Mass media is claimed to be the most effective tool in raising awareness on HIV/AIDS among the public both in urban and rural areas in Tanzania. However, in Tanzania mass media remains expensive and inaccessible to most of the remote rural populations. In addition, most of the print media are based on a commercial basis and due to poor circulation of money; mass media is not easily accessible in rural areas. Though there had been an increase in the number of radio stations in the country, those reaching rural areas are still few and with poor and sporadic signals. More so, a radio set is still a luxury to most rural households. This study investigated the following areas: how much do rural populations know about HIV/AIDS from mass media; what gaps are there in their knowledge/awareness, the reasons for the existing gaps and what can be done to bridge the gaps. The study used both qualitative and quantitative methods of data collection and found that there were gaps in the HIV/AIDS awareness/knowledge in the remote rural population that need to be urgently addressed.

Shukrani Mbirigenda

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Mass Media and HIV/AIDS in Tanzania

Shukrani Mbirigenda

Absence of Mass Media in Fighting HIV/AIDS in Remote Rural Population

The Case of Ebuyu Village in Morogoro, Tanzania

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ACRONYMS AND ABBREVIATIONS

ABC	Abstinence, Being faithful and Condom
ACP	AIDS Competence Process
AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti-retroviral Drugs
CBOs	Community Based Organizations
FGDs	Focus Group Discussions
FM	Frequency Modulation
GDP	Gross Domestic Product
Hakielimu	A Non-Governmental Organization dealing with the rights of children to good education
HIV	Human Immunodeficiency Virus
HTA	High-Transmission Areas
ILO	International Labour Organization
ISHI, LIVE	Multimedia campaigns against the spread of HIV/AIDS infection among the youth sponsored by USAID and the Government of the United Republic of Tanzania
KAP	Knowledge, Attitudes and Practices
MCH	Mother and Child Health
MDG	Millennium Development Goals
MMEM	Mradi wa Maendeleo ya Elimu ya Msingi also known as PEDP
MP	Member of Parliament
MVU	Mobile Video Unit
NACP	National AIDS Control Programme
NGO	Non-Governmental Organization
NIMR	National Institute for Medical Research

NSGRP	National Strategy for Growth and Reduction of Poverty
OUT	Open University of Tanzania
Oxfam	International NGO that works in attempt to reduce poverty in developing countries around the world.
PEDP	Primary Education Development Plan
RCHC	Reproductive Child Health Clinic
RFA	Radio Free Africa
RRA	Remote Rural Areas
RRP	Remote Rural Populations
RTD	Radio Tanzania Dar es Salaam
SPSS	Statistical Package for Social Sciences
STI	Sexually Transmitted Infections
TACAIDS	Tanzania Commission for AIDS
TAMEYODA	Tanzania Media and Youth Development Association
TB	Tuberculosis
TV	Television
UN	United Nations
UNAIDS	United Nations Programme on HIV/AIDS
URT	United Republic of Tanzania
US	United States
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
YES	Youth Employment Summit

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Shukrani Kassian Mbirigenda

DEDICATION

To my mother Lidwina Hugo Mwaluli and little Hope Kassian. I will always love you.

ABSTRACT

Today the mass media is claimed to be the most effective tool in raising awareness on HIV/AIDS among the public both in urban and rural areas. However, the mass media remains expensive and inaccessible to most of the remote rural populations in Tanzania. In addition, most of the print media are based on a commercial basis and due to poor circulation of money; mass media is not easily accessible in rural areas. Recently, there ha been an increase in the number of radio stations in the country, but those reaching rural areas were few and with poor and sporadic signals. More so, a radio set was still a luxury to most rural households.

This research investigated the following areas: how much do rural populations know about HIV/AIDS from mass media; what gaps are there in their knowledge/awareness, the reasons for the existing gaps and what can be done to bridge the gaps. The study used both qualitative and quantitative methods of data collection and found that there are gaps in the HIV/AIDS awareness/knowledge in the remote rural populations.

We therefore recommend that Tanzania needs an alternative media away from the mainstream media that would cover remote rural areas' news. Local people's initiatives should be at the centre, lest we tell them what to do and tread on their toes. We argue that before we jump to the condom solution, we should first of all disseminate adequate information on HIV/AIDS to raise people's awareness in remote rural parts of the country that not only do not have condoms, but also do not have the capacity to acquire them.

CHAPTER ONE

BACKGROUND TO THE STUDY

1.1 Introduction

HIV/AIDS known as the disease of the 1980s has prevailed over the last two decades, posing a serious moral, social and economic danger to the future of the global society. According to the United Nations Programme on HIV/AIDS (UNAIDS) 2003 Fact Sheet, over 60 million people worldwide have been affected with HIV since it was diagnosed, and it is estimated that between 2000 and 2020, over 68 million people are likely to die prematurely in the 45 countries most affected by the disease (Shayo, 2001).

Many sub-Saharan African countries have reported a significant decrease in the life expectancy estimates for their people in part due to HIV/AIDS (Huang *et al*., 2005). The loss of productive workers to HIV/AIDS threatens the economic stability of these countries. At a local level, it also threatens the stability of families, many of which are already living in poverty. Additional HIV/AIDS related costs, and the loss of the family breadwinner, can push families affected into deeper financial crisis. Although there has been development of antiretroviral drugs, the treatment of HIV/AIDS has progressed insignificantly in sub-Saharan Africa because of the difficulties in obtaining these drugs and the cost usually associated with them (www.uri.edu/artsci/ecn/starkey/ECN398%20-Ecology,%20Economy,%20Society/envirprob2006.pdf, 2005). According to Oxfam (www.oxfamireland.org/overseas_work/countries/tanzania.shtml, 2005), Tanzania had around 2 million men, women and children living with HIV/AIDS, and in 2006 it was estimated that the country would lose about 24 million workers by the year 2020. In addition to the loss of life involved, HIV/AIDS affected people and their families spent part of their savings for treatment instead of investing, as a result, the GNP per capital index had dropped from 0.29 to 0.26 leading to a stagnated economic growth. Life expectancy of a Tanzanian, like many of the sub-Saharan Africa countries' people had gone down by 0.05, from 0.43 to 0.38 (Nyoni, 2001).

The mass media in Tanzania had been praised by scholars for playing a major role in informing people about HIV/AIDS (Nyoni, 2000). As of 2006 there was neither a cure nor a vaccine for HIV/AIDS thus prevention is perhaps the best way and may be the only choice to curb the spread of this deadly disease. However, if the mass media was a major way in disseminating HIV/AIDS knowledge or awareness information, then remote rural populations (RRP) were being left alone in their fight against the disease because they do not have access to mass media due to different costs associated with it. This problem pointed to the need for a detailed study on the link between mass media and HIV/AIDS knowledge/awareness in the remote rural areas. This study aimed at finding out knowledge levels of remote rural populations on HIV/AIDS and the role played the mass media in acquisition of that knowledge.

1.2 Background of the Problem

Tanzania reported the first HIV/AIDS case in 1983 in Kagera region in the Northwest part of the country, where three patients were diagnosed (Rugemalila *et al*., 1994). Only three years later, cases of HIV/AIDS were accounted over nearly all the regions of Tanzania mainland. Since then Tanzania had been spending fortunes on the disease. For example, in 1991, it spent 195 US dollars for every paediatric patient of AIDS and 290 US dollars on every adult AIDS patient thus in total it spent 25-27 million US dollars for AIDS treatment, almost half of its annual budget of 58 million US dollars (Rugemalila *et al.*, 1994:1).

The mass media has over the years accelerated the dissemination of HIV/AIDS awareness in Tanzania. A study done on 5 million listeners on the influence of a radio soap opera Twende na Wakati (Let's be current) revealed that 82 percent were said to have adopted a method of HIV/AIDS prevention as a direct result of listening to the programme (Newman, 2005). However, other studies testify that mass media in Tanzania is still expensive and out of reach for a great number of rural populations (Mandara, 1999). The fact that the mass media had expanded vertically due to the

political reforms in the 1990s is something we could not deny (Table 1). However, this vertical expansion was not proportional to the horizontal expansion (wider outreach).

Table 1: Vertical expansion of media due the 1990s political reforms

Media Institutions	Number of media before reforms 1960s-1980s	Number of media after reforms 1980s-2000s	% of growth
Newspapers	5	80	93.75
Magazines	3	11	72.73
Radio Stations	1	10	90
Television Stations	0	7	100
Media Associations	1	12	91.67

Source: Mkisi, 2001, A Comparison of Media Institutions before and after the Economic and Political Reforms

Currently, private Frequency Modulations (FM) radio stations, newspapers and a few television (TV) stations had expanded their outreach to a number of regions in Tanzania. There were about 500 registered newspaper titles, 34 TV stations, and over 60 radio stations at the time of the study (The Guardian, August 24, 2005). However, the situation illustrated that most of the rural areas were far from the centre of communications, some were unreachable during rainy seasons thus contributing further to the inaccessibility of print media. Electronic media were unprocurable to the most of the rural populations. TV and internet were out of reach altogether because they were expensive and needed electricity which, most of the villages in rural areas did not have. Even the radios were still unaffordable for the majority of the rural populations. Data field experiment in Tanzania on an entertainment-education radio opera, Twende na Wakati revealed that a system of satellite families had to be set up in return for radios and batteries. Only then about 30 families agreed to listen regularly to the Soap Opera, fill out on their diaries on their relations, and be personally interviewed at certain interval. Twende na Wakati whose themes were Family Planning and HIV/AIDS prevention, also revealed that in 1993-1995 throughout Tanzania, about 5 million people listened to the Opera (Vaughan, 2005). In 2006 Tanzania's population was estimated at

36,766,356, five million is only 14 percent of the whole population and most of those who listened were probably urban residents (Kaiser, 2006).

Broadcast signals from most of the radio stations in Tanzania were weak and intermittent in rural areas, which further lowered audience exposure. Adding to a problem of low level of information accessibility due to low level of education of journalists, manipulation by politicians to suit their political gains made rural populations more vulnerable. Evidence indicated that 60 percent of new infections in Tanzania occurred in people aged between 15 to 24 years, yet only 15 percent of the youth believed they were at risk of contracting HIV/AIDS (USAID, 2005). With poor means of communications and lack of mass media in the rural areas, the percentage could even be higher.

The above statistics illustrated the reason for aggressive action, as studies related to the role of the mass media in spreading HIV/AIDS awareness were done mainly in towns and cities or in villages among the elite members of the society or in the villages that were near the cities and towns. This left out the people living in remote areas that had poor infrastructure. One can raise criticism on the awareness campaigns by asking. Do RRPs have enough information if the mass media was the source of HIV/AIDS information in the country?

Morogoro region, where this study was carried out had a population of 1,222,737 people, and it ranked fifth in 1993 (counting the number of people infected by HIV/AIDS) (Rugemalila *et al*., 1994). In July 29, 1997 The Daily News reported that from January to September 1997, there were 48 reported rape cases in the region alone. Out of the 48 cases, nobody knew how many were infected with HIV/AIDS and if village populations had this information about their region and how they could avoid being infected. Thus, the study assessed the remote rural people's awareness/knowledge on HIV/AIDS, focussing on print media (newspapers, periodicals, magazines, journals, etc) and electronic media, particularly radio to appraise their role in imparting this awareness/knowledge since they were claimed to play a major role.

1.3 Statement of the Problem

Many awareness campaigns had been launched, but the spread of HIV/AIDS had been increasing at an alarming rate. HIV/AIDS was still the leading cause of death among adults in Tanzania (USAID, 2005). According to National Aids Control Programme (NACP) surveillance Report No. 11, 1996, HIV/AIDS had rapidly spread to the rural communities and in 1997, more than 10 percent of women attending antenatal clinics situated in some rural areas were detected to be HIV infected (http://www.tanzania.go.tz/hiv_aids.html, 2005). The spread of the virus infection did not correspond to the spread of the mass media to the rural communities. Despite these facts, it was argued that the mass media programmes had achieved increasing HIV/AIDS awareness to 100 percent and doubling condom sales in 3 years to over 20 million (http://www.usaid.gov/stories/tanzania/pc_tanzania_ishi.html, 2005).

The Tanzania Demographic Health Survey claimed that nearly all people had basic information on HIV/AIDS, and it quoted radios as the main source of information (TDHS, 1996). TDHS discovered that in Morogoro, 97.9 percent of females and 99.3 percent of male had basic knowledge of HIV/AIDS. The above data indicated that awareness of HIV/AIDS was high and linked to radio as the main source. This was in contrast to information, which suggested that HIV/AIDS in rural areas was spreading rapidly against the low spread of mass media in those communities. Therefore, if the mass media was playing a major role in spread of HIV/AIDS awareness/knowledge in the country, its absence in the RRA would leave the population void of the awareness/knowledge.

1.4 Objectives of the Study

The objective of this study was to investigate the relationship between the availability of the mass media and the remote rural populations' awareness/knowledge of HIV/AIDS.

1.4.1 Specific Objectives

The specific objectives of this study were as follows:

1. To examine the present level of knowledge of remote rural populations on HIV/AIDS.
2. To assess the sources of the existing knowledge.
3. To evaluate the role of the mass media in the acquisition of the existing knowledge amongst rural populations.

1.5 Research Questions

The research aimed at answering the following questions:

1. How much do the rural populations know about HIV/AIDS?
2. From what sources do rural population acquire knowledge about HIV/AIDS?
3. What role is the mass media playing in provision of the information about HIV/AIDS?

1.6 Significance of the Study

In 1999 specific case rates of HIV/AIDS indicated that there were 28.2 cases per 100,000 population of males and 26.5 per 100,000 populations of females (http://www.tanzania.go.tz/hiv_aids.html, 2005). For both sexes, most cases fell within the age of 20-49 years, peak age for female being 25-29 years while that of males being 30-34 years. This active age plays a major role in the country's economy, thus its being infected affects agricultural and industrial production and service delivery as well as socio-demographic parameters such as life expectancy. Furthermore, AIDS orphans had been on the increase while communities and the government could hardly cope with the increasing resource demand to cater for their needs (http://www.tanzania.go.tz/hiv_aids.html, 2005).

Tanzania is one of the world's poorest countries (www.oxfamireland.org/overseas_work/countries/tanzania.shtml, 2005), and was

struggling to eradicate poverty, ignorance and diseases that affected mostly the rural populations. However, HIV/AIDS posed a major setback as it linked with poverty to form a vicious cycle. Thus, curbing the spread of HIV/AIDS could provide a way towards true obliteration of poverty. As the region was struggling to rebuild the East African Community, Tanzania's comparative advantage lied in agriculture, which depended on the rural population still (The Citizen, July 22, 2005).

Since the mass media was identified as a major way of disseminating HIV/AIDS information, it was important to measure the level of knowledge/awareness of the Tanzanian populations on HIV/AIDS particularly the rural populations who were far from the reach of mass media. Failure to do this, would threaten the involvement of the remote rural populations in the fight against HIV/AIDS thus posing a serious danger in the future of the country's economy as well as frustrating its effort to eradicate poverty. The study findings aimed at helping the policymakers to design intervention methods to raise knowledge/awareness among the remote rural populations on HIV/AIDS to salvage it from peril. This was crucial since HIV/AIDS had become a leading cause of death and thus requiring urgent attention.

1.7 Conceptual Framework

This part of thesis attempts to accurately define or explain different concepts that are used in the study and in the wider sense the theories that the study followed. These concepts are remote rural populations (RRP), HIV/AIDS, mass media and knowledge/awareness. The study used an awareness scale to measure the awareness level of the populations under study, and this scale is presented below.

1.7.1 Remote Rural Populations (RRP)

Remote Rural Populations (RRPs) are the inhabitants living in distant, far-off areas, which are usually isolated and secluded from the modern means of communications. Most of the year these places were inaccessible due to bad infrastructures such as poor

roads, no telephone lines and no post offices. RRPs did not have electricity, could not afford fuel such as kerosene, and had no secondary schools (even no primary schools in some places). Generally, poverty was the basic feature of the RRPs, most of the households (if not all) lived on less than a dollar per day, and it had been established that poverty significantly influenced the spread of HIV/AIDS, which ultimately led to a loss of economically active segments of the society, leading to a reduction in income (TACAIDS *et al.*, 2005). RRPs lived in mud walled houses with grass thatched roofs, children who attended school could not afford uniforms (which is a requirement for most schools in Tanzania). RRPs had three or four wells per thousand of people to fetch water and some areas do not have wells at all, but depend on river water for both drinking and washing. Such places also had severe cases of malnutrition among the under-fives and families had farms between 0.5 to 2 acres and mostly were subsistence, and some poor starved, some even died of hunger or diseases (Ballart, 1996).

