PROPOSAL FOR:

Baseline Assessment of PLHIV Households in Busega District: Socio-Economic Conditions, Service Access, and Priority Needs.

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1.0 Survey Background

Tanzania has recorded notable achievements in the national response to HIV and AIDS over the past two decades. These achievements are largely attributed to the expansion of HIV testing services, the scale-up of antiretroviral therapy (ART), the strengthening of prevention of mother to-child transmission (PMTCT) programs, and the adoption of community-based service delivery approaches. As a result, national data and programmatic reports indicate steady progress toward the global 95-95-95 targets, with a large proportion of people living with HIV (PLHIV) now aware of their HIV status, initiated on lifelong treatment, and achieving viral load suppression.

Evidence from the Tanzania HIV Impact Survey (THIS 2022-2023) shows that the adult HIV prevalence stands at approximately 4.4 percent, which translates to about 1.5 million adults living with HIV in the country. The survey further estimates an annual HIV incidence of 0.18 percent, equivalent to nearly 60,000 new infections per year. Viral load suppression among adults living with HIV was reported at 78 percent. While these figures demonstrate clear progress in treatment outcomes, they also point to persistent gaps, particularly among specific population groups such as young people and men, who continue to show comparatively lower service uptake and retention.

Routine national HIV program data also indicate high levels of treatment coverage. More than 90 percent of PLHIV are aware of their status, and the majority of those diagnosed are currently

receiving ART, with a significant proportion achieving viral suppression. These gains reflect sustained investments in differentiated service delivery models, HIV self-testing initiatives, improved laboratory systems, and strengthened supply chain management for HIV commodities.

However, despite these epidemiological and programmatic successes, HIV remains closely linked with a range of structural and socio-economic challenges. National reports consistently highlight issues such as stigma and discrimination, food insecurity, limited livelihood opportunities among affected households, delayed uptake of antenatal care services, and weak follow-up mechanisms for mother-baby pairs. In addition, condom use among high-risk groups remains suboptimal, and vulnerable populations, including adolescent girls and young women, sero-discordant couples, and economically disadvantaged households, continue to experience a disproportionate burden of HIV-related risks and socio-economic vulnerability.

It is important to note that most of the existing data in Tanzania are derived from facility-based reporting systems and large-scale national surveys. While these sources are useful for understanding overall epidemiological trends and service coverage, they do not adequately capture household-level realities. In particular, they provide limited information on the socio-economic conditions of PLHIV households, including income status, food security, access to social protection, and community-level barriers to service utilization. These household-level factors are critical for designing integrated interventions that go beyond clinical care to address the broader determinants of health and well-being.

In Simiyu Region, and more specifically in Busega District which is the target baseline survey area, there is a noticeable lack of disaggregated and localized data on households affected by HIV and AIDS. Available information is largely facility-based and does not provide a comprehensive picture of the number, distribution, and socio-economic conditions of PLHIV at the household level. This data gap presents a significant constraint for organizations and development partners that intend to design targeted and evidence based interventions.

In light of this context, there is a clear need to conduct a baseline household survey in Busega District. The proposed survey will generate reliable and context-specific data on PLHIV households, including their socio-economic conditions, access to services, and priority needs. The

findings will serve as an evidence base for intervention design, program targeting, and resource mobilization. The study will adopt a baseline survey approach consistent with national surveys such as the Tanzania HIV Impact Survey and the Tanzania Demographic and Health Survey, both of which emphasize the importance of household-level data in informing targeted and effective programming.

2.0 Purpose of the Busega District Baseline Survey

The overall purpose of this baseline survey is to generate reliable and context-specific evidence that will inform the design, planning, and subsequent implementation of targeted interventions for

people living with HIV and AIDS in Busega District. The survey is intended to provide a clear understanding of the magnitude, distribution, and socio-economic situation of PLHIV households in the district so that future programmatic responses are grounded in empirical data rather than assumptions.

