THE UNITED REPUBLIC
OF TANZANIA

PRIME MINISTER’S OFFICE

Tanzania Commission for AIDS
(TACAIDS)

NATIONAL BEHAVIOUR
CHANGE COMMUNICATION
GUIDELINES ON HIV AND AIDS
INTERVENTIONS

May, 2012
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NATIONAL BEHAVIOUR CHANGE COMMUNICATION GUIDELINES ON HIV AND AIDS INTERVENTIONS

May, 2012
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## ACRONYMS

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<thead>
<tr>
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<th>Description</th>
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<tr>
<td>AED</td>
<td>Academy for Education and Development</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<td>ANC</td>
<td>Antenatal Care</td>
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<td>ART</td>
<td>Anti-Retroviral Therapy</td>
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<td>ARV</td>
<td>Anti-Retroviral Drug</td>
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<td>BCC</td>
<td>Behaviour Change Communication</td>
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<td>FBO</td>
<td>Faith Based Organization</td>
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<td>FHI</td>
<td>Family Health International</td>
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<tr>
<td>GoT</td>
<td>Government of Tanzania</td>
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<tr>
<td>HBC</td>
<td>Home-Based Care</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HMIS</td>
<td>Health Management Information System</td>
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<td>ICT</td>
<td>Information Communication Technology</td>
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<tr>
<td>IDU</td>
<td>Injecting Drug Users</td>
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<td>IEC</td>
<td>Information, Education and Communication</td>
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<td>ILO</td>
<td>International Labour Organization</td>
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<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<td>MoHsw</td>
<td>Ministry of Health and Social Welfare</td>
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<td>MSM</td>
<td>Men who have sex with men</td>
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<td>NACP</td>
<td>National AIDS Control Programme</td>
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<td>NGOs</td>
<td>Non-Governmental Organizations</td>
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<td>NHACAS</td>
<td>National HIV/AIDS Communication and Advocacy Strategy</td>
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<td>NMSF</td>
<td>National Multi-sectoral Strategic Framework</td>
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<td>OI</td>
<td>Opportunistic Infection</td>
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<td>PEP</td>
<td>Post-Exposure Prophylaxis</td>
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<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
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<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<td>TACAIDS</td>
<td>Tanzania Commission for AIDS</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<td>THIS</td>
<td>Tanzania HIV/AIDS Indicator Survey</td>
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<td>THMIS</td>
<td>Tanzania HIV/AIDS and Malaria Indicator Survey</td>
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<td>UN</td>
<td>United Nations</td>
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<td>United Nations Joint Programme on HIV and AIDS</td>
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<td>UNICEF</td>
<td>United Nations Children’s Education Fund</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>VCT</td>
<td>Voluntary Counseling and Testing</td>
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<td>WB</td>
<td>World Bank</td>
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FOREWORD

Tanzania like many other Sub Saharan African countries has made use of interventions aimed at controlling the HIV and AIDS epidemic which is claiming the lives of thousands of her people and threatening national social and economic development efforts. For several decades, the epidemic has negated development efforts. Tanzania is confronted with a generalized epidemic with an average HIV prevalence of 5.7 percent. HIV infection is widespread amongst the general population throughout the country in both urban and rural areas with noticeable variation between and within the regions as per the Tanzania HIV and Malaria Indicator Survey data of 2007-2008. The devastating Impact of the epidemic is felt in all sectors, as it causes widespread suffering among individuals, families and communities across the country.

In Tanzania recent data show that unwanted behaviours are major public health barriers to an effective local response to HIV and AIDS. In 2006 the international political community led by UNAIDS, set the goal of universal access to comprehensive HIV prevention and treatment programs, care, and support by 2010. Implementation of this goal has been affected by the fact that different stakeholders use different interventions which are not specific in behaviour change. Several efforts to address Behaviour change communication, resulting in substantial decreases in some of its aspects have been made. The development of the Behaviour Change Communication Guideline comes at an opportune time and it is hoped that it will allow all stakeholders to take on the challenge to increase the adoption of positive behaviours among the public and positively support the fight against HIV and AIDS.

Peniel M. Lyimo
Permanent Secretary
Prime Minister’s Office
ACKNOWLEDGEMENTS

The Tanzania Commission for AIDS wishes to acknowledge with sincere gratitude all those who contributed to the production of this document.

Our thanks go to all participants from the Government of Tanzania in particular the Ministry of Health and Social Welfare, Ministry of Education and Vocational Training, different nongovernmental organizations and institutions at the national, regional, district levels who, so earnestly, have given their time, energy and contributions to make this guideline possible.

We acknowledge with special gratitude the financial contributions provided by the international partners towards production of this guideline. These include the AED and USAID. We specifically wish to thank the AED for their technical collaboration and support during the development process of the guideline.

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We feel indebted to the late Geoffrey Majengo, TACAIDS Director of Advocacy and Information, who initiated the process and for his constructive comments. May the Almighty God rest him in peace. Others are Dr. Elizabeth Mapella: IEC/BCC Head, Reproductive and Child Health Section (RCHS) Leah Ndekuka: Head BCC Unit, National Malaria Control Program (NMCP) and Dr. Godfrey Kiangi: Head of Health/Education Unit.

Appreciation is also extended to the local government, UNICEF, Help Age International and media representatives. Our sincere gratitude is extended to the US Government, USAID, AED and T-MARC in particular Charlotte Cerf and Sona Karia, Robert Karam of John Hopkins-CCP Project, Deo Ngwanasabi - Chief of party-CCP project and Azizi Taka of FHI.

We thank all other who we could not mention by their names for their significant roles in the production of this guideline.

Dr. Fatma Mrisho
EXECUTIVE CHAIRMAN
EXECUTIVE SUMMARY

The Behaviour Change Communication Guideline has been developed to guide HIV and AIDS stakeholders in addressing behavior change in line with National Multisectoral Strategy Framework (NMSF 2008 - 2012). This guide builds on achievements made to date in addressing adoption of best behaviours among the public.

It provides guidance to various stakeholders regarding the approaches, interventions and activities that will be undertaken to address HIV and AIDS. The Guideline has been developed through an extensive review and consultative process with participation of various stakeholders.

The results from the 2007/08 Tanzania HIV and AIDS and Malaria Indicator Survey (THMIS) show that 6 percent of Tanzanian Adults aged 15 - 49 are infected with HIV in which the prevalence is higher among women (7 percent) than men (5 per cent).

