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Rapid Field Assessment of HIV Vulnerabilities and Service Delivery Gaps in Border Zones

Tanzania, January – May 2010

IOM– Tanzania in Collaboration with Ministry of Home Affairs Immigration Department 2010

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- Uphold the humane dignity and well-being of migrants.

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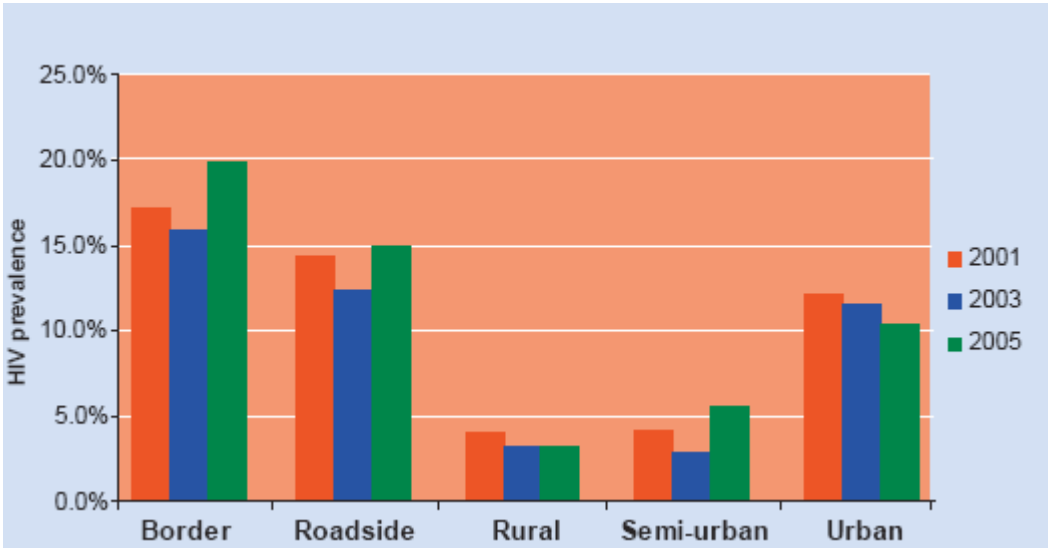
1 Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral Drugs
CBO	Community Based Organization
CHACC	Council HIV/AIDS Control Coordinators
DC	District Commissioner
DIO	District Immigration Officer
DMO	District Medical Officer
HIV	Human Immunodeficiency Virus
IOM	International Organization for Migration
KAP	Knowledge, Attitudes and Practises on HIV and AIDS
NGO	Non Governmental Organisation
RIO	Regional Immigration Officer
RMO	Regional Medical Officer
RPC	Regional Police Commissioner
TPA	Tanzania Ports Authorities
VCT	Voluntary Counselling and Testing

2 Introduction

For the past 25 years Tanzania has experienced a generalised HIV epidemic. The current prevalence of 5.7% translates into around 1.8 - 2 million adults and children living with HIV, 80,000 AIDS deaths per year, and the epidemic is still growing with more than 200,000 new infections every year. The epidemic figures show clear gender, age, geographic and regional disparities: it affects more women than men (6.6% and 4.6% respectively), prevalence in particular age groups such as young women between 15 and 24 is six times higher than in young men. Urban areas, road- and border sites also show much higher prevalence estimates than the national average or rural areas[1,2].

Figure 1



Source: The HIV Epidemic in Tanzania Mainland: Where we come from, where it is going, and how are we responding? World Bank and UNAIDS 2008

Studies in Eastern and Southern Africa (and elsewhere), suggest that mobility has been a key factor in the spread of HIV and AIDS as well as of related sexually transmitted diseases[3] [4] and the association of temporary migration and HIV infection is affirmed by several studies in Southern Africa[5] [6]. Hence it is a likely interpretation

[1] Tanzania HIV AIDS Malaria Indicator Survey 2007-08

[2] UNAIDS and WB/ASAP, 2008, Dar es Salaam. The HIV Epidemic in Tanzania Mainland, where we have come from, where it is going, and how are we responding?

[3] Caballo, M. , 2007, The challenge of Migration and Health. International Centre for Migration and Health (ICMH), Geneva

[4] Dodson, B and Crush J., 2003, Mobile 'Deathlihoods' :Migration and HIV/AIDS in Africa. Paper for UNAIDS Project: AIDS in Africa; Scenarios for the Future.

[5] Lurie M, 2004, Migration, sexuality and the spread of HIV/AIDS in rural South Africa. SAMP Migration Policy Series no 41. SAMP, Cape Town

[6] Lurie, M et al. 2003, Who Infects Whom? HIV-1 Concordance and Disconcordance among Migrant and Non-Migrant Couples in South Africa' AIDS, 17: 2245-52

of the geographical disparities in the Tanzanian epidemic that mobility contributes to the high prevalence rates at road- and border sites.

The Tanzanian National Multi-sectoral Strategic Framework on HIV and AIDS 2008 – 2012 as well as the National Prevention Strategy 2009-2012 recognise mobile populations and mobility affected areas such as migrant workers, fishery folk, transport workers and residents of specific hot spot areas as a priority area, which demands special attention with provision of appropriate biomedical and prevention services.

As a means to examine HIV vulnerabilities and service delivery gaps at border sites IOM Tanzania undertook a rapid field assessment in Jan – April 2010 of HIV knowledge, attitude and practices (KAP), mobility patterns, sexual networks and service delivery in three border areas. The assessment covered land, lake and ocean borders with a focus on four different population groups:

- Immigration and other uniformed staff working on the border
- Transport workers and border community
- Fishermen and fishing community
- Seagoing personnel and port community

The objectives of the assessment were to:

- Assess HIV Knowledge, Attitude and Practices among the four targeted population groups.
- Assess mobility patterns and sexual networks among the four targeted population groups.
- Assess availability and service delivery gaps of HIV preventive, diagnostic and curative services among the four targeted population groups.
- Identify potential future implementing partner organizations in the targeted border communities.

This report presents the findings from the three sites as well as recommendations for how to address the service delivery gaps and mitigate HIV vulnerabilities within the assessed border zones.

3 Methodology

The assessment was conducted during three field visits to three geographical destinations:

1) Port of Dar es Salaam (Temeke District)
2) Kigoma /Kagera Region (Kigoma, Kasulo, Kibondo, and Ngara District)
3) Mbeya Region (Kyela District)

Please see table 7 for list of border posts included.
The sites were selected to represent land, lake and ocean borders as a means to address a variety of border zones, mobile populations and mobility affected areas. Furthermore, the sites were selected on the basis of IOM Tanzania's prior

engagement with both the Port of Dar es Salaam as well as border management in Kagera and Kigoma regions.

The methodology used was the same in all three sites and the assessment was carried out by a team of two research leaders from IOM Tanzania, two research assistants and one observer from the Ministry of Home Affairs - Immigration Department. All interviews, except those where the informants were fully conversant in English, were carried out in Kiswahili with direct translation to English.