Such places had very few people who have gone beyond standard seven level of education whereby a few who went to form four levels were without any certificates since they failed their examinations. A typical remote rural population in Tanzania would be areas like those of Ebuyu, Ihoti, Isyaga, Sali, Lusanga in Morogoro region and many other villages in which its people had to walk long distances to get to health centres and other basic social services. In this study, such areas exemplify typical RRA.

1.7.2 HIV/AIDS

HIV/AIDS stands for Acquired Immune Deficiency Syndrome, which is a disease caused by Human Immunodefiency Virus (HIV). The disease is spread by heterosexual intercourse with HIV/AIDS infected partner, by prenatal (perinatal) also called vertical way where parents transmit it to the child, blood transfusion from a HIV positive donor to a negative recipient, use of unsterilized health care instruments, penetrative anal intercourse, intravenous drug abuse and treatment of haemophiliacs with blood products, among many others. What is referred as AIDS is the late consequence of HIV infection (http://www.tanzania.go.tz/hiv_aids.html, 2005). However, Transmission of HIV/AIDS

in Tanzania like in other African countries is mainly through heterosexual sex. The incubation period for the disease is about 5 to 10 years during which a person might not show any symptom. The ailments that a HIV positive person is luckily to suffer from are tuberculosis, persistent cough, rashes, boils, sores and other skin disorders; excessive loss of weight, diarrhoea and total bowel incontinence, which are referred as opportunistic diseases (Rugemalila *et al.,* 1994).

1.7.3 Mass Media

Mkisi (2001) defined mass media as the technical means of communication, which reaches millions of people exemplified by television, radio, newspaper, motion pictures, magazines and periodicals. Mass media such as newspapers, radio and television have tremendous ability to reach masses of people at the same time and in relatively shorter time than other forms of communication (Maganga, 1996). Today, in addition to newspapers, periodicals, magazines, etc which are referred as print media and television and radio which are heaped together as electronic media, we have the internet, which is a fast growing electronic media form. However, mass media in this study will be denoting a device through which information reach the populace through all forms of print media and radio.

1.7.4 Awareness/knowledge

In normal circumstances, awareness would mean perception of a situation or fact while knowledge would mean facts, information, and skills acquired through experience or education (theoretical or practical) (www.cssforum.com.pk/off-topic-discussions/computers-technology/364-oxford-ifinger-dictionary-2-1-a.html, 2006). In this study, HIV/AIDS knowledge and awareness meant the information about basic transmission modes and prevention (TDHS, 1996). It is the information about the intensity of the problem and how individuals perceive themselves as vulnerable and how much the epidemic has affected their area. Thus, in this study the words knowledge and awareness are used interchangeably.

1.7.4.1 The Knowledge/awareness scale

Here, awareness/knowledge is measured in a percentage scale that runs from zero to hundred, zero being no knowledge/awareness and hundred excellent or full knowledge/awareness. One to thirty means poor awareness/knowledge, thirty one to fifty means moderate, and fifty-one to eighty is good awareness/knowledge and eighty one to hundred excellent (full) awareness/knowledge (Table 2). The familiarity with the causes, the means of transmission, prevention, attitude towards infected people and cure were employed as indicators of awareness/knowledge. In the scale, zero to nine percent meant that the populations simply knew that HIV/AIDS existed. Ten to thirty percent meant that most of the population knew that the disease existed and were familiar with one or two of the indicators (Table 2). The scale from thirty one to fifty percent signified that the communities' majority were acquainted with three to five of the indicators. From fifty-one to eighty percent denoted that the majority of the population were familiar with all the indicators but this was not reflected in their everyday behaviour and practices. Eighty one to hundred percent meant the majority of population were knowledgeable of all the indicators, and that knowledge matched their everyday behaviour and practices.

Table 2: The Knowledge/awareness scale

Scale in %	**Explanation**	**Level of knowledge**
0-9	-Knowledge that HIV/AIDS exists -No familiarity with any of the indicators	No Knowledge
10-30	-Knowledge that HIV/AIDS exists -Familiarity with 1 to 3 indicators	Poor
31-50	-Knowledge that HIV/AIDS exists -Familiarity with 4 to 6 indicators	Moderate
51-80	-Knowledge that HIV/AIDS exists -Familiarity with all the indicators -No reflection of that knowledge in every day's behaviour, practice and attitude	Very good

81-100	-Knowledge that HIV/AIDS exists -Familiarity with all the indicators -Knowledge is reflected in every day's behaviour, practice and attitude	Full or excellent

Source: Author, 2005

1.8 Theory Guiding the Study

Bandura's Social Learning Theory interpreted through Sabido's Entertainment-Education Theory underlies this study. The theory claims that people are modelled for behaviour change through different means of social communications e.g. radio, newspapers, drama, etc. (www.leaonline.com/doi/abs/10.1207/S1532785XMEP0303_03, 2005). Bandura's theory explains human behaviour in terms of continuous reciprocal interaction between cognitive, behavioural, and environmental influences. It claims that human behaviour is learned observationally through modelling, from observing others, one forms an idea of how behaviour are performed and later this serves as a guide for action. However, Bandura points out that learning could occur without change in behaviour, unlike behaviourists who argue that learning has to result in permanent change in behaviour.

Bandura further warned that children and adults acquire attitudes, emotional responses, and new styles of conducts through filmed and televised modelling. Thus, media are an important ingredient in the formative mix (learn it today perhaps act tomorrow). This is operationalized in attention, retention and motivation.

- Attention, including modelled events (distinctiveness, affective valence, complexity, prevalence, functional value) and observer characteristics (sensory capacities, arousal level, perceptual set, past reinforcement),
- Retention, including symbolic coding, cognitive organization, symbolic rehearsal, motor rehearsal),
- Motor Reproduction, including physical capabilities, self-observation of reproduction, accuracy of feedback, and

- Motivation, including external, vicarious and self reinforcement.

In attention, the subjects tell themselves, "I never thought of that before!" In retention, the action may lie dormant, available for future use as long as one remembers it, the subject tells, "I figured out what I was doing wrong." In motivation, the subjects tell themselves, "why not do it? It worked out fine for them." The most common (and pervasive) examples of social learning situations are television commercials. Commercials suggest that drinking a certain beverage or using a particular hair shampoo will make us popular and win the admiration of attractive people. Depending upon the component processes involved (such as attention or motivation), we may model the behaviour shown in the commercial and buy the product being advertised (Bandura, 2006). Awareness and expectations of future reinforcements or punishments can have a major effect on the behaviours that people exhibit (coe.sdsu.edu/eet/articles/**social**learn/start.htm, 2006). There are related arguments that claim that in Africa, India and Latin America, popular soap operas that included plots about family planning and HIV prevention have reportedly increased clinic visits and changed health behaviours (Keller and Brown, 2002).

As mentioned earlier, in Tanzania, a soap opera, Twende na Wakati influenced people (both men and women) to reduce a number of sexual partners and increased condom adoption. This influence of behaviour was through certain intervening variables, including self-perception of risk of contracting HIV/AIDS, self-efficacy with respect to preventing HIV/AIDS (a belief that the individuals can control their own futures), interpersonal communication about HIV/AIDS and identification with, and role modelling of, the primary characters in the radio soap opera (Keller and Brown, 2002). Consequently, a conclusion was that mass media is the best way for Tanzanian youth to reach their peers with a life saving message ISHI! LIVE! (USAID, 2006).

Studies done in Tanzania on the Bandura's social learning theory interpreted through Sabido's entertainment-education theory in relation to HIV/AIDS (apart from "Twende na Wakati") demonstrated that mass media actually make people aware of the epidemic, but refuted the second part that people's behaviour changed as a result of the

knowledge acquired. Mukyanuzi (2001) found that girls in Arusha secondary schools knew HIV/AIDS was a severe disease and knew how it was transmitted but did not perceive themselves as vulnerable to get it. Even those who realised that they were susceptible could not translate that knowledge into preventive behaviour. A study conducted in Mbeya region in 1994 showed that drama made a remarkable change in knowledge, but attitude and condom practice remained the same after the drama. The multiple predisposing factors including risk sex with strangers, breaking virginity, risk rape sex, liquor and polygamy prevailed even after the drama (Rugemalila *et al.*, 1994:53). This study aimed at attesting Bandura's and Sabido's theories using the RRP to monitor the results.

1.9 Conclusion

Studies claimed that awareness of the modes of HIV/AIDS transmission in Tanzania was high. In urban areas, rejection of misconception related to HIV/AIDS was also widespread, four out of five adults proportion knew that a healthy-looking person may be HIV positive, and almost the same proportion knew that HIV/AIDS could not be transmitted by witchcraft or by sharing food with someone who has HIV/AIDS (TACAIDS *et al.*, 2005). We argued that while this might be the case in towns and cities, in remote rural areas people still lacked adequate knowledge/awareness of HIV/AIDS.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

HIV/AIDS has received extensive discussion by numerous authors. Thus this study was not an attempt to open a Pandora box rather this chapter is dedicated to critically presenting and discussing the views of other writers on the topic and find possible perspectives which were forgotten or overlooked.

2.2 General Overview of History of Mass Media in Tanzania

Before colonialism, forms of traditional cultural manifestation such as drama, literature and dance played an effective role in communication. A tutor at the Tanzania School of Journalism (TSJ) in Dar es Salaam, describing the traditional communication system had the following to say:

> "…There was rumour from one mouth to another and to others that the chief was about to marry a beautiful bride from across the river. There was the drum beating to inform the community that aggressors had invaded their area. There was a way of yelling that informed people that cattle rustlers had swept away a community member's heads of cattle. They understood these communications and life went on." (Sturmer, 1998).

To Ullamaija Kivikuru (cited in Sturmer, 1998), these traditional media still play a significant role in the villages of north-eastern Tanzania. Colonial policies of European powers had a severe impact on Africa's media landscapes so that many particularities of the continent's actual communication channels are considered a colonial heritage. Tanzania, ruled by Germany and Britain had an advantage under Britain. In Great Britain, there was no legal tool to normalize the establishment of print

media except the Newspaper Libel and Registration Act of 1881 that indebted publishers to enter their periodicals into public record. The development of Tanzania's electronic media has, hence, a history along the lines of British Broadcasting Corporation (BBC). The colonial masters regarded broadcasting as the most efficient medium since it was able to overpass great distances and to reach the illiterates. The colonial mass media were centralised and the mouthpieces of the government. In respect to the native population, the administration regarded a monopoly on the information sector as central requirement for ruling and educating the society and as a result controlled the flow of communication. A strong nationalist press in Tanzania could only develop during the last years of foreign rule in which Julius Nyerere was the editor of Sauti ya TANU "The Voice of TANU" (Sturmer, 1998).

After independence in 1961, Tanzania like many African states, that Francis P. Kasoma accused of 'press phobia' strengthened its influence on the media sector by commanding statutory controls. Leaders were convinced that privately owned newspapers would act without accountability and tend to overstretch the limits of press freedom. Therefore, politicians assumed that uncontrolled journalism would jeopardize the national integration by creating the atmosphere of dissatisfaction and disunity. Concerning this, newsgathering and distribution was monopolised by national news agency known as Shirika la Habari la Taifa popularly known as SHIHATA (Sturmer, 1998).

According to Ogunade (cited in Sturmer 1998), Tanzania with an area of 364,900 square miles, includes the highest and lowest parts of Africa, which were great barriers to communication. Tanzania's size, relatively low population density, few urban centres, and scattered rural population had all influenced aspects of its mass media. For example, daily newspapers were urban oriented and large capital expenditures were required to bring radio signals to the scattered rural population. However, Tanzania had an advantage of the widespread use and understanding of a national language, Kiswahili. Despite this, the high illiteracy, little urbanization, and low per capita income of the masses had combined to stunt the growth of the press and make radio the pervasive

medium to RRPs it is to the time of the study. The press, up to date remain a medium with a limited audience in the rural areas largely due to high illiteracy, low income and distribution problem. After its independence, Tanzania experimented with the largest and most ambitious rural newspaper project in East Africa and its Kiswahili monthly "Elimu Haina Mwisho" (Education Has No End), with a circulation of 100,000 copies. Due to some reasons, probably high cost of running, the newspaper could not be sustained and was therefore stopped from printing.

However, at the time of study, radio, newspapers, magazines, pamphlets, brochures and other forms of print media, television, internet, films and all other forms of audio-visual tools were more effective than ever before. After the political changes in Europe in the late 1980's, donors compelled Tanzania to adopt the structures of democratic societies. The implementation of multi-party policies led to mushrooming of private newspapers, radio and television stations. Journalists' associations and media councils had taken the place of the government, and the credo of journalistic ethics had replaced restrictive media laws (Sturmer, 1998).

However, though by 2005 Tanzania had about 500 registered newspaper titles, 34 television stations, and over 60 radio stations (The Guardian, Wednesday, August 24, 2005), most of these were elitist and urban-oriented. Radio was probably the country's most important means of disseminating news as indicated by survey of Tanzania's communication system done by Condon. However, there is no accurate available data that is up-to-date on the number of radio sets in use in the country, especially in rural areas. According to Sturmer (1998), by 1981, an estimated 500,000 radio receivers and 7,200 television sets in Zanzibar were in use.

Zanzibar's communication sector had never corresponded to that of the mainland thus communication was not a union factor. The island had both the first newspaper, Msimulizi, and the first daily of the country: The English and Gujerati paper Ruta was published in 1914. Moreover, on March 15th 1951, Zanzibar's broadcasting station "Sauti ya Unguja" was inaugurated just a few months before "Sauti ya Dar es Salaam." By launching the first colour television in Africa on January 12th 1974,

Television Zanzibar is also on Africa's media-historic record. For a long time the Tanzanian government held back on the introduction of television partly out of a desire to wait until it has capacity for local production. However, since its introduction the rural areas populations could not take advantage of the media due to high running cost involved (Sturmer, 1998).

Other means of communication such as public speeches, rallies, demonstrations, dances, oral literature and group singing were utilised before colonialism to communicate contemporary messages. It was common for communities and groups to communicate with government leaders and politicians through traditional dancing, songs, folklores, and messages and all of these were unmistakably compelling. In these complicated days for both the population and the government, the mass media were important tools in motivating discourse and informing people on diverse issues. Nevertheless, communication scientists and international journalists' associations claim that the media sector of the East African state is not yet ready to perform these roles for three reasons. The first is that the mass media are heavily urban-based. Although about 70 percent of the population, live in rural areas, both electronic and print media focus on the country's economic and political centre, Dar es Salaam. In the about three million inhabitants' metropolis, nearly 80 percent of Tanzania's periodicals appear, and all primary television and radio stations are located.

The second reason is that the major proportion of the news people lack experience in the mass communication. Due to "Mageuzi" (a Swahili word for change based on the 1990's political reforms), the mushrooming of the media sector has led to an increasing need for journalists, and thus, to a strong competition for able journalists. The number of media workers raised from 600 in 1992 to more than 3,000 in 1996, but only a few of them graduated from one of the country's two journalistic facilities, the state-run Tanzania School of Journalism (TSJ) in Dar es Salaam, now known as the Institute of Journalism and Mass Communication (IJMC) under the University of Dar es Salaam or the Catholic Mwanza based St. Augustine University of Tanzania (SAUT), formerly known as Nyegezi Social Training Centre (NSTC). Hence, professional ethics

often remain unconsidered and outrageous hoaxes resulting from scoop-hunting are the order of the day.

Lastly, one of the outcomes of the above-mentioned development is that the elected government under Benjamin W. Mkapa (a former minister of Information, founding director of the national news agency SHIHATA, and former editor of the party papers) fearing the country's disintegration had to use undemocratic ways to put strain on the media. By July-August 1996, four newspapers had been banned from publication. In addition, the Tanzania Broadcasting Commission had revoked radio and television licenses from altogether twelve stations (Sturmer, 1998).

