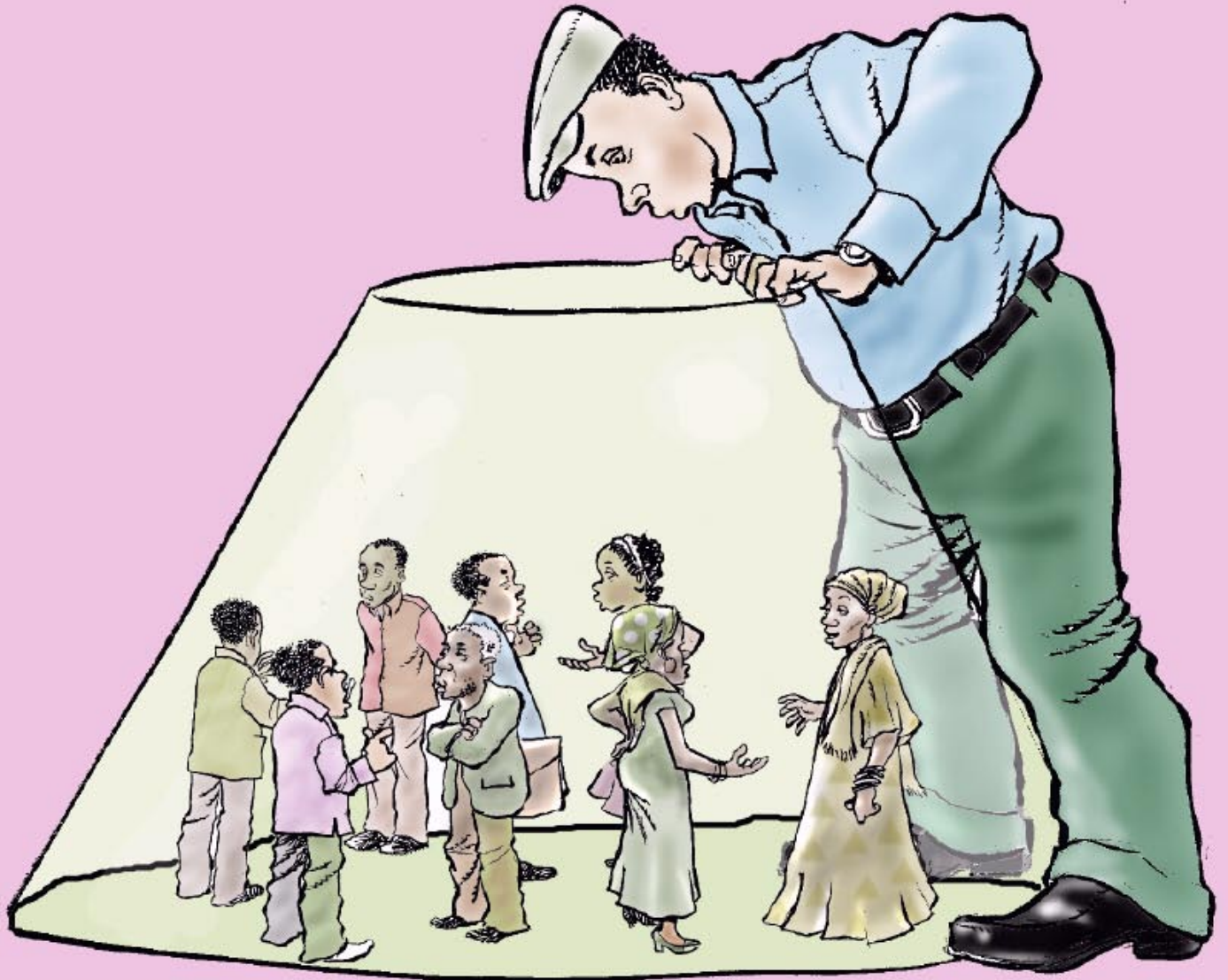


UNITED REPUBLIC OF TANZANIA



MINISTRY OF HEALTH AND SOCIAL WELFARE



REPORT OF THE SITUATIONAL ANALYSIS ON HIV / AIDS COMMUNICATION IN THE HEALTH SECTOR

APRIL 2010



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The Ministry of Health and Social Welfare through the National AIDS Control Programme (NACP), wishes to recognize and acknowledge the great support that has been received from various supporters and well wishers towards the initiation of the development of the communication strategy and hence the situational analysis process. This activity was envisaged when the idea of developing the communication strategy for HIV/AIDS response in the health sector. It was realized this process was to be preceded by a situational analysis among various stakeholders and partners in the HIV/AIDS response in the country. As such a comprehensive list of stakeholders was drawn all the way from the National level to the District level and community level. Due to limited resources – both money and time, this list was reduced to the following in order to conduct in-depth interviews and respond to formulated questionnaires.

1. Association of Journalist Against AIDS in Tanzania (AJAAT)
2. African Medical & Research Foundation (AMREF)
3. Centers for Disease Control and Prevention (CDC) Tanzania Office
4. Clinton Health Access Initiative (CHAI)
5. Counseling and Nutrition Support (COUNSENUTH) Project
6. Don Bosco Life Choices Program
7. Elizabeth Glaser Pediatric AIDS Foundation (EGPAF)
8. Family Health International (FHI)
9. FEMINA
10. (International Center for AIDS Programs (ICAP) – Tanzania
11. International Youth Foundation
12. JHPIEGO
13. John Snow Incorporation (JSI)
14. Marie Stopes Tanzania
15. Ministry of Education and Vocational Training
16. National Council for People living with HIV and AIDS (NACOPHA)
17. PATHFINDER
18. Population Services International (PSI)
19. Program for Appropriate Technology in Health (PATH)
20. Tanzania Red Cross Society
21. Service, Health & Development for People Living with HIV/AIDS (SHIDEPHA+)
22. Students Partnership Worldwide (SPW)
23. Strategic Radio Communication for Development (STRADCOM) Project
24. Tanzania Commission for AIDS (TACAIDS)
25. Tanzania Media Women Association (TAMWA)
26. Tanzania German Programme to Support Health (GTZ)
27. Tanzania Marketing and Communication (T-MARC)
28. Tanzania Youth Alliance (TAYOA)
29. Walio katika Mapambano na AIDS Tanzania (WAMATA) HQ

Apart from the above list as representatives at National level, eight regions were selected to represent all the 21 regions of Tanzania Mainland. These regions were Arusha, Dar es Salaam, Dodoma, Iringa, Kigoma, Mara, Mtwara and Shinyanga.

From all these institutions and regions, we thank all those individuals who agreed and set time to meet the team of consultants and interviewers to respond to in-depth interviews and/or fill in the questionnaires sent to them for this purpose. The Ministry of Health and Social Welfare is indeed very thankful to the team of Consultants – Prof. Eustace Mohundwa and Dr. Calista Simbakalia and their affiliated assistants - under the auspices of Health Scope Tanzania Ltd for a job well-done.

Finally and most important the Ministry is very thankful to our partners who funded this project – namely CDC Tanzania office, STRADCOM and SIDA, we believe this was done as part of our long standing collaborative relationships for which we wish to sustain.

Dr. Deo Mtasiwa
Chief Medical Officer

Ministry of Health and Social Welfare
April 2010.

ACRONYMS

AIDS	Acquire Immune Deficiency Syndrome
AMREF	African Medical Research Foundation
ARV	Antiretroviral
CHACC	Council HIV/AIDS Control Coordinator
CHAI	Clinton Health Access Initiative
CBO	Community Based Organization
CDC	Centers for Diseases Control and Prevention
CSO	Civil Society Organization
DACC	District AIDS Control Coordinator
DHS	Demographic and Health Survey
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
FHI	Family Health International
GTZ	Tanzania German Programme to Support Health
HIV:	Human Immune Deficiency Virus
IEC	Information Education and Communication
MoHSW	Ministry of Health and Social Welfare
NACP	National Aids Control Programme
NGO	Non- Governmental Organizations
PATH	Program for Appropriate Technology in Health
PLHA	People living with HIV/AIDS
PSI	Population Services International
RACC	Regional AIDS Control Coordinator
SPW	Student Partnership Worldwide
SHDEPHA	Service, Development for People Living with HIV/AIDS
STRADCOM	Strategic Radio Communication for Development
TACAIDS	Tanzania Commission for AIDS
TAHEA	Tanzania Home Economics Associations
THIS	Tanzania Health Indicator Survey
THMIS	Tanzania HIV/AIDS and Malaria Survey
T-MARC	Tanzania Marketing and Communication Company
UNDP	United Nations Development Program
USAID	United State Agency for International Development
WAMATA	Walio katika Mapambano Dhidi ya VVU/ Ukimwi Tanzania

EXECUTIVE SUMMARY

This situation analysis was conducted in eight regions which were purposefully selected to represent the five zones of Tanzania Mainland, taking into account the diversity in the prevalence of HIV in the different regions of the country, as per the THMIS 2007 - 8 survey reports.

The regions in question are

1. Arusha,
2. Dar es Salaam,
3. Dodoma,
4. Iringa,
5. Kigoma,
6. Mara,
7. Mtwara,
8. Shinyanga.

Two main methodological approaches were used. The first one was a survey of the major communication practitioners, identified as the main partners of NACP in HIV and AIDS Communication. A list of these players was compiled and a detailed self administered questionnaire was sent to them. The questionnaire sought to elicit information about their communication practice, the communication challenges they addressed in their messages and communication material, and the scope of their coverage. The questionnaire also sought information on how they selected the communication challenges to address, the process used for crafting the message and pre testing them, and the channels they used for disseminating the message; their experience with monitoring and evaluating their communication interventions. The response rate was much lower than expected, and even those who returned their filled questionnaire had skipped many questions, especially those dealing with the health sector intervention areas.

The unexpected finding is that some of these so called major communication partners of NACP did not have communication interventions within the health sector specific intervention areas.

The results from the questionnaires are presented and discussed in the second chapter. The high lights of the findings include:

Their communication interventions targeted high risk groups for HIV prevention, HIV infected adults and children, the general population, parents and influential adults and health care workers; Government officials community and traditional leaders.

Missing from the list are children and young adolescents. These need to be targeted for formation of positive attitude and behaviour. The communication interventions have not moved beyond the behaviour change paradigm to encompass behaviour formation.

The geographical coverage of their communication interventions is varied. For some it is nationwide. This means that the messages can not be tailored to address local situations. All reporting players however reported that they did pre- test their materials extensively and covered urban and rural populations as well as age groups.

Formative research was not always used to inform the identification of the communication challenges; rather most of them derived their challenges from official government documents such as the National Multisectoral Framework and the Health sector HIV and AIDS strategy. They also cited the THMIS 2007 – 8.

All welcomed the proposed communication strategy. It would guide their operations and facilitate coordination and harmonization of communication interventions of the different players.

They expressed frustration with the prevailing situation which is free for all to communicate messages. It is a situation in which conflicting messages co-exist as not all players espouse orthodoxy in HIV and AIDS, and this is confusing to the general public.

Not all did have mechanisms in place for monitoring and evaluating their communication interventions.

Fear arousal and loss – framing of messages persist but some players are beginning to use the gain – frame for crafting messages and materials.

The second approach entailed in depth interviews with key informants, chosen to represent those regarded as Frontline HIV and AIDS communication practitioners. These comprised four categories, namely clinicians, and nurses who work in HIV and AIDS Care and Treatment Clinics, Regional and District AIDS Control Coordinators, and Leaders of NGOs and CBOs who are active in the HIV and AIDS field. All these categories are involved in health communication, including patient education for the clinicians and nurses.

As with the major communication practitioners the interviews sought to elicit information about their communication practice, and the interviews covered more or less the same ground. The results of these interviews are presented and discussed in the third chapter of this report. Major findings include:

The top three intervention areas in which the frontline communication players were engaged were:

For clinicians

- Condom use
- PMTCT
- Prevention of sexual transmission of HIV

For nurses:

- PMTCT
- Preventions of HIV transmission in health care settings.
- IEC

For RACCs and DACCs:

- PMTCT
- Prevention of sexual transmission of HIV
- Prevention of HIV transmission in health care settings.

For NGOs

- Condom use
- IEC
- Home based care.

Their top three issues of concern were:

Clinicians

- Stigma reduction
- Condom use
- Prevention of new HIV infections

For Nurses.

- Preventions of new HIV infections
- Correct use of ARVs
- Condom use

For RACCs and DACCs

- Correct use of ARVs
- Involvement of men
- HIV testing

For NGOs

- Preventions of new HIV infections
- Elimination of harmful customs and traditions
- Stigma reduction

Problems and setbacks faced by the frontline communication practitioners included the following:

Clinicians

- People do not disclose their HIV status to their partners.
- Some people are not willing to accept their positive HIV test results.
- Some people do not believe that condoms provide protection against infections.
- Some patients discontinue use of ART when they regain their health on the false belief that they are cured.

Nurses

- Some people want to be tested without going through counseling.
- Some are not willing to disclose their positive HIV status to their partners.
- Some PLHAs are getting married and having children
- Some people on ART do not take their ARVs according to instructions.
- Some people rely on traditional medicine instead of getting tested and put on ART.

RACCs/DACCs

- Low capacity to produce relevant IEC materials.
- Lack of equipment and supplies, mainly transport and funds.
- Patients on ART stop taking the medicine.
- Continued opposition to condom use due to religious beliefs and misconceptions about condoms
- Persistence of the belief that AIDS is caused by witchcraft.

NGOs

- Persistence of erroneous beliefs about condoms.

- Pornographic videos continue to be shown.
- Persistence of erroneous belief that NGOs which are active in HIV/AIDS control are in it for the money.

Most of the communicators mentioned specific materials produced by the major communicators and others as having being useful to them but they reported of communication methods which were underutilized for disseminating HIV and AIDS messages:

- Traditional songs and dances,
- Videos,
- Plays,
- Group discussions and role play.

These were underutilized mainly due to financial utilized constraints.

Most did not have any formal training in health communication and indicated that they needed to be trained. Some of them indicated specifically that they needed assistance in developing communication materials of relevance to the regions/ districts; while others wanted to be enabled to develop their own communication materials. This implies dissatisfaction with the available materials.

In depth interviews were also conducted with informants who were selected for their affinity with the audiences of the communication interventions beamed to them by both the major and frontline communication practitioners. These included patients seen at HIV and AIDS Care and Treatment Clinics, Politicians and Administrators at the district, and local levels, and Religious Leaders. The thrust of the interviews was to obtain some information about what people in the communities make of the HIV and AIDS messages and materials they receive. The results are presented in the fourth chapter of this report.

The major findings include the following:

They came up with the long list of the communication messages and materials from which community members learned a great deal about HIV and AIDS, as well as organizations whose materials they found effective. They also identified materials and messages which were confusing.

They recognized and attributed many changes in their communities to the HIV/AIDS communication:

- Increased up take of the HIV testing services.
- Declining numbers of deaths.
- Declining level of stigma.
- More PLHAs were open about their status.
- Increasing rate of condom use.

Most were aware of the HIV and AIDS educators who did not practice what they say and this was of concern to them.

Many informants did not recognize the role of social, structural and vulnerability factors associated with the HIV infections of the young girls and married women, they simply blamed these women for their behaviour.

They identified factors within the health services which hinder access to these services and factors about ARVs which impede adherence with the regimen.

Most of them did not mind listening to and viewing HIV/AIDS programs jointly with their children. For some this provided an opportunity to make sure that the children paid attention and to clarify issues for them.

The final chapter collates the results from different sections and presents those against the backdrop of the four objectives which the Situation Analysis sought to realize. The objectives were:

- To obtain a data bank of information regarding communication issues on HIV/AIDS in the country from different levels, areas, and partners for the development of the HIV/AIDS communication strategy for the health sector (2008 ÷ 2012)
- To identify strengths and weaknesses in current communication activities on HIV/AIDS from different players.
- To identify information needs by various audiences.
- To document best practices in HIV/AIDS communication interventions in the country.

The ultimate objective is to obtain a comprehensive understanding of the current status of health communication within the health sector HIV/AIDS intervention areas. This is expected to inform the formulation of the Communication Strategy which will galvanize communication interventions to facilitate realization of the objectives of all activities in the health sector specific intervention areas.

The discussion of the findings is in the form of a running commentary. It is made in each chapter, and relates these findings to the communication challenges that the proposed Communication Strategy will need to address.

CHAPTER 1: BACKGROUND AND TERMS OF REFERENCE

BACKGROUND

For more than two decades the HIV/AIDS epidemic in Tanzania has continued to pose major challenges to the country's economic and human development, and has been declared a national disaster. It has relentlessly affected many people of all walks of life, decimating men and women between the ages of 20 and 49 years – the productive and reproductive segments of the population. The epidemic as it involves overtime, demands readjustments in our interventions in terms of intensity and scope, throughout the implementation process. For example, while initial interventions were primarily focused on prevention in the early years of the epidemic, the current focus is also on care, treatment and support – especially during this time of ARV availability. As such IEC activities have to ensure that none of the major orientation and focus – i.e. prevention as well as care and treatment is compromised during this period.

The epidemiological outlook of the HIV/AIDS has been observed to change overtime, from the double digits (10.6% - 12.1%) prevalence rate levels during the period (199 – 2001); to single digit (8.9 – 9.0%) prevalence rates in recent years (2004 – 2005) among blood donors (NACP Surveillance Reports 199 – 2005)

From the antenatal surveillance report we also noted that the HIV prevalence rate has also been falling as shown in figure 1 below (9.6% in 2001/02 to 8.2% in 2005/06

According to the Tanzanian HIV Indicator Survey (THIS) of 2003/2004 the HIV prevalence rate among 15 – 49 was 7 percent and has since decreased to 5.8% as reported in the recent Survey (THMIS 2007/2008)

The HIV/AIDS awareness/knowledge level also has risen from below 5.7% in the early 1990s, to over 90% in recent years in the adult population (DHS 2004). These apparent achievements are as a result of a number of interventions which have been implemented throughout this period of the epidemic by different actors in the country. The IEC activities must have a role in contributing to the increase awareness/knowledge levels.

