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

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ABSTRACT: *This paper is based on a research which was conducted in Mtwara Region, Tanzania, to assess determinants of community participation in planning HIV and AIDS interventions under the National Multisectoral Strategic Framework (NMSF) on HIV and AIDS. The findings indicated that 69.0% of the respondents were not aware of NMSF interventions; 77.0% had unfavourable attitude towards the interventions; and 81.8% did not participate in planning the interventions. Furthermore, using ordinal logistic regression, it was found that community awareness of ($p \leq 0.001$) and attitude towards HIV and AIDS interventions ($p \leq 0.005$), access to planning information ($p \leq 0.001$), education level ($p \leq 0.05$), and community satisfaction with involvement in planning ($p \leq 0.001$) had significant impacts on the chances of participating highly in planning the interventions. The results substantiate a need for decentralisation in order to address obstacles which constrain participation in planning HIV and AIDS interventions.*

KEYWORDS: NMSF, HIV, AIDS, Community, Participation, Planning

INTRODUCTION

The urgency of preventing the spread of the fatal human immune-deficiency virus (HIV) has made collaboration at all levels of society imperative (UNAIDS, 2004). The participation of community in planning for HIV and AIDS interventions in Tanzania started in 2003 following the need for a multisectoral approach to address the problem of HIV epidemic (URT, 2010a). This was through the establishment of the National Multisectoral Strategic Framework on HIV and AIDS (NMSF) (URT, 2010a). The NMSF is an innovative way of involving communities in scaling up national HIV and AIDS response. The NMSF translates the Tanzania National Policy on HIV by identifying and providing strategic guidance to the planning of programmes, projects and interventions to be executed by different stakeholders in Tanzania. Millennium Development Goal Number 6 that was on halting HI and AIDS and United Nations General Assembly Special Session on HIV and AIDS goals and indicators were incorporated in the National Multisectoral Strategic Framework (URT, 2008). The framework was designed to work with Local Government Authorities since they are key players in ensuring that HIV and AIDS services are provided at Councils, Districts and community levels (URT, 2011).

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

sector, civil society organizations, and the communities (URT, 2008). The third phase is from 2013 to 2017; it builds on the previous experiences and challenges encountered in phase II (URT, 2013).

All sectors and Local Government Authority (LGA) Councils in Tanzania are implementing HIV and AIDS activities under NMSF (URT, 2013). However, participation of community in planning for HIV and AIDS inteventions under the framework in the country was reported to be low (URT, 2010b). The same problem was encountered in Mtwara where low community participation in planning for HIV and AIDS interventions was reported to be one of the challenges in the region (MRO, 2011). Low community participation in planning, threatens ownership and sustainability of interventions. Therefore, the research on which this paper is based was conducted in Mtwara Municipal and District Councils with the objectives to: examine attitudes of individuals towards HIV and AIDS interventions, examine levels of community participation in planning for HIV and AIDS interventions and determine extents to which attitude towards HIV interventions and awareness of NMSF interventions influence individuals' participation in planning for HIV and AIDS interventions.

LITERATURE REVIEW

The Concept of Community Participation

Community participation is a social process through which community members voluntarily take part in both formal and informal activities, programmes and discussions to bring about planned change or improvement in community life, service or resources (WHO, 2009). It is further described as a social process in which groups with shared needs living in a certain geographical area actively identify needs, make decisions, and set up mechanisms to achieve solutions (Bichmann *et al.,* 1989). However, heterogeneous groups and individuals can become a community and collectively take action to attain shared and specific goals (Mattessich and Monsey, 1992). Participation is one of the most important concepts in planning and development, because it is potentially a vehicle for different stakeholders to influence development strategies and interventions, which are mostly dominated by professional experts in the government and private sector (Ahmed and Shahidul, 2009). Participation combines the experiences, knowledge and understanding of various groups and citizens (Ahmed and Shahidul, 2009).

