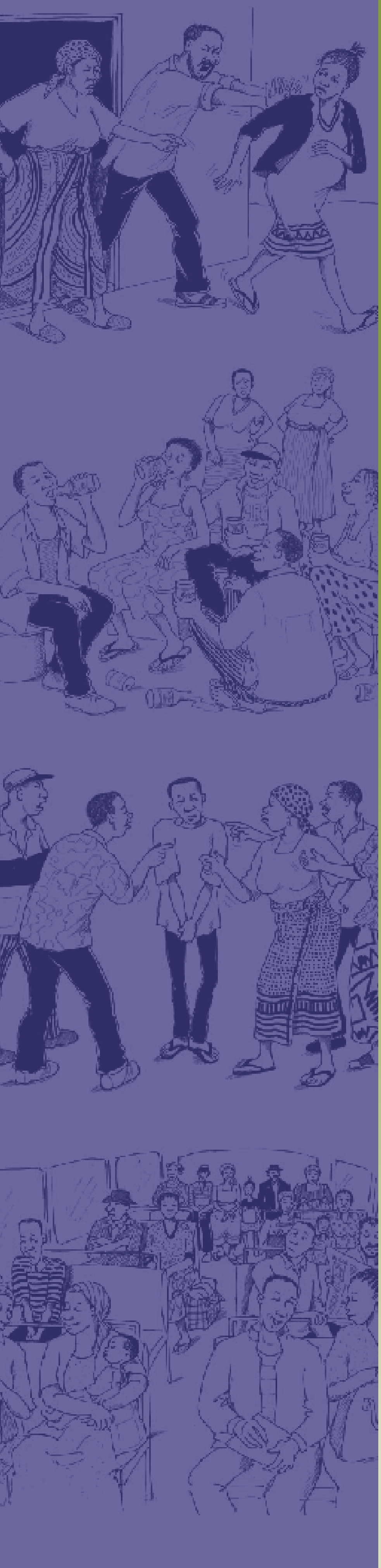

United Republic of Tanzania
Prime Minister's Office
Tanzania Commission for AIDS

National Guide on the Integration of Stigma and Discrimination Reduction in HIV Programs

FEBRUARY 2009

Contents

Foreword

Public health practices show that stigma and discrimination is one of the major public health barriers to effective global responses to HIV and AIDS. The International political community, led by UNAIDS in 2006, set a goal of universal access to comprehensive HIV prevention and treatment programs, care and support by 2010. The efforts to reduce HIV and AIDS stigma also are supported by goal 6 of the Millennium Development Goals (MDGs), which aims to halt and reverse the spread of HIV by 2015.

Stigma undermines national efforts to fight transmission of the virus, as noted in the study in Tanzania by Ogden & Nyblade (2005). The research found that HIV-related stigma in Tanzania is pervasive and takes many forms. It also shows that most people find it difficult to recognize their own stigmatizing attitudes and behaviors and even harder to change. As such, changing moral-based attitudes is a challenging and sensitive issue.

The President of United Republic of Tanzania H.E. Jakaya Mrisho Kikwete has led efforts to encourage Tanzanians to utilize the testing, care and treatment services available in their communities. In July 2007, he and his wife set a national example by being tested for HIV themselves and allowing the public to witness. Despite such efforts, uptake of HIV preventive services continues to be poor, with the most common barrier attributed to stigma.

This *Stigma Reduction Guide* is a result of research and intervention efforts by a team that has been involved in HIV-stigma reduction for a number of years. As such, Tanzania may leverage these previous efforts and be in a better position to improve stigma and discrimination reduction activities in HIV and AIDS programming. This guide draws from the best practices of and lessons learned on stigma reduction from the various community-based organizations working in HIV/AIDS activities. The Stigma Toolkit for Action also informed the writing and utilization of this guide.

While there are stigma reduction guides that target specific audiences, this one is more generic and can be used with various audiences. Guides for specific audiences in Tanzania should follow.

Our mutual efforts in reducing HIV-related stigma and discrimination are needed in meeting goal 6 of the Millennium Development Goals. This *Stigma Reduction Guide* is a step forward in that direction.

Dr. Fatma H. Mrisho
Executive Chairman
Tanzania Commission for AIDS

Acknowledgment

The *Integration of Stigma and Discrimination Reduction in HIV Programs Guide* (referred to as the *Stigma Reduction Guide*) is the result of research and intervention efforts by a special team of experts who have been involved in HIV and AIDS stigma reduction efforts in Tanzania. We recognize with special thanks the technical and financial support of our development partners as well as international and national stakeholders.

Tanzania Commission for AIDS would like to further extend our sincere acknowledgement to the document preparation team members: Lusajo Kajula (MUHAS), Pfiriael Kiwia (KPE), Aparna Jain (ICRW), Wilbrod Manyama (KPE), Fausta Philip (MUHAS), Gideon Kwesigabo (MUHAS), Jessie Mbwambo (MUHAS), Kerry MacQuarrie (ICRW) and Laura Nyblade (ICRW) for this recommendable work.

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To you all we say thank you very much.

Introduction

Tanzania is a leading country in addressing HIV stigma and discrimination. The Tanzanian National Policy on HIV/AIDS (2001) and the Health Sector HIV and AIDS Strategies Plan (HSSP) 2008-2012 identified the role that stigma plays in increasing the spread of HIV, and recognized stigma reduction as a key guiding principle that must be addressed by all sectors, at all levels.

As in many countries, HIV stigma is high in Tanzania. In a recent survey with people living with HIV, 63 percent of women and 50 percent of men reported experiencing stigma in the past year.[1] Since 2005, care and free HIV treatment services have been opportunities to normalize HIV and AIDS and reduce stigma in the treatment context. Community groups, nongovernmental organizations, researchers, policy makers and other stakeholders have worked to address HIV-related stigma in Tanzania since the onset of the epidemic. Drawing on ground-breaking research that identified the three actionable causes of stigma,[2] many of these groups piloted stigma-reduction projects, built national expertise and developed effective stigma-reduction tools that are available in Kiswahili. These efforts place Tanzania in a unique position to scale up stigma and discrimination reduction activities in HIV/AIDS programming.

To build on these stigma-reduction efforts and the strategies as outlined by the Government of Tanzania in the HSSP (2008-2012), this guide has been developed to provide experience-based direction for programs seeking to integrate stigma reduction. The guide is based on the accumulated lessons learned, experiences and practices by various community-based organizations to reduce stigma, as well as the research-based *Understanding and Challenging Stigma: A Toolkit for Action*[3] (herein known as *Stigma Toolkit for Action*). The guide draws from two organizations' experiences in conducting HIV-related stigma reduction programming using the *Stigma Toolkit for Action:* (1) Kimara Peer Educators and Health Promoters Trust (KPE) in Kinondoni Municipality, Dar es Salaam, and (2) Muhimbili University of Health Sciences (MUCHS).

This guide is designed for use by a wide variety of stakeholders working in Tanzania—grassroots organizations, program designers, donors, researchers, policy makers, media, and planners and implementers of HIV and AIDS activities at all levels—to strengthen HIV stigma reduction efforts in their specific contexts. The guide first provides an overview of key concepts with respect to HIV-related stigma and discrimination. It then delineates the three essential steps to begin HIV stigma reduction work, as follows:

I. **Act now by using existing resources**: Skilled human resources and tools to reduce HIV-stigma in Tanzania do exist and are accessible.

II. **Integrate** stigma reduction activities and messages into existing HIV/AIDS programs.

III. **Engage key stakeholders** to broaden the impact.

Finally, the guide concludes with suggestions on how to scale up integrated stigma reduction activities countrywide.

Key Concepts

Before describing in detail the three approaches for stigma reduction in HIV programming, this guide highlights key concepts around stigma and discrimination.

What is stigma?

"HIV/AIDS-related stigma can be described as a 'process of devaluation' of people either living with or associated with HIV and AIDS. This stigma often stems from the underlying stigmatization of sex and injecting drug use—two of the primary routes of HIV infection. Discrimination follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status. Discrimination occurs when a distinction is made against a person that results in being treated unfairly and unjustly on the basis of belonging, or being perceived to belong, to a particular group." (UNAIDS fact sheet on stigma and discrimination, December 2003, www.unaids.org)

What does stigma look like?

