importance of community participation, it is suggested that the relevant authorities should address barriers to low community participation in the planning process.

DECLARATION

I, Joel Elia Mwanga, do hereby declare to the Senate of Sokoine University of Agriculture, that this dissertation is my original work done within the period of registration and that it has neither been submitted nor being concurrently submitted in any other institution.

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Date

The above declaration is confirmed by:

Prof. Kim A. Kayunze

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Date

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DEDICATION

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LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immuno Deficiency Syndromme
CHAC	Council HIV and AIDS Coordinator
CSO	Civil Society Organization
EPP	Essential Planning Package for HIV and AIDS Interventions
FGD	Focus Group Discussion
GIS	Geographic Information System
HIV	Human Immune Deficiency Virus
IFAD	International Fund for Agricultural Development
KI	Key Informant
LGA	Local Government Authority
MAC	Multisectoral AIDS Committee
MDG	Millennium Development Goal
MKUKUTA	Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania <i>(Tanzania National Strategy for Growth and Reduction of Poverty)</i>
MTEF	Medium Term Expenditure Framework
NACP	National AIDS Control Programme
NMSF	National Multisectoral Strategic Framework for HIV and AIDS <i>(Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania)</i>
NSGRP	Tanzania National Strategy for Growth and Reduction of Poverty
O & OD	Opportunities and Obstacles to Development
PHC	Primary Health Care
SADC	Southern African Development Community
SPPT	Social Psychology of Participation Theory
TACAIDS	Tanzania Commission for AIDS

TDV	Tanzania Development Vision
TMAP	Tanzania Multisectoral AIDS Project
TOMSHA	Tanzania Output Monitoring System for HIV and AIDS
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
URT	United Republic of Tanzania
WHO	World Health Organization

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background to the Problem

Success and sustainability in any development programme, HIV and AIDS inclusive, are highly dependent on the degree of participation and involvement of the stakeholders, including the beneficiaries (URT, 2012a). Participation of communities at all stages of planning and implementation promotes feelings of ownership and ensures sustainability (WHO, 2009). Stone (1989) argues that people's participation in development projects may help bring effective social change rather than impose an external culture on a society. Similarly, by referring to the experience of rural development programmes, community participation in the design and management of a project greatly enhances the likelihood of project success due to improved goodness of fit and increased sustainability (Shrimpton, 1989).

The escalation of HIV and AIDS crisis has made Tanzania to consider it as a public health problem hence the need for concerted efforts in addressing the epidemic. The participation of community in planning for HIV and AIDS interventions in Tanzania started in 2003 following the need for a multisectoral approach to address the problem of HIV epidemic (URT, 2010a). This is an innovative way of involving communities in scaling up national HIV and AIDS response.

The HIV epidemic in Tanzania still poses a major threat to the country's development. The epidemic is a result of a complex interplay among biological, socio-cultural and socio-economic factors, and its impact has caused widespread suffering among individuals, families and communities across the country (URT, 2013a). An estimated

2 million adults and children are living with HIV and AIDS in Tanzania (URT, 2013b). Hitherto, Tanzania has an estimation of over 200 000 new infections and an average of 80 000 AIDS deaths per year. In addition, the country has 2.2 million orphans and vulnerable children of whom about 1 million were orphaned due to HIV and AIDS (URT, 2013c). Tanzania's HIV prevalence rate decreased from 7% to 5.1% from 2004 to 2012 (URT, 2013a). Despite the slight fall in the prevalence rate, the epidemic's variation differs widely from one region to another, with Manyara reporting the lowest (1.5%) and Njombe the highest (14.8%) (URT, 2013a).

The urgency of preventing the spread of the fatal virus and the highly personal nature of HIV transmission has made collaboration at all levels of society imperative (UNAIDS, 2004). In order to overcome the aforementioned HIV/AIDS challenges, the National Multisectoral Strategic Framework on HIV and AIDS (NMSF) was initiated in 2003 (URT, 2010a). It translates the National Policy on HIV by identifying and providing strategic guidance to the planning of programmes, projects and interventions to be executed by different stakeholders in Tanzania. The NMSF framework was designed to work with Local Government Authorities (LGAs) since they are key players in ensuring that HIV and AIDS services are provided at Councils, Districts and community levels (URT, 2011).

Since the NMSF inception, programmes designed by NMSF have been implemented in phases for a period of five years for each phase. The first phase was from 2003 to 2007 and emphasized on HIV prevention through capacity building and empowering of communities, families and individuals to respond to the challenges and threats of the epidemic (URT, 2003). The second phase was from 2008 to 2012 and emphasized on more evidence based prevention strategies and underscored the importance of mobilizing

responses at all levels of government, the private sector, civil society organizations, and the communities (URT, 2008). The third phase is from 2013 to 2017; it builds on the previous experiences and challenges encountered in phase II (URT, 2013a).

Different donors including the World Bank and Tanzania Multisectoral AIDS Project (TMAP) supported NMSF I and partly II before they phased out. The establishment of NMSF grants took over after other donors pulled out (URT, 2013c). The first two phases were donor funded, but in 2009 they pulled out leaving the programmes in hands of the government. To maintain the activities for phase two, in 2009, the government established NMSF grant as a funding mechanism for supporting phase two activities (URT, 2013d). Activities implemented under this initiative include enabling environment, prevention, care and support and impact mitigation (URT, 2008). The grant has been extended to the year 2016 when it will phase out (URT, 2011).

Mtwara is one of the regions in Tanzania, where HIV and AIDS interventions through NMSF are being implemented. The first case of HIV and AIDS in Mtwara region was discovered in 1985 (URT, 1996). By the year 2004, Mtwara had a HIV prevalence rate of 7.4% which was above the national average of 7% (URT, 2003). The prevalence dropped from 7.4% to 3% in 2008 (URT, 2008). Currently, Mtwara is among eight regions in the country where HIV prevalence rate has increased. The prevalence rate in Mtwara region increased from 3% in 2008 to 4.1% in 2012 (URT, 2013). According to URT (2010b), participation of community in planning for HIV and AIDS interventions under NMSF in the country was reported to be low. The same problem was encountered in Mtwara where low community participation in planning for HIV and AIDS interventions was reported to be one of the challenges in the region (Mtwara, 2011). Low community participation in planning, threatens ownership and sustainability of intervention. Therefore, this study was

designed to determine factors contributing to participation of community in planning for HIV and AIDS interventions under NMSF in Mtwara region. This is because participation of community in planning is imperative for the ownership and sustainability of HIV and AIDS interventions.

1.2 Problem Statement

The central government of Tanzania has increasingly been pushing for responsibility for planning to communities, and they have been asked to play a greater participatory role in these processes (Peter *et al.*, 2013). As pointed out previously, NMSF was designed to work with LGAs in providing services of HIV and AIDS non-medical interventions through community participation in planning (URT, 2012b).

Despite the remarkable investment made by the government in providing the guidelines for planning HIV and AIDS interventions under NMSF and its dissemination, yet there has been low community participation (URT, 2010b). However, low community participation in planning for HIV and AIDS interventions under NMSF does not only hinder the success of the programme, but also its ownership and sustainability. Either low people's participation in development projects may fail to bring effective social change rather than impose an external culture on the society (Stone, 1989). Furthermore, there is limited information on factors determining community participation in planning for HIV and AIDS interventions in Tanzania, particularly in Mtwara Region. The study therefore intended to fill this gap by generating empirical information on factors associated with participation in planning for HIV and AIDS interventions.

1.3 Research Justification

The study will inform HIV and AIDS response programmes that work towards UNAIDS' vision of zero new HIV infections, zero discrimination and zero AIDS related deaths (UNAIDS, 2011). Furthermore, the study will inform implementation of NMSF which translates international agreements, declarations, treaties and conventions which deal with HIV (URT, 2011). These include Beijing Platform of Action, United Nations General Assembly Special Session on HIV and AIDS (UNGASS), New Partnership for Africa's Development, Southern African Development Community (SADC), Millennium Development Goal (MDG) number 6, Great Lakes Initiative on HIV and AIDS, East African Community and Africa Region AIDS Care Capacity Network (URT, 2008).

The implementation of NMSF is part of adherence to international efforts to contain the HIV and AIDS epidemic (URT, 2011). The NMSF also translates the national HIV policy 2001 and makes a link to the Tanzania National Strategy for Growth and Reduction of Poverty (NSGRP II) and the 2025 Development Vision which stipulate the need to address HIV in the development agenda (URT, 2011). Therefore, determination of factors contributing to participation of community members in planning for HIV and AIDS interventions is imperative.

1.4 Objectives

1.4.1 General objective

To assess determinants of community participation in planning HIV and AIDS interventions under National Multisectoral Strategic Framework in Mtwara, Tanzania.

1.4.2 Specific objectives

- (i) To examine attitudes of individuals towards HIV and AIDS interventions
- (ii) To examine levels of community participation in planning for HIV and AIDS interventions
- (iii) To determine extents to which attitude towards HIV interventions and awareness of NMSF interventions influence individuals' participation in planning for HIV and AIDS interventions

1.5 Research Questions

The following questions were aimed at meeting the first and second objectives which were attained descriptively.

- (i) What are the community attitudes towards HIV and AIDS interventions under NMSF?
- (ii) To what extent are community members participated in planning for HIV and AIDS interventions under NMSF?
- (iii) To what extents do attitude towards HIV interventions and awareness of NMSF interventions influence participation of community in planning for HIV and AIDS interventions?

1.6 Hypothesis

The following null hypothesis was in line with analysing the third objective:

Chances of participating highly in planning of HIV and AIDS interventions are the same for people with different attitudes towards HIV and AIDS interventions and different levels of awareness of NMSF interventions. Low, moderate and high participation were measured in terms of points scored on index scale.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 The Concepts of Community Participation and Planning

2.1.1 Participation

The word participation originated from Latin, referring to “part taking” which means to take part or to share in (Schenker *et al.*, 2005). Community participation is a social process through which people voluntarily take part in both formal and informal activities, programmes and discussions to bring about planned change or improvement in community life, service or resources (WHO, 2009). It is described as a social process in which groups with shared needs living in a certain geographical area actively identify needs, make decisions, and set up mechanisms to achieve solutions (Bichmann *et al.*, 1989). However, heterogeneous groups and individuals can become a community and collectively take action to attain shared and specific goals (Mattessich *et al.*, 1992).

Participation is one of the most important concepts in planning and development, because it is potentially a vehicle for different stakeholders to influence development strategies and interventions, which are mostly dominated by professional experts in the government and private sector (Ahmed and Shahidul, 2009). Participation combines the experiences, knowledge and understanding of various groups and citizen (Ahmed and Shahidul, 2009).

Watson (2002) cited three reasons on the need to promote community participation in programmes: firstly, participation is assumed to lead to individual and community empowerment, as people gain skills in assessing needs, setting priorities and controlling their development; secondly, community involvement relies on the use of local knowledge, which offers complementary insight that should be considered alongside

epidemiological approaches; and thirdly, participation fosters higher levels of motivation and enhances effectiveness of interventions.

According to Takyi and Yussif (2013), participation level ranges from low to high depending on stakeholders' participation. Low participation is considered as 'no participation' since people do not participate in the decision making process that eventually defines participation as a 'means in response to an order (Asnarulkhadi and Fariborz, 2011). The degree of community participation ranges from mere reception of programme information to wielding power over priorities and resources (Tones and Green, 2004). At its lowest degree or level, people's participation can take the form of being coerced (UN, 1981 cited by Asnarulkhadi and Fariborz, 2011). However, there is no people's control at this lowest stage (Asnarulkhadi and Fariborz, 2011). Even if the state or the government practises the consultative approach to community development in a partnership programme by giving people the choice within the predetermined projects, people's participation is induced (Asnarulkhadi and Fariborz, 2011). The participation at 'induced' or 'partnership' stage is not mainly concerned with the process of mobilizing the people, who should be regarded as the recipients or beneficiaries of the development introduced, but of uppermost importance is 'the participation of the organized community as such' (White, 1982 cited by Asnarulkhadi and Fariborz, 2011). It refers to working in partnership with other stakeholders on each aspect of the decision, developing alternatives and identifying solutions (Takyi and Yussif, 2013).

Empowerment is the process of building stakeholders' capacity to make informed decisions and take responsibility (Stiftel, 2000). Where local people are involved in decision-making during all stages of the project cycle, participation is at higher-levels, and the best results follow and the reverse is the case and also evident. Thus, where local

people are only involved in information sharing and consultation, project outcomes are much poorer (Mosse, 2001). The participation is not just an end in itself, but it is more than a means (Cohen and Uphoff, 1980). Therefore, the cooperation and power sharing between the people and the development agencies is essential in promoting participation as a means towards an end so as to increase the level of peoples' participation towards empowerment (Oakley and Marsden, 1984).