At all sites a combination of interview tools and techniques were used:

- Close-ended structured interviews on HIV Knowledge, Attitude and Practices
- Social Mapping within gender segregated focus groups to obtain information about mobility patterns, sexual networks and access to HIV and health services
- Semi structured open-ended key informant interviews to obtain information about mobility patterns, sexual networks and HIV and health service delivery
- Structured open-ended questionnaires to obtain information about the HIV related activities carried out by NGOs/CBOs in the border community

Beyond the district and regional authorities all informants were identified by a snowball technique using the below inclusion criterions:

1) Immigration officers and border police age 18-49 years of age at the time of the study working on the border post
2) People crossing the border, resident or working on a daily basis in the immediate border community age 15-49
3) Government, private-non-profit and private-for profit service providers of preventive or curative HIV services within the border community.

At each site the district authorities were involved and informed about the assessment and Regional and District Medical Officers (RMO's and DMO's), Regional Immigration Officers and District Immigration Officers (RIO's and DIO's) as well as Council HIV/AIDS Control Coordinators (CHACC) served as key informants in all districts visited by the assessment team.

Figure 2

In each district included in the assessment the Council HIV/AIDS Control Coordinator (CHACC) was asked to identify the key CBO's and NGO's working in the border community or across the border. The team visited the identified organisations and conducted structured open-ended interviews to obtain information about the work of the organisations as well as the challenges and unmet needs as perceived by the organisations.

All immigration officers and border police officers present on the day of the assessment were interviewed using a close-ended questionnaire on HIV Knowledge, Attitudes and Practices (KAP). Officers were informed about the content and purpose of the assessment and that their participation was entirely voluntary.

Through the snow-ball method informants from the community around the border site as well as mobile populations (truck drivers, fishermen and seafarers) were identified and likewise interviewed using a close-ended structured questionnaire on HIV Knowledge Attitude and Practices.

Only informants who gave an informed consent were interviewed and included in the assessment.

Beyond the KAP survey a number of gender segregated focus groups were organised both within the fishing and road border communities. Participants were identified in order to represent both the sedentary community around the border site and the mobile population passing through. The focus groups used the Participatory Rural Appraisal Technique of social mapping where participants, through drawing, illustrate their mobility patterns as well as points of delivery of preventive, diagnostic and curative health services within their travel routes. During the focus groups also sexual networks and practices within the border communities were explored.

All data collected via KAP survey questionnaires were entered and analyzed in the public health software EPI info. Spot checks were used to ensure the quality of the data entry.

The key-informant and focus group data were recorded by notes and later grouped into themes by the two research leaders and information triangulated between groups as well as with key informant interviews.

In the section below follows the results of the assessment. Comparisons to the national survey data on HIV Knowledge, Attitude and Practices as identified by large national household based surveys have also been made. However, consideration should be made for the sampling of this rapid assessment as snow-ball techniques were used rather than random sampling, in addition, the number of informants in each group were small (see Table 1). Furthermore attention should be drawn to the possible interview-bias, i.e. the extent to which the presence of the interviewer may have affected the answers from the respondent. It is possible that some of the answers, especially those related to sensitive issues such as number of sex partners and sexual habits, could have been adjusted by some of the respondents to “please” the interviewer. This is a well known dilemma when collecting information by interviewing and the survey team tried to mitigate the extent of this bias by underlining anonymity and confidentiality, stressed his/her neutral role as interviewer and the opportunity to speak Kiswahili was always given.

4 Results

4.1 Informants

A total number of 145 informants were interviewed on HIV Knowledge Attitude and practices (KAP) out of which 56 were uniformed staff (51 men and 8 women) and 86 (42 men and 44 women) were either residing/working in the border community or belonging to a mobile population passing through the border areas. Out of the 86 informants from border communities and mobile populations 23 came from fishing communities, 48 from road borders/truckstops and 15 from the Port of Dar es Salaam.

The team conducted 10 male focus groups and 10 female focus group discussions using social mapping and semi structured open-ended interview techniques. The groups contained a total of 47 male informants with an average age of 35 years and 51 women with an average age of 32 years.

A total number of 15 key informant interviews were carried out: 6 in Kigoma/Kagera region, 5 in Mbeya region and 4 in the Port of Dar es Salaam.

In total the team interviewed 22 CBO's and NGO's: 13 in Kigoma/Kagera region, 6 in Mbeya and 3 in the Port of Dar es Salaam.

Table1 List of Informants

Individual KAP questionnaires	**145 informants** **56** Uniformed staff (51 men and 8 women) **86** residing/working in the border community or belonging to a mobile population passing through the border areas of which:. **23** from fishing community **46** from road border/truckstops **15** Seafarers or port community
Focus groups	**10 Male focus groups** with a total of 47 informants, average age 35 of which: **6** groups of fishermen **3** groups of truck drivers and men working at truck stops **1** group of cross-border traders **10 Female focus groups** with a total of 51 informants, average age 32 of which: **6** groups of women from fishing community **2** groups of barmaids at border sites **1** group of guesthouse owners at border sites **1** group of cross-border traders
NGO/CBO interviews	**22 CBOs and NGOs** **13** CBO's and NGO's in Kagera and Kigoma region **6** CBO's and NGO's in Mbeya region **3** CBO's and NGO's in Temeke district around the Port of Dar es Salaam
Key Informants	**A total number 15 key informant interviews** **6** key informants from Kagera and Kigoma region **5** key informants from Mbeya region **4** key informants from the Port of Dar es Salaam

4.2 HIV Knowledge, Attitudes and Practices

Table 2 shows HIV knowledge in the general Tanzanian population as identified by the national household survey THMIS 2007/8 compared with the uniformed staff and border community/mobile population groups that were interviewed during the rapid assessment. Table 3 stratifies the group of border community/mobile population into fishing community, road border/truckstop and seafarers/port community.

Keeping in mind the small sample size and that selection bias is inherent in using the snow ball technique to identify informants both table 1 and 2 show that HIV knowledge among uniformed staff and the border community/mobile population groups are comparable to the levels of the general population.

Table 1 HIV Knowledge

	Uniformed Staff (n=59)			Border community and mobile populations (n = 86)			General population as per national household based survey		
	All (n=59)	Men (n=51)	Female (n=8)	All (n=86)	Men (n=42)	Female (n=44)	All	Men	Female
% That have heard of HIV and AIDS	100%	-	-	100%	-	-	-	98.9%	98.4%
% That knows using condoms reduces the risk of contracting HIV	81%	-	-	81%	-	-	-	89.3%	85.2%
% that knows limiting sex to one uninfected partner reduces the risk of HIV transmission	97%	-	-	84%	-	-	-	86.6%	81.8%
% that knows abstaining from sex reduces the risk of HIV transmission	90%	-	-	91%	-	-	-	89.3%	85.2%
% that knows that a healthy looking person can be HIV positive	95%	-	-	90%	-	-	-	85.6%	79.5%
% that rejects HIV can be transmitted by mosquito bite	83%	-	-	74%	-	-	-	73.1%	72.2%
% that rejects HIV can be transmitted through supernatural means	92%	-	-	83%	-	-	-	88.9%	83.9%
% that rejects HIV can be transmitted through sharing food and utensils	86%	-	-	78%	-	-	-	82.5%	80.9%