One of the priority strategic objectives of the Prevention Strategy is to increase adoption of safer sexual behaviours and reduction in risk taking behaviours.

Increased adoption of safer sexual and reduction of risk taking behaviours will be realized through expanding the coverage and scope of the existing behavioural interventions, with specific focus on MCP, transactional sex, early debut, cross generational sex, alcohol abuse and condom use (Prevention Strategy 2009 - 2012). Thus one of the main priorities of NMSF is to promote reduction in the number of sexual partners, and increase mutual fidelity in both marriage and other types of relationships. It is a complex goal which requires changes in sexual behaviours, social values and norms that support and reinforce this sort of behaviour.

Messages around partner reduction are very important though not often clear or not tailored to specific target audiences or partner type within cultural contexts. Often they do not address the root causes of these behaviours or the underlying social norms. In addition, the public may not thoroughly understand the risk of being connected to sexual networks.

One of the main priorities for HIV prevention in Tanzania is to align the prevention response to the drivers of the epidemic (National Multi Sectoral Prevention Strategy 2009 - 2012). Approximately 80% of HIV infections arise from sexual contact between HIV – infected and un-infected individuals. Vertical infections from mothers to newborns represent 18 % of HIV infections and medical transmission for 1.8%. Therefore behavioural interventions are a key in addressing the key driver of the epidemic which is unprotected sex. Some of the interventions include reducing multiple and concurrent sexual partnerships, early debut especially for young girls cross generational and transactional sex. Target audiences include at risk adults and youth who have more than one sexual partner, men and women who engage in commercial sex and their clients, and migrant workers.

Given the seriousness of the epidemic, correct information in communication materials on HIV and AIDS is important since they reach a large proportion of the population. They can create great public awareness
of HIV and AIDS which can make an individual to critically look at the challenges that HIV and AIDS presents to make an informed decision to help its control.

Equally, the communication materials (BCC/IEC) can play an influential part as an agent of change so that the knowledge acquired is translated into practice or desired behavioural change. Educational materials with correct messages can disseminate useful information to the public to bring about the desired behavior change.

The guide will use behaviour change theories to enable implementers understand people’s behaviour, situations and influences to develop messages that respond to the concerns within the situation and finally use communication process and media to persuade people to increase their knowledge and change the behaviours and practices that make them at risk.

The Guidelines outline the following important guiding processes which are clearly expressed in the entire document in each aspect of HIV and AIDS intervention:

- Identify key issues
- Situation Analysis
- Evidence
- Drivers
- Objectives
- Target Audiences
- Key behaviors
- Message concepts
- Channel of Communication
- Monitoring and Evaluation
Chapter 1: Introduction

Tanzania has since the outbreak of the HIV and AIDS epidemic in 1983, relied heavily on communicating to the people about the new disease, how it spreads, and what they can do to prevent its spread, and invariably, how they can protect themselves from getting infected. And when methods for treating it or the opportunistic infections that accompany it came along, communication was, and continues to be the main intervention for getting those who feel to be personally susceptible for HIV infection to access counseling and testing services, and for those who are infected to utilize Care and Treatment Clinics, and to adhere to the prescribed regimen of Anti Retro Therapy (ART). The modality of this BCC guideline has largely been that of Information, Education, and Communication (IEC).

Because HIV is mainly a behavioural disease, the IEC intervention has therefore been concerned with behaviour change. The thrust of IEC is on equipping individuals with the knowledge and motivation to change their behaviour. It builds on the belief that once an individual is convinced that change of behaviour is in his own interest, he or she will do whatever it takes to surmount any obstacles and act accordingly. Psychological theories, such as the Cognitive Dissonance theory however posit that when the obstacles are deemed insurmountable by the individuals concerned they get frustrated and may even redefine and negate the nature of the threat. They may deny its existence, or they may come to see it as their fate, something about which they can do nothing.

There is therefore a move away from IEC to Behaviour Change Communication (BCC), which besides seeking to equip the individuals with knowledge and motivation; it also seeks to identify the obstacles to behaviour change in the social and physical environment and to modify them. This is meant to make it easy for people to effect the desired behaviour change.

TACAIDS is following suit, and has formulated these guidelines to spearhead the change from the IEC approach to that of BCC.

This paradigm shift from IEC to BCC implies a conceptual and programmatic refocusing on the strategic elements of social and behavioural change. It is for this very reason, that these guidelines on BCC are both relevant and necessary.

These guidelines cover all the elements of the HIV and AIDS Programme, ranging from prevention of infection, to mitigation of the impact of the disease. This is because BCC addresses the risk for infection and their precursors among the target population, as well as the attitudes and behaviours of service providers. Service providers need to be non-judgmental towards their clients, and to keep any information about them confidential. This serves to increase the demand for and access to quality Treatment as well as Care and Treatment and Support services, and for those who are on ART to adhere to the prescribed regimen. BCC operating as advocacy and lobbying also seeks to modify policies and programmes to make them conducive to an effective and acceptable service delivery. In effect BCC is integrated into all HIV and AIDS programmes and is not a standalone intervention.
Purpose of the Guidelines
These guidelines are aimed for use by all those who are involved in the HIV and AIDS programme, no matter how they define their core responsibilities. All of them, in one way or another, have to communicate with individuals or groups of people, either as people who are at risk for HIV infection, or as clients who need particular forms of HIV and AIDS related services. Others may be professionals who plan for, and allocate resources into various forms of health and social services, or politicians and legislators who lay down the laws and regulations for the conduct of the economic and social arrangements, including those that seek to protect the human rights of People Living with HIV and AIDS, or of vulnerable population categories such as women and the youth.

Other people with whom they communicate may be private entrepreneurs whose business is to facilitate accessibility and affordability of commodities that are essential for HIV prevention or for the protection of those who provide care for the infected.

In other words anybody who has anything at all to do within the HIV and AIDS programme is a communicator. It is incumbent on him or her to communicate effectively regardless of the purpose of the communication and the type of audience with whom she or he communicates. All are therefore enjoined to seek guidance from these guidelines on how to go about their communication in line with the BCC approach.

BCC: A synopsis
BCC is not unique to the HIV and AIDS field. Many health and development fields use BCC to improve people’s health and well being. BCC builds on IEC, and emphasizes that communication should be strategic and guided by systematic processes and behavioural theories.