The concept of community participation in this study represents a bottom-up or grassroots approach to programme planning and decision-making. In this aspect, community members are involved in defining their health problems and finding solutions (WHO, 2009). Community participation has been a central theme in health-related discussions for many years. It was present in the World Health Organizations' constitution, confirmed in the Alma-Ata Declaration (Peter *et al.,* 2013). Community participation in health activities was enshrined as a cornerstone of Primary Health Care with success being subsequently demonstrated in many healthcare programmes, including more recently in HIV prevention (Hadley and Maher, 2000; Jones *et al.,* 2005). The fourth principle of the Alma-Alta Declaration stated that "The people have the right and duty to participate individually and collectively in the planning and implementation of their primary health care" (Peter *et al*., 2013).

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

The Concept of Planning

There are certainly many different ways of looking at the concept of planning. The theme and objective of the planning exercise largely influence these variations (Cooksey and Kikula, 2005). Planning is defined as a continuous process, which sets out objectives, identifies existing resources and implementation capabilities to achieve the objectives over a specific period of time (URT, 2007). It is a continuous process that involves making decisions or choices about alternative ways of using available resources, with the aim of achieving particular goals in the future (Cooksey and Kikula, 2005). Therefore, planning for HIV and AIDS interventions is to identify problems and make decisions about which ones should be tackled and in what order of priority. It is about consensus building among the community members. Consensus is required in making priorities because not all problems or needs can be met at once, given that resources are always limited. By allowing communities to prioritise local development objectives, it is expected that this will motivate them to own the outcomes of their decisions (Fjeldstad *et al.*, 2010).

General Information on HIV and AIDS

In Tanzania, the HIV and AIDS epidemic began in 1983, with the diagnosis and reporting of three cases in Kagera region. By 1986, all regions had reported cases of HIV and AIDS. Since then, HIV and AIDS in Tanzania continued to spread predominantly through heterosexual contact as in other sub-Saharan countries (URT, 2012). There has been a dramatic increase in the number of AIDS cases as more HIV infected people have succumbed to opportunistic infections arising from suppressed immune systems (URT, 2012). In response to the epidemic, the government formed the National Policy on HIV (URT (2001) and the National HIV and AIDS Control Programme (NACP) under the Ministry of Health (URT, 2001). Initially, HIV and AIDS was perceived purely as a health problem and campaigns to deal with it involved the health sector only through NACP. However, escalation of the HIV and AIDS crisis has made Tanzania to consider it as a public health problem hence the need for concerted efforts in addressing the epidemic. As HIV and AIDS epidemic affects all sectors, its control demands a well coordinated response. The Tanzania Commission for AIDS (TACAIDS) has been established to provide leadership and coordination of multisectoral responses. This followed the formation of the NMSF, which was developed in line with international guidelines on HIV and human rights to ensure the accountability of the government and other stakeholders (the private sector, development partners, civil society organizations, and community) in their actions within the national response to HIV and AIDS (URT, 2008). The National response consisted of developing strategies to prevent, control and mitigate the impact of the HIV/AIDS

epidemic through health education, decentralization, multisectoral response and community participation (URT, 2001).

Linkages Among Participation, Planning and HIV/AIDS Interventions Success

Participation does not take place in a vacuum, but in a socio-political context. Findings from a study on attitude to rural development projects revealed that improper and inadequate awareness, low level of exposure, negative attitude, insufficient training, lack of encouragement by chiefs and elders of the community, intermittent change of government, and selfishness on the part of the youth leaders were the factors that affected youth participation in development programmes (Okwusi, 2008). A study to identify the limits of local participation in local government planning in Tanzania found that lack of awareness, ignorance of people, poor leadership at community level, lack of facilitation capacities at local leadership, dependency syndrome and lack of capacity in planning and implementation at local community were the constraints to community participation (Cooksey and Kikula, 2005). Some literature has also indicated the influence of age, attitude and occupation in participation with regard to development projects. Angba *et al.* (2009) reported that there was positive correlation between age and participation in development projects. It was further reported that age of respondents affects their attitude towards participation in development projects. However, occupation correlates positively and significantly with age (Angba *et al.*, 2009).