The focused communication interventions to specific vulnerable populations undoubtedly have contributed significantly behavior change processes resulting into the reduction of the HIV prevalence rates. The government desire is to reduce the prevalence rates to decimal levels. This can only be achieved through consented efforts by all players through the Multisectoral response and especially effective communication strategies from these actors.

In the course of fighting the HIV/AIDS pandemic in Tanzania a number of partners and agencies (NGOs, CBOs and CSOs) have been involved through the Multisectoral collaborative efforts. Many of these organizations are conducting HIV/AIDS interventions through information delivery and communication activities, targeting the general public or specific population (vulnerable) groups in the country. As such the Tanzanian community is currently accessing HIV/AIDS information from a number of different sources. Occasionally some of this information demand extra services to be provided or implemented by the public sector, especially the health sector. The services demanded, many times require the government to increase its own service inputs through procurement of supplies and commodities which have been promoted through such partner services. This is the case especially when such services or commodities are just promoted but not provided by the same organizations or institutions.

It is from this understanding that the need to develop a National Communication Strategy for HIV/AIDS in the Health Sector 2008 ÷ 2012 in Tanzania Mainland was envisaged. In order to achieve the goal of having one National Communication Strategy for HIV in the Health Sector, NACP engaged two (2) consultants to lead the process of developing a National Communication Strategy in the Health Sector for Universal Access to Prevention, Care and Treatment in the country.

The process of communication strategy development had two major areas of focus:

- i) Situation analysis
- ii) Strategy development

This chapter introduces the findings of the Situational analysis, which forms the basis for the formulation of the Communication Strategy.

SITUATION ANALYSIS

In preparation for the development for the health sector communication strategy for HIV/AIDS a need for the understanding of what is on the ground in regard to HIV/AIDS information and communication was assessed. Successes and challenges in responding to the HIV/AIDS epidemic through information and communication in the country were analyzed. Assessment performed aimed at documenting who is who in HIV/AIDS response and what is/are the main objective(s) or key issues being communicated to general public or specific target audience. A situation analysis on the HIV/AIDS communication strategy was described and analyzed types of information being delivered, the source of such information, who delivers it and who is the main target audience. The exercise has also informed us on the number of the different players in HIV/AIDS communication and the most effective means of communication and channels as well as challenges or constraints being faced by these players at various levels. Information about different aspects of HIV/AIDS was collected in order to provide an overall picture of the epidemic in a given region or district. It will describe and explain what is happening and to identify factors that (Differently) drive the HIV/AIDS epidemic in the country. It will also identify and highlight the priority problems and needs of each target audience to assist future plans and accelerate HIV prevention efforts through effective communication.

Objective for the Situation Analysis

The overall goal is to establish a comprehensive picture/situation of the current status of communication activities on HIV/AIDS in the country, especially in the health sector. The information thus gathered will be used during the development of the communication strategy: The specific objectives will be as follows:

- To obtain a data bank of information regarding communication issues on HIV/AIDS in the country from different levels, areas, and partners for the

development of the HIV/AIDS communication strategy for the health sector (2008 – 2012)

- To identify strengths and weaknesses in current communication activities on HIV/AIDS from different players.
- To identify information needs by various audiences.
- To document best practices in HIV/AIDS communication interventions in the country.

Scope of Work

In order to meet critical timeframes in communication strategy development and planning, the NACP recruited a team of two consultants from HealthScope Tanzania to assist with the conducting situation analysis. Information was generated at the national level and from the regional and districts levels as well as Health HIV/AIDS partners at different levels. Sources of information will include partners working in 8 regions selected to represent the zonal areas of the country (East, West, North, South and Central zones).

The regions selected were:

1. Arusha,
2. Dar es Salaam,
3. Dodoma,
4. Iringa,
5. Kigoma,
6. Mara,
7. Mtwara,
8. Shinyanga.

Methodology for Situation Analysis

Data collection tools were developed by consultants in consultation with the NACP. Data were collected in 5 zones simultaneously.

Information/data were obtained from key informants that included:

- opinion leaders including religious leaders,

- political and administrative leaders

Identified and sent self administered questionnaires to media practitioners.

Identified and interviewed key stakeholders involved in HIV/AIDS communication activities at the regional and district and health facility levels.

This report has five chapters, including this one.

The second chapter provides findings of the analysis of the performance of the major communication partners of NACP. These are communication practitioners who besides implementing health communication interventions through the mass media nationwide, produce health communication materials for use by others in the country.

The third chapter provides findings of the analysis of the performance of frontline communication practitioners. These are communicators who deal directly with audiences in health facilities and in the community. Most of them make use of the communication materials provided by the major communication practitioners as aids to their largely interpersonal communication with their audiences.

The fourth chapter provides findings of in-depth interviews with informants who were selected because of their familiarity with community members who are the targeted audiences of the health communication of both the major and front line communication practitioners. This provides an analysis of what the audiences make of the various health communication messages and material coming their way. It is in effect an assessment of the effects of the health communication that reaches the audience.

The fifth chapter provides a synthesis of the findings of the entire study presented in accordance with the objectives of the situation analysis study.

CHAPTER 2 THE COMMUNICATION PARTNERS

Since the ultimate objective of the project was to formulate a Communication Strategy to spearhead the communication interventions designed to address the communication challenges inherent in the implementation of the health sector specific HIV and AIDS interventions it was decided to determine the current HIV and AIDS communication in order to determine the communication challenges which communicators come up against.

In this chapter we are reviewing the results from the questionnaire which was sent to 36 communication partners identified by NACP. These are the organizations and projects which currently formulate much of the communication materials which are disseminated to those involved in direct communication with audiences in the country, or whose messages are aired by the mass media that have regional or national coverage. The idea was to find out how they go about their communication activities, how they determine the communication needs to address, and the communication challenges they come up against.

As it turned out only 50 percent of the communication partners returned the questionnaires after repeated reminders. Worse still many questionnaires were not completed fully.

Communication challenges addressed and how these are identified.

The first question sought to find out the specific challenges within the intervention areas in which they worked their communication activities addressed.

Not everyone who returned questionnaire specified the communication challenges. Some of them simply listed the actual intervention areas they implemented.

The following were the communication challenges:

- Communities not accepting specific messages (102);
- Messages disseminated by other communication practitioners found to be insensitive to the cultural aspects which underlie particular high risk behaviour (104);
- Lack of or weak evaluation methods for assessing the effectiveness of messages (104);
- Lack of team work among health communication practitioners (107);
- Lack of monitoring of health communication activities at the health facility, district, regional and national level (107);
- Lack of national guidelines on health communication and standards (107);
- Promoting condom acceptance and use (1010);
- Incorrect and inconsistent condom use (1012);
- Creating dialogue between couples on family planning and condom use (1010);
- Fear of HIV testing (1012);
- Giving the right information to people (1011);
- Problems associated with cross generational communication (1013);

- Fear of disclosure (1013).

A concrete example of the communication challenge arising out of lack of team work among communication practitioners was provided by one respondent who observed that

The youth are exposed to more than one preventive measure: most of the communication messages address abstinence and faithfulness while in school, but communicators out of schools promote condom use as a preventive method (1015).

It appears that some partners addressed communication challenges arising from the activities of other communication practitioners, while others were concerned about the framework in which HIV and AIDS communication is supposed to operate, namely lack of communication guidelines and monitoring mechanisms.

Yet other partners targeted motivational issues rather than simply disseminating information. It is not enough to churn out messages that inform and educate people. It is common knowledge that those who know and possess the skills may not be engaging in the appropriate preventive or health care seeking behaviour.

Some of the obstacles may be issues of motivation or social structural. These too are communication challenges which need to be addressed.

The questionnaire sought to explore in greater detail about the nature of communication challenges and how they had been addressed in the communication activities implemented during the last three years. Questions to this end proved difficult and many skipped them.

This is unfortunate because such concrete examples would have provided a sense of what is realistic for the proposed Communication Strategy to aim at.

The population categories targeted

The youth and high risk groups were identified by most of those who returned their questionnaires as the population categories they targeted.

The youth were identified as young people of both sexes aged 10 ÷ 24, and 15 ÷ 24, or simply youth in and out of school.

The high risk groups identified were

- sex workers,
- injecting drug users,
- drug users in general,
- migrant workers,
- homosexuals

Other target groups identified were:

- couples,

- women of reproductive age,
- pregnant mothers,
- HIV infected adults,
- HIV infected children,
- TB/HIV patients,
- Employees in several institutions.

Others targeted were:

- The general population,
- parents and influential adults,
- health care workers,
- local government officials,
- community leaders,
- traditional leaders,

It is clear from this list that both primary and secondary audiences were targeted. Furthermore it is also clear that in the segmentation of the audience some were identified as targets because of their potential role for creating an enabling environment not only for preventive behaviour of others but also to facilitate their accessing services and adherence with medication.

Missing however were children and young adolescents who should be targeted for formation of positive attitudes and behaviour. There is need to move beyond the behaviour change paradigm. One study done in Tanzania about youth sexuality found that some children have their sexual debut even before attaining menarche or spermarche (Muhondwa 1999). The “playing at roles” as fathers and mothers which young children in some cultures engage in and is ignored by adults as child play, prepares the children for actual sexual behaviour starting at very young ages.

Geographical coverage of communication activities

The questionnaire sought to find out the geographical coverage of the communication interventions implemented by the organizations.

The findings indicate that the coverage of most organizations was either nationwide or Tanzania Mainland. Others had regional coverage limited to specific regions and districts:

- Five regions ÷ Iringa, Morogoro, Pwani, Dar es Salaam and Zanzibar (101);
- Two regions of Lindi and Mtwara (105),
- 26 districts of Tanzania \mainland and Zanzibar (108),
- Six regions of Kilimanjaro, Arusha, Shinyanga, Tabora, Lindi and Mtwara (1011), ,

- 17 regions of Manyara, Morogoro, Lindi, Arusha, Pwani, Mara, Mwanza, Kilimanjaro, Mbeya, Iringa, Dar es Salaam, Mtwara, Singida, Ruvuma, Kagera, Shinyanga, Tanga(1012);
- Iringa, Mafinga, Dodoma, Shinyanga, Lindi, Arusha, (1015),
- Nine regions ÷ not specified, (1016).

This broad range coverage has the inherent problem of going for the common denominator when there may be unique aspects even within different wards of the same districts. This has been brought into sharp focus by the recent THMIS where for instance Iringa has a prevalence of 15.7 per cent while Manyara has a prevalence of 1.5 per cent. For the health communication to be relevant it has to be tailored to the situations and needs of people in different locations. It is important to match the response to the local epidemiological situation.

The importance of pre-testing communication messages and materials

Given the extent geographical coverage of the materials these organizations produce, and the complaints voiced by audiences in remote areas about not understanding the messages contained in the materials, a question was posed to find out how extensively they pre-tested their messages and materials.

Most respondents indicated that they pre-tested their messages and materials extensively, covering urban and rural populations, as well as age groups. One respondent indicated that the organization has a feedback mechanism for obtaining the reactions of their readers (109).

This claim by most respondents to pre-test their materials extensively remains a thorny issue, because given the diversity of the country not only in the drivers of the epidemic but also in the proficiency with standard Kiswahili, one would have seen different versions of the materials produced made to suit specific populations in different areas.

One respondent however made an enigmatic response:

“Pre-testing of communication materials we use is always carried out by NACP or MOHSW since the materials are produced at the central level” (105).

Why the challenges addressed by communication interventions were selected

The responses indicated that the organizations used different approaches to select the communication challenges they addressed in their communication interventions. These included:

- Challenges derived from base line.
- Challenges selected because they seem to hinder realization of the goals of the project.
- Deduced from the observation about the pattern of condom use in relationships.
- Identified by stake holders, including NACP.
- Challenges are based on research data collected from a variety of sources.

It is gratifying that most organizations selected the challenges they addressed in an acceptable manner, namely some objective indication of communication needs. It is of some concern that a few organizations that submitted the filled questionnaire did not respond to this question or made some indeterminate responses such as

“We look for what will bring change in for example stigma reduction HBC” (102);

“It is important to address the real information needs which also contribute to meeting our MDGs (104);

“To increase knowledge of HIV Care and ART in the population, increase demand of ART services, maximize adherence to care and treatment, etc. (106).

What are listed in this case are goals to which communication seeks to contribute; they are not even communication objectives or communication challenges. No information is given on how these were selected.

The role played by the Health Sector HIV/AIDS Strategic Plan in communication activities.

Since what is proposed is a communication strategy to facilitate communication in the implementation of Health Sector specific interventions, and the Health Sector does have a strategic plan, respondents were asked to indicate whether the strategy has played any part in informing the selection of the communication challenges which their communication activities address.

Most of the organizations which sent in their filled questionnaire indicated that the Health Sector HIV/AIDS Strategic Plan guides their communication activities. Only one organization did not respond to the question.

The responses were varied but the following were typical:

It provides overall guidance and priorities.

It provides us with the national vision and ensures that our interventions are in line with national policy.

It plays a big role in our strategic plan.

Other Government documents used in formulating communication interventions

Respondents were asked to indicate other government documents they have used in formulating the communication activities besides the Health Sector HIV/AIDS Strategic Plan.

A range of documents were given. These documents include:

The National Multisectoral Strategic Framework;

The National HIV and AIDS Communication and Advocacy Strategy;

National Guidelines for Care and Treatment;

National Guidelines for PMTCT;
National Guidelines for HCT;
TB infection control guidelines;
Drug control Commission Strategy;
Zanzibar Kick Start Plan and HIV prevention among IDUs
Tanzania HIV Indicator Survey 2003 ÷ 2004;
Tanzania HIV and Malaria Indicator Survey 2007 ÷ 2008;
The Adolescent and Health Development Strategy.

The anticipated role of the proposed Health Sector HIV/AIDS Communication Strategy.

Tanzania has numerous guidelines some of which were cited in response to the previous question. All of these do indicate areas in which communication is needed. Furthermore there is already the TACAIDS Communication and Advocacy Strategy. The question sought to elicit the ideas of these organizations which are very active in HIV and AIDS communication about the added value which the proposed HIV Sector communication strategy might have in their communication activities.

The responses were very informative. They included:

- It will act as a guide and will facilitate coordination/harmonization of communication interventions among stakeholders;
- It will provide guidance on how to target BCC activities to target groups;
- It will identify communication gaps in the health sector;
- It will ensure that guidelines and policies are followed;
- To reinforce the message use within the community;
- It will support and approve the communication activities being implemented;
- It will enable stakeholders to leverage resources by not having different partners sending the same information in different forms;
- It will facilitate adoption a brand for Care and Treatment services akin to the *Nyota ya Kijani* in family planning.

One respondent felt however that

The communication strategy would have to be distributed to all partners and stakeholders to be discussed and check the specific role needed to play (1015).

It is noteworthy that two respondents felt that

The communication strategy will be easy to disseminate in public and will be legal (102).

It will support and approve the communication message that goes out to the community (108).

At least in these two cases one senses a feeling of frustration with the current situation which seems to be free for all to communicate what ever their ideological position dictates regardless of its opposition to the scientific evidence that informs communication in the field of HIV and AIDS. Such people and organizations are allowed to get away with it regardless of the confusion they create among the people,

some of whom are at risk for HIV infection or stand to gain by accessing the available services.

Much as these concerns may be shared by many stakeholders, including members of the audience, as Chapter 4 shows, this may not be a realistic expectation of the role which the proposed communication strategy can play. It is a cry for policy and legal responses by the Government, which would be difficult to enact and enforce given the prevailing democratic governance and liberal dispensation.

If anything, this situation provides a communication challenge to enable the common man to understand how his or her own true interests are best served and to act accordingly, even if doing so may be going against the cultural norms or religious doctrines. It is exactly in the same way that believers of some faiths are able to go against what they are taught and are able to access family planning services, including using condoms. It is also an advocacy challenge to enable the custodians of religious faiths to interpret specific teachings widely, as has happened in Muslim Indonesia. Indeed the Tanzania Family Planning Services did at one time send some Muslim Clerics to Indonesia on a study tour which had a positive impact on family planning acceptance by Muslims (Simbakalia, C. personal communication).

It should be pointed out that two organizations did not respond to the questions. Both organizations did indicate that they had used the Health Sector HIV/AIDS Strategic Plan, and the TACAIDS Communication and Advocacy Strategy. **Their silence may indicate a feeling of uncertainty of the proposed communication strategy having any added value.**

The role of formative research in determining communication needs and communication objectives.

Health communication is based on solid medical, epidemiological and behavioural evidence, and hence the need for it to be informed by formative research. But there are numerous examples where health communication is not based on such foundation, and this makes evaluation of such communication activities tenuous. Respondents were asked questions meant to gauge their commitment to the procedure that requires one to proceed with communication intervention based on formative research findings. One was whether a good literature review can be a substitute for formative research and the other was whether familiarity with the lives and problems of the audience can be a substitute for formative research.

Some agreed with the proposition that a good literature review can be a substitute for formative research. It is gratifying that the large majority did not.

Those who thought that literature review would be a substitute had this to say:

“strongly agree with the statement because with the bulk of the information we have, we could carry out a situational analysis using reports, studies, literature

and determine the communication needs which require our urgent attention” (104);

“Yes I do believe. Take an example of when we developed our communication materials we did a lot of refractive (sic) reviews. We used AYA, FHI, SPW books and many others. The Ministry of Education HIV/AIDS curriculum was also used. Ultimately we came up with our documents (108);

“Yes, I do believe in good literature review. It can be a substitute for formative research. This is because from the literature review one can obtain information on knowledge, attitudes and behavior of the target population to whom you want to design (sic) their communication needs, behaviors and habits” (105).

One respondent was non-committal and stated simply that:

“It depends on what is in the literature review” (1013).

