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HIV/AIDS Prevalence in the Southern Highlands of Tanzania and the Challenges Facing Donor Funded Projects in Kilolo District, Iringa Region

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Abstract

Tanzania, like any other Sub Saharan African country has been grappling with HIV/AIDS since 1980s. While the national average of HIV/AIDS infection was 4.8% in 2019, the Southern Highlands display high prevalent standing at 9.1%. This is appalling given the presence of various donor-funded projects focusing on the prevention of HIV/AIDS in the region. This paper sought to unravel the inherent reasons behind the failure of donor-funded projects to effectively address HIV/AIDS infection in the Southern Highlands of Tanzania especially in Iringa Region. A mixed-method approach was applied whereby quantitative and qualitative data were collected and analysed. The findings revealed a number of donor-funded projects operating in Kilolo District focusing on prevention of the HIV/AIDS pandemic. It was also observed that the donor-funded projects encounter a number of challenges which hinder their efforts to scale down HIV/AIDS prevalence. The challenges include irregular monitoring and evaluation of the programs, lack of leadership and management skills as well as limited training to build the capacity of beneficiaries. This paper recommends that more efforts should be made to increase the level of inclusiveness at the local level along with improving monitoring and evaluation mechanisms. This will enhance the sustainability of donor funded projects and hence reduce the severity of HIV/AIDS in the region especially in Kilolo District.

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Introduction

Since 1980s, the world has been grappling with the prevalence of the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (HIV/AIDS). Statistics show that over 70 million people have been infected with HIV/AIDS; and close to 35 million people have died since the beginning of the pandemic (Rio, 2017; Dave *et al.*, 2019). Data also shows that by the end of 2015, approximately 36.7 million people were living with HIV/AIDS; and there were 2.1 million new infections (Joint United Nations Program on HIV/AIDS-UNAIDS, 2016). Comparatively, the Global South is more severely affected by HIV/AIDS than the Global North mainly due to high levels of poverty (Kabote & Niboye, 2012). The Sub Saharan Africa (SSA) is particularly overburdened by HIV/AIDS as statistics indicate that the region accounts for 76% of the global population of HIV/AIDS infected people and 76% of the total new HIV/AIDS infections (Wang *et al.*, 2016; UNAIDS, 2016). Moreover, of the 1.8 million deaths recorded in 2010, about 1.2 (66%) were from SSA (World Health Organisation-WHO, 2011) and in 2015, this rose to 75% (Wang, *et al.*, 2016). This indicates that mitigation efforts, if any were futile. Given the prevailing HIV/AIDS status, particularly in the Global South, there is doubt as to whether the goal of ending HIV/AIDS as a public health threat by 2030 will be achieved (Ssekalembe, *et al.*, 2020; UNAIDS, 2020; WHO; 2016).

The burden of the pandemic and the number of the people living with HIV (PLWHIV) in specific countries in SSA has been changing over time while varying in each country. For instance, the HIV/AIDS prevalence in Swaziland, Botswana and Lesotho exceeds 20%, while in Somalia and Senegal it is only 0.5% (Rio, 2017). In addition, Nigeria has estimated 3.1 million people living with HIV/AIDS, which accounts for 10% of the global HIV/AIDS burden (Burlew, *et al.*, 2014). In the 1990s, Uganda had the highest number of PLWHIV estimated at 18.5% before plummeting to only 5% in 2002; and slowly rising again to 7.3% with an estimated 1.6 million people infected in 2013 (Mafigiri, *et al.*, 2017). Ethiopia sustained low-intensity mixed pandemic of 1.1% with 720,000 people living with HIV/AIDS and 27,104 newly diagnosed cases (Girum, *et al.*, 2018).

In Tanzania, statistical data relating to HIV/AIDS in the country have been fluctuating. For instance, the HIV/AIDS prevalence declined from 7% in 2003/2004 to 5.1% in 2011/2012 among people aged 15-49 years (Tanzania HIV Impact Survey-THIS, 2005, 2013). However, in 2019 the HIV/AIDS infection rate among Tanzanians aged 15-49 stood at 4.8% while the prevalence among people aged 15-24 decreased from 2% in 2013 to 1.4 in

2017 (THIMS, 2018 cited in Mtasingwa, 2020). The declining trend of HIV/AIDS prevalence is attributed to the increased efforts by the government of Tanzania in collaboration with the international community to ensure that different legal and policy frameworks are reformed, strengthened and developed to address the pandemic (Mtasingwa, 2020; United Republic of Tanzania -URT, 2005; 2010).