Table 2 HIV Knowledge in sub-groups

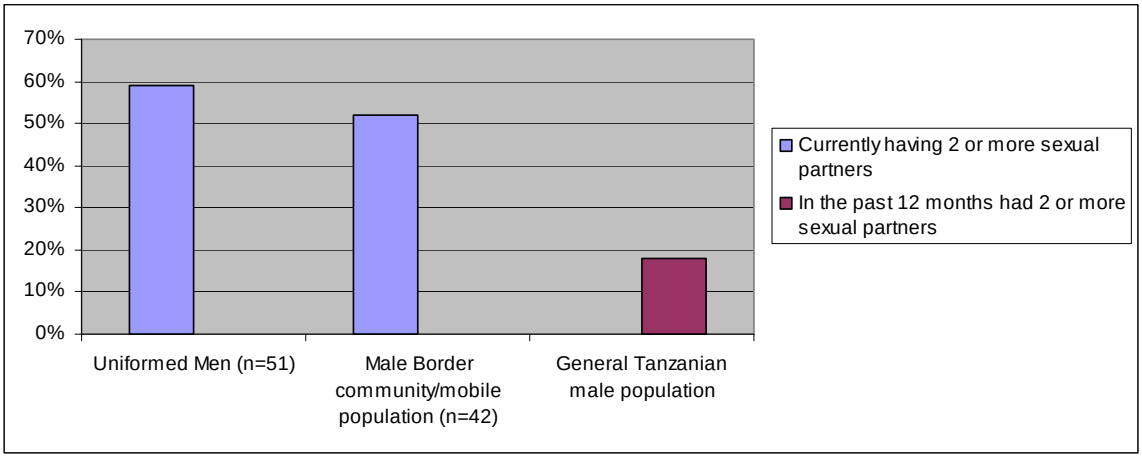
	Fishing community			Road border/Truckstop			Seafarers and Port community			General population as per national household based survey		
	All (n=23)	Men (n=10)	Female (n=13)	All (n=48)	Men (n=21)	Female (n=27)	All (n=15)	Men (n=11)	Female (n=4)	All	Men	Female
% That have heard of HIV and AIDS	100%	-	-	100%	-	-	100%	-	-	-	98.9%	98.4%
% That knows using condoms reduces the risk of contracting HIV	74%	-	-	85%	-	-	80%	-	-	-	76.3%	68.6%
% that knows limiting sex to one uninfected partner reduces the risk of HIV transmission	70%	-	-	85%	-	-	100%	-	-	-	86.6%	81.8%
% that knows abstaining from sex reduces the risk of HIV transmission	91%	-	-	90%	-	-	93%	-	-	-	89.3%	85.2%
% that knows that a healthy looking person can be HIV positive	87%	-	-	92%	-	-	87%	-	-	-	85.6%	79.5%
% that rejects HIV can be transmitted by mosquito bite	78%	-	-	71%	-	-	80%	-	-	-	73.1%	72.2%
% that rejects HIV can be transmitted through supernatural means	70%	-	-	90%	-	-	80%	-	-	-	88.9%	83.9%
% that rejects HIV can be transmitted through sharing food and utensils	70%	-	-	79%	-	-	87%	-	-	-	82.5%	80.9%

Table 3 and 4 show the responses regarding HIV practices among uniformed staff working at the border and the border community/mobile population who participated in the assessment. Whereas HIV knowledge levels were similar to the general population risk behaviours appear much more frequent in the border community.

The mean number of sexual partners for mobile men or men residing/working in the border community was found to be *more than three times higher* than that of the average Tanzanian man and for women the mean was almost twice that of women from the general population. The mean number of sexual partners was found to be lower among uniformed staff than the remaining border community/mobile population.

In Tanzania the primary mode of HIV transmission is heterosexual intercourse with multiple concurrent partnerships being one of the most common risk behaviours. As showed in figure 3 the practice of multiple concurrent partnership seems to be much more frequent in the border community/mobile populations than among the general Tanzanian population with 59% of the uniformed staff interviewed responding that they currently are having two or more sexual partners and 52% and 14% of respectively men and women from the border community/mobile populations responding that they are currently having two or more sexual partners. For men this is almost three times as frequent and for women more than five times as frequent as when the national survey asked respondents if they had had two or more sexual partners *in the same year*.

Figure 3 Frequencies of Multiple Concurrent Partnerships



When looking at the frequencies of condom use within the border community it appears that uniformed men use condoms slightly more frequently than the mobile men or men that are residing/working in the border community. However even in the group of men that are currently practicing multiple concurrent partnerships, 50-60% of the men say they have never used a condom in the past month.

Figure 4 Frequency of condom use

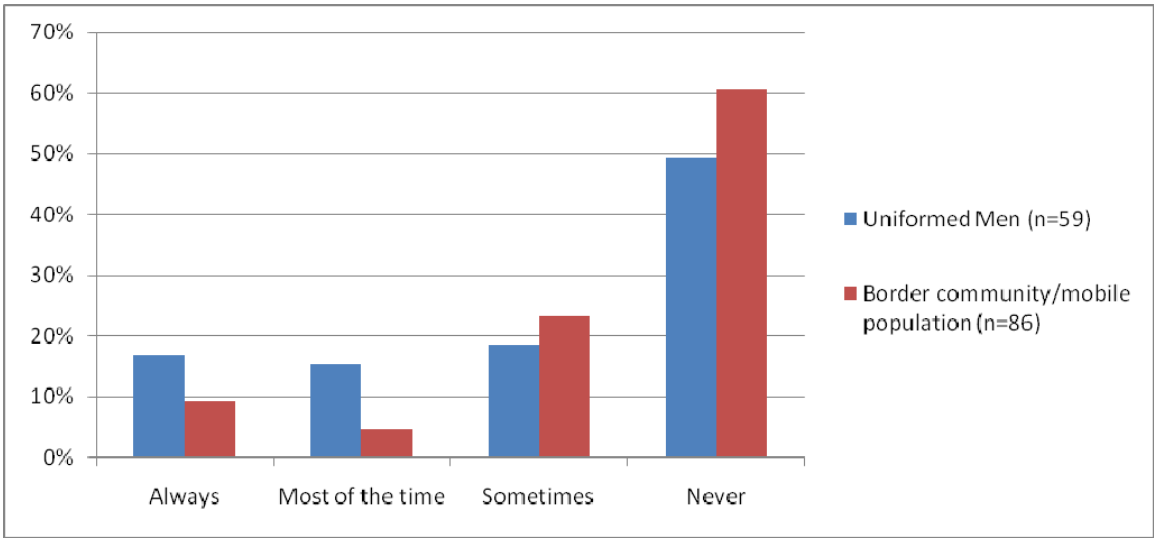
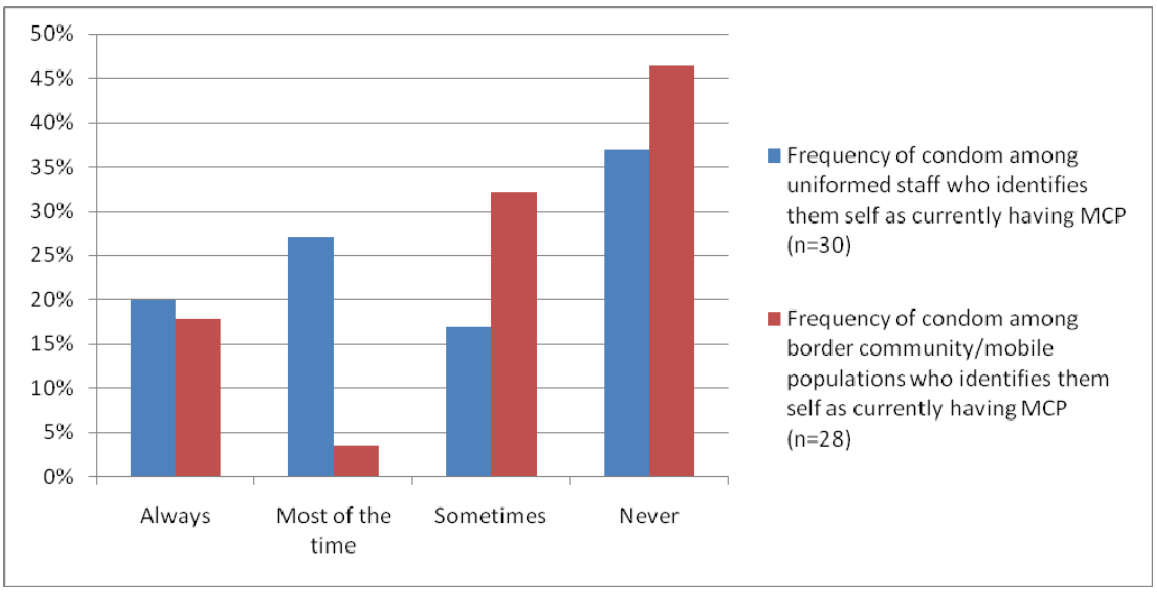