The pro-formative research expressed the views in the following manner:

“Literature review can be used as an addition to formative research. Different time, environment, age groups, geographical (sic), social economical status vary and affect people’s way of understanding, and therefore one cannot always rely on literature review alone” (106);

“Formative assessment is critical in understanding your audience’s state as regards knowledge, attitudes, practices and behaviors. This should not be substituted with literature review which only provides partial information as a guide but the formative assessment is able to have more qualitative information” (1014);

“I would say formative research is more informative and cannot be substituted by desk reviews. Formative research gives you the current needs whereas desk reviews can have information from other non-targeted groups” (1010);

“A literature review may provide a feel of what the issues are. To do so it needs to be up to date, current and context specific. The situation on the ground is dynamic. It is not easy to substitute the real situation with dated information. Ideally formative research should always be conducted to help define communication needs and objectives” (101).

The question about familiarity with the target audience also elicited mixed responses. Typical responses from those who thought that familiarity with the audience could be a substitute for formative research included the following:

“True, any communication material should carry the messages which are very deep on familiarity of the community taking into consideration the community needs” (1015)

Agreed because each one has a way of conceptualizing the message” (102).

Typical pro-formative research views were expressed as follows:

“Familiarity is not sufficient in message development and ideally, should be accompanied by formative research and pre testing with the intended beneficiaries and key stakeholders. (101);

“It is difficult to determine what one needs without asking what their needs are” (1018);

“Familiarity is not wholesome by itself. One needs to assess the acceptability of the intervention and what the recipient wants” (103).

As usual there were a few organizations which skipped these two questions.

What one usually comes across are rationalizations of having to cut corners largely due to lack of adequate resources or time to go through all the steps. The health services are replete with interventions which lack base line data. None of this however was voiced by those who accepted literature review and familiarity with the target population as substitutes for formative research

It is also the case that one does not necessarily have to conduct one’s own formative research if current information obtained by acceptable methods is available pertaining to the situation of the intended target population.

Specific arrangements to keep messages and materials salient and attractive over time

One often comes across tattered posters and faded billboards which have been standing for a long time. There are also cases of display material that no longer attract the attention of people.



This kind of permanent display of eclectic posters on the wall in a health facility may be ornamental rather than educational.

The questionnaire sought to elicit information on how the organizations which are active in health communication keep their messages and materials salient and attractive over time.



A bill board which has seen better times



A mural whose identification is no longer legible.

The responses obtained were varied. Some claimed to

“use few words, attractive pictures which are self explanatory” (1010),

“use humor, music and drama and other entertainment elements to help us reach our behavior change objectives” (1013),

“revise materials, messages, and visuals periodically” (101),

“monitor their placement” (103),

“review regularly with target audience” (1010),

“update materials with time and to clean bill boards” (1012),

“work with experienced graphic design organizations and advertising agencies and testing materials for resonance with audiences” (1014).

Communication materials in such a fast changing field as HIV and AIDS have a limited shelf life. What may have been orthodoxy a few years ago is no longer valid today. It challenges everybody in the field, especially communication practitioners whose activities have to change in tandem with the medical science and epidemiology of the disease, as well as new understanding of the behavioural patterns which influence the epidemiology of the disease. A case in point is the behaviour which predisposes couples to discordance of HIV status where the woman may be the infected partner (de Walque, D. 2006, Lingappa, JR et al 2008), and the realization that many heterosexual liaisons involve anal sex which may increase the susceptibility of the woman for HIV infection (Carter, M. Grijsen, MA. 2008). The same can be said about the role of multiple and concurrent sexual partnerships involving older men in explaining the increased risk of HIV infection for adolescent girls (Hope, R. 2007, Luke, N. & Kurz, KM. 2002). It is worth noting that the

scientific evidence for the efficacy of some traditional healers' medicine in boosting immunity and not just treating opportunistic infections is growing. Communication practitioners have to keep abreast with this development especially in the context where some traditional healers advertise almost magical cures for AIDS.



This bill board conveys a misleading message. The effectiveness of condoms depends on how it is used; condoms do not provide complete protection to the users automatically.

Communication materials dealing with culturally sensitive issues of sexuality and sexual behaviour

In Tanzania and other sub Saharan countries, the sexual mode of HIV transmission remains predominant. Communication practitioners have to walk the tight rope in broaching their messages to deal with the associated factors without offending cultural sensitivities and risking censorship. The questionnaire sought to elicit information about how the organizations get around the censorship of the moral guardians when they have to deal with this subject. Perhaps the fate of the ISHI campaign whose electronic messages and materials provoked Parliamentarians to voice disapproval leading to their withdrawal was outstanding because it was publicly expressed, and the effects were almost instantaneous as the slogans which had become popular became anathema (Muhondwa & Kamazima 2005).

The responses were varied and informative. One respondent claimed that
“they normally work with gate keepers from the word go” 10101).

Another one claimed that

“it is very difficult to do so. Humor, cartoons, allegories and music help” (1013).

One other respondent wrote:

“Use the right words, right time and right channels. People are changing. Continuous communication will reduce cultural sensitivity. People will understand and message will become common to the society” (1010).

For most respondent three methods were the safety mechanisms: extensive pre-testing of the messages and materials, developing messages and materials using the participatory approach, and getting the messages vetted by the Ministry of Health or local authorities before placement.

Much as concern is for the limitations which cultural sensitivity imposes on expression by health communication practitioners it is also incumbent upon the health communication practitioners to acquire intercultural communication competency so that they can communicate without offence. This rests on an appreciation of the world views of other cultures. There is rationality even in the most bizarre beliefs and practices of strange cultures. And much more to the point, although the communication principle when addressing young people is to use their own language and metaphors, the fact that such messages and material are also accessible by their guardians it is important to target the guardians and moral custodians so that they understand what is going on.

Evaluation of the communication interventions implemented

The questionnaire sought to establish whether evaluation of the communication intervention was always done.

Most of the respondents replied in the affirmative. One did not respond to the question while another one made a rather long winded response, to the effect that:

“this is a big challenge for the project. In our interpersonal communication we try to conduct pre- and post-test surveys to gauge learning, but this is often a challenge to administer and quality is variable. We also try to solicit feedback from participants of our community outreach, but this is not consistent, because of the limited capacity of our implementing partners” (101).

There is no doubt that the HIV/AIDS epidemic has been a disaster, but there are many ways in which it has been a blessing in disguise. One impact for the health services have been the realization that the response to the epidemic cannot be in the usual manner that the business of health care is conducted. It has brought into sharp focus issues of ethics and human rights, and the need for evidence of the efficacy and effectiveness of interventions implemented and services provided. No wonder one finds almost unanimity among HIV/AIDS communication practitioners not only for the need for formative research and pre-testing, but also for evaluation.

Lasting impact of communication interventions

One of the questions required the communication practitioners to identify what they considered to have been lasting impacts of their communication interventions. The responses obtained were varied and informative. **What seems to be lacking is the appreciation that the impact of HIV/AIDS information, education and communication is optimal when it is part and parcel of a package of interventions rather than as a stand alone intervention.**

With the exception of four respondents who chose not to answer the question, and another one who claimed to have added a new word for cross generational sex accompanied by interventions to stop cross generational sex, most respondents claimed specific outcomes:

- Increased enrolment to care and treatment services;
- Increased uptake of HIV testing;
- Increased knowledge and adoption of positive attitudes and behaviours;
- Breaking the silence regarding youth sexuality and vulnerability;
- Increased number of VCT clients;
- Increased number of youths seeking information;
- Increased number of condoms distributed;
- Increased adherence to ART medication;
- Decrease numbers of STD cases and teenage pregnancy;
- Decrease of drug use.

It is doubtful that such impacts can be attributed to health communication alone. It is imperative that health communication practitioners become realistic about what can be achieved by health communication alone, and the role health communication can play when it is an integrated component of a package of health interventions within the health sector HIV and AIDS response.

Communication activities in the health sector intervention areas

The questionnaire asked respondents to reflect on the communication activities of their organizations in the health sector specific interventions of Care and \treatment, Counseling and Testing, PMTCT, Prevention and Treatment of STIs, Home Based Care and Condom use and to indicate communication or advocacy issues the organization may not have been able to address, and why.

A most significant finding is that even though all the organizations to which the questionnaire was sent had been identified by NACP as partners believed to be active in communication in the health sector specific intervention areas. This belief was not borne out by the responses. In the first place even though the request to complete the questionnaire was accompanied by a letter from NACP explaining the purpose of the study less than half of the organizations did not complete the questionnaire. Secondly half of the organizations which returned their filled questionnaires did not give any response on the Care and Treatment, Counseling and Testing. About two thirds did not give any

response on STIs. Even the intervention area of Condom use was not responded to by 44 per cent, while a fifth of those who returned completed questionnaires simply indicated that there was still too much stigma attached to condoms.

One can only surmise that many of these organizations were active in the other components of the multisectoral response, and not the health sector specific response.

The few who did respond to the question made some interesting observations:

On care and treatment

One respondent wrote that the national ART curriculum did not cover provision of adolescent friendly services and child disclosure counseling and therefore these were the issues which the organization had not been able to take up in their communication activities.

Another respondent mentioned stigma and discrimination, adherence to ART, and early infant diagnosis. It is not clear why these communication issues were not taken up.

A third respondent mentioned low knowledge among members of the community on the eligibility for ART. It is not clear why the organization could not address this communication issue.

Counseling and testing

Issues not taken up included

- The youth not willing to test in health facilities within their own communities because of concerns about confidentiality;
- Resistance to couple counseling;
- The age at which children can give consent for testing believed to be 18 years;
- Disclosure and partner notification;
- Disclosure among discordant partners;
- Inadequate counseling skills for disclosure on the part of health care providers;
- Lack of counseling and testing facilities.

Some of these issues are communication issues, but it was not made clear why they were not taken up, while others seem to be problem areas that communication might contribute to their resolution, but it not clear why the reporting organizations felt unable to address them.

PMTCT

Only five responding organization reported on this intervention area:

- Lack of guidelines on child counseling and testing;

Lack of male involvement in PMTCT services partly because RCH clinics are not male friendly;

Role of traditional birth attendants;

“We have not worked on exclusive breast feeding because we don't get clients who opt for this”

“We have not been able to advocate for the issue of PMTCT with policy makers such as MPs, RCs, etc but expect to do this in partnership with other organizations.”

STIs

Only four respondents reported on this, but only one gave a relevant response:

“We have not been able to address this area because of lack of experts in this area who can lead us professionally” (109).

Another one simply outlined a communication issue and did not indicate why they had not addressed it:

“Lack of privacy due to limited rooms, judgmental attitudes, and poor confidentiality among providers, leading to self medication” (101).

Home Based Care

Only four responding organizations took this up.

One reported that they provide the service, and that it is done by qualified personnel, another wrote that some community members still believe that AIDS is caused by witchcraft, while the third wrote that they address it at a small scale because it is hard to identify the needs of the community.

The fourth one gave what appears like a homily:

“Home based care is simply an approach to deliver certain care services. It is unclear to us whether there is standardization and whether services also contain PAIN MANAGEMENT, particularly ORAL MORPHINE for chronic patients. There is a huge challenge with patients who need pain management to access ORAL MORPHINE” (1013).

Condom use

It is surprising that even for an issue which almost every sector has a role, many had nothing to say, and only two wrote that they distribute condoms, and that it is well covered. The few that made observations wrote the following:

“These are not promoted enough. There is still too much stigma attached to condoms” (1013);

“Condom use among married couples and fiancés” (106);

“Not well enough addressed for PLWHIV population” (106);

“Development of comprehensive knowledge on condom history, condom use and condom effectiveness. Always addressing condoms in a dual perspective – for family planning and for protection against STIs and HIV” (104);

“Condom education for older youths (15 – 24 years) in and out of school is a challenge. Though most initiate sex during this period, there is total resistance to condom education because of the moral view that it amounts to licensing premarital sex and misconception that it hastens sexual debut” (101).

It is clear that embedded in most of the factors mentioned by the responding organizations about all the intervention areas are communication challenges. That these were not made explicit and reasons as to why they were not addressed given, constitute a challenge for the proposed communication strategy. Communication practitioners should be able to identify the challenges which they have to address so as to facilitate effective implementation of these interventions by their colleagues who have the medical, nursing, and pharmaceutical skills to provide direct personal health services do so effectively.

Need for multi media and media mix in health communication

Respondents were asked to reflect on their own communication practice to determine if they could have used other communication channels, and why some media are underutilized.

Among those who submitted their questionnaires only two skipped the question. From the responses made the following appear to be the underutilized methods and media:

- The ‘tabloid’ mass media;
- Community theatre;
- Interpersonal communication in the form of patient education, counseling, and home visits;
- Mobile phones;
- Photo novella;
- Radio and TV spots;
- The internet – blogs, websites, on line publications;
- Story telling;
- Traditional dance groups
- Child-to-child, child – parent communication;
- Local events organized at ward and village levels;
- Road shows;
- Use of community based health workers;
- Transit media – bus and truck painting.

One responding organization called for
“investing in training musicians about HIV/AIDS and for them to use the opportunities they have” (1013).

It is a very informative array of underutilized communication methods and media. It is a challenge for the proposed communication strategy to advocate for the use of these and to stimulate capacity building for their effective use.

Persistence of fear arousal and loss framed messages

The following were identified as the drawbacks of such approaches in HIV/AIDS communication:

Most people are not touched by the messages;
The messages do not reflect people's needs;
They create difficulties for behavior change;
Sometimes they lead to misuse of resources;
They lead to increased fear and denial.

One respondent however still saw a role for fear arousal of messages:

“There are some conditions/contexts in which they can be used, such as during the outbreak of rift valley fever. Many people avoided eating meat and drinking milk” (107).

Examples of gain framed messages and material

Organizations were invited to share their own messages framed in the positive approaches. A few did so though they did not send in samples of such materials:

- *“Si Mchezo, Fema, ABC mpaka Z poster, Chagua Maisha. These promote healthy lifestyles for young people and provide non-threatening information/message about HIV and AIDS, STIs, pregnancy, gender issues” (101);*
- *“Angaza had three phases communication strategy all aimed to address “fear” and benefits. The final one “fanya uamuzi sahihi” was very popular some of tested youth showed the benefits gained after testing and knowing the results.” (103);*
- *“Kama kweli unampenda utamlinda, badili tabia” (1010l);*
- *“Club ya mashujaa” (1012).*

Constraints in implementing communication interventions

Organizations were asked to indicate the kinds of constraints they face in carrying out their communication activities. Those who did so mentioned a wide range of constraints.

- The infrastructure to support implementation of some of the messages we disseminate is weak or does not yet exist e.g. services for injecting drug users, and services for survivors of gender – based violence;
- It is a lengthy and expensive to process and develop quality communication packages;
- Shortage of funds;

- Shortage of print media;
- Demand for materials outstrips our ability to supply;
- Over reliance on print material like posters and leaflets;
- Lack of monitoring and evaluation tools of IEC materials;
- Shortage of current documentaries on HIV/AIDS;
- Too much censorship, making materials lack clarity;
- Language barrier, especially in rural areas, necessitating translation of materials into local languages;

Of particular interest are the constraints faced by those who tend to implement their communication interventions as a stand alone intervention. They end up being frustrated because the demand they create for services cannot be met. This arises because the services are not yet there. Had their communication intervention been part of a package they would not have created demand for non-existent services. If anything their communication intervention would have addressed the health authorities in order to establish such services, which are obviously urgently needed by the affected people or those at risk. As some advocacy activists and lobbyists have found out it is counterproductive to invite the guests in when the room is not ready.

Producing attractive communication material which have the potential for being effective, because they have been through the lengthy cycle is expensive. This is a challenge which the proposed communication strategy will have to address. The answer may lie in what one respondent to an earlier question suggested: closer partnership among communication practitioners to avoid duplication and to exploit the comparative advantages which each partner may have, even in the issue of resource mobilization.

Forms of assistance needed

The organizations were asked to indicate the forms of assistance they needed in order to be more effective in what they do.

The following are some of their needs

- The National AIDS programs and the international organization who support it should collaborate with the private sector;
- Technical assistance from the Government;
- Reinforcement of the BCC Technical Working Group to be able to provide support to communication practitioners;
- Additional resources;
- NACP and TACAIDS to hold communication updates;
- Expedite the process of getting permission;
- Make drama and documentaries on HIV/AIDS available;
- Provide institutional capacity support for producing communication materials;

- Official circular showing the needs for communication practitioners to collaborate;

As with the list of constraints here is a list of activities that the proposed communication strategy will advocate for their implementation. This will make the communication practitioner more prolific in producing communication material and in producing materials that have great potential for pushing forward the health sector specific mandate within the multisectoral response to HIV and AIDS.

Need for indirect communication to create a supportive environment

The bulk of communication interventions appear to target people with a view to enabling them to change behaviour and less on indirect communication for creating a supportive environment that would make behaviour change easier. Organizations were asked to give examples of their own communication materials which have had this objective of creating a supportive environment. Just as with gain framed messages and material a number of examples were given. These include:

- Ujamaa's curriculum based education intervention assist beneficiaries to acquire skills;
- The Daraja initiative seek to facilitate parent-child communication;
- Establishment of 'Connect and Learn' centres in Tanga;
- Sensitization meetings precede distribution of IEC material in communities;
- Growth and Change seek to build skills among young girls;
- Maisha bora na Kinga dhidi ya UKIMWI;
- Marie Stopes works concurrently in service provision and behaviour change promotion;
- Wahapahapa weekly radio serial drama;
- Peer education intervention by T-MARC as well as making sure about condoms being available and accessible;

As samples of the materials were not provided let alone evaluation reports of these materials it is not possible to vouch for their potential for creating supportive environments or for their potential for imparting skills. If anything they attest to the need to look at this side of the communication coin.

CHAPTER 3 FRONTLINE COMMUNICATION PRACTITIONERS

The Health Sector HIV and AIDS Strategic Plan (HSHSP) 2008 – 2012 identifies nine intervention areas and delineates challenge in each area.