Stigma and discrimination (described as actions taken by people or institution as a result of stigma) can manifest in a range of forms including: physical and social exclusion (e.g., separation of eating utensils, isolation at social events), including violence; verbal (e.g., gossiping, name calling or pointing fingers); loss of identity and status (e.g., losing respect in the family and community); and institutional (e.g., loss of employment, housing or customers). Stigma may also be internalized and affect the way individuals think about themselves. For instance people living with HIV may internalize the stigma they are experiencing, leading to feelings of shame, inferiority, embarrassment or lack a sense of purpose. This may prohibit them from seeking care or treatment services or pursuing potential life opportunities, like further education, a promotion or starting a business.

What causes stigma and how can it be addressed?

In 2005, a comparative study conducted in Ethiopia, Tanzania, Vietnam and Zambia found that stigma is consistent across contexts in forms, consequences and key drivers.[4,5] These studies identified three programmatically actionable drivers of stigma: (1) lack of recognition of stigma; (2) fear of acquiring HIV through casual contact; and (3) values linking people living with HIV to assumed immoral behavior.

Limited recognition of stigma

Causes: People are often unaware that their attitudes, words and actions are stigmatizing toward people living with HIV, and of the resulting negative consequences. The research found that even those with good intentions toward people living with HIV often stigmatize them unknowingly.

Proposed action: Creating awareness of what stigma is and its negative effects on individuals, families and communities is a crucial first step to reducing stigma. Programs can begin building awareness in multiple ways, including through the development of information, education and communication (IEC) materials that provide information about HIV-related stigma and what it looks like, and community outreach education events.

Fear of contracting HIV through casual contact (fear-driven stigma)

Causes: Fear that HIV can be transmitted through casual contact, for example through non-invasive interactions such as touching a person living with HIV or sharing dining plates and utensils, drives stigma in the form of isolation. These unfounded fears of daily, routine, casual contacts influence people to change their behavior and physically avoid people living with HIV.

Proposed action: Consistent and continuous delivery of correct information on HIV transmission is needed to combat unfounded fears of casual transmission. Programs can address these fears through talk shows on local radio, community theater and dramas, peer education approaches and leaflets.

Values linking people with HIV to assumed immoral behavior (socially driven stigma)

Causes: Values driven by social, gender and sexual norms often link people with HIV to assumed "immoral" behaviors. For example, assumptions are often made that people living with HIV were infected through behavior considered socially "improper" or "unacceptable" such as being unfaithful or promiscuous, leading to shame and blame for the people living with HIV, and often their families.

Proposed action: Promote openness and guided discussions about sexual values, prejudices and contexts in which risky behavior takes place. Successful stigma reduction programs provide individuals and organizations with sufficient time and space to self-reflect and change. Stigma is deeply ingrained and tends to differ among individuals. People need both the adequate time and space to examine their own attitudes and behaviors before they can initiate and commit to change.

Approaches for Scaling Up Stigma Reduction

I. Act now by using existing resources

Tanzania has practical, tested tools in Kiswahili that work with a wide range of target audiences, a cadre of master trainers ready to share their experiences and expertise, and IEC materials available for use (see Appendix 1). Most importantly, HIV stigma is a social issue so everyone has a role to play in addressing it.

Resource #1: Stigma Toolkit for Action

The *Stigma Toolkit for Action* provides a wide range of flexible and adaptable exercises to raise awareness about, address and catalyze action against stigma. It provides a way for different communities and target groups to determine what stigma means and looks like, understand its root causes and effects, and plan action to combat it. The exercises are based on participatory learning processes: sharing feelings and experiences, analyzing issues, and taking action. Recommended exercises are included in Appendix 2.

The toolkit, which has been translated into Kiswahili, includes various modules addressing stigma in a wide range of settings. It has been used extensively in Tanzania with different populations, including health care providers, home-based care providers, youth, faith-based leaders, community leaders, people living with HIV, and nongovernmental and community-based organization staff. Program experience has shown that the toolkit provides effective language to communicate complex issues across groups, particularly on sensitive issues like sexuality. For example, the exercise, *Breaking the "Sex" Ice,* works extremely well at providing faith-based leaders a way to discuss these challenging issues. The toolkit also provides common language and terminology for people coming from different experiences and perspectives to talk to one another about HIV-related stigma and discrimination. The common language facilitates discussion, which increases understanding and acceptance.

Resource #2: Master Trainers

A cadre of master anti-stigma trainers exists throughout Tanzania (see Appendix 3). They are available and can be engaged by whomever needs technical assistance on stigma-reduction programming and training others in stigma reduction.

Resource #3: IEC Materials

KPE and the TUMAINI program have developed simple, user-friendly IEC brochures. They are designed to describe stigma in simple terms, and they use simple images (see Appendix 1) to underscore the messages. These brochures have been distributed at outreach meetings, during home-based care visits and at health facilities, and have been well-accepted among community members.

II. Integrate stigma-reduction into existing HIV programs to ensure sustainability

Organizations working on HIV prevention, care, treatment and support should integrate stigma and discrimination programs within existing activities to ensure long-term sustainability. By using an integrated approach, a whole host of new activities or services are not required. As such, it is not necessary to commit ongoing funds to sustain a stand-alone stigma and discrimination program after an initial investment is made to integrate. This is not to say that integration is the only way to go—adding specific stigma and discrimination activities to a project is also a feasible and often desirable approach. Targeted stigma reduction activities may have a place in particular circumstances such as anti-stigma campaigns for youth, orphans and vulnerable children; in health care settings, etc.

Integration of stigma reduction into existing HIV programs involves five steps: (1) assess institutional capacity, (2) address stigma within the implementing organization, (3) assess the target population, (4) plan and implement the integration, and (5) monitor and evaluate the effort. Steps one through three, which constitute the organization's situational analysis, take anywhere from two days to two weeks, depending on the size of the organization and the target population.

Step 1: Assess institutional capacity

To determine the best way to integrate stigma reduction activities into an ongoing intervention, an organization will need to assess institutional and budgetary commitment, policies, procedures, capacities, opportunities and staff needs.

Step 2: Address stigma within the implementing organization

Successful stigma reduction programs provide individuals and organizations with sufficient time, space and support to learn, self-reflect and gain the understanding and skills necessary to change. Even though staff may have been working in HIV prevention, care or treatment for a long time, they may have concerns, fears or misconceptions that they never felt comfortable to obtain clarity on. For example, even though KPE staff was well aware of how HIV is transmitted, some members expressed a fear of HIV infection when going to the home of someone living with HIV. Other staff acknowledged that when they learn that someone has HIV, they believe that person will die young despite knowing the facts about ARVs and maintaining good health. They, like so many other people, had not yet internalized that people with HIV can live long and healthy lives.

Therefore, before working with community members and others beyond your organization or project, it is vital to provide staff with opportunities to explore and recognize stigma in their own work and personal lives. The *Stigma Toolkit for Action* can be used to do this in a safe and non-threatening way, increasing staff's empathy toward others and sincerity in how they support and care for people living with HIV and their families.

Options for Addressing Stigma within Your Own Organization

Use the *Stigma Toolkit for Action* to train all staff. Depending on the results of the assessment, objective and planned activity of the training, the toolkit will allow for flexibility for the duration and the depth of the training. The toolkit provides the space for learning and self-reflection to uncover unspoken fears and values that may unintentionally lead to stigmatizing attitudes and behaviors, as well as methods to integrate anti-stigma messaging into ongoing work.

Another option is to send a few staff to a training of trainers. Then, these trained staff can lead trainings in your organization with the rest of the staff. The trained staff can also help an organization to think through feasible ways of effective integration.

Step 3: Assess the target population

Assessing the target population will provide a better understanding of the current situation with respect to HIV stigma and discrimination in that group (e.g., community, health care setting, media, etc.). The information gathered will provide guidance in developing a tailored approach to the program.

The target population assessment can include:

- Focus group discussions with staff or community members or leaders.
- A community mapping exercise, or root-cause analysis of stigma, to identify where stigma occurs in the community.