Figure 5 Frequency of condom use among men who say they currently have multiple concurrent partners



Transactional sex and commercial sex work also appear very frequent in the border areas though there are no national data for comparison. However, the focus groups as well as the key informant interviews confirmed high rates of transactional sex in the border areas.

As mentioned earlier the sample sizes become very small when stratifying the data set by fishing community, road border/truckstop and seafarers/port community.

However when considering with what was found in the focus group discussions and key informant interviews, multiple concurrent partnerships may be particularly common in the fishing communities, though the mean number of sexual partners is higher in the big truckstops and port community.

In general a higher percentage of both men and women in the border areas responded that they have had an HIV test compared with the general population, though only 20% of the fishermen interviewed said they had ever had an HIV test compared with the national estimate of 29.2% for men. This corresponds well with information gathered during focus groups, key informant, NGO, and CBO interviews that all confirmed low levels of service delivery in the fishing communities. The women in the fishing community showed much higher frequencies of HIV testing which is at least partly explainable by women being tested during antenatal care visits. Overall, the number who would accept an HIV test, if offered, is - especially among men - higher than the number who has ever tested. This indicates a high acceptance of HIV testing if services are easily available. The high uptake of HIV counselling and testing services when available was confirmed by several NGO's which had conducted mobile HIV counselling and testing and found that the number willing to test was much higher than the capacity of the mobile teams.

Table 3 HIV Practices

	Uniformed (n=p)			Border community and mobile populations (n = a)			General population as per national household based survey*			
	All (n=59)	Men (n=51)	Female (n=8)	All (n=86)	Men (n=42)	Female (n=44)		All	Men	Female
% who has paid money for sex	-	41%	-		67%	-	Has paid money for sex in the past 12 months	-	8.3%	-
% who has received money for sex	-	-	13%	-	-	52%	-	-	-	-
% who has given gifts for sex	-	31%	-	-	21%	-	-	-	-	-
% who has received gifts for sex	-	-	25%	-	-	57%	-	-	-	-
% who has ever been forced to have sex[i]	-	-	25%	-	-	21%	-	-	-	-
Mean number of sexual partners	-	9.9	4.9	-	21.9	4.2	Mean number of sexual partners	-	6.8	2.4
% who is currently having 2+ sexual partners	-	59%	0%	-	52%	14%	% who confirms having 2+ sexual partners in the past 12 months	-	17.9%	2.6%
% who has ever tested for HIV		88%	100%	-	47.6%	84.1%	% who has ever tested for HIV	-	29.2%	40.9%
% who would accept an HIV test if offered one	-	90%	88%	-	81%	91%	-	-	-	-

**source: Tanzania HIV/AIDS Malaria Indicator survey 2007/08*

Table 4 HIV Practices in sub-groups

	Fishing community (n=a)			Roadborder/Truckstop (n=b)			Seafarers and Port community			General population as per national household based survey*			
	All (n=23)	Men (n=10)	Female (n=13)	All (n=48)	Men (n=21)	Female (n=27)	All (n=15)	Men (n=11)	Female (n=4)		All	Men	Female
% who has paid money for sex	-	60%	-	-	81%	-	-	46%	-	Has paid money for sex in the past 12 months	-	8.3%	-
% who has received money for sex	-	-	52%	-	-	44%	-	-	25%	-	-	-	-
% who has given gifts for sex	-	30%	-	-	19%	-	-	18%	-	-	-	-	-
% who has received gifts for sex	-	-	54%	-	-	67%	-	-	0%	-	-	-	-
Mean number of sexual partners	-	7.9	2.7		27.0	5.3		25.6	3.8	Mean number of sexual partners	-	6.8	2.4
% who is currently having 2+ sexual partners	-	70%	15%	-	57%	11%	-	27%	25%	% who confirms having 2+ sexual partners in the past 12 months	-	17.9%	2.6%
% who has ever tested for HIV	-	20%	85%	-	52%	82%		64%	100%	% who has ever tested for HIV	-	29.2%	40.9%
% who would accept an HIV test if offered one	-	70%	100%	-	86%	89%		82%	75%	-	-	-	-

**source: Tanzania HIV/AIDS Malaria Indicator survey 2007/08*

Table 5 and 6 show HIV and gender attitudes among uniformed staff and border communities/mobile populations and among fishing communities, road border/truckstop and seafarers/port communities. The variables that are comparable to the national survey data show gender inequalities comparable to those of the general population. By and large, the findings of the rapid assessment confirm how prevailing gender norms and inequities contribute to HIV vulnerabilities within the border areas. Furthermore the KAP data along with the focus group discussions indicate that gender norms may be more traditional in the fishing communities than at the other border areas, which corresponds with the fishing communities being more rural and harder to reach.