Health communication interventions implemented and communication challenges addressed

Health sector HIV and AIDS interventions were listed and the respondents were asked to indicate the intervention they implemented and the communication challenges they addressed.

There were major differences among the four categories of communication practitioners in the ranks they accorded to the different interventions – the rank order was computed on the basis of the number of times each intervention was mentioned by the members in each category.

The ranking system takes into account multiple responses an individual can make. Convergence and divergence among the Rank Orders of each intervention across the categories of communicators indicate similarity or differences in the appraisal of the intervention by the categories of communicators.

Table 3.1. Rank Order of the intervention accorded by each category of front line communicators

INTERVENTION	CLINICIANS	NURSES	RACCS/DACCS	NGOs
1.PMTCT	2	1	1	6
2. Prevention of sexual transmission of HIV	3	8	2	4
3. Prevention of HIV transmission in health care settings	5	2	3	7
4.Care and Treatment	7	4	7	8
5. Home Based Care	9	7	9	3
6. Laboratory Services	8	9	4	9
7.Counseling and Testing	6	5	8	5
8. IEC	4	3	5	2
9. Promoting Condom Use	1	6	6	1

It is clear from this table that clinicians tended to be preoccupied with issues of condom use - and condom promotion. They ranked the intervention as number 1, followed by

prevention of HIV transmission from mother to children - ranked as number 2, and prevention of sexual transmission of HIV was ranked third.

Nurses on the other hand had PMTCT as number 1 followed by prevention of HIV transmission in health care settings came second. Interestingly HIV testing and counseling came up as the third top most areas of their preoccupation.

The study found that even though RACCs and DACCs have the overall role of coordinating HIV and AIDS control activities in the region and district respectively they often provided direct services to patients/clients. They indicated PMTC, prevention of sexual transmission of HIV and prevention of transmission in health care settings as the top most intervention areas in which they worked.

A number of NGOs have sprung up and are active in HIV and AIDS control. Even though many of the NGOs are involved in the multi-sectoral response the NGOs which were covered by this study were also asked to indicate the health sector specific intervention areas in which they operated. Not surprisingly they indicated promotion of condom use, IEC, followed by Home Based Care as the three top most intervention areas in which they are involved. It would be interesting to know what NGOs communicated under the intervention area of IEC. The question, however, listed the Health Sector specific intervention areas and asked them simply to indicated the ones they implemented

It is also informative to look at the bottom three intervention areas of the operation of the four categories of frontline communicators.

For clinicians these were Home Based Care, laboratory services, and rather surprisingly because the clinicians we interviewed were working in CTC, health facility based care and treatment.

For nurses these were laboratory services, prevention of sexual transmission of HIV and Home Based Care.

For RACCS and DACCS these were Home Based Care, HIV counseling and testing, and finally care and treatment.

Communication challenges faced by frontline communication practitioners

Respondents were asked to indicate what they found to be the communication challenges in the intervention areas in which they worked. This proved to be a difficult thing for them to do. Lengthy explanations had to be given, and even then some of the responses given were not true communication challenges. They were mainly issues about which these respondents were concerned, and these encompassed communication as well as non-communication issues.

This is an area for which much work needs to be done. It is not easy to come up with a communication strategy when there is no clarity about the communication issues and challenges which communicators are confronted with and need to overcome.

Be that as it may, the issues of concerns expressed by the four categories of Frontline Communication Practitioners, arranged in ascending order of the ranking were as follows:

Table 3:2. Issues of concern expressed by each category of Frontline Communicators

Rank Order	Clinicians	Nurses	RACCS/DACCS	NGOs
1	Stigma reduction	Prevention of new infections	Correct use of ART	Prevention of new infections
2	Condom use	Correct use of ART	Involvement of men	Harmful customs and traditions
3	Prevention of new infections	Condom use	HIV testing	Stigma reduction
4	Correct use of ART	Disclosure of HIV status to partners	Disclosure of HIV status to partners	Condom use
5	Harmful customs and traditions	-	-	-
6	Reduction of MTCT	-	-	-
7	Disclosure of HIV status to partners	-	-	-

No one issue was common to all the four categories of communicators. The issue of condom use was raised by three groups: clinicians, nurses, and NGOs. These three groups also mentioned the issue of prevention of new infections.

Preventing new infections requires that one knows where these infections are coming from, and who is at risk of getting infected. In effect it is knowledge of the drivers of the epidemic in each location. Front line communicators need to have this knowledge so that their HIV/AIDS communication interventions can be targeted appropriately. It is noteworthy that among the health professionals, namely clinicians, nurses and RACCs/DACCs the concern for prevention of new infections was coupled with that for disclosure of HIV status to partners, and, with the exception of RACCs/DACCs, for condom use. Given the high rate of discordant couples in Tanzania, where at least two thirds of infected couples are discordant (de Walque 2006), and HIV discordant couples represent an important target group for HIV prevention (Lingappa et. al. (2008). This is because HIV transmission is high in couples that do not use condoms, do not know their own HIV status or that of their partners, and those who know that they are infected but do not disclose their HIV status to their partners. In this context it is right and proper for these frontline

health communication practitioners to be concerned about the three issues, and to address these issues in their messages. It is gratifying that among the communication achievements reported by clinicians (Table 3.3 below) are that HIV positive women have managed to get their partners to go for HIV testing, and that Couples are going together for HIV testing.

For clinicians and nurses whose clients may not be willing to disclose their HIV status to their partners, presumably out of fear of the negative outcomes of such disclosure (Maman, et. al. 2001), they need to find support mechanisms for them to do so, but also to warn them that not disclosing their status and continuing to have unprotected sex with their partners has ethical and legal implications since the partners constitute identifiable third parties that clinicians and nurses have ethical and legal obligation to inform them about their real risk for infection if they are not already infected, and to protect them from getting infected by their partners.

Another issue which was raised by three groups was correct use of ART. The issue of harmful customs and traditions was raised by two groups, as was the issue of stigma reduction.

Exactly what the communication challenges associated with these issues are were not stated. And some of these issues require other forms of intervention besides communication. The issue of harmful customs and traditions is a matter of cultural change which is mediated by many factors including legislation and law enforcement, and not just communication.

It is interesting that some of the things they said do give some hints about the communication challenges. For instance one of the respondents said about condom use that:

“Watu wanataka kujua kama kondomu ni kinga, mbona bado maambukizi hayapungui hali kondomu zinatumika sana?”
“People want to know if condoms do provide protection: Why is it that HIV infections are not declining while condoms are being used very much?”

For communicators the communication challenge is how to explain about correct and consistent condom use in all risky sexual encounters – defined as having unprotected sex with partners of unknown HIV infection status, and to eroticize condom use. Eroticizing condom use has not been given the significance it deserves given the constant refrain of how condoms impedes sexual pleasure and satisfaction as the reason for not using condoms. This would be gain framing of condom use messages.

Communication achievements realized

Respondents were asked to indicate what they considered to be their communication achievements during the past three years, and to identify the results which had given them great satisfaction.

Table 3.3. Communication achievements realized during the past three years identified by the four categories of health communicators

S/N	Clinicians	Nurses	RACCs/DACCs	NGOs
1	HIV positive women have managed to get their partners to go for HIV testing.	More mothers have enrolled for PMTCT services	Reduction of new infections	PLHAs have become open about their HIV status.
2	Couples are going together for HIV testing.	Many patients are on ART	Increased uptake of counseling and testing services.	Increased uptake of counseling and testing services.
3	Harmful customs and traditions are losing their grip.	Patients on ART have got better	Reduction of deaths due to opportunistic infections	Increased uptake of ART.
4	People ask for condoms	Those on ART continue to live in apparent good health		People on ART are in good health.
5	The health of people on ART has improved	There is less stigma		Stigma reduced.
6				Increased condom use

One nurse expressed the communication achievement of getting patients to use ART correctly as follows:

“Kuna mama mmoja alikuja amechoka kabisa. Tukamtibu. Leo hii anakuja na baiskeli na amelea wateja wengi sana. Hii inaonyesha jinsi elimu yetu inavyoleta mabadiliko kwenye jamii”

“One woman came in a very bad condition. We treated her. These days she rides a bicycle to come to the clinic and has managed to motivate many people to come to the clinic. This shows how our education can bring changes in the community”.

One RACC however was noncommittal about the communication achievement. He said:

“Siwezi kuwa na uhakika kuwa ni shughuli zetu za mawasiliano zilizoleta mabadiliko”

“I cannot be certain that it is our communication activities which have brought about the changes”.

With regards to the increased uptake of counseling and testing one DACC described it as “an epidemic of testing”: “mipuko wa upimaji”.

With regard to the willingness of PLHAs to be open about their HIV status one member of the NGO group had this to say:-

“Waathirika wamekuwa tayari kuhamasisha jamii na kutumika kama mfano”
“PLHAs are ready to motivate community members and to serve as models”

It is a moot point whether all these outcomes can be attributed to communication alone. The specific case of what the DACC termed an epidemic of testing is associated with the Voluntary Counseling and Testing Campaign which was launched by President Jakaya Kikwete. The response to the campaign was a subject of two interrelated investigations [Muhondwa (2008), Muhondwa, Mosha and Makwaya (2008)]. Many factors were found to have contributed to the population response to the campaign. These included specific measures made by local health and administrative authorities to set up more testing sites and to extend the hours of operation. Many people went along because it was very convenient to do so, and to join others.

Problems and setbacks encountered during implementation of communication interventions

Respondents were also asked about the problems and setbacks they had encountered as they implemented their communication interventions.

A number of issues were raised by each category of frontline communication practitioners. There was much overlap in the problems identified by the different groups as the following table shows.

Table 3.4. Set backs in implementing health communication interventions identified by the four groups of front line health communication practitioners.

S/N	Clinicians	Nurses	RACCs/DACCs	NGOs
1	People do not disclose their HIV status to their partners.	Some people want to be tested without going through counseling.	Low capacity to produce relevant IEC materials.	Secular NGOs and the Government continue to promote condom use.
2	Some people are not willing to accept their positive HIV test results.	Some are not willing to disclose their positive HIV status to their partners.	Lack of equipment and supplies, mainly transport and funds.	Not enough condoms to meet the demand.
3	Some people do not believe that condoms provide protection against infections.	Some PLHAs are getting married and having children	Patients on ART stop taking the medicine.	Persistence of erroneous beliefs about condoms.
4	Some patients discontinue use of ART when they regain their health on the false belief that they are cured.	Some people on ART do not take their ARVs according to instructions.	Continued opposition to condom use due to religious beliefs and misconceptions about condoms	Medicines for STIs are no longer provided freely.
5		Some people rely on traditional medicine instead of getting	Persistence of the belief that AIDS is caused by witchcraft.	Pornographic videos continue to be shown.

		tested and put on ART.		
6				Persistence of erroneous belief that NGOs which are active in HIV/AIDS control are in it for the money.

One clinician made the following observation:

“Tunapata shida kuelezea kuhusu kondom kwa vijana kwa sababu wazee wanasema kuwa tunahamasisha ngono kwa watoto wao”

“We have problems explaining condom use to the youth because the elders think that by doing this we are encouraging their youth to engage in sexual activities.”

Another one said:

“Asasi za dini zinashinikiza imani kuwa Mungu ataponya tu, na imani za asili zinaona kuwa ni ugonjwa wa kulogwa”

“Faith-based organizations insist on the belief that God will cure people, while traditional beliefs insist that HIV is a disease which is due to witchcraft.”

Among the NGO group there was a clear difference between faith based organizations and secular one especially on the condom issues:

For instance faith based NGO saw it as a major setback when the Government and secular NGOs continue to promote condoms, while for secular NGOs the setback was that there were not enough condoms to meet the growing demand for them. They also decried the persistence of erroneous beliefs about condom such as condoms being laden with HIV virus and that they were porous.

“watu wanapata taarifa tofauti ambazo si za kweli kama vile kondom inabeba virusi au kwamba kondom zina vitobo”

Implicit in the problems identified are clear communication challenges. High level of competence in using different communication methods, and the ability to formulate persuasive messages that provide motivation is necessary for addressing these challenges. This is attested to by the reports about the training these communicators had in health communication. These are dealt with towards the end of the chapter. It is also clear that lack of uniformity of messages reaching the people and the presence of detractors pose a problem which the proposed communication strategy has to address.

It is noteworthy that even though in Table 3.3 couples were testing together and infected individuals were bringing their partners for testing unwilling to disclose HIV status appears in this table as a set back. This has to be a continuing agenda, as long as new infections still occur.

Concepts and issues in health communication which are unclear

Respondents were asked if there were concepts and issues in the intervention areas and the communication activities they implemented which were not quite clear to them as educators.

Some 54 per cent of the clinicians covered by the study said there were no such concepts and issues. The rest mentioned the following:-

- The issue of discordance of HIV status among sexual partners;
- What to do when couples who are infected with HIV wish to raise a family;
- The life cycle of the HIV virus in the body and how ARVs interrupt the cycle;
- The life expectancy of a person who is on ARVs and takes them correctly;
- New infections for someone who is already infected;
- Post exposure prophylaxis and the side effects of ARVs;
- The duration with which the HIV virus can survive outside the body of a human being.

Among the nurses 23 percent claimed that nothing was not clear to them. The others mentioned the following:-

- Discordance of HIV status among sexual partners;
- Messages on bill boards were not clear;
- The origin of the HIV virus and AIDS;
- The types of the HIV virus e.g. HIV 2, etc.
- There is always something new coming up in the HIV and AIDS care component



A bill board carrying very informative and timeless messages: You are entering a dangerous zone. But it does not say that you could be the purveyor of the danger!

Most RACCs and DACCs reported that there were no concepts and issues which were not clear to them. A few of them however mentioned the following:

- How to communicate in order to bring about behavior change;
- The whole concepts of health communication;
- How to communicate with children aged 8-15 years;
- Provider Initiated Testing and Counseling.

Among NGOs the situation was quite different from the other categories. Only one respondent (NGOs Kigoma) asserted that there were no concepts and issues which were not clear to her. Another respondent claimed that they were often asked technical questions whose answers they did know (NGOs Arusha), while another one admitted that there were many concepts and issues which were not clear (NGOs Mara) although he did not specify what they were.

The unclear concepts and issues mentioned by the NGO group were the following:-

- Discordance of HIV status among sexual partners;
- Conflicting HIV test results;

- How it is that a child born to an infected mother can be uninfected;
- Exclusive breastfeeding by an infected mother without the baby getting infected;
- The window period of HIV infection.

Members of the NGO group also found the following to be setbacks as well:

- Lack of access for communication guidelines;
- They did not know who was responsible for producing educational brochures and leaflets;
- The slogan “Tanzania without AIDS is possible” which is prominent on the VCT campaign poster/billboard that features President Kikwete urging people to go for HIV testing, was not clear – did it mean that those who were already infected should be killed off?”

It is evident from these findings about issues which these communicators found confusing that some educators are not qualified to educate. In the presence of detractors whose intention is to send messages which are contrary to the correct ones such educators cannot be counted on to clear the ensuing confusion among the people. It is gratifying however that many were open about the areas in which they needed help, presented in later sections of this chapter. The proposed communication strategy needs to address the issue of capacity building of the front line communication practitioners.

Issues which the frontline communication practitioners did not accept but had to disseminate.

Respondents were subsequently asked if there were things they were obliged to educate their audience about, but which they themselves did not accept.

Most clinicians (80%) said there were no such things. The rest mentioned condom use, medical circumcision for the prevention of HIV transmission, abstinence, HIV testing, and multiple sexual partners.

They wondered how anyone could promote abstinence for others when they themselves were not abstaining, or how one can advise others to go for HIV testing when they themselves have never tested; or how they could speak strongly against multiple partners when they themselves had multiple partners.

Among the nurses, only 18.6 per cent said there was nothing they educated people about which were not acceptable to them. The rest mentioned the following issues:

- Educating discordant couples to practice safe sex;
- Exclusive breastfeeding by an infected mother;
- Condom use as an effective method of preventing infections;
- Early weaning of children of infected mothers.

All but one RACC among the RACCs /DACCs group said there was nothing they educated people about that they themselves did not accept. The one member said he had problems with providing PMTCT to mothers without involving their partners.

As for the NGO group the only issue about which misgivings were expressed was about condom use. Some members had reservations purely on religious grounds while others had problems with the effectiveness of condoms.

The contrast between clinicians and nursing is sharp. Nurses need more help. The clinicians who expressed their reservations point to a major problem of role modeling which is dealt with in the next section.

One thing about the NGO group is that their members are in the business of health communication out of their own volition, albeit for different reasons, whereas all the other categories find that it is one of the tasks they have to perform as part of their professional jobs, hence the problem of not having the commitment to perform the task well. This is not helped by not having specific training, as it is made clear in subsequent sections. They need motivation and skills for health communication.

Role modeling by health of preventive behaviour by communication practitioners

Role modeling of HIV and AIDS preventive behavior has not been a major strategy in HIV and AIDS control. Part of the explanation has to do with the clandestine nature of the behavior. Nevertheless it could be argued that if, for example, health workers used condoms correctly and consistently much as they might be seen to be engaging in multiple partnerships ÷ as one respondent in this study suggested that they do ÷ they would have much lower rates of HIV infection, and the people around them would want to know why. This would be role modeling even without their actual use of condoms being directly observed by the people, and their regular as well casual partners would tell others about it. Essentially the issue is about the need to avoid the duplicity of advocating adoption by the audience of particular forms of behaviour which members of the audience know that the advocate does not practice. In one observational study some eminent persons who had addressed an HIV/AIDS public meeting in the morning and spoke quite forcefully about the need for the youth to change their behaviour in order to protect themselves against HIV infection were later observed consorting with girls who had been in the audience (Muhondwa, Sayore, Mayanga & Zubwa, 1997). In another study it was found that many health workers who succumbed to AIDS had not been

infected in the course of carrying out their health care duties, but they had contracted HIV in the same way that members of the general public get infected (Muhondwa & Fimbo 2006).