Over the past decades, the severity of HIV/AIDS has been declining at the global¹ and national levels largely due to the unprecedented efforts exerted by Donor Assistance for Health (DAH) (Dieleman, *et al.*, 2018). Such support has mainly been coming from the Department for International Development (DFID), the USA President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to fight AIDS, Tuberculosis and Malaria (the Global Fund). Also included are the Bill and Melinda Gates Foundation, Australia's Department of Foreign Affairs and Trade (DFAT) and the United States Agency for International Development (USAID), among others (Burrows, *et al.*, 2016). According to Marten (2019), DAH in Africa is distinctively categorised into three phases; the pre-treatment era, which began in the 1980s focused on prevention, palliation and support for those affected by the pandemic. The second era began in the early 2000s, and it has also been referred to as the "golden age of global health". This era is marked by a large scale movement of making antiretroviral (ARVs) accessible and available to the affected millions of people (Myburg, *et al.*, 2021). This period also witnessed five-fold increase of DAH between 1990 and 2010; from \$ 5.59 billion to \$26.7 billion especially in resource-constrained countries. It is also reported that by 2010, about 28.7% (\$ 8.1 billion) of all global DAH went to SSA (Marten, 2019). The third period, spanning from 2010, witnessed dwindling of DAH partly due to the 2008 global financial crisis (Kirigia, *et al.*, 2011). This period witnessed not only stagnation of funds for HIV/AIDS but also increased focus on short term, heavily biomedical interventions, to the detriment of other longer-term care services and broader initiatives. Since 2002, international HIV/AIDS assistance from donor governments rose dramatically with disbursement rising from 1.2 billion in 2002 to \$ 5 billion in 2007, and reaching \$ 8.6 billion in 2014 (Oberth & Whiteside, 2016). DAH has focused on different interventions in different phases.

Tanzania has been receiving a fair share of DAH allocated to HIV/AIDS activities. For instance, in 2007, the total donor-funded budget for

¹ By 2011 decrease of new HIV infections by 50% countries including 13 countries in SSA while 8 million individuals were accessing ART by the end of 2011 (E-Sadr *et al.*, 2013).

HIV/AIDS accounted for 90%, and only 10% was funded by the national budget (Kelly & Birdsall, 2008). The Global Fund injected a total of US \$ 288.5 million to HIV/AIDS in round one of the funding phase and \$ 104.1 in round four in 2007 (Kelly & Birdsall, 2008). Also, the World Bank provided a total of US \$70 million from 2003 to 2008 that was channelled through different structures, including the public sector fund (\$32 million), institutional support to TACAIDS, support to Zanzibar AIDS Commission worth (\$5 million) and the Community HIV/AIDS response Fund worth \$ 14 million (Kelly & Birdsall, 2008). Again, the President's Emergency Plan for AIDS Relief (PEPFAR) committed funds for the five year period 2004-2008 worth \$804 million that was contracted to local NGOs and International NGOs² who worked together to address the pandemic (Kelly & Birdsall, 2008). This support enabled introduction of care and treatment clinics (CTC) for PLHIV which expanded from 96 centres in 2004 to 1100 in 2010. Moreover, the number of PLHIV using ARVs, which was 23,951 in December 2005, reached approximately 384,816 by 2010 and up to 44,368 people in 2013 (Marten, 2019; Levira, *et al.*, 2015). Also, HIV/AIDS-related mortality and new HIV/AIDS infection decreased from 46% in 2005 to 41% in 2013 (Levira, *et al.*, 2015). These statistics portray increased care and treatment as well as HIV/AIDS prevention, which are crucial for combating HIV/AIDS in the country.

Various DAH projects have been implemented in different zones of Tanzania including the Southern Zone. Evidence shows that the DFPs working to address HIV/AIDS in the Southern Zone include TUNAJALI and BORESHAAFYA under the USAID, Johns Hopkins Program for International Education in Gynaecology and Obstetrics (JHIPIGO), Benjamin Mkapa Foundation and President's Emergency Plan for AIDS Relief (PEPFAR) (Exavery, *et al.*, 2020). Similarly, the Walter Reed programs has been implementing a comprehensive HIV/AIDS care and support programme in the Southern Highlands since 2004, in collaboration with the Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDEC) and community Non-Governmental Organisation (NGOs) (Siyame, 2017). With the existence of several DFPs that work to address HIV/AIDS, one would expect the prevalence of HIV/AIDS be relatively low. While the national average HIV/AIDS prevalence rate stands at 5.1%, some regions, especially in the Southern Highlands, have the highest HIV/AIDS prevalence averaging 9.4% with Njombe recording

² Academy for Educational Development, AMREF, CARE International, Catholic Relief Services, Elisabeth Glaser Pediatric AIDS Foundation, Family Health International, Management Sciences for Health, Pathfinder International, Futures Group. OGAC

11.4%, Iringa 11.3%, Mbeya, 9.3% and Songwe 5.8% (MoHCDGEC, 2018; NBS, 2017). As the statistics suggest, the Southern parts of Tanzania still have relatively high HIV/AIDS prevalence rates.