2.2.1 Mass Media and Knowledge on HIV/AIDS

In RRA, mass media is limited to transistor radio and to some degree print media. Generally, newspapers and other forms of print media would find difficult in getting there because of the poor infrastructure, and even if they were to reach, they would lack the market among the poor majority of the population. Hansson (2006) conducted a research on mass media in Tanzania and found that media in Tanzania carried frequent report about HIV/AIDS and media workers thought that they had an impact. However, there were crucial flaws in HIV information conveyed in Tanzanian mainstream media, for example, mass media distanced their audience from the issues being discussed. Hansson argued that information about HIV/AIDS was deduced mostly from political statements, workshops and statistics. It was rare that media institutions approach 'the man in the street' to ask for his/her opinion about this topic that concerned all Tanzanians. The media workers made little reflection on how grassroots levels perceived the information. They took for granted that audience understood the media messages. There was also a habit of regulating the language to use in HIV/AIDS information so that it could be politically correct but in doing so, it distanced information from the targeted group.

Safe sex advertisements and warning against unsafe sexual practices (*ngono zembe*) that were on television, radio and newspaper (Shayo, 2001) were unlikely to

reach remote rural populations. Even in some areas of a city like Dar es Salaam, there were a handful of people who did not know what “ngono zembe” meant. The warning against unsafe sexual practices included the advertisements to convince people to use condoms that scholars like Shayo (2001) claimed to help in prevention of HIV/AIDS infection. Whether condoms helped in curbing the spread of HIV/AIDS or not was not the central focus of this study, but how many people in remote rural areas knew the proper use of condoms.

Like some parts of the country’s RRAs, after the collapse of the cotton market due to problems of lack of inputs, lack of marketing facilities and poor infrastructure, the study area had no steady cash crop to generate real income (Ballart, 1996). Thus, people could not afford mass media like transistor radio, which were considered a luxury in a community, a community that from time to time could not even satisfy its basic needs thus making hunger a constant visitor. Therefore, it was clear that if we were to take a rain check on this matter, we would realize that the mass media could not reach people in remote rural areas, in which case, something else should be excogitated to spread the awareness and basic knowledge on HIV/AIDS.

2.3 Rural areas and Data on HIV/AIDS

Between 1st January and 31st December 1999, 8,850 AIDS cases were reported to the National AIDS Control Programme (NACP) from 20 regions of mainland Tanzania bringing the number of AIDS cases to 118,713. Simulation model estimated that only 1 out of 5 AIDS cases were accounted. NACP estimated that 44,250 AIDS cases occurred in 1999 and 600,000 cumulative cases had occurred from 1983 to 1999 (www.ppu.go.tz, 2005). An analysis of HIV/AIDS in Tanzania performed in 1997 showed a worsening epidemiological situation whereby the epidemic had rapidly spread to rural areas, increasing the previously low rural prevalence to more than 10% in some areas. Mother-to-child transmission appeared to be on the increase, as more and more women continued to become infected (http://www.tanzania.go.tz/hiv_aids.html, 2006).

HIV/AIDS has become firmly established in both urban and rural areas in Tanzania (Hales, 2003)

Claims were that urban areas had a higher prevalence than the rural (Shayo, 2001), while this might be a well accepted 'fact' at a theoretical level, it might not be so in real life, since rural people lacked testing facilities and many HIV/AIDS cases went unnoticed. Moreover, towns and cities had a higher population rate than most of rural areas; therefore the ratio would go with how big was the population, not just numbers. If a city had a population of 1 million and out of them 200,000 were HIV positive (20%) and a village had a population of 20,000 and 7,000 were HIV positive (35%), the conclusion should then be that the rural area was more affected. However, how can we achieve such knowledge if the rural people lacked means of communications and information to give them HIV/AIDS awareness information? Most of the data that were available about HIV/AIDS in Tanzania were from antenatal clinics, blood donors and voluntary counselling and testing centres and in rural areas these services did not exist. Looking at the data we saw that the difference was not all that huge. According to UNAIDS (2002) Tanzania's rate of prevalence for women attending antenatal clinics was 17% for urban areas and 14% for rural areas (www.unaids.org/en/Regions_Countries/Countries/tanzania.asp, 2002). In Bunda District, for example, there was an approximation of 8% of HIV/AIDS incidences and it was only 1% of the District that has been tested. A large number of village faces die weekly from HIV/AIDS and open discussion is nearly absent (http://yogizz.free.fr/malaika/pro_hiv.html, 2006). A study conducted in a community of prostitutes in Morogoro, revealed that HIV positive prostitutes returned to their home villages when they started to get sick and finally died (Katapa and Shundi, 2003; Mlay, 2006). We canot remove the possibility that these prostitutes could have unsafe sexual contacts in their villages before they died. In 1994, a small area with a population of 20,000 people's mobility was followed up. It was shown that mobility and marriage were critical contextual factors, and sexual mixing was dynamic and diffuse. However, it did not appear to be possible to identify and target spread or maintenance networks.

Thus, an area-based strategy seemed more feasible and suitable than an approach aimed at high-risk networks (Boerma, 2001).

A UN Report of 1989 confirmed that sub-Saharan African countries had both inaccurate or scarce data on HIV/AIDS, and those available were hardly reliable. Sixteen years after this UN report, the situation had not shown any significant improvement in Tanzania, in which data was still scarce, inaccurate, and those dying or living with HIV/AIDS in the remote parts of the country as well as in towns and cities were not known. This explained the reason for some scholars' claim that urban areas had higher prevalence of HIV/AIDS than rural areas, a claim that could not be justified. To address this, thorough research at grassroots levels was crucial.

2.4 HIV/AIDS and the Beliefs in Witchcraft

In Africa, the transmission of HIV/AIDS takes place against an environment of general ignorance and the saga of traditional medicines as cures. The pains made over many years to help people understand the risks connected with certain practices were still insufficient, given the scale of the predicament (Holvoet, 2005). In addition, AIDS in Africa destroys communities because of beliefs in witchcraft. In many parts of Tanzania, HIV/AIDS cases concealed behind beliefs of witchcraft thus making the disease related cases to be dealt as bewitchment and taken to witchdoctors for cure (Katapa and Shundi, 2003; The Malaika project at http://yogizz.free.fr/malaika/pro_hiv.html, 2006). HIV/AIDS victims needed support from the community, which ranged from economic, social to psychological. Though AIDS was and still is an incurable disease, the society can help the victims to live comfortably with HIV/AIDS without stigmatising them. Stigma plays a major role in fuelling HIV infection (Joinet, 1994; Hales *et al*., 2003; TACAIDS *et al.,* 2005).

There was an urgent need for provision of basic knowledge on HIV/AIDS and to get rid of all the mysteries associated with it. We cannot help RRP concerning HIV/AIDS spread if there was no assessment done to know how much it did know

already, and how far it was from what it was supposed to know. Witchcraft was a common belief among people in Tanzania and they were travelling long distance to look for witchcraft suppression which was referred as being 'shaved' (kunyolewa) or being 'cleansed' (kujisafisha) (Maia, 2005). Each time people got diseases they were not familiar with and were unable to find better explanations, they tended to run for explanations to witchcraft and religious fates. If RRPs do not get basic knowledge on the disease, stigma would always be attached to the disease because people still consider HIV/AIDS as a shameful disease that infects promiscuous individuals (Hales, 2003).

2.5 Knowledge about HIV/AIDS

Educating people about HIV/AIDS and teaching them skills in critical thinking, decision making and communication, improves their self-confidence and ability to make informed choices, such as postponing sex until maturity and how to protect themselves from HIV/AIDS, other STIs and unwanted pregnancies (www.unaids.org/en/Regions_Countries/Countries/tanzania.asp, 2002). Sub-Sahara African countries had 13 education based HIV/AIDS prevention programs targeting children and youth (Valerio, 2004). TACAIDS was the strategic leader and coordinator of such programs in Tanzania mainland. The Zanzibar AIDS Commission (ZAC) was responsible for overall leadership and coordination of the response on the islands, others were like U.S. President's Emergency Plan for AIDS relief, but none of them had reached the remote areas of the country. Historically, Tanzania urban areas have received the bulk of HIV education programming, with rural areas being left behind. Most of the primary school children in rural areas were not aware of the cause of HIV infection and the lack of proper knowledge on the transmission of HIV translated into lack of protective and health practices (http://yogizz.free.fr/malaika/pro_hiv.html, 2006).

When the country launched a mass media campaign to promote discussions of the female condoms between partners to prevent spread of HIV/AIDS, it was demonstrated that only about 38 percent of the respondents had been exposed to the

mass media campaign (www.guttmacher.org/pubs/journals/2815102.html, 2006). The mass media exposure significantly increased the likelihood that a man or a woman would discuss use of the female condom with a partner, which in turn strongly influenced the intention to use the female condom in the future (Sabido, 2006). Though people have been praising the power of the mass media in influencing people, it is the peer educators and providers (however, limited coverage they had) who had stronger impact than the mass media on an individual's intention to behaviour change and practices (Agha and Rossem, 2002).

Tanzania had tried a number of interventions to reduce the number of HIV/AIDS infections. The National AIDS Committee coordinated a concerted national response against the scourge in five main areas, these are multisectoral involvement including participation of NGOs, decentralization to the districts, ward, and village levels and community mobilization (Rugemalila *et al.,* 1994:1). In 2006, eleven years later, most of these have not taken place in the remote rural parts of the country; no community mobilization, no management of STIs and no involvement to prevent and control AIDS. Since AIDS is a late consequence of HIV infection, the long incubation period of between 5 and 10 years and the absence of significant symptoms at the early stages of infection, made it impossible to know the exact number of HIV infections in the country. The only reliable data available was that of from blood donors and the few sero-prevalence studies in selected regions (http://www.tanzania.go.tz/hiv_aids.html, 2005).

HIV/AIDS is an issue for every Tanzanian, every household, every community and society in general, but there were a good number of Tanzanians in rural areas who did not have enough information on HIV/AIDS thus prevention and control was an unreachable star for them. Honourable Malecela, J.S., the then MP and first Vice President (1994) argued that training on AIDS prevention should start before puberty because it was easier to help one maintain safe behaviour than to help one change from risk to safe behaviour. The most important measure to curtail spread of HIV/AIDS is to launch campaigns on educating children; he argued (Rugemalila *et al.*, 1994:2ff).

2.6 Conclusion

Literature showed that mass media could shape people in acting a certain way, and in Tanzania mass media was a role model in relaying HIV/AIDS information to the populace. However, the history of mass media in Tanzania has had its own setbacks that affected it to the time of study (2006). The AIDS pandemic was taking place in Tanzania amidst beliefs in witchcraft and absence of data of people living and dying from the disease. Therefore, we not only argue that RRA did not have enough information on the disease but also lacked data on people who were living or dying from HIV/AIDS.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

The chapter discusses the methodology adopted in order to accomplish the objectives. The sections describe the study area, criteria used to select the area, the general approach to the study, sampling procedures, data collection methods, data analysis techniques and limitations of the study.

3.2 Site Selection

The study was carried out in Ebuyu/Liheta village in Ulanga (Mahenge) District in Morogoro region which is in the Southern part of Tanzania bordering Songea. The study area was chosen based on the following criteria:

1. Poor geographical location for accessing HIV testing facilities.
2. Remoteness from the centre of the modern means of communications with difficult or bad infrastructure that was almost impassable at some point in the course of the year.
3. Locality that had no or difficult access to modern means of communication such as televisions, transistor radios, print media, internet, etc.
4. Rural area that had little or no literature written about HIV/AIDS status.

Based on the characteristics mentioned above, a village called Ebuyu/Liheta within Morogoro region in Ulanga (Mahenge) District was chosen.

The study was conducted between August and October 2005, in a remote rural village of Ebuyu/Liheta and its surroundings, located in Ulanga District in Morogoro region, which is in the southern part of Tanzania. Ulanga is among the poorest districts in Morogoro region. It is land locked and has only one road that connects it to the regional headquarters. During the rain season, the mountainous Ulanga with its slippery

earthly roads was a difficult area to reach by vehicle (Ballart, 1996; Maia, 2005). A rather steep mount Ndororo, few kilometres from the district headquarters and mount Mbangayao, which is after the headquarters on the way towards Ebuyu/Liheta village made access to the district a double hassle. Another setback in getting to Ulanga was the Kilombero River (situated about 80 km from Mahenge), which was difficult to cross in both dry and wet seasons. When the river flooded, the ferry could not be used, which was also the case when the water was low; and both extremes were common.

Getting to Ebuyu/Liheta and its surrounding villages, i.e. Ihoti, Kunamahomba, Isyaga, Sali, Lusanga, etc involved forty-five kilometre travel from the district centre and walking about twenty kilometres from the main earthly road that had no reliable means of transport. In 2005, Ebuyu/Liheta village had a population of about 3,117 people. Among these 2,234 were abled bodies, 1,373 being female and 861 male. There were 188 female children of 0-5 years and 174 male. It had a total number of 521 schoolchildren, with one primary school that had seven teachers and no secondary school (Field data, 2005). Most of the villagers were Christians with two or three scattered Moslem families. The people in the area were peasants growing paddy and maize and some sunflower. Cotton which was grown in most parts of the lowlands as the main source of income was less compared to previous years due to lack of inputs, lack of marketing facilities and poor infrastructure (Ballart, 1996).

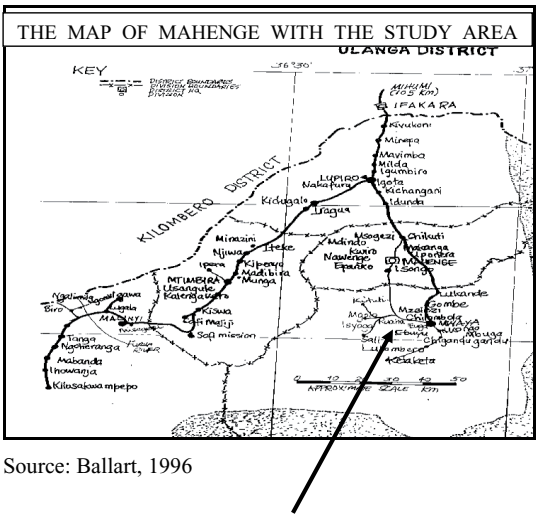
The rains in this area start in November, December and January. February and March are period of heavy rains which start to decline in early April. During November to January period there is increased stress in preparation of farms and at the same time people start to experience shortage of food up to months of January and February. Harvest season for paddy starts from May to June, for maize is from April up to June and cotton is harvested from July to September. The people migrate to towns in June and August when there is no field work and come back in September ready to prepare the farms (Ballart, 1996).

The area has been experiencing worsening situation in all sensitive areas such as decreasing social and economic services, increasing costs of basic needs and

increased rates of school dropouts, rates of absenteeism, unemployment, alcoholism, even use of drugs in some villages. Ulanga District was at one time famous for its production of rubies that attracted many people from all over the country (the coming together of people from different places, as much as we would not want to admit could be a source of HIV infection to spread in certain areas). Selous Game reserve which is one of the famous reserves in the country is located in the district. This could be a source of income but due to poor transport, the Game Reserve can only be reached during dry seasons of June, July, August and September (Ballart, 1996).

The village had an old, hand-drawn map that could be found in the office of the Village Executive Officer (VEO). The village was divided into three sub-villages (vitongoji), which were Ebuyu, Mabwerebwere and Chiraga. Ebuyu was the largest part of them all. The village had 301 illiterate people, with Ebuyu having 117, Mabwerebwere 81 and Chiraga 103. According to the 2001 census, the village had 471 households; among them 210 households had radio sets though most of them were just monuments of old time's fame. The village had no data on people who had died or lived with HIV/AIDS, and there was no organization or individual working on HIV/AIDS awareness campaign or related fields.