A study by Bani *et al.* (2014) on evaluation of awareness, attitude and participation of men in family planning programmes in Abyek, Iran observed that awareness and attitude were positively and significantly related to men's participation in family planning. It was reported that men with positive attitude participated in family planning as opposed to men with negative attitude. In a work to investigate the linkage between awareness and participation, Brahmi and Thakur (2011) found that 90% of people who were not aware about the development project they studied had poor participation. The authors had the view that lack of awareness about the project was the primary cause of poor participation. Elham *et al.* (2008) argued that level of awareness of interventions influences community participation in planning. Mubyazi *et al.* (2007) argued that people need to be adequately sensitized to ensure their informed and desired participation. Chifamba (2013) identified several factors among others which hinder community participation including poor community headship in some villages not giving feedback to community members, lack of information, ignorance, high level of poverty for most community members, lack of transparancy and accountability among community leaders, especially on funds contributed for rural development projects. However, Harriet *et al.* (2013) opined that differences in levels of knowledge between local citizens and government officials lead to mistrust and marginalization which affect local community participation.

Participation of community in designing, planning and implementing HIV and AIDS activities is still limited in Tanzania. Sikika (2013) reported that citizens did not actively participate in planning and implementation of plans to address issues that affect their lives, health and HIV and AIDS issues being examples. The government of the United Republic of Tanzania realized poor community participation as evidenced in the quote: "In many cases, the target population does not actively participate in the setting up process" (URT, 2008 cited by Sikika, 2013). It further added that this might result in lack of ownership and interest from the very beginning. Therefore, government and non-governmental organizations' presence at the grassroots, close to the poorest of the poor, is important in promoting participation (Chifamba, 2013). The study revealed that consequential participatory development process require development facilitators or change agents to go to the people, live with them, learn from them, work with them, start

with what they know, and build on what they know. Continuous community sensitization, mobilization and general awareness creation initiatives done by government and non-governmental organizations staff, in collaboration with community leaders on various development issues, were also said to have helped in motivating and increasing the level of community participation in rural development.

Lack of access to information and understanding of policy can be barriers to community participation (Aref, 2010). A study conducted by Nomvakaliso (2007) indicated that high or active participation is mostly likely when different stakeholders involved in a project or programme are satisfied with the level at which they are involved. Kumar (2002) has identified three major obstacles to people's participation in project management. These include structural obstacles, administrative structures and social obstacles. Structural obstacles were largely responsible for the atmosphere of passivity and dependence that prevails in rural communities and formed part of the centralised political systems which are not oriented towards people's participation. This type of situation is typified by a "top-down" development approach adopted by development initiatives like the integrated rural development approaxh to implementation of programmes. Furthermore, the administrative structures that are control-oriented provide little significant space to local people to make their own decisions or control their resources. On the other hand, social obstacles such as the mentality of dependency, the culture of silence, domination of the local elite or gender inequality militate against people's participation (Barasa and Jelagat, 2013).

Khan (2009) pointed out that bureaucratic domination in the local councils, lack of knowledge, and lack of expertise in technical matters are the root causes of non-participation. The assertion was supported by Herriet *et al.* (2013) who reported that lack of knowledge is the root cause of community participation. Brahmi and Thakur (2011) reported that lack of basic education causes narrow vision of the project hence poor community participation. Angba *et al.* (2009) found that educational level correlates significantly and positively with age. It was further argued that as one attains a higher level of education, attitude towards participating in development projects is likely to be more favourable, but attitudinal levels may vary among people with almost the same levels of education. In essence, the higher the educational level attained the more favourable the attitude towards participating in development projects. Angba *et al.* (2009) assert that educational levels are highly significant in the extent, intensity and pattern of participation. It was further expressed that effective participation obviously requires communicative and human relational skills which must be learned; hence those who are better educated would be better empowered for participation because their attitude would likely be favourable.

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

are relatively low among women who are married. Instead, they are represented by their husbands (Chifamba, 2013).

