P r o p o s a l

for

REACHING THE ADOLESCENTS THROUGH PARENT/FAMILY EDUCATION

HIV Prevention Program for Kagera, Tanzania

1. Problem Statement

On a global level, one of the most important problem facing the world is the prevention and control of HIV/AIDS among the adolescent and young population between the ages of 10-24. These young people constitute a target group and a potential resource for prevention of HIV/AIDS infection. About 30% of the world's population is between 10-24 years old. In many developing countries, more than half of the population is below the age of 25.

1.1. The target population are rural adolescents (10-18 years old), residing in the north-western region of Kagera in Tanzania, East Africa. Given the relative rural solidarity and the existing traditional interaction between parents and their children in the rural areas, the project intends to reach this target population through their parents.

1.1.2. The project objective is to form groups of parents in villages who will work with their children 'against transmission of HIV.' These nuclei of parents are intended to be replicated within and in other villages, and localities. The formed groups will consist of 10-25 adults each. In each village one could have 2-3 groups of parents working with their children to change behaviors and lifestyle associated with the transmission of HIV infections.

1.1.3. Opposition to the project is likely to originate from sentiments against too much talk about AIDS and related issues. 'People are tired of listening about AIDS and related topic' (Ingrid, 1990). Opposition to the project will be outweighed by the benefits as will be presented by the project; and also by the tactical approach to the parents and the

adolescents.

1.1.4. Administratively, Kagera region is divided into five districts of Bukoba, Muleba, Karagwe, Biharamulo and Ngara. Each district, in turn, is divided into ward;, and each ward is sub-divided into 'kata,' finally, a kata into a ten-house cell. The political structural base will facilitate the organization and operations of the project in the rural areas.

1.1.5. According to the 1978 National Census[1], there were 1,326,183 people in Kagera region, 269,626 households with an average size of 4.9. But according to the preliminary survey of 1988 of Tanzania Census, the population of only two districts of Bukoba and Muleba is now close to a million. See attached tables of the breakdown of Kagera children and young people by age (0 -24), sex and district.

1.1.6. Kagera is 98% rural. HIV/AIDS was detected there in 1983. Since then, it has increased in geometrical progression. To-day, 60% of AIDS cases in Tanzania are located in Kagera (along the western shore of Lake Victoria). The region suffers from 33% rate of HIV infection, with 41% (in 1988) of adults between 25-34 infected. Infection rates of HIV/AIDS in Kagera are among the highest in the world for a rural population. Pediatric HIV/AIDS is on the rise in Kagera. (See the attached tables of seropositivity among Kagera children with HIV/AIDS, a study by Nyamuryekunge, K., 1989). Comparatively, in neighboring Uganda, there are 12,444 AIDS cases, and of June, 1990, there is an estimated 1,000,000 HIV+ people in Uganda. Of the 12,444 AIDS cases in Uganda, 1,309 are children 11 years and under (Bagarukayo, et al., 1990).

1.1.7. The World Health Organization (WHO) has estimated that by the year 1992, there will be a cumulative total of about one million AIDS cases in sub-Sahara Africa. Of these 800,000 will be adults and 200,000 children. Of the cumulated total, 80% of the cases in children are projected to occur between 1988-and 1992 (WHO, 1989).

1.2. Specifically, in terms of the danger for HIV transmission, young people in Kagera engage in risk behaviors related to HIV transmission: adolescents are sexually active at a very early age. (See the attached tables a comparative study of the subject by Bagarukayo and colleagues, 1989). They are leading a high risk-taking lifestyle: there is an unprecedented significant increase in the abuse of alcoholism, and drugs (marijuana), teen pregnancies, homicides and suicide rates, school dropouts, and a host of theft, (armed) robberies and break-ins and other sorts of violence (Rumuli, 1989).

1.2.1. There is an urgent need for a HIV infection prevention program for the young people.

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[1]1988 Tanzania Population Census is not yet available.

Prevention is the only hope for the young people in Kagera (in Africa, for that matter). Prevention consists in changing and reducing risk behaviors associated with HIV transmission, changing and reducing risk-taking lifestyle and risk factors associated with transmission of HIV infections. Specifically there needs be a comprehensive program consisting in changing risk behaviors related to transmission of HIV infection, implementing strengthened sexually transmitted diseases (STD) control and treatment programs, and keeping blood supplies, injections and syringes clean.

1.2.2. Therefore, research is needed to develop methods and techniques to understand, prevent and/ or change high-risk sexual and drug-abuse behaviors and to sustain the changed behaviors over time. In addition, research is needed to identify psychological, social, and cultural barriers and enhancers to these behavior changes. As a related subject, research is needed to determine the role of alcohol consumption patterns in the region in the initiation and maintenance of high risk behaviors. New and innovative strategies for enhancing and enforcing protective behaviors must be developed. Measuring and testing methodologies for strategy effectiveness must be designed.