Figure 1: Map of the study area



Source: Ballart, 1996

3.3 Data Collection and Analysis

The study was mainly qualitative with the purpose of getting the perspectives and knowledge of the respondents on HIV/AIDS. The little of the quantitative component was adapted to provide statistical data on the actual number of people involved in the research, their basic characteristics, level of education, economic income and levels of well being etc. On this account, both qualitative and quantitative information (sequencing approach) were to complement each other and thus make the final result of the research much richer and its recommendations sounder (Fielding and Schreier, 2001).

The main objective of the study was to find the knowledge/awareness level of the RRPs but since the assumption was that mass media was the model for spreading the awareness; the study had first to assess the presence of the mass media in the study area. This was to act as a control measure in three ways.

1. If there was low level of knowledge/awareness and yet mass media was present with HIV/AIDS information there would have been a need to find an explanation for the ignorance and question the accuracy and appropriateness of the mass media.
2. If mass media was not there and yet there was knowledge/awareness, there would be a need to research for alternative sources that were taking the role of the mass media in spreading HIV/AIDS information among the RRPs.
3. If there were both no mass media and no knowledge/awareness then again there would be a need to question the role of the mass media in spreading HIV/AIDS awareness in RRAs.

The research was carried using the rapid rural appraisal methodology, which is a process of learning about rural conditions in an iterative and expeditious manner. It is multi-disciplinary natured and has an in-built flexibility in the process of collecting information. Since the study was time limited, rapid rural appraisal was chosen because it is a systematic activity designed to draw inferences, conclusions, hypotheses and assessments, including acquisition of new information in a limited period of time (Kashyap, 2006). In addition, transect walks and direct observations with key informants, semi-structured interviews and social mapping methods were made.

Besides reviewing relevant literature concerned with HIV/AIDS related activities in Tanzania, the study involved collection of primary data. The instruments used in data collection were: questionnaires, Focus Group Discussions (FGD), interviews, and resource and social mapping. There were 301 questionnaires, which were adapted into local language (Kiswahili). These questionnaires were distributed to 301 households. This took into account the target groups identified in the study project document. Some parts of the questionnaires were formatted to allow open-ended responses. Then individuals identified as knowledgeable people, were taken as key informants for interviews using both semi-structured and open questionnaires. Four FGDs with young people (both male and female), village authorities' leaders, village elders and teachers were attempted.

The study pursued a further in-depth study of particular cases of great and special interest to provide a deeper representation of issues that came out in the focus group discussions. Resource and social mapping were utilised. This was a powerful tool for a visual representation of the localities showing various resources (e.g. land, water sources, and recreation areas, socio-economic infrastructure, including roads, schools and clinics). Three groups from the targeted population (14 students, 19 youth and 11 adults; of which 20 were female and 24 male) were involved in the exercise of mapping existing resources and threats within their localities with the guidance of the researcher. Through mapping exercises, the researcher was able to locate the areas with incidences of HIV/AIDS, places where the villagers considered dangerous or risky in the fight against HIV/AIDS. The study also employed direct observation. This enabled the researcher to gather relevant and sufficient information even before interviewing started. Although it was not possible to observe people in actual risky situations, it was possible, however to systematically observe existing behaviour, attitude towards HIV/AIDS and the risks taken by the disadvantaged groups such as women.

Qualitative data was subjected to content analysis for appropriate information while quantitative data provided the requisite statistics to enrich the qualitative justifications and statements made. Statistical Package for Social Sciences (SPSS) computer software was utilised for data analysis.

3.4 Sampling Procedures

The study picked 301 households from the available 471 households. It used both probability and non-probability sampling to select the needed groups thus probability sampling was used for questionnaires but interviews and FGDs used non probability sampling. The main guiding criteria for the choice were:

- The type or group of people that were to be studied were HIV/AIDS infected, families with people living with HIV/AIDS, school dropouts, gender, people who

were considered knowledgeable by other villagers, people working in the health field, village authority, etc.

- The types of activities in which the members of the mentioned target groups were engaged in (i.e. what does the family do to earn a living).
- The traditional ways of social differentiation i.e. the elders (mbuyi), the adults, the young and children.

The sampling frame consisted of people living with HIV/AIDS and/or those in high risk of being infected, people affected by HIV/AIDS and those considered knowledgeable by the other villagers (men and women). There were also village officials ranging from village government to the medical team. A probability sample of 301 households out of 471 (63.91%) was drawn from this population using available list of the population from the office of the Village Executive Officer (VEO). This sample was representative with +3% degree of accuracy (Bernard, 1994). Then a non-probability sample was drawn from the former sample for interview, FGDs and mapping. The sample consisted of 54 schoolchildren, 15 business people, and 19 employed people including seven primary school teachers, two Roman Catholic priests, VEO, three village nurses, a drug seller (pharmacist) and one village catholic catechist. 192 of the total sample were peasants who formed the majority of the locality while 21 persons had other activities. The research expected to include more people with higher education, but unfortunately, people in this group were rather limited. Due to lack of testing facilities, only one person living with HIV/AIDS was identified, and one family that was affected with HIV/AIDS was involved in the research. Others were 41 people who had never attended formal education or dropped out of primary education, two religious leaders, seven local leaders and six individuals whom other villagers named as "knowledgeable people." Unfortunately, the village had no individuals or groups working on HIV/AIDS related field. The sample took into account the age, gender, exposure, education level, and economic capacity of the respondents.

3.5 Limitations of the Study

The first and foremost limitation was inherently embedded in the case study method. A case study is an empirical inquiry that investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not evident; and in which multiple sources of evidence are used (Yin, 1984). The study was limited to only one village and its results cannot be generalized to a wider population. However, we can generalize the findings to 'theory' analogous to the way a scientist generalizes from experimental results to theory, analytical generalization (Yin, 1984). Another limitation was that the village was far from town and with very poor means of transport almost impassable at times especially during the rainy seasons. Again, Sex was a taboo in this community under study thus it was not easy at first to get people to talk about it especially for older members. Since the populace was not familiar with the idea of research, rumours started to spread that if someone went for interview he/she would be told of his/her HIV status by the researcher and many were not comfortable with the idea of knowing their status.

The researcher tried to design ways that circumvented the limitations. The case study limitation was poised by involving a larger sample size of over 60 percent of the households. Due to the poor transportation, the researcher had to go to collect data during a dry season (September to October). The researcher also got help from the catholic parish priest of a nearby parish who had a parish car; therefore, he could travel back and forth the village and the district headquarters with ease. The sexual taboo obstacle was solved by the use of questionnaires where respondents had to write without signing their names so they felt safe that nobody would know who wrote what. As for the last limitation of HIV status, the researcher had to give explanation once again about the aim of the study and at the end, I shared the findings with them.

3.6 Conclusion

This study selected a remote rural area in Ulanga district in Morogoro region as a case study not to make generalization, but to illuminate the issue studied. Both qualitative and quantitative methods in rapid rural assessment as well as participatory rural appraisal were used. Thus, it was able to use these methods to compliment each other.

CHAPTER 4

DATA PRESENTATION AND ANALYSIS

4.1 Introduction

The data analysis followed the strategy of the proposition that if mass media were the major tool in disseminating HIV/AIDS information and ultimately raising awareness and if RRPs could not access it then the RRA s would be without HIV/AIDS knowledge. The research used 312 questionnaires that were distributed to 312 households (63.91%); 301 (96.47%) of the total questionnaires were returned. The questionnaires were distributed according to the social categories of the village, age, gender, level of education, marital status and occupation. The village had three sub-villages, Ebuyu, Mabwerebwere and Chiraga. Each of the sub-villages was given 104 questionnaires. From Ebuyu 101 questionnaires were returned, Mabwerebwere had 98 and Chiraga 102, making 301 questionnaires in total (Table 3).

Table 3: Respondents by location

Sub-village (kitongoji)	Gender		Total	Percent
	Male	Female		
Ebuyu	49	52	101	33.5
Mabwerebwere	54	44	98	32.5
Chiraga	47	55	102	34.0
Total	150	151	301	100.0

Source: Field data, August to October 2005

Ten questionnaires were distributed to three top primary school students of standard five and six, and their teachers. These classes had in their science syllabuses a topic on HIV/AIDS, thus the students were expected to be “knowledgeable people.” Among the ten questionnaires, nine were returned to the researcher, which was 90% of the total questionnaires distributed (Table 4).

Table 4: Teachers and Students Profile

	Frequency	%
Male	8	88.9
Female	1	11.1
Total	9	100.0

Source: Field data, August to October 2005

Most of the questionnaires were dully filled with exception of five questionnaires (5.81%) that were distributed among the families with drunkards members and committed Catholics, the latter thought that their answers to some of the questions would mean making a moral judgment.

4.2 Respondents' social-economic profile

4.2.1 Age and gender

The age and gender of respondents involved in the research are as shown in Table 5 below.

Table 5: Cross tabulation of the respondents' age and gender

Age	Gender		Total	%
	Female	Male		
Below 18	25	24	49	16.3
20-25	43	17	60	19.9
26-30	25	10	35	11.6
31-35	23	12	35	11.6
36-40	15	30	45	15.0
Above 41	20	57	77	25.6
Total	151	150	301	100.0

Source: Field data, August to October 2005

Table 5 above indicates that 179 (59.5%) of the respondents were aged between below 18 and 35 years old. This was purposely done as it is argued that this was the group that was mostly affected by HIV/AIDS pandemic. The Table also points out that 150 (49.8%) of the respondents were males and 151 (50.2%) were females. This was an

effort to balance the two genders since the two genders thought and looked at things differently. Furthermore, over 50 percent of Tanzanians who live below the poverty line, females take a higher percentage than males, which affects their access to medical care including that for STIs and HIV/AIDS (Tanzania National Website, 2005).

4.2.2 Education

Education plays a key role in learning and knowing the importance of health issues. People who have different levels of education tend to react to health issues differently. Educated people tend to be more knowledgeable in matters of health (therefore should be more aware of HIV/AIDS than those who are not educated) because they can read the newspapers, pamphlets, banners, posters, etc. In addition, these people are presumed to have travelled more than those who do not have formal education because often schools are not located in the local areas thus cannot meet people, come across different types of mass media which could increase their awareness on HIV/AIDS.

Out of the 301 respondents 233 (77.4%) had primary education, Twelve (4%) had secondary education, 41 (13.6%) had no formal education and 13 (4.3%) had colonial primary education. While 2 (0.7%) had higher education. The research data reflect the low level of education of the population. Before the ward had a secondary school, the only secondary school was at the district level in Mahenge.

In 2005, the ward had built its own secondary school called Mwaya and the village was showing good progress, unlike its neighbouring villages of Euga, Isyaga and Sali, each year more than six students were being selected for secondary education. However, there were two obstacles. One was that people had already lost heart with the past poor performance and the poor performance of the newly built secondary school in national examinations. Secondly was the lack of fund to pay for the tuition fees. The villagers were mostly peasants who had nowhere to sell their produces. Coupled with the fact that their farming was subsistence (Ballart, 1996), it was understandable that most parents could not pay the school fees of about Tshs 50,000/- for each child per year. The few citizens who had gone beyond secondary school education were located elsewhere

in towns and cities. It was unlikely, however, to find a highly educated person in remote rural areas, which was why the secondary school (Mwaya) was facing a shortage of qualified teachers, as the teachers posted in the ward could not stay for more than a year. This trend was apprehensible as most of the highly educated people were located in towns and cities where they could lead a comfortable life and utilize their education, which rural areas could barely offer.

Male members of the community had more formal education than females. Out of 41 respondents who had no formal education, 34 (83%) were women (Table 6). This revealed the mentality of the community that considered educating a female child a waste of time and resources. One of the respondents remarked in an interview "To educate a female child? I would better use my money to buy alcohol. She will get pregnant and leave me confused!" This had a big implication in the study for more women than men were vulnerable to the transmission of HIV/AIDS. More so, in physical care of HIV/AIDS infected relatives, women were more involved than men, meaning that their low level of education increased their chances of becoming infected. Illiteracy and lack of formal education was on the rise in Tanzania. In the 1980s, the level of literacy in the country was around 80 percent and many people could read and understand messages for their well-being (http://www.tanzania.go.tz/hiv_aids.html, 2005). In 2005, the figure has dropped to less than 60 percent, which meant that less people could understand written messages. This was the result of less young people getting enrolled to schools and this was unfortunate because it was found out that the prevalence of HIV/AIDS in educated women was lower than in uneducated ones (http://www.tanzania.go.tz/hiv_aids.html, 2005)

Table 6: Respondents' Education and Gender

Education	Female	Male	Total	%
Colonial education	10	3	13	4.3
Primary education	103	130	233	77.4
Secondary education	4	8	12	4.0
No formal education	34	7	41	13.6
Higher education	0	2	2	0.7

Total	151	150	301	100.0

Source: Field data, August to October 2005

4.2.3 Marital Status

Data demonstrates that there was 3 (0.9%) of divorced people involved in the research, 130 (43.1%) of married couples, single people were 91 (30.2%), 71 (23.5%) were staying together without formal arrangements and 6 (2.3%) of the total were widows/widowers.

4.2.4 Occupational status

The research tried to include all the employed people available in the village; these included the Village Executive Officer (VEO), the primary school teachers, the nurse, the clinical officer (CO) and the village catechists. It also included business people, students and others, in a community where majority were peasants. The assumption was that the employed people had more purchasing power than the peasants, thus, they could acquire different types of media tools and gain more knowledge on HIV/AIDS than the poor peasants. In addition, they could also buy condoms if they needed them. Table 7 below shows the occupational status of the respondents in accordance to their gender.

Table 7: Occupational Status of the Respondents According to their Gender.

Occupation	Gender		Total	%
	Female	Male		
Student	24	30	54	17.9
Business Person	4	11	15	5.0
Employed	6	13	19	6.3
Peasant	105	87	192	63.8
Other	2	19	21	7.0
Total	141	160	301	100.0

Source: Field data, September 2005

According to Table 7 above, peasants were 192 (63.7%). The females were higher than males. However, when it came to employment, women were fewer than men

in the ratio of 1:2.16. As it reverberated in the education level (Table 3), more male children were sent to school than female children, with a ratio of 1:1.25. The ratio for business people between the two genders was 1:2.75 with males being more than females. From these data we could deduce that the community had a low purchasing power, which presented a difficult in accessing mass media and the use of condoms.

4.2.5 Direct observations

The study area had no poster, banner, board or anything that warned people or raised awareness on HIV/AIDS pandemic. The only display board to raise HIV/AIDS awareness was in Mwaya, about 40 km away. The researcher was able to meet one person wearing a t-shirt with ISHI campaign message "Wait or use a condom." However, in an area where only a handful passed through secondary school education, such a message was of no use because most could not understand the English language. Moreover, since it was election campaigns time, there were many t-shirts and posters with election slogans all over the village. Most of the radios that people had were not working, mainly this was due to lack of money to buy batteries or the radios were faulty. Generally, only a handful cared about national and international news, the few villagers who had radios listened mostly to sports news on RTD and Radio ONE. The villagers came to one who had returned from town or city to ask for pieces of newspapers, not to read but to use for tobacco rolling to smoke. However, before they used it for tobacco they perused through the pages, and this was accurately what they called reading newspapers.

Traditional dances played a significant role in the lives of the locals in the study area. "Sangula" and "Shinyagu" the two traditional dances of the area were second hot stuff in this community after the local brew, and were mostly played till late on Sunday evenings. However, in 2005 the village authorities had banned it, arguing that it contributed to early pregnancies. If it was true, then it could as well be a factor in promoting the spread of HIV/AIDS. Though if songs were composed to raise awareness on HIV/AIDS, sangula and shinyagu could have been the best way to reach majority of

the population, none of the two dances had any song to raise awareness on HIV/AIDS; instead, they had many lyrics that helped in promoting promiscuity among the youth and adults. For example, a Sangula song had lyrics with words such as “tukutane kisimani dada” which meant “young lady, let’s meet at the well.” Wells in this community had a long history of being used as meeting places for lovers who had something to hide about their relationship. The same was true for the farms; a woman (most often if it was the farm of the woman that was used) who had extra-marital affair, would use them as meeting places. In these places, the partners did the intercourse in a hurry for fear of being caught, and the grass was used as bedding, therefore, even if they were to use condom, it could easily be pricked or slip and partners become exposed to HIV/AIDS virus.