METHODOLOGY

Research Design, Sample and Sampling

A cross-sectional research survey design was used in which data were collected once. The selection of this design was based on the fact that it is of less cost and saves time comparing to other designs (Olsen and St. George, 2004).The sample size included respondents of the age category from 15 to 49 years, due to fact that, that category is of sexually active people and 80% of HIV prevalence is through sexual intercourse (URT, 2012b). Therefore, the contribution of the selected age category in terms of prevention efforts is very important in the fight against HIV and AIDS epidemic in Tanzania. A sample size of 192 people was randomly selected from the population where HIV and AIDS interventions under NMSF were being implemented. The sample size was statistically enough, especially in view of arguments by Bailey (1994) that regardless of the population size the bare minimum sample size for a research in which inferential analysis is to be done is 30 cases, and that in most cases 100 cases are taken. Besides the 192 respondents for questionnaire administration, 12 focus groups were selected for qualitative data collection through focus group discussions (FGDs). Having 12 focus groups was in line with advice by Bryman (2004) who argues that there is a tendency to have 10 to 15 focus groups in a whole study. For each of the 12 focus groups, about 8 community members were purposively selected, based on their being considered to be very knowledgeable. The purposefully selected members for FGDs were not re-interviewed for the structured questionnaire.

Research Instruments and Data Collection

The data for this paper were collected from September 2014 to February 2015 in Mtwara Region, Tanzania, from 192 respondents. Copies of a questionnaire, a key informant interview guide and a FGD guide were the instruments for data collection. The questionnaire was prepared based on the essentials of a good questionnaire, i.e. short and simple, and organized in a logical sequence moving from relatively easy to more difficult questions. Technical terms, vague expressions and those affecting sentiments of the respondents were avoided.

Data Analysis

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

The ordinal logistic regression model is shown as follows:

$$P(y) = \frac{e^{\alpha + \beta 1x1 + \ldots \beta kxk \quad k}}{1 + e^{\alpha + \beta 1x1 + \ldots \beta kxk}}$$, where:

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

e = the natural log

α = the intercept of the equation

β_1 to β_k = coefficients of the predictor variables

x_1 to x_k = predictor variables entered in the regression model

In the research for this paper:

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

X_1 = Individual attitude in terms of number of points scored on a Likert scale

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

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

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

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

X_6 = Net income (Annual earnings in cash)

X_7 = Age (Number of years since one was born)

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

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

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

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

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

FINDINGS

Awareness of NMSF Interventions

Awareness of NMSF interventions was determined using a 5-statement index scale (Table 1) on which the respondents would score a minimum of 0 and a maximum of 8 points. On the scale, scores ranging from 0 to 4 were considered to denote not being aware of the interventions while scores ranging from 5 to 8 were considered to indicate being aware of the interventions. It was found that the mean score was 2.3 out of 8.0, which was within the not aware category. It was also found that 69.0% of the respondents were not aware about NMSF interventions

while 31.0% were aware of them, which means that the majority of the respondents were not aware of NMSF interventions. The majority of the respondents did not exactly know what was going on in their respective areas with regard to planning HIV interventions. The findings indicated that the respondents had not adequately met with HIV technical experts during their previous meetings. Moreover, the majority of the respondents did not have access to planning information. Furthermore, the findings indicated that the majority (73.4%) of the respondents had never heard about the HIV policy. Additionally, 15.3% claimed that HIV policy was not clear and 11.3% said it was clear.

Table 1. Awareness of NMSF interventions indicators (n=192)

Statements about awareness	n	Maximum possible score	Minimum Score	Maximum Score	Sum	Mean
Awareness of planning of HIV and AIDS interventions	192	1	0	1	73	0.4
Participation in planning of HIV and AIDS interventions under NMSF	192	1	0	1	62	0.3
Meet with a technical expert for HIV and AIDS during meetings	192	4	0	4	195	1.0
Access to planning information about HIV and AIDS	192	1	0	1	63	0.3
Heard of HIV and AIDS policy	192	1	0	1	51	0.3
Total	**-**	**8**	**-**	**-**	**-**	2.3