According to the BCC approach sustained behaviour change is effective only when combined with changes in the broader socio-economic environment within which communities and individuals operate. Such changes affect underlying and contextual factors such as government and international policies, national structures and systems. The changes have to also affect values and practices, traditional and cultural beliefs, as well as changes in socio-economic relations and gender relationships of people. In other words BCC is behaviorally focused and socio-culturally contextualized. In addition, national policies affecting the availability and accessibility of quality sexual and reproductive health services related to the provision of HIV/AIDS and STI services.

In the context of the AIDS epidemic, BCC is an essential part of a comprehensive program that includes education, services - medical, social, psychological and spiritual, and commodities - condoms, gloves, needles and syringes. Before individuals and communities can reduce their level of risk or change their behaviours, they must first understand – through education - basic facts about HIV and AIDS, adopt key attitudes, learn a set of skills and be given access to appropriate products and services. They must also perceive their environment as supporting behaviour change and the maintenance of safe behaviours, including seeking appropriate treatment for prevention, care and support devoid of stigma. Unlike the IEC approach, it is committed to behaviour change, and seeks to effect social change in order to make it possible for behaviour change to take place. Secondly it avoids the tendency to blame people for not
making changes in their behaviour, by making it unethical to try to persuade people without removing the barriers which prevent them from making behaviour change.

In Tanzania and in most parts of the world, HIV is primarily a sexually transmitted infection (STI). Development of a supportive environment requires national and community-wide discussion of partner relationships, sex and sexuality, risk, risk settings, risk behaviors and cultural practices that may increase the likelihood of HIV transmission. A supportive environment is also one that deals, at the national and community levels, with stigma, fear and discrimination, as well as with policy and law. The same issues apply to unsafe injection of illegal drugs as behavioural contexts in which HIV infections takes place.

BCC leads societies to confront cultural ideals and practices that can contribute to HIV transmission. Effective BCC is vital to setting the tone for compassionate and responsible interventions. It can also produce insight into the broader socioeconomic impacts of the epidemic and mobilize the political, social and economic responses needed to mount an effective program.

BCC draws on many behaviour change theories and models including the *Health Belief Model*, *Theory of Reasoned Action*, *Stages of Change Theory*. These theories and models help in understanding what influences behaviour adoption or maintenance and contribute to the planning, implementation and evaluation of BCC interventions.

*The Health Belief Model* stipulates that a person’s health-related behaviour depends on the person’s perception of four critical areas: the severity of a potential illness, the person’s susceptibility to that illness, benefits of taking preventive action, and the barriers to taking that action.

*Theory of Reasoned Action* states that an individual’s behaviour is primarily determined by the person’s intention to perform that behaviour. This intention is determined by two important factors: the person’s attitude toward the behaviour (i.e., beliefs about the outcomes of the behaviour and the value of these outcomes) and the influence of the person’s social environment or subjective norm (i.e., beliefs about what other people think the person should do, as well as the person’s motivation to comply with the opinions of others).

*Stages of Change* theory has been conceptualized as a five-stage process or continuum related to a person’s readiness to change: (i) pre-contemplation, (ii) contemplation, (iii) preparation, (iv) action and (v) maintenance. People progress through these stages at varying rates, often moving back and forth along the continuum a number of times before attaining the goal of maintenance. In this model, people use different processes of change as they move from one stage of change to another. Efficient self-change depends on doing the right thing (processes) at the right time (stages). According to this theory, tailoring interventions to match a person’s readiness or stage of change is essential. For example, for people who are not yet contemplating becoming more active, encouraging a step-by-step movement along the continuum of change may be more effective than encouraging them to move directly into action.
In this document preference is given to the PRECEDE – PROCEED Model which is commonly used to guide health promotion and intervention mapping programmes. It addresses both the intra- and interpersonal factors as well as environmental factors. It is augmented by the Stages of Change theory in dealing with intrapersonal factors.

**Methodology of BCC**

The BCC methodology is guided by theory. We shall apply the **PRECEDE – PROCEED MODEL** of health promotion which has gained the status of a theory.

According to this model one has to proceed by analysing a community's health needs and why these exist. One then goes on to specify five different “diagnoses”:

- Social
- Epidemiological
- Environmental
- Behavioural
- Educational administrative/policy.

The PRECEDE – PROCEED model directs initial attention to outcomes and forces the planner to begin there.

It encourages to ask WHY the situation is as it is, before asking HOW the situation can be changed. The determinants of health must be diagnosed before the intervention is designed.

Behavioural theories help BCC programmes to develop strategies that reinforce healthy behaviour or change unhealthy behaviour.

Often the choice of theories is eclectic – Taking the most relevant propositions from a number of theories.

The PRECEDE – PROCEED Model posits that one **starts at the end** when analyzing the situation, and **at the beginning** when implementing the intervention, which can be purely educational, policy or administrative, depending on the findings of the situation analysis, also referred to as Formative Research.
Action in this model starts at the end, which is with an assessment of Quality of Life. For the purpose of these Guidelines, we propose to start with the health conditions which are to be prevented, namely HIV/AIDS/STIs.

We move backwards in the precede mode through the assessment of the behaviour that predispose individuals to infection and the environmental factors that facilitate involvement in the risk behaviour, and hence to infection, to the assessment of the determinants of the behaviour. In this model the determinants are termed as Predisposing, Reinforcing and Enabling factors.

This analysis leads to the conclusion as to whether the requisite intervention is educational or health promotional, or both. It is educational when the objective is to modify the predisposing, enabling and reinforcing factors. It is health promotional when the objective is to modify the social and physical environmental factors that serve as the contexts in which high risk behaviour takes place, or those that constrain moves for behaviour change. And it is both simply because these factors operate synergistically in facilitating or impeding behaviour change.

This sets off the intervention action in the proceed mode, all the way to the HIV/AIDS/STIs.

The precede mode is the formative research component, while the proceed mode is the intervention component.

The interventions comprise formulation and dissemination of BCC messages and materials through a variety of appropriate channels, to the primary audience in their constituent segments, and to the secondary audiences or gate keepers through advocacy and lobbying.
With regards to prevention, BCC proceeds from a correct understanding of the epidemiology of the HIV/AIDS/STI problems, in different sections of the Tanzanian society.