2. Center for Traditional Medicines, Green Cross, Inc.

2.1. Green Cross, Inc. is a non-profit organization located in the North West of Washington, DC. Established in 1984, Green Cross is committed to health care for the individual and for the global community through practice, research, education, and collaborative projects. Since its opening of its **You Street Clinic** in Washington, D.C., Green Cross has helped people with problems such as drug and alcohol abuse, immune system issues including Epstein-Barr, Chronic Fatigue Syndrome and HIV/AIDS, as well as allergies, blood sugar imbalance, sickle cell anemia, pain syndromes, etc.

2.2. Center for Traditional Medicines (CTM) is a project of Green Cross, Inc. Besides incorporating the expansion of Green Cross objectives and philosophy on a global level, CTM other objective is to organize, promote and establish cooperation and collaboration of worldwide traditional medical practice, research and education.

2.3. Green Cross, Inc. has an international staff composed of professionals in various fields from the U.S., China, Africa, the Middle East, and The Caribbeans. It has working relations with institutions in many countries throughout the world.

2.4. Among their accomplishments, Green Cross and the Center for Traditional Medicines have established a good track record alleviating inner city health related problems drug addiction, HIV/AIDS management and control documented in the CTM's Ancient Roots: A Modern Medicine, an International Journal of Traditional Medicine.

3. The Project and its Objectives

3.1. The Project is a joint effort of professionals from diverse academic background including medical and behavioral sciences. Their diverse experiences and upbringing give them unique qualifications for conducting the project. The objective is to understand, change and prevent risk behaviors associated with the transmission of HIV infection and other issues related to HIV transmission among the adolescents.

3.2. Beneficiaries: CTM's Project primary and direct beneficiaries are Kagera region adolescents. Secondary and indirect beneficiaries of the project will be the parents/families, and thirdly, society at large.

3.2.1. In changing high risk behaviors related to the transmission of HIV infection and reducing risk factors, the young people will increase their chances of avoiding AIDS and prolonging their productive lives.

3.2.2. Individual families are suffering from enormous economic, psychological, social and emotional impact caused by the loss of the members of their families who die from AIDS. It is projected that there will be a significant change and reduction of risk behaviors and risk factors which will result in reduction of HIV infection and subsequent deaths related to AIDS. Reduction in such deaths will reduce family suffering.

3.2.3. The project will benefit society at large. Most of AIDS casualties are among the most productive segment of society. The depletion of both material and human resources related to AIDS is yet to be measured. The overwhelming cost of every kind created by AIDS related orphans will be reduced according to the reduction in the rates of HIV infections.

3.3. Involvement of target population in developing the project.

3.3.1. The project intends to present to the parents the problem of HIV transmission and the associated issues among their children. The project will assist the parents in formation of groups and administration of their groups; setting up the agenda and time table, and running the operations.

3.3.2. The project intends to incorporate the program designed for other socio-economic issues which can lead adolescents to engage in risk-taking lifestyle associated with the transmission of HIV infection (see Rutayuga, 1990a & 1990b). The program objective is to change prevalent young people's risk-behaviors or factors related with the spread of HIV infection.

3.4. The project expects through the influence of the adolescents' parents, to change the risk behaviors and risk factors associated with the transmission of HIV, and the reduction of risk-taking lifestyle.

3.5. The effectiveness of the project will be measured by:

3.5.1. The numbers of the groups within individual villages, and the numbers of participating villages.

3.5.2. The regularity in attending meetings/sessions to exchange views and report their findings/results.

3.5.3. Adolescents' self reporting on a number of targeted behavioral modifications.

3.5.4. Participant observation methodology conducted by the project.

4. Plan of Action and Intervention

4.1. Research needed to determine high-risk behaviors and risk factors associated with HIV transmission, psycho-social and cultural barriers and enhancers to behavioral change. Research will include:

a/ Formulation of data gathering instrument and schedule. Local people will be involved in the process.

b/ Actual interview and participant observation

c/ Analysis of data

4.2. Intervention includes equipping the parents with tools and skills to be able to deal with modern day adolescents.

4.2.1. Education on:

a/ Present day and traditional family: role, duties & obligation of parents; duties/obligation of children.

b/ Basic knowledge to the approach and solution of psycho-social problems of modern adolescents.

c/ HIV/AIDS: its nature, transmission, prevention/protection.

4.2.2. Counseling:

a/ Learning and reenforcing traditional techniques approaches of grandparents and aunts.

b/ Encouraging, learning from, and reenforcing traditional birth attendants' counseling techniques.

c/ Learning basic modern counseling techniques

d/ Integrating traditional and modern counseling techniques

4.2.3. Program for the adolescents: (see Rutayuga, 1990a. & 1990b.). The program is intended to:

a/ Education about HIV/AIDS, its nature, transmission, consequences, prevention/protection.

b/ Sensitize the adolescents about HIV/AIDS.

c/ Raise their self-worth, reduce risk-taking and destructive behaviors.