In this study respondents were asked if they were aware that some HIV and AIDS educators did not always put into practice what they tell other people to do. The following table shows that most of the respondents answered in the affirmative.

Table 3.5. Aware of educators who do not practice what they teach

RESPONSE	CLINICIANS	NURSES	RACCS/DACCS	NGOS	TOTAL
YES	29 (82.9)	34 (79.1)	12 (80)	54 (91.5)	129 (84.0)
NO	6(17.1)	6 (14)	1 (6.6)	4 (6.8)	17 (11.2)
DON'T KNOW	0	0	2 (13.3)	1 (1.7)	3 (2.0)
TOTAL	35	43	15	59	152

A much higher proportion of respondents in the NGO group were aware of this phenomenon compared to the other groups ÷ presumably because they were part and parcel of the communities which are the target of education by the HIV/AIDS educators and among whose members these educators secure their consorts.

It is also noteworthy that a sizeable number of respondents among the clinicians and nurses groups claimed that the phenomenon did not exist. It is plausible that they were generalizing from their own behavior. In other words they assumed that since they themselves were not doing it others were also not doing it.

Whether the practice of some Health Educators not practicing what they educate others about is a cause for concern

Respondents were asked if this phenomenon was of concern to them. Again the following table shows that most of the respondents were very much concerned by this.

Table 3.6. Whether worried by educators not practicing what they teach

RESPONSE	CLINICIANS	NURSES	RACCS/DACCS	NGOS	TOTAL
YES	26 (74.3)	31 (72.1)	12 (80)	51 (86.4)	120 (78.9)
NO	3 (8.6)	2 (4.7)	0	3 (5.1)	8 (5.3)
DON'T KNOW	6 (17.1)	10 (23.1)	3 (20)	5 (8.5)	24 (15.8)
TOTAL	35	43	15	59	152

NGOs also had a higher proportion of members who were concerned by the phenomena compared to the other categories.

Obviously what this reveals is a concern for some HIV and AIDS educators not practicing what they teach.

One implication of this is that the proposed communication strategy should also regard those who work in the field of HIV/AIDS as a target group for appropriate communication interventions, and not just ordinary health workers. They may have both skills and performance deficits.

It is worth noting that what those who reported that they were not worried by the phenomenon said:

- # That HIV/AIDS educators are also fallible human beings;
- # that even the people whom they educate are discerning, they just don't copy whatever someone else does ;
- # that people should follow what the preacher says and not what he does.

The second point is worth noting. Perhaps consideration needs to be made for compiling a short compendium of 'Facts for preventing HIV infection and living with the infection' and distributing it widely so that it can be a check list against ordinary people can assess the authenticity of messages reaching to them. This would be akin to the 'Facts for Life' booklet (Revised Edition, 1993) which brought together the child health information that every family in the developing world had a right to know. It was for use by communicators, and was published jointly by UNICEF, WHO, UNESCO and UNFPA in partnership with 165 leading medical and children's organizations.

Communication methods and materials found most helpful

Respondents were asked about communication methods and materials which they found most helpful in their work. The following table displays the response of the four groups.

Table 3.7. Communication methods and materials which the four groups of communicators found most helpful

S/N	Clinicians	Nurses	RACCs/DACCs	NGOs
1	Actual objects, such as medicines and condoms	Brochures and leaflets	Announcements through mobile public address system.	Actual objects
2	Announcements through mobile public address systems	Flip charts	Billboards	Billboards
3	Billboards	Models of the male and female genitalia	Cinema films (using TACAIDS vans)	Books
4	Books	Video shows	Exhibitions and displays	Brochures and leaflets

5	Brochures and leaflets		Interpersonal communication	Performances by artists
6	Cinema films (using TACAIDS vans)		Mass rallies	Songs
7	Interpersonal communication		Pamphlets	Video shows
8	Models of male and female genitalia		Patient education at health facilities	
9	Posters		Performances by artists	
10	Video shows		Role play during discussions	
11			Seminars and workshops	
12			Television	
13			Traditional dances	
14			Video shows	
15			Brochures and leaflets	

The largest range of items came from the RACCs/ DACCs group. They mentioned 15 items.

Clinicians came up with a list of 10 items, with four clinicians saying they only use interpersonal communication.

One clinician made the observation that

“Mimi kama mimi situmii zana yoyote ile, sana natumia zaidi ujuzi wangu, maana natoa elimu kwa mtu mmoja mmoja tu ninayemuona kule kliniki.: (Clinician, Kahama)

“I for one don’t use any communication materials. I use my knowledge with individual patients whom I see at the clinic.”

Another clinician reported that

“Mimi zaidi ya kuona wagonjwa sijihusishi na shughuli za mawasiliano.” (Clinician, Tarime)

“Personally I am not involved with communication activities, I only see patients.)

This is a clear misunderstanding of what communication; communication channels and communication material are all about. It is a major challenge for the proposed Communication Strategy, because some of the communicators have no idea that they are communicating, and that they need to know how they can make their communication more effective by using appropriate materials and channels.

Sources of communication materials used

Asked about the sources of sources of the materials they used a variety of sources were mentioned. It is worth noting that many respondents reported that they make their own

materials, others use hired materials, and yet others claimed not to know where the materials they use come from. Indeed some of the posters on display and the pamphlets they used during their patient education sessions carried no logo of NACP or TACAIDS, and did not show the identity of their producers.

This is another challenge for the proposed Communication Strategy. It is not clear whether the materials used everywhere are true to the orthodoxy that TACAIDS and NACP espouse. A good example is the “Faithful Condom User billboard which was put up along Kilwa Road in the vicinity of St. Anthony Secondary School in Dare es Salaam.



The Anti Condom bill board.

The sources mentioned are shown in the following table

Table 3.8. Sources of communication materials identified by the four groups of communicators

S/N	Clinicians	Nurses	RACCs/DACCs	NGOs
1	NACP	NACP	NACP	District Councils
2	TACAIDS	TACAIDS	TACAIDS	ANGAZA
3	Ministry of Health	EGPAF	Ministry of Health	FEMINA
4	RMQ's office	Clinton Foundation	EGPAF	Pro-Life Tanzania
5	FHI	Mkapa Foundation	Red Cross	District/Regional Hospitals
6	CDC	FHI	SPW	
7	EGPAF	TUNAJALI	AMREF	
8	PATHFINDER	Coptic Hope Centre	PSI	
9	FEMINA		TAHEA	
10	TUNAJALI		FHI	
11	AIDS Relief			
12	AMREF			
13	USAID			
14	GTZ			
15	Clinton Foundation			

Two clinicians reported seeing communication materials but they did not know where they came from.

It is an interesting finding that NACP and TACAIDS were not reported among the sources of communication materials by the NGO group. It is possible that such materials reached them through the Regional and District Hospitals and they failed to know their origin.

Deliberate and inadvertent creation of demand for non existent services

Frontline health communication practitioners were asked if they had ever created demand for non existent HIV/AIDS services, and if their information, education and communication may have inadvertently stimulated demand for non existent services even though that may not have been the objective of the communication

Most respondents gave 'No' as the answer to both questions. And some of those who had something to say did not make clear cut answers. Some substantive reports of such communication interventions, made mainly by members of the NGO group, included the following:-

- Education was given about the importance of balanced diet for PLHAs. This created the demand for nutritional support which the Government was not ready

- to support. Members of the concerned NGO tried to mobilize resources for this purpose but this was not sustainable.
- An NGO working in the intervention area of Home Based Care educated community members about the importance of treating opportunistic infections. This created demand for drugs for sick PLHAs being looked after at home. There were no funds for this.
 - After community sensitization the youth in the village said they wanted VCT services to be established in their own village. They were not prepared to travel to other villages which had health facilities which offered the services.
 - After sensitizing those who prepare dead bodies for burial about self protection, they demanded gloves. The local hospital has been providing such gloves, but this seems to be unsustainable because gloves are not being distributed to all villages as a matter of routine.
 - Women were sensitized about use of female condoms. But these are not readily available like male condoms.
 - People who had turned up for counseling and testing and tested positive demanded that they should be enrolled for ART immediately. This is not the current arrangement for accessing ART.
 - After sensitization parents demanded counseling and testing for their children. The DMO did not authorize this form of service,

Indications are that this form of creation of demand for non existent services is real. Health communication practitioners should advocate to, and lobby the relevant authorities for making such services available, before they embark on sensitizing people about those services.

Underutilized communication methods and media

The following were reported to be the alternative or additional communication methods and media the four groups as not being used much, and which they would like to use much.

CLINICIANS Plays

- Imbedding messages in the songs of traditional dances
- Video showing the natural history of AIDS
- Employing PLHAS as educators
- Home visits

NURSES

- Plays
- Using patients/PLHAS
- Video shows
- Exhibitions and displays
- Home visits

RACCS/DACCS

- Group discussions

Role play

Play

Exhibition and displays such as the annual exhibition oriented by TACAIDS during the “sabašaba” festival

- NGOs: - More use of plays and performances by artists
- Group discussion
 - Brochures and leaflets which address love situations
 - Video shows about the plight of PLHAS
 - Cinema shows
 - o To produce and disseminate education programs in local radio and TV station

.The reasons why these alternative or additional methods and materials were not used were financial constraints. Artists, PLHAs and discussants have to paid

Electricity supply was also given as another constraint. It is noteworthy that video, cinema shows, were preferred so that they could show pictures showing the plight of those who get infected.

This is essentially a desire for a method that would help people to understand the full impact of the disease as opposed to creating fear. The breach of privacy involved in shooting such videos as well as the appropriate form of incentives for those who volunteer apart, it is a communication method which should be explored and fully utilized. It certainly makes the message more salient if the video portrays people in circumstances that the audience can identify with. We are familiar with pictures from other countries, and those in the mass media struggle to find the appropriate pictures from the local scene for their features. The fact that many PHLAs have come out appropriate incentives can be worked out to profile them and document their experiences.

But it is interesting that some of them preferred embedding messages in society’s popular culture, such as popular tunes and traditional dance.

Whether Frontline health communication Practitioners received any formal training in Health Communication

These frontline communicators were asked if they had ever received formal training in Health Communication/Health education or HIV and AIDS education.

Training received by members of the clinicians group

Some of the CLINICIANS (62.9%) indicated that they had received some training. Some 34 per cent said that they never did, and one clinician was quite emphatic in saying that there was no such formal training.

In response to a subsequent question it turned out that among those who said they had received training, two said it was part of their pre-service course. Others said they

received training in health communication in the context of the short courses and seminars on such AIDS related subjects as CTC, VCT, STIs, TB/HIV and PITC. These courses lasted between one week and six weeks.

Training received by members of the nurses group

Most (86%) of the nurses reported that they had received formal training in Health Communication. Three nurses said this was part of their pre-service education.

For most of these nurses this had been part of the various short courses and seminars they had attended on specific AIDS related subjects such as PMTCT, PITC, TB/HIV, HBC, CTC, ART and VCT. Among these seminars of nurses mentioned counseling course. The duration of these short courses and seminars ranged from five days to six weeks.

Training in Health Communication received by members of the RACCs/DACCs

RACCs and DACCs were divided in more or less two groups of those who said that they had received formal training (60%) and those who said they had received no such training (40%) Two did not make any response.

Most health workers who said they had received formal training in health communication indicated that this had been among the things covered by the various short courses they had attended over the years.

Of particular significance is information about a seminar on Health Education organized by NACP and another one on BCC which two members said they attended. Such courses need to be formalized, updated, and organized periodically in different parts of the country so as to give HIV/AIDS workers some orientation in basic health communication.

Like most of the other health workers covered many those who said they had received formal training, it was in the context of the short courses and seminars they had attended over the years on specific HIV and AIDS subjects.

Training received by members of the NGO group

Most (85%) of the members of the NGO group claimed to have received formal training in health communication. Five members stated that they never received such training, and responses are missing for four members.

However like members in other groups they too received the training while attending various HIV and AIDS related seminars.

Interestingly some of the communication aspects those who said had received formal training included:-

- life skills
- communication skills

- facilitation skills
- crafting messages
- BCC
- counseling

It is therefore not surprising that only five respondents indicated that they required training in health communication. Many requested training generally.

The challenge here is to have some form of standards that communicators can aim for. This requires that they receive training at least in the basics of health communication.

Forms of assistance required by Frontline Health Communicators

Assistance requested by the group of Clinicians

When asked about the kind of assistance they needed to enable them to be more effective in their communication activity only 40 per cent of the clinicians said they wanted training in health communication and one of the mentioned specifically the Health Education course offered at the Iringa PHC Institute.

Other two wanted to be trained in counseling

The rest mentioned they wanted assistance in a wide range of areas other than training .These included:

- Brochures and leaflets
- TV and computers
- Equipment such 4 machines
- Transport
- Coming for cell phone vouchers
- Allowance and incentives
- More staff to alleviate staff shortage

Assistance requested by members of the nursing group

As for the form of assistance required by nurses the type of assistance which most of them mentioned

- Further training :- in unspecified way
- Training in health communication
- Supplies and equipment
- More health staff to alleviate shortage
- Specific budget for health communication

Among the equipment and supplies required were vehicles, videos, gloves and models of the male and female genitalia.

With specific reference to vehicles, one nurse put the request as follows:-

“Tunahitaji usafiri wa uhakika wa kutembelea wagonjwa”

“We need reliable transport for visiting patients at their homes” (Nr. Arusha)

As for the request for supported training, it was expressed as followed:-

“Kuwe na mafunzo ya mara kwa mara ili kuendana na mabadiliko yanayotokea”
(Nr. Dodoma).

“There is need for training which is organized periodically in order to enable health workers cope with the changes and developments which occur in the field”
(Nr. Dodoma).

It is interesting that some of the participants who expressed need for training in health communication were concerned with what they perceived to be poor quality of the communication materials they see:-

“Tupewe elimu ya kutosha juu ya mawasiliano juu ya HIV and AIDS ili tuboreshe pia matangazo yetu yaletе maana, na yasimpe mtu kazi ya kuanza kufikiria ujumbe una maana gain. (Nr. Mtwara)

“ We would like to receive training in health communication so that we can improve our materials so that their meaning is clear The reader should not be given the additional task of having to decipher the meaning of the message” (Nr. Mtwara).

Behind this request is the observation made about posters and billboards whose messages are alleged not to be complete or explicit. The implication for the proposed Communication Strategy is to come up with ways of improving the media literacy at least of the frontline communicators.



A bill board which was given as an example of bill boards and posters that carry incomplete or unclear messages.

It is noteworthy with specific reference to the bill board depicted above that even though the words Salama condoms form the background and the logo on it clearly shows what is at stake, the message on the bill board was said to be incomplete or unclear. This exemplifies the need for media literacy.

This issue came up in Mtwara in connection with the poster showing President Kikwete urging people to go for voluntary counseling and testing (Muhondwa, Masha & Makwaya 2008) shown below. There are also references to the poster in this report with regard to the message that “*Tanzania bila UKIMWI inawezekana*” not being clear.



Even the messages on this VCT campaign poster/billboard have been found by some people to be unclear.

Assistance requested by the RACCs/DACCs group

Only five members of the group wanted training in health communication.

The forms of assistance required included:-

- being involved in developing communication material for their region/district
- being enabled to develop their own communication material

Implied in such requests is criticism of the available health communication material, and constitutes a challenge for the proposed Communication Strategy in terms of capacity building for formative research, message crafting and selection of appropriate methods and media.



The two messages given as Special Message appear to be an attempt at being politically correct, but this results in the AIDS message not standing out prominently.

The billboard carries multiple messages. It is not clear what the injunction to change behaviour, ostensibly because TB can be treated, relates to. Need was also voiced for training in health communication that would provide knowledge and skills for communicating with children and the youth.

The challenge here is to build the capacity of frontline communicators to use methods and media that are attractive to this population group, such as cartoons and messages set to popular tunes.

Of interest is the request made by one respondent :- not for training in health communication in general, but training in:-
 “Situational analysis, message design, and population participation” (DACC: Shinyanga).

It is an expression of need for capacity building in deriving messages from educational needs following sound formative research and behavior analysis.

Like other groups they too expressed need for a specific budget for health communication, transport and educational CDs to be showed to the appropriate audience.

The challenge here is to ensure that health communication is not left to happen by chance but to be planned for, and executed like any other activity, and with a budget set aside for it.

Members of this group also requested for assistance to address local problems. For instance one respondent from Iringa called for research to examine the alleged aphrodisiac properties of the 'U|anži' |oča| brew. It is alleged that when people have taken the brew they cannot resist the urge for sex, resulting in the kind of sexual behaviour that fuels HIV transmission in the region.

They also wanted specific training on how to communicate with children and the youth who come forward during such annual events as the torch race.

Of particular significance is the request made by one respondent :- not for training in health communication in general, but raining in:-

“situational analysis, message design and population participation” (DACC. Shinyanga).

RACCs and DACCs also expressed need for a specific budget for health communication, transport and educational CDs to be showed to the appropriate audience.

Assistance requested by the NGO group

Among the NGO group only five members indicated that the form of assistance they required was for training in health communication. Most of them requested training generally.

Furthermore most of the forms of assistance which member of the NGO group wanted were material:-

- funding
- government support
- allowances for volunteers
- supplies and equipment which included communication materials, CDs, music equipment and projectors.
- transport
- cinema van
- institutional support for PLHAs

Government support was required in order to lower their dependence on foreign donors. **In as much as some of the forms of assistance may not be for health communication they are very relevant to it because communication in the HIV/AIDS field cannot be a stand alone activity. The state of the health infrastructure limits what communicators can advocate for, and similarly health communication seeks to facilitate realization of the outcomes that health services seek to attain. It is a synergistic relationship.**

CHAPTER 4: THE AUDIENCES OF HIV AND AIDS COMMUNICATION

This survey covered three types of audiences of the HIV and AIDS Communication: People Living with HIV and AIDS (PLHAs), Political and Administrative Leaders (P/AL) and Religious Leaders (RL).