Step 4: Plan and implement the integration

On completion of the situational analysis (i.e., steps 1-3 above), an organization will be well-positioned to begin the process of integrating stigma into a program. The examples below illustrate the process and outcomes of this for three different organizations.

Step 5: Monitor and evaluate

Finally, as with any program, it will be important to monitor and evaluate the effectiveness of integrating stigma reduction into activities. Monitoring should be participatory with the awareness of the community in addressing stigma. Valid quantitative indicators are available for measuring stigma and discrimination with different target groups, including communities, health care providers and people living with HIV.[6]

III. Engage key stakeholders to broaden the impact

In addition to integrating stigma reduction into all existing programming, stigma reduction can be enhanced by engaging two key stakeholders: (1) influential community leaders; and (2) people living with HIV. The situational analysis can help determine the opportunities to achieve this.

Engage key leaders

An important area of additional stigma reduction programming is working with key leaders from the beginning to expand and catalyze stigma reduction. While behavior change starts with the individual, for that change to be sustained, the community norms that perpetuate and reinforce stigma also

Three Organizations Integrate Stigma Reduction Into Their Ongoing Programs

Example 1: KPE integrated stigma and discrimination messages in their existing community "edutainment" activities by developing new drama and skit storylines, and songs focusing on stigma and discrimination. They also used a variety of participatory exercises and tools from the *Stigma Toolkit for Action* in discussions with community members following the entertainment piece. In addition, KPE added specific stigma and discrimination activities to their work plan, such as outreach to *Balozis*, local community leaders in Tanzania. This included training them in a workshop on the common causes and consequences of HIV stigma using the *Stigma Toolkit for Action* and providing them technical support to integrate stigma and discrimination programming into their ongoing responsibilities.

Example 2: Student Partnerships Worldwide's (SPW) situational analysis resulted in the integration of stigma-reduction activities not only with their target population, but among their own staff as well. SPW, which offers reproductive health education for in- and out-of-school youth, designed and conducted a training of trainers (TOT) program on stigma awareness and reduction for its staff, with assistance of master trainers from KPE and MUHAS. After the training, SPW developed a radio program known as "positive voice" that focused on helping youth understand and deal with both fear and socially driven stigma, as well as how stigma can negatively affect sexually responsible behaviors, for example by discouraging people who are, or are afraid they are, infected with HIV from accessing testing, care and treatment services.

Example 3: From 2004-2006, the TUMAINI project (followed by the FHI/Deloitte Tunajali Project in 2007) integrated stigma and discrimination activities into home-based care programs for people living with HIV by training all sub-grantees and volunteers working with sub-grantees on recognition and awareness of stigma and its effects as well as creating action plans of addressing stigma as a provider and within the homes they are attending. TOT training was done for sub-grantees so that they would be able to train new sub-grantees and volunteers in case of replacements.

KPE's Experience Engaging Key Leaders

KPE involved *Balozis,* local community leaders, in their stigma and discrimination program from its onset. *Balozis* participated with KPE staff in the anti-stigma "training of trainers," allowing them to reflect on stigma within themselves and their lives, while also learning facilitation skills on stigma and discrimination messaging and action. *Balozis* became a key resource for people in their communities, providing referrals and support to people living with HIV, and advocating on behalf of people living with HIV who faced stigma. For example, one *Balozi* actively supported an orphan whose parents had passed away from AIDS. The orphan's extended family members had seized the family house. The *Balozi* took the case to the local magistrate and successfully disputed it. The property was returned to the orphan. The KPE experience also showed that the community held the *Balozis* responsible for upholding anti-stigma norms and countering stigma-related actions. For example, community members held *Balozis* accountable for protecting people's property rights, especially of women and children affected by HIV and AIDS, because they knew the *Balozis* had learned how property grabbing can be a serious form of HIV stigma.

must change. Experience has shown that influential leaders model behaviors in the community and can help establish new non-stigmatizing norms, which catalyze change in the community. By tapping into the right people, a program can cultivate a network of anti-stigma advocates (change agents) who lead by example and set new precedents for acceptable behaviors.

Meaningful engagement of people living with HIV

The most effective stigma reduction programming happens when people living with HIV play a central role. People living with HIV can provide firsthand experience to help design effective anti-stigma programs and share their lived experiences as co-facilitators and trainers. Programs that foster the direct interaction between people who have HIV and people who do not to reduce stigma through dispelling rumors, myths and assumptions about people living with HIV and reducing fears of and misconceptions about HIV transmission through casual contact. For example, in one of KPE's stigma reduction workshops, half of the participants were known community members living with HIV. Several other participants expressed discomfort with their participation. By the end of the training, these participants felt remorseful for their behavior toward their fellow community members living with HIV. They said, *"We didn't know that we were stigmatizing"* and were able to shake hands and hug the individuals living with HIV. However, it is essential to ensure that the involvement of people living with HIV is done in an ethical way and that participation is voluntary.

Effective ways of expanding stigma programs to include people living with HIV are: 1) train people living with HIV as anti-stigma trainers using the *Stigma Toolkit for Action;* 2) engage people living with HIV as co-facilitators in workshops, trainings and sensitization meetings; 3) engage people living with HIV to provide HIV-related services such as home-based care, lay counselors or treatment assistants at care and treatment centers (CTCs); and (4) work with people living with HIV to address internalized stigma (e.g., loss of hope, feelings of worthlessness and inferiority) by providing space and support to them. This last option is important not only for your own program and activities, but for any stigma reduction work.

Involving a Person Living with HIV—Example of Catalyzing Change

One person living with HIV who attended a KPE stigma reduction workshop mobilized other people living with HIV in his neighborhood to discuss stigma. These discussions evolved into regular support group meetings for people living with HIV. Now members are strong advocates for their own rights and seek services and treatment.

Way Forward

Tanzania is poised to be a leader in combating HIV-related stigma on a national level. To continue the process of scaling up stigma reduction efforts, the following four steps are recommended:

1. Expand the pool of national master anti-stigma trainers.

The health care system is a good point of departure for scaling up in-country anti-stigma training capacity. Health workers and caregivers need access to on-the-job training, which should include stigma reduction activities in standard training manuals and curricula. In addition, pre-service training for nurses, doctors and other health professionals should incorporate an anti-stigma component.

2. Use a cascade approach, where master trainers conduct training of trainers (TOT) either by sector, region or district.

A cascade approach that is used across sectors and geographical areas will maximize the reach of potential of stigma reduction trainers. By conducting TOTs in different districts, regions and sectors, stigma-reduction messages and capacity-building will extend throughout the country.

3. Make tools and resources more widely known and available. This can be achieved in several ways, including:

- Posting the Kiswahili stigma reduction toolkit on nationally sponsored Web sites;
- Printing and distributing more Kiswahili stigma reduction toolkits and illustrations to master trainers; and
- Creating a Web site where organizations and institutions can receive stigma reduction updates and information.

4. Establish a national stigma reduction working group to exchange experiences, successes and challenges.

To ensure that lessons learned on stigma reduction are shared among various disparate groups, people who are conducting stigma reduction activities in Tanzania should form a working group to coordinate efforts and facilitate regular communication. This group should include members from the Ministry of Health and Social Welfare, representatives from organizations working to address HIV and AIDS, and people living with HIV.

Endnotes

1. Tanzania stigma-indicators field testing group. (2005). *Measuring HIV Stigma: Results of a Field Test in Tanzania* (Working Report). Washington, DC: Synergy.

2. Mbwambo, J., Kilonzo, G., Kopoka, P., & Nyblade, L. (2004). *Understanding HIV-Related Stigma in Tanzania*. Dar es Salaam: MUCHS.