More specifically, the baseline assessment seeks to establish a household-level profile of HIV affected populations, including their socio-economic conditions, access to treatment and support services, and the key structural challenges that affect their well-being and treatment outcomes. The information generated through this process will serve as a foundation for evidence-based planning, prioritization of interventions, and effective targeting of resources. In addition, the findings will strengthen resource mobilization efforts by providing credible data that can be used to justify programmatic investments by development partners and funding agencies.

3.0 Survey Objectives

3.1 Main Objective

The main objective of the proposed baseline study is to assess the socio-economic conditions, level

of access to HIV-related services, and priority needs of households affected by HIV and AIDS in Busega District.

3.2 Specific Objectives

The specific objectives of the baseline survey are:

(i) To identify and estimate the number and geographical distribution of households affected by HIV and AIDS within the study area

(ii) To assess the socio-economic status of PLHIV households, including sources of income, employment status, and food security conditions

(iii) To examine the level of access to HIV treatment, care, and support services, including enrolment in ART and utilization of related health services

(iv) To identify key household and community-level challenges affecting PLHIV, including stigma and discrimination, livelihood constraints, nutritional challenges, and barriers to accessing health services

(v) To generate practical and evidence-based recommendations that will guide the design and targeting of appropriate interventions for PLHIV households in Busega District

4.0 Key Research Questions

The baseline survey will be guided by the following set of research questions:

(i) What is the estimated number and geographical distribution of households affected by HIV and AIDS in the study area?

(ii) What are the socio-economic characteristics of these households in terms of income, employment, food security, and living conditions?

(iii) What is the current level of access to ART and other HIV-related health and support services?

(iv) What livelihood and nutritional challenges are faced by PLHIV households, and how do these challenges affect treatment adherence and overall well-being?

(v) What formal and informal support systems are currently available to PLHIV households,

and what critical gaps remain in service provision?

5.0 Methodology

5.1 Study Design

This study will employ a cross-sectional, household baseline survey design to generate both quantitative and qualitative information on households affected by HIV and AIDS in Busega District. The cross-sectional approach is considered appropriate for establishing a snapshot of current socio-economic conditions, service access, and priority needs prior to the implementation of any intervention. As such, the design will enable the generation of baseline indicators against which future program outcomes can be measured.

The proposed design is consistent with nationally recognized HIV survey methodologies, particularly the Tanzania HIV Impact Survey (THIS 2022-2023), which utilized a population based, cross-sectional household survey framework to assess HIV related indicators across the country. Similar to the Tanzania HIV Impact Survey, our present proposed Busega survey study

will adopt a household level approach in order to capture both demographic and socio-economic characteristics of affected households. However, given the scope and objectives of the current assessment, the study will focus on structured interviews and will not include biomarker testing.

In line with standard household survey practice as applied in national surveys such as THIS and the Tanzania Demographic and Health Survey (TDHS), the study will collect data at the household level using structured questionnaires administered to eligible respondents. This approach is suitable for capturing information on household composition, income sources, food security, access to health and social services, and HIV-related care and support needs. The household-based design is particularly relevant in the context of HIV programming, where treatment outcomes and vulnerability are closely linked to socio-economic and family-level factors.

While the THIS survey applied a two-stage cluster sampling approach at national scale, the present study will adopt a district level sampling strategy appropriate to the geographical scope and available resources. The emphasis will be on identifying and surveying households affected by

HIV within selected wards and communities in Busega District in order to obtain representative and programmatically useful data.

Overall, the selected cross-sectional household survey design is methodologically appropriate for a baseline assessment, cost-effective within the available resources, and aligned with national and international best practices for generating evidence to inform targeted HIV interventions.

5.2 Survey Study Area

The study will be conducted in Busega District, which is one of the districts of the Simiyu Region, Tanzania. The district is predominantly rural, with livelihoods largely dependent on smallholder agriculture, livestock keeping, and informal economic activities. Health and social services are provided through a network of dispensaries, health centres, and community based programs, including Care and Treatment Clinics (CTCs) offering HIV services.