Table 1: Typologies of Participation

Participation level	Brager & Specht (1965)	Hollnsteiner (1977)	Johnston (1982)
High	Community control	Community control	Participating through creativity
C O N T I N U U M	Community has delegated authority	People's representation on decision making body at the council level	Participating by taking initiative
	Plans jointly	<ul style="list-style-type: none"> • Consultation starting with plan formulation 	Participating by giving suggestions and making criticisms aimed at improvement of an activity
	Advises	<ul style="list-style-type: none"> • Presents tentative decision, consult community, then decide 	
	Community is consulted		
	Community receive information	<ul style="list-style-type: none"> • Announces decision, permits questions • Sells decision to community 	Voluntary participation prompted by awareness Voluntary participation stimulated by a reward
Low	Non participation	Decide, announces decision thro bulletin	Participation in response to an order or to force

Source: Adopted from Asnarulkhadi and Fariborz, 2011

The concept of community participation in this study represents a bottom-up or grassroots approach to programme planning and decision-making. In this aspect, community members are involved in defining their health problems and finding solutions (WHO, 2009). Community participation has been a central theme in health-related discussions for many years. It was present in the World Health Organization (WHO) constitution, confirmed in the Alma-Ata Declaration (Peter *et al.*, 2013). Community participation in health activities was enshrined as a cornerstone of Primary Health Care (PHC) with

success subsequently demonstrated in many healthcare programmes including more recently in HIV prevention (Hadley and Maher, 2000, Jones *et al.*, 2005). The fourth principle of the Alma-Ata Declaration stated that ‘The people have the right and duty to participate individually and collectively in the planning and implementation of their primary health care (Peter *et al.*, 2013).

Research on a number of health promotion efforts documents that projects with substantial community participation are more likely to succeed than those that focus on external practices. For example, Manikutty (1997) initiated and compared two water supply and sanitation projects within the same water authority in Kerala, India; one promoted community participation and the other did not. People within the project that involved the community benefited from an improved water supply and were more likely to improve their sanitary habits, claim satisfaction with the project, and continue their involvement. Similarly, a study of urinary schistosomiasis interventions in Ghana explored varying health education and community participation approaches in different communities (Arteetey *et al.*, 1999). The study demonstrated that greater community participation in the education process led to more self-help health initiatives.

A study in Uganda explored the key factors leading to the success of initiatives to prevent river blindness (human onchocerciasis) (Katarawa *et al.*, 2000). Where community members felt they were involved in the planning and execution of the project, prevention targets were significantly more likely to be exceeded. In Peru, an unusual collaboration between a women’s health organization, and United States Agency for International Development (USAID) has resulted in an expansion of community participation to improve the quality of reproductive health services in rural areas (Rogow, 2000). Originally, the programme was designed to work exclusively with local women.

However, the women argued early on that if change was to occur, their husbands also needed to participate. The project management was reluctant to use funds designated for improving women's health on workshops for men; however, in keeping with the programme's approach of listening to community perspectives, the project heeded the advice of the local women. Later the project viewed the parallel work with men as an element critical to the programme's success (Rogow, 2000).

2.1.2 Planning

There are certainly many different ways of looking at the concept of planning. The theme and objective of the planning exercise largely influence these variations (Cooksey and Kikula, 2005). Planning is defined as a continuous process, which sets out objectives, identifies existing resources/ potentials and implementation capabilities to achieve the objectives over a specific period of time (URT, 2007). It is a continuous process that involves making decisions or choices about alternative ways of using available resources, with the aim of achieving particular goals in the future (Cooksey and Kikula, 2005).

Therefore, planning for HIV and AIDS interventions, is to identify problems and make decisions about which ones should be tackled and in what order of priority. It is about consensus building among the community members. Consensus is required in making priorities because not all problems or needs can be met at once given that resources are always limited. Once a plan has been prepared, what follows is implementation. In the course of implementation, some objectives set in the plan are achieved, and some are not. Also, with time, new priorities emerge due to changes in socio-economic aspects and policy environment. For this reason, there is a need for periodic review of the plan to update the plan so as to reflect the implementation status, and accommodate new priorities.

The local government reform process in Tanzania aims to ensure that citizens at the grassroots level are involved in the planning and implementation of development programmes in their local areas (Fjeldstad *et al.*, 2010). This is inclusive of all non medical HIV interventions under NMSF (URT, 2009). Through participatory planning and budgeting, the reforms envisage that development programmes, HIV inclusive, will be relevant to local needs and engender a sense of ownership to facilitate implementation. Propelled by the decentralisation of responsibility and financial resources for delivering public services from central government to local government authorities (LGAs), the Opportunities and Obstacles to Development (O&OD) planning approach was initiated in 2002. This methodology was expected to promote transparency and accountability in community development through the introduction of participatory processes to identify and prioritise community needs (Fjeldstad *et al.*, 2010).

According to the National Framework on Participatory Planning and Budgeting, O&OD planning is an instrument for facilitating ‘bottom-up’ participatory development. The O&OD methodology provides guiding principles for participatory planning and budgeting in LGAs by describing the legal framework, roles and responsibilities of government institutions at different governance levels including district, ward and village/street levels. In addition, this methodology aims to harmonise different participatory approaches used for specific projects and by different donors into a more comprehensive bottom-up approach to planning. The O & OD approach is consistent with key national development documents, including the Tanzania Development Vision (TDV) 2025 and the National Strategy for Growth and Reduction of Poverty (MKUKUTA) (Fjeldstad *et al.*, 2010). The MKUKUTA is the National Framework which accords high priority to poverty reduction in Tanzania’s development agenda. It aims to achieve the

vision 2025 and the MDGs while recognising the effect and influence of HIV and AIDS on poverty (URT, 2008).

Development of the three-year community plan at the village/street plan is outlined in the HIV participatory planning handbook (URT, 2009). Village/ Street plans are collected and compiled at the ward level and then submitted to the Council. Selection of priorities from ward plans, is done at the Council level and thereafter intergrated into the LGA plan i.e Medium Term Expenditure Framework (MTEF). The review, monitoring, evaluation and updating of the plan on an annual basis ensures that the three-year plan is a living and evolving document. By allowing communities to prioritise local development objectives it is expected that this will motivate them to own the outcomes of their decisions (Fjeldstad *et al.*, 2010).

2.2 General Information on HIV and AIDS

According to UNAIDS (2014), there were an estimated 35 million people living with HIV globally at the end of 2013. This number is rising as more people are living longer because of antiretroviral therapy, alongside the number of new HIV infections which, although declining, is still very high (UNAIDS, 2014). An estimated 0.8% of adults aged 15-49 years worldwide are living with HIV, although the burden of the epidemic continues to vary considerably between regions and countries (UNAIDS, 2014). Of the 35 million people living with HIV, 24.7 million are living in sub-Saharan Africa, the region hardest hit by the epidemic whereby nearly one in every 20 adults is living with the virus in this region (UNAIDS, 2014).

In Tanzania, the HIV and AIDS epidemic began in 1983, with the diagnosis and reporting of three cases in Kagera region. By 1986, all regions had reported cases of HIV/AIDS.

Since then, HIV and AIDS in Tanzania continued to spread predominantly through heterosexual contact as in other sub-Saharan countries (URT, 2012b). There has been a dramatic increase in the number of AIDS cases as more HIV infected people have succumbed to opportunistic infections arising from suppressed immune systems (URT, 2012b).

In response to the epidemic, the government formed the National HIV/AIDS Control Programme (NACP) under the Ministry of Health (URT, 2001). Initially, HIV/AIDS was perceived purely as a Health problem and campaigns to deal with it involved the health sector only through NACP. The National response consisted of developing strategies to prevent, control and mitigate the impact of the HIV/AIDS epidemic through health education, decentralization, multisectoral response and community participation (URT, 2001).

HIV/AIDS has been declared a national crisis and is now one of the top priority development agenda in the government, along with poverty alleviation and improvement of the social sector services (URT, 2001). All sectors and Councils in Tanzania are implementing HIV/AIDS activities (URT, 2001). The Tanzania Commission for AIDS (TACAIDS) has been established to provide leadership and coordination of multisectoral responses. As HIV/AIDS epidemic affects all sectors, its control demands a well coordinated response. Therefore, the formation of HIV Policy became inevitable to provide the framework, direction and general principals in the national response interventions in the prevention, care and support of those infected and affected by the epidemic and mitigation of its impact. However, in view of the complex social, ethical, legal cultural and economic aspects of the HIV/AIDS epidemic; the policy is subject to review from time to time in order to address emerging issues (URT, 2001).

The National HIV Policy and the National Multisectoral Strategic Framework are developed in line with international guidelines on HIV and human rights to ensure the accountability of the government and other stakeholders (the private sector, development partners, civil society organizations (CSOs), and the community) in their actions within the national response to HIV/AIDS (URT, 2008). The National Strategy for Poverty Eradication (MKUKUTA II) and the National Development Vision 2025 stipulate the need to address HIV in the development agenda. MDGs and UNGASS goals and indicators have been incorporated into the National Multisectoral Strategic Framework (URT, 2008).

2.3 Conceptual Linkages among Community Participation, Planning and HIV/AIDS Interventions

Conceptually, community with high awareness of NMSF interventions and favourable attitude towards HIV and AIDS interventions is expected to participate in planning. Community with low awareness and unfavourable attitude is expected to show low participation level in planning for HIV and AIDS. Members of the community, whether directly or indirectly affected by HIV and AIDS, are expected to take part in deriving a solution by participating in interventional planning. The way the community reacts to the disease is an important step toward developing HIV prevention interventions (Mbuagbaw and Shurik, 2011). Historically, health care projects with strong community participation have been more successful, considering such bottom-up approaches often gain more acceptance by local populations than top-down, government-imposed solutions (Mbuagbaw and Shurik, 2011). The spread of HIV is often linked to socio-cultural and behavioural factors that are particular to specific communities (Mbuagbaw and Shurik, 2011). The result is a problem that, in reality, can only be addressed within that community, by the community itself.

Community participation in decision-making processes for planning, budgeting and implementation of HIV and AIDS activities is crucial in fighting the HIV and AIDS pandemic. Participation of community in identifying problems, setting priorities and defining context-based solutions of local relevance is of crucial importance as far as HIV and AIDS response is concerned (Sikika, 2013). Community participation in the response to HIV has been accepted as an essential element within health services and programmes for a variety of reasons. First, HIV services have a much greater reach when stakeholder communities participate in their design (Mbuagbaw and Shurik, 2011). Reductions in vulnerability to HIV are achieved primarily through actions people take to protect themselves. Finally, the community has a right to be involved in decisions that affect their every-day lives (Mbuagbaw and Shurik, 2011).

Community participation has played a central role in the fight against HIV since the onset of the epidemic. It has a positive effect on safer sex practices, social integration and identity (Ramirez-Valles, 2002). Community members have important contributions to make in developing a plan of action based on priority issues identified (Sikika, 2013)

2.4 Theoretical Explanations about Linkages among Community Participation, Planning and HIV/AIDS Interventions

This study was led by the theoretical insights of a social psychology of participation, which leans towards the model of empowerment. According to Morgan (2001), much of the literature on community participation is driven by ideological and political commitments to participation, contested and framed either as a basic human right, a pragmatic strategy to utilise services or as a pathway to empowerment. The social psychology of community participation was promoted as a conceptual framework for action research seeking to explore the pathways between community participation, health

and social development (Baatiema *et al.*, 2013). The starting point of this framework is that the poor and marginalised often lack a sense of control over their health and well-being, leading to a sense of fatalism, and a tendency to wait for outside actors and agencies to take control of local health problems (Baatiema *et al.*, 2013).

Against the aforementioned background, the framework seeks to draw attention to ways in which communities can be ‘empowered’ to exercise greater agency over their health, by changing health-damaging behaviours where possible, and making optimal use of available health services. Baatiema *et al.* (2013) idealised the notion of the public sphere. The framework advocates that, for participation to offer community empowerment, it should take place in a social space where all participants have the right to participate fully in the design, implementation and evaluation of programmes, with programmes being driven by a synthesis of ‘local’ and ‘expert’ knowledge, with both knowledge systems being accorded equal respect. Rappaport (1987) suggests that participation is most likely to empower marginalised communities to exercise greater control of their lives (and more specifically their health) if it is framed within a dialogical and facilitative approach through knowledge negotiation and power transfer from health professional to communities.

Health-enabling community participation should involve genuine sharing of power amongst health experts and decision makers on the one hand, and marginalised groups on the other (Baatiema *et al.*, 2013). Such an approach is said to build a sense of community ownership of local problems (as opposed to a sense that such problems can only be solved by outside professionals), and to encourage communities to contribute to the development of concrete strategies through which they can improve their health (Baatiema *et al.*, 2013). This approach resonates with the views of Robert Chambers who argues that poor

communities can be empowered by taking responsibility and action in cases where experts are ready to share power and control over programmes (Baatiema *et al.*, 2013).