Table 5 HIV attitudes

	Uniformed (n=p)			Border community and mobile populations (n = a)			General population as per national household based survey*		
	All (n=59)	Men (n=51)	Female (n=8)	All (n=86)	Men (n=42)	Female (n=44)	All	Men	Female
% that finds women are justified to refuse sex if the husband has a disease that can be transmitted through sex	90%	-	-	77%	-	-	-	86%	83%
% that finds that women are justified to insist on condom use if the husband has a disease that can be transmitted through sex	95%	-	-	80%	-	-	-	80.8 %	75.6%
% that thinks men should have control over decisions made in relationships	20%	-	-	26%	-	-	-	-	-
% that think it means that if a woman carries a condom it means she is sleeping around	24%	-	-	34%	-	-	-	-	-
% that thinks it acceptable for the man to slap or push the woman around if there is a disagreement between a husband and wife	3%	-	-	12%	-	-	-	-	-

**source: Tanzania HIV/AIDS Malaria Indicator survey 2007/08*

Table 6 HIV attitudes in sub-groups

	Fishing community (n=a)			Road border/Truckstop (n=b)			Seafarers and Port community			General population as per national household based survey*		
	All (n=23)	Men (n=10)	Female (n=13)	All (n=48)	Men (n=21)	Female (n=27)	All (n=15)	Men (n=11)	Female (n=4)	All	Men	Female
% that finds women are justified to refuse sex if the husband has a disease that can be transmitted through sex	78%	-	-	71%	-	-	93%	-	-	-	86%	83%
% that finds that women are justified to insist on condom use if the husband has a disease that can be transmitted through sex	74%	-	-	79%	-	-	93%	-	-	-	80.8%	75.6%
% that thinks men should have control over decisions made in relationships	26%	-	-	18.8%	-	-	47%	-	-	-	-	-
% that think it means that if a woman carries a condom it means she is sleeping around	44%	-	-	25%	-	-	47%	-	-	-	-	-
% that thinks it acceptable for the man to slap or push the woman around if there is a disagreement between a husband and wife	13%	-	-	13%	-	-	7%	-	-	-	-	-

**source: Tanzania HIV/AIDS Malaria Indicator survey 2007/08*

4.3 Mobility patterns

Table 7 shows the border posts that the team visited and the number of exits and entries per year. The large land-border posts and truckstops namely Kabanga, Rusumo, Kassumulo and Tunduma are clearly the border posts with the highest annual number of officially registered entries and exits. The people passing through are both private travellers, cross-border traders, truck drivers and other workers in the road transport sector. The routes of these groups are often long journeys between the big cities in Eastern and Southern Africa such as Kigali, Dar es Salaam, Nairobi, Kampala Lusaka, Harare, Lilongwe and Johannesburg. Beyond the long distance travellers there is a number of small-scale cross-border traders travelling across the border on daytrips to sell different types of goods. These traders are not always registered when entering and exiting as they sometimes bypass the border posts. The border posts also seem to attract a high number of women, who travel either from the neighbouring communities or further away rural areas to make money in the guesthouses, bars and many of them engage in transactional sex.

The smaller border posts on the lakes (Kiberisi, Kigoma port and Itungi port) and smaller roads (Mabamba, Murusagamba and Manyovu) have much fewer registered entries and exits and are a small part of the larger transport corridor between the big sub-Saharan capitals. It is important to note that the number of entries and exits listed in table 7 only represent *actual longer term travellers* and that beyond these there is much higher number of day-pass that are not registered. These day-passes are used by fishermen and cross-border traders, who enter and exit on the same day selling small quantities of locally produced goods such as local-brew, fruits, charcoal, vegetables or dried fish.

Beyond the registered entries and exits there appears to be a vast amount of unregistered cross-border movements especially on the lakes. On a weekly basis the fishermen and boat-owners in Kiberizi travel back and forth between Congo, Burundi and Tanzania fishing and selling fish. The same pattern was seen at Lake Nyasa though there the fishermen seem to move more seasonally between fishing camps spending a few months in each camp as well as on a monthly basis travelling to Malawi selling dried fish when business is low in Tanzania. The women in the fishing communities are partly sedentary sustaining themselves and their families from subsistence farming and making 500-1000 Tsh (0,4 – 0,8 USD) a day by cooking for the fishermen. The remainder of the women derive their income by drying and selling fish either directly in the community or in nearby towns. Although some women travel several days to sell fish, the majority leave early in the morning, sell fish during the day and return home late in the evening so that they do not have to spend money on accommodation. A large group of women around Lake Nyasa also make part of their income by producing pots and selling them either in towns such Kyela or along the Tanzanian and Malawian shores of Lake Nyasa.

Table 7 Border posts and Number of Entries and exits per year

Border post	No of Exits (2009)	No of Entries (2009)
KIGOMA –KAGERA		
Kigoma Port[7] (lake border post to Congo DRC and Burundi)	~ 882	~ 1224
Kiberizi[8] (lake border post to Congo DRC and Burundi)	~ 2,286	~ 2,100
Manyovu[9] (land border post to Burundi, Kasulo district)	~3,728	~ 5,268
Mabamba (land border post to Burundi, Kibondo district)	192	203
Murusagamba (land border post to Burundi, Ngara district)	240	108
Kabanga (land border post to Burundi, Ngara district)	28,380	31,021
Rusumo (land border post to Rwanda, Ngara district)	21,152	20,878
MBEYA		
Itungi / Kiwira port (lake border to Malawi)	417	318
Matema (lake border to Malawi)	-	-
Kassumulo (Land border to Malawi)	42,614	48,594
Tunduma (Land border to Zambia)	134,538	135,855
Dar es Salaam		
Seaport border post	311 (registered at immigration 2009) 21102 (registered with TPA 2009)	335 (registered at immigration 2009) 21102 (registered with TPA 2009)

4.4 Fishing communities

The fishing communities visited were by far the poorest and most underserved areas in terms of health service delivery and HIV prevention messages. HIV knowledge was fairly good or at least comparable to the general population but risk behaviour was

[7] We were provided with date for Nov and Dec 2009 hence the number presented estimated on the basis of these monthly numbers of entries and exits

[8] We were provided with date for Nov and Dec 2009 hence the number presented estimated on the basis of these monthly numbers of entries and exits

[9] We were provided with date for Oct, Nov and Dec 2009 hence the number presented estimated on the basis of these monthly numbers of entries and exits

found to be high. Sex work is common but transactional sex was more common than sex for money.

> *"When there are no fish for several days what are these girls supposed to do to fill their stomach? They often also have a child or more to feed at home"*
>
> - *Woman 20 years old, Kiberisi*

Multiple concurrent partnerships appear more the rule than the exception in the community as one of the informants expressed it:

> *"Every fisherman has a wife and one or several concubines who gets a regular supply of fish"*
>
> - *Health worker, Kyela district*

The price for sex was reported to be anywhere between a plate of food or 100 Tsh – 1000 Tsh (0.1 – 0.8 USD) and in general both the men and the women reported that the use of condoms during these encounters was entirely up to the man's decision.

> *"When girls are hungry they do not thinking about HIV"*
>
> *- Woman 41 years old, Matema Beach*

Transactional sex was also reported as a means for women in the community to regain her business if she had lost her goods due to bad weather or lack of market. Several of the women reported that they had experienced losing all their savings in these ways and that sometimes transactional sex was the only way to regain a stock of fish that would allow them to make an income. The men reported that that it was common practice to have a wife in one place and girlfriends in the other fishing camps. These girlfriends were perceived different from sex workers that the men would pick up in a bar or at a guesthouse and hence considered as an 'exclusive' relationship condoms were generally not used in these relations. In one time transactional sexual encounters the men said condoms are more frequently used, though several said that it depends how drunk the man is and how available the condoms are during these encounters.