Despite the presence of these services, there is limited household level data on the socio-economic conditions of people living with HIV and AIDS (PLHIV) in the district. The selection of Busega

District is informed by the need to generate localized evidence that will support targeted program design and implementation for HIV-affected households.

5.3 Target Population

The primary target population for this study will comprise households with at least one member living with HIV in Busega District, who will be recruited through confidential referral mechanisms within existing HIV service delivery structures. Eligibility for participation will therefore be determined through voluntary linkage from Care and Treatment Clinics (CTCs), community health workers, home based care providers, and PLHIV support groups, rather than through direct community identification. This approach is intended to ensure privacy, prevent unintended disclosure of HIV status, and comply with national ethical guidelines governing HIV-related research.

In addition to PLHIV households, the study will include selected community and institutional stakeholders who are directly involved in HIV service delivery, coordination, and social support. These will include:

(i) Health care providers working in Care and Treatment Clinics (CTCs)
(ii) Community health workers and home-based care providers
(iii) Local government officials, including social welfare and community development officers
(iv) Leaders or representatives of PLHIV support groups, where such groups exist

These stakeholders will participate as key informants and will provide complementary qualitative information on the availability, accessibility, and quality of HIV related services, as well as community level challenges, referral systems, and existing support mechanisms for PLHIV households.

5.4 Sampling Strategy

The study will adopt a multi stage sampling approach tailored to the district context and the specific focus on PLHIV households.

At the first stage, a purposive selection of wards with known HIV service points, for example facilities that offers CTC services, will be undertaken in consultation with district health authorities. This will ensure inclusion of areas with a higher likelihood of identifying PLHIV households.

At the second stage, households affected by HIV will be identified through collaboration with health facilities, community health workers, and PLHIV support networks, while ensuring

confidentiality and ethical considerations. From the identified list, households will be selected using a systematic or simple random sampling approach, depending on the availability and completeness of the sampling frame.

Given the exploratory and programmatic nature of this baseline assessment, an estimated sample size of approximately between 100 and 150 PLHIV households will be targeted. This sample size is considered adequate to generate indicative district level findings that can inform intervention design within the available time and resource constraints.

Key informants will be selected purposively based on their roles in HIV service provision, while participants for focus group discussions will be drawn from PLHIV support groups and community stakeholders.

5.5 Data Collection Methods

Data collection will employ both quantitative and qualitative methods in order to obtain a comprehensive understanding of the situation of PLHIV households.

5.5.1 Household Survey

A structured questionnaire will be administered to eligible respondents in selected households. This Survey will design a specific questionnaire that will facilitate capturing information on:

(i) Household demographics and composition
(ii) Socio-economic status and sources of livelihood
(iii) Food security and nutritional status
(iv) Access to HIV treatment, care, and support services
(v) Health-seeking behavior and service utilization
(vi) Experiences of stigma and discrimination
(vii)Priority needs for socio-economic support

5.5.2 Key Informant Interviews (KIIs)

Key informant interviews will be conducted with health care providers, community health

workers, and local government officials to obtain insights into:

(i) Availability and coverage of HIV services
(ii) Referral systems and support mechanisms
(iii) Programmatic challenges and service gaps

5.5.3 Focus Group Discussions (FGDs)

Where feasible, focus group discussions will be conducted with PLHIV support groups to explore shared experiences, coping strategies, and community-level challenges in greater depth.

All data collection tools will be pre-tested prior to field deployment to ensure clarity, relevance, and cultural appropriateness.

5.6 Data Analysis Plan

Quantitative data that will be gathered from the household survey will be entered, cleaned, and analyzed using a specially chosen statistical software preferably STATA. The quantitative analysis will focus on descriptive statistics, including frequencies, proportions, and cross-tabulations, to generate a profile of PLHIV households in terms of socio-economic conditions, service access, and priority needs.

Qualitative data, however, from key informant interviews and focus group discussions will be transcribed and analyzed using thematic content analysis. Emerging themes will be used to

complement and contextualize the quantitative findings, particularly in relation to service barriers, stigma, and livelihood challenges.

The results will be presented in the form of tables, charts, and narrative summaries to support evidence based recommendations for program design and targeting.