The questions sought to get them to focus on what was happening in society concerning HIV and AIDS, and what people in their communities made of the health communication for the control of HIV and AIDS, though, invariably they answered them from their own perspectives.

Effective communication methods and media

The first question required these informants to identify the communication methods and media which community members found more effective in providing them with education about HIV and AIDS. The following table provides a list of the methods/media they mentioned and provides a comparison of importance of each method in terms of the rank order of that method in each group.

Table 4.1. Rank order of different communication method and media accorded by the three categories of audiences

METHOD/MEDIA	PLHAS	P/A Leaders	R. Leaders
Radio	1	1	1
TV	2	2	3
Brochures/Leaflets	3	8	4
Posters and Billboards	4	7	-
Mass rallies	5	4	16
Newspaper/Magazines	6	3	2
Pamphlets	7	14	8
Seminars	8	9	10
Home visits	9	11	-
Testimonies of PLHAS	10	-	-
Plays	11	6	-
Announcements	12	-	-
Traditional Dances	13	-	-
“Matamaŝha”	14	-	7
Speeches/Lectures	15	4	6
Q & A	16	-	5
Choir	17	13	-
Church/Mosque teachings	-	-	9
Patient education at CTCs	-	-	11
Peer group meetings	-	-	12

The PLHA group mentioned more methods and media compared to the other two groups. The methods and media which only they mentioned include

- Testimonies by PLHAs
- Announcements
- Traditional dances
- “Matamasha”

The radio and TV feature prominently in each group.

Mass rallies,” matamasha” and speeches are forms of public gatherings. They may be specially organized for HIV and AIDS education or they may provide opportunities for HIV and AIDS education to be given even if that was not the primary objective for the gatherings. These feature prominently among the PLHAS and Political/Administrative leaders. These have the advantage of being able to attract people who would otherwise not be inclined to attend HIV and AIDS meetings.

Methods and messages considered to be confusing

The next question was whether they were aware of methods or messages which members of the public found confusing.

Most members in each of the three groups were not aware of any such methods and messages.

Some Political and Administrative leaders mentioned:

- Condom use,
 - o In this connection one member complained that the Salama Condom Advert which characterizes a condom as a mosquito net was not in good taste (P/AL, Dar es Salaam).
- The Red Ribbon and how this is supposed to symbolize HIV and AIDS was not clear.
- Some people could not make the distinction between HIV and AIDS.

Some 46.3 percent of members of the PHLA group said there were no confusing messages. Confusing issues mentioned included:

- Why infected couples should be asked to use condoms in their sexual relations.
- The message that “AIDS kills” was discouraging.
- The slogan that “Tanzania without AIDS is possible” was confusing because it did not tell people what they should do in order to make this possible.

- The word FATAKI was not understood.
The adverts put up by Traditional Healers claiming to treat HIV and AIDS were also confusing ÷ they wondered why the government allowed such lies to be propagated.

Underlying the complaint about traditional healers is the continuing orthodoxy in HIV and AIDS that there is no cure, which appears to conflict with the claims that traditional healers make. Research shows that some medications administered by traditional healers appear to work like ARVs which bring relief to sick people – who for all intents and purpose appear to have been cured. Indeed one of the factors associated with people stopping to take ARV when they feel better is the belief that they are cured. This is a communication challenge that needs to be addressed.

As for Religious leaders, a third of them said there was no confusing message. The other two thirds raised the following issues:

- Condom use:
- A Religious leader in Dar es Salaam made the observation that condom adverts appear to arouse sexual desire.
- It was confusing to use erotic songs and music to pull the crowd for HIV and AIDS education.
- It was not correct to advise the youth to have one faithful sexual partner. The correct thing should be to advise them to wait until they get married.

At least two of these concerns are worth considering. Some health personnel seem to regard the role of performing artists as well as traditional dances simply as crowd pullers. It does not matter to them what performances they put up or what songs they sing as long as they attract the crowd to gather so that they as the educators can have the audience to educate. It is imperative that the performances and the songs are seen as educational, and they should carry authentic messages that people can remember and ponder about. As for condom adverts they have to come up with innovative ways of portraying the good life that condom use can bring to the people. Indeed condoms can be eroticized without arousing sexual desire.

Organizations whose communication material and messages have been effective

These informants were asked to identify organizations whose or communication methods and messages appear to have been effective.

The group of Political and Administrative leaders came up with the largest list of such organizations: 20 of them. The PLHAs group had a list of 17 organizations, while Religious leaders mentioned only six of such organizations.

It is also worth noting that there were members in each of the groups who said they did not know of such organizations. The PLHA group had 44%, Religious leaders had 33% and Political and Administrative leaders had 18%.

The organization mentioned included local and nation-wide organizations.

Table 4.2. Organizations perceived to have effective methods and messages

SN	PLHAs	P/A Leaders	Religious Leaders
1	SHIDEPHA+	TACAIDS	AIDS RELIEF
2	SPW	TUNAJALI	BAKWATA
3	TUSAIDIANE	World Vision	Churches
4	UHAI CENTRE	UMINTA	Individual PHLAs
5	FEMA	KISELET	Islamic Foundation
6	JITEGEMEE	MASAYODENI	TACAIDS
7	MULIKA	FEMA	
8	NYOTA NJEMA	OKOA JAMII	
9	PATHFINDER	PASADA	
10	Radio Faraja	SHKUMU	
11	Individual PLHAs	EGPAF	
12	AIDS RELIEF	AMREF	
13	AMREF	AFRICARE	
14	HARAKATI Group Sanaa	NACP	
15	EGPAF	CDS	
16	ANGAZA	JICA	
17		Diocese Of Central Tanganyika	
18		PSI	
19		SHIDEPHA+	
20		COMMUNITY ALIVE	

What Political and Administrative Leaders thought was particularly effective or salient about the messages and media of these organizations included the following:

- Helping people to form income generating activities and including HIV and AIDS education among their activities
- Religious organizations were consistent in speaking out against pre- an extra-marital sexual relations.
- The method of mounting displays and exhibitions in venue of public meetings attracted much attention.
- Showing cinema films about AIDS is both informative and entertaining.

The PLHA group identified the following:

- Individual counseling
- Plays and performances at public meetings
- The live examples provided by PHLAs
- Disclosure of sero- status in public and giving testimonies by individual PHLAs.

This brings into sharp focus the challenge for setting up standards for best practices in HIV and AIDS communication, against which communication messages and methods can be assessed. It is obvious that not all the organizations cited would measure up, because their perspectives are known to be unorthodox. Some may be contributing to the confusion that people have as a result of being bombarded with conflicting messages, the case of condom use being a clear example of this. The communication challenge would be to enable people to recognize unacceptable messages when they hear them.



A billboard overloaded with multiple messages

Changes in the communities attributed to health communication

Respondents in all groups came up with more or less similar changes in their communities which they attributed to HIV and AIDS education.

PLHAs identified the most changes 12, followed by Political and Administrative leaders who mentioned eight, and Religious leaders had the least changes - five.

The following table list the changes in mentioned by each group.

Table 4.3. Changes in communities attributed to health communication

TYPE OF CHANGE	PLHAS %	P/A Leaders %	R Leaders %
Increase uptake of testing	47.9	25	44.4
Declining deaths	6.3	-	-
Stigma reduced	8.3	16.7	11.1
PLHAs are open about this status	8.3	12.5	-
Increase uptake of ARV	6.3	8.3	-
People know more about HIV and AIDS	8.3	-	-
Increased use of condoms	4.2	16.7	-
PLHAs requiring good health	16.0	-	-
Erroneous customs and traditions reduced	4.2	8.3	-
Reduced rate of how transmission	2.1	12.5	-
Reduced rate of opportunistic, infection	2.1	-	-
PLHAs having healthy babies	2.1	-	-
People more willing to assist orphans	-	4.2	-
More people are not testing by looking	-	-	11.1
More people have turned to God	-	-	11.1
Risky behavior declining	-	-	22.2

Out of the 16 types of changes mentioned, only two types of changes appear in all the three groups while five appear in two groups. Eight appear only in one of the three groups.

The issue of increased uptake of HIV testing was the most outstanding change that respondents mentioned in that it was mentioned by the highest proportion of members in each group.

Other forms of changes which attracted substantial responses in each of the groups were:-

- PLHAs regaining good health
- Stigma reduced
- Increased use of condom
- PLHAs being open about their status
- Reduced rate of HIV transmission

- Reduced risk of behavior for HIV infection.

It is clear that communication alone could not be credited with having brought about all these changes. The challenge is to enable communicators to understand the synergy resulting from communication working in tandem with other drivers of social change generally and of the behavior change of individuals in particular. This calls for familiarity with theories and models of behavior change.

HIV and AIDS educators not practicing what they teach

The issue about HIV and AIDS educators not acting according to what they teach was also taken up with these groups.

The following table shows that some said the phenomenon was common while others said it was not, and there were those who said they did not know if this happens.

Table 4.4. Percent of respondents in each group who were aware of the phenomenon

Response	PLHAs	P/A Leaders	R Leaders
Yes, aware	80.5%	82.4%	50%
No, Not aware	4.9%	5.9%	33.3%
Don't Know	7.3%	11.8%	16.7%

Except for the Religious leaders group among whom only 50 percent said they were aware of this phenomenon, majority of members of the other two groups said they were aware of it.

As to whether those who knew about the phenomenon were concerned about it, most of them said they were except four PLHA group members and two members among the Religious leaders group.

Two opposite views from the PHLA group about this phenomenon are worth noting:

People have become very knowledgeable about HIV and AIDS and so this does not cause any problem (PLHA, Kigoma)

If he tells me that one gets infected through sexual intercourse and then turns around to seduce me, what am I supposed to believe? (PLHA Mtwara).

Issues about HIV and AIDS not yet understood by community members

Respondents were asked if there were any issues about HIV and AIDS that people in the community had not yet understood.

The majority of respondents among the PLHA group (53.7%) said that there was no such an issue. Figures in the other groups were lower: 41.2 percent among Political and Administrative leaders and 33.3 percent among Religious leaders.

The issue of condom use, especially issues around the effectiveness of condoms, featured in all the groups as one that had not yet been understood. Indeed a respondent among the Political and Administrative leaders wondered why it was that despite condoms being used widely new infections were still occurring.

Other issues mentioned by members of the PLHA group included:-

- the symptoms of HIV infection,
- the relationship between TB and HIV,
- PMTCT,
- Discordance among couples.

For Political and Administrative leaders the only other issue they thought was still not well understood was the validity of HIV test results. They wondered if some tests do give wrong results.

Similarly among the Religious leaders the only other issue which was not well understood was the use of ARV.

All these issues that people still do not understand pose communication challenges, requiring enabling people to acquire new knowledge and to change their beliefs, and in the case of condom effectiveness, to acquire the skills and motivation necessary for correct and consistent condom use.

Issues being promoted for the control of HIV and AIDS that were unacceptable to community members

These groups of informants were also asked if there were issues being promoted for HIV and AIDS control that were not acceptable in their communities.

As with the previous question the majority (61%) of respondents in the PLHA group said there was no such thing. The proportions were lower in the other two groups - 47.1% among the Political and Administrative leaders, and 33.3% among Religious leaders.

Very few issues came up. PLHAs mentioned:-

- Self disclosure of HIV status to the public;
- Testing HIV positive and not getting the ARVs;
- Use of condoms by couples both of whom are infected.

That PLHAs who were interviewed at CTCs should raise these issues indicates the how difficult it is to communicate effectively. No person is under obligation to disclose his or her HIV status to the general public. The PLHAs who do so simply feel that they have a message they wish to share publicly out of their volition. The only obligation is for HIV infected people to disclose their status to their significant others, especially their sexual partners. It is possible that within PHLA groups there is pressure on members to go public, but this is in violation of an individual human right to privacy. It is a moot point why an infected person should not want everybody in the community to know his or her HIV status.

PHLAs should also know the medical indications for enrollment into ART, and to explain this to those who have not reached this stage who need to take pride in being able to lead healthy lifestyles in terms of nutrition and seeking care for opportunistic infections, such that they are able to maintain high levels of immunity. Similarly they should know the importance of preventing re-infection, possibly with different types of HIV, and hence the need to use condoms. Health communication with PHLAs need to take into account the unique circumstances of each individual, including providing reinforcement for the new behaviour adopted, and to empower them with knowledge and interpersonal skills to withstand undue pressure to do things which they do not feel happy about.

Political and Administrative Leaders, in turn mentioned

- testing for HIV infection before marriage;
- Condom use.

Religious leaders mentioned

- safe sex;
- Condom use.

Why young girls and married women get infected with HIV.

Young girls

New infections appear to occur among young girls. These informants were asked to explain why this happens in their communities.

Respondents in the three groups gave more or less similar explanations for this phenomenon, as shown in the following table:

Tabl 4.5. The factors identified and the proportion of respondents in each group who cited the factor (Informants made multiple responses).

SN	FACTOR	PLHAS	P/A Leaders	R Leaders
1,	Poverty	46.3%	58.8%	33.3%
2.	Desire for things	43.9%	41.2%	50%
3.	Sexual desire	24.4%	17.6%	-
4.	Seduction by wealthy or powerful people	7.3%	23.5	50%
5.	Poor upbringing	4.9%	-	16.7%
6.	Prestige	2.4%	-	-
7.	Foolishness	2.4%	-	-
8.	Distant schools	2.4%	-	-
9.	Copying bad habits	2.4%	-	-
10.	Alcohol corruption	2.4%	-	-
11.	Lack of employment	2.4%	-	-
12.	Rape	-	5.9%	-
13.	Body structure facilitates getting infected easily.	-	-	16.7%

The number one explanation according to PLHAs and Political/Administrative leaders was that of poverty. This was the number two explanation among Religious leaders.

Studies of sexual behaviour among adolescent girls however show that even girls from well to do families do engage in sexual activities that expose them to the risk of HIV infection. For them poverty may not be the underlying factor (Hope, R. 2007). They have other needs, including satisfying sexual desire (Nguma & Muhondwa (2009)).

The number two explanation among PLHAs and Political/Administrative leaders was the desire for material things. This came first among Religious leaders. While this may be related to poverty it has unique aspects for even girls from wealthy families may desire things which are much more of sentimental/symbolic value rather than material value.(Nguma & Muhondwa 2009).

Sexual desire came third and fourth among PLHAs and Political/Administrative leaders. Again studies (Vander Zanden, JW. 1985) show that with maturation girls begin to experience new feelings and these coupled with observation of what happens among their peers lead them into exploration of, and experimentation with sexual relationships.

The issue of seduction by older people or people in position of power such as teachers or wealthier people featured highly in all the three groups. In the context of poverty, and desire for material things, as well as the girls' own sexual desire young girls constitute an easy prey for such people.

Studies have shown however that once girls become aware that they are sexually attractive to men they may take the initiative to attract heir attention and to behave in a

manner that may be interpreted by the latter as an invitation for seduction. Betty Komba-Malekela and Rita Liljestrom make the observation, in discussing how girls in Tanzania establish contacts with the men they like, that “*the girls ...maintain that they themselves had chosen their boyfriends. They do so by flirting with their eyes, by swaying their hips when walking near the men...*” (Chapter 7 in Tumbo-Masabo & Liljestrom, R. (1994). In such cases girls may therefore not be the hapless victims of the machination of men, but are themselves imbued with human agency to act in what they consider to be their own interests.

The PLHAs group came up with a much longer list of factors compared to the other two groups presumably because they can empathize with girls who become infected.

Married women

Explanations given as to why married women get infected were also varied though not to the same extent as for young girls.

The three groups came up with more or less the same factors as the following table shows:

Table 4.6. Factors accounting for married women getting infected with HIV (informants made multiple responses).

SN	Factor	PLHAs	P/A Leaders	R Leaders
1	Being unfaithful	68.3%	88.2%	66.7%
2	Polygamy	14.6%	-	16.7%
3	Infected by partners	17.1%	41.2%	33.3%
4	Discord among couples	7.3%	41.2%	16.7%
5	Infected during child delivery	2.4%	-	-
6	Infected through caring for infected people	2.4%	5.9%	-
7	Not afraid of getting pregnant	-	5.9%	-
8	Body structure - easily infected	-	-	16.7%

The fact of being unfaithful on the part of married women was top most among the three groups. This has resonance in the context of discordance where between 30 and 40 per cent of the infected couples are couples where the female partner is the infected partner (de Walque 2006). As de Walque correctly observes, “This is at odds with the levels of self-reported marital infidelity by females, and with the common perception that unfaithful males are the main link between high risk groups and the general population (de Walque 2006:1).

The PLHA group mentioned six factors while the other two groups mentioned five each. Unfaithfulness features as the number one factor in all the groups. May be an underlying factor for the women being unfaithful such as to bring the infection home and infect one

partner was the factor of discord among the couples. It ranked fourth among PLHAs and Religious leaders but was ranked third by Political and Administrative leaders.

Marital discord may be the visible manifestation of other underlying factors, including lack of sexual satisfaction. This is increasingly becoming recognized as an important factor that needs to be addressed in order for mutual faithfulness among partners to be realized. It is an aspect of sexual health which has not been given the significance it deserves. A Ten Country Research Report on Multiple and Concurrent Sexual Partnerships in Southern Africa of the One Love Project (The Soul City Institute, n.d., Rassool, R. 2009) found that sexual dissatisfaction and lack of communication were two of the reasons for having multiple and concurrent partnerships. The communication challenges arising from these findings include how to address explicitly sexual dissatisfaction in the media without being offensive, and the language to use in communicating complex and technical sexual information and knowledge.

Male partners were incriminated as being responsible for infecting their female partners by all the three groups. This may not necessarily be incorrect given the finding reported by de Walque that among 60 ÷ 70 percent of discordant couples it is the males who are infected (de Walque 2006).