> *"This woman looks nice and I know her. We trust each other and don't need a condom"*
>
> *-Fisherman, Matema beach*

In terms of service delivery reports obtained from the fishing communities as well as NGO's and district authorities, fishing communities are underserved areas. They are generally hard to reach. Often the fishing camps are only accessible by boat. Some efforts have been made to reach the fishing communities with mobile HIV counselling and testing, peer educators and primary health care services. However, the delivery is patchy and does not match the high risk environment. The community is general aware of where services can be obtained but due to the transport cost accessibility is limited.

Fishing communities were much more remote and rural. The prevailing gender norms in the fishing community represent a significant barrier to HIV prevention efforts.

Lake Tanganyika borders Congo (DRC) and Burundi and migrants from these two countries were often sound in the fishing community in Kiberisi as well as in other

fishing camps on the Tanzanian side of the lakeshore. According to the District Medical Officers (DMO) this represented an additional challenge for HIV prevention efforts as both these countries are "war torn with a weak public service infrastructure", hence fishermen from these countries have little knowledge about HIV and HIV prevention.

4.5 Road border/truckstops

The rapid assessment team conducted interviews at three large border sites: Rusumo which is on the corridor between Kigali (Rwanda) and Dar es Salaam, Kabanga on the corridor between Bujumbura (Burundi) and Dar es Salaam and Kassumulo on the corridor between Tanzania and Malawi. The team also paid a visit to Tunduma, which is the largest of the border sites on the corridor between Tanzania and Zambia. As Tunduma is already serviced by the USAID Road project the team did not conduct interviews there.

A common feature for all four sites is high volumes of people and trucks passing through. Truck drivers generally stay in these sites for a few days but sometimes up to a few weeks in order to clear their goods and continue the journey. Around the border are communities of petty traders, guesthouses and bars servicing the transport workers and other travellers. Sex work is very common in these sites and takes place in guesthouses, bars, trucks and parking lots. Both truck drivers and the surrounding community said that sex work by minors is quite common.

> *"I see girls down to the age of 11 coming with STI's. In the past three months I have seen 10 girls who are only 11 years old who are pregnant and another 15 with STI's, but still there is no health education in the primary school"*
>
> - *Health professional at clinic close major border site*

Unlike the fishing community sex is sold for money rather than gifts or food. The price for sex is around 5.000-10.000 Tsh (3.7 – 7.4 USD) with a condom and approximately double the price without. The transport workers and other men in the community state that the use of condoms with sex workers is always negotiable, - it depends on what you want and how much you are willing to pay.

> *"Rusumo is known to be a good place to make business. You get more money to sell sex here"*
>
> - *Business man, Rusumo border site*

In addition barmaids, the workers in the guesthouses and food vending women often have regular, longer term relationships with truck drivers or businessmen that frequently travel the same route. These men often have a wife at home and one or more girlfriends in the places that they frequently visit.

> *"I was in a relationship with the man from the custom, now he left and I have a new boy friend he is a driver. He is married but he passes through once a month"*
>
> *- Barmaid, Burundian side of Kabanga border site*

> *"You know being out on the road is so lonely. You can't imagine. You miss your wife so then it is nice to have a woman"*
>
> - *Truckdriver, Rusumo border site*

"It is comfortable to have a girl there [Rwanda] cause my wife here will not know about it"

- *Cross border trader, Rusumo*

As with fishing community condoms are generally not used in longer term relationships despite the partners being aware that the partnership is not exclusive. Condoms appear more common but far from consistently used during one-time sex between a client and a sex worker. The men mention reduced sexual pleasure, "the heat of the moment", alcohol and unavailability of condoms as the main reasons for not consistently using condoms during these types of encounters.

"Love issues are very difficult to control even if people know they might do otherwise"

- *Burundian business man Kabanga*

The USAID Road project is, as mentioned earlier, providing HIV prevention and will soon provide treatment services targeting the transport workers at Tunduma border site. However, despite this there still appears to be unmet needs in this site given the tremendous volume of people passing through this border. The other sites visited are not systematically targeted by any specific programmes designed to meet the needs of the transport workers or the immediate border community.

In Kassumulo and on the Burundian side of Kabanga border PSI has done some awareness raising activities and put up roadside HIV awareness materials. Also in Kabanga there is a private clinic that provides free VCT and some amounts of free condoms.

By and large, condoms are available in the communities, from small shops and from some guesthouses. However there was no systematic distribution of condoms at the border sites. Relying on shops implies access only during opening hours and guest houses often only provide condoms at the reception upon request. In addition the majority of the guesthouses visited did not provide free condoms. It was also reported that the condoms provided at guesthouses sometimes had passed their expiration date.

Both women around the border sites and the transport workers perceive condom availability as a barrier to condom use. Some women who identified themselves as sex workers said that sometimes after 9-10 pm when the "dukas" (shop in Kiswahili) are closed you are forced to pay up to 10-20 times the normal price for a condom.

At Rusumo and at the Burundian side of Kabanga as well as at Kassumulo border posts, the women in the border community all mentioned lack of family planning products and easily accessible HIV counselling and testing as a major concern. Some women considered unwanted pregnancies as a more serious concern than HIV.

From interviews with DMO's and health workers, availability of ARV's and refill of drugs for transport workers is a challenge. Several women on the Burundian side of the border independently mentioned that because of the stigma related to HIV some women took ARV-medicines, which they bought through private business men rather than through a clinic.

Overall it appears that the Burundian and Congolese border communities seek health services in Tanzania due to the weak infrastructure of the conflict/post-conflict Congolese and Burundian health systems. The District Medical Officers in Ngara and Kibondo highlighted that this posed a challenge to the Tanzanian health system which are funded through a per-capita-block grant. The Burundians and Congolese people seeking health services causes an additional burden on drug-budgets and human resources. The DMO in Kibondo also highlighted that they had a high number of loss to follow-up ARV clients on the Burundian side of the border since they were not able to capture this group through the peer educator system that is otherwise used in the district.

4.6 Seafarers and port community

The seafarer and port community in many ways differ from the other sites that the rapid assessment visited. Tanzania Ports Authority (TPA) employs around 3500 permanent staff and TPA provides health services directly to their own employees and their families trough a clinic run by TPA. TPA in 2009 adopted an official HIV policy and has taken several initiatives towards increasing awareness of HIV among its employees. The challenges according to the Chief Medical Doctor are the implementation of the policy and the commitment of the general management to fund and implement HIV activities.

Outside the restricted area of the port where the boats are docked, are the truck stops where trucks are waiting to load and un-load their goods. The USAID Road project has recently opened a wellness centre in this area (Kurasini district) that is directed towards the transport workers as well as the immediate community around the truck stops. The wellness centre provides a recreational space, HIV information, HIV counselling and testing as well as primary health care services. The site is connected to the community via peer educators and a web of CBO's and NGO's through which additional HIV related activities are conducted.

The foreign seafarers (21,102 entries in 2009[10]) are not specifically targeted by the above efforts. HIV knowledge in the group is relatively high, however, risk behaviour likewise and condom use inconsistent.

> *"I use a condom when I am sober, but when I am out of the ship I often get drunk and forget the condom"*
>
> *- Seafarer from Tonga Island*

The Mission to Seafarers provides some HIV information to foreign seafarers and is also mandated to assist any seafarer who falls sick during his/her time in Dar es Salaam. However, both the seafarers and the Mission to Seafarers confirm that efforts to address HIV vulnerabilities among seafarers are very limited in scope.