According to one composer, there was no particular song for raising HIV/AIDS awareness, despite that in the 1980s there was a song with a line or two of its lyrics talking about the disease, but it was hardly played at all. Furthermore, the village had no individuals or groups working on HIV/AIDS awareness campaigns and no data of people who had died or lived with HIV/AIDS.

The village had one dispensary that opened in September 2004, was located in Chiraga and had two health workers, a nurse and a clinical officer. As you enter the village from the nearby village of Euga, there was a sign post written “Zahanati ya Ebuyu” meaning “Ebuyu Dispensary.” At the dispensary itself, there were many posters for raising awareness on malaria and family planning campaigns (see Appendix 1). However, there was one poster on HIV/AIDS, but it was not on raising awareness, rather on warning against discrimination of HIV infected individuals (see Appendix 2). In the primary school teachers’ office, there was another poster warning students not to detach from fellow students who were HIV positive who wanted to donate money for provision of desks in the school (see Appendix 3). These posters were in Kiswahili and were user friendly in that they were in a simple language that most people could understand.

4.2.6 Interviews

Interviews with various individuals (10) provided a number of information. About eight (8%) had multiple partners, five of the cases had multiple partners before and after marriage. Only 2 (2%) of the sampled respondents used condoms in their relationships and 7 (7%) denied radios and newspapers being sources of HIV/AIDS awareness. All ten individuals (100%) indicated that radios were unaffordable to majority of the population, and about four (4%) indicated to had learnt about HIV/AIDS through taking care of infected relatives, one (1%) by being infected and visiting Voluntary Counselling and Testing (VCT) services and two (2%) from religious and educational institutions. While about three (3%) got information about HIV/AIDS at the local brew pub where those who heard from radio or other sources narrated to others who do not have channels of information. Three of the respondents (3%) argued that the Anti retro-viral drugs (ARV) distribution programme was marginalising the rural poor, as it only covered the city and town dwellers.

The Catholic Church had argued in the past that the AIDS virus was roughly 450 times smaller than spermatozoon and spermatozoon can easily find its way through the condom (Bradshaw, 2003). Therefore, it was said that these margins of uncertainty should represent an obligation on the part of the health ministries and all campaigns to act in the same way as they do concerning cigarettes, which they state to be a danger. The World Health Organization (WHO) had condemned the Vatican's views saying that they are incorrect and dangerous especially at the time when the world faced a pandemic that had already claimed the lives of more than 20 million and still affected at least 42 million. Against the Vatican's views, WHO argued that condom use reduced the risk of HIV infection by 90 percent. However, WHO admited that there may be breakage or slippage of the condom but not holes through which the virus could pass (Bradshaw, 2003).

It is against this backdrop that the interviews with the two clergies in-charge of the study area were conducted. The two revealed that the Catholic Church had been slow in responding to HIV/AIDS because of ethical dilemma involved. The Church opposed

any kind of contraception because it broke the link between sex and procreation. They indicated that they were trying to inspire the laity to take seriously the call to serve God in their brothers and sisters. In their ministry, they had to walk long distances to visit their Christians, to deliver spiritual needs as well as HIV/AIDS awareness information. One clergy said, "…at times we (clergy) can as well be obstacles to various ventures, the laity should then find innovative ways to offer response as local Church, but they cannot do so against the present situation of ignorance." The clergy pointed that whereby one of the couples is infected with HIV/AIDS, the partners should listen to their conscience. They are the ones that can choose appropriate means, in order to defend themselves against the infection. Both parties should make such intimate decisions as equal and loving partners.

4.2.7 Focus Group Discussions and Mapping

Three focus group discussions were carried out which involved village leaders, seven primary school teachers and 32 youth who indicated that HIV/AIDS was a real threat and people were dying in the villages, but associated the cause of deaths with witchcraft. The village authority indicated that according to the 2001 census, most of the radios that people claimed to had were out of order and print media was not available. Thus, the mass media had shut out this population in its fight against HIV/AIDS. The VEO pointed that people were interested in reading newspapers. However, FGDs were quick to pinpoint out that this did not mean that one would buy a newspapers if they were available. Given the lack of funds among the villagers, one would prefer buying a kilo of salt instead of a newspaper. The study also found out that those who claimed to read newspapers (like Kasheshe, Uwazi, Ijumaa, etc) were not doing so periodically.

Teachers disclosed that in the past the Ministry of Education used to offer HIV/AIDS training skills to head-teachers and their assistants for teaching Standard Five, Six and Seven pupils, because the topics of HIV/AIDS were in the syllabuses. The primary schools had a topic on HIV/AIDS in the science syllabus for Standard Five to seven. However, this village school had only one copy of the science book and it did not

even had a cover, thus it was difficult for the researcher to know the title of the book. This book in chapter six had a topic on sexually transmitted diseases with HIV/AIDS as one among them. It gave a general knowledge on what HIV/AIDS was, causative agent, how the disease was spread, what were the diagnosis, what could be done to avoid being infected and what care were to be given to the HIV/AIDS infected people. It was from this that the researcher opted to pick three top students of Standard Five and Six to measure their level of HIV/AIDS awareness from the knowledge they had acquired in class.

The respondents were able to locate places in the village map that they considered threats in connection to HIV/AIDS. They pointed out local brew bars, petty traders who were vending products in the village especially selling second-hand clothes, home utensils and cosmetics**.** Other things that were posed as threats were traditional dances like "Sangula" and "Shinyagu" and other activities that brought people together in groups, including boreholes that women fetched water. They indicated that wives inheritance was a risk factor that could lead many to be infected. However, by then people were not directly inheriting wives, but they were still having sexual contacts (even living together in some cases) with widows of people who had died without knowing the causes of their husbands' deaths. They argued that though in the past condoms were distributed, people did not know how to use them, and they had no one to turn to for help.

4.3 The Absence of the Mass Media

4.3.1 Sources of HIV/AIDS awareness

According to the Tanzania Demographic Health Survey of 1996, radio, print media, religious institutions, community meetings, health workers, relative and friends were playing a principle role in raising HIV/AIDS awareness in the country. The researcher used similar sources of information to collect data. The results are as presented in Table 8 below.

Table 8: The Sources of HIV/AIDS awareness/knowledge

Source	Frequency	Percent
Community meetings	14	4.7
Educational institutions	25	8.3
Friends and relatives	14	4.7
Health worker	28	9.3
Newspapers/posters/ Pamphlets, etc (print media)	31	10.3
Radio	137	45.5
Religious institutions	35	11.6
Others e.g. being infected	7	2.3
Others e.g. sports	10	3.3
Total	301	100.0

Source: Field data, August to October 2005

The results in Table 8 above seems to indicate that the radio played a major role in spreading HIV/AIDS knowledge/awareness by 137 (45.5%), followed by religious institutions such as churches and mosques which occupied 35 (11.6%) as said, Newspapers, posters, banners, pamphlets, brochures, etc raised awareness to 31 (10.3%). Health workers occupied 28 (9.3%), educational institutions such as school 25 (8.3%) while both community meetings and friends and relatives carried 14 (4.7%). Activities like sports increased awareness to 10 (3.3%) and other sources like experience of being infected contributed to 7 (2.3%).

The findings showed that mass media (radio and print media) played a major role (168 respondents that is 55.8%) in raising HIV/AIDS knowledge/awareness, while religious institutions such as churches, mosques and educational institutions like school together contributed 60 (18.9%). However, this evidence conflicts with the rest of the methods of data collection such as interviews, direct observation and focus group discussions (FGDs) as presented later in the chapter.

4.3.2 People who owning Radios and reading Newspapers

Most respondents claimed to read newspapers and listened to radio, although some of the radios owned were not working anymore. There were 171 (56.8%) of the respondents owning radios and 130 (43.2%) had no radios. Again 200 (66.4%) of the respondents said that they often read newspapers, while 101 (33.6%) denied. However, as indicated before the radios referred here according to other sources i.e. FGDs, interviews and transect walks were out of order because they were faulty or had no batteries. According to the 2001 census done by the village authority, most of respondents who answered 'Yes' to the question were proud owners of useless gadgets. This had an implication on the question that required them to state whether radios helped them to acquire knowledge on HIV/AIDS. Most respondents answered 'Yes' to this question too, but then failed to answer the questions that required them for a show-of this awareness on HIV/AIDS. Again some 200 (66.4%) of the respondents indicated to often read private sensational newspapers (e.g. Kasheshe, Uwazi, Ijumaa, etc.), while 101 (33.6%) admitted to not reading the newspapers.

In the interviews and FGDs, the researcher found that 'often' for them meant thrice or twice in a year, when a relatives or one of the villagers return from town or city bringing an old newspapers. Direct observations showed that there were no evidence of people reading newspapers, pamphlets, brochures, or anything related to print media. When the researcher tried to give fifty people a second set of questionnaires that required them to state the frequency of reading newspapers, among the 48 copies that were returned, 44 (92%) had a frequency that ranged from four months to six months, with the rest 4 (8%) ranging from two to three months. None had a frequency of once in a month. Therefore, the above evidence can be misleading if admitted without using other sources of information verification.

4.3.3 Role of the radios and newspapers in HIV/AIDS awareness/knowledge

Radios and newspapers were the two mass media tools that to some extent reached RRA. TDHS (1996) cited the two as main ways in disseminating HIV/AIDS awareness

information in the country, therefore, the researcher wanted to find out if the respondents thought of them as a resourceful medium. The results illustrate that ten respondents (3.4%) were not sure whether radio and newspapers were the main sources of HIV/AIDS awareness for the community. About 32 (10.6%) of the respondents disagreed that the two were not sources of knowledge on HIV/AIDS, while 259 (86%) confirmed to be educative on HIV/AIDS. Other methods of data collection such as in-depth interviews contradicted the above information, as they indicated that most people did not have access to these media tools. However, for this population awareness meant knowing that there was a disease known as HIV/AIDS, thus each time they got a newspaper (be it after five months or more) and read any topic on HIV/AIDS they would consider that as awareness.

However, the researcher found that other means that RRP used to disseminate information among themselves included, rumour mongering in local brew bars, during farming when people got together to help each other, burial services, etc. In these places those who had radios would tell others what they had heard. The Church was also an important platform for current news among the community and peer educators played a major role, including school children who spread the knowledge to families at home and peers who were not attending school.

4.4 Vulnerability of Contracting HIV/AIDS

The way individuals perceived themselves as being vulnerable to HIV/AIDS affected their behaviour. Someone who thought that he/she was not vulnerable would not take precautions or try to learn more about the disease but those who consider themselves vulnerable or already were affected tended to be cautious and want to learn more. The results of these inquiry whether the respondents considered themselves vulnerable to HIV/AIDS or not are as shown in Table 9 below.

Table 9: Risks in contracting HIV/AIDS

	Frequency	Percent	Cumulative Percent
No answer	7	2.3	2.3
Great risk	70	23.3	25.6
Moderate risk	53	17.6	43.2
Small risk	62	20.6	63.8
No risk at all	109	36.2	100.0
Total	301	100.0	

Source: Field data, August to October 2005

Seventy (23.3%) of the respondents considered themselves at great risk of getting HIV/AIDS (Table 9). Some said that they did not trust their partners, because they were drunkards so they could get involved in an unsafe sex under the influence of alcohol, and after all one could not know if the others were infected until they started getting sick. Other respondents established that there was a big risk because people shared pins for removing jiggers that were common in the village. In addition, rape cases that had recently been happening in the locality had increased the chance of getting HIV/AIDS.

The Sexually Transmitted Infections (STI) among the population had as well increased the vulnerability of contracting HIV/AIDS. Further, people did not know the symptoms of HIV/AIDS or how to avoid being infected. The unmarried people pointed out that they had a big risk because there were no testing facilities in the neighbourhood, therefore they could marry an infected partner who would eventually infect them. Twelve (17.1%) respondents said that since the community had a low purchasing power, it could not share the cost of health services, which pushed it to use of the street syringes by unqualified nurses, but those syringes were unsafe, as they might have been used before. As if being single was a ticket, some respondents put it simply that since they were unmarried they could have multiple partners. In an interview, a respondent argued that disagreement in the family between partners could be a factor for one part to be unfaithful, as that part could be tempted to look for consolation elsewhere. Others indicated that since HIV/AIDS was a disease; we all stand a risk of contracting it. This

showed a poor understanding of HIV/AIDS because it was conceived to be like common cold or flu that one had little or no control over its spread.

The 53 (17.6%) of the respondents indicated to have a moderate risk of being infected claimed to hold enough knowledge/awareness on HIV/AIDS therefore in a way they could control their destiny. However, some said that since they were just living together without any bond (marriage), if the partner started getting sick they would dump her/him before they were infected. This was a revelation that the respondents thought that HIV positive individuals could only infect others after they started to getting sick. For them, someone could not be HIV infected and yet appear healthy. With such understanding, HIV positive persons could infect many before they started getting sick and eventually die. Some respondents indicated that because of their young age they were safe as HIV/AIDS was only affecting people at the age of 20 to 49 years old. Some women disclosed that they did not trust anyone to be safe, but they had nothing to do as they could not avoid having sexual intercourse and could not force their partners to use condoms (worse still was the fact that they had never heard of a female condom).

About 62 (20.6%) of the respondents regarded running a small risk of being infected said that they were faithful in relationships. In the households where partners indicated that they trusted each other, the researcher gave separate questionnaire to each partner and it came out that in a number of cases while one partner claimed to trust the other, the other part was not sure about the faithfulness of the other. Pupils indicated that if they had sexual relationships among themselves, there was only a slim chance that they could be infected. They were unable to realise that even among the students there might be infected people.

The 109 (36.2%) of the respondents considered themselves to had no risk of infection and claimed that they had not been involved in unsafe sex. In FGDs, there were 14 respondents who indicated to had only one sexual partner, but they could not guarantee that their partners did not have other lovers. Women were more sceptical on their husbands' faithfulness. In addition, transect walks showed a different trend away from faithfulness, especially in the local brew bars and traditional dancing parties. Some

respondents who said they run no risk of getting HIV/AIDS, expressed behaviour and practices that contradicted their claim. Moreover, the awareness maintained here was a dangerous risk factor because it made people relaxed, making neither effort to learn more nor pushing authority to give knowledge on how to defend themselves from contracting HIV/AIDS.

About ten (3.3%) of the respondents did not disclose whether they were at risk or not, but went on to give reasons, as they said that they could not know the risk they were involved in because they did not have enough knowledge/awareness on the disease and had never been tested. They indicated that if they were already infected, there was no use of talking about risks, it was only HIV negative people who run a risk of being infected, while they were unable to tell whether they were already infected or not.

4.5 The Eight Indicators of Awareness

In examining the HIV/AIDS awareness/knowledge, the researcher used the following 8 indicators:

1. Understanding of how HIV/AIDS transmission.
2. Knowledge of the ways people can protect themselves from contracting HIV/AIDS.
3. Non-use of condoms in relationships and why.
4. If the population knew that HIV/AIDS was a national disaster.
5. Attitude of the people towards a HIV/AIDS infected person
6. Would they maintain a normal relationship with an infected person or not.
7. Cure for HIV/AIDS.
8. Whether one can know if an individual is HIV/AIDS infected by just looking.

4.5.1 Transmission of HIV/AIDS

On this indicator, none of the respondents could mention all the ways that transmitted HIV/AIDS. Most of them gave one or two ways, and even those given were in need of

correction, for example, one said that: “having sexual intercourse with a person who is suffering from HIV/AIDS could infect a person.” However, oneonly needs to have sexual intercourse with a HIV/AIDS infected person for one to contract it, whether the person has started getting sick or not. Others said that a broken piece of a bottle could transmit HIV/AIDS and they could not explain how.

Some respondents in FGDs consistently claimed that the newly born child could infect a pregnant mother during delivery. This was a fact turned upside-down, as it was the HIV/AIDS positive mother who could infect her child during delivery or breast-feeding. Others just mentioned syringes, razor blades and scissors as ways that transmitted HIV/AIDS, yet they could not mention satisfactory answers on how those instruments could transmit HIV/AIDS. Condoms were also pinpointed not as means to preventing HIV/AIDS infection, but once that can transmit it. A number of the respondents simply could not mention any of the ways. All these indicated that the knowledge gap in the absence of mass media has created a vacuum in the fight against the killer disease in the remote rural areas. Therefore, in this indicator the respondents did not score a point.