6.0 Ethical Considerations

This proposed baseline survey will adhere to established ethical standards for conducting research

involving people living with HIV and AIDS. Given the sensitivity of HIV related information, particular attention will be paid to confidentiality, voluntary participation, and non-disclosure of participants' HIV status. Essentially, the following considerations will strictly adhered to

(i) Informed Consent

Participation in the study will be entirely voluntary. All eligible respondents will be provided with clear information about the purpose of the study, the type of data to be collected, the expected duration of the interview, and their right to decline participation or withdraw at any time without any consequences. Written or verbal informed consent will be obtained prior to data collection.

(ii) Confidentiality and Privacy

All information collected during the study will be treated as strictly confidential. Interviews will be conducted in a private setting to ensure that responses cannot be overheard by other household members or community members. Personal identifiers will not be included in the dataset; instead, unique codes will be used to anonymize respondents.

(iii) Non-Disclosure of HIV Status

The study will not publicly identify or label any household as HIV-affected. Recruitment of participants will be conducted through confidential referral mechanisms involving Care and Treatment Clinics (CTCs), community health workers, and PLHIV support networks. At no point will the research team disclose an individual's HIV status to any third party.

(iv) Approvals and Permissions

Prior to data collection, the study will obtain the necessary administrative permissions from relevant district authorities, including the District Executive Director's (DED) office, the District Medical Officer, and local ward and village leadership. The study will also comply with national ethical guidelines governing HIV-related research.

7.0 Expected Output

Upon completion of the proposed baseline survey, the following outputs are expected be resultant

(i) A cleaned and anonymized dataset of surveyed PLHIV households of selected areas of Busega District

(ii) A comprehensive baseline survey report presenting key findings

(iii) A mapped profile of socio-economic needs and service gaps among PLHIV households

(iv) Evidence based and actionable recommendations to guide intervention design and targeting

These outputs will then provide Living with Dignity Foundation Tanzania (LWDFT) organization with a solid foundation for program planning, monitoring, and resource mobilization.

8.0 Implementation Timeline

The Busega baseline survey is proposed to be implemented over a period of three months, staring immediately after acquisition of funding and is structured as follows:

Month One: Preparatory Phase

The preparatory phase is expected to entail the following activities

(i) Consultations with the Prime Minister-TAMISEMI office in Dodoma for project introductions, research permit applications, presentations and approvals

(ii) Development and finalization of data collection tools

(iii) Stakeholder consultations and administrative approvals

(iv) Recruitment and training of enumerators

(v) Pre-testing and refinement of tools

Month Two: Data Collection

The second month shall be devoted to the field work specific forte gathering of necessary information. This exercise shall entail the following exercises

(i) Household survey implementation
(ii) Key informant interviews
(iii) Focus group discussions (where applicable)
(iv) Daily data quality checks and supervision

Month Three: Data Processing and Reporting

The final month of the survey project shall be dedicated to performing

(i) Data entry, cleaning, and analysis
(ii) Qualitative data transcription and thematic analysis
(iii) Drafting of the baseline survey report
(iv) Validation of findings with key stakeholders

9.0 Use of Survey Findings

The findings of this baseline survey will be used to:

(i) Inform the design of targeted interventions for PLHIV households in Busega District (ii) Support the development of funding proposals and resource mobilization efforts for LWDFT feature interventions
(iii) Guide evidence-based planning and prioritization of services
(iv) Strengthen coordination between health, social welfare, and community-level support programs

10.0 References

1. National Bureau of Statistics (NBS) [Tanzania] & ICF. (2016) *Tanzania Demographic*

and Health Survey (TDHS) 2015–2016. Dar es Salaam, Tanzania, and Rockville, Maryland, USA: NBS and ICF.