Several studies have been conducted on the role of DFPs in the fight against HIV/AIDS (Grepin, 2012; Nattrass *et al.*, 2016; Htun, *et al.*, 2021). Whereas some studies have examined the role of DFPs with regards to capacity building (Bennett, *et al.*, 2011; Sanga, *et al.*, 2019), others have assessed the financial contributions towards HIV/AIDS activities (Kates & Wexler, 2018). Other studies have also established the factors contributing to the prevalence of HIV/AIDS in the Southern Highlands (Mwakalobo, 2007; Lwidiko, *et al.*, 2018; Sanga, *et al.*, 2019). TACAIDS for instance, identified structural, behavioural and biomedical factors as accounting for the prevalence of HIV/AIDS in the Southern zone (TACAIDS, 2008). Other studies have addressed the prevalence of HIV/AIDS in zones with a focus on special groups like the youth (Mwita, *et al.*, 2007; Mpondo, *et al.*, 2017). Also relevant to this study, Sadock (2020) gives a historical account of HIV/AIDS prevalence in the Southern Highlands.

The major concern of this paper is that despite the presence of several DFPs in the Southern Zone, the rate of HIV/AIDS is persistently high, averaging 9.1%. From the reviewed literature, none of the empirical studies have explained why the contribution of DFPs in the reduction of HIV/AIDS has not been felt given the persistently high rate of infections in the Southern Zone. This paper, therefore, explores the challenges that DFPs have been encountering while implementing HIV/AIDS interventions in Kilolo District in Iringa Region. It is expected that by exploring the challenges facing the DFPs, HIV/AIDS intervention programs can be strengthened to scale down the HIV/AIDS prevalence in the Zone and the country at large.

Methodology

Study design and area

The study was conducted in Kilolo District in Iringa Region in the Southern Highlands of Tanzania. Kilolo is one of the districts in Iringa Region with the highest rates of HIV/AIDS standing at 11.3%. Apart from exhibiting higher rate of HIV/AIDS, Kilolo District also experiences weak health systems that may infuriate the impact of those who are already affected by the disease (Joseph & Maluka, 2021 and Maluka & Joseph, 2021). In addition, the district is predominantly rural; with the majority of residents relying mostly on subsistence farming which makes their vulnerability to HIV/AIDS higher, hence the need for implementation of HIV/AIDS

interventions through DFPs (Maluka, *et al*, 2020). An exploratory case study design was employed. This design was deemed suitable because it enabled measuring the occurrence for all factors under investigation where multiple outcomes and exposures can be studied (Schooneboom & Johnson, 2017). Moreover, the design also enabled gathering of information easily and quickly thereby permitting data on all variables to be collected at once (Regnault, *et al.*, 2018). On the other hand, a mixed method approach was used to gather data through a mixture of quantitative and qualitative methods. This approach was preferred as it minimised the weakness of each approach by ensuring the credibility of the gathered information (Regnault, *et al.*, 2018; Harrison & Reilly, 2011).

Study population and sampling strategy

This study involved major stakeholders who participate in the implementation of HIV/AIDS interventions under DFPs in Kilolo District. These included health care workers, the Council Health Management Team (CHMT) and coordinators of donor funded projects. For health workers, sampling started with the existing 64 health facilities in Kilolo in which 30(46%) of the facilities were the target. To obtain the 30 facilities, a simple random sampling strategy was employed. Accordingly, a lottery technique was adopted whereby all facilities were accorded identification names and toasted in a dish to give each facility an equal opportunity of being selected. From each of the selected facilities, purposive sampling was used to obtain 3-4 health care workers, comprising facility in-charges and health care workers who provide HIV/AIDS-related services at the Care and Treatment Clinics (CTC). In total, 115 respondents participated in the study through the administered questionnaires. Health care workers were important in the implementation of HIV/AIDS interventions as they could provide information about the effectiveness of the implemented interventions and the way forward. Key informants were purposively sampled, and included 12 participants 6 (six) from the Council Health Management Team (CHMT), and 6 (six) coordinators of donor funded projects. These participants provided information related to the implementation of the projects, challenges encountered during the implementation and factors contributing to high HIV/AIDS prevalence in Kilolo district.

Methods of data collection

Multiple techniques were used to collect data to ensure credibility and validity of the research findings. The techniques included questionnaires, in-depth interviews and documentary review. In this way, possible fundamental biases arising from the use of a single method were highly minimised.