Attitude Towards HIV and AIDS interventions

Attitude towards HIV and AIDS interventions was determined using a 12-statement Likert type summated scale on which the respondents would score a minimum of 12 points (if one would choose strongly disagree, i. e. 1, for all the 12 statements) and a maximum of 60 points (if one would choose strongly agree, i. e. 5, for all the 12 statements) . On the scale, scoring 12 to 35 points, 36 points and 37 to 60 points denoted having an unfavourable, neutral or favourable attitude, respectively. The findings indicated that the mean score was 28.6 points out of 60.0, which implies that, overall, the respondents had unfavourable attitude towards HIV and AIDS interventions. However, not all the respondents had an unfavourable attitude towards HIV and AIDS interventions; on the basis of the above cut-off points for people with various levels of attitude towards HIV and AIDS interventions 23.0% of the respondents had favourable attitude while 76.0 had unfavourable attitude and only 1.0% had neutral attitude. The results in Table 2 indicate the proportions of the respondents who had different levels of attitude on the 12 statements that were used.

Table 2. Attitude scores in percentage

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

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

Level Of Community Participation

The level of participation in planning for HIV and AIDS interventions was determined using a 7-statement index scale (Table 3) on which one would score a minimum of 0 and a maximum of 12 points. On the scale, 9 to 12 points, 5 to 8 points and 0 to 4 points were used to denote high, medium and low levels respectively of participation in planning interventions for HIV and AIDS control. The results indicated the average overall score was 3.2, which means that, overall, the respondents had low participation in planning HIV and AIDS interventions.

Table 3. Participation level indicators (n=192)

Statements about participation	n	Max. possible score	Min. score	Max. score	Sum	Mean
Number of HIV and AIDS planning meetings attended for the last 12 months	192	4	0	4	199	1.0
Having ever attended any event on HIV and AIDS	192	1	0	1	83	0.4
Having participated in selecting multisectoral AIDS committee members and given feedback	192	1	0	1	58	0.3
Whether involved in decision making with regard to identified activities	192	1	0	1	58	0.3
Awareness of activities in village/street plans	192	1	0	1	50	0.3
Level of satisfaction with involvement in planning of HIV and AIDS interventions	192	2	0	2	84	0.4
Involvement in planning for HIV and AIDS interventions	192	2	0	2	72	0.4
Total		**12**				3.2

Furthermore, the findings indicated that 69.3% (133), 12.5% (24) and 18.2% (35) of the respondents had been participating to low, medium and high extents respectively in planning HIV and AIDS interventions.

Reasons for Inadequate Participation In HIV AND AIDS Interventions

The respondents were asked to give reasons for inadequate attendance in planning meetings, HIV events, participation in selection of multisectoral committee members, involvement in decision making with regard to identified activities and awareness of activities in village/street plans. The selection of questions was based on five constructs of participation. With regard to the reasons for inadequate attendance in attending planning meetings as seen in Table 4, the respondents mentioned that government and donors planned for them, lack of follow up from the council, lack of knowledge in planning, lack of information, and planning meetings being not conducted.

Table 4. Reasons* for inadequate attendance in HIV planning meetings (n=153)

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

*Multiple response table

Besides the results presented in Table 4, other findings indicated that 43.2% of the respondents had attended HIV events while 56.8% who were the majority had not attended. Since events were conducted at the village/street levels, the researcher decided to ask the respondents about the reasons behind their non-participation. The reasons mentioned for inadequate participation in HIV and AIDS interventions included whether attending or not attending brought any difference; lack of awareness; it is wastage of time; and some claimed that they were not HIV and AIDS positive. The scores for respective responses are indicated in Table 5.

Table 5. Reasons* for inadequate attendance on HIV events (n=97)

Response	Respondents	
	n	Percentage
It doesn't bring a difference	35	36.1
I was not aware of the event date	34	35.1
It is wastage of time	24	24.7
I am not a HIV positive person	4	4.1
Total	**97**	**100.0**

*Multiple response table

When asked whether they participated in members' selection, the findings indicated that the respondents had no information; they claimed that non-existence of the committee itself; they were not involved in the selection process, and the least one was that it does not make any difference even if committee members are selected. Table 6 shows the percentage scores for the respective responses.