Also a correct understanding is required of the sexual behaviour and risk profiles associated with the different prevalence rates of HIV/AIDS/STIs of the different segments of the primary audience / sections of the target population. The analysis of the formative research findings allows for the segmentation of the primary audience. The premise is that the primary audience is not homogeneous. Each segment needs to be identified and their unique situation understood, so that the intervention that is drawn up to target them is appropriate and relevant. BCC has no room for generic messages. The messages have to be tailored to the communication needs of each segment. For instance taking adolescents as a segment among the youth target population, it is still important to identify those who have had sexual debut, for whom the message would be to delay their sexual debut until they have passed their 18th birthday, while those who are already sexually active the message would be about reducing sexual partners and having protected sex.

The fundamental problematic behaviour that needs to be modified is unprotected sexual behaviour involving may be penile – vaginal or penile – anal sexual intercourse.

The recognition of unprotected penile – anal sex is recent, and research is still underway to unravel its drivers and contexts. Suffice it to say that it also occurs among spouses. This is providing a window for understanding the spread of the AIDS epidemic in Tanzania, since it is believed that its efficiency for HIV transmission is similar to unprotected homosexual intercourse.

The different forms of sexual relations in which unprotected sexual behaviour occurs have to be delineated. For some segments of the target population it may be:

- Casual sex that takes place in different contexts, such as among people in marriage or long term partner relationships when they travel away from home;

- Intergenerational sex involving young women with much older men, fueled by economic and other motives by the young women. It is worth mentioning here that recent research points to a phenomenon of Child Sex Abuse involving young girls and boys by boys and men of varying ages. This research also indicates that there are men who prefer to abuse such girls whose ages range from infants to girls aged ten years. It posits the possibility of having men in Tanzania who are pedophiles. Not surprisingly such acts of sex abuse are not mediated by use of condoms.

- Multiple and Concurrent Partnerships by either party in a marriage or other forms of long-term relationships, fueled by a diversity of motives, including sexual exploration and pursuit of sexual pleasure with new partners. This is especially the case where marriage partners are locked in conjugal sexual norms that are highly ritualized, allowing for no experimentation and variation, lest the innovating partner be accused of having been unfaithful, and consequently they are devoid of sexual excitement. In the Tanzanian context such relationships are recognized and referred to as “Nyumba ndogo” for the male spouse or “Serengeti Boys” for the middle age female spouse.
It is noteworthy that even young men and women may engage in multiple and concurrent partnerships as part of their search for a suitable long term partner, or as a hedonistic exploration of sexual pleasure with a variety of sexual partners. The common situation, however, is one of a series of temporary monogamous partnerships rather than multiple and concurrent partnerships.

For some women unprotected sexual behaviour may take place within the context of sex work. Anecdotal evidence points to unprotected sex as a particular form of sexual service that some clients demand, and it is charged highly compared to sex with the protection of condoms.

It is now recognized that some men in Tanzania prefer to have sex with fellow men. This form of sex may also be protected or unprotected.

All this shows the importance of segmenting the target population not only in terms of demographic variables but also by behavioural profiles for preventive purposes. The unique situation of each segment has to be understood so that appropriate interventions can be drawn up. Therefore messages have to be tailored to the communication needs of each segment, and proceeds from a correct understanding of who is doing what, and with whom, and why they are doing it.

Segmentation is particularly important when targeting the youth. The youth who have had their sexual debut have to be distinguished from those who have not.

The youth who have not had their sexual debut need to be encouraged to delay their debut as long as possible – to practice abstinence. Towards this end they may need training in interpersonal skills to enable them resist pressure to engage in sexual behaviour, including being able to assess correctly and to avoid sexually charged environments.

For the youth who are sexually active the appropriate message may be for them to:

- desist from continuing with sexual activity, that is to return to abstinence, or
- reduce the number of sexual partners, or
- desist from engaging in sexual liaisons with much older partners, or
- increase the rate of correct and consistent condom use in their sexual encounters.

It is noteworthy young women may be coerced against their will into sex with much older partners, but others may do so out of their own volition. Between these two extremes there are a number of reasons along the continuum of volition in which girls act neither entirely of their own free will nor entirely due to coercion. The BCC approach directs that intervention need to be directed to men and the community in general in order to change the norms that tend to normalize intergenerational sex. Advocacy for instituting or legal measures that negatively sanction cases of intergenerational sex is an appropriate intervention. And in the Tanzanian case we are talking about effective enforcement of the Sexual Offences Act that criminalizes sex with girls who are less than 18 years of age.
With regards to Care, Treatment and Support, BCC has to address the behaviour of the clients and the service providers, as well as the policy and programmatic arrangements for service delivery.

It is important to understand the response of the clients to the service being provided. For instance experience with the HIV Counseling and Testing campaign people may not go for counseling and testing for different reasons. When these are addressed, the response overwhelms the service providers.

Recent research into the phenomenon of adherence with the ART regimen shows that there are different forms of suboptimal adherence, fueled by economic and social factors, including suboptimal adherence by men for masculinity considerations, which is an indictment of the programmatic arrangements for providing ART.

Some service providers manifest poor social relations with clients. For some of them it may be a question of lacking the appropriate communication and interpersonal skills (skills deficit). They may also not be aware of the ethical standards that should govern their conduct. For others this arises from working conditions that they view as difficult, and hence they are unable to do what they know they should do (performance deficit).

It is noteworthy that in one district the health authority reshuffled the nursing personnel to different duty stations during the campaign period in order to ensure that no client would worry about being counseled and tested by people who know them and might disclose their status to other community members, resulting in that district registering a very high level of turn out for counseling and testing. The common belief in the communities in that district was that the nursing personnel do not keep the test results confidential. This shows the interconnection between prevention and care and treatment which BCC seeks to address. This is particularly important within the context of the stigmatizing society in which health care seeking, and service delivery takes place.

With regards to the wider society, the intervention has also got to take into account the erroneous beliefs about contagion and personal responsibility for HIV/STI infection, and address vulnerability factors, such as those affecting females, and the youth.

**Steps in the BCC formulation process**

(i) **Formative Research**
This is the assessment of the epidemiological, environmental, and behavioural situation among the target population according to the PRECEDE – PROCEED Model.