Structured questionnaires that used both open-ended and close-ended questions were employed to capture respondents' opinion on how DFPs were implemented to ensure that HIV/AIDS programs attained their intended goals. This technique was used because it enabled collection of demographic information such as sex, age and employment status. These variables were further used to authenticate the respondents who met the study requirements to engage in the study. This technique was also used to collect information on the respondents' perspectives in relation to the effectiveness of the implemented DFPs and the associated challenges. The open ended-question enabled respondents to express themselves freely and discuss matters related to overall HIV/AIDS in Kilolo; and how DFPs were implemented to ensure that HIV/AIDS programs were successful.

In-depth interviews (IDIs) were held with selected key informants, including CHMT and coordinators of DFPs in the district. Through IDIs, participants provided in-depth analysis of the overall implementation of DFPs in the district. Moreover, participants were able to deeply explain the factors which hinder effective implementation of DFPs. An interview guide was developed to capture the prevailing HIV/AIDS context in the district. Interviews were conducted at the participants' homesteads or workplaces from January to March 2019. Interview sessions lasted between 45 minutes to 1 hour; and were conducted in Kiswahili as a familiar language, which is also used in public offices. Prior undertaking of actual interview, information and arrangement were made in order to avoid disruption of the participant schedule.

In addition, evidence from documents was collected in order to gain an understanding of HIV/AIDS status as well as overall implementation of DFPs. A document review guide was developed; and documents were selected based on the pre-identified themes, which included global and national information on HIV/AIDS and country-specific reports from relevant departments and sectors. The reviewed documents included the Comprehensive Council Health Plans (CCHPs), which provided information on the status of HIV/AIDS in Kilolo District. Other documents included HIV/AIDS program reports, workshop reports and project progress reports that address HIV/AIDS in the studied area. These reports provided a good opportunity for detailed analysis of implementation of DFPs, the challenges experienced as well as the perceptions of the stakeholders on the trends of the disease in the district. On the whole, the documents enabled comparison, triangulation and confirmation of the findings generated from the interviews and questionnaires.

Data analysis

Analysis of data was done according to each data collection method adopted. Quantitative data obtained using structured questionnaires were cleaned and arranged. Unstructured data were translated qualitatively. In addition, the organization of data was done through coding and analysis with the use of the Statistical Package for Social Sciences (SPSS) computer software program. This enabled interpretation of data and presentation using frequencies, percentages, tables and figures. Qualitative was also analysed thematically, in which case data was categorized according to merging related themes. In this context, six stages were involved as propagated by Braune & Clarke (2006). The stages included familiarization with the collected data, generating initial codes, searching for themes, reviewing themes and naming themes. Lastly, themes were used to guide key findings as presented in section 3.

Ethical issues

This study adhered to all ethical research protocols (Creswell and Poth, 2018; Mills and Gay, 2016). To begin with, research approval was obtained from Kilolo District Executive Director through the District Medical Department. The researcher then obtained an introductory letter which was subsequently presented to the in-charges of the involved health facilities. Participants were also provided with information on the nature of the study before participating in the study (Creswell and Posh, 2018). Respondents were also granted freedom to withdraw from the study due to any discomfort or other reasons. The collected data was treated confidentially by hiding the identity of participants throughout. Lastly, all scholarly works used in this study have been dully acknowledged.

Findings

This section presents findings with regard to the challenges encountered by the donor funded projects in a bid to address the severity of HIV/AIDS in the Southern Highlands of Tanzania. The results are premised on the view that DFPs have for a long time served to improve the general health wellbeing of communities including addressing HIV/AIDS-related challenges. The major findings in this study are anchored on the services that DFPs offer to reduce HIV/AIDS, issues surrounding training of personnel working in health facilities, how DFPs undertake feasibility studies before projects take off, the question of monitoring and evaluation (M&E) of the implemented DFPs, as well as leadership and management skills among DFP's personnel.

Services offered by DFPs to reduce HIV/AIDS in Kilolo district

In order to reduce the prevalence of HIV/AIDS in highly affected areas, DFPs are said to have been conducting a number of activities that cut across clinical and non-clinical roles. Findings revealed that Kilolo District has many DFPs focusing on HIV/AIDS-related challenges. Specifically, different DFPs which have been implemented in the last five years in Kilolo district; and were mostly supported by USAID, PSI, PEPFAR, Global Fund and the Benjamin Mkapa Foundation. Similarly, two most popular projects, namely TUNAJALI and BORESHA AFYA have been operating in the area. Findings revealed further that the DFPs focus on different areas related to HIV/AIDS. Some 27(23.4%) of the respondents revealed that DFPs were involved in conducting major and minor maintenance of health facility infrastructure; and another 21 (18.2%) indicated that DFPs play the preventive role, treatment and taking care of HIV/AIDS patients. It was found also that 12 (10.4%) of respondents asserted that DFPs were undertaking capacity building whereas 14 (11.1%) of respondents argued that DFP were mostly engaged in supply of medicine and medical supplies. Moreover, HIV/AIDS test and counselling was mentioned by 22 (19.1%) while provision of health facility workers attracted 19(16.5%) of the respondents. During interviews, it was also revealed that community mobilisation and raising awareness through meetings were mentioned as important services undertaken by DFPs. The support given by DFPs was affirmed by one of the DFP coordinators thus;

I can rightly testify that we have done a great job of providing education and mostly conducting training with health workers in the district. We have gone even further and monitor the provision of services at the CTC and we provide supportive directives to health workers (IDI with DFPs Coordinator).