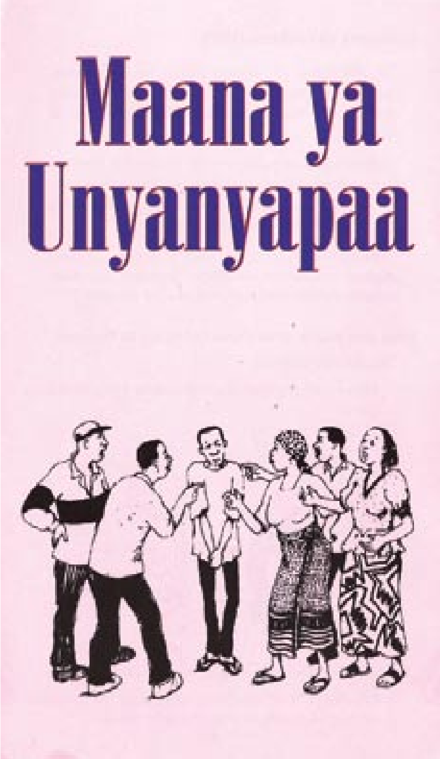
3. Kidd, R., S. Clay, and C. Chiiya, *Understanding and Challenging HIV Stigma: Toolkit for Action*. Second ed. 2007, Brighton: International HIV/AIDS Alliance, AED and International Center for Research on Women (ICRW).

4. Ogden, J., & Nyblade, L. (2005). *Common at Its Core: HIV-Related Stigma Across Contexts*. Washington, DC: ICRW.

5. Nyblade, L., Pande, R., Mathur, S., MacQuarrie, K., Kidd, R., Bantenyerga, H., et al. (2003). *Disentangling HIV and AIDS Stigma in Ethiopia, Tanzania and Zambia*. Washington, DC: ICRW.

6. Tanzania stigma-indicators field testing group. (2005). *Measuring HIV Stigma: Results of a Field Test in Tanzania* (Working Report). Washington, DC: Synergy.

Appendix 1—Examples of IEC Materials



Maana ya Unyanyapaa

Kulingana na Goffman (1963)

> *"ni fenomena ya kijamii yenye mambo mengi inayohusisha masuala ya jamii na uchumi katika mazingira ya mambo yanayomuathiri mtu kiakili na kijamii."*
>
> *"Unyanyapaa ni suala ambalo linapoteza thamani kwa undani sana na kusababisha kushushwa kwa utu wa mtu au kikundi mpaka mtu anaonekana aliyechafuliwa na kutokuhesabika kabisa"*
>
> *"kuwachukulia wengine vibaya tofauti na mtu anayenyanyapaliwa au kikundi kukubali kupotoka huko na kuhalalisha kudharauliwa na wengine"*

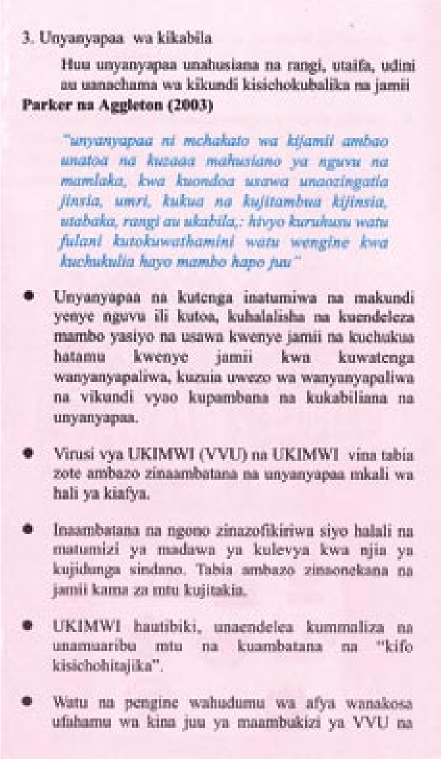
Kuna aina tatu za unyanyapaa kulingana na Goffman

1. Machafuko ya mwili

   Huu ni unyanyapaa unaohusiana na kuharibika kwa mwili

2. Unyanyapaa unaohusiana na kumshushia mtu hadhi

   Kumfanya mtu aonekane asiyekuwa na thamani, asiye mwaminifu au mwenye roho mbaya.



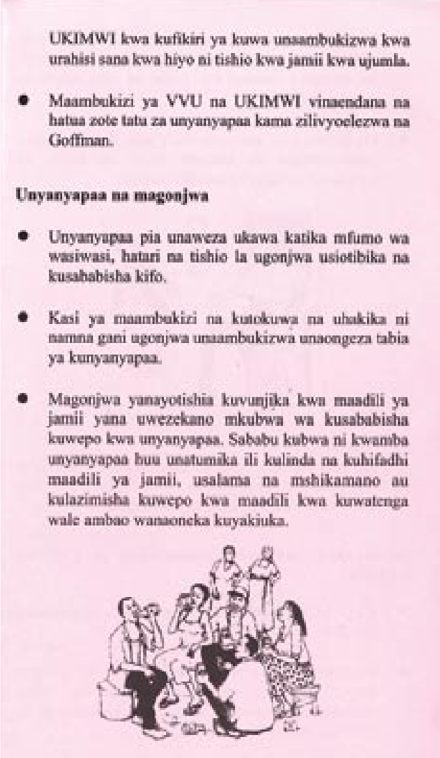
3. Unyanyapaa wa kikabila

   Huu unyanyapaa unahusiana na rangi, utaifa, udini au uanachama wa kikundi kisichokubalika na jamii

Parker na Aggleton (2003)

> *"unyanyapaa ni mchakato wa kijamii ambao unatoa na kuzaaa mahusiano ya nguvu na mamlaka, kwa kuondoa usawa unaozingatia jinsia, umri, kukua na kujitambua kijinsia, utabaka, rangi au ukabila,: hivyo kuruhusu watu fulani kutokuwathamini watu wengine kwa kuchukulia hayo mambo hapo juu"*

- Unyanyapaa na kutenga inatumiwa na makundi yenye nguvu ili kutoa, kuhalalisha na kuendeleza mambo yasiyo na usawa kwenye jamii na kuchukua hatamu kwenye jamii kwa kuwatenga wanyanyapaliwa, kuzuia uwezo wa wanyanyapaliwa na vikundi vyao kupambana na kukabiliana na unyanyapaa.
- Virusi vya UKIMWI (VVU) na UKIMWI vina tabia zote ambazo zinaambatana na unyanyapaa mkali wa hali ya kiafya.
- Inaambatana na ngono zinazofikiriwa siyo halali na matumizi ya madawa ya kulevya kwa njia ya kujidunga sindano. Tabia ambazo zinaonekana na jamii kama za mtu kujitakia.
- UKIMWI hautibiki, unaendelea kummaliza na unamuaribu mtu na kuambatana na "kifo kisichohitajika".
- Watu na pengine wahudumu wa afya wanakosa ufahamu wa kina juu ya maambukizi ya VVU na



UKIMWI kwa kufikiri ya kuwa unaambukizwa kwa urahisi sana kwa hiyo ni tishio kwa jamii kwa ujumla.

- Maambukizi ya VVU na UKIMWI vinaendana na hatua zote tatu za unyanyapaa kama zilivyoelezwa na Goffman.

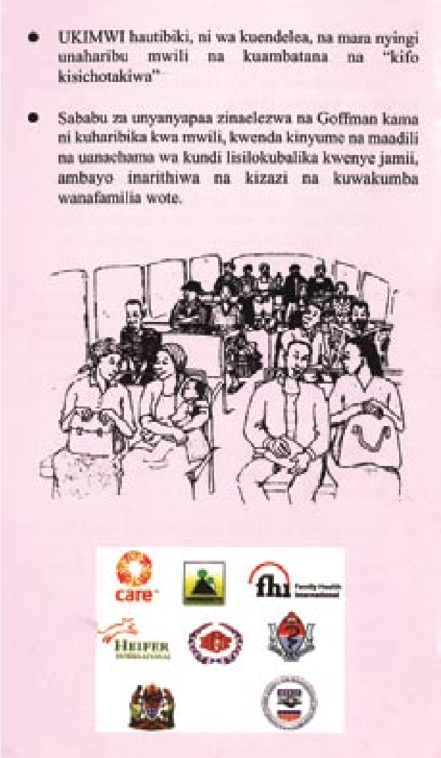
Unyanyapaa na magonjwa

- Unyanyapaa pia unaweza ukawa katika mfumo wa wasiwasi, hatari na tishio la ugonjwa usiotibika na kusababisha kifo.
- Kasi ya maambukizi na kutokuwa na uhakika ni namna gani ugonjwa unaambukizwa unaongeza tabia ya kunyanyapaa.
- Magonjwa yanayotishia kuvunjika kwa maadili ya jamii yana uwezekano mkubwa wa kusababisha kuwepo kwa unyanyapaa. Sababu kubwa ni kwamba unyanyapaa huu unatumika ili kulinda na kuhifadhi maadili ya jamii, usalama na mshikamano au kulazimisha kuwepo kwa maadili kwa kuwatenga wale ambao wanaoneka kuyakiuka.