4.3. Time-line for the planned activities. The project is to be accomplished in ..... phases:

4.3.1. Phase One: Preparatory work - will take four to six months

a/ Initial contacts with central and local government ministries, and officials to secure project approval.

b/ Contact appropriate institutions, such as university, schools, Non-Governmental Organizations (NGOs), and health facilities in the locality for collaboration and to secure appropriate data

c/ Setting up the district/region administration office for the project.

d/ Hiring process of project workers (office, and village).

e/ Site selection methodology and process.

4.3.2. Phase Two: Preparation for, collecting and entering data and analysis of risk behaviors, factors and barriers and enhancers to behavior change. - Will take one and half to two years.

4.3.3. Phase Three: Intervention will follow as spelled out in IV. Plan of Action, but will be subject to modification in accordance to evidence presented by the data collected during that time. This phase will last from six to eight months.

a/ Parent Education/training in counseling will take place simultaneously.

b/ Adolescent program can be initiated at the same time.

*c/ Development of measurement instrument for program effectiveness. Monthly assessment of project

4.3.4. Phase Four: Preliminary analysis of data, and interpretation. This phase should go hand in hand with the whole intervention process. - Four months

a/ Measurement and

b/ Evaluation

4.3.5. Final analysis of data and interpretation for publication of fieldwork. Approximately one and half years.

5. <u>Qualification of key personnel</u>

5.1. Qualifications

a/ Academic qualifications

b/ Work experience

c/ Unique qualifications of knowledge and skills: the fact that they are natives of the region gives them superior knowledge and understanding of local conditions, cultures and customs. Thus they bring to research unique perspectives drawn from years of first-and experience and analytical studies, and insight of their own cultures. Their native knowledge of local languages gives them suitable intuition into sophisticated behavioral patters.

5.2. Amount of time dedicated to the project

a/ Principal investigator(s), and facilitator(s) - full time

b/ All local personnel - full time

c/ Consultants - part time /or on hourly basis

5.3. Resumes attached.....

6. Method of Evaluation

6.1. Measurement of project's effectiveness (*see part III - D.)

The project expects, through the adolescents' parents, to influence a change of their risk behaviors and risk factors associated with the transmission of HIV, and the reduction of risk-taking lifestyle.

The effectiveness of the project will be measured by:

6.1.1. The numbers of the groups within individual villages, and the numbers of participating villages.

6.1.2. The regularity in attending meetings/sessions to exchange views and report their findings/results.

6.2.3. Adolescents' self reporting on a number of targeted behavioral modifications.

6.2.4. Participant observation methodology conducted by the project.

6.3. Method of monitoring progress and /or problems

7. Benefit of the Project

9. Budget (See the attached).

Summary

The "Kagera triangle" named after the river which runs through it is considered by the US Bureau of the Census to have the highest regional concentration of HIV/AIDS in the world. The triangle includes southern Uganda, northwestern Tanzania, Ruanda and Burundi. The peoples living in the four countries are ethnically and linguistically related. This proposal concentrates on the Haya of northwestern Tanzania but other HIV/AIDS research being conducted in neighboring countries is relevant and can offer many points of comparison given the fundamental cultural and social similarities. Recent history and research done so far point to the likelihood of HIV transmission among these countries.

The principal objective is to re-examine the present role of Haya women presumably altered and certainly stressed by many serious events in recent years: the Uganda-Tanzania war (1979), the escalation of HIV/AIDS morbidity and mortality rates for both men and women (1983 on), AIDS-related orphanhood, and four decades of rapid population growth which had already resulted in marked changes in the dependency ratio before the AIDS epidemic arrived. Women were (and some presumably still are) the caregivers to their families; because HIV/AIDS ratios are 1:1 (male:female) many women, aged 20-45, are known to require rather than being able to render care.

Two sources of data will be used; one is already available, the other is to be obtained with (partially) the research support being Requested in this proposal. Original field notes, (described in greater detail below) are available from the period 1951-55, and two brief trips in the 1960s and 1970s. The new fieldwork will be centered on returns to the three villages in three different Districts (all Haya) which were the focus of the 1950s fieldwork. Non-trivially in 1987 the HIV rates in the Districts were 30.9, 9.7 and 4.6 respectively. In short a gradient appears to exist which offers important comparisons for how Haya women are coping with different circumstances.

The principal method to be followed is the use of participant observation by the PI's and their colleagues; it involves staying close to or in the villages, talking--using key questions--with persons, observing schedules, listening, attending public events, and private when possible combined with systematic village wide visits to every household/family to ascertain the changes (anticipated as many) in the intervening period. In addition, the very fact of being resident in the District(s) make the daily, weekly, monthly flow of information inevitable. The new data convert the 1950s data into a longitudinal study. New technologies make the integration of the two major data sets easier and quicker.

Because the objectives of Ukimwi are already known to the PIs two kind of results are anticipated--basic analytical findings on social change processes, and fromthat vantage point, what best means can be devised to support and ameliorate Haya organized and donor supported interventions.