2.5 Empirical Linkages among Participation, Planning and HIV/AIDS Interventions

Participation does not take place in a vacuum, but in a socio-political context. Findings from a study on attitude to rural development projects revealed that improper and inadequate awareness, low level of exposure, negative attitude, insufficient training, lack of encouragement by chiefs and elders of the community, intermittent change of government, and selfishness on the part of the youth leaders were the factors that affected youth participation in development programmes (Okwusi, 2008). A study to identify the limits of local participation in local government planning in Tanzania found that the lack of awareness, ignorance of people, poor leadership at community level, lack of facilitation capacities at local leadership, dependency syndrome and lack of capacity in planning and implementation at local community were the constraints to community participation (Cooksey and Kikula, 2005).

Some literature has also indicated the influence of age, attitude and occupation in participation with regard to development projects. Angba *et al.* (2009) reported that there was positive correlation between age and participation in development projects. It was further reported that age of respondents affects their attitude towards participation in development projects. However, occupation correlates positively and significantly with age (Angba *et al.*, 2009). Angba *et al.* (2009) argued further that the coefficient, though low, suggests that occupation and age have some influence on respondents' attitude towards participating in development projects.

A study by Bani *et al.* (2014) on evaluation of awareness, attitude and participation of men in family planning programmes in Abyek, Iran observed that, awareness and attitude were positively and significantly related to men's participation in family planning. It was reported that men with positive attitude participated in family planning as opposed to men with negative attitude. In the work to investigate the linkage between awareness and participation, Brahmi and Thakur (2011) found that 90% of people who were not aware about the development project had poor participation. The authors had the view that lack of awareness about the project was the primary cause of poor participation. Elham *et al.* (2008) argued that level of awareness of interventions influences community participation in planning. Mubyazi *et al.* (2007) argued that people need to be adequately sensitized to ensure their informed and desired participation.

Chifamba (2013) identified several factors among others which hinder community participation including poor community leadership in some villages not giving feedback to community members, lack of information, ignorance, high level of poverty for most community members, lack of transparency and accountability among community leaders especially on funds contributed for rural development projects. However, Takyi and Yussif (2013) opined that differences in levels of knowledge between local citizens and government officials lead to mistrust and marginalization which affect local community participation.

Participation of community in designing, planning and implementing HIV and AIDS activities is still limited in Tanzania. Sikika (2013) reported that citizens did not actively participate in planning and implementation of plans to address issues that affect their lives, health and HIV and AIDS issues being examples. The government of the United Republic of Tanzania realized poor community participation as evidenced in the quote:

“In many cases, the target population does not actively participate in the setting up process” (URT, 2008 cited by Sikika, 2013). It further added that this might result in lack of ownership and interest from the very beginning. Elham *et al.* (2008) argued that frequency of contact with technical experts influences participation.

Government and non-governmental organizations’ presence at the grassroots, close to the poorest of poor, is important in promoting participation (Chifamba, 2013). The study revealed that consequential participatory development process requires development facilitators or change agents to go to the people, live with them, learn from them, work with them, start with what they know, and build on what they know. Continuous community sensitization, mobilization and general awareness creation initiatives done by government and non governmental organizations staff in collaboration with community leaders on various development issues were also said to have helped in motivating and increasing the level of community participation in rural development.

Lack of access to information and understanding of policy can be barriers to community participation (Aref, 2010). A study conducted by Nomvakaliso (2007) indicated that high or active participation is mostly likely when different stakeholders involved in a project or programme are satisfied with the level at which they are involved. Local elites form connivance with local administration for their own interests and bypass the needs of the mass. So the scanty participation that exists is limited only to the rich, and participation of the rural poor is minimal. Siddiquee (1995) argued that, poor people are hardly included in projects. It was further argued that committees are mostly dominated by people with strong socio-economic or political background. Furthermore, prevailing socio-economic and political contexts act as important deterrents to grassroots’ participation in the development process.

Kumar (2002) has identified three major obstacles to people's participation in project management. These include structural obstacles, administrative structures and social obstacles. Structural obstacles were largely responsible for the atmosphere of passivity and dependence that prevails in rural communities and formed part of the centralised political systems which are not oriented towards people's participation. This type of situation is typified by a "top-down" development approach adopted by development initiatives like the Integrated Rural Development Programmes. Furthermore, the administrative structures that are control-oriented provide little significant space to local people to make their own decisions or control their resources. On the other hand, the social obstacles such as the mentality of dependency, the culture of silence, domination of the local elite or gender inequality militate against people's participation (Barasa and Jelagat, 2013).

Khan (2009) pointed out that bureaucratic domination in the local councils, lack of knowledge, and lack of expertise in technical matters are the root causes for non-participation. The assertion was supported by Takyi and Yussif (2013) who reported that lack of knowledge is the root cause of community participation. This was however, found by Brahmi and Thakur, 2011 who reported that lack of basic education causes narrow vision of the project hence poor community participation. Angba *et al.* (2009) found that educational level correlates significantly and positively with age. It was further argued that, as one attains a higher level of education, attitude towards participating in development projects is likely to be more favourable. But attitudinal level may vary, however. In essence, the higher the educational level attained the more favourable the attitude towards participating in development projects. Angba *et al.* (2009) asserted that educational levels are highly significant in the extent, intensity and pattern of participation. The authors further argued that participation increases with education.

It was further expressed that effective participation obviously requires communicative and human relational skills which must be learned; hence those who are better educated would be better empowered for participation because their attitude would likely be favourable.

Community participation can, however, be considered in gender perspective. Participation is made more complex by the fact that even though women form the bulk of community labour force for community projects, they are often marginalised when it comes to access to information, decision-making and access to opportunities for capacity building (Barasa and Jelagat, 2013). It was further, however found that educated women participated more in development programmes of government (Angba *et al.*, 2009). The author further reported education as a major determinant of effective participation in development projects. The educated people would most likely appreciate development better than the less educated. It was further argued that if the people appreciate development their attitude towards participation is likely to be favourable. Marital status of respondents is another factor which determines participation in rural development initiatives. In most cases levels of participation are relatively low among women who are married. Instead, they are represented by their husbands (Chifamba, 2013).

2.6 Gaps in Literature

There is limited information on factors determining community participation in planning HIV and AIDS interventions in many countries. Chifamba (2013), Elham *et al.* (2008), Aref (2010), Nomvakaliso (2007), Siddique (1995), and Kumar (2002) identified several factors which hinder community participation in rural development initiatives. However, among the conducted studies none of them reflected on community participation in planning HIV and AIDS interventions. Fjeldstad *et al.* (2010) found little evidence that

participatory approach to development has provided a basis for community participation in planning and budgeting in Tanzania. This is in line with findings reported by Cooksey and Kikula (2005). Therefore, the study for this dissertation was intended to fill in this gap by generating empirical information on factors associated with participation in planning for HIV and AIDS interventions, particularly in Mtwara Municipal and Mtwara District Councils.

2.7 Conceptual Framework

The framework presented in Fig.1 accommodated a set of independent variables that were thought of influencing community participation in planning HIV and AIDS interventions under NMSF. The dependent variable was measured in terms of points scored on an index scale. The independent variables incorporated in this framework were attitude towards HIV and AIDS interventions, frequency of contact with technical experts on HIV and AIDS programmes during planning meetings, access to information in planning HIV and AIDS interventions, understanding of HIV Policy, level of satisfaction with involvement in planning HIV/AIDS interventions, number of HIV Planning meetings attended for the last 12 months, attendance in HIV and AIDS events, participation in selecting multisectoral AIDS committee members, involvement in decision making with regard to identified HIV and AIDS activities and awareness of individuals on activities in village/Street plans. All these independent variables were conceived of having direct effect on the dependent variable. However, there were other forces collectively referred to as background variables which were conceived of having indirect effect on the dependent variables. These were age, sex, marital status, education, residence, respondent's income and main occupation.

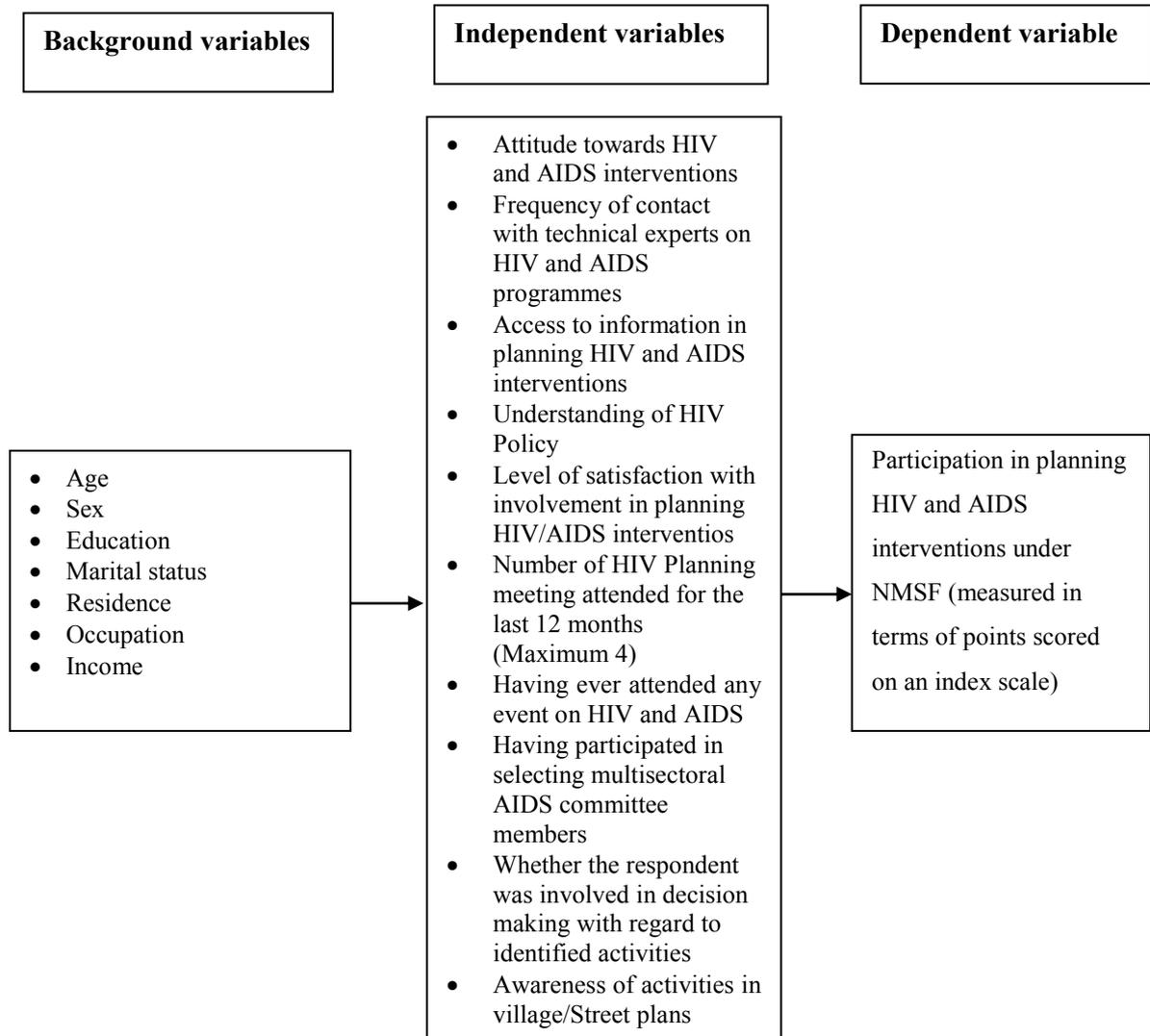


Figure 1: Conceptual framework

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

3.1 Description of the Study Area and Its' Justification

Mtwara Region is one of 26 regions of Tanzania Mainland and is the southernmost region. It lies between longitudes 38° and 40°30" east of Greenwich. It is also situated between latitudes 10°05" and 11°25" south of the Equator. River Ruvuma forms part the Southern border between Mtwara Region and Mozambique. On the West side the region borders with Tunduru District (Ruvuma Region) while Lindi Region is on the North. Administratively, Mtwara Region has seven councils which include Mtwara Municipal Council, Masasi Town Council, Mtwara, Newala, Masasi Tandahimba and Nanyumbu District Councils. It has an area of 16 720 km², of which 85% is suitable for agriculture, human settlements and livestock keeping.