To develop BCC, it is important to identify the target populations as clearly as possible. Target populations are defined as primary or secondary. Primary populations are the main groups whose HIV and AIDS-related behavior the BCC interventions are intended to influence. Secondary populations are those groups that influence the ability of the primary population to adopt or maintain appropriate behaviors.
Target populations include:

- **Individuals at high risk or vulnerability**, such as sex workers, their clients, youth, migrant workers, IDUs, or uniformed services personnel

- **People providing services**, such as health workers, private practitioners, pharmacists, counselors and social service workers

- **Policy makers**, such as politicians

- **Leaders and authorities, formal and informal**, including law-enforcement, social and religious leaders

- **Local communities and families.**

A formative BCC assessment should start by seeking out all available studies, including data from in-depth assessments or rapid ethnographic assessments, behavioral surveillance surveys and other related studies. After synthesizing this information, a formative BCC assessment protocol can be developed. The formative BCC assessment should collect information on risk situations, showing in detail how decisions are made in different situations, including what influences the decisions and settings for risk. For example:

- Why individuals and groups practice the behaviors they do, and why they might be motivated to change (or unable to change) to the desired behaviors
- Perceptions of risk and risk behaviors
- Influences on behavior, such as barriers or benefits
- Insights of opinion leaders
- Patterns of service use and opinions about these services
- Perceptions of stigma and discrimination
- Future hopes, fears and goals
- Media and entertainment habits
- Health care-seeking behaviors
- Media resources

Formative BCC assessments make use of qualitative methods, such as focus group discussions, key informant interviews, direct observation, participatory learning methods, rapid ethnographic assessments, mapping and in-depth interviews. Where possible, the organizations that are directly engaged with the population, such as community-based and non-governmental groups, should participate in the formative BCC assessment with assistance from appropriate research institutions.
(ii) Analysis of the findings
A major part of the analysis allows for making a distinction between primary and secondary audiences.

- The primary audience comprises people who are at risk of getting infected because of their behaviour and lifestyle.
- Secondary audiences are people who influence the behaviours of the primary audience.
- BCC requires that different messages be formulated to reach the primary and secondary audiences.

Distinguish between segments in the primary audience.

- Segmentation of the primary audience means dividing the audience on the basis of the findings of formative research into different groups of people according to distinctive behavioural or demographic characteristics.
- BCC requires that messages should be customized to suit the segments which have similar needs, preferences and characteristics.

BCC programmes define three levels of objectives:

- **Communication objectives** – describe sought after changes in the indirect causes of behaviour – the Predisposing, Enabling and Reinforcing factors according to the PRECEDE – PROCEED Model. These are knowledge, attitudes, or social norms.
- **Behaviour Change objectives** – these describe the sought after changes in behaviour which would protect the primary audience from getting infected.
- **Overall programme objective** i.e. the anticipated results of the programme in terms of outcomes.

What is required are observable changes in behavior, as specified in the behavior change objectives. These are the final program outcomes. Such changes are generally preceded by intermediate changes. Such changes include:

- **Knowledge change**: an increase in knowledge among targeted youth on modes of transmission
- **Attitude change**: an increase in perception of personal risk or a change in authorities’ attitudes toward promoting condoms to youth
- **Environmental change**: an increase in acceptance of messages about condom use on television

Although some of these changes are not directly related to behavior change, they can function as necessary environmental antecedents or as shifts that reflect an increasingly supportive environment.

An effective BCC strategy needs to be developed to guide achievement of intermediate and longer-term outcomes. Examples of BCC objectives are:
• Increased demand for information about HIV and AIDS.
• Increased knowledge about HIV and AIDS.
• Increased self-risk assessment.
• Increased demand for information on STIs.
• Increased demand for services.

(iii) Developing “SMART” objectives
In formulating objectives it may be desirable to specify communication objectives and behavioural change objectives. The former include the kind of intermediate changes in knowledge, attitudes and beliefs while the later refer to the desirable behaviour that need to be adopted. With reference to the Stages of development theory, it may be desirable to seek to establish where members of the target population are in terms of willingness and intention to change their behaviour.

– **Specific**: indicate who or what is the focus of the effort and what type of change is needed
– **Measurable**: indicate a quantity, e.g. percentage of change
– **Appropriate**: change should be sensitive to audience needs and preferences, social norms and expectations
– **Realistic**: specify what can be achieved reasonably under existing conditions and with available resources
– **Time bound**: state the time period for achieving the behaviour change.

(iv) Development and pretesting messages and materials
A message consists of carefully crafted information that is targeted at specific population groups. It should be designed to meet BCC objectives and to stimulate discussion and action. Messages are the most critical element in developing a BCC strategy—and they are the area where most strategies fail. Messages also need to take into account where different segments of the target population are along the continuum of stages of change. For instance those who have never contemplated the need to change and those who do want to change their habits, even for reasons other than health protection need different messages.

The following steps are to be used when developing the theme and key messages.

**Step 1** - Develop a profile of the target population from formative BCC assessment.

**Step 2** - Identify desired behavior change.

**Step 3** - Understand and take into account the varying situations that could affect action and decision-making.

**Step 4** - Identify the information or data that you want understood by the target population.

**Step 5** - Develop key benefit statements that take the hopes and aspirations of the target population into account: “If I do X (use condoms, get information, seek out treatment), I will benefit by
“Y” (remaining fertile, being seen as responsible, protecting my family, saving money, looking smart and sophisticated, attracting the opposite sex, etc.) Whatever the benefit, it will have to outweigh any disadvantages or “costs” the audiences might feel.

**Step 6** - Develop messages from key benefit statements. Messages should be simple, attractive and make clear the benefits of what is being promoted, through words or images.

Messages that promote products, such as condoms, must include information on where to get those products and how to use them. If a message promotes skill development or specific services, then the services that are being promoted must actually exist.

People may also need messages that help them feel they can succeed. This may be accomplished through messages that model success and positive outcomes.

Developing messages may involve preparation of a “creative brief” i.e. a document that is submitted to firms contracted to produce the messages and materials. This specifies the kind of changes desired and factors associated with the changes.

Development of specific communication support materials should be based on decisions made about channels and activities. They can include:

- Print materials for peer educators, such as flip charts and picture codes.
- Print materials to support health workers on specific care issues.
- Television spots for general broadcast.
- Promotional materials about the project, for advocacy.
- Scripts for theater and street theater.
- Radio or television soap opera scripts.