Table 6. Reasons* for inadequate attendance in selection of MACs members (n=125)

Response	Respondents	
	n	Percentage
I had no information	49	39.2
There is no committee	48	38.4
I was not involved	16	12.8
It does not make any difference	12	9.6
Total	**125**	**100.0**

*Multiple response table

Responding to the question on whether they were involved in decision making with regard to the identified activities, the respondents had different responses. They responded that the council plans and implements HIV and AIDS interventions; the community members are not involved because of their low education; and leaders and council management communicate without their knowledge. The percentage scores for each response are shown in Table 7.

Table 7. Reasons* for inadequate participation in decision making (n=108)

Response	Respondents	
	n	Percentage
The council plans and implements HIV/AIDS Interventions	54	50.0
Community members are not involved because of their low education	38	35.2
Their leaders and council communicate without their knowledge	16	14.8
Total	**108**	**100.0**

*Multiple response table

The respondents were also asked if they were aware of HIV and AIDS activities in their village/street plans. This was meant to determine if the plans existed and if they were prepared in a participatory way. More than three-fifths (63.5%) of the respondents gave different responses. The mentioned reasons for inadequate awareness in the village/street plans were planning dates not being communicated on time; what they planned was not implemented; some claimed leaders prepared plans without their knowledge, and HIV was not their priority. The responses are indicated in Table 8.

Table 8. Reasons* for inadequate awareness of village/street plan on HIV (n=122)

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

*Multiple response table

Extents to Which Attitude Towards HIV/AIDS Interventions And Awareness Of NMSF Influence Participation

In order to meet the third objective and test the hypothesis of the research, ordinal logistic regression model was used. The findings are indicated in Table 9.

Table 9. Results for ordinal logistic regression model

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

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

DISCUSSION

Awareness of NMSF Interventions

The majority of the respondents were not aware about NMSF interventions in Mtwara Municipality and Mtwara District Councils. This was indicated by unawareness of what was going on in their respective areas with regard to planning HIV interventions. The majority had not adequately met with HIV technical experts during their previous meetings, did not have access to planning information and ignorance of National (Tanzania) HIV policy. The problem of low awareness about NMSF interventions was also observed from FGD participants and key informants. During the FGDs, the following was said: *"We have hardly heard of NMSF interventions in this area. The problem with our leaders is that they don't take any initiative to involve communities in those issues from which they don't get financial gain"* (Female, 47 years, Mtwara District Council, December 18, 2014). Another one said the following: "*It is difficult to get involved in issues that you are not aware of"* (Male, 24 years, Mtwara Municipal Council, December 21, 2014).

During key Informants interviews the following was also said: *"The dissemination of NMSF was done to the community leaders who in turn were expected to do a similar exercise to raise awareness with regard to the subject to their local people. However, the trickle-down effect to the community members has been very low because only few leaders did such dissemination. As a result, the majority of community members have remained not informed of NMSF interventions"* (Male KI aged 32 years, Mtwara Municipal Council, December 21, 2014). Another Key Informant said the following: "*As a community leader, I can't speak of anything related to HIV and AIDS during public meetings because I do not have adequate knowledge and information about the subject matter*" (Female KI aged 38 years, Mtwara District Council, December 21, 2014). All these citations give evidence to the fact that most community members were not aware of the NMSF interventions.

A finding that is similar to the above arguments by the key informants was reported by Brahmi and Thakur (2011) that 90% of community members had no awareness about rural development projects, and this had negative influence on community participation. Okwusi (2008) obtained similar findings that inadequate awareness of development projects affected community participation in the development programme. Similarly, Elham *et al.* (2008) reported the level of community awareness of development programmes as an influencing factor of community participation. It was also revealed during FGDs that people did not participate due to being not aware of NMSF interventions. *"Why should I participate in planning something that I am not even aware of?"* (Female, 24 years, Mtwara Municipal Council, December 21, 2014). "*I have hardly heard of NMSF interventions in this area, so I don't have any contribution to make during planning process*" (Male, 47 years, Mtwara District Council, December 18, 2014). The results are also in line with those reported by Bani *et al.* (2014) who reported positive influence of awareness on mens' participation in family planning. Based on empirical evidences from the previous aforesaid studies and the research findings with regard to the level of community awareness of various programmes, probably the level of respondents' awareness may influence community participation in planning HIV and AIDS interventions.