Additionally, material support to those already infected by HIV/AIDS especially orphans were also facilitated by DFPs and or local NGOs that receive funds directly from donors. CHMT members summed up the support by DFPs as follows:

For the last five years I have been in the district, we have registered many international and local agencies that work with our health workers to prevent new HIV/AIDS infections but also reduce the existing burden of HIV/AIDS prevalence. Each funding agency has a specific area of focus but mostly the assistance covers capacity building for health workers so that they may deliver good services, while others provide support for community awareness program.

This support has been really fundamental (IDI with CHMT member).

Besides supporting activities focusing on people infected with HIV/AIDS, some groups affected by HIV/AIDS are also supported. For instance, it was further revealed that orphans also received material support from DFPs or local NGOs that receive funds directly from donors.

Challenges encountered in implementing donor funded projects

While the efforts made by DFPs are highly commended, there were still complaints among respondents which hinted the challenges that DFPs have been experiencing which have resulted into little impact when it comes to scaling down of HIV/AIDS in Kilolo District. The limitations are further detailed in the subsequent sections.

Insufficient training of personnel working in health facilities

In order for the donor funded projects to run HIV/AIDS programs effectively in highly affected regions, training of health workers has been prioritised. This study has established that while the majority of services offered by DFPs include capacity building, respondents expressed dissatisfaction over the nature, duration and composition of the capacity building programs. It was further revealed that not all health workers working in care and treatment clinic (CTC) departments at the district had attended the required training from the DFPs working in the district. Table 1 shows the respondents' level of satisfaction regarding the nature of training.

Table 1: Respondents' views on training offered by DFPs in Kilolo District

Levels of satisfaction		
	Frequency	%
Not Satisfied	58	49
Less satisfied	36	30
Satisfied	17	15
Very satisfied	06	06
Total	115	100

According to the data presented in Table 1, the majority of respondents expressed their dissatisfaction with the nature of the training supported by DFPs in the district. Accordingly, 58(49%) of the respondents were not satisfied, 35(30%) were less satisfied, 18(15%) were satisfied whereas only

7(6%) were very satisfied. Regardless of the level of satisfaction, these findings suggest that more than 79% of the respondents were not satisfied. Respondents revealed that the selection process for attending training, and the nature of training did not cater for the needs of the beneficiaries. The findings resonated with the opinions from interviews especially with CHMTs who attested that some of the training undertaken missed out necessary criteria:

The selection of participants during the capacity building did not include those who were supposed to be part of the training. For example, sometimes personnel in the CTC department were not involved. Again, as CHMT, we are not given adequate opportunities to provide technical advice, including those who really deserve to participate in the organised training (IDI with CHMT).

Supporting the CHMTs argument, one of the DFP coordinators in the interviews had this to say:

Of course, I admit the challenges we are encountering when we plan training in this district. We often find ourselves overwhelmed by the big number of personnel to train amidst financial constraints. Sometimes, we are forced by the prevailing circumstances to shorten training days so as to involve as many participants as possible given the available budget (IDI with DFP Coordinator).

The respondents' views are all in harmony with the concern that training was inadequate. In this regard, it is important to conduct capacity building training among health personnel so as to ensure that the implementing health care workers are well equipped with relevant skills needed for effective prevention and mitigation of HIV/AIDS.

Insufficient feasibility studies

The quest for thorough feasibility studies before implementation of the project has a greater potential to guarantee the sustainability of the implemented strategies. In caution, Mukherjee and Roy (2017), and Mapako and Mbewe, (2013) contend that if the feasibility study undertaken is of substandard, it can highly affect the project success. With regard to the findings of this theme, respondents were of the view that most of the DFPs did not conduct sufficient feasibility studies before project implementation. It was revealed that this could easily be detected considering the fact that the activities of DFPs did not adequately address the demands and needs of the community. Consequently, the failure to undertake thorough feasibility

studies resulted to, among others, failure to ascertain the likelihood that the projects would yield the expected results. This has also led to the failure to take into account the economic, technical, legal and socio-cultural milieu of the areas in which DFP was implemented. Ultimately, the implemented activities may not contribute to the desired goals. Table 2 summarises the respondents' views on the factors contributing to inadequate feasibility studies.