4.5.2 Ways of Protecting against Contracting HIV/AIDS

On this issue, the respondents demonstrated a bit of understanding of the ABCs, Abstinence, Being Faithful to one partner and the use of Condoms. However, some said that there was no way individuals could protect themselves or others from contracting HIV/AIDS. Around 42 (14%) of the respondents showed the total lack of knowledge. About 15 (5%) of the respondents (including some in the medical field) said that one could avoid HIV infection by having a balanced diet. Though, balanced diet can help an HIV/AIDS infected person live a longer, health life, it cannot protect one from being infected.

However, one respondent summarised the right answer in one sentence, that people can protect themselves if only they had the right knowledge/awareness on the disease. Twenty two percent of all the people involved in the research (19 cases) were

mal-informed on some of the ways to protect themselves and their partners from contracting HIV/AIDS. This part of population if added to the 14 percent (12 cases) that showed complete lack of knowledge, it totals up to 36 percent (31 cases). This implied that a good number were still ignorant of the ways to protect themselves or their partners against contracting HIV/AIDS. The sample showed a good understanding of ways of avoiding infection so scored a point for this indicator.

4.5.3 The Use of Condoms

On this, the respondents were asked to state if they had ever used condoms in their sexual relationships, and the results were that 7 respondents (2.3%) gave no answer. In this community there were over 90 percent Catholics, because Catholics do not encourage the use of condoms thus devout Catholics could be expected to be reluctant to say whether they used condoms or not. However, 179 (59.5%) of the respondents indicated that they had never used condoms in their sexual relationships and 115 (38.2%) indicated to had used condoms at least once in their sexual relationships.

Those who had never used condoms in their relationship claimed to be faithful in their marriages. A few said that they did not use condoms because they were afraid of unsafe sex (ngono zembe). This was a clear case of misunderstanding of what unsafe sex was all about, because unsafe sex was exactly about not using condoms in sexual relationships with multiple partners. Yet, some said that they did not use condoms because they did not know how to use them. A few cases claimed that there was no way to avoid HIV/AIDS, so why bother with the use of condoms and the like yet individuals know condoms were not a sure protection. Others argued that condoms had HIV virus placed in them. Other answers given are as indicated in Table 10 below.

Table 10: Different Reasons for not using condoms

Answer	Frequency	%
The aim of sexual contact is to give birth	5	1.7
There is no need to use a condom in a marriage relationship	3	1.0
Not familiar with condom usage	9	3.0

Not promiscuous	3	1.0
The local has not experienced outbreak of HIV/AIDS pandemic	4	1.3
There is trust between the partners	8	2.6
Religious faith is against the use of condoms	17	5.6
Wanting to get a child	7	2.3

Source: Field data, August to October 2005

The above answers point to the lack of knowledge on the part of the respondents on the use of condoms and HIV/AIDS in general. Direct observations showed that there was only one place selling condoms in the whole village and that shop was selling about 24 packets of three condoms in a month. From this it is evident that even the 115 (38.2%) respondents who had claimed to use condoms were not often using them, unless there was another source of getting condoms in the village, but observations showed no sign of such a source.

Cross tabulations on the use of condoms, age and gender reveals that those who never used condoms were clustered between the ages of 20-35; this was 17 (45%) of all who were not using condoms. According to sources, this age group was the one mostly affected by HIV/AIDS. Again, those below 18 years were leading compared to all other age groups in not using condoms, 13 (25.5%) were not using condoms; yet according to USAID Tanzania mission, 60 percent of new infections happened to occur in this age group. Both groups (USAID, 2005), (under 18 years, 20-35 years) considered themselves running small risk or no risk at all of contracting HIV/AIDS. About 27 (9%) of the respondents indicated that since the local area had no HIV/AIDS infected people there was no need to use condoms, but how could the local area be declared HIV infected if there were no facilities for testing HIV status of the people? The majority of the respondents were not using condoms and gave wrong reasons for not doing so and they scored no point.

4.5.4 Attitude, Relationship, Cure and HIV Status

About 11 (3.6%) of the respondents indicated that they were not sure what would be their attitude towards a HIV/AIDS infected person, while 170 (56.4%) saw such a

person as abnormal. Sixty six (22%) stated that an HIV/AIDS infected person was a normal person, but 45 (15%) declared that it would depend on the circumstances. Three percent (9) decided to remain silent. Around 127 (42.1%) indicated that it would maintain a normal relationship (not sexual) with an HIV/AIDS infected person, while 162 (54%) would end a normal relationship with an infected person. About half (56.4%) of the interviewee had a wrong attitude towards HIV infected person, while 54 percent would end a relationship they already had with an infected person. Therefore, the sample scored no point on both indicators.

In the question that wanted the respondents to state whether HIV/AIDS had a cure or not, ten respondents (3.3%) did not show what they knew, while 45 (15%) said that they did not know. Most respondents, 224 (74.4%) declared that the disease was incurable, while 22 (7.3%) said it could be cured, and 15 (5%) did not know whether an HIV infected individual could be known by looking at or not. However, 209 (69.4%) indicated that one could not know if someone was infected by just looking, and 77 (25%) confirmed that one could know if someone was infected or not by just looking. Respondents showed a good understanding on both indicators and thus scored 2 points. The above results demonstrate that there was a lot to be desired by the rural population concerning HIV/AIDS awareness/knowledge.

4.5.5 HIV/AIDS as a National Disaster

Data analysis showed that 177 (59%) of all the respondents denied that HIV affected people in every community, 93 (31%) confirmed that HIV existed in all communities and 21 (10%) did not know anything. This showed that the interviewee did not know that HIV/AIDS was already a national disaster in Tanzania and it called for urgency at all levels, therefore, the sample scored no point on the awareness scale.

4.6 The Awareness Scale Score

There were eight indicators to test the awareness of the community, which are modes of HIV transmission, attitude, relationship, cure, HIV status, condoms use and ways of protection. If we were to rate this community in the awareness scale, therefore, the result would look like table 11 below.

Table 11: Awareness scale score

Indicator	Score
Modes of HIV transmission	X
Ways of protection	✓
Use of condoms	X
Awareness of HIV as a national disaster	X
Attitude towards affected/infected people	X
Relationship with infected people	X
Cure for HIV/AIDS	✓
Could HIV status be known by looking?	✓

Source: Field data, September 2005.

Running these results in the awareness scale, the community had knowledge of three indicators, which put it at a score of 10 to 30 percent that means poor knowledge/awareness of the disease.

4.7 People's Awareness Contentment

About 13 (4.2%) of the interviewee gave no answer to the question asking them to state if they were satisfied with HIV/AIDS awareness already received, while 109 (36.2%) respondents were not satisfied, 17 (5.6%) were not sure and 162 percent (54%) were satisfied. These statistics showed that quite a number of people knew that they did not have enough knowledge/awareness and thus, they were not satisfied with the present effort in raising awareness on HIV/AIDS. However, though indicators showed that people were not aware of the HIV/AIDS pandemic, a lot more were satisfied with the present effort.

FGDs with the village authorities revealed that there were no efforts being done to educate people on HIV/AIDS. The malaria campaign was the only campaign that had accomplished a good job in making people aware of malaria and how to protect themselves. The campaigners used print media such as posters, brochures, pamphlets, etc (see Appendix 1) and also visited villages with their entourage presenting dramas, giving T-shirts with messages, playing music to attract people and so on.

Direct observations showed that the study area had nothing to warn people about HIV/AIDS. The village dispensary area had many posters for raising awareness on malaria and family planning methods, but none on HIV/AIDS (see Appendix 2). The primary school had a poster in the teachers' office warning pupils against segregating fellow students who were HIV/AIDS infected (see Appendix 3), but if this raised awareness then it was among the teachers themselves because few members of the public were into the office. However, this poster would be of use if teachers relayed the information to students and later students did the same to to their families and peers at home. Ballart (1996) argues that this area had teachers who lacked motivation and thus students ended up doing manual work than being taught. Some of the practices that were going on in the village such as widow inheritance and sharing of pins for removing jiggers indicated that people were not aware of the danger and nobody did anything to educate them. The whole ward of Euga where the study took place had no Non Governmental Organizations, Community Based Organizations, and groups or individuals working on HIV/AIDS awareness.

4.8 Conclusion

Data showed that the study area lacked any substantive knowledge on HIV/AIDS and mass media was absent. The study found that few interviewees had radios disseminated HIV/AIDS knowledge among fellow villagers in their daily activities i.e. local bars, farming, traditional dancing gatherings, burial services, peer educators, etc. The study concluded that it is these areas of communication that should be carefully studied to see

if there was a way they could be improved to reach the RRA with HIV/AIDS awareness information.

CHAPTER FIVE

ABSENCE OF MASS MEDIA IN FIGHTING HIV/AIDS

5.1 Introduction

In this chapter it is argued that from analysis of the data provided in the previous chapter, the awareness of RRP has a number of shortcomings: danger of the type of awareness, the danger of contentment of the awareness and the danger of lack of Voluntary Counselling and Testing (VCT) facilities in RRA.

5.2 Awareness/knowledge of Remote Rural Populations

As noted in the last chapter, those who participated in the research were asked to indicate the sources from which they had received most of the HIV/AIDS information. Data suggested that the awareness/knowledge of remote rural populations had a number of shortcomings. The RRP did not realise how radio and print media played an insignificant role in raising HIV/AIDS awareness that they could hardly depend on them. They neither knew what HIV/AIDS awareness/knowledge was nor what they were supposed to know about the disease, which made the matter more complicated because even if they were to get the print media, they could not know what they were to look for.

RRP lacked a second set of information to compare with theirs that was why they could not realise the insignificant role played by the media in their life in the spread of HIV/AIDS awareness/knowledge. They thought that what they got was what everyone else was getting, so there was no need to complain or even ask for more information. For RRP, getting a newspaper about thrice in a year was enough or hearing from a friend who came from town/city was satisfactory. Some believed that everything they were told by those who seemed to be more knowledgeable. When the ARVs were introduced in the country, the RRP were misinformed that scientists had discovered a

cure for HIV/AIDS, and they easily trusted the news, after all they had no way of counter checking the information.

Awareness/knowledge for RRP was the state of being conscious that there was a disease namely HIV/AIDS. The proper understanding of the causes, modes of transmission, preventive measures, and the risks that they were involved were out of question. Though it was a good start to the right direction, such kind of awareness/knowledge was shallow, dangerous and miles away from the real truth. Town dwellers who are infected with HIV/AIDS tended to have sexual relationships and spread the virus among the innocent, unsuspecting RRP, while the RRP in return spread it further among themselves without knowing (http://www.tanzania.go.tz/hiv_aids.html, 2005).

Since the mass media shut away RRP from its campaigns against the spread of HIV/AIDS, RRP had no information on the trend of the disease in the country, which was why they said that the disease was not found in their local areas. They perceived HIV/AIDS as largely a disease of the urban dwellers. After all, the mass media covered very little on the trend of HIV/AIDS among the RRP, what was printed or broadcast was mostly about the trend among the towns' and cities' folks. If there was anything that was broadcast about HIV/AIDS trend among the RRP was usually based on hearsay and unrealistic data based on reports from district authorities and from researches. RRP lacked the necessary information, which left them to bask in the bliss of ignorance that exposed them to the infection of the disease. In fact, members of RRP dying from HIV/AIDS only caused a ripple on the water.

5.3 Danger of RRP's Awareness/knowledge

RRP's awareness had a number of shortcomings, which included the danger of the type of awareness/knowledge, the danger of being satisfied by such awareness/knowledge, and the danger of the lack of VCT facilities. The awareness/knowledge of RRP involved simply the consciousness that HIV/AIDS existed. The question of how many were

already infected, how many were in the danger of being infected, the modes of transmission, prevention, the trend of the disease in the country, etc was not of a big concern. Other studies have shown that people have the basic knowledge of the disease though their practices, behaviours and attitudes do not change.

However, among the RRP even the basic knowledge did not exist, therefore, we could not talk of matching knowledge, attitudes and practices (KAP). KAP demands that one has the basic knowledge and then we can see the behaviour, attitude and practice if they match that knowledge. In the case of RRP, there was no knowledge to match the behaviours, attitudes and practices or there was misinformation on HIV/AIDS that matched their behaviours, attitudes and practices. If individuals knew that HIV/ AIDS was a disease they could do nothing to protect themselves, and if they manifested behaviours and practices that put them at risk, we could not blame them, it was what they knew. If someone knew that a HIV/AIDS person was an abnormal person you could not be surprised when she/he expressed negative attitudes towards an infected person.

According to Tanzania National Website (http://www.tanzania.go.tz/hiv_aids.html, 2005) societal, behavioural and biological determinants, singly or in combination provide opportunities for HIV infection to occur to an individual. The RRP had all of them combined, things like belief in witchcraft instead of HIV/AIDS infection as a cause of sickness, low income leading to less access to medical care including that of STIs and HIV/AIDS, cultural norms, beliefs and practices that subordinate women to wife inheritance, polygamy, female circumcision and obligatory sex in wedlock were common. The knowledge/awareness that HIV/AIDS existed was crucial, yet not enough to curb the spread of the virus, let alone to protect people from being infected.

Some RRP members knew about condom use as a means of protection against HIV/AIDS, yet they could not afford them, they had basic needs in their homestead that required more attention of the limited resources/funds the family owned e.g. salt, clothes, church offerings, children demanded fees to go to school, among others. Still

they were some who believed that condoms were the ones spreading HIV/AIDS. RRA lack adequate awareness/knowledge on HIV/AIDS so as to protect themselves and others; with some practices such as sharing pointed objects to remove jiggers, members of the homestead were left at the mercy of fate.

The acknowledgement that HIV/AIDS had a cure raised a frightening alarm. This group engaged in behaviours that put them at risk of contracting the disease in a false hope that in case they were infected they could be treated. This group (from the questionnaire sample) had two males and four females. Women being a marginalised group in the society (Ballart, 1996) were more vulnerable than men. The danger increased if this misinformation was spread among other members of the RRP. Due to the lack of availability of other sources of information, misunderstanding and misinformation Tanzania's response to the epidemic in rural areas will be badly impaired (Hales, 2003). The fact that some believed that HIV/AIDS infected individuals could be recognised by looking at them should raised doubts. On one hand, a fat, health-looking person could be taken as a HIV/AIDS negative and in such a shroud of belief; a health carrier could infect many people. On the other hand, those who looked thin, ill-looking people, though healthy could be taken as HIV/AIDS positive individuals. Since some respondents pointed out that a HIV positive person was an abnormal, chances were that they could be discriminated by the rest of the community members. After all stigma and discrimination against people living with HIV/AIDS were quite common in Tanzania (Tanzania National Website, 2005).

Respondents pointed out as resourceful people revealed a wrong perception of HIV/AIDS, but those who pointed them, and others swallowed everything coming from such sources who were themselves misinformed. Rumours from one mouth to another could be more dangerous than mass media, especially if sources were taken as reliable ones. RRP were prone to lies from town and city folks who used some women/girls/men for their own sexual gains.

RRP were content with their knowledge and did not know if there was anything more to be known. This satisfaction led to relaxation to an extent that people could

ignore messages on HIV/AIDS. Coupled with the politicians' utterance that every Tanzanian had basic knowledge on HIV/AIDS made their satisfaction even more confident and justified. On 30th September 2005, in his end of month address to the nation the then President of URT said that according to researches, every Tanzanian had knowledge/awareness on HIV/AIDS (RTD, Kipindi Maalum 30th September 2005). This was either the usual manipulation by politicians to suit their course or misinformation on their part. If awareness was simplified to mean the consciousness that there is a disease called HIV/AIDS then we can say with certain confidence that every Tanzanian knew the disease, but do they know the modes of transmission, means of prevention, how prone they were to the disease and how much their locality and nation at large was affected? .