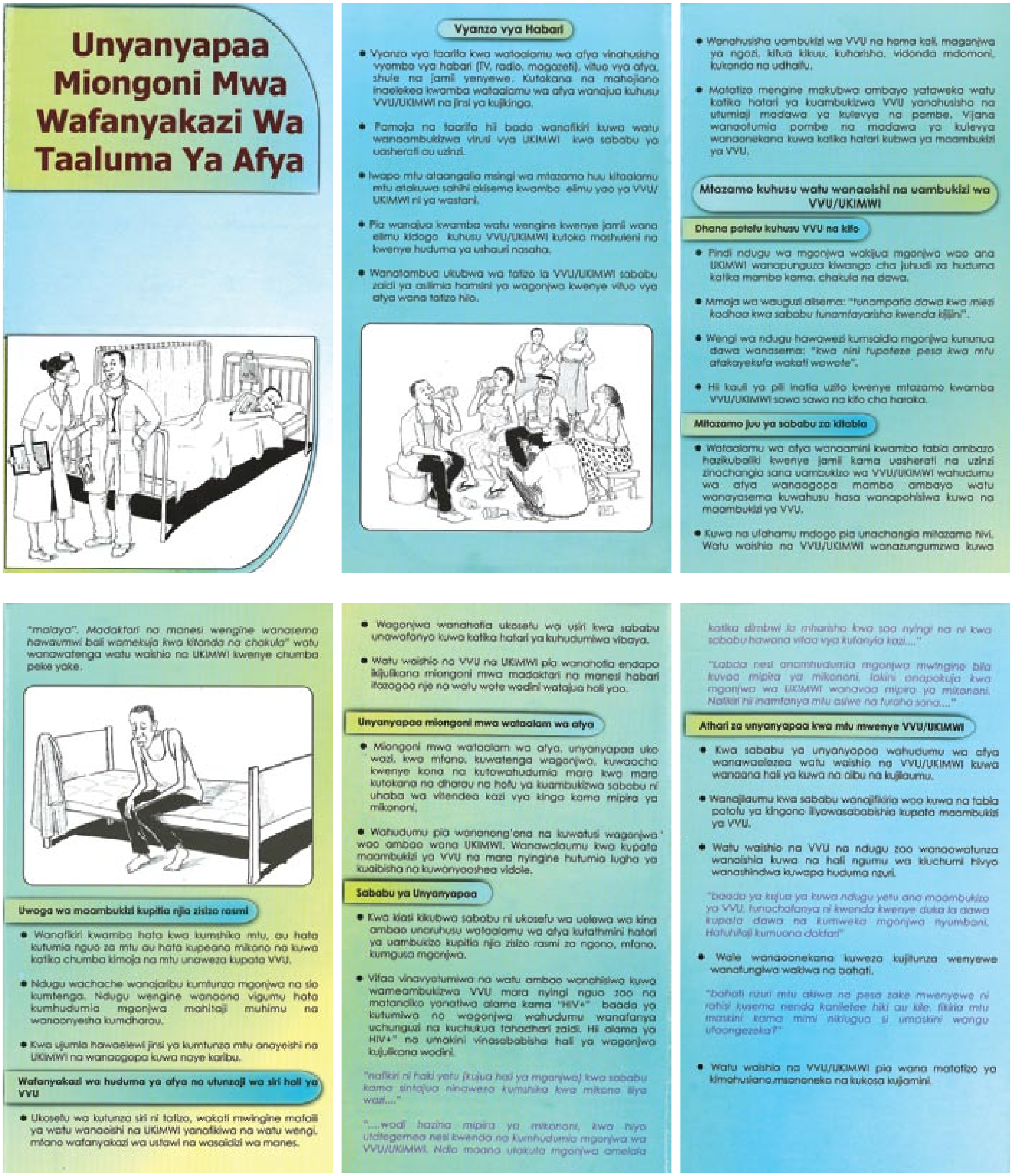
- Unyanyapaa wa magonjwa unakuwa mkubwa pale ambapo unaambatana na tabia potofu au pale sababu ya ugonjwa inaonekana kama ni mtu kujitakia mwenyewe.
- Pia unyanyapaa unakuwa mkali zaidi ikiwa ugonjwa unaaambatana na kukiuka imani za kidini au unatokana na tabia za maadili mabovu.
- Pia pale ambapo ugonjwa hautibiki, haubadiliki, ni mkubwa, wa kuendelea na kusababisha kuharibika kwa mwili kwa kasi au kifo kisichotakiwa.

Unyanyapaa wa wenye maambukizi ya VVU na UKIMWI

- VVU na UKIMWI vina tabia zote za unyanyapaa mkali wa magonjwa.
- Unaambatanishwa na ngono isiyokubalika kwenye jamii, kujidunga madawa ya kulevya, tabia zisizokubalika kwenye jamii na kuonekana ni za kujitakia mwenyewe.



- UKIMWI hautibiki, ni wa kuendelea, na mara nyingi unaharibu mwili na kuambatana na "kifo kisichotakiwa"
- Sababu za unyanyapaa zinaelezwa na Goffman kama ni kuharibika kwa mwili, kwenda kinyume na maadili na uanachama wa kundi lisilokubalika kwenye jamii, ambayo inarithiwa na kizazi na kuwakumba wanafamilia wote.



Unyanyapaa Miongoni Mwa Wafanyakazi Wa Taaluma Ya Afya

Vyanzo vya Habari

- Vyanzo vya taarifa kwa wataalamu wa afya vinahusisha vyombo vya habari (TV, radio, magazeti), vituo vya afya, shule na jamii yenyewe. Kutokana na mahojiano inaelekea kwamba wataalamu wa afya wanajua kuhusu VVU/UKIMWI na jinsi ya kujikinga.
- Pamoja na taarifa hii bado wanafikiri kuwa watu wanaambukizwa virusi vya UKIMWI kwa sababu ya uasherati au uzinzi.
- Iwapo mtu ataangalia msingi wa mtazamo huu kitaalamu mtu atakuwa sahihi akisema kwamba elimu yao ya VVU/UKIMWI ni ya wastani.
- Pia wanajua kwamba watu wengine kwenye jamii wana elimu kidogo kuhusu VVU/UKIMWI kutoka mashuleni na kwenye huduma ya ushauri nasaha.
- Wanatambua ukubwa wa tatizo la VVU/UKIMWI sababu zaidi ya asilimia hamsini ya wagonjwa kwenye vituo vya afya wana tatizo hilo.
- Wanahusisha uambukizi wa VVU na homa kali, magonjwa ya ngozi, kifua kikuu, kuharisha, vidonda mdomoni, kukonda na udhaifu.
- Matatizo mengine makubwa ambayo yataweka watu katika hatari ya kuambukizwa VVU yanahusisha na utumiaji madawa ya kulevya na pombe. Vijana wanaotumia pombe na madawa ya kulevya wanaonekana kuwa katika hatari kubwa ya maambukizi ya VVU.

Mtazamo kuhusu watu wanaoishi na uambukizi wa VVU/UKIMWI

Dhana potofu kuhusu VVU na kifo

- Pindi ndugu wa mgonjwa wakijua mgonjwa wao ana UKIMWI wanapunguza kiwango cha juhudi za huduma katika mambo kama, chakula na dawa.
- Mmoja wa wauguzi alisema: "*tunampatia dawa kwa miezi kadhaa kwa sababu tunamtayarisha kwenda kijijini*".
- Wengi wa ndugu hawawezi kumsaidia mgonjwa kununua dawa wanasema: "*kwa nini tupoteze pesa kwa mtu atakayekufa wakati wowote*".
- Hii kauli ya pili inatia uzito kwenye mtazamo kwamba VVU/UKIMWI sawa sawa na kifo cha haraka.