Mtwara Region is poised to become the next highest growth Zone of Tanzania, based on the exploitation of world class proven reserves of industrial minerals and hydrocarbon resources, respectively in the Southern regions of Tanzania and offshore the coast of Mtwara in the Indian Ocean (Simbakalia, 2012). Currently, there are more than six oil and gas exploration companies which are active onshore and offshore the coast of Mtwara Region. These major world class economic activities in the region have attracted people from different parts of the world to come and work in Mtwara. Research in Africa has long demonstrated that the prevalence and patterns of spread of infectious disease are closely associated with patterns of human mobility (IFAD, 2002). Thus the continuous movement of people is an underlying factor in the spread of HIV/AIDS. The aforesaid major world class activities are both found in Mtwara District Council. The majority of workers at gas and oil extraction sites in Mtwara District have their residence in Mtwara

Municipal Council. The foreseen interaction needs concerted efforts to curb the spread of HIV and AIDS through community participation. It was due to the aforementioned reasons that the researcher purposively chose and conducted this research in the two councils of Mtwara Municipal and Mtwara district.

3.2 Research Design

A cross-sectional research survey design was used in which data were collected at a single point in time and at once. The selection of this design was based on the fact that it is of less cost and saves time comparing to other designs (Olsen and St, 2004).

3.3 Population and Sample

In this study, the population consisted of all community members where HIV and AIDS interventions under NMSF were being implemented. The sample size was 192 respondents which was determined as described in the following formula;

$$n = \frac{Z^2 * p (1 - p)}{d^2} \text{ (Cochran, 1977 cited by Bartlett } et al., 2001)\dots\dots\dots(i)$$

n = sample size;

where:

Z = a value on the abscissa of a standard normal distribution (from an assumption that the sample elements are normally distributed), which is 1.96 or approximately 2.0 and corresponds to 95% confidence interval;

p = estimated variance in the population from which the sample is drawn, which is normally 0.5 for a population whose size is not known;

d = acceptable margin of error (or precision), whereby the general rule is that in social research d should be 5% for categorical data and 3% for continuous data

(Krejcie *et al.*, 1970 cited by Bartlett *et al.*, 2001). In this research, 5% was used since substantial categorical data were collected.

Using a Z-value of 1.96, a p-value of 0.5, a q-value of 0.5, and a d-value of 0.5% (which is equivalent to 0.05), the sample size (n) which was determined would be 384.

$$n = \frac{1.96^2 * 0.5 (1 - 0.5)}{0.05^2} = (3.8416 \times 0.25) / 0.0025 = 1 / 0.0025 = 384.$$

However, a sample size of 192 which is half of the calculated $n = 384$, was randomly selected. The sample size was statistically enough, especially in view of argument by Bailey (1994) that regardless of the population size the bare minimum sample size for a research in which inferential analysis should be done is 30 cases, and that in most cases 100 cases are taken. Furthermore, the sample size of 192 was justified on the fact that “too large a sample implies wastage of resources, and too small a sample diminishes the utility of the results” (Cochran, 1977 cited by Bartlett *et al.*, 2001).

The sample size included respondents of the age category of 15 to 49 years, which was selected due to the fact that they were sexually active and that 80% of HIV prevalence is through sexual intercourse (URT, 2012b). Therefore, the contribution of the selected age category in terms of prevention efforts is very important in the fight against HIV and AIDS epidemic in Tanzania.

Besides the 192 respondents for questionnaire administration, 12 focus groups were selected for qualitative data collection through focus group discussions (FGDs). Having 12 focus groups was in line with advice by Bryman (2004) who argues that there is a tendency to have 10 to 15 focus groups in a whole study. In each of the 12 focus groups, the number of discussants was about 8, which was in line with the suggestion by Morgan (1998 cited by Bryman, 2004) that a typical focus group size should have 6 to 10

members. The explanation for this is that, with fewer discussants, difficult topics may not be discussed effectively while with more discussants, some participants do not give their opinions. In each of aforementioned villages/streets, about 8 members for FGDs were purposively selected based on their being considered to be very knowledgeable. The purposefully selected members for FGDs were not re-interviewed for the structured questionnaires.

3.4 Sampling Techniques

A multistage sampling procedure was used to obtain the respondents. Mtwara Municipal Council and Mtwara District Council were purposively selected to represent urban and rural areas as per Section 3.1. Mtwara Mjini Division, Ufukoni Ward, Magomeni A and Mbae streets were obtained through random selection in Mtwara Municipal Council. Moreover, Mayanga Division, Naumbu Ward, Majengo and Imekua Villages were selected through random sampling in Mtwara District Council. Before applying the random sampling technique, stratification sampling procedure was used to obtain two strata, one for men and the other one for women. In each stratum, 50% of respondents were randomly selected. From this, 43 men and 43 women were selected from rural and urban areas which made a sample size of 192 respondents. The sub-sampling frames from which the respondents were selected were individuals aged between 15 and 49 years for the main reason given in Section 3.3. A sample size of 16 key informants (KIs) including community development and planning officers, and village/street leaders were also interviewed, 8 from each of the two councils of Mtwara Municipality and District.

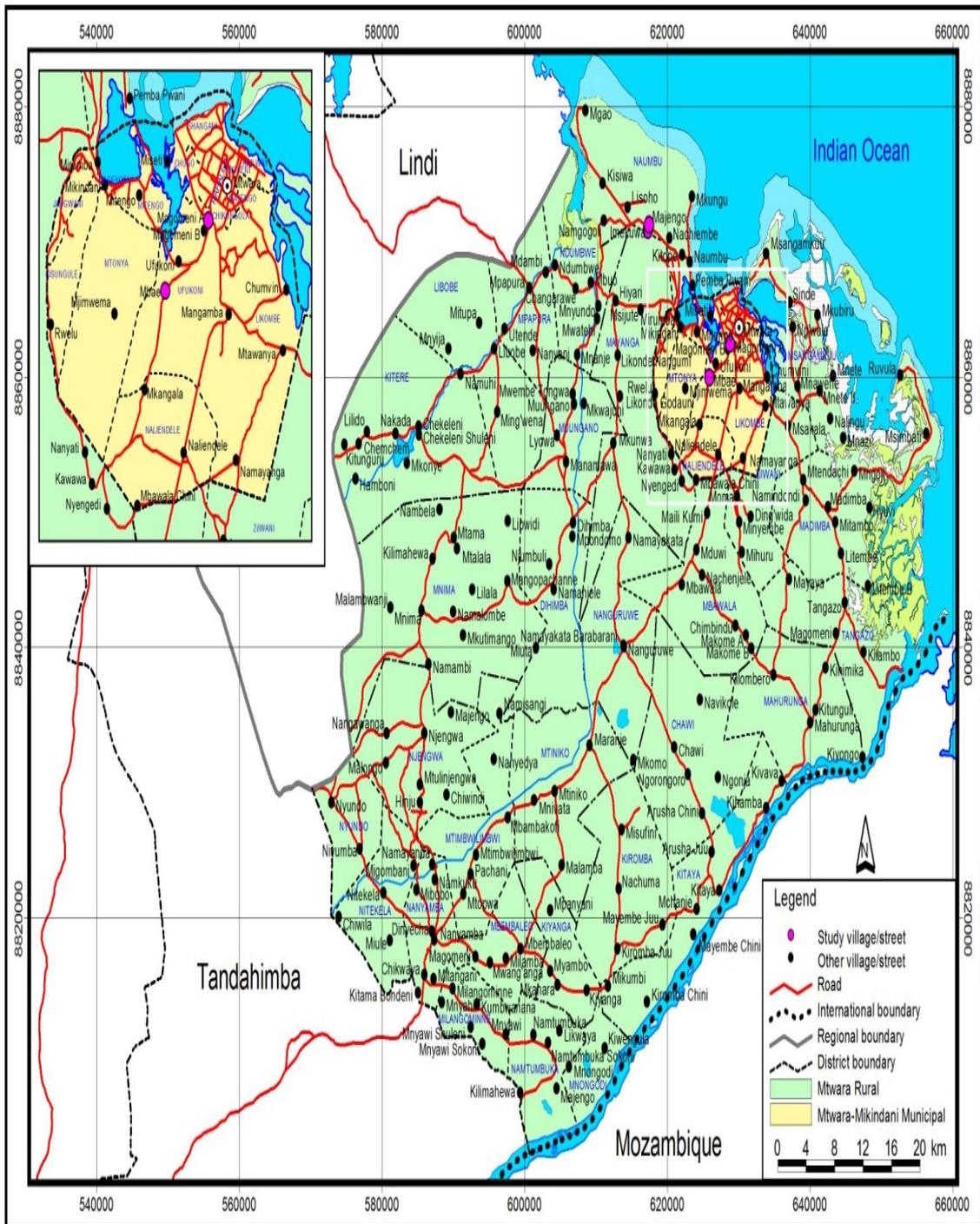


Figure 2: Study areas in Mtwara Municipal and District Councils

3.5 Data Collection

3.5.1 Instruments for data collection

The researcher used three instruments in collection of data. These were a structured questionnaire, a checklist for key informants (KIs) and a guide for Focus Group Discussions (FGDs), attached as Appendices 1, 2 and 3 respectively.

3.5.2 Primary data collection

The questionnaire was used to gather data from community members where HIV/AIDS NMSF interventions were being implemented while the checklist for KIs was used to collect data from community development officers, planning officers and village/street leaders. The FGD guide was used for focus group discussions.

3.5.3 Secondary information collection

Secondary information was used to supplement the primary data. HIV and AIDS information and some literature on community participation were obtained from TACAIDS regional office in Mtwara. Background information concerning the study area was obtained from Mtwara Municipal and Mtwara District Councils. The focus was to obtain data which could not be obtained through primary data sources.

3.6 Measurement of Participation

An index scale from seven statements was used as a measure of community participation in planning HIV and AIDS interventions. The possible minimum and maximum index scores were 1 and 12 respectively. According to seven identified indicators of participation as shown in Appendix 1 (Section D), three levels of participation were considered in the index scale whereby 1 = high level (9-12), 2 = Medium level (5-8) and 3 = Low level (0-4).

3.7 Data Analysis and Interpretation

Both quantitative and qualitative data analysis methods were applied. For quantitative data from the questionnaire copies, descriptive and inferential statistics were used. For descriptive statistical analysis, frequencies, percentages, mean and measures of variations were applied. For inferential statistical analysis, an ordinal logistic regression model was used. Since the dependent variable was a ranked variable as explained in Section 3.6, while the independent variables were a mixture of continuous and categorical variables, the statistical model of choice was ordinal logistic regression (Agresti and Finlay, 2009).

The ordinal logistic regression model is shown as follows:

$$P(y) = \frac{e^{\alpha + \beta_1 x_1 + \dots + \beta_k x_k}}{1 + e^{\alpha + \beta_1 x_1 + \dots + \beta_k x_k}}, \dots\dots\dots(ii)$$

where:

$P(y)$ = the probability of the success alternative occurring

e = the natural log

α = the intercept of the equation

β_1 to β_k = coefficients of the predictor variables

x_1 to x_k = predictor variables entered in the regression model

In this research:

$P(y) = 1$) = the probability of participation at the highest level in planning HIV and AIDS interventions

X_1 = Individual attitude (0=Unfavourable and Indifferent, 1=Favourable)

X_2 = Level of satisfaction with involvement in planning HIV/AIDS interventions (0=Not satisfied, 1=Satisfied)

X_3 = Awareness on NMSF interventions (0=Not aware, 1=Aware,)

X_4 = Understanding of Tanzania HIV Policy (0=No, 1=Yes)

X_5 = Access to information in planning HIV and AIDS interventions (0=No, 1=Yes)

X_6 = Net income (Annual earnings in cash)

X_7 = Age (Number of years after birth)

X_8 = Sex (0=Female, 1=Male)

X_9 = Education (0=Illiterate, 1=Educated i.e Primary, Secondary and College)

X_{10} = Marital status (0=Single, 1=Married)

X_{11} = Residence (0=Rural, 1=Urban)

X_{12} = Main occupation (0=Non-salaried employment i.e Farming and Business/Trade,
1=Salaried employment)

In measuring attitude towards HIV and AIDS interventions, a Likert scale on which the possible minimum and maximum scores were 12 and 60 respectively was constructed. The total scores for each statement was obtained by adding up the scores that different respondents got for the same statement. The average total scores from individual respondents were compared with points for negative (unfavourable), neutral (indifferent) and positive (favourable) attitudes. In this case, the most favourable attitude was represented by 60; the neutral attitude was represented by 36; and the most unfavourable attitude was represented by 12. Therefore, unfavourable attitude was denoted by 12 to 35; favourable attitude was denoted by 37 to 60; and indifferent attitude was represented by 36.

3.8 Limitations of the Research

Respondents had high expectation from the researcher to give them monetary allowances due to their participation in the research. This was because it is generally believed that HIV and AIDS programmes are funded by donors and so have lots of money. However, to ensure that the work was done, the researcher clearly took his time to tell the respondents about the purpose of the research and his role as a student before the interview.