2. National Bureau of Statistics (NBS) [Tanzania], Office of the Chief Government Statistician (OCGS) Zanzibar, TACAIDS & Ministry of Health. (2023) *Tanzania HIV Impact Survey (THIS) 2022–2023*. Dar es Salaam: National Bureau of Statistics. Available at: www.nbs.go.tz (Accessed: [insert date]).
3. Tanzania Commission for AIDS (TACAIDS), National AIDS Control Programme (NACP) & United Republic of Tanzania. (2021) *National HIV and AIDS Strategic Framework 2021–2025*. Dar es Salaam: TACAIDS.
4. UNAIDS. (2023) *Global AIDS Update 2023: Confronting inequalities – Lessons for pandemic responses from 40 years of AIDS*. Geneva: UNAIDS. Available at: https://www.unaids.org (Accessed: [insert date]).
5. United Republic of Tanzania, Ministry of Health, NASHCoP. (2024) *Annual Program Report: The National HIV, STI, and Hepatitis Control Program, No. 29; 2021–2024*. Dar es Salaam: Ministry of Health, Tanzania.

BUDGET: Busega District PLHIV Household Baseline Survey (TZS)

Item	Description	Unit	Qty	Unit Cost (TZS)	Total Cost (TZS)
1. Preparatory Phase					
Consultations and administration approvals	Travel Arusha-Dodoma-Arusha for 2 staff × 3 trips; Per Diem 200,000/person/night × 2 nights	Trip	3	864,000	2,592,000
Printing & tool development	Questionnaires, KII/FGD guides, stationery	Set	1	800,000	800,000
Enumerator recruitment	Ads, shortlisting	Activity	1	400,000	400,000
Training of enumerators	10 enumerators × 3 days × 100,000/day + Trainer 1,500,000	Person day/Trainer	11	409,091*	4,500,000
Pre-testing of tools	2 days × 10 enumerators × 100,000 + 2 trips × 64,000	Day/Trip	2	1,264,000	2,528,000
Subtotal Preparatory Phase					**10,820,000**
2. Field Data Collection					
Household surveys	10 enumerators × 20 days × 100,000/day	Person-day	200	100,000	20,000,000
Field supervision	3 staff × 20 days × 200,000/day + Arusha-Busega-Arusha 80,000 × 2 × 3 staff	Person-day	60	208,000*	12,480,000
Transport: Car hire	1 car × 20 days × 100,000/day	Day	20	100,000	2,000,000
Transport: Motorcycles	2 motorcycles × 20 days × 50,000/day	Day	40	50,000	2,000,000
Travel: Enumerators & staff	Arusha-Busega-Arusha 160,000 people (3 staff)	Person	3	160,000	480,000

FGD logistics	3 FGDs, venue + refreshments 300,000 each	FGD	3	300,000	900,000
KII logistics	10 interviews, refreshments / transport 20,000 each	Interview	10	20,000	200,000
Tablets	8 units × 1,000,000 TZS	Unit	8	1,000,000	8,000,000

Item	Description	Unit	Qty	Unit Cost (TZS)	Total Cost (TZS)
ODK or KoboCollect setup	Software & licensing	Set	1	500,000	500,000
Subtotal Field Data Collection					**46,560,000**
3. Data Processing & Analysis					
Data entry & cleaning	2 clerks × 15 days × 100,000/day	Person-day	30	100,000	3,000,000
Qualitative transcription	3 FGDs + 10 KIIs	Task	1	500,000	500,000
Data analysis	Analyst fee + software use	Task	1	1,500,000	1,500,000
Report writing	Consultant fee	Task	1	2,500,000	2,500,000
Validation workshop	Venue, refreshments, transport	Workshop	1	1,000,000	1,000,000
Subtotal Data Processing & Analysis					**8,500,000**
4. Project Coordination					

Project coordinator	1 coordinator × 3 months × 1,500,000/month	Person month	3	1,500,000	4,500,000
Communication & office costs	Internet, airtime, stationery	Lump sum	1	1,000,000	1,000,000
Contingency (5%)	5% of total budget	Lump sum	1	3,385,000	3,385,000
Subtotal Project Coordination					**8,885,000**
TOTAL BUDGET					**74,765,000**