If you were to tell members of RRA that they had insufficient awareness on HIV/AIDS, they could probably look at you as someone from the Mars. They could say, "…and who are you? Do you want to say that you know more than the President? The President said that and the media announced it so it must be true!" May be when politicians speak of Tanzania as a country, they have in their focus the cities, towns and business centres. As Rugumamu (2005), correctly observes that effective state control and service delivery in most African countries tend to be largely confined to the capital cities and a few commercial towns. Using David Edwards' words (2006) to be fair in Africa, the logic is at least consistent, if authority is the final arbiter of truth, then it is right that common sense and rational thought be discarded in deference to the same authority.

5.4 Danger of the lack of VCT centres

Remote rural areas did not have VCT centres and some even had no dispensary in the neighbourhoods. The RRP had to walk 20 kilometres to be treated for malaria or for Reproductive Child Health Clinic (RCHC formerly MCH) facilities. Since RRP did not have reliable means of transport, they relied on walking. Because of these long

distances of walking, women tended to give birth at home, and people tended to rely on traditional herbs for treatment of common diseases including sexually transmitted ones.

In the remote rural areas, if you met people seeking for treatment at a dispensary or hospital then you knew that all the known herbs had failed to treat the infection. This tendency of going to the dispensary/hospital after a long time since the symptoms of the disease had manifested made treatment difficult. The danger increased when it came to STIs. Studies have shown that patients with STIs are 2 to 9 times more likely to be infected with HIV (http://www.tanzania.go.tz/hiv_aids.html, 2005). When STIs are left for a long time without treatment, they leave scars on the private parts that make individuals in question more vulnerable to HIV/AIDS if they were to have sexual contact with an infected partner. With the little knowledge on the diseases on the part of the RRP, individuals could go infecting others before they realised that the problem was serious. This was confirmed by the medical team involved in this research that noted an increase of STI in the locality. If this was the case with diseases such as gonorrhoea, syphilis, etc. then one could start showing symptoms within 24 hours after being infected, which was risky to a disease such as HIV/AIDS, as one could live up to 15 years before symptoms started to show.

While the claim that the study area and its neighbourhood had not yet experienced an outbreak of HIV/AIDS might be true at a face value, HIV/AIDS was insidiously paving its way in the area. Since the village was far from VCT facilities, HIV cases remained at speculative level, denial and attributed to witchcraft. The belief in witchcraft made it difficult to convince people with wife-inheritance traditions not to marry women whose husbands or wives may had died from AIDS (http://www.tanzania.go.tz/hiv_aids.html, 2005). Even those cases referred as HIV/AIDS, some still gave a benefit of doubt that they might had been something else. In such an environment of ‘may be,’ ‘may be not,’ a lot more people could be infected, and death would be speeded up by the fact that individuals would not know how to live with HIV/AIDS and remained healthy.

One of the major determinants of HIV transmission was the unsafe blood transfusion. The HIV transmission rate through transfusion of contaminated blood was almost 100 percent. Although in Tanzania all centres rendering transfusion service are equipped with facilities to ensure safe blood transfusion, due to lack of regular supplies of reagents and equipment and lack of reliable power supply in some centres there is still some risks of transfusing contaminated blood (http://www.tanzania.go.tz/hiv_aids.html, 2005). This situation was amplified in the RRA that depended on district hospitals that had bad infrastructure. Unethical as it may sound, you could not leave someone who needed urgent transfusion to die because you could not test the HIV status of the blood for whatever cause.

The lack of voluntary counselling and testing facilities, summed up with the lack of education on the RRP to help them realise the importance of knowing their HIV status left them to think that HIV/AIDS was still a far-off disease until people started dying in massive numbers as it was experienced in towns and cities. The RRP were more prone to HIV/AIDS due to poverty, poor health systems and limited resources for prevention and care. Thus, left on their own, RRP were likely to be a time bomb in the fight against HIV/AIDS and poverty.

In implementing the Millennium Declaration and the Millennium Development Goals adopted by 189 Heads of States and Government in 2000, Tanzania cannot tackle the spread of HIV/AIDS by the year 2015 if the remote rural population is not equipped with the right awareness/knowledge and VCT facilities. According to sources, agriculture accounts for 45 percent of GDP in Tanzania, with a recent average growth rate of 4.8 percent, 60 percent of export earnings, and 82 percent of peoples' livelihoods. Inadequate extension services and poor infrastructure were cited as major setbacks to rural development/growth (www.tanzania.go.tz/pdf/nsgrptext.pdf, 2005). These constraints are more pronounced in remote rural areas and they are not only setbacks to fight against poverty but also in the fight against HIV/AIDS. About 40 percent of all the orphans in Tanzania lost their parents through HIV/AIDS and difficult chore of caring

for these orphans has mostly fallen on the grandparents (Sunday Citizen, 30 October 2005).

5.6 Conclusion

This chapter demonstrated that RRP had insufficient awareness to avoid being infected with HIV/AIDS and they had too much trust on mass media which they were not getting often as well as from hear-say, gossip and rumours. Since they lacked VCT facilities it was not easy to say with certainty on the spread of the disease among them. RRA should be given priority in the implementation of Millenium Development Goals (MDGs) if Tanzania is ever to eradicate poverty and spread of HIV/AIDS in the country. Therefore, we argue that if HIV/AIDS prevention and care programmes were to be effective, RRP must be involved in their design and implementation.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

> The size of the lie is a definite factor in causing it to be believed, for the vast of the nation are in the depths of their hearts more easily deceived than they are consciously and intentionally bad. The primitive simplicity of their minds renders them a more easy prey to a big lie than a small one, for they themselves often tell little lie but would be ashamed to tell a big one (www.rjgeib.com/thoughts/hitler/hitler.html, 2006).

Nothing explains better the state of media in Tanzania than these words of Adolf Hitler in Mein Kampf. Media can tell big lies and rural population would believe them. Rural people, as Hitler would put it are afraid of telling big lies themselves but can easily fall prey to them. The media can furthermore refrain from telling the truth about the RRA either because they tend to give homage to the power that might be (a kind of licking the hand that feeds it) or because they are for profit, and the RRA are not newsworthy. In this chapter, we will present a summary of the study findings, give recommendations, and propose possibilities for further research.

6.2 Summary of the Findings

This study argues that RRA lack substantive knowledge on HIV/AIDS and the population did not realise that they were fighting HIV/AIDS without the help of mass media, a tool that has been evaluated as effective in spreading awareness/knowledge on the killer disease. Other findings of the study were:

6.2.1 Bandura's social learning theory

This theory could not be validated. As knowledge and practices are not the same, data consistently contradict not the theories but interpretations of the theories. Practice, behaviour and attitude do not flow automatically from the knowledge someone has, for if this was the case those who knew the law, but continued to break it. However, experience teaches us a different lesson, for if people who know could have been behaving almost instinctively, like a dog following a bone then the spread of HIV/AIDS would have stopped long ago. Knowledge needs to be realized in actions and this calls for efforts and commitment. What we need is not really behaviour change but rather mind change; we need to tune the mind to implement the knowledge we have.

However, Bandura and Sabido's theories of 'monkeys see, monkeys do' would not work with the RRP because they did not have models to influence their behaviours. They only had each other's ignorance to observe and this could drown them down. RRP did not have anyone or anything to pay attention to, no motivation and thus had inadequate or nothing to retain in as far as HIV/AIDS is concerned. It is awareness and expectations of future reinforcements and punishments that can have a major effect on the behaviours that RRP exhibit on regards to HIV/AIDS. RRP lacked the knowledge thus their behaviours could not be modelled according to HIV/AIDS awareness and expectations of future reinforcements and punishments. They should first be aware that acting in a certain way with regards to HIV/AIDS will produce a certain effect in their lives (reward or punishment) therefore they could either refrain or do the act, but RRP had neither one to pay attention to nor to motivate them to act in a certain positive way so as to avoid being infected.

6.2.2 The absence of the mass media and knowledge gap

Mass media though very important in spreading information all around the globe, its role was undermined among the RRA. Most of the RRA were still marginalized because of poor roads, lack of electricity and information and technology (Kaale, 2005). Data analysis established that RRA did not have both HIV/AIDS awareness campaigns and

CBO based campaigns with a possibility of reaching a large population. The radio that could have been the best possible way to reach the remote rural parts of the country was undermined by poverty. A number of people in RRA had a low income thus living below the poverty line, which made it impossible not only to acquire radios but also batteries for the radios. More so was the fact that radio signals that reach those parts of the country were sporadic and intermittent. Due to lack of appropriate knowledge, HIV/AIDS was generally not perceived as a priority at the district level and community level and thus overall prevention effort in Tanzania appears to be weak and fragmented (Hales et al, 2003).

6.2.3 RRP unawareness of the knowledge gap

RRP were not ignorant but rather helpless. They did not realise that the absence of mass media created a knowledge gap but subconsciously knew that their knowledge was not enough. They were ready to learn if opportunities were presented to them, this was indicated by their desire to read newspapers and having radios even those that did not work. The ISHI meetings that were converged around the country did not reach the RRP's youth's ears and sad enough was the fact that most of the youth population was found in the rural areas. However, as Hales (2003) claims that prevention was losing ground in Tanzania and more effort and funds were directed in the rush of expanding care, support and treatment programmes, and since we still believed that rural areas were less affected by HIV/AIDS then the programmes are concentrated more in towns, cities and business centres.

6.2.4 RRP unawareness of the risks

RRP were content with their HIV/AIDS knowledge and were susceptible to lies by those who were from towns, commercial centres and cities, who would want to use them for their own gains. Moreover, RRP still depended on the traditional ways of communication like rumours from mouth to mouth. This kind of communication was

very dangerous when it came from ignorant sources but considered as reliable source by the rest of the community.

Since RRP did not know that they had inadequate knowledge on HIV/AIDS, they appraised the mass media and other minor sources and got involved in practices that were putting them at risk in contracting the disease. They thought that HIV/AIDS was not in their vicinity; therefore, there was no need to take precautions. As a result, they were consistently involved in unsafe sexual behaviours such as remarrying of wives whose husbands had died, sharing of pointed objects like pins, among many others. Even some of the health workers in the RRA lacked the education to protect themselves and others against being infected.

6.2.5 Mainstream media can misdirect people

There is a reduction on social discipline for making good decisions about social and sexual behaviour, traditional values and norms are no longer cherished but are at times eroded by the mainstream media. RRP's knowledge from mass media left gaps because it was not received regularly, the reason being that either mainstream media (that are for profit) had no interest in the RRA, therefore wrote hearsay stories or do not bother to write at all. Investigative journalism in Tanzania is still a mile wide and inch thick, thus media rumour mongering is an order of the day (Stummer, 1998). Facts about RRP's status on HIV/AIDS were not reported and when they were, were distorted and people were misinformed.

6.3 Recommendations

Based on the study findings the following recommendations are put forward. Some of the recommendations aim at helping the RRP to get more knowledge/awareness on HIV/AIDS. Others are towards making mass media more accessible by the RRP or compliment the role of the mass media.

6.3.1 RRP's alternative in alternative media?

6.3.1.1 What is alternative media?

There is no clear, objective definition and no clear attributes for alternative media. However, alternative media can be understood better if it is put vis-à-vis mainstream media. Mainstream media are media institutions (public or private) most often aiming at maximizing profit or selling an elite audience to advertisers for main source of revenue. Mainstream media is virtually always structured in accord with and to help reinforce society's defining hierarchical social relationships, and is generally controlled by and controlling of other major social relations, particularly corporations (Albert, 2006).

On the other hand, alternative media does not aim at maximizing profits. It does not primarily sell audience to advertisers for revenue, and as a result it seeks broad and non-elite audience. Alternative media is structured to subvert society's defining hierarchical social relationships, and is structured profoundly different from and as independent of other major social institutions, particularly corporations, as it can be. It also sees itself as part of a project to establish new ways of organizing media and social activity and it is committed to furthering these as a whole, and not just its preservation (Albert, 2006). Alternative media therefore are those media practices falling outside the mainstreams of corporate communication (Huesca, 2006).

Everywhere in the world, people are day after day voting with their feet and turning away from the mainstream and seeking the truth (Watson and Jones, 2006). Alternative media is not perfect, it too makes mistakes but it actively attempts to tell the truth rather than actively attempting to hide or misdirect the reader. When it makes mistakes, also makes the retraction clear, rather than burying it in small type on insignificant pages in the paper. People know almost instinctively that there is something wrong with this world and that the truth behind modern day development is being purposefully shielded from them by media conglomerations owned by faceless corporations in league with Kafkaesque authorities (Watson and Jones, 2006).

6.3.1.2 Alternative media in Tanzanian environment

Alternative media covers news and voices that are largely or glossed-over by the mainstream press. As Walter Lippman (2006) puts it, the news and the truth are not the same. Tanzanian media might be offering news about the RRP but not the truth. In fact content of Tanzania newspapers appeared to be vague, crisis oriented, and lacking in any serious analysis.

Most of the for-profit mainstream media in Tanzania have been a basket of critics for hoax scoop-hunting stories aiming at selling the papers. They are manipulated to get profit; making the independent journalism compromised. They are concerned with the sale and not the truth. Using Neil Postman's (2006) words to speak about Tanzania, we can say that today Tanzanians are dis-informed by the mass media which is altering the meaning of being informed. Disinformation does not mean false information. It means misleading information, information that is misplaced, irrelevant, fragmented or superficial; information that creates the illusion of knowing something, but which in fact leads one away from knowing. The media creates the environment that all is well in the rural areas and at the same time making the rural populations think that they know a lot about HIV/AIDS awareness, which is not the case. With the high illiteracy in the rural areas the populations can easily be mislead by the media especially recently with the commercial advertisement on condoms.

What we need in Tanzania, may be is public broadcasting and print media that would promote strong, non-profit alternative sources of information for the RRA. Most of the media in Tanzania are not selling content to audience but rather selling audience to sponsors. This gives the sponsors a disproportionate influence over what people get to hear, see or read. The sponsors want to support media that put audiences in a passive, non-critical state of mind, which makes them easier to sell things to (http://www.fair.org/index.php?page=7&issue_area_id=60, 2006). To make this a success, media tend to give as little information on the truth as possible so as the population can buy the products of the sponsors. Another fact is that the remote rural populations are of little importance to the sponsors because advertisers typically find

affluent audiences more attractive than poorer ones, which end up reorienting the range of content offered to public and outreach of most of the media in Tanzania.

Due to all these, Tanzania needs non-profit, grassroots citizens' watchdog of the news media that critiques botched and bungled news stories and sets the records straight on important issues that have received slanted coverage such as the trend of HIV/AIDS in the remote rural areas (http://www.en.wikipedia.org/wiki/Alternative_media, 2006). Alternative media need to have some goals and ways to evaluate themselves so as not to fall in the trap of the mainstream. Concerns, myths, doubts about HIV/AIDS in the remote rural areas will persist and objections will be newsworthy and exploited by people with axes to grind, and some of us will even say, "We all know that, so what?" But when "we all know" is not challenged the result as Nicoll and Killewo (2006) put is lack of action in the political, public health, and individual terms needed to fight HIV. Alternative media is not to take a role of a teacher but a guru who has to inspire. RRP have a lot of potency tapped inside them, all that is needed is a way to release that potency.

RRA should be equipped with reading/recreational centers where newspapers and radio can be made available for the local population. It would not be necessary to get every day's newspapers but even old ones so long as they come regularly, they would be of great help to the knowledge/awareness of RRP. The Central government in collaboration with the local government can see to this possibility. However, this calls for good governance because these centers together with the media tools involved will have to be taken care of.

6.3.2 Lessons from Uganda

Tanzania's neighbour, Uganda has recorded a significant decrease in the number of AIDS patients at the country's leading hospital, Mulago, HIV infection rates fell from 44.2 percent in 1989 to 23 percent in 1999. This was contributed by four factors: high level of political commitment to the fight against HIV/AIDS, openness about the

epidemic, involvement of all sectors of society and the government policy of decentralization.

When Museveni came to power, he launched the ACP (AIDS Competence Process) to spearhead struggle against HIV/AIDS. ACP's objectives were to prevent further transmission of HIV, create mechanisms to care for infected and their families and create capacity to contain the epidemic. The backbone of the programme was information, education and communication, i.e. to make people *aware* of the problem and translate this awareness into behaviour change. ACP in Uganda conducted information campaigns on radio, television an in newspapers, distributed leaflets and posters and put up billboards across the country. This was made possible due to political commitment of Ugandan government and help from donors. However due to limited outreach of the rural areas, ACP had to use existing administrative and social institutions. They used local councils not only to get messages to every village but also to ensure that anti-AIDS activities were initiated and implemented at the lowest level (Kirungi, 2001).