Mitazamo juu ya sababu za kitabia

- Wataalamu wa afya wanaamini kwamba tabia ambazo hazikubaliki kwenye jamii kama uasherati na uzinzi zinachangia sana uambukizo wa VVU/UKIMWI wahudumu wa afya wanaogopa mambo ambayo watu wanayasema kuwahusu hasa wanapohisiwa kuwa na maambukizi ya VVU.
- Kuwa na utaalamu mdogo pia unachangia mitazamo hivi. Watu waishio na VVU/UKIMWI wanazungumzwa kuwa "malaya". Madaktari na manesi wengine wanasema *hawaumwi bali wamekuja kwa kitanda na chakula*" watu wanawatenga watu waishio na UKIMWI kwenye chumba peke yake.

Uwoga wa maambukizi kupitia njia zisizo rasmi

- Wanafikiri kwamba hata kwa kumshika mtu, au hata kutumia nguo za mtu au hata kupeana mikono na kuwa katika chumba kimoja na mtu unaweza kupata VVU.
- Ndugu wachache wanajaribu kumtunza mgonjwa na sio kumtenga. Ndugu wengine wanaona vigumu hata kumhudumia mgonjwa mahitaji muhimu na wanaonyesha kumdharau.
- Kwa ujumla hawaelewi jinsi ya kumtunza mtu anayeishi na UKIMWI na wanaogopa kuwa naye karibu.

Wafanyakazi wa huduma ya afya na utunzaji wa siri hali ya VVU

- Ukosefu wa kutunza siri ni tatizo, wakati mwingine mafaili ya watu wanaoishi na UKIMWI yanafikiwa na watu wengi, mfano wafanyakazi wa ustawi na wasaidizi wa manes.
- Wagonjwa wanahofia ukosefu wa usiri kwa sababu unawafanya kuwa katika hatari ya kuhudumiwa vibaya.
- Watu waishio na VVU na UKIMWI pia wanahofia endapo ikijulikana miongoni mwa madaktari na manesi habari itazagaa nje na watu wote wodini watajua hali yao.

Unyanyapaa miongoni mwa wataalam wa afya

- Miongoni mwa wataalam wa afya, unyanyapaa uko wazi, kwa mfano, kuwatenga wagonjwa, kuwaacha kwenye kona na kutowahudumia mara kwa mara kutokana na dharau na hofu ya kuambukizwa sababu ni uhaba wa vitendea kazi vya kinga kama mipira ya mikononi,
- Wahudumu pia wananong'ona na kuwatusi wagonjwa wao ambao wana UKIMWI. Wanawalaumu kwa kupata maambukizi ya VVU na mara nyingine hutumia lugha ya kuaibisha na kuwanyooshea vidole.

Sababu ya Unyanyapaa

- Kwa kiasi kikubwa sababu ni ukosefu wa uelewa wa kina ambao unaruhusu wataalamu wa afya kutathmini hatari ya uambukizo kupitia njia zisizo rasmi za ngono, mfano, kumgusa mgonjwa.
- Vifaa vinavyotumiwa na watu ambao wanahisiwa kuwa wameambukizwa VVU mara nyingi nguo zao na matandiko yanatiwa alama kama "HIV+" baada ya kutumiwa na wagonjwa wahudumu wanafanya uchunguzi na kuchukua tahadhari zaidi. Hii alama ya HIV+" na umakini vinasababisha hali ya wagonjwa kujulikana wodini.

"nafikiri ni haki yetu (kujua hali ya mgonjwa) kwa sababu kama sintajua ninaweza kumshika kwa mikono iliyo wazi..."

"....wodi hazina mipira ya mikononi, kwa hiyo utategemea nesi kwenda na kumhudumia mgonjwa wa VVU/UKIMWI. Ndio maana utakuta mgonjwa amelala katika dimbwi la mharisho kwa saa nyingi na ni kwa sababu hawana vifaa vya kufanyia kazi...."

"Labda nesi anamhudumia mgonjwa mwingine bila kuvaa mipira ya mikononi, lakini anapokuja kwa mgonjwa wa UKIMWI wanavaa mipira ya mikononi. Nafikiri hii inamfanya mtu asiwe na furaha sana...."

Athari za unyanyapaa kwa mtu mwenye VVU/UKIMWI

- Kwa sababu ya unyanyapaa wahudumu wa afya wanawaelezea watu waishio na VVU/UKIMWI kuwa wanaona hali ya kuwa na aibu na kujilaumu.
- Wanajilaumu kwa sababu wanajifikiria wao kuwa na tabia potofu ya kingono iliyowasababishia kupata maambukizi ya VVU.
- Watu waishio na VVU na ndugu zao wanaowatunza wanaishia kuwa na hali ngumu wa kiuchumi hivyo wanashindwa kuwapa huduma nzuri.

"baada ya kujua ya kuwa ndugu yetu ana maambukizo ya VVU, tunachofanya ni kwenda kwenye duka la dawa kupata dawa na kumweka mgonjwa nyumbani. Hatuhitaji kumuona daktari"

- Wale wanaoonekana kuweza kujitunza wenyewe wanafungiwa wakiwa na bahati.

"bahati nzuri mtu akiwa na pesa zake mwenyewe ni rahisi kusema nenda kaniletee hiki au kile, fikiria mtu maskini kama mimi nikiugua si umaskini wangu utaongezeka?"

- Watu waishio na VVU/UKIMWI pia wana matatizo ya kimahusiano,msononeko na kukosa kujiamini.

Appendix 2—Recommended Exercises of the *Stigma Toolkit for Action*

Recommended exercises from the *Stigma Toolkit for Action* to address the three stigma drivers

Naming the Problem (Module A)

i. Naming Stigma through Pictures (Exercise A1)—use illustrations A1, A2, A3, A4, A5, A11, A12, A13, A14, A15, A16, A17, A20, A27

ii. Our experience as stigmatizer and stigmatized (Exercise A2)

iii. Defining stigma (Exercise A4)

More Understanding Less Fear (Module B)

iv. Fears About Non-Sexual (Casual) Contact (Exercise B3)

v. Fears About Caring for PLHAs at Home (Exercise B4)

vi. Why People Don't Believe AIDS Facts (Exercise B6)

Sex, Shame, and Blame (Module C)

vii. Breaking the "Sex Ice" (Exercise C5)

viii. Judging Characters (Exercise C4)

Tip on Module A: If constrained for time or working with a population familiar with stigma and its effects, do exercise A6 (Forms, effects and Causes) only and drop A1, A2, and A4.

Tip on Module C: Do exercise C5 before C4. Add C3 (Double Standards) when working with faith-based organizations

Recommended exercises from the *Stigma Toolkit for Action* for developing an action plan

Moving To Action (Module G)

i. Ten Steps For Moving Toward Action (Exercise G3)

Appendix 3—List of Master Anti-Stigma Trainers

Trainer Name	Organizational Affiliation	Postal Address	Contacts (phone, e-mails)
Mbonimpa Buyekwa	Tumaini Project	Dar es Salaam	0713-323130 0754-471844 +022-2460863
Hellen Mbunde	EMAU	Dar es Salaam	0754-495870 0713-775699 hellenmbunde@yahoo.com
Elifuraha Ngowi	Saidia Kudhibiti Ukimwi Vijijini (SAKUVI)-Moshi	Box 6427, Moshi	0754-430560 elifurahan@yahoo.com
Godfrey T. Muhoza	KKKT-DMP	Box 837, DSM	0713-314137 nicegt2003@yahoo.com
Gerald Mayuni	Child in the Sun- Mbezi	Dar es Salaam	0784-593328 mayuni_g@yahoo.com
Ivon Florian	Katibu wa CCM Kimara	Box 12415,DSM	0754-571008
Mary R. Muasa	WAMATA-Arusha	Box 67, Arusha	0784-326737
Remmy Muhango	Tumaini Project	Box 9130, DSM	0713-248172 0754-333419
Dionisia Tililo	WAVUMO (Watu Wanaoishi na VVU) Box 5041, Morogoro	Morogoro	0754-774754 0754-823839
Wency Katunzi	Tumaini Project	Dar es Salaam	0784-783332 nkatunzi@yahoo.com
Julius Kaaya	TANOPHA	Dar es Salaam	0754-447345 tanopha@yahoo.co.uk
Awena Malendo	Kimara Peer Educ.	P.O.Box 65080 DSM	2420858, 24211,38 kimarapeer@udsm.ac.tz
Tatu Mustafa	Kimara Peer Educators	Box 75360, DSM	0754-420576 2420858, 24211,38 kimarapeer@udsm.ac.tz
Babuel A. Lyimo	Umoja wa Mapambano Dhidi ya Ukimwi (UMWI)	Box 780, Marangu, Moshi	0713-393880 babue12004@yahoo.com
Justine M. Katunzi	Training Coordinator Stigma (MUCHS)	Box 923, DSM	0713-343069 katunzi@hotmail.com
Grace K. Benedict	Kimara Peer Educators	Box 75360, DSM	0713-4405453 graceben2003@yahoo.com
Elizabeth Semwaiko	Kimara Peer Educators	Box 75360, DSM	0754-912135 2420858/9, 2421138 kimarapeer@udsm.ac.tz
Dr. Naomi V. Mpemba	Society for Women and AIDS in Africa Tanzania Branch	Dar es Salaam	0754-314853 nmpemba@yahoo.co.uk
Conrad P. Mushi	WAMATA-Dar	Dar es Salaam	0754-877070 Off.2700282 (DSM) Conrpeter 2001@yahoo.com