Questionnaire: Busega District PLWHIV Household Baseline Survey

Section A: Household Identification and Consent

1. **Household ID:** _____
2. **Ward / Village:** _____
3. **Date of Interview:** _____
4. **Enumerator Name / Code:** _____
5. **Consent:**
    - Household head/eligible respondent has provided informed consent

Section B: Household Demographics and Composition

1. Name of household head: _____
2. Sex of household head: [ ] Male [ ] Female [ ] Other
3. Age of household head: _____ years
4. Household members:

S/N	Name	Age	Sex	Relationship to HH Head	HIV status (Yes/No/Unknown)	ART enrolment (Yes/No)	School attendance (if <18)

5. Total household members: _____
6. Number of adults (≥18 years): _____
7. Number of children (<18 years): _____

Section C: Socio-Economic Status and Livelihood

1. Main source of household income (multiple possible):
    - Farming / Agriculture
    - Livestock keeping
    - Small business / Trade
    - Formal employment
    - Casual labor

    - Remittances / Support from relatives
    - Other (specify): _____
2. Approximate monthly household income (TZS): _____
3. Does the household own land? [ ] Yes [ ] No
    - If yes, size (acres): _____
4. Household assets (tick all that apply):

- Radio / TV
- Bicycle / Motorcycle
- Mobile phone
- Solar panel
- Livestock (specify): _____ 5.

Employment status of household head:

- Employed full-time
- Employed part-time
- Self-employed
- Unemployed

Section D: Food Security and Nutrition

1. In the past 30 days, how often did the household have enough food?
   - Always
   - Sometimes
   - Rarely
   - Never
2. Has any household member gone a whole day without eating due to lack of food in the past month? [ ] Yes [ ] No
3. Main sources of food:
   - Own farm production
   - Purchase from market
   - Food aid / support
   - Other: _____

4. Number of meals per day usually eaten by household members: _____ 5. Any household members under 5 years with malnutrition signs? [ ] Yes [ ] No

Section E: Access to HIV Treatment, Care and Support Services

1. Are there any members living with HIV in this household? [ ] Yes [ ] No

2. If yes, list ART enrolment status:

Name	On ART? (Yes/No)	ART adherence (Good/Fair/Poor)	Last viral load checked (date)

3. Distance to nearest Care & Treatment Clinic (CTC): _____ km
4. Mode of transport to clinic: [ ] Walk [ ] Bicycle [ ] Motorcycle [ ] Bus/Taxi 5. Do household members receive other HIV-related support? (Check all that apply)
    - Nutritional support / food supplements
    - Counseling / psychosocial support
    - Home-based care visits
    - Economic / livelihood support
    - Other: _____
6. Barriers to accessing services (multiple possible):
    - Distance / transport costs
    - Stigma / discrimination
    - Clinic hours inconvenient
    - Long waiting times
    - Lack of ART / medications
    - Other: _____

Section F: Health Seeking Behavior and Service Utilization

1. In the past 12 months, how often have household members sought health services?
    - Regularly (≥1 per quarter)
    - Occasionally (<1 per quarter)
    - Rarely / never
2. Do household members use preventive health services?

- HIV testing

- Family planning
- Immunizations
- Other: _____

3. Who makes health decisions in the household?
    - Head of household
    - Spouse / partner
    - Other (specify): _____

Section G: Experience of Stigma and Discrimination

1. Have any household members experienced stigma due to HIV status? [ ] Yes [ ] No
2. If yes, type of stigma:
    - From family
    - From community
    - From health providers
    - Other: _____
3. How often do household members face stigma?
    - Often
    - Sometimes
    - Rarely

Section H: Priority Needs for Socio-economic Support

1. What types of support would most help the household? (Rank top 3)
    - Income-generating activities / livelihood support
    - Food / nutritional support
    - Health care / ART access support
    - Psychosocial counseling
    - School fees / education support
    - Housing / shelter support
    - Other: _____
2. Are there household members interested in participating in skill-building or livelihood programs? [ ] Yes [ ] No

End of Household Questionnaire

Enumerator Signature: _____
Date: _____