Some respondents were reluctant to respond to the interview questions claiming that many researchers had visited them for interviews but they had not got any feedback from them about their findings. Other potential participants refused completely to be interviewed. The researcher had to explain to them that the findings would be shared with them through Council HIV and AIDS coordinators during planning sessions. Moreover, the respondents were told that responding to the research questions was based on their own consent.

Despite the above problems encountered, it is important to note that they did not invalidate the findings. The number of refusals from some respondents did not amount to any adverse consequences. This authenticates that the respondents had a choice to refuse or to participate in the interviews or withdraw from them.

CHAPTER FOUR

4.0 RESULTS AND DISCUSSIONS

4.1 Socio-Demographic Characteristics of the Respondents

The socio-demographic characteristics of the respondents studied were age, sex, education, marital status, main occupation and individual annual net income. The age of the respondents ranged from 15 to 54 years. Among the 192 respondents, 13.0% were between 15 and 24; 21.4% were between 25 and 34; 30.7% were between 35 and 44 and 34.9% were between 45 and 54 years old. The mean age for all the respondents was 38.4 ± 10.31 years.

In terms of education, the study findings revealed that 13.0% of the respondents were illiterate; 57.8% had attained primary school education; 24.0% had attained secondary education; and 5.2% had attained college education. The findings imply that most of the respondents in the study area had primary education, which is important for their daily economic activities as well as for acquiring and understanding HIV/AIDS information. However, lack of basic education i.e illiteracy has an influence on local peoples' participation in development projects (Brahmi and Thakur, 2011). Angba *et al.* (2009) asserted that education is a major determinant of effective participation in development projects. Educated people would most likely appreciate development better than less educated ones. If the people appreciate development, their attitude towards participation is likely to be favourable.

In terms of marital status, 69.8% of the respondents were married while the rest (30.2%) were single, which means they had never married, were divorced or widowed at the time of research. Marital status determines community participation in development initiatives

where in most cases levels of participation are relatively low among women who are married (Chifamba, 2013). The respondents had the following main occupations: salaried employment (11.5%), farming (59.9%) and business/trade (28.6%). The low percentage of salaried employment could be due to low level of education among the respondents; the majority had attained only primary education. The female and male respondents had the mean annual net incomes of 1 569 790.36/= and 1 570 871.88/= respectively. The socio-demographic characteristics of the respondents are shown in Table 2.

Table 2: Socio-Demographic characteristics of the respondents

Variable	Sex	
	Male %	Female %
Age category (Years)		
15-24	8.3	17.7
25-34	20.8	21.9
35-44	37.5	24.0
45-54	33.3	36.5
Education		
Illiterate	13.5	12.5
Primary	52.1	63.5
Secondary	31.3	16.7
College	3.1	7.3
Marital status		
Married	67.7	71.9
Single	32.3	28.1
Main occupation		
Salaried employment	8.3	14.6
Farming	68.8	51.0
Business/Trade	22.9	34.4

4.2 Awareness of NMSF and Attitude towards HIV and AIDS Interventions

Awareness of NMSF interventions was analyzed to find respondents' awareness level of NMSF interventions while their attitude was analysed to find whether they had favourable, neutral or unfavourable attitudes towards HIV and AIDS interventions.

The results under this Section 4.2 meet the first objective of the research.

4.2.1 Awareness of NMSF interventions

In order to determine the level of awareness about NMSF interventions, an index scale was developed. Five statements were constructed with the lowest score of 0 and the highest score of 8. The scores ranging from 0 to 4 were considered as being not aware while scores ranging from 5 to 8 were considered as being aware.

The findings in Table 3 indicate that the mean score was 2.31 which falls within the not aware category. They therefore revealed that 69.0% of the respondents who were the majority were not aware about NMSF interventions while 31.0% were aware of them. The problem of awareness about NMSF interventions was also observed from FGD participants and key informants. During the FGDs, the following was said:

“We have hardly heard of NMSF interventions in this area. The problem with our leaders is that they don’t take any initiative to involve communities in those issues from which they don’t get financial gain” (Female, 47 years, Mtwara District Council, December 18, 2014).

Another one said the following: *“It is difficult to get involved in issues that you are not aware of”* (Male, 24 years, Mtwara Municipal Council, December 21, 2014).

During the Key Informants interviews the following was also said:

“The dissemination of NMSF was done to the community leaders who in turn were expected to do a similar exercise to raise awareness with regard to the subject to their local people. However, the trickle-down effect to the community members has been so low that few leaders did such dissemination. As a result, the majority of community members

remain not informed of NMSF interventions” (Male KI aged 32 years, Mtwara Municipal Council, December 21, 2014).

Another Key Informant said the following: *“As a community leader, I can’t speak anything related to HIV and AIDS during public meetings because I do not have adequate knowledge and information about the subject matter”* (Female KI aged 38 years, Mtwara District Council, December 21, 2014).

A finding that is similar to the above arguments by the key informants was reported by Brahmi and Thakur (2011) that 90% of community members had no awareness about the rural development projects, and this had negative influence on community participation. Okwusi (2008) obtained similar findings that inadequate awareness of development projects affected community participation in the development programme. Similarly, Elham *et al.* (2008) reported the level of community awareness of development programmes as an influencing factor of community participation. It was also revealed during FGDs that people did not participate due to being not aware of NMSF interventions.

“Why should I participate in planning something that I am not even aware of?” (Female, 24 years, Mtwara Municipal Council, December 21, 2014).

“I have hardly heard of NMSF interventions in this area, so I don’t have any contribution to make during planning process” (Male, 47 years, Mtwara District Council, December 18, 2014).

The results are also in line with those reported by Bani *et al.* (2014) who reported positive influence of awareness towards mens' participation in family planning. Based on empirical evidences from the previous aforesaid studies and the research findings with regard to the level of community awareness of various programmes, probably the level of respondents' awareness may influence community participation in planning HIV and AIDS interventions.

Respondents being not aware of NMSF interventions are indicated by low scores which are summarized in Table 3. The level of awareness could have positive effect on their participation. The majority did not exactly know what was going on in their respective areas with regard to planning HIV interventions. This might have negative influence on their participation as the findings indicate non-participation of the majority in planning for HIV interventions under NMSF interventions. The findings indicate that the respondents did not adequately meet with the HIV technical experts during their previous meetings. This result was comparable to that reported by Elham *et al.* (2008) that the frequency of contact with a technical expert influenced community participation in development programmes. However, lack of contact with experts would lead to lack of expertise in technical matters (Khan, 2009). This was further mentioned as one of the root causes of non-participation.

Moreover, the majority of respondents did not have access to planning information. This is another factor that could probably affect their participation in planning HIV and AIDS interventions under NMSF. The finding is comparable with the one reported by Aref (2010) that lack of access to information was a barrier to community participation in development projects. Furthermore, the finding indicates that the majority of respondents had hardly heard of the National (Tanzania) HIV policy. It was found that 73.4% had

never heard about the HIV policy. Moreover, 15.3% claimed that HIV policy was not clear and 11.3% said it was clear. The policy provides the general framework for collective and individual response to the HIV and AIDS pandemic. Understanding the policy motivates individuals to know their responsibilities in relation to the national response and perform them (URT, 2001). The unawareness of HIV policy could probably have a negative influence on community participation towards NMSF interventions. The result is comparable with that reported by Aref (2010) that lack of understanding of policy was among the barriers to community participation.

Table 3: Awareness of NMSF Interventions indicators (n=192)

Statements about awareness	N	Minimum Score	Maximum Score	Sum	Mean
Awareness on planning of HIV and AIDS interventions	192	0	1	73	0.38
Participation in planning of HIV and AIDS interventions under NMSF	192	0	1	62	0.32
Meet with a technical expert for HIV and AIDS during meetings	192	0	4	195	1.02
Access to planning information about HIV and AIDS	192	0	1	63	0.33
Heard of HIV and AIDS policy	192	0	1	51	0.27

4.2.2 Attitude towards HIV and AIDS interventions

The attitudinal statements that were used and the respective scores in percentages are presented in Table 4. The findings indicate that the mean score was 28.64, which implies that, overall, the respondents had unfavourable attitude towards HIV and AIDS interventions as per attitude categories as described in Section 3.7 for unfavourable, favourable and indifferent attitude. The results in Table 5 indicate that there were 76.0%

respondents who had unfavourable attitudes; 1.0% with indifferent attitude and 22.9% with favourable attitude. The FGD participants supported the finding that unfavourable attitude towards HIV and AIDS interventions was the cause of non-participation in planning; they said:

“HIV interventions are for some government people to benefit financially. I don’t see the impact of these interventions in our area. It is better that the government should buy cars using HIV funds for carrying people living with HIV to hospital for treatment”. One of the FGD participants (Female, 49 years, Mtwara District Council, December 21, 2014) said so.

Another FGD participant (Male, 20 years, Mtwara Municipal Council, December 21, 2014) said that:

“It is better that I do my business to get food rather than attending non-paying stuffs which are useless”.

The research finding is in line with what has been reported by Okwusi (2008) who conducted a study on attitude towards rural development projects. It was revealed that youth’s unfavourable attitude was among the factors that affected their participation in development programmes. Likewise, unfavourable attitude affects community participation in planning HIV and AIDS interventions under NMSF.

Table 4: Attitude scores in percentage

Statements about attitude*	1	2	3	4	5
HIV and AIDS interventions under NMSF is for government and NGOs people to benefit financially	42.2	17.2	24.0	10.9	5.7
HIV and AIDS interventions under NMSF are specifically for prostitutes and people living with HIV	39.1	22.9	19.3	15.1	3.6
Community participation in planning for HIV and AIDS interventions is not important as it can't bring any change in terms of HIV and AIDS prevalence	41.7	20.3	20.3	13.0	4.7
There is no need for HIV and AIDS interventions as the magnitude of its impact is minimal	38.5	22.4	21.4	15.1	2.6
When you participate in HIV and AIDS events, the community see you as an HIV infected person and try to avoid you	27.1	33.9	21.9	10.9	6.3
HIV and AIDS interventions are full of abusive languages; you can not withstand the discussion	22.4	30.2	30.2	14.1	3.1
Community participation in planning for HIV and AIDS interventions under NMSF is very important as it reflects the real need of the community	26.0	28.6	21.4	9.4	14.6
HIV and AIDS interventions under NMSF are for the entire community	27.1	30.2	21.9	9.9	10.9
Community participation is highly required to contain the spread of HIV and AIDS	29.7	25.5	21.9	13.0	9.9
HIV and AIDS interventions are not for government and NGOs to benefit financially	25.5	28.6	26.0	10.4	9.4
The magnitude of the impact of HIV is great; so HIV and AIDS interventions under NMSF are very important to address the problem	24.0	32.3	21.4	9.9	12.5
Traditional practices which contribute to the spread of HIV and AIDS need open discussion for people to avoid and protect themselves from contacting the virus	34.9	24.0	18.8	7.3	15.1

*1=Strongly disagree, 2=Disagree, 3=Undecided, 4=Agree, 5=Strongly agree.

Table 5: Overall attitudes towards HIV and AIDS interventions

Overall attitudes	Frequency	Percentage
Unfavourable	146	76.0
Undecided	2	1.0
Favourable	44	22.9
Total	192	100.0

Comparison of individual attitude towards HIV and AIDS interventions was done between and among respondents with various background variables. The attitude scores were measured using a number of points scored on the Likert scale, and these were not

normally distributed. Therefore, Mann-Whitney U Test was used to compare the scores between urban and rural residents, male and female, married and single, younger and older, different education levels and main occupations as shown in Table 6.

The results indicate that the median score by urban residents was 36.0% while the median score by rural residents was 21.0%. The difference in the two scores was significant ($p \leq 0.001$), implying that there was significant difference in attitude between urban and rural residents at the 0.1% level of significance. A similar finding was reported by URT (2012b) that respondents in urban areas are more likely than those in rural areas to express accepting attitudes towards HIV interventions. It was reported that 36.0% of women and 55.0% of men in urban areas expressed accepting attitudes compared with 21.0% of women and 35.0% of men in rural areas.