Trainer Name	Organizational Affiliation	Postal Address	Contacts (phone, e-mails)
Lucas C. Mkwizu	KICOSET	Box 6968, MOSHI	0754-481552 lucasmkuzu@hotmail.com woykili@yahoo.com
Fabian S. Ninalwo	Kibamba Community Based Information & Council Centre	Box 76796, DSM	2129949 0754-515714
Explasia Ngasoma	Kimara Pee Educ.	P.O. Box 75360 DSM	0755-417652
Sabas Masawe	MUCHS	Box 21496, DSM	0713-278039 sabasimasawe@hotmail.com
Willibrod Manyama	Kimara Peer Educ.	Box 75360, DSM	2420858, 2421138 kimarapeer@udsm.ac.tz
Mary Bhakome	NGO-Technical AIDS Committee	Box 71518, DSM	0754-804547
Ramadhani Soud	Magomeni Islamic Centre, Damba Madrasat	DSM	0754-601-825
Judith Mulundu	TUMAINI PROJECT	DSM	0754-404713
Pfiriael Kiwia		P.O.Box 75360 DSM	2420858, 2421138 0753 570014, 0713 338900 kimarapeer@udsm.ac.tz
Abdukhakim Morison Suod	BAKAIDS Mara		Sheikh
Peter Bwana Nyalufujo	Watoto Wapime UKIMWI	Musoma	Advisor
Malli Selisi	Center for widow & Children Assistance	Karagwe	Legal advisor
Magawa Ndaro Abdallah	Pact	DSM	Project Officer
Noklasko Mjumba	Community Care Trust (COM-CARE)		Coordinator Jali Watoto
Hezbon William	Watoto wapinge UKIMWI		Children Educator
Edna Leonard	WOMEDA-Karagwe		Field Officer
Elenest Ndiege	Anglican Church Mara		Project Officer
Respicius John	MAPEC-Kagera		Peer Education Coordinator
Joyce Ramadhani	CHIYOWONET	Musoma	Volunteer
Marget Mariki	Com-care Mara		Counsellor
Juma Masisi	Womeda Karagwe	Karagwe	Legal adviser
Steven Eustale	SAWATA Karagwe	Karagwe	Coordinator-Children-OVC
Shammy Deud	CHIYOWONET	Musoma	Field Officer
Ajuna Jefta	KAYODEN	BUKOBA	Board Member
Elihuruma	AESIT		Community Educator
Patrick Rapando	SAWATA-Karagwe		Community Educator
Robinah Kimbugwe	Pact Tanzania		Coordinator-Stigma Jali Watoto
Gabriel John	CHIYOWONET	Musoma	Volunteer
Janet Yusuph	MAPEC Mara	Musoma	Peer Educator
Deus	Roots & Shoots	Bunda	Coordinator
Mariamu	Roots & Shoots	Bunda	Peer Educator
Rev. Dismus Mofulu	CCT/KLM/UMADIKU	P.O. Box 1901 Dodoma	dmofulu@yahoo.com
Maundi Kenneth	Kanisa la Uinjilisti—Mbeya	P.O. Box 219 Mbeya	0744604 278
Joshua Edmund	Kanisa la Udugu la Kikristo	P.O. Box 996	Edmundjoshua@yahoo.com
Elissey E. Magiri	Muheza D.D.H. Anglican Diocese, Tanga	Private Bag Muheza	magiricholoy@yahoo.com
Major Isaac Pepete	The Salvation Army Church	P.O. Box 7622 Dar es Salaam	022 285 0468
Bishop John Nkola	Africa Inland Church Tanzania	P.O. Box 53 Shinyanga	actshy@komclass.com

Trainer Name	Organizational Affiliation	Postal Address	Contacts (phone, e-mails)
Mohammed N. Juma	Dar es Salaam Islamic Club	P.O. Box 45012 Dar es Salaam	jumamn@yahoo.com
Fr. Raphael Millanzi	Lindi Catholic Diocese	P.O. Box 435 Lindi	0744 068 730
Fr. Evarist K. Abedi	Same Catholic Diocese	P.O. Box 8 Same	0744 537 799
Fr. Reginald Moyo	TEC	P.O. Box 152 Songea	(02?) 260 2423
Clotilda Ndezi	CCT	P.O. Box 1454 Dodoma	0744 431 490 (026) 232 1722
Fr. Casimir Magwiza	Catholic Diocese Tanga	P.O. Box 5 Korogwe	0744 285 182
Laurent S. Mapunda	WCRP/Tanzania	P.O. Box 76951 Dar es Salaam	(022) 286 2504 wcrptz@cats-net.com
Jitto Ram	Dar es Salaam Islamic Club	P.O. Box 12542 Dar es Salaam	0744 695 467 mikono@raha.com
Paul A. Mwanga	CCT	P.O. Box 1454 Dodoma	Paul_mwanga@yahoo.com
Sheikh Suleiman M. Gorogosi	BAKWATA	P.O. Box 21422 Dar es Salaam	0741 401 400
Sharif Hussein Hashim	BAKWATA	P.O. Box 1256 Tanga	0748 549 400
Sheikh Abubakar Zuberi	BAKWATA	P.O. Box 10 Tanga	0744 381 296
Sheikh Hassan Chizenga	BAKWATA	P.O. Box 21422 Dar es Salaam	dyomboka@yahoo.com
Willy Hyera	ACT- ASWT	P.O. Box 32 Njombe	0748 39 076
Elias Mtenga	Local Government leader	Dar es Salaam	0713 605674
Joseph Rweyemamu	Local Cell Leader	Kimara Baruti Dar es Salaam	0713 292374
Anthony Gause	Ward Multi-Sectral AIDS Committee		0754 218654
Elias Humbo	Local Cell Leader	Kimara Dar es Salaam	0713 404616
Twilumba Mkumbo	Kimara Lutheran Church	Kimara Lutheran Church	0754 883193
Rev. (Student) Mkumbo Mitula	C/O Kimara Community	Mwaneromango Theological Collage	0754 861161
Suleiman Ndege	Local Cell Leader	Matangini Community	0753 684070
Takia Adam	Local Cell Leader		
Menrad Lembuka	NGO-		0754 219194
Harun Hassan	Ward Multi-Sectral AIDS Committee	Matangini	0754 225016 0787 225016
Urther Haule	Ward Multi-Sectral AIDS Committee	Matangini	0756 689353
Ramadhan Mashaka	Local Cell Leader	Mavurunza	0754 273453
Everlyine Manyemba	Nursery School Teacher-Anglican Church-Kimara	Matangini	0753 054502
Mahija Mwinjuma	Women Group	Matangini	0757 644070
Dr. Everlyne Kiama	Kimara Government Dispensary	Matangini	0754 333059
Mary Gasper	Kimara Resort	Kimara DSM	0713 244059
Flora Kayuza	Ward Multi-Sectral AIDS Committee-Teacher	Mavurunza Primary School-Matangini DSM	0754 654774
Revy Kapinga	NGO- Women Tudaidiane Community	P.O. Box 53427 Dar es Salaam	0754 567461
Mary Kessy	NGO- Women Tudaidiane Community	P.O. Box 53427 Dar es Salaam	