Language barriers represent a part of the problem with the majority of foreign seafarers in Dar es Salaam coming from China, Korea and the Philippines speaking little, or no, English or Kiswahili.

According to the key informants and the seafarers themselves the majority of seafarers spend their time on land in the bars and brothels of Dar es Salaam. Some

[10] Personal communication TPA, Chief Medical Officer, OY Mbwambo, April 2010

nationalities tend to go to the more expensive hotels in town, but the larger group frequent a handful of bars that are known to be pick-up places for sex workers. There also seem to be an organized pimp business with men bribing the guards in the port and for a service fee from the seafarers taking them on a tour of the town including to a number of smaller brothels in the Kinondoni area of Dar es Salaam.

4.7 Uniformed staff

The uniformed staffs at border sites have been specifically targeted with HIV information and education through the HIV programmes of the Ministry of Home Affairs. The programme appears to have been effective in that HIV knowledge is quite high. Risk behaviours in terms of number of partners and frequency of condom use also appear to be lower among the uniformed staff than among the general border community.

However, the immigration officers and border police still appear to be a vulnerable group. The nature of their work means they are posted to different border areas. According to their contracts it is possible for the staff to bring their families to their post, though several chose to leave their families at home or in the urban areas where there are better access to schooling and/or the support of the extended family.

According to the KAP survey multiple concurrent partnerships were quite frequent among the uniformed staff (56% of uniformed men said they currently had two or more sexual partners) and in the group currently having multiple concurrent partnerships 37% reported to have never used a condom in the past month.

Some reports from the fishing community indicated that immigration officers in some places received sexual bribes from people who either wanted to avoid paying for visas or who had stayed illegal in the country. This was also acknowledged by some officers. However, the team found no firm evidence that supported sexual bribes to be a common practice between immigration officers and migrants.

Among the police officers there were also some reports in the border community of sexual bribes or police officers misusing their position of power to have sex.

> *"Policemen are at high risk because they spend so much time away from their wives. Sometimes when they have brought a criminal to the station the policeman can get attracted to her and in the station he can do anything he wants to the prisoners. I have seen that many times.'*
>
> - *Police woman*

> *"After 1992 when the government of Tanzania started to train policemen on human rights they do not abuse their power to get sex, but before it was common"*
>
> - *Police woman*

However, much more frequently the officers themselves and the border community confirmed that uniformed staff bought sexual services from sex workers along side with the truck drivers, businessmen, fishermen etc. As such it appears that the uniformed staff to a large extent is part of the complex sexual networks at the

border sites. In terms of access to health care services the uniformed services are better off than the general population as they have been targeted by specific information campaigns and the police services are provided with care and treatment services via the police force health system.

5 Conclusions

As illustrated by figure 1 in this report sero-prevalence data from border sites shows high prevalence of HIV in border communities. The overall findings of the rapid assessment have been that HIV knowledge in the border communities including the mobile populations and uniformed staff is relatively high and comparable to the levels of the overall populations. However, risk taking behaviours, especially high levels of transactional sex, multiple concurrent partnerships and limited condom use were found to be widespread along the border areas.

The border areas appear to be HIV hot spots or as described by a recent regional assessment conducted by IOM and USAID in southern Africa [11] "spaces of vulnerability" with high levels of risk behaviour. Due to the mobility patterns these hot spots represent a bridge between the community the migrant comes from and the community which the migrant enters, hence fuelling new infections not only within the immediate border site but also beyond.

The rapid assessment found an unmet need for both preventive and curative HIV services as well as other health services and it appears that both a number of low-cost highly effective interventions are needed as well as longer term efforts to reduce the HIV vulnerabilities in these sites. At the same time the assessment urges that the limited funding available for HIV prevention is directed less towards regular information and education activities and more towards targeted communication for social change and services that directly reduces risk behaviours.

On the short term it is essential to improve condom availability in these sites, with bars and guesthouses being directly involved in disseminating HIV messages and providing free condoms. HIV counselling and testing services and family planning counselling and products should be available on site either permanently or through frequent and regular mobile clinics. Both HIV counselling and testing services and family planning services should be gender sensitive and youth friendly, targeting girls and boys in- and out of school.

Targeted social change communication programs should be implemented in fishing communities, road border sites as well as in the port community. In the fishing community micro-credit schemes should be available for women and girls as a means to avoid transactional sex encounters driven by extreme poverty. Recreational facilities as an alternative for truck drivers and seafarers should be established in the high risk zones and serve as a site for promoting healthy behaviour.

[11] Regional Assessment on HIV-Prevention Needs of Migrants and Mobile Populations in Southern Africa, IOM, Feb, 2010

In the longer perspective efforts should be put into reducing waiting times at border sites and a programme of national scale should ensure that an evidence based package of services for border sites is developed and delivered in a sustainable way in all border areas as opposed to the current situation where service delivery is patchy and project based. Furthermore, with the EAC protocol being harmonised, efforts to synchronise clearing and immigration procedures between different countries should be done, allowing truck drivers and cross-border traders to reduce waiting times. The so-called one-stop-one-shop posts where border posts harmonise the immigration and clearance procedures could significantly reduce the waiting time for truck drivers and others, including night time at the border site. At the same time governments could ensure that these sites serve as entry point for HIV and other service delivery such as consistent messages on HIV, condom distribution, HIV counselling and testing to the hard to reach mobile groups such as truck drivers, cross-border traders and other travellers.

ANNEX 1

List of Meetings and informants

Date / Place	Institutions / Informants
KIGOMA – KAGERA	
21/01/2010	ICAP regional office Kigoma , Ms Veneranda Rwegasira (officer in Charge) phone +255-784-485557, email vr2237@columbia.edu and Mr Ashah Mhamballah (adherence psychosocial support officer) phone +255-754-268987, asm2154@columbia.edu
	Regional Administrative Secretary (RAS), Kigoma
	Regional Medical Office,r Kigoma, Dr, Valentino Bangi phone 0784-997924, +255-752-992-788 email: kisongafrancis@yahoo.co.uk
	Regional Immigration Officer, Kigoma, Mr. Herbert B. Kiondo, phone +255-754-271-200, email hkingodi@yahoo.com
	Immigration Kigoma HIV Counselor, Zakaria Sunduva, phone =255-784-520-840
	Kigoma rural District HIV/AIDS Control Coordinator (DACC), Laurent Biswamo, phone +255-754-918-722
22/01/10	Chairman of the boat fishermen's association in Kiberisi Kiogma, Ramadhani Issa, phone +255-755-292461
25/01/2010	District Medical Officer, Kigoma rural distirct, Dr. Katoloe, phone +255-713-49221 or +255-767-492-221, email kibegwa07@yahoo.com
	Council HIV/AIDS Control coordinator, Kigoma rural district, Mr Bernard Rusomyo, phone +255-712-491-552
	Red Cross Society Kigoma, Ms Jane Chagie, phone +255-754-407-450, email chagiejane@yahoo.com
	Kigoma AIDS Control Network (KACON), Tresure Mr. Pascal Hamenya and Director Anna Kichambati, phone +255-713-488-090 or +255-784-488-090 email akichambati@yahoo.com
	United Muslim Fighters against AIDS, UMFAA, Kigoma, Program Coordinator Maulid Ntahondi, phone +255-0713-660-229 or +255-0714-426-083 email ujiji_umfak@yahoo.com
	Carpenters Association for Youth Development (CAYODE) Kigoma, Executive Director Mr. Forehead Nsanze, phone +255-784-596-903 or +255-714-098-932 or +255-769-913-437 email cayode_kigoma@yahoo.co.uk
	Kigoma Vijana Development Association (KIVEDEA), Executive Director, Mr. Sindela, phone +255-754-787-874 or +255-786-855-855 email s_cartney@yahoo.com