Tanzania can learn from Uganda and other countries in Africa that have registered a considerable success in the fight against HIV/AIDS. Tanzania has not taken seriously the issue of HIV/AIDS so far. At the political level there is neither serious commitment nor openness about the epidemic (TACAIDS *et al.,* 2005), just like the rural population lack adequate awareness on HIV/AIDS so is the rest know little about the state of the rural areas on HIV/AIDS. While the country has lived with a serious generalized HIV/AIDS epidemic for the past 20 years, there has been little perceptible sense of national urgency to address this critical problem. Lack of knowledge cut across Tanzanian society, health professionals and government leaders are poorly informed as community members in rural village. Thus, meaningful and sustained behaviour change is proving to be elusive goal (Hales, 2003). Not all the sectors are involved in the fight against HIV/AIDS in country, and the left out sectors are usually those that would have played a major role like the grassroots levels of villages. Some of these problems have started being addressed recently (TACAIDS *et al.,* 2005).

Though decentralization is an old phenomenon in country, the lower authorities are not used as they should have been. TACAIDS, (Tanzania's main organ dealing with HIV/AIDS) whose main mission is to provide strategic leadership for a national multi-sectoral response to HIV/AIDS leading to the reduction of further infectious associated diseases and the adverse socio-economic effect of the epidemic conducts its activities mostly in Dar es Salaam and big centres and has done nearly little in the rural areas where the populations do not know what is TACAIDS or what are its activities. The preventive initiatives that exist are small, limited in geographic coverage, and generally not coordinated between implementing partners (Hales, 2003).

TACAIDS, unlike ACP does not work with the grassroots level and does not reach every village despite its huge budget each year. However, the reality of Uganda calls for a need to work at the more decentralized levels of governance to implement an appropriate response to the epidemic and this speaks to urgency of expanding and strengthening local leadership (Hales, 2003). Mass media in Tanzania instead of fighting against HIV/AIDS, they are promoting it, the gutter-press in Tanzania is mushrooming at an alarming speed with pornographic photos and the radios DJs calling themselves names like "sexiest DJs." In such a surrounding we cannot expect to positively spread knowledge/awareness on HIV/AIDS (Ngetti, 2005). However, if Tanzania wants to offer HIV/AIDS information to RRP it can take on the footsteps of Uganda but put into Tanzanian context. This means creating a culture of zero tolerance for those people who are ineffective in their areas of work in all levels of authorities.

Tanzania needs strong leadership because the issues surrounding HIV/AIDS are deeply embedded in cultural and social beliefs and practices, many of them intimate, personal and private. Leadership means creating an environment in which HIV/AIDS is not discussed in secrecy and shame, but openly and with compassion. This requires that RRP are equipped with the facts about HIV/AIDS and how to prevent it, and that the children in RRA have access to services, skills and support needed to develop safe behaviours from the start and spread the message (UNAIDS, 2002).

6.3.3 Short term recommendations

The study presented that news on HIV/AIDS awareness/knowledge through the mass media hardly reach the RRP and if they do, are distorted and the RRP are misinformed. Therefore, we recommend that TACAIDS like their malaria campaigns counterpart should start a mobile team of experts to go and empower the RRA on HIV/AIDS awareness/knowledge and the proper use of condoms. The traditional dancing groups' songs composers could be the first target group because they have a possibility to reach a large population with the life saving message.

Different ways of disseminating information among the RRP like traditional dances, the knowledgeable (wise) people, etc should be strengthened and encouraged; the religious and educational institutions should as well be encouraged to spread awareness among the people. Those people 'knowledgeable people' among the RRA could be more informed and equipped with radios and print media on HIV/AIDS so that they can disseminate accurate and adequate information on the disease.

To avoid top-down approach, national, regional and district authorities should cooperate with the village government of the RRP to develop CBOs that will be trained on HIV/AIDS awareness/knowledge to see that the population is aware of the cause, modes of transmission, means of protection, and HIV/AIDS trend in their areas. The CBOs could then be used to distribute available print media on HIV/AIDS. Simple, inexpensive signposts, posters, banners, etc should be placed in the RRA to warn people against HIV/AIDS. For example a signpost could read "*Karibu Zahanati ya Ebuyu, Kumbuka huwezi kumjua mwenye UKIMWI kwa kumwangalia tu*" that is "Welcome to Ebuyu dispensary, remember you cannot know who has HIV/AIDS by looking."

Village governments can organise events such as "HIV/AIDS Week" with various activities, during which brochures on HIV/AIDS awareness could be distributed to the participants. There could be drama to raise awareness on HIV/AIDS, local dances with songs to conscientise people on HIV/AIDS, HIV/AIDS essay writing competitions and could be culminated with different sporting events e.g. football, netball, athletic, etc. The early years of independence can set an example when the national feasts were

celebrated in villages, wards; etc where different entertainments were conducted with a particular message (theme) to educate the audience.

Emphasis should be put on education, both formal and informal. Adult education in RRA should be revived and reading/recreational centres should act as an ongoing education for those who have finished standard seven.

6.3.4 Long term recommendations

Exercise books could be printed with HIV/AIDS awareness knowledge in addition to the multiplying tables that are now common. Packets of salts and other basic household needs could as well have printed messages to warn against HIV/AIDS and some important facts i.e. ways that can spread, ways of protection. There is an urgent need to start VCT centres at different places in the RRA, some of which can be mobile VCT so as to sustain both prevention and care. The mobile VCTs can be incorporated in the "HIV/AIDS Week" in the villages. Given enough awareness that people would have achieved if the short-term recommendations are put in place, there should be no difficult in people making use of the facilities of VCT.

TACAIDS should see that the Mobile Video Unit (MVU) visits the RRP from time to time. PSI/Tanzania argues that it uses MVU and road shows to reach high-transmission areas (HTA) and rural areas. According to the PSI/Tanzania website, MVU and road show teams utilize entertaining and educational videos, skits and contests to educate target audience on HIV/AIDS/sexually-transmitted infections and promote protective behaviour using ABC (Abstinence, Be faithful and use Condoms) message strategy. It is said that approximately 400 MVU shows and 600 road shows are performed each year, reaching hundreds of thousands of people (www.psi.org/where_we_work/tanzania.html, 2005). However, none of these MVU and road shows was able to reach RRP such as those of Ebuyu, Lusanga, Isyaga, Sali and its periphery. The monthly youth newsletter, "AMUA" (DECIDE) too was unable to reach RRA's youth, and yet they are the ones that need it most. Efforts should be made to see that RRP are also served by these modern means of communication.

At a national level, efforts are to be directed in making sure that the Millennium Developments Goals (MDGs) give priority to RRA. Most of the poorest of the poor live in the RRA; therefore, effort should be directed towards those areas. Since HIV/AIDS and poverty is a vicious circle and since poverty hinders RRP's access to mass media and health facilities, its solution would pave way forward in curbing the infection. It is poverty that hinders a move from knowledge/awareness to actual action/realization. People in urban areas sell their bodies for money because they are poor, in RRA they cannot buy condoms because of poverty. Therefore, the ultimate answer lies in improving life condition of the people. Policy development, which appears to be the strongest component of the current policy environment, must be accompanied by effective policy implementation and enforcement at all levels of government, civil society, and the private sector. In fact, the need for effective, well-implemented, and enforced policies is a crosscutting issue that affects the HIV/AIDS response in ways as diverse as workplace initiatives, post-exposure prophylaxis, and prevention of mother-to-child transmission protocols, school curriculums, gender equity, and resource allocation. In addition, health workers should be given the frontline role in managing the HIV/AIDS epidemic thus they should be equipped with knowledge, skills and tools required to handle this responsibility (Hales, 2003).

Up to the time of research (August to October 2005) Tanzania had no structured and comprehensive in-school programmes (Hales, 2003). Therefore, the Ministry of Education should see that it prepares teachers who are also trainers on HIV/AIDS awareness education. Though HIV/AIDS is placed as STI, one need not engage in sexual activities to contract it, therefore, the HIV/AIDS education should as well be brought down to class three and four of primary education, in addition to class five, six and seven that already have in their syllabuses. The Ministry should see that the schools especially those in RRA have enough teaching materials on the disease. Once the primary school teachers educate the students, I hope that the children will pass on the message to their families and neighbours (http://yogizz.free.fr/malaika/pro_hiv.html, 2006). Therefore, Government and communities should support RRA with public

information campaigns to raise awareness/knowledge and combat stigma (UNAIDS, 2002).

6.4 Areas for Further Research

The study on HIV/AIDS and rural areas is not new (Boerma, 2001). Other studies such as on poverty (Ballart, 1996) are also common. This did not exhaust all the possible aspects. It concentrated on the print media and radio as the only electronic media. More so is the fact that the study was limited to only one village and its neighbourhood. Therefore, it is the hope of the researcher that other researches can be done in other regions and districts in Tanzania to see if data would replicate itself. This need not be on mass media and HIV/AIDS; it can be on the role of the mass media on RRP's development, mass media's influence on RRP's voting, etc.

Furthermore, the same research could be carried out in the same area to see if with the passage of time, RRP have gained more awareness/knowledge on the disease, have remained static or even deteriorated from the present level. All these are aimed at increasing capacity of the policy makers and implementers in terms of understanding and designing solutions to the problems of RRP that hinder the imparting of knowledge in the fight against HIV/AIDS, ignorance, poverty, etc.

6.5 Conclusion

This work demonstrated to a large extent that the absence of the mass media in the remote rural areas creates a knowledge gap on HIV/AIDS awareness, and what we get from the mainstream media that over 90 percent of the Tanzanians are aware of HIV/AIDS (TACAIDS *et al.,* 2005) might not be wholesome true. Since AIDS is a late consequence of HIV infection, the long incubation period of between 5 to 10 years and the absence of significant symptoms at the early stages of infection, make it impossible to know the exact number of HIV infection in the country (http://www.tanzania.go.tz/hiv_aids.html, 2005). This adding to the poor

knowledge/awareness of RRP, the disease could spread at an alarming rate in the RRA. With the emerging of the rural areas in the scourge, the production of food and cash crops is bound to suffer, as the labour force becomes sick and eventually die from AIDS (http://www.tanzania.go.tz/hiv_aids.html, 2005).

The RRP have insufficient knowledge on HIV/AIDS and certainly, mass media is not the major source as claimed elsewhere. Mass media has left RRA lagging behind as it looks for profit and RRA do not offer such incentive. Therefore, something other than the mainstream media should be devised to fill this gap. Mass media can only provide relevant information to RRP if it is designed as alternative media and go through the news that are relevant to RRP but are glossed-over by the mainstream media.

The mushrooming of TB cases in the RRA should serve as a warning. With some already impaired by TB, HIV/AIDS will just make the matter worse. The need for RRP to be educated and imparted with the knowledge on HIV/AIDS addresses urgent concern. This study underscores the pressing need of the government and civil societies to work with RRP on effective prevention, treatment and care strategies for them which calls for unparallel political commitment to build the partnership needed to raise critical financial and human resources (UNAIDS, 2002).

It is responsibility of the Government of Tanzania to ensure that financial and management support to fight the epidemic in RRA is available. Since the demand countrywide is so high, development partners and civil society (including private sector) share responsibility and moral obligation to compliment government efforts (TACAIDS *et al.,* 2005). The condom solution might be running after a false rabbit, the problem is that, human race is being prevented from taking action by its oldest and most stubborn enemy, institutional greed. At the heart of the problem lies poverty, as few individuals get richer, the majority are getting poorer and those few are making business out of the misery of others. However, the solution to RRP's problem lies in the RRP themselves. The policy makers and implementers need to draw upon the resources and experiences of local initiatives as the only effective response, rather than giving set of ready-made solutions from above to be implemented. Local people know what they are able to offer.

Outsiders sometimes trample on their toes. Imported programmes often fail because they fail to address local conditions. Funding organizations can be a help or a hindrance. Thus, local initiatives need encouragement, capacity building and financial support, not answers imposed from outside (the Ugandan model). This is not downplaying the need for international input which is necessary to provide the needed financial assistance, equipments to overcome the knowledge gap and more so is the reality that they have accumulated knowledge and experience in tackling the disease. However, as it was indicated earlier, this is to be looked at from a Tanzanian reality for HIV/AIDS in Tanzania right now is not only a health problem but also a developmental problem centred on poverty, therefore the government as it focuses on Millennium Development Goals (MDG) should see that RRP are given the right weapon to fight the killer disease.

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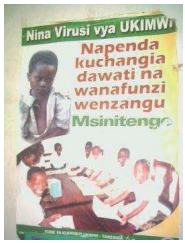
APPENDICES

Appendix 1: One of the many posters of campaigns against malaria found at the village dispensary

Appendix 2: A Poster warning against discriminating people living with HIV/AIDS found inside the dispensary building

Source: Field data: September 2005

APPENDIX 3: A poster warning against segregating students living with HIV/AIDS found in the teachers' office at the village Primary School



Source: Field data: September 2005

APPENDIX 4: Questionnaire for data collection

QUESTIONNAIRES ON REMOTE RURAL PEOPLE'S KNOWLEDGE ON HIV/AIDS AND THEIR ATTITUDES TOWARDS HIV POSITIVE PERSON.

PART I: PERSONAL PARTICULARS

1. What is your age? (Tick one)
a) Below 18
b) 20-25
c) 26-30
d) 31-35
e) 36-40
f) Over 41 years

2. What is your sex? (Tick one)
a) Male
b) Female

3. What is your level of education? (Tick one)
a) No formal education
b) Primary education
c) Secondary education
d) Higher education (college, university, etc.)

4. What is your occupation at present? (Tick one)
a) Student
b) A farmer
c) An employee

d) Private business

e) Other (please indicate)……

5. What is your marital status? (Tick one)

a) Married

b) Not married

c) Staying together

d) Widow/widower

e) Divorced

PART II: UNDERSTANDING OF THE PEOPLE ABOUT HIV/AIDS

6. How does the society get to know about HIV/AIDS?

a) From the community

b) From Radio

c) From newspapers/pamphlets/posters

d) From religious institutions e.g. Churches and mosques

e) From learning institutions e.g. schools

f) From health worker

g) From a relative or a friend

h) Other ways like being HIV positive.

i) Other sources (please indicate)

7. Do you have a radio?

a) Yes

b) No

8. Do you read newspapers, magazine and listen to radio often?

a) Yes

b) No

9. If your answer to question 8 above is 'YES' please state how often

a) Everyday

b) weekly

c) Monthly

d) After 2 months

e) After 3 to 6 month

f) After 6 to 12 months

g) Yearly

10. Is it true that there are HIV positive people in every society/community? (Tick one)

a) Yes

b) No

11. Do you know any person with any HIV/AIDS in your community?

a) Yes

b) No

12. If the answer in question 11 above is yes, how do you regard such a person?

a) As a normal person

b) As an abnormal person

c) Depends on the situation.

13. Would you maintain a relation with a HIV positive person?

a) Yes

b) No

14. Can AIDS be cured?

a) Yes

b) No

c) I do not know

15. Can you know that individuals are infected by just looking at them?

a) Yes

b) No

c) I do not know

16. What are the chances of you getting infected with HIV/AIDS?

a) Great

b) Moderate

c) Small

d) Nil

17. What are the reasons for your answer above? (Question 16)

18. Mention some ways in which HIV/AIDS is transmitted

19. Can one avoid getting HIV/AIDS? If "YES", please explain how?

20. Have you ever used a condom?

a) Yes

b) No

21. If your answer to question 20 is "NO", please state why?

22. What is it that makes you worried about HIV/AIDS?

23. What do you wish could be done about HIV/AIDS? (What are your dreams?)

24. Are you satisfied with the effort being done to spread knowledge (awareness) on HIV/AIDS in your area?

a) Yes

b) No

c) Not sure

25. If your answer to question 24 is “No”, what do you think could be done to improve the situation?