Trainer Name	Organizational Affiliation	Postal Address	Contacts (phone, e-mails)
Faustin Mawanja	Mtaa Multi-Sectral AIDS Committee	DSM	
Neema Luwanja	Kimara Lutherran Church-emplyee	DSM	
Respius Mgimba	Mtaa Multi-Sectral AIDS Committee	Millenium Primary School; Bonyokwa	0717 037832
Albert Okeno	Local Cell Leader	Kimara Mavurunza	0753 770766
Zaharan Rashid	Mtaa Multi-Sectral AIDS Committee	DSM	0784 645476
Daniel Mgige	Local Cell Leader	DSM	0713 271016
Dorcus Chumo	Mtaa Multi-Sectral AIDS Committee	DSM	0784 464133
Fatma Mpoto	Ward Multi-Sectary AIDS Committee	DSM	0786 374650
Ruth Mwaisoba	Mtaa Multi-Sectral AIDS Committee	DSM	0713 84738
Joseph Msiska	Mtaa- Multi-Sectral AIDS Committee	DSM	0757 857 282
John Chilipweli	Ward Multi-Sectral AIDS Committee	DSM	
Felista Magoha	Ward Multi-Sectral AIDS Committee	DSM	
Zainabu Kipoka	Local Cell Leader	DSM	
Benard Ukuta	Local Cell Leader	DSM	0753 283513
Asha Mikidadi	Local Cell Leader	DSM	
Peter Mandawa	Local Cell Leader	DSM	
Mwaimuna Iddi	Employee-Kimara Baruti Local Government Office	Baruti, DSM	
Edward Joseph	Ward Multi-Sectral AIDS Committee	Kimara Baruti, DSM	
Yohana Lazaro	Ward Multi-Sectral AIDS Committee	Kimara Baruti, DSM	0787 212158
Rosemary Kalumanzira	Ward Multi-Sectoral AIDS Committee	Matangini, DSM	0753 004184
Ally Linjepe	Religious Leader	Matangini, DSM	0787 286634
Jazila Mohamed	Peer Educator	NGO-Matangini Community Center, DSM	
Rashid Hussein	Peer Educator	NGO- Mburahati Community Centre, DSM	
Gideon Wilson	Peer Educator	NGO-Matangini Community Center, DSM	0713 618636
Merina Mabena	VCT Counsellor	Kimara Peer Educators, DSM	info@kimarapeer.org 0784 429889
Frida Mashilanga	Counsellor/HBC provider	NGO-Matangini Community Center, DSM	0713 641867
Mateso Athuman	Peer Educator	NGO- Mburahati Community Centre, DSM	
Theresia John	Peer Educator	NGO- Mburahati Community Centre, DSM	0753 422746
Fatihiya Bakari	Peer Educator	NGO- Mburahati Community Centre, DSM	0753 583271
Halima Bakari	Peer Education Coordinator	Kimara Peer Educators	0784 512971
Hawa Yahaya	Peer Educator	NGO- Mburahati Community Centre, DSM	0713 213352

Trainer Name	Organizational Affiliation	Postal Address	Contacts (phone, e-mails)
Gloria Mpangala	Peer Educator	NGO- Mburahati Community Centre, DSM	
Zenna Hassan	Counsellor/HBC provider	NGO-Matangini Community Center, DSM	0757 440485
Yahaya Said	Peer Educator	NGO- Mburahati Community Centre, DSM	0755 175970
Cosmas Mtukula	Municipal /District AIDS Coordinator	Mtwara	
Michael Bakiri	Teacher-Shangani Primary School	Mtwara	
Salum A. Malenga	Chair person-TUWAWA_NGO	Mtwara	
Melania Felix	Secretary- NGO-Pemwa	Lindi	
Rukia M.Japh	Community AIDS Coordinator	Lindi Municipal Health Office	
Asha Fundi	Member-NGO-LISAWE	Lindi	
Sharifa Mkufu	Counsellor/Care Giver- NGO-Pemwa	Lindi	
Zuhura Mwase	Ward Executive Officer	Lindi Municipal Office	
Rachel L.Mbelwa	Community Development Officer	Mbeya Rural District Office	
Jacqueline Kessy	District AIDS Coordinator	Mbeya	
Naiman Ituga	NGO-Nyota Group Peer Educator	Mbeya	
Joseph Singundali	District Education Officer	Mbeya Rural District Office	
Mfaume Nguche	NGO-Nyota Group Peer Educator	Mbeya	
Gervas William	Chairperson-Local Government office; Airport.	Kigoma	
Exavery Kehegwa	Municipal AIDS Coordinator	Kigoma Municipal Office	
Rashid Ulimwengu	Religious Representative-Municipal AIDS	BAKWATA-Kigoma	
William S.Mtevi	Religious Representative-Municipal AIDS	Anglican Church-Kigoma	
Annah R. Ndile	Bukoba Municipal Council, Social welfare.	Bukoba	
Julius Majula	Municipal AIDS Coordinator	Bukoba	
Theonest Rutamigwa	Religious Leader-Roman Catholic	R-C Bukoba Parish	
Winifrida Mukono	Coordinator-SHIDEPHA +	Bukoba	
Dickson Kinyanka	TYDC	Igunga	
John Mbele	TYDC	Tabora	
Devotha Macheku	TYDC	Igunga	
Emmanuela Lusinde	TYDC	DSM	
Darius Mhawi	TYDC	DSM	
Nestory Kaziba	TYDC	Nzega	
Flora Simbila	TYDC	Nzega	
Theresia Olemako	CISO	Kilimanjaro	
Hakimu Hamad	CISO	Bukoba	
Evance K Kaganda	CISO	Bukob	
Charles Kamugisha	CISO	DSm	
Josephine Majili	CISO	DSM	
Delvin Shayo	CISO	DSM	

Trainer Name	Organizational Affiliation	Postal Address	Contacts (phone, e-mails)
Bryson Lugemera	CISO	Bukoba	
Joshua Mutagahwa	CISO	Bukoba	
Kanisia Ignas	Roots & Shoots	DSM/dar	
Abdala Mambia	R&T	DSM	
Deus Cosmos	R&T	Mara	
Kezia Edward	R&T	Mara	
Kuruthum Rashid	R&T	Coast	
Mauled Hussein	R&T	Coast	
Christopher Rutuku	R&T	Bagamoyo	
Revocatus Edward	R&T	Kigoma	
Joyce Komba	R&T	Mkuranga	
Omary Sultan	TYDC	Dar	
Fortunatus Fulgence	KAYODEN	Karagwe	
Ajuna Jephta	KAYODEN	Karagwe	
Neema Kecheule	KAYODEN	Karagwe	
Stella Felix	KAYODEN	Karagwe	
Ndenengo Malisa	IDYDC	Iringa	
Jacob Lupetu Milinga	IDYDC	Iringa	
Abdurahman Makarabo	IDYDC	Iringa	
Patrick Dan Simwimba	IDYDC	Iringa	
Maria Msilu	IDYDC	Iringa	
Godfrey Mwautwa	IDYDC	Iringa	
Anisia Mwinuka	IDYDC	Iringa	
Cesilia Msamba	IDYDC	Iringa	
Mohamedi Haji Abdallah	ZANGOC	Unguja	
Asha Abdi Khatibu	ZANGOC	Unguja	
Mohamedi Khamisi Juma	ZANGOC	Unguja	
Amina Suleiman Kessy	ZANGOC	Unguja	
Mwajuma Ismail Saidi	ZANGOC	Unguja	
Fatma Abdallah Ali	ZANGOC	Unguja	
Hawa Juma Shaban	ZANGOC	Unguja	
Sada Abdallah Issa	ZANGOC	Unguja	
Siti Hamadi Ali	ZANGOC	Unguja	
Khadija S. Khalfan	ZANGOC	Unguja	
Hilika Hamad Mwinyi	ZANGOC	Unguja	

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