Attitude Towards HIV And AIDS Interventions

The findings indicated that the majority of the respondents had unfavourable attitude towards HIV and AIDS interventions under NMSF. The FGD participants supported the finding that unfavourable attitude towards HIV and AIDS interventions was the cause of non-participation in planning; they said: *"HIV interventions are for some government people to benefit financially. I don't see the impact of these interventions in our area. It is better that the government should buy cars using HIV funds for carrying people living with HIV to hospital for treatment"*. One of the FGD participants (Female, 49 years, Mtwara District Council, December 21, 2014) said so. Another FGD participant (Male, 20 years, Mtwara Municipal Council, December 21, 2014) said that: *"It is better that I do my business to get food rather than attending non-paying stuffs which are useless".*

The research finding is in line with what has been reported by Okwusi (2008) who conducted a study on attitude towards rural development projects and found that youth's unfavourable attitude was among the factors that affected their participation in development programmes. Conversely, unfavourable attitude constrains community participation in planning HIV and AIDS interventions under NMSF in Mtwara Municipality and District Councils.

Level of Community Participation

Despite the efforts made by the government to push the community to participate in planning, yet the study indicated that the participation was still low in all indicators. The findings indicated that there were low scores on all constructed participation indicators. The findings further indicated that the majority of the respondents did not participate in planning HIV and AIDS interventions under NMSF. The finding is in line with Sikika (2013) who reported that participation of community in designing, planning and implementing HIV and AIDS activities in Tanzania is still limited. The author further reported that citizens did not actively participate in planning and implementation of plans to address issues that affect their lives, health and HIV and AIDS issues being examples. From the findings of the study on which this paper is based, it was observed that low participation in planning was existing in the study area. The factors which mostly contributed to low community participation included dependency syndrome, lack of follow up from the Council, lack of planning knowledge and information, planning meetings being not organized, ignorance of HIV planning, previous plans not having been implemented, and HIV being not given a priority at the grassroots level.

Extents to Which Various Factors Influence Participation

Considering the summary of the findings from ordinal logistic regression, the Nagelkerke R^2 value was 0.793, which means that the independent variables entered in the model explained 79.3% of variance in the dependent variable (participation in planning HIV and AIDS interventions). The results showed that attitude towards HIV and AIDS interventions and awareness of NMSF interventions had positive impacts that were significant (Wald = 5.186, $p \leq 0.05$ for attitude, and Wald = 28.525, $p \leq 0.001$ for awareness). In view of these results, the null hypothesis which said that chances of participating highly in planning of HIV and AIDS interventions are the same for people with different attitudes towards HIV and AIDS interventions and different levels of awareness of NMSF interventions was rejected. Other variables with significant impacts included communities' satisfaction with involvement in planning HIV and AIDS interventions (Wald = 46.700, $p \leq 0.001$), access to information in planning (Wald = 5.651, $p \leq 0.05$), and education (Wald = 6.175, $p \leq 0.05$). These findings

show that people who are satisfied with involvement in planning are much likely to attend planning meetings as opposed to people who are not satisfied. This is mainly because they appreciate the level of involvement with regard to participation in the planning process. Similar findings were reported by Nomvakaliso (2007) who asserted that high or active participation is mostly likely when different stakeholders involved in a project or programme are satisfied with the level at which they are involved.