Table 6: Comparison of individual attitudes between respondents

Groups	Median scores %	Mann-Whitney U Test (P value)
Urban residents	36.0	0.001
Rural residents	21.0	
Male	23.5	0.05
Female	22.0	
Single	25.5	0.05
Married	22.0	
Younger	20.0	0.05
Older	23.0	
Illiterate	22.0	0.001
Primary	20.0	
Secondary	48.0	
College	48.0	
Salaried employment	41.0	0.05
Farming	22.0	
Business/Trade	22.0	

The attitude scores compared between male and female indicated that the median score by female was 22.0% while the median score by male was 23.5%. The difference in the two

scores was significant ($p \leq 0.05$) implying that there was significant difference in attitude between female and male respondents at the 5% level of significance. Although the difference in attitude was not big, men had more positive attitude compared to women. This might be caused by the difference in education level between female and male respondents. People with more education are likely to have more access to more information compared to those with less education. Angba *et al.* (2009) asserted that access to information is a major determinant of effective participation in development projects. It is further reported that people who are informed would most likely appreciate development better than less informed ones. If people appreciate development, their attitude towards participation is likely to be favourable.

The attitude scores compared between married and single respondents indicated that the median score by married respondents was 22.0% while the median score among single respondents was 25.5%. The difference in the scores was significant ($p \leq 0.05$) implying that there was significant difference in attitude between married and single respondents at the 5% level of significance. The findings are similar to those reported by Chifamba (2013) that levels of participation in development projects are relatively low among women who are married. The probable reason for this could be caused by the difference in attitude between married and single respondents.

The attitude scores compared between younger and older respondents indicated the median scores were 20.0% and 23.0% for younger and older people respectively. The difference between the two scores was significant ($p \leq 0.05$) at the 5% level of significance. Angba *et al.* (2009) reported similar findings that ages of respondents affect their attitude towards participation in development projects. Old people are probably

likely to participate more in HIV interventions compared to youth due to their deep understanding and immense experience over the impact of the pandemic.

The attitude scores compared across different education levels indicated that the median score by illiterate was 22.0%, while the median score by primary, secondary and college were 20.0%, 48% and 48.0% respectively. The difference in the scores was significant ($p \leq 0.001$) implying that there was significant difference in attitude across respondents with various education levels at the 0.1% level of significance. However, there was no significant difference in attitude between the respondents with secondary and college education as both had the median score of 48.0%. This finding is in line with URT (2012b), which reported that respondents' attitude increases with level of education. It was further reported that women and men with at least secondary school or college education are more likely than other respondents to have positive attitude towards HIV programme. The study is also in line with that reported by Angba *et al.* (2009) that as one attains a higher level of education, attitude towards participation in development projects is likely to be more favourable. In essence, the higher the educational level attained, the more favourable the attitude towards participation in development projects.

The attitude scores compared across main occupations indicated that the median score for those with salaried employment was 41.0% while the median score for farming was 22.0% and for business/trade was 22.0%. The difference in the scores was significant ($p \leq 0.05$), implying that there was significant difference in attitude between salaried employment, farming and business/trade at the 5% level of significance. However, there was no difference in median scores between the farmers and business/trade. Angba *et al.* (2009) reported similar findings that occupation had some influence on respondents' attitude towards participation in development projects. From the study, the salaried

employees had more education than those with other occupations (farmers and business/trade). The probable reason for the difference in attitude by occupation might be attributed to the education level of respondents.

4.3 Community Participation in Planning

This section 4.3 aims at assessing the level of community participation in planning for HIV and AIDS interventions. Knowing the participation level was of paramount importance for setting strategies to ameliorate the situation in case it was low. The results in this Section 4.3 meet the second objective of the research.

4.3.1 Level of community participation

Despite the government efforts to push the community to participate in planning, yet the study indicates almost low scores in all participation indicators. Section 3.6 shows measurements of community participation. Table 7 indicates that there were low scores on all constructed participation indicators. Furthermore, it indicates that the total mean score was 3.15 with the minimum score of 0 and the total maximum score of 12.

Table 7: Participation level indicators (n=192)

Statements about participation	N	Minimum Score	Maximum Score	Sum	Mean
Number of HIV and AIDS planning meetings attended for the last 12 months	192	0	4	199	1.04
Having ever attended any event on HIV and AIDS	192	0	1	83	0.43
Having participated in selecting multisectoral AIDS committee members and given feedback	192	0	1	58	0.30
Whether involved in decision making with regard to identified activities	192	0	1	58	0.30
Awareness of activities in village/mtaa plan	192	0	1	50	0.26
Level of satisfaction with involvement in planning of HIV nad AIDS interventions	192	0	2	84	0.44
Involvement in planning for HIV and AIDS interventions	192	0	2	72	0.38

Since the total mean score of 3.15 falls within the range of 0-4, therefore, the results mean that there was low community participation in planning HIV and AIDS interventions in Mtwara region as indicated in Table 8. Furthermore, the findings indicate that 69.3% (133), 12.5% (24) and 18.2% (35) of the respondents participated to a low extent, to a medium extent and to a high extent respectively in planning HIV and AIDS interventions in Mtwara District and Municipal Councils.

Table 8: Level of community participation (n=192)

Participation level	Frequency	Percent
Low	133	69.3
Medium	24	12.5
High	35	18.2
Total	192	100.0

In order to find the relationship between variables, the overall participation was correlated with other variables recorded at the ratio level, particularly age, income, overall attitude and awareness. The findings are summarised in Table 9.

Table 9: Correlation between some independent variables and the dependent variable*

Independent Variable	n	Correlation Coefficient (r-value)	Sig. (p-value)
Age of respondents	192	0.252***	0.000
Total net Income of respondents per month	192	-0.005	0.949
Overall attitude towards HIV and AIDS interventions	192	0.696***	0.000
Extent of awareness of NMSF interventions	192	0.944***	0.000

*The dependent variable was participation in planning HIV and AIDS interventions

***Correlation is significant at the 0.001 level (2-tailed)

The results in Table 9 show that age of respondent had positive correlation with the dependent variable which is community participation in planning HIV and AIDS

interventions. This implies that old individuals are likely to participate more in planning HIV interventions under NMSF. This was also revealed during key informant interviews; one of the Key Informants said that:

“When it comes to issues of volunteering in development programmes, youth hardly participate. This might be largely attributed to their unfavourable attitude towards these programmes” (Male KI, 52 years, Mtwara District Council, January 03, 2015).

“Youth do not have time to participate in these programmes because they think there are no tangible benefits. It is for this same reason that they ignore important stuffs, and that is why even the prevalence of HIV and AIDS is high among youth compared to old people” (Female KI, 36 years, Mtwara Municipal Council, January 07, 2015).

Furthermore, the findings based on the Mann-Whitney U Test in Section 4.2 show that age was significantly related to attitude ($p \leq 0.05$) at the 5% level of significance. However, the observed significant relationship was not very strong. The implication for this finding is that individual participation towards planning HIV and AIDS interventions tends to improve with increasing age of respondents. It is with this observation that youth hardly participate in planning because of their younger age. Angba *et al.* (2009) reported similar findings that there was a positive correlation between age and participation in development projects.

However, the total net income of respondents had negative correlation with the level of participation. This means that people with low income participated more in planning of HIV and AIDS interventions as compared to people with high income. The research finding is against what Siddiquee (1998) reported that scanty participation in development

projects was limited only to the rich, and participation of poor was minimal. The empirical information reported is not in line with what was found in this study.

The respondents' overall attitude towards HIV and AIDS interventions had positive correlation with community participation which was the dependant variable. The relationship between overall attitude and community participation in planning HIV and/AIDS interventions was strong at the 0.1% significance level. The finding is comparable with that reported by Bani *et al.* (2014) who found a positive correlation between mens' attitude and their participation in family planning. It was further reported that mens' attitude was positively associated with participation. The result depicts that people with favourable attitude towards HIV and AIDS interventions are likely to participate more in planning of such interventions.

Respondents' extent of awareness of NMSF interventions had a positive correlation with the dependent variable which was community participation in planning HIV and AIDS interventions. The relationship between extent of awareness and community participation in planning was very high and significant at the 0.1% level of significance. The results imply that the more people are aware of NMSF interventions, the more they likely to participate in planning HIV and AIDS interventions. Brahmi and Thakur (2011) reported similar findings that 90% of community members who were not aware about the project had poor participation. Similar findings were reported by Okwusi (2008) who asserted that inadequate awareness of rural development projects was among the factors that affected participation in development projects. The finding is also comparable to that reported by Elham *et al.* (2008) that level of awareness of people about interventions influenced their participation in planning development projects. It was also reported that

general awareness creation helped in motivating and increasing the level of community participation in rural development (Chifamba, 2013).

4.3.2 Reasons for inadequate participation in HIV and AIDS Interventions

A number of questions were used to probe the issue of inadequate participation in planning HIV and AIDS interventions. The respondents were asked to give reasons for inadequate attendance in attending planning meetings, HIV events, participation in selection of multisectoral committee members, involvement in decision making with regard to identified activities and awareness of activities in village/street plans. The selection of questions was based on five construct of participation.

With regard to reasons for inadequate attendance in attending planning meetings as seen in Table 10, the respondents mentioned that government and donors plan for them, lack of follow up from the council, lack of knowledge in planning, lack of information and some claimed that planning meetings were not conducted. The highest percentage of respondents showed their planning dependency towards the government and donors. The planning dependency was also observed during the FGDs from the following quotes:

“Planning is the government’s responsibility, and we are the recipients of whatever is planned for us” (Male, 24 years, Mtwara District Council, December 21, 2014).

“There are planning officers working with the government whose work is to plan for us and Council HIV and AIDS coordinators ensure programmes are implemented. I don’t see the need for us to get involved as we trust their work” (Female, 49 years, Mtwara Municipal Council, January 07, 2015).

The finding is comparable to the argument by Barasa and Jelagat (2013) who asserted that dependence that prevailed among communities was not oriented towards people's participation in development projects. It was further argued that the mentality of dependency, the culture of silence, domination of the local elite or gender inequality militated against people's participation. Aref (2010) and Chifamba (2013) reported similar findings that lack of access to information could be a barrier to community participation.

Lack of follow up from the government was comparable to results of a study by Chifamba (2013) which showed that government and its presence at the grassroots was important in promoting participation. Respondents claimed that lack of follow up from the council, which is the government, hindered their participation in planning for HIV and AIDS interventions. The finding was in line with those obtained during FGDs that:

“It seems that there is lack of seriousness by the council people in planning process. Personally I have never seen any council representative during planning process. This discourages me to participate” (Male, 43 years, Mtwara Municipal Council, January 07, 2015).

“There is no one who makes follow ups on whether community was involved in planning; it seems they have their plans at hand” (Female, 31 years, Mtwara District Council, December 21, 2014).

With regard to knowledge, the finding was similar to that reported by Takyi and Yussif (2013) who asserted that low knowledge level accounted for low participation of stakeholders at the local level. Furthermore, Khan (2009) and Takyi and Yussif (2013)

reported a similar finding that lack of knowledge among others were the root cause of non-participation in development projects. Cooksey and Kikula (2005) identified similar constraints to community participation including poor leadership at community level, lack of facilitation capacities at local leadership, dependency syndrome and lack of capacity in planning and implementation at local community.

Table 10: Reasons* for inadequate attendance in HIV planning meetings (n=153)

Response	Respondents	
	n	Percentage
The government and donors do for us	57	37.3
Lack of follow up from the council	36	23.5
I don't have knowledge	29	19.0
Lack of information	20	13.1
Leaders do not organize meetings	11	7.2
Total	153	100

*Multiple response table

Besides the results presented in Table 10, other findings indicate that 43.2% of respondents had attended HIV events while 56.8% who were the majority had not attended. Since events were conducted at the village/street levels, the researcher decided to ask the reasons behind their non-participation. The reasons mentioned for inadequate participation in HIV and AIDS events included whether having attended or not brings no difference; lack of awareness; it is wastage of time; and some claimed that they were not HIV and AIDS positive. The probable reasons for the aforementioned respondents' responses could be due to their ignorance about importance of events and lack of access to information. The scores for respective responses are indicated in Table 11.

Table 11: Reasons* for inadequate attendance on HIV events (n=97)

Response	Respondents	
	n	Percentage
It doesn't bring a difference	35	36.1
I was not aware of the event date	34	35.1
It is wastage of time	24	24.7
I am not a HIV positive person	4	4.1
Total	97	100

*Multiple response table

Knowing reasons for inadequate community participation in selecting Multisectoral AIDS committee (MACs) members, was one of the researcher's intention. In response to poor community participation, the government of the United Republic of Tanzania has made several efforts, one of them being the introduction of the MACs. The guidelines for forming MACs were introduced in 2003 in order to provide basic planning framework for effective response to HIV and AIDS, and play a key role in the design of HIV and AIDS related activities at the local level. Moreover, the guidelines instructed the MACs to involve the community in planning processes for the response to the HIV and AIDS epidemic, increasing AIDS awareness, as well as record keeping on HIV and AIDS activities (Sikika, 2013). This had the intention to improve community involvement in planning in response to their problems. This could eventually lead to improved planning and implementation and consequently lead to overall improvement of HIV and AIDS services in Tanzania (Sikika, 2013). It was further argued that in addition to the formation of MACs, the government had allocated funds within its budget for strengthening of the MACs at the village/street and ward levels.