**(v) Conduct pre-testing**

Pre-testing is key to ensuring that messages and activities reach the intended segments of the target populations. It is important to pre-test at every stage with all audiences for whom the communication is intended, both primary and secondary. Pre-testing should be done of messages, prototype materials, and training packages.

Pre-testing of media, messages and materials should evaluate:
- Comprehension
- Attraction
- Persuasion
- Acceptability
- Audience members’ degree of identification

Several versions should be pre-tested and audience reactions compared.
Although not as important as pre-testing with members of the target population, pre-testing and discussions should also be done with stakeholders, since their views may differ from those of the target population. This is not always possible, but with an eye toward minimizing controversy, programmers should attempt it, since disagreement with stakeholders can derail or compromise a program.

(vi) Disseminating the messages to relevant audiences using appropriate channels

Messages can be delivered through mass media—for example, television or radio spots; articles in periodicals; or material in brochures, posters, flip charts, picture codes or comics—or in-person, by health workers, peer educators, counselors, or other trained personnel. Additional means of delivery include musical or dramatical performances and community events. Messages can be reinforced with “gimmicks” such as key chains or stickers.

It is important to think about how particular channels can help achieve particular goals. Each medium has its own advantages and disadvantages, so that each may be best suited to a particular circumstance. For example, research has shown that mass media can raise awareness of specific facts, because the mass media are assumed to carry a certain authority and reliability. Mass media can also model behaviors and positive attitudes in the person of respected members of the target community. Later on in the process, however, target populations appear less interested in media authority than they are in the opinions and behaviors of people to whom they feel close. Interpersonal communication becomes primary, while the mass media play a supporting role.

If mass media are used, it is important to know which radio stations and TV programs are popular with the target population.

Peer education (or peer facilitation) is a cornerstone of all interventions with target populations. Peer educators can help reach specific groups, model safe behaviours, stimulate community discussions and provide referrals to appropriate services.

In resource-constrained settings, it is especially important to look for opportunities to link various channels, taking advantage of a maximum number of opportunities. If there is a national campaign, for instance, interpersonal messages should be linked to messages in the mass media. If the chief medium chosen is radio talk shows for youth, issues related to youth and HIV and AIDS should be scheduled as discussion topics. Links should also be created to messages that promote condoms through a social-marketing campaign.

(vii) Monitoring to ascertain that dissemination is going according to plan and that the relevant audiences are reached

Monitoring is part of the ongoing management of communication activities, and it usually focuses on the process of implementation. The following should be closely monitored:
Reach: Are adequate numbers of the audience being reached over time?

Coordination: Are messages adequately coordinated with service and supply delivery and with other communication activities? Are communication activities taking place on schedule, at the planned frequency?

Scope: Is communication effectively integrated with the necessary range of audiences, issues and services?

Quality: What is the quality of communication (messages, media and channels)?

Feedback: Are the changing needs of target populations being captured?

(viii) Evaluation of the effectiveness of the interventions

This seeks to establish the changes effected in the determinants of the behaviour, and the actual behaviours.

Evaluation refers to the assessment of a project’s implementation and its success in achieving predetermined objectives of behavior change. BCC interventions should be evaluated against their stated objectives and in reference to a baseline that may be qualitative or quantitative (or both). For large-scale interventions, baseline quantitative research may be repeated to demonstrate changes in knowledge, attitudes and reported behaviors relative to communication and project-level behavior change objectives. Change can also be assessed through qualitative research into target-group responses to interventions. Qualitative evaluation involves examining data that are designed to illustrate changes in audience behavior.

(ix) Elicit feedback and modify the interventions

As programs evolve, target populations acquire new knowledge and behaviors, and communication needs may change. The needs of target populations must be periodically reassessed to understand where they stand along the behavior change continuum. As epidemics develop, the types of information and communication needed by target populations evolve from basic HIV and AIDS information to discussions related to stigma, care and support and sustaining safe practices. Monitoring and evaluation studies should lead directly to modifications of the overall program, as well as of the BCC strategies, messages and approaches.

Day-to-day monitoring will provide information for making adjustments in short-term work planning. Periodic program reviews can be designed to take a more in-depth look at program progress and larger-scale adjustments or redesign. Involving stakeholders, target audiences and partners as much as possible will provide a better look at what is happening; help make appropriate decisions; and make sure that the people affected by any decisions will be fully aware of them.
Chapter 2: Background to, and Situation Analysis of the HIV and AIDS Epidemic in Tanzania

Tanzania, like other countries in the sub-Saharan African region, has been devastated by the HIV and AIDS epidemic for more than a quarter of a century.

About 5.7% of adults aged 15 to 49 years (6.6% of women and 4.6% of men) in Tanzania, or approximately 1.5 million people, are currently infected with HIV, nearly 10% of them, children. (THMIS 2007/2008)

HIV surveillance reports indicate that in 2008, there were approximately 217,704 new HIV infections in the country (77,734 in urban and 139,970 in rural areas). The predominant mode of HIV transmission in the country (80%) is through heterosexual contact between HIV-infected and uninfected individuals. Approximately 18% of the transmissions are through vertical infections from mothers to newborns and 1.8% is through medical transmissions.

The epidemic varies across geographical, socio-demographic and socio-economic subgroups. For instance, women are more disproportionately affected than men, and adults over 30 years old are more likely to be infected than younger adults. Individuals that are either married or formerly married are more likely to be infected than those who are single. There is also a higher prevalence among those living in wealthy households than those who live in poor ones. Urban residents are more disproportionately affected than their rural counterparts (9% versus 5%). HIV prevalence also varies across geographical regions of the country, from the lowest rate, 1.5% in Manyara Region, to 15.7% in Iringa Region. HIV prevalence among women attending antenatal clinics was 8.2% in 2006. HIV prevalence has shown a declining trend among women attending ANC clinics from 9.6% (2001/02), 8.7% (2003/04), 8.2% (2005/06) to 7.0% (2007/08) [ANC Surveillance Report no. 22 of 2011].