Table 2: Reasons for inadequate feasibility studies (N=115)

Reasons	Frequency	%
Relying on assumptions about the severity of HIV consequences	18	16
Overlooking the contribution of community members'	17	14
Limited time to undertake thorough feasibility studies	23	20
Financial constraints to conduct effective feasibility studies	22	18
Inadequate DFPs staff to conduct feasibility studies	13	11
Relying on secondary information while planning the projects	15	12
Reluctance of community members to provide effective cooperation with DFPs	07	05
Total	115	100

Explanations by respondents as to why DFPs did not undertake thorough feasibility studies before the projects took off varied across respondents. But what was very clear among respondents and interview participants was the fact that the failure to take into account effective feasibility studies has a detrimental effect on the reduction of HIV/AIDS in Kilolo District.

Community participation in HIV/AIDS reduction

It has been underlined that HIV/AIDS infects members within the community and impacts are highly felt within the community (Boutayeb, 2009; Taraphdar, 2011). Thus, proper involvement of the community members in the fight against the impacts associated with HIV/AIDS cannot be underestimated. Bearing this in mind, the researchers probed respondents on the space given to communities in the implementation of different HIV/AIDS programs. The findings revealed poor community participation in the DFPs implemented HIV/AIDS programs, and this hinders their

sustainability because community members do not feel as part of the implemented projects. Respondents mentioned different reasons that made DFPs not to prioritize community participation while implementing HIV/AIDS programs. The reasons included deliberate ignorance of community knowledge, which attracted 19 (16.1%) of the participants; and demand for allowances and compensation for their time as mentioned by 12 (10.3%) of the respondents. Another 14(11.8%) of the respondents mentioned DFPs' budget constraints, which constrained sufficient involvement of community members, while 28(23%) pointed to poor feasibility studies that failed to unravel actual community needs. Other reasons included DFPs officials' belief in their own knowledge and skills 24 (20.4%), and poor approach to selecting community members to participate in the programs, which was mentioned by 21(17.7%) of the respondents. Interviews with respondents also echoed the challenges that DFPs faced while addressing the aspect of community participation. One of the respondents opined thus:

Most of the implemented HIV/AIDS programs have not focused on tracing and understanding how the community members feel and how they can be part of solving these problems. Community members cannot direct their whole energy to the project once they feel that most of the solutions emanate from DFP officials (IDI with CHMT).

One of the DFP coordinators was also in agreement with the CHMT's stance on the failure to engage communities in the implementation of DFPs hence;

The quest for funding has held us back in enabling and engaging all communities as desired in order to address HIV/AIDS issues. Our efforts have fallen short and we think we need to do more than this to have all communities on board if we are to yield sustainable results (IDI with DFP coordinator).

Although there was a feeling of inadequate that community involvement, the limited community engagement was appreciated. For instance, it was revealed that the involvement of communities in identifying their needs has facilitated appropriate interventions in terms of both reduction of new HIV/AIDS infections and mitigation of some HIV/AIDS-related effects. This reveals the significance of community participation towards the success and sustainability of DFP programs.

Monitoring and Evaluation (M&E) of HIV/AIDS programmes

Monitoring and evaluation (M&E) should be conducted regularly during the implementation of programs to identify gaps and devise timely solutions. The researchers sought to investigate how M&E was conducted by DFPs to ensure that the implemented projects were on track. Findings revealed that most of the DFPs did not conduct regular M&E exercises in order to know the actual performance of the projects. The elusiveness of the practices is illustrated by lack of sustainability strategies for organisations that had started to support communities by offering humanitarian services. Failure to mainstream better M&E practices has a causal linkage with failure to transition from donor survival phase to sustainability. Respondents expressed their views as to whether or not they were satisfied with the nature of the undertaken M&E activities as illustrated in Table 3 below.

Table 3: Respondents' Satisfaction with M&E of HIV/AIDS Programs

Levels of agreement	No	%
Strongly disagree	30	26
Disagree	61	54
Not sure	04	03
Strongly agree	08	07
Agree	12	10
Total	115	100

Based on the findings in Table 3, some 26% of the respondents strongly disagreed implying that they were not satisfied with the form of monitoring and evaluation mechanisms whereas 54% disagreed, making a total of 80% who expressed their dissatisfaction with the model of M&E undertaken. Further probing was done to investigate the reasons for such disagreement among the respondents. It was revealed that the M&E approach applied in the implemented projects was not inclusive enough to involve all those who had participated during the implementation of the interventions. Moreover, once M&E was done, participants did not get timely feedback on the programmes that were being implemented. This was well affirmed by a participant during interviews:

I remember we used to respond to different questionnaires that were brought to us by those who were responsible for running the programmes, but they never gave us feedback. As a result, we rarely know the extent the implemented programs have succeeded or; what has been a significant hindrance. Failure to be informed on the

continuity of the ongoing HIV/AIDS programs affects even our participation in the programmes (IDI with CHMT).