When asked whether they participated in members' selection, the findings indicated that respondents had no information; claimed non-existence of the committee itself, claimed they were not involved in selection process, and the least one was that it does not make

any difference even if committee members are selected. Table 12 shows the percentage scores for the respective responses.

Table 12: Reasons* for inadequate attendance in selection of MACs members (n=125)

Response	Respondents	
	n	Percentage
I had no information	49	39.2
There is no committee	48	38.4
I was not involved	16	12.8
It does not make any difference	12	9.6
Total	125	100

*Multiple response table

The respondents might have experience from other places where they were involved in selection of members and yet unfunctional MACs. The probable reason for the response that it does not help might have been caused by this fact. Sikika (2013) reported theoretical existence of MACs within the Local Government Authorities (LGAs) that they were not functioning as per the purposes of establishment. It was further reported that MACs members did not have an understanding on the planning and budgeting procedures. It was noted that it could be difficult for the MACs to involve community in planning because the committee members themselves did not know planning and budgeting procedures.

Responding to the question on whether they were involved in decision making with regard to the identified activities, the respondents had different responses. They responded that the council plans and implements HIV and AIDS interventions; the community members are not involved because of their low education; leaders and council management communicate without their knowledge. The percentage scores for each response are shown in Table 13.

Table 13: Reasons* for inadequate participation in decision making (n=108)

Response	Respondents	
	n	Percentage
The council plans and implements HIV/AIDS Interventions	54	50.0
Community members are not involved because of their low education	38	35.2
Their leaders and council communicate without their knowledge	16	14.8
Total	108	100

*Multiple response table

The majority of the respondents had the opinion that plans were normally prepared at the council level. This implies the practice of top down approach and not bottom up. Sikika (2013) reported similar findings that participation of community in designing, planning and implementing HIV and AIDS activities in Tanzania is still limited. It was further reported that target population does not actively participate in setting up process (URT, 2008 cited by Sikika, 2013). Respondents had also the opinion that, lack of education might have made the council to ignore them in the planning process. This is also comparable with a study by Takyi and Yussif (2013) who reported that differences in levels of knowledge between local citizens and government officials lead to mistrust and marginalization which affect local community participation.

Respondents were asked if they were aware of HIV and AIDS activities in their village/street plans. This was meant to see if the plans existed and if they were prepared in a participatory way. More than three-fifths (63.5%) of the respondents gave different responses. The mentioned reasons for inadequate awareness in the village/street plans were planning dates not being communicated on time; what they planned was not implemented; some claimed leaders do prepare plans without their knowledge, and HIV was not their priority. The responses are indicated in Table 14.

Table 14: Reasons* for inadequate awareness of village/street plan on HIV (n=122)

Response	Respondents	
	n	Percentage
Planning dates were not communicated timely	53	43.4
What we planned is not implemented	33	27.0
Plan is prepared by leaders without our knowledge	27	22.1
HIV is not the priority for me	9	7.4
Total	122	100

*Multiple response table

The study revealed that community priorities were not taken on board as they were not implemented. A similar finding was observed during FGD sessions; it was argued that:

“Frankly speaking we have been involved in planning processes previously. However, whatever we planned was not implemented. Why should I continue to participate?”

(Female, 41 years, Mtwara Municipal Council, December 21, 2014).

“I do not have any information on whatever is implemented because are not within what we planned and agreed” (Male, 17 years, Mtwara District Council, December 21, 2014).

This had probably hindered their participation in planning HIV and AIDS interventions at their respective areas. If the community participated in planning, they would be in a position to know what was planned. Sikika (2013) reported similar findings that community members were not aware of plans and budgets related to HIV and AIDS at their areas. It was further reported that 15 of the 78 respondents said that they were aware of plans, and this was approximately 19%. The communication flow from the leaders to the community with regard to the planning was also poor. People were not aware about the planning dates, and so this might be a reason which hindered their participation.

4.4 Extents to which Attitude towards HIV/AIDS Interventions and Awareness of NMSF Influence Participation

The results in this Section 4.4 meet the third objective and are also about results of testing the null hypothesis. In order to meet this objective and test the hypothesis, ordinal logistic regression model was used. The variables used in this research, their operational definitions, scale and levels of measurements are presented in Appendix 4. The ordinal logistic regression model was specified as seen in chapter three, and the results are seen in Table 15.

Table 15: Results for ordinal logistic regression model

Variables	Estimate	Std. Error	Wald	df	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
Attitude	0.034	0.015	5.186	1	0.023	0.005	0.064
Satisfaction	3.848	0.563	46.700	1	0.000	2.744	4.951
Awareness of NMSF interventions	4.294	0.804	28.525	1	0.000	2.718	5.870
Understanding of Tanzania HIV policy	0.346	0.461	0.566	1	0.452	- 0.556	1.249
Access to information	1.210	0.509	5.651	1	0.017	0.212	2.207
Net income	1.890	1.227	0.024	1	0.878	- 2.216	2.594
Age	- 0.005	0.015	0.093	1	0.760	- 0.035	0.026
Sex	- 0.030	0.312	0.009	1	0.924	- 0.641	0.582
Education	0.686	0.276	6.175	1	0.013	0.145	1.228
Marital status	0.031	0.352	0.008	1	0.929	- 0.659	0.722
Residence	- 0.055	0.365	0.022	1	0.881	- 0.769	0.660
Salaried employment	0.874	0.515	2.881	1	0.090	- 0.135	1.884

Model Summary: Cox and Snell $R^2 = 0.777$, Nagelkerke $R^2 = 0.793$, Model fitting information Chi-square 288.506 ($p < 0.001$), Test of Parallel Lines -2 Log Likelihood = 26.726 ($p < 1.000$)

Considering the summary in Table 15, the Nagelkerke R^2 value was 0.793, which means that the independent variables entered in the model explained 79.3% of variance in the

dependent variable. The results in Table 15, showed that attitude towards HIV and AIDS interventions and awareness of NMSF interventions had positive impacts that were significant (Wald = 5.186, $p < 0.05$ for attitude, and Wald = 28.525, $p < 0.001$ for awareness). In view of the above results, the null hypothesis which said that chances of participating highly in planning of HIV and AIDS interventions are the same for people with different attitudes towards HIV and AIDS interventions and different levels of awareness of NMSF interventions was rejected.

Other variables with significant impacts as seen in Table 15 include communities' satisfaction with involvement in planning HIV and AIDS interventions (Wald = 46.700, $p < 0.001$), access to information in planning (Wald = 5.651, $p < 0.05$), and education (Wald = 6.175, $p < 0.05$). The findings show that people who are satisfied with involvement in planning are much likely to attend planning meetings as opposed to people who are not satisfied. This is mainly because they appreciate the level of involvement with regard to participation in planning process. Similar findings were reported by Nomvakaliso (2007) who asserted that high or active participation is mostly likely when different stakeholders involved in a project or programme are satisfied with the level at which they are involved.

In line with access to planning information, the implication of this finding is that people with access to information are more likely to participate more in planning HIV and AIDS interventions compared to people without access to information. Aref (2010) reported similar findings that lack of access to information could be one of the barriers to community participation in development projects. Another similar study conducted by Chifamba (2013) identified lack of information among other factors that hindered community participation in development projects. The implication for the impact of

education level is that educated people are likely to attend planning meetings compared to those who are not educated. The probable reason for this is that those who are better educated would be better empowered for participation because their attitude would likely be favourable. Angba *et al.* (2009) reported similar findings that education is a major determinant of effective participation in development projects. The author further argued that effective participation obviously requires communicative and human relational skills which must be learned.

4.5 Views on how to Improve Participation

When asked to give their views on how to improve participation in planning, about two-fifths (42.4%) of the respondents mentioned feedback over previous plans was the major suggestion for improving participation in the planning of HIV and AIDS interventions. Communities need to get feedback on whatever thing they participated in; otherwise, they might think planning is wastage of their time as nothing comes out of it. The least suggestion was to establish organized structure for planning at community grassroots. This is probably there is no stable structure to coordinate planning activities related to HIV and AIDS interventions under NMSF. Other suggestions are indicated in Table 16.

Table 16: Community views* to improve participation

Statement	Responses	
	n	Percent
Feedback over previous plans to motivate participation	75	42.4
Adequate community sensitization/mobilization	50	28.2
Leaders trained on planning knowledge	24	13.6
HIV and AIDS planning combined with other development programmes	13	7.3
Follow up from the council to ensure people do participate in planning	8	4.5
Establish stable organized structure for planning at community grassroots	7	4.0
Total	177	100.0

*Multiple response Table

The respondents advised that there should be adequate sensitization to the community on the importance of planning. Mubyazi *et al.* (2007) reported similar findings that people need to be adequately sensitized to ensure their informed and desired participation. The author further argued that it makes no sense to let people participate in any activity without them being told why they have to be and/or are being brought on board. The respondents had the view that leaders be skilled in planning and budgeting process in order to improve community participation in planning HIV and AIDS interventions. Since HIV and AIDS interventions had being treated as a separate programme during the planning cycle, the respondents had the opinion that combination with other development programmes would be inevitable for improved participation. The respondents further argued that a close follow-up by the council would motivate people to participate hence improved participation.

4.6 Relevance of the Social Psychology of Participation Theory (SPPT) in the Study

Area

Community participation is driven by ideological and political commitments to participation, contested and framed either as a basic human right, a pragmatic strategy to utilise services or as a pathway to empowerment (Morgan, 2001). As a pathway to empowerment, the SPPT advocates that for participation to offer community empowerment to exercise greater agency over their health, it should take place in a social space where all participants have the right to participate fully in the design, implementation and evaluation of programmes, with programmes being driven by a synthesis of local and expert knowledge, with both knowledge systems being accorded equal respect (Baatiema *et al.*, 2013). Rappaport (1987) suggests that participation is most likely to empower marginalised communities to exercise greater control of their lives (and more specifically their health) if it is framed within a dialogical and facilitative approach

through knowledge negotiation and power transfer from health professionals to communities.

In view of the findings, the social psychology of participation theory (SPPT) explains the level of participation of the people of Mtwara Municipal and District Councils in planning HIV and AIDS interventions as follows. Their participation in such interventions is generally low, as revealed by the research findings. Therefore, if the problem of low participation is not addressed, communities will not get the chance for empowerment hence will fail to exercise greater agency over their own health. With this regard, a tendency to wait for outside actors and agencies to take control of local health problems will likely continue to exist. Finally, it will affect ownership and sustainability of HIV and AIDS interventions under NMSF.

CHAPTER FIVE

5.0 CONCLUSIONS AND RECOMMENDATIONS

5.1 Conclusions

Based on the results meeting the first objective, it is concluded that there was a high proportion of people with unfavourable attitude towards HIV and AIDS interventions under NMSF in Mtwara Municipal and Mtwara District Councils. However, there were significant differences in attitude between urban and rural community; male and female people; married and single people; younger and older people; and across education levels and occupations. The results imply that urban residents, men, single people, older people, people with higher education level, and salaried employees are likely to have more positive attitudes toward HIV and AIDS interventions under NMSF compared to their counter parts.

In view of the finding meeting the second objective, it is concluded that the proportion of community members with low participation was very high and that few people participated in planning HIV and AIDS interventions in Mtwara Municipal and Mtwara District Councils. The problem of low participation was partly attributed to dependency syndrome; lack of follow up from the Council; lack of planning knowledge and information; planning meetings not organized, ignorance of HIV planning; previous plans not implemented; and HIV not given a priority at the grassroots level. Furthermore based on the significant relationship observed between awareness of NMSF interventions and participation and attitude towards HIV/AIDS interventions and participation, it is concluded that there was positive and strong correlation between participation and awareness of NMSF and attitude towards HIV and AIDS interventions.

On the basis of the findings meeting the third objective, it is concluded that attitude towards HIV and AIDS interventions and awareness of NMSF interventions are among the factors which have strong influence with regard to community participation in planning. Besides the aforementioned factors with significant impact others include access to planning information, satisfaction on involvement in planning and education level.

5.2 Recommendations

In order to improve community participation in planning HIV and AIDS interventions, the following recommendations which have been derived from the findings of this study are given. To facilitate their effective implementation, the recommendations are divided into policy level, local government level and grassroots level.

Policy level recommendations

- (i) In line with the conclusion that community members have unfavourable attitude towards NMSF interventions, it is recommended that the national (Tanzania) HIV policy should include dissemination strategies and follow up measures for its effective implementation. Through dissemination, awareness towards NMSF interventions will be improved and change for positive attitude enhanced.
- (ii) Based on the conclusion that community participation was low, it is recommended that TACAIDS should update its monitoring and evaluation system to include indicators for community participation in planning HIV and AIDS interventions to ensure its effective implementation and follow up measures aiming at improving participation.