In line with access to planning information, the implication of these finding is that people with access to information are more likely to participate in planning HIV and AIDS interventions compared to people without access to information. Aref (2010) reported similar findings that lack of access to information could be one of the barriers to community participation in development projects. Another similar study conducted by Chifamba (2013) identified lack of information among other factors that hindered community participation in development projects. The implication for the impact of education level is that more educated people are likely to attend planning meetings compared to those who are not educated. The probable reason for this is that those who are better educated would be better empowered for participation because their attitude would likely be favourable. Angba *et al.* (2009) reported similar findings that education is a major determinant of effective participation in development projects. The author further argued that effective participation obviously requires communicative and human relational skills which must be learned.

Implication to Research and Practice

The findings from the research on which this paper is based are intended to generate empirical information on factors associated with participation in planning for HIV and AIDS interventions, particularly in Mtwara Municipal and Mtwara District Councils. This is because participation of community in planning is imperative for the ownership and sustainability of HIV and AIDS interventions. Furthermore, the findings will inform implementation of NMSF which translates international agreements, declarations, treaties and conventions which deal with HIV (URT, 2011). The implementation of NMSF is part of adherence to international efforts to contain the HIV and AIDS epidemic (URT, 2011). The NMSF also translates the Tanzania national HIV policy 2001 and makes a link to the Tanzania National Strategy for Growth and Reduction of Poverty (NSGRP II) and the 2025 Development Vision, which stipulates the need to address HIV in the development agenda (URT, 2011). Therefore, determination of factors contributing to participation of community members in planning for HIV and AIDS interventions, which was done in the research from which this paper is based, was worth doing.

CONCLUSION

Based on the results meeting the first objective, it is concluded that a high proportion of people with unfavourable attitude towards HIV and AIDS interventions under NMSF in Mtwara Municipal and Mtwara District Councils. The council management teams should ensure dissemination of steering tools including Essential Planning Package (EPP) for HIV and AIDS interventions, National Multisectoral Strategic Framework, national HIV policy and Participatory planning for HIV and AIDS using the Opportunities and Obstacles approach to development is done to community leaders. The leaders in turn will do dissemination to the grassroots to improve communities' attitude towards HIV and AIDS interventions.

Additionally; since the villages/streets organise public meetings concerning different issues like environment, education and health; it is recommended that HIV and AIDS issues should be incorporated in every meeting and reported.

In view of the findings meeting the second objective, it is concluded that the proportion of community members with low participation was very high and that few people participated in planning HIV and AIDS interventions in Mtwara Municipal and Mtwara District Councils. The problem of low participation was partly attributed to dependency syndrome, lack of follow up from the Council, lack of planning knowledge and information, planning meetings not being well organized, ignorance of HIV plannin, previous plans having not been implemented, and HIV being not given a priority at the grassroots level. Councils should provide proper guidance and sufficient clarification on what is required as far as HIV and AIDS planning process is concerned. This will enable communities to participate in the planning process and carry out activities more efficiently. In addition to that, community leaders should address the hindrances to community participation within their capacity and areas of jurisdiction.

On the basis of the findings meeting the third objective, it is concluded that attitude towards HIV and AIDS interventions and awareness of NMSF interventions are among the factors which have strong influence on community participation in planning. Besides the aforementioned factors with significant impact, others were access to planning information, satisfaction on involvement in planning and education level. The Councils should ensure that plans which emanate from grassroots are shared before being incorporated in their Medium Term Expenditure Framework. Furthermore, Community sensitization for awareness raising should be a continuous process rather than a one-off process. Lessons should be learned from practical approaches so that appropriate measures to improve the situation can be taken. What is important to know is that even if the community may be seen as uninformed in some aspects, it is the target beneficiary, often the greatest implementer and the final user of the interventions or programme. Community leaders should make sure that what they learnt from dissemination meetings are in turn disseminated to the community grassroots through village/street meetings. This will help to solve the identified hindrances to participation in planning HIV and AIDS interventions.

Future Research

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

This paper was on planning of HIV and AIDS interventions, but implementation, monitoring and evaluation of such interventions have not been researched on. Such researches are proposed to generate pertinent empirical information which can inform strategies to improve implementation, monitoring and evaluation of HIV and AIDS interventions.

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