Available data also indicate recent declines in national HIV prevalence; from 7.1% to 5.7% overall, from 8% to 7% among women and from 6% to 5% among men (THMIS). Similar trends have also been observed among antenatal women and blood donors. The HIV prevalence trends appear to correlate with trends in some HIV transmitting risk behaviour. For instance, there have been declines in early sex (before age 15) from 15% to 11% and 24% to 11% among female and male teenagers aged 15 to 19 respectively from 2003 to 2008. During the same period, casual sex with non-marital, non-cohabiting partners declined from 46% to 29% among men and 23% to 16% among women aged 15 to 49 years (THMIS 2007/08).

In 2008, 18% of men and 3% of women had multiple partners in the previous year, and 29% of married/cohabiting men and 16% of such women had sex with multiple partners.

Although condom use during casual sex increased from 38% to 43% among women and 50% to 53% among men aged 15 to 49 years during 2003 to 2008, still less than half of these sexual acts were protected with condoms.
There is little data on the HIV transmission risk behaviour of HIV-infected individuals; although 8% of married or cohabiting couples were in HIV-discordant relationships and 67% of HIV-infected individuals had HIV-negative spouses.

Social and behavioural factors associated with the spread of the epidemic

The HIV epidemic in the country is driven by a complex set of intertwining biological, behavioural, and underlying socio-cultural and socio-economic factors. These factors or drivers of the epidemic are:

Biomedical
- Low levels of male circumcision especially in some regions.
- High level of HIV-discordance and low levels of knowledge of HIV serostatus.
- High prevalence of sexually transmitted infections, including herpes simplex virus type 2 (HSV-2).
- Low coverage of quality-assured blood transfusions.

Mother-to-child HIV transmission
- Which may occur in the womb, during delivery and or during breastfeeding

Behavioural
- Multiple concurrent partnerships
- Early sex
- Cross-generational sex
- Transactional sex/commercial sex work
- Low and inconsistent condom use
- Intravenous drug use/substance abuse
- Men having sex with men (MSM)

Cultural
- Social cultural norms and practices
- Lack of male circumcision
- Large number of HIV-discordance couples with low levels of knowledge of individuals’ own and their partners’ HIV status
- Gender inequities and gender-based violence
- Wealth and poverty
- Population mobility for work or trade
- Conflict situations
- Alcohol and drug abuse
Coverage and Scope of HIV and AIDS Prevention Programmes

Tanzania’s current HIV prevention approach is comprised of various behavioural and biomedical interventions for the general population and vulnerable groups. Most biomedical interventions such as Prevention of Mother-To-Child Transmission (PMTCT), HIV counseling and testing (HCT), blood transfusion safety, STI case management, medical infection control and post-exposure prophylaxis (PEP) are drawn from national technical guidelines that are based on current evidence and are regularly updated.

However condom promotion and most behavioural interventions such as mass media, life skills training, peer education approaches and programmes addressing underlying drivers of the epidemic are not based on up-to-date national technical policies, guidelines or communication strategies. There are national policies and technical guidelines for medical male circumcision, HIV prevention for MARPs and HIV prevention with HIV infected individual. There has been recent increase in coverage of biomedical interventions, although it is not yet universal.

The proportion of individuals who have ever tested for HIV and picked up their results recently increased from 15% for men and women in 2003 to 37% for women and 27% for men in 2008 according to the NACP surveillance of HIV and Syphilis infections.

The proportion of antenatal mothers receiving access to PMTCT services increased from virtually none nine years ago to 61% in 2008 (Antenatal Clinic Report).

The number of zonal blood transfusion centres recently increased to seven, and the number of blood units collected from voluntary non-remunerated blood donors by the National Blood Transfusion Service increased to 67,000 in 2007, although this number still significantly lags the estimated needed units of 350,000 to 500,000 annually.

The coverage of HIV prevention services remains uneven (THMIS 2007/2008).

- More than 60% of adults in Tanzania have never been tested for HIV.
- More than 40% of antenatal mothers do not have access to PMTCT services, and the uptake of anti-retroviral prophylaxis by HIV-exposed infants and their mothers is less than 50% (ANC report).
- Less than half of risky sexual acts were protected by condoms and more than 60% of adults do not have comprehensive knowledge of HIV prevention (ANC report).
- About one third of STI clients are not appropriately managed according to national guidelines, including being provided with preventive counseling on condom use and partner notification, and less than half are referred to or provided HCT.
- Less than half of blood transfused in the country is channeled through the national quality assured system, while only 5% of facilities met the minimum requirements for infection control in health facilities in 2007 (THMIS).
Underlying socio-cultural and socio-economic factors influencing HIV transmission are not adequately addressed by the current HIV prevention programmes.

The strategic information for tracking impact and coverage of HIV prevention services is also limited. For instance, HIV incidence data is limited and therefore rarely used to inform and track HIV prevention programmes.

Major Behaviour Change Communication Strategies

The major strategies for behaviour change promotion in Tanzania have thus far focused on:
- Emphasis on communicating messages through mass media
- Encouraging interpersonal communication/social change approaches
- Emphasis on youth education and life skills
- Development of educational programmes in the workplace

Sexual behaviour change interventions in Tanzania are implemented by a wide range of partners in a multi-sectoral landscape.

Mass Media Programmes

These programmes aim to raise general awareness, promote comprehensive knowledge and improve utilization of HIV prevention, care and treatment services. In line with the communication strategy, multi-media communication approaches involve TV, radio and print media such as newspapers. These programmes are supported by the government and development partners and are implemented by national and international public and private institutions including civil society organisations. Some of major programmes in Tanzania include:

- Femina-HIP, a shared media platform developed for partners to collaborate, complement and reinforce, rather than duplicate, their efforts.
- The Tanzania Communication and Marketing Company (T-MARC) is a local non-profit that designs and implements health communications campaigns. The MoHSW/NACP had radio and billboard programmes (Fataki) and behaviour change programmes focusing on cross-generational sex which were very effective.
- The National AIDS Control Programme (NACP) sponsors radio and TV programmes promoting safe sexual behaviours (e.g. Tingisha – Radio Tumaini).
- Tanzania Commission for AIDS (TACAIDS) has benefited from all Regional Multi-Sectoral AIDS Coordinators (RMACs, RCTS, DACS CHACS) with cinema vans that are used for education campaigns.