- (iii) The central government should consider coordination roles of HIV interventions under NMSF at all levels mandatory whereby failure of its implementation will hold leaders accountable. This will reduce if not eliminate the aforementioned hindrances to community participation in planning processes.

Municipal level recommendations

- (i) The council management teams should ensure dissemination of steering tools including Essential Planning Package (EPP) for HIV and AIDS interventions, National Multisectoral Strategic Framework, national HIV policy and Participatory planning for HIV and AIDS using Opportunities and Obstacles approach to development is done to community leaders. The leaders in turn will do dissemination to the grassroots to improve communities' attitude towards HIV and AIDS interventions.
- (ii) The councils should provide proper guidance and sufficient clarification on what is required as far as HIV and AIDS planning process is concerned. This will enable community to participate in planning process and carry out activities more efficiently. This requires that councils provide for such activities in their Medium Term Expenditure Frameworks (MTEFs) budgets and conduct frequent supportive supervisions.
- (iii) The Councils should ensure that plans which are emanated from grassroots are shared before being incorporated in their MTEFs. This will help to solve the identified hindrances to participation in planning HIV and AIDS interventions.

Street level recommendation

- (i) Since the villages/streets organise public meetings concerning different issues like environment, education and health, it is recommended that they should incorporate HIV and AIDS issues in every meeting and report them.

- (ii) The community leaders should address the hindrances to community participation within their capacity. This will in turn improve community awareness of and their attitude towards HIV and AIDS interventions which seem to have positive and strong correlation with participation. The more the awareness of and attitude towards HIV and AIDS interventions improved, the more people participate in the planning process.

- (iii) Community sensitization for awareness rising should be a continuous process rather than a one-off process. Lessons should be learned from practical approaches so that appropriate measures to improve the situation can be taken. What is important to know is that even if the community may be seen as uninformed in some aspects, it is the target beneficiary, often the greatest implementer and the final user of the intervention or programme. Community leaders should make sure that what they learnt from dissemination meetings are in turn disseminated to the community grassroots through village/street meetings.

Suggestions for Further Research

- (i) The findings presented in this study are a result of a survey conducted in one region which cannot be representative of the total Tanzania population. Therefore, there is a need for more studies on the same subject in other regions, especially in urban and rural areas where NMSF interventions are being implemented.

(ii) Upon completion of the research with the given research questions and the scope, it was observed that some critical and relevant issues have not been covered by this research. In this study the prime focus was given in planning stage whereas the other stages like implementation, monitoring and evaluation stages remained untouched which can be a relevant and interesting areas for future research.

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APPENDICES

Appendix 1: A questionnaire for Individuals for Research on:

Questionnaire No.

**Determinants of Community Participation in Planning HIV and AIDS Interventions
Under National Multisectoral Strategic Framework in Mtwara Region, Tanzania**

By

Joel Elia Mwanga

M.A. (Rural Development Student), Mobile Phone: +255 752 333 334/783 505 897

My name is Joel Elia Mwanga, a student from Sokoine University of Agriculture. I am conducting a study on the “**Determinants of community participation in planning HIV and AIDS interventions under National Multisectoral Strategic Framework in Mtwara Region**”. This research is being conducted in partial fulfilment of the requirements for my degree in Master of Arts in Rural Development. Kindly provide answers to the questions as honestly and precisely as possible. All informations provided will be kept confidential and will only be used for the purpose of this research.

A. BACKGROUND INFORMATION

1. District: 1. Mtwara Municipal Council [] 2. Mtwara District Council []
2. Name of Ward
3. Name of Street/Village:.....
4. Please indicate residence: 1. Urban [] 2. Rural []
5. Sex of respondent: 1. Male [] 2. Female []
6. Marital status: 1. Married [] 2. Single []
7. Age in complete years:
8. Level of education: 1. Illiterate [] 2. Primary school [] 3. Secondary school []
4. College []

9. Main occupation: 1. Salaried employment [] 2. Farming [] 3. Businessmen/Trade []

10. Would you kindly tell me your main sources of income and the amounts you obtained from them during the 2013/14 year

Sources of income	Costs	Gross income	Net income
Crop production			
Livestock production			
Wages/Salaries			
Others (Specify)			

B. ATTITUDE TOWARDS HIV AND AIDS INTERVENTIONS

11. Please kindly say whether you agree or disagree with the statements in the following statements and the extent to which you do so

(Key: 1= Strongly disagree, 2=disagree, 3=Undecided, 4=Agree, 5=Strongly agree)

No	Statements about attitude	Connotation	1	2	3	4	5
1	HIV and AIDS interventions under NMSF is for government and NGOs people to benefit financially	-					
2	HIV and AIDS interventions under NMSF are specifically for prostitutes and people living with HIV	-					
3	Community participation in planning for HIV and AIDS interventions is not important as it can't bring any change in terms of HIV and AIDS prevalence	-					
4	There is no need for HIV and AIDS interventions as the magnitude of its impact is minimal	-					
5	When you participate in HIV and AIDS events, the community see you as an HIV infected person and try to avoid you	-					
6	HIV and AIDS interventions are full of abusive languages; you can not withstand the discussion	-					
7	Community participation in planning for HIV and AIDS	+					

	interventions under NMSF is very important as it reflects the real need of the community						
8	HIV and AIDS interventions under NMSF are for the entire community	+					
9	Community participation is highly required to contain the spread of HIV and AIDS	+					
10	HIV and AIDS interventions are not for government and NGOs to benefit financially	+					
11	The magnitude of the impact of HIV is great; so HIV and AIDS interventions under NMSF are very important to address the problem	+					
12	Traditional practices which contribute to the spread of HIV and AIDS need open discussion for people to avoid and protect themselves from contacting the virus	+					

C. AWARENESS OF NMSF INTERVENTIONS

12. Do you know anything about planning of HIV and AIDS interventions in your area?

No = 0 Yes = 1

13. Do you participate in planning for HIV and AIDS interventions under NMSF?

No = 0 Yes = 1

14. During the last 12 months how many times did you meet with a technical expert specifically for HIV and AIDS during your village/Street meetings?

0,1,2,3,4 times

15. Do you have an access to planning information about HIV and AIDS interventions?

No = 0 Yes = 1

16. (a) Have you ever heard of HIV and AIDS Policy? No = 0 Yes = 1

(b) If yes, was it clear to you? No = 0 Yes = 1

D. LEVEL OF COMMUNITY PARTICIPATION IN PLANNING HIV AND AIDS INTERVENTIONS

17. Levels of participation in HIV/AIDS interventions

No.	Indicator of participation	Index score	Reasons for inadequate attendance or negative answer
1	Number of HIV Planning meetings attended for the last 12 months (0-4)		
	Not attended even once = 0		
	Attended once = 1		
	Attended twice = 2		
	Attended three times = 3		
	Attended four times = 4		
2	Having ever attended any event on HIV and AIDS		
	No = 0		
	Yes = 1		
3	Having participated in selecting multisectoral AIDS committee members and given feedback		
	No = 0		
	Yes = 1		
4	Whether the respondent was involved in decision making with regard to identified activities		
	Not involved = 0		
	Involved = 1		
5	Awareness of activities in village/Street plan		
	Not aware = 0		
	Aware = 1		
6	Level of satisfaction with how you are involved in planning of HIV and AIDS interventions 0 = Not satisfied, 1 = A little satisfied, 2 = Much satisfied		

7	<p>How have you been involved in planning for HIV and AIDS interventions?</p> <ul style="list-style-type: none"> • Coerced participation (Non participation) = 0 • Induced participation (Participation by giving suggestions and making criticisms aimed at improvement of an activity) = 1 • Spontaneous participation (Citizens define the problem and decide the action) = 2 		
Total points scored			

E. GENERAL FACTORS INFLUENCING INDIVIDUAL'S PARTICIPATION IN PLANNING

1. What are the factors that constrained your participation in activities for planning HIV and AIDS interventions? (*Answers to be filled in the following table*)

Item	Reason
Not attending HIV and AIDS planning meetings	
Not undergoing training	
Not participated in selecting Multisectoral AIDS committee members	
Not participated in decision making with regards to identified activities	
Not aware of activities at the village/Street level	

F. VIEWS ON HOW TO IMPROVE PARTICIPATION IN HIV/AIDS INTERVENTIONS

2. Respondents' views on how to improve participation of HIV and AIDS interventions under NMSF

.....

.....

.....

.....

THANK YOU FOR YOUR COOPERATION

Appendix 2: A checklist of items for discussion with community development officers, planning officers, village/ street leaders for Research on:

Questionnaire No.

Determinants of Community Participation in Planning HIV and AIDS Interventions Under National Multisectoral Strategic Framework in Mtwara Region, Tanzania

By

Joel Elia Mwanga

M.A. (Rural Development Student), Mobile Phone: +255 752 333 334/783 505 897

-
- 1 Name of the District Council:.....
 - 2 Designation of key informant:.....
 - 3 When does planning process start?
 - 4 How do you give information over planning process to the community?
 - 5 How do you involve community in planning for HIV and AIDS interventions in your area?
 - 6 Do you know the importance of community participation in HIV planning?
 - 7 How was the community response towards planning for HIV and AIDS interventions in the last 12 months?
 - 8 What could be the influencing factors towards planning HIV and AIDS interventions under NMSF?
.....
 - 9 What are your views on how to improve community participation in planning HIV and AIDS interventions under NMSF?
.....
.....

THANK YOU FOR YOUR COOPERATION

Appendix 3: A checklist of items for discussion in FGD for Research on:

Questionnaire No.

**Determinants of Community Participation in Planning HIV and AIDS Interventions
Under National Multisectoral Strategic Framework in Mtwara Region, Tanzania**

By

Joel Elia Mwanga

M.A. (Rural Development Student), Mobile Phone: +255 752 333 334/783 505 897

-
1. Name of District Council:.....
 2. Name of village/street:
 3. Are you aware of HIV and AIDS interventions that were implemented in your area for the last 12 months?.
 4. What are those interventions that you are aware of?
 5. Did you participate in planning HIV and AIDS interventions in your area?
 6. How were you involved in planning?
 7. Were there problems associated with your participation in HIV and AIDS planning?
 8. If yes, what were those problems?
 9. What are your views on how to improve community participation in planning HIV and AIDS interventions?

THANK YOU FOR YOUR COOPERATION

Appendix 4: The variables used in the research, their operational definitions, scale and levels of measurements

Variables	Operational definitions	Scale	Level of measurements
Age	Number of years after birth	Ratio	Years
Sex	Being a male or a female	Nominal	0 = Female, 1=Male
Education	The level of education one has	Ordinal	0 = Illiterate, 1=Educated i.e. Primary, Secondary and College
Marital status	Having a spouse around or away	Nominal	0 = Single, 1=Married
Residence	An establishment being used by a host as their main place of dwelling	Nominal	0 = Rural, 1=Urban
Main occupation	A persons' usual or principle work or business especially as a means of earning a living	Nominal	0 = Non-salaried employment i. e. Farming, Business/Trade 1 = Salaried employment
Net income	What remains for an individual after subtracting all the costs	Ratio	Annual earning in cash
Attitude	A tendency to respond positively or negatively towards HIV and AIDS interventions	Ordinal	0=Unfavourable and Indifferent attitude 1 = Favourable attitude
Frequency of contacts	Number of times individuals met with technical experts specifically for HIV and AIDS during their village/street meetings for the last 12 months (Maximum of 4 times)	Ordinal	0 = Zero times 1 = One time 2 = Two times 3 = Three times 4 = Four times
Understanding of Tanzania national HIV policy	The ability to understand the disseminated national HIV policy	Nominal	0 = No, 1=Yes
Access to information	Is the notion that the public can obtain planning information about HIV and AIDS interventions	Nominal	0 = No,1=Yes
Satisfaction	The state of being satisfied with involvement in planning HIV and AIDS interventions	Nominal	0 = Not satisfied 1 = Satisfied
Meetings	Number of HIV planning meetings attended for the last 12 months (Maximum of 4 meetings)	Ordinal	0 = Not attended even once 1 = Attended once 2 = Attended twice 3 = Attended three times 4 = Attended four times
Attended HIV event	Being present at an event on HIV	Nominal	0 = No,1=Yes
Participation	The action of taking part in selecting Multisectoral AIDS Committee (MACs) members	Nominal	0 = No, 1=Yes
	Level of taking part in planning HIV and AIDS interventions under NMSF	Ordinal	1= High, 2=Medium, 3=Low
Involvement	The condition of being involved in decision making with regard to identified HIV activities	Nominal	0 = Not involved 1 = Involved
Awareness on NMSF interventions	Knowledge of a situation or fact	Nominal	0 = Not aware 1 = Aware