Moreover, financial constraint was identified as affecting the undertaking of M&E of the implemented programs. It was revealed, for instance, that monitoring of the ongoing projects needed to be done periodically, at least on a quarterly basis; but when this was not done; it affected the whole M&E process. The same is true with the evaluation process, which is essentially done at the end of the project in most cases when the programme is about to end.

Leadership and management skills among DFP personnel

It was evident from the findings that DFP leadership and management were marred by significant leadership challenges. Respondents mentioned different leadership and management practices that were missing among the DFP personnel. Figure 1 indicates a number of leadership and management practices that were missing among the DFPs personnel who implemented HIV/AIDS projects in the study area.



Figure 1: Missing leadership and management practices

Figure 1 has unveiled the role of management and leadership needed to execute different DFPs to reduce the severity of HIV/AIDS. Through the analysed parameters, findings showed that of all challenges, management

and leadership practices, motivation and incentives among personnel were mentioned by 20% of respondents whereas undertaking regular staff supervisory assessments was the least mentioned attracting only 8% of the respondents. The data collected from interviews also corroborated the above quantitative data whereby respondents revealed their dissatisfaction with DFP officials in relation to the manner they managed the programmes. Participants clearly addressed the problem of the DFPs leaders in innovating new things and get things done. Lack of such practices has a bearing on the implementation of the projects geared scaling down HIV/AIDS.

Discussion

This paper has attempted to address the major hindrances to the implementation of donor funded HIV/AIDS programs in the Southern Highlands of Tanzania, particularly in Kilolo District in Iringa Region. It has been revealed that despite the existence of a number of DFPs, HIV/AIDS prevalence is still quite high. It was unveiled that the region has the highest burden of HIV/AIDS prevalence standing at 11.3%. While structural, biomedical and behavioural challenges accentuate the HIV/AIDS burden in the region, the role of DFPs is of vital importance. This section discusses the major limitations that DFPs face while attempting to redress the problems associated with HIV/AIDS.

It has been revealed that it is very crucial to undertake a feasibility study before actual implementation of HIV/AIDS programs. This is because it determines the success of the program. According to Kuteesa, *et al.*, (2019), feasibility study is a significant determining factor for the success of programs. It is argued that when undertaking a feasibility study, seven components need to be well thought out, namely acceptability, demand, implementation, practicality, adaptation, integration and expansion (Bowen, *et al.*, 2009). It has been shown in this paper that lack of feasibility studies is among the factors that are linked to the failure of DFPs to make the expected impact on the reduction of HIV/AIDS. This is in line with the findings unveiled by Ntozi, *et al.* (1999) that lack of feasibility studies led to the failure of DFPs to realise the expected results. It has also been shown that effective involvement of stakeholders before implementation of HIV/AIDS programs is critical and thus, needs to be well considered during the feasibility study. In Uganda, for instance, use of stakeholders in the identification of key HIV/AIDS problems and how to address them was successfully done; and this facilitated smooth implementation of activities, and consequent achievement of the desired program goals (Day, *et al.*, 2018).

The quest for undertaking inclusive M&E has largely dominated the terrain of DFPs during the implementation of HIV/AIDS interventions. As Nash, *et al.* (2009) rightly assert, M&E systems are ideally the cornerstone of HIV/AIDS services, as they serve to provide data to inform national programs and priorities while guiding the delivery of high-quality prevention, care and treatment. As for DFPs that were implemented in Kilolo District, most of those components were not perfectly adhered to, thereby slowing down the implementation of HIV/AIDS programs. These findings corroborate a study by Deogratias (2019) that was conducted in Dar es Salaam which focused on M&E of the implemented strategies. The study found the factors which accounted for the failure of M&E activities in the region included non-adherence to professionalism, lack of skilled M&E officials, poor reporting systems and inadequate or delayed disbursement of funds and reluctance of the clients to provide valid information. Again, a study conducted in Ethiopia on the effectiveness of M&E systems for the implemented DFPs revealed a number of challenges that hindered the process. The challenges included non-adherence to professionalism, lack of skilled officials, poor project reporting and delay in disbursement of funds (Ramathamo, 2013). Undertaking M&E is imperative for performance of DFPs and thus, efforts towards strengthening M&E system are of outmost importance. For effective HIV/AIDS M&E tasks to be conducted, the following components need to be prioritised, organisational structure of M&E unit, human capacity, HIV/AIDS M&E partnerships, HIV/AIDS M&E plan and advocacy (UNAIDS, 2009). Other components include survey and surveillance, routine program monitoring data, supportive supervisions and data auditing, HIV/AIDS database, HIV/AIDS evaluation, research and learning and using data for decision making (UNAIDS, 2009).