It is important that communities be empowered to understand the drivers of the HIV epidemic in their own communities so that they can participate effectively in the struggle to control the epidemic. This means that the epidemiology of HIV transmission has to be brought down to the level that everybody can understand. People should know how some of their time honoured cultural beliefs and customs can be harmful by facilitating exposure to infection or transmission of the infection to others. Knowledge of the phenomenon of new infections occurring among young women including married women should be made common, as well as its determinants. This is a communication challenge.

Readiness to change is an important concept in theories of behavior change. Communicators need to know where target audiences are on any particular issue they are advocating so that they can address the specific barriers, including how to prepare people for change. This is another area that requires appreciation of the explanations those community members make for their own customs and traditions and is an attribute of intercultural communication competence.

Continuing resistance by some people to go for HIV testing

Informants were asked to explain why some people still hesitated to go for HIV testing:

Again a variety of explanations were given and some of these were common to all the groups, as the following table shows:

Table 4.7. Factors which account for the continued resistance to go for HIV testing (informants made multiple responses)

SN	Factor	PLHAS	P/A Leaders	R Leaders
1.	Stigma	41.5%	29.4%	33.3%
2.	Fear	53.7%	82.4%	66.7%
3.	Cumbersome testing procedures	-	11.8%	-
4.	Lack of confidentiality in health facilities	4.9%	-	16.7
5.	Poor understanding of the importance of testing	--	5.9%	16.7%
6.	Threatening education given at health facilities	2.4%	-	-
7.	Inadequate health education	-	-	16.7%
8.	Influenced by traditional healers	2.4%	-	-
9.	The belief that they have been bewitched	2.4%	-	-

The factor of fear features prominently in all the groups. This entails the fear of hopelessness, the feeling that one cannot be able to cope with knowing that one has the virus. This has over the years been manifested by people committing suicide when they test HIV positive.

Of particular importance is the factor relating to cumbersome testing procedures. As we noticed in earlier sections there is this reluctance to have to go through counseling, with some people asking to be tested without counseling. It is also alleged that for some people pre-test counseling amounts to a rehash of what they know about AIDS and HIV transmission. The content of pre-test counseling, as well as the role it is supposed to play need to be revisited, particularly as AIDS gets to be seen as another disease, and in the context of a shortage of well trained counselors. At a time when Provider initiated HIV testing is being introduced it is important to avoid doing things as a matter of routine. The fact that confidentiality is lacking in the health facilities is confounded with stigma. Confidentiality however is an ethical principle which should be upheld regardless of the diagnosis.

That some people are put off by HIV and AIDS education which appears to arouse fear of the disease is worth of attention. In previous sections we have come across concerns about the form of education which are discouraging. This is a communication challenge of building the capacity of educators to be able to frame the education for behavior change in terms of the benefits rather than the costs of the behaviour. It is a move away from loss-framing to gain-framing in crafting messages.

The role of traditional healers and belief in witchcraft are also highlighted here. There is a need to have clear policy about traditional healers whose activities

undermine the HIV/AIDS control activities. But this can only be a product of a common understanding of what “treatment and cure” mean because in functional terms the moribund and bed ridden individual who regains good health after taking ARVs or equally efficacious medication administered by a traditional healer is cured.

According to this perspective the traditional healers who claim to be able to cure AIDS may not necessarily be cheating the people. Besides being a policy issue this is also a bona fide communication issue. It is imperative that people be empowered to know when a traditional healer is making false claims in light of the available scientific evidence.

Explanation for poor adherence with ART

The issue of poor adherence for the ARV regimen was taken up with the informants. It is not surprising that the PLHA group had the most number of explanations for the phenomenon.

It should also be noted that eight almost 20 percent of members of the PLHA group dismissed the issue as irrelevant. As far as they know people on ARVs were taking them according to the regulations. As noted in earlier sections, they may be generalizing from their own behavior.

The factors that came up are outlined in the following table:-

Table 4.8. The factors identified to explain poor adherence and the rank order of each factor derived from the multiple responses of the members in the three groups

SN	Factor	PLHAS	P/A Leaders	R Leaders
1	Inadequate food	1	1	3
2	Lack of correct understanding	2	2	1
3	Difficult regimen	3	-	-
4	Perceived problems with the ARVs	4	-	-
5	People giving up	5	4	-
6	Carelessness	6	5	-
7	Some do not want people to know	8	3	2
8	Long distances to health facilities	7	6	-
9	Long queues at health facilities	-	7	-
10	Alcohol consumption	9	-	-

Food insufficiency was ranked top by the PLHA and the Political/Administrative leaders groups. It came third among Religious Leaders.

Lack of correct understanding of drug use was ranked second by the PLHA and Political/Administrative leaders groups but came top in the Religious Leaders group.

Evidently this is an indictment of the education and communication given to those taking ARVs. People need to know not simply about what would happen if they do not take the drugs in accordance with the regulations but rather how the drugs work in their body and how an individual can maximize the benefits he or she will enjoy by taking the drug according to a particular schedule.

This is closely related to the third and fourth factors namely that ARVs have a difficult regimen and that they have inherent problems - two factors which were mentioned only by PLHAs.

These are not purely communication issues. They relate to the current state of the science of ARVs and the technology for making them available. Communication however can help a great deal by explaining these aspects of ARVs so that individuals can be emotionally and intellectually prepared to cope with the complexity of ART - much in the same way that cancer patients can be helped to understand and to come to terms with surgical operations which alter radically their conception of their own identities and manage to enjoy a good measure of quality of life after losing one or both breasts for women and after losing their testicles for men.

The fifth and sixth factors were mentioned by the PLHA and Political and Administrative Leaders groups. They were ranked by the two groups in more or less the same magnitude of significance. These shift the focus to the individuals taking ARVs. People are seen as giving up hope ÷ presumably in the face of difficult regimen and inherent toxicity and

other side effects associated with the ARVs, while others are simply thought of as careless.

This amounts to “victim blaming.” Why should anybody who went on ART with the hope of gaining the benefits that the drugs give, and the evidence for such benefits being clearly manifested in the lives and health of those who take them correctly, simply give up or become careless? It could be due to the collapse of the social support mechanisms or due to radical changes in one’s social milieu that leaves one with no reason for living. And these should be legitimate issues for policy and social programming.

The issue of alcohol consumption which was mentioned by only one member of the PHLA group is also worthy of attention. PLHAs are subjected to all kinds of polemics and injunctions when they get on ART. No wonder one of the changes attributed to communication reported earlier is that people have turned to God. Some people are appalled when PLHAs grab condoms, or when they are seen enjoying an alcoholic drink. This is a serious communication issue. We need to unpack what is meant by positive living for PLHAs. Just as a positive or negative HIV test results should lead to reflection of one’s life style and how to live subsequently, what the individual does after that is a matter of the individual’ choice. Life has to continue. No one should be coerced into turning to God or to living a life without the small joys of everyday life one is used to.

Poor health seeking behaviour for STIs

STIs are co-factors in the transmission of HIV. Correct treatment of STI is therefore a preventive method for HIV. Informants were asked why some people in their communities did not seek STI treatment from health facilities.

The following table outlines the responses given by the three groups of respondents.

Table 4.9. Rank order of the multiple responses made by members in each group

Response	PLHAs	P/A Leaders	R Leaders
Don't Know	3	-	-
Feeling ashamed	1	1	1
Do not want people to know	2	2	-
Do not realize the full impact of STIs	4	6	-
Fear of the association of STIs and HIV	5	3	-
Cumbersome procedures of seeking medical care	6	4	-
Lack of confidentiality at health facilities	-	7	2
STI drugs readily available from drug stores	-	5	-
Ashamed of having to expose themselves to health workers of opposite sex	-	8	-
Care seeking is too expensive	-	9	
Abusive language of health workers	-	-	3

The issue of sick people feeling too ashamed to seek STI treatment from health facilities came out top among the three groups. This is clearly associated with the second and seventh factors, namely not wanting other people to know about their condition, and lack of confidentiality in health facilities.

The factors of cumbersome procedures of seeking medical care, the medical care being too expensive, and the abusive language of health workers are associated with the availability of STI drugs in drug stores which are sold without a doctor's prescription.

Clearly these are policy issues, though communication has a role to play both as an intervention targeting potential STI sufferers, and health care providers in health facilities. Health communication in terms of advocacy for a policy of zero tolerance for STI drugs without prescription is also indicated.

A response which is also worth noting is the one about people not knowing the full impact of untreated STIs. This is very much a communication issues. The natural history of many diseases is not commonly understood and hence subsequent complications or sequelae may be perceived as new disease entities quite unrelated to the original disease.

It appears that as knowledge about STIs being co-factors for HIV infection become known it is creating new problems for those who are scared of HIV and AIDS. They would rather avoid having the potentiality of HIV being investigated let alone confirmed when they seek treatment for STIs. This is also a communication challenge.

The health services were also incriminated in that they are not seen as friendly for people with STIs. So called cumbersome procedures which presumably include having to attend specific STI clinics, make return visits for laboratory test results and in some cases the requirement that one invites one's consort's or actually brings them along for treatment. This is confounded by health care providers who do not observe confidentiality, and are abusive.

Communication has to make the rationale for these procedures understood by the general population, and particularly those who get sexually transmitted infections, and address the attitudes of health workers.

The issue of people with STIs not being willing to be attended by health workers of the opposite sex is real and is known to affect the utilization of health services for other types of health problems whose correct diagnosis require undressing before the health worker and having to disclose embarrassing information. This is a cultural issue.

It is a cultural change issue and communication can be instrumental in bringing about the change. This however needs to be coupled with serious efforts to improve quality of care, which includes making the care socially acceptable by addressing the performance deficits, including unethical conduct of health care providers. This is a specific case where the effectiveness of health communication may be

compromised by factors within the health services and therefore becomes an advocacy issue for making health care seeking for STI easier for the affected people.

Not surprisingly political and administrative leaders gave the most factors presumably because they get to hear about the problems people face with regard to accessing all sorts of social services, and not just health services.

Communication channels through which people usually receive or access HIV/AIDS information, education and communication

Informants were asked to indicate the communication channels through which they usually receive or access HIV/AIDS information education and communication. They were actually presented with a list of communication channels for this purpose.

The resulting pattern of preference of the communication channels is presented in the following table. The rank order takes into account the fact that people access multiple channels.

Table 4.10. Rank order of channels derived from the responses of the three groups

Channel	PLHAs	P/A Leaders	R Leaders
Radio	1	1	1
Television	2	2	2
Brochures and leaflets	5	4	3
Posters and banners	7	11	5
Billboards	4	3	6
Seminars and workshops	6	5	7
Churches and mosques	3	7	4
Schools	10	10	10
Public rallies	9	6	8
Home visits by health workers	12	8	9
Talks at health facilities	8	9	11
T/Shirts and caps	4	12	12

Radio and TV were ranked number one and two supportively by all the three groups.

The print channels of brochures and leaflets were also ranked highly by all the groups, with the rank order ranging from three to five.

The responses were mixed with regard to the display channels of posters and banners and bill boards. Apparently bill boards fared better than posters and banners. This indicates that they are perceived to play different roles.

It is ironic that while T/shirts and caps were poorly ranked by both the political/administrative leader as well as religious leaders they were highly ranked by PLHAS.

Schools were poorly ranked by all the three groups presumably because they do not know about the HIV/AIDS education which is provided in or through schools. This is in sharp contrast with churches and mosques.

The finding that some of the methods that health communication practitioners prefer were poorly ranked is of great significance.

It was noted earlier that some people find the messages in posters, banners and bill boards not explicit, and it was suggested that this might be an issue of low levels of media literacy. Messages delivered during public rallies and during health talks in health facilities may attract low attention for some people whose concerns are not necessarily the subject of those messages.

T/shirts are very popular with organizers of HIV/AIDS events but it appears that these may serve different functions other than disseminating messages printed on them.

Why home visits and the interpersonal communication which is their hallmark were ranked low may be an indictment of how the communication is actually done. Here is an efficacious method which appears not to be effective because of the way it is done.

Why schools are ranked the lowest by all the groups is a cause for concern, as it was discussed before. It is a research issue why schools which give authentic education should fare better than churches and mosques whose messages may not be congruent with the scientific evidence.

Communication channels found more easily accessible

Informants were subsequently asked about the communication channels that community members found more easily accessible. These were mentioned spontaneously, and it is informative to compare the ranking of the spontaneously generated list with the ranking of the channels read out to them. The following table shows the results of the comparison of the two approaches for each group.

Table 4.11. Rank order for the communication channels derived from spontaneous responses from and prompted responses for the three groups.

S. N.	Channel	PLHAs Prompted versus Spontaneous	P/A Leaders Prompted versus Spontaneous	R Leaders Prompted versus Spontaneous
1	Radio	1 - 1	1 - 1	1 - 2
2	TV	2 - 2	2 - 2	2 - 1
3	Brochures and leaflets	5 - 3	4 - 3	3 - 6
4	Posters and banners	7 - 13	11 - -	5 - -
5	Bill boards	4 - 5	3 - 4	6 - 7
6	Seminars and workshops	6 - 8	5 - -	7 - -
7	Churches and mosques	3 - 6	7 - -	4 - 3
8	Schools	10 - 9	10 - -	10 - -
9	Public rallies	9 - 10	6 - 5	8 - 8
10	Home visits	12 - 7	8 - 8	9 - -
11	Talks at Health facilities	8 - 4	9 - -	11 - -
12	T/shirts and caps	11 - 11	12 - -	12 - 4
13	Newspapers and magazines	- - 12	- - 6	- - 5
14	Books		- - 9	
15	Plays		- - 10	
16	Cinema		- - 7	
17	“Matamasha”		- - 11	

It is apparent from the table that both radio and television feature highly as rank orders one and two in all the groups. In other words radio and television are the two most common communication channels the people get their HIV and AIDS messages from and which they find easy to access. This is not surprising given the proliferation of local FM radio and television stations which complement the few stations which have nation-wide coverage.

Providers of HIV/AIDS information, education, and communication need to exploit the potential of local radio and TV stations. This also opens the way for designing and disseminating targeted communication to different situations of remote locations, besides opening up local involvement in mass media communication.

Brochures and leaflet were ranked high for accessibility than coverage except among religious leaders among whom the pattern was reversed. Here also one sees the potential for making these channels more effective by localizing their content to take into account the different and sometimes unique epidemiological and social situations.

Given the dissatisfaction with existing communication materials expressed by frontline communication practitioners and their request for capacity building in producing locally situated communication material, coupled with the complaint made by both the frontline communication practitioners and the audience of health communication about messages on posters and banners as incomplete or unclear – which indicates poor media literacy – and the high rating given to leaflets and brochures shown in the table above, one practical implication is for communication practitioners to invest more in producing and disseminating leaflets and brochures because they are amenable to carrying fully developed arguments and messages that are expository, rather than posters and bill boards where such kind of messaging is not possible. Further more given the proliferation of FM radio stations and TV stations more effort should go into discussion and phone – in programmes and less in radio and TV spots. Soap operas and programmes in the genre of “*Wahapahapa*”, radio drama stand to provide more mileage in engendering correct understanding of the complex HIV and AIDS issues by the general population.

Posters and banners appear to be problematic. This is in sharp contrast with bill boards.

Seminars and workshops are also problematic presumably because not everyone can be invited to attend. Those who attend such functions appear to find them very educative.

Except among religious leaders church and mosques generally do not appear to be places for HIV/AIDS education. It could be an expression of reservations about the content of such education when it is given.

As for schools which were not highly regarded as channels for HIV/AIDS education, while this might be due to not knowing what actually goes on in schools, it might also reflect the incredulity about the education given because the youth in school do not appear to lead lives of abstinence and hence the common social problem of unwanted pregnancy, among school girls, sometimes involving their own teachers, and HIV infection. This however ignores the much stronger forces within the communities which appear to outweigh the education and information given in schools. The HIV and AIDS education given to the youth in school as well as to those out of school needs to be complemented with concerted interventions to change the social norms in the community and to create supportive social environments which make it easier for the youth to put into practice what they are taught. This is one of the communication challenges that the FATAKI campaign seems to be addressing, according to the Fataki Campaign’s Programme Summary on the Soul Beat Africa site, Nov. 23, 2009.

Public rallies appear to be poor communication channels from the perspectives of PLHAs and religious leaders. Political and administrative leaders however appear to consider them favorably presumably because they also tend to be avenues for pursuing their own political and administrative agendas.

Home visits and the talks in health facilities were also poorly ranked. Only PLHAs found the health talks at Care and Treatment Clinics easily accessible largely because they have the motivation to learn as much as possible about AIDS and how to live with the virus.

The group of political and administrative leaders mentioned the most channels compared to the other two groups, even though they ranked the channels which they alone mentioned low.

Attitudes towards joint listening to and viewing HIV/AIDS communication with children

Finally the situation analysis explored attitudes towards joint listening to and viewing HIV/AIDS information, education and communication programmes on the radio and television by children and adults. This is particularly pertinent for households which have only one receiver.

The responses are presented in the table below. Since the question was not amenable to multiple responses the comparison across the three groups is in terms of proportions.

Table 4.12. Reactions by members of the three groups to the question about children and adults sitting together to listen to and to view radio and TV programmes about HIV and AIDS.

	Responses	PLHAS	P/A Leaders	R Leaders
1	Strongly against joint exposure	4.9%	11.8%	0
2	Against joint exposure	14.6%	17.6%	33.3%
3	Don't not mind joint exposure	82.9%	70.6%	66.7%

It appears that most informants in all the groups expressed liberal views about the matter. The group of PLHAs was the most liberal with 82.9 per cent indicating that they did not mind listening to and viewing such programmes in the company of children. They were closely followed by the group of political and administrative leaders among whom 70.6 per cent expressed such liberal attitudes. Religious leaders had the distinction of having no members expressing very conservative attitudes about the issue.

Perhaps it is with noting that those who were against joint exposure did so because this was seen to be against cultural values. These values require strict separation by age and gender especially when it comes to exposure to issues of sexuality and reproduction. The following excerpts from the statements which were made attest to this.