Date / Place	Institutions / Informants
	KIGOMA – KAGERA
	ACTIONAID Kigoma, Program coordinator Optatus Likwelile, phone +255-786-374-185 or +255-713-177-511, email: optatus.likwelile@actionaid.org
28/01/2010	District Executive Director (DED) for Kibondo District
	District Medical Officer(DMO) Kibondo District
	Council HIV/AIDS Control Coordinator (CHACC) Kibondo District
	Ms Jane Kobozi, HIV/AIDS supervisor, Tanzania Christian Refugee Services (TCRC), Kibondo District
	Dr. Chabadi, Representative from Shedefa-plus, PLWHA-group in Kibondo District
29/01/2010	District Immigration Officer (DIO) for Ngara District, Mr Antipas Nogela, phone +255-784-484-244
	District Commissioner Ngara District
	District Executive Director, Ngara Ditrict, Mr. Mattias Mwangu, phone +255-755-998-430 or +255-787-998-430 or +255-655-998-430, email m_mwangu@yahoo.co.uk
	Acting District Medical Officer (DMO) Ngara District, Mr. Antonio Maganga, phone +255-784-626-328
	Council HIV/AIDS Control Coordinator (CHACC) Ngara District, Ms. Josephine Lousatira, phone +255-785-424-366
	Officer Commanding District Police Ngara
02/02/2010	Evangelical Lutheran Church of Tanzania (ELCT) Aids Control Project in Ngara , Coordinator Mr. Charles Gabagambi, phone +255-0784-817-440, email gabagambicharles@yahoo.com
	Tumaini Fund, Ngara, Mr. Ainess Samuel, phone +255-688-983-398, email ainessamuel@yahoo.com
	Tanzania Christian Refugee Services (TCRS) Ngara
	WAMATA in Ngara, Program Coordinator Mr. Charles Mushatzi, phone +255-784-446-520, wamatangara@yahoo.com
	Human Development Trust in Rulenge , Ngara district, Director of Programmes Malanilo Simon and Program officer Moses Kabogo
03/02/10	Kabanga Nickel, Andre Msolo, CAMP Administrator phone +255-784-262-097 or +255-767-262-097, email adrew_msolo@kabanga.net and Ray Kohlsmith, Interim Site Manager/Senior Geologist, phone +255-767-173-803 and rkohlsmith@xstratanickel.ca
	Murusagamba Health Centre

Date / Place	Institutions / Informants
MBEYA	
22/02/10	Regional Immigration Officer, Mbeya, Mr. Rashid Matana, phone +255-784-278-005
	Regional Administrative Secretary, Mbeya, Ms. Beatha Swai, phone +255-754-384-125, email swai_b@yahoo.com
23/02/2010	Regional Police Commander, Mbeya Region
	Regional Medical Officer, Mbeya, Dr. Machibya, phone +255-754-462-788, email rmo_mbeya@yahoo.com or msataha@hotmail.com
	Deputy Regional AIDS Control Coordinator, Dr. Msuya Supham, phone +255-753-893-177 or +255-714-619-411 email msuya5sn@yahoo.com
	Deputy District Immigration Officer (DIO), Kyela District, Mr. Kosmos D. Shawa
	District Administrative Secretary (DAS), Kyela District, Mr Masomelo
	District Commissioner (DC), Kyela District, Mr. Abdallah Kihato, phone +255-754-698-802 or +255-734-698-802
	Acting District Executive Director 9DED) Kyela District
	Council HIV/AIDS Control Coordinator (CHACC) phone +255-713-566-611 or +255-767-566-611
	Officer Commanding Station Police, Kyela District
25/02/2010	Clinical Officer in Charge of government Dispensary at Kasumulo border site
26/02/20	Immigration Officer in Charge, Tunduma border post
	Program Coordinator, FHI-Safe-TY-Stop Tunduma
	Roman Catholic health centre hosting ANGAZA VCT site in Tunduma
	District Medical Officer, Kyela District
	Shdepha+, PLWHA-group Kyela, Counsellor Mr. Paul Garvas Kikoma, phone +255-784-236-453, email shdepha+kyela@yahoo.com
	Mango Tree, Director Mr. Andilie Ibrahim, phone +255-784-380-638
	St. Johnhus Centre, Home Based Care Coordinator Mr Nuru Njumbo, phone +255-755-329-713
	SHAFA CBO Kyela, Chairperson Ms Judith Mfundo, phone +255-754-348-326
27/02/2010	Ward Executive Officer, Matema , Kyela District
	Doctor in Charge, Matema Hospital, Dr. LJ Mwakilulele phone +255-786-074-900, email lmwakilulele@yahoo.com

Date / Place	Institutions / Informants
DAR ES SALAAM	
08/04/2010	Council HIV/AIDS Control Coordinator (CHACC) Temeke District, phone +255-713-634-926, email hmakom@rocketmail.com
	Tanzania Port Authorities, Medical Officer in Charge Dr. Mbwambo, phone +255-784-785-966 email ombwambo@gmail.com or ombwambo@tanzaniaports.com
	Mission to Seafarers, Reverend Lole Imayo, phone =255-784-740-226 email lole.timayo@mtsmail.org
	Tanzania Port Authorities, Chief of fire and Safety Mr. Mussa Biboze, phone +255—715-868-184, email biboze@yahoo.com
	Tanzania Port Authorities, Port Operations manager Mr. Ngokota, phone +255-784-390-665, email ngokota@hotmail.com
09/04/2010	Tanzania Port Authorities, Harbour Master
	Tanzania Seafarers Union (TASU) General Secretary, Mr. Mchafu Chakoma, phone +255-713-278-364 or +255-787-278-364, email mchakoma@yahoo.com or tasuunion@yahoo.com
	Port Health Officer, Mr. Rutua, Ministry of Health and Social Welfare
12/04/2010	Wayode – Kurasine, Dar es Salaam, General Secretary Elisas Mkapa, phone 0784-769-758, email wayodenews@yahoo.com
	Kigamboni Accademia , Dar es Salaam, Project Director Meshack Munyi, phone 0712-260-445, email schoolacademia@yahoo.com
	Vilipe Vijbweni Kigamboni , Dar es Salaam, General Secretary, Thomas Manyama, phone 0713-282-371, email schoolacademia@yahoo.com
15/04/2010	Tanzania Episcopal Conference, Catholic Secretariat, Father Gallus Marandu, phone +255-754-624-399, email fgallus@gmail.com

IOM International Organization for Migration
OIM Organisation Internationale pour les Migrations
OIM Organización Internacional para las Migraciones

For further information on Migration & Health, contact:

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