Another concern discovered in the study area is the tendency to ignore community participation in designing and implementing DFP programs that seek to reduce the prevalence of HIV/AIDS. When communities are not engaged in the implementation of the projects, its sustainability becomes compromised contributing to ultimate failure. Low community participation in the implemented DFPs programs has detrimental effects on the attainment of the expected outcome. When community participation is inadequate, and the spirit of ownership and acceptance of programs is lacking the chances to achieve anticipated outcomes are unpredictable. This view is supported by a systematic review by Iwelunmor, *et al.*, (2016) that failure to involve community members through selected key stakeholders in implementing HIV/AIDS interventions and recruiting community members may not ensure that the appropriate social norms are addressed during the recruitment and

program awareness. Notably, community participation in HIV/AIDS interventions has the potential of mobilising support for project success. As revealed in the study conducted in Mara and Mwanza Tanzania, encouraging community participation ensured social support from the community and family members; and this is crucial for sustainability of HIV/AIDS intervention programs (Mgabo, *et al.* 2020). As emphasised by Hershey (2011), during the implementation of DFPs, the community should be at the centre and hence, they should be empowered to take up certain responsibilities such as diagnosis and surveillance through community health workers, to strengthen communication and share information through community leaders.

The importance of training beneficiaries of the implemented HIV/AIDS programmes cannot be overemphasized. This is in line with what Burlew, *et al.*, (2014) assert; that more health workers must be educated, trained and deployed to deliver the relevant services especially in the Sub-Saharan Africa (SSA). This is because of the existing shortage of human resources for health in SSA, and the urgent need to provide HIV/AIDS prevention, care and treatment services. The present study acknowledges the significance of training despite the shortcomings with regard to accuracy, relevance and timing of the training. Training should be conducted to enable acquisition of skills and knowledge crucial for conducting the planned activities effectively and efficiently to bring about the expected outcomes. Iwelunmor, *et al.*, (2016) stress the importance of consistent and timely training which also makes use of equitable training materials. Training and capacity building need to involve all key stakeholders in the community not only to have a common understanding on the pandemic, but also the topics covered should be holistic to address all other HIV/AIDS-related aspects. For instance, a study that was conducted in Nigeria under PEPFAR established different topics that were taught during the training of HIV/AIDS as well as the number of selected stakeholders (Burlew, *et al.*, 2014). Specifically, the topics covered prevention of Mother to Child Transmission of HIV/AIDS (PMTCT), male circumcision, behavioural change and counselling and testing, among others (Burlew, *et al.*, 2014). Clear soliciting of stakeholders and thorough choice of topics potentially led to the success of the training program and its implementation as well.

Study limitation

While the present study has many strengths regarding its theoretical and practical contribution to the body of knowledge, it has a number of limitations as well. First, the study employed an insufficient number of

respondents at the district level, since it was confined to health workers, CHMT and DFPs personnel alone. If more participants were to be involved in the study, a much more representative sample providing representative views could be drawn. Again, the prevalence of HIV/AIDS may be caused by a myriad of factors including biomedical and behavioural aspects that have not been dealt with in this paper; rather the emphasis was placed on the nature of the implemented DFPs in the studied area. It is worth noting, however, that the study has successfully underscored the major constraints facing DFPs in Kilolo district that have contributed to the persistent prevalence of HIV/AIDS. Secondly, while this study cannot be used to generalise the views from the Southern Highland zone which covers five regions with different districts, still it offers insights for important policy improvement that, if used by DFPs, can serve to reduce the prevalence of HIV/AIDS in the southern zone and Tanzania in general. Third, the authors are aware that the causes of the prevalence of HIV/AIDS go beyond other contextual constraints facing DFPs that are implemented in the Southern zone. If such challenges are addressed, the prevalence of HIV/AIDS in areas that are highly affected by HIV/AIDS can be reduced.

Conclusion and recommendations

While donor funded projects are commendable for facilitating programs geared towards reduction of HIV/AIDS infection especially in highly affected regions, the existence of DFPs does not always guarantee reduction in HIV/AIDS prevalence. This is because of diverse challenges that arise due to the failure to consider the significance of pre-implementation activities such as feasibility studies but also crucial aspects during implementation. In addition, while the LMICs depend entirely on DFPs, it is suggested that the government on its part should allocate enough funds to supplement donor efforts in combating HIV/AIDS and its impacts. While this study has confined itself to DFPs as the main cause of the prevalence of HIV/AIDS in the Southern Highland of Tanzania, more studies are needed to analyse other contextual specific factors namely community and health systems factors that may be attributed to the prevalence of HIV/AIDS in the region.

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