“Haifai kabisa kuchanganya jinsia zote kwa pamoja. Haifai kabisa kutokana na mila zetu” (P/A Leader, Arusha).

“It is not proper to put members of the opposite sex together. It is against our customs” (P/A Leader Arusha).

“Matangazo mengine si mazuri kama la FATAKI” (P/A Mtwara”

Some programmes are not good such as the one about FATAKI” (P/A Leader, Mtwara).

From the liberal wing the following excerpts are good examples:

“Watoto wanatakiwa kuelwa na kujua kuhusu HIV/AIDS (P/A Leader, Shinyanga)

“Children need to understand about HIV/AIDS (P/A Leader Shinyanga).

The implication here is that adults do clarify issues from the programme so that the children can benefit fully.

“Mimi napenda tusikilize tukiwa pamoja ili nao wapate kuelimika nami pia nawaelimishea” (PLHA, Mara).

“I like it when we listen together so that they too can be educated, and I can also educate them” (PLHA, Mara).

The implication here is that children pay more attention to the programme when they are together with their parents than when they are on their own.

One person with liberal views went as far as suggesting that bill boards should be painted on buses and house roofs exactly in the same way that commercial adverts are displayed:-

“Matangazo yabandikwe kwenye mabasi na paa za nyumba kama wanavyofanya matangazo ya biashara “ (PLHA, Shinyanga).

These attitudes have serious implication for scheduling HIV and AIDS programmes on radio and television. When these programmes are aired during prime time it is likely that conservative parents will ask children to go away while they listen/watch. Children can only watch when the programmes are repeated at other times. There seems to be no problem in liberal households.

CHAPTER 5: SYNTHESIS OF THE FINDINGS.

In this chapter a synthesis of the findings from the different components of the Situation Analysis study is made. The objectives of the study which were delineated in the first chapter serve as the anchor for the synthesis.

Objective 1:

To obtain information regarding the communication issues on HIV and AIDS addressed by health communication practitioners.

Many findings about communication issues on HIV and AIDS presented in different components of the study relate to this objective. This section brings these issues into sharp focus and makes their affinity with this objective explicit.

For analytical purposes the communication issues are grouped into five categories:

- Issues concerning the framework in which health communication in HIV and AIDS is practiced;
- Issues concerning the health services and provision of HIV and AIDS services;
- Issues concerning ART, and use of ARVs in particular;
- Issues about the motivation of the target population for HIV and AIDS communication to put into practice what they learn;
- Issues about the social structure that constrain the ability of the target population for HIV and AIDS communication to put into practice what they learn, and their vulnerability for HIV infection.

Issues concerning the framework in which health communication in HIV and AIDS is practiced

- Lack of national guidelines on health communication and standards;
- Lack of guidelines on child counseling and testing;
- Lack of mechanism for monitoring of health communication activities at the health facility, district, regional and national level;
- Lack of or weak evaluation methods for assessing the effectiveness of messages;
- Lack of team work among health communication practitioners resulting in inefficient use of resources.
- Ineffective methods of promoting condom acceptance and use;
- Inability to create dialogue between couples on family planning and condom use and to facilitate disclosure of positive HIV test results.

Category one issues require advocacy by health communication practitioners with the relevant authorities to put in place a frame work which will make it possible for the health communication practitioners to implement health communication interventions efficiently and effectively.

Issues concerning the health services and provision of HIV and AIDS services;

- Care providers are at risk of HIV infection, and some are in need of the HIV/AIDS services they provide to others, they constitute audiences for appropriate health communication interventions, in support of the Strategic Plan for the control of HIV & AIDS for health workers at the work place (2006 – 2011);
- Care providers not trained in providing adolescent friendly services and child disclosure counseling;
- Inadequate counseling skills by some counselors;
- RCH clinics not conducive for male involvement in PMTCT;
- Lack of privacy and confidentiality hampering utilization of care for STIs;
- Some people want to be tested without going through counseling.
- Drugs for STIs are no longer provided freely.
- Health workers lack skills to communicate with children aged 8-15 years;
- Some health workers are unable to explain conflicting HIV test results;
- The window period of HIV infection not explained to motivate people to go for repeat HIV testing;.
- The symptoms of HIV infection not explained, people have come to know the symptoms of AIDS which appear too late.
- The relationship between TB and HIV not clearly explained;
- The need for couples, both of whom are infected, to use condoms has not been explained;
- The need for testing for HIV infection before marriage has not been explained.
- Cumbersome testing procedure
- Lack of confidentiality in health facilities
- Threatening education given at health facilities
- Long distances to health facilities
- Long queues at health facilities.

All these issues have the effect of non use or less than optimal use of specific types of HIV/AIDS services that health communication practitioners try to promote among their primary and secondary target populations.

They also need to target health authorities to create an environment which is conducive for the effective and ethically correct performance by health care givers.

Issues concerning ART generally, and ARVs in particular

- Incorrect use of ART

- Some patients discontinue use of ART when they regain their health on the false belief that they are cured
- Some people on ART do not take their ARVs according to instructions.
- Post exposure prophylaxis;
- The side effects of ARVs;
- Testing HIV positive and not getting the ARVs - eligibility for ART;
- Difficult regimen of ARVs.
- Other perceived problems with the ARVs.

As noted in the fourth chapter, these issues are not straightforward communication issues. They relate to the current state of the science and technology of ARVs. Health communication can however help a great deal by explaining these aspects of ARVs so that individuals can be emotionally and intellectually prepared to cope with the complexity of ART.

Issues about the motivation of the target population for HIV and AIDS communication to put into practice what they learn

- Communities not accepting specific messages;
- Incorrect and inconsistent condom use;
- Prevention of new infections;
- Acceptance of Condom use;
- How to help couples who are infected with HIV and who wish to raise a family;
- Post exposure prophylaxis;

That knowledge in and of itself does not necessarily lead to behaviour change is a well understood principle. It is often up to health communication practitioners to know the theories of behaviour change and to use them in their bid to enable their audiences to change their behaviour. This also means understanding the vulnerability factors as well as the social structural factors that need to be modified to make it much easier for people to change behaviour. Health communication in the form of advocacy can play an important role in bringing about modification of these factors. But in the final analysis individuals have to have the motivation to change behaviour. Appropriate health communication can engender creation of motivation.

Issues about the social structure that constrain the ability of the target population for HIV and AIDS communication to put into practice what they learn, and their vulnerability for HIV infection.

- Fear of HIV testing;
- Fear of disclosure;
- Role of traditional healers in PMTCT not defined;
- Stigma reduction;
- Acceptance of Condom use;
- Disclosure of HIV status to partners;
- Harmful customs and traditions;
- Reduction of MTCT;
- Involvement of men;
- Some people are not willing to accept their positive HIV test results;
- Some people do not believe that condoms provide protection against infections;
- Some people rely on traditional medicine instead of getting tested and put on ART;
- Persistence of the belief that AIDS is caused by witchcraft;
- Pornographic videos continue to be shown;
- Self disclosure of HIV status to the public;

- Use of condoms by couples both of whom are infected;

- Inadequate food and its effect on adherence with ART;
- Some people do not want people to know that they are infected with the HIV;
- The continuing censorial attitude towards people living HIV is also attributable to weakness of the current health communication. Positive living does not mean that people living with HIV should not enjoy the small joys of everyday life.

Implicit in all these social structural issues are communication challenges. Health communication practitioners are expected to design and to implement communication interventions which address all these issues. Some of these factors, in effect, aid and abet high risk behaviour and transmission of HIV, while others prevent effective utilization of HIV/AIDS services. Some health communication practitioners may need capacity building to enable them to address all these factors effectively.

Objective 2:

To identify strengths and weakness in current communication activities on HIV/AIDS from different players.

In this section factors or issues are sorted out and presented in the two categories of strengths and weaknesses. The strengths and weaknesses are essentially derived from an

evaluation of the different achievements as well as problems and setbacks identified by health communication practitioners, which are presented in different parts of the situation analysis findings.

Strengths

- Health sector HIV/AIDS strategic plan provided overall guidance and priorities for communication interventions.
- Other official document used for selecting issues for communication interventions. These include
 - The National Multisectoral Strategic Framework.
 - The National HIV and AIDS Communication and Advocacy Strategy
 - Tanzania HIV Indicator Survey 2003 ÷ 2004
 - Tanzania HIV and Malaria Indicator Survey 2007 ÷ 2008
 - The Adolescent and Health Development Strategy.
- Despite a plethora of official documents that communication practitioners used in preparing their communication materials all the major players expressed the view that the proposed health sector HIV/AIDS communication Strategy would play a unique role in guiding health communication interventions.
- Most frontline communication practitioners decried the current situation in which anybody can disseminate their messages, and in which misleading messages prevail.

Weaknesses

- Inability to segment the audience;
- Nationwide coverage precludes pre-testing of messages to ensure that they are appropriate and understandable by the audiences everywhere. This cannot be guaranteed given the cultural and situational diversity of the Tanzania society;
- Formative research results not always used as the basis for selecting the issues taken up in health communication interventions;
- The untenable situation which allows anybody to communicate what ever their ideological position dictates regardless of its opposition to the scientific evidence that informs communication in the field of HIV and AIDS. This means that not all communication materials in the public arena authentic;
- Unrealistic expectations for the role of the proposed communication strategy a legal document to enforce orthodoxy in messages;
- Tendency by major Health Communication practitioners to accept alternatives for formative research
- Not all major communication partners had specific mechanisms for keeping their messages and materials especially print materials salient and attractive over time;
- Both major Communication partners and frontline communication practitioners did not indicate how they handle the cultural sensitive issues of sexuality and sexual behaviour, and how they placate the gate keepers and moral custodians;

- Evaluation of communication intervention is not always done even though there was unanimity among HIV/ AIDS Communication practitioners for the need of evaluation;
- Both major Communication partners and frontline communication practitioners make unwarranted attribution of changes and outcomes solely on health communication as though health communication is a stand alone activity;
- Inadequate multimedia and media mix in health communication;
- Persistence of fear arousal and loss framing of messages. Examples of messages and materials crafted in the gain frame were cited by some major communication partners but these were not made available for assessment;
- Not much goes into creation of a supportive environment for a behaviour change as manifested by the perceived obstacles for seeking STI care expressed by the representatives;
- Some frontline communicators appeared not to be qualified to carry out health communication activities and did not see the need for training in health communication.

It is apparent that the current practice of health communication has more weaknesses than strengths. It is this situation which justifies the need for formulating a communication strategy.

Objective 3:

To identify information needs by various audiences

Information needed by health communication practitioners:

- The importance of using multiple media for message dissemination
- Capacity building for translating obstacles to communication into communication challenges, and the appropriate approaches to address them, such as advocacy for creation of supportive environment for their primary target audiences.
- Basic skills in health communication.
- Familiarity with the basic of HIV/AIDS services, including ART so that they can give correct explanation about these services and procedures to their primary audiences, and provide motivation to cope with the perceived cumbersome procedure and complex regimen. It is competence in performing the traditional role of Health Education, namely promoting what was termed compliance, but which is now called adherence.
- The importance of being role models for the behaviour they promote among their primary audience in order to avoid sending conflicting messages in the form of what they say and what they do.
- Capacity building to produce relevant IEC materials;
- Expertise in health advertising and use of brief punch lines in addition to the expository methods of message crafting and presentation of traditional health education;

- Importance of role modeling of HIV preventive behaviour to avoid confusion among some audiences.

Information needs for health care providers

- How they might be at risk of HIV infection, not only due to the risky working environment and their own health care giving practices at the work place, but also by their high risk behaviour in the community;
- How their professional behaviour and conduct in the course of providing health care can prevent health care seeking by primary audiences of health communication;
- How diagnostic and therapeutic routine procedures can prevent utilization of different forms of HIV/AIDS services;
- Why they need to uphold health care ethics, including respect for patients and keeping the information they obtain in the course of providing care confidential.

Information needs for moral custodians

- Appreciation of the fact that moral standards are not static, they change over time;
- Appreciation of the fact that opposition to messages, ostensibly, on moral grounds, can be a scapegoat for safeguarding personal interests;
- Ability to assess the potential for HIV transmission of customs and traditions;
- Appreciation of the fact that even religious scripts may have different interpretations.

Information needs for ordinary people

- Information to enable them to identify the drivers of the HIV/AIDS epidemic within their own communities;
- Information to enable them to recognize erroneous messages from unorthodox sources;
- Information to provide them with motivation to cope with so called cumbersome procedures and complex regimen;
- Skills to use condoms correctly, and motivation to use them consistently;
- Education to enable them to understand the contexts in which HIV may be transmitted, correct assessment of their susceptibility to HIV infection, and motivation to adopt appropriate risk reduction strategies;
- Media literacy, so that they have the ability to effectively and efficiently comprehend and utilize mass media content;
- Education to clear misconceptions about positive living by PLHAs ÷ e.g. that PLHAs should not take alcohol;
- Recognize stigmatizing attitudes and behaviour, and work towards stigma reduction.

Objective 4:

To document best practices in HIV/AIDS communication interventions in the country

Defining what constitutes best practice in health communication is problematic. The selection of the communication challenge may be informed by formative research; the message may be well crafted, pre-tested, and disseminated through the appropriate channel, reach and be accepted by the target population. The target population may even popularize the message such as to coin slogans may be coined from the message. But the message may be found unacceptable by the gate keepers and moral custodians. This is what happened with the old ISHI campaign. The campaign was defined as best practice by the country UNDP office. They described as

“probably Tanzania’s most successful HIV/AIDS campaign aimed at youth...The ISHI message is on billboards, on television and in print media. It is almost everywhere you look in urban Tanzania...” ‘Usione Soo! Sema Naye,’ meaning ‘don’t be shy, talk to your partner,’ has become a popular, powerful and inspirational slogan known to many young people across the country. The message behind ISHI is to abstain from sex, stay faithful by sticking to one partner who is not infected, or use a condom.” (UNDP 2004)

But this was rejected by parliamentarians who managed to prevail on the Prime Minister to get the campaign stopped on the grounds that the way the message was put across offended Tanzania’s morality (Muhondwa & Kamazima, 2005).

During data collection for this situation analysis the ISHI campaign was given by a number of informants as the only example of health communication materials which were withdrawn because they were seen to be in conflict with Tanzania’s morals, customs and traditions:

“Maneno yaliyotumika yalionekana ya kihuni, kama “usione soo, sema naye. Pia picha ilionekana kuhamasisha kitendo”

: *“The words which were used were seen as uncouth namely ‘Dont be shy, tell him/her’ and the picture used was seen to arouse sexual desire” (NGO, Mtwara).*

One leader went to the extent of attributing the ban on the ISHI materials to former President Benjamin Mkapa!.

The issue here is should the ISHI campaign still be considered as best practice despite what happened to it? Or are we back to the proverbial statement that *“the surgical operation was a success but the patient died!”*? The fact that it ended the way it did means that it had some weaknesses that other interventions should watch out for. Foremost among these weaknesses is what to do about the gate keepers and moral custodians who are not the primary audience of the communication messages (Muhondwa & Kamazima 2005).

During the data collection for this report we also came across people who were offended by the current FATAKI campaign messages ostensibly because they promote disrespect for old people.

One strong opponent of the messages put it as follows:

“Hata vijana wanaweza kutokumheshimu mzee: Yule mzee Fataki yule. Pengine tangazo la Fataki lingewekwa vijijini watu wangelingoa.”

“The youth would have no respect for old people: they would simply say that old man is a Fataki. If the Fataki advert were put up in rural areas people would take it down” (NGO, Mtwara).

Another one said:

“Watu wengi hawapendi neno Fataki (Malaya, Mcharazaji) Linaleta chuki kwenye jamii” (NGO, Mtwara)

Many people do not like the word Fataki meaning promiscuous. It causes disharmony in the community” (NGO, Mtwara).

All one needs is for such opponents to channel their complaints to their local Members of Parliament who in turn may ask awkward questions in Parliament. In this way opposition may be galvanized against the FATAKI campaign. It is unfortunate that members of parliament with health backgrounds, and even those who were AIDS activists before getting into parliament rarely explain health related controversial issues to their fellow members, as the ISHI incident showed (Muhondwa & Kamazima 2007). .

Admittedly the FATAKI campaign may be seen as best practice as its programme summary placed on the Soul Beat Africa site, November 23, 2009 shows.

Ideally realization of this objective required that specific case studies of communication interventions, and samples of their communication messages and materials to be evaluated against specific criteria. This however was not done because of time constraints.

It is envisaged that the workshops for formulating the communication strategy will provide the opportunity for the communication players to present their own work. The choice of the players who will be invited to show case their work will be informed by the findings of this study concerning sources of communication materials which frontline communicators provided. These include:

- AIDS Relief
- AMREF
- ANGAZA
- Clinton Foundation
- EGPAF
- FEMA
- FEMINA
- FHI

- Mkapa Foundation
- PATHFINDER
- PSI
- Red Cross
- SPW.

Conclusion

The authors of this report feel that they have made an adequate survey of the terrain of current communication in support of the implementation of the Health Sector HIV and AIDS intervention areas, even without not identifying what current communication interventions qualify to be considered as best practices in this health communication undertaking. The issues which have been highlighted and discussed constitute a firm foundation for formulating the Communication Strategy to spearhead the communication activities that address the germane issues in implementing the Health Sector HIV and AIDS intervention areas as currently defined in the Health Sector HIV and AIDS Strategic Plan (HSHSP) 2008 ÷ 2012.

The HIV and AIDS field is a fast changing human enterprise, and the interventions have to change as more medical science and technology yield new tools to deal with the disease, and as epidemiology and the social sciences yield a deeper understanding of the dynamics of risks, prevention approaches and therapy management of the infection. This means that the ensuing communication strategy will have to change in tandem or be superseded by another one that responds adequately to, and provides better guidance in dealing with the emerging issues.

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