Interpersonal Communication or Social Mobilization Programmes

The major organisations supporting these approaches include:
- PSI/Tanzania, a non-governmental organisation (NGO) that implements discussion groups among intravenous drug users on harm reduction, one-on-one outreach with sex workers promoting condom use, small group workshops on partner reduction for men having sex with men (MSM/CSW) and peer education on abstinence for youth.
• The Ministry of Education and Vocational Training (MoEVT) has developed a strategic plan and is rolling out life skills curricula in schools. The Prevention and Awareness in Schools of HIV/AIDS project (PASHA), a MoEVT initiative, is running a peer education programme for primary schools, with a focus on communication about HIV/AIDS among peer groups.

• TAYOA (Tanzania Youth Aware Trust Fund) runs a youth FM AIDS-Radio programme targeting rural and urban schools and out-of-school youths.

• The African Medical and Research Foundation (AMREF) is involved in the development and implementation of the MEMA kwa Vijana (good things for young people) programme.

• Most of the programmes which support life skills being taught in schools such as TANESA, Mema kwa Vijana, Students Partnerships Worldwide (SPW) and Peace Corps also have out-of-school programmes on behaviour change communication.

• Family Health International (FHI), through its Ujana Project, supports organisations that provide HIV education to young people. FHI also implements the ISHI Campaign, a nationwide programme to increase the perception of risk of contracting HIV in target districts among 10 to 24 year olds. The Kijana AMKA project was used for testing

Programmes for BCC in the Work place

• HIV/AIDS Business Coalition of Tanzania (ABCT), an NGO involved in HIV/AIDS at work places, offers training for peer educators and promotes workplace interventions.

• A number of MDAs implement workplace behavioural change interventions. These include: Tanzania Breweries, Tanzania Harbour Authority, Mtiwba Sugar Company, Kagera Sugar Company and Urafiki also implement behavioural change activities in workplaces.

• The Tanzania Informal Economy Networks on AIDS Initiative (TIENAI) is now establishing itself in all regions.

Achievements of Behaviour Change Communication Programmes

• HIV and AIDS knowledge among adults is currently over 98%. Gains have been made in increasing comprehensive HIV knowledge. Currently, 39% of women and 42% of men aged 15 to 24 have comprehensive knowledge of HIV/AIDS.

• There have also been improvements in sexual behaviour among youth. Early sexual debut decreased among young women and men 15 to 19 years old, from 15% to 11% and 24% to 13% respectively from 2004 to 2008.

• During this same period, secondary abstinence among teenagers aged 15 to 19 increased from 50% to 65%. Secondary abstinence refers to people who are sexually experienced but choose to become abstinent (no longer sexually active).

• Multiple partnerships among teenagers aged 15 to 19 decreased from 20% to 10%. The median age at first sex for women and men was already high and held steady.

• In the MoEVT, 75% of secondary schools and 48% of primary schools were actively providing life skills-based HIV education on the mainland of Tanzania by 2007.
Challenges in Behaviour Change Communication Programmes

The main gaps in behavioural intervention programmes include:

- Low coverage of mass media, especially in rural areas and lack of quality assurance for mass media messages.
- Most programmes do not provide avenues for interactive communication with audiences so their effect is not immediately known.
- The focus of behaviour change communications has not yet fully aligned with current epidemic drivers. For instance, there are few initiatives and messages targeting concurrent multiple partnerships, transactional sex and stigma and discrimination.
- In general there has been too much focus on the mass media for BCC when interpersonal communication may be more effective in certain cases.
- The quality of in-school education programmes for HIV life skills is not currently tracked; anecdotal evidence indicates some weaknesses there.
- There have been instances of over-emphasis on abstinence education without mentioning other HIV prevention approaches necessary to equip young people for transition into adulthood.
- There is no standardized curriculum for training peer educators for out-of-school youths. Individual programmes have their own training manuals that have not been harmonized to ensure that messages are consistent.
- Most interventions do not focus on modifying cultural norms and practices or promotion of positive behavior is important.
- Most youth interventions do not include parents, guardians and other adults. Since most youth live in households with adults these interventions might miss opportunities to influence the target audience.
- The coverage of workplace interventions is still very low, though quite a lot has been done in recent years.

Best practices of Behavioural Interventions in Tanzania

- Programmes such as Mema kwa vijana (good things to young people) were found to be comprehensive in content and they produced teaching-learning materials for Tanzanian schools as well as materials for community and peer education.
- The assessment of the ISHI programme reported a reduction in multiple partners, an increase in the consistent condom use, an improvement in HIV and AIDS dialogue, an improvement in partner communication and an improvement of youth HIV risk perception among those in the target districts.
- The TANESA programme in Mwanza provided best practices for school-based behaviour change intervention. Its comprehensive peer education programme was accepted by the Ministry of Education and Culture and was replicated nationwide.
- Student Partnership Worldwide (SPW) was found to have successfully met 11 and partially met five of the 16 UNAIDS benchmarks for effective programmes.

Recommendations

A publication titled Review of HIV Epidemiology and HIV Prevention Programmes and Resources in Tanzania Mainland was produced by TACAIDS in May 2009. It made the following recommendations:

- In the short to medium term, there should be a strategic shift of HIV prevention to focus on population groups with a disproportionately higher incidence of HIV infection and which don’t currently constitute the focus of HIV prevention. These groups include urban residents, older individuals, married and formerly married individuals, working and wealthy men and women and high prevalence geographic regions.
• Secondly, programmes should balance interventions, giving priority to those that have the potential for the greatest impact on HIV transmission at this stage of the epidemic. These include reduction of sexual partners, HIV-discordance, medical male circumcision and consistent condom use especially among those that engage in high-risk sex and among MARPS.

• Thirdly, there should be more domestic investment into HIV and AIDS control and HIV prevention in particular. Part of this investment should include the development of policies and technical guidelines for medical male circumcision. Programmes for MARPs and a specific policy on condom promotion should be prioritized as well.

• The upcoming revision of the HIV and AIDS policy should incorporate emerging issues of male circumcision, MARPs, multiple partnerships, couple HCT and disclosure as well as HIV prevention among infected people.

• At the programme level, the roll out of proven interventions to meet national targets for universal access should be expedited. The modest targets for some interventions such as blood transfusion safety, condom use and other essential prevention services should be reviewed.

• There should be a strategic shift in behavioural interventions to more interactive approaches and interpersonal communication, with messages on the drivers of the epidemic. There should also be improved linkages and reinforcement of messages across all communication channels including mass media for maximum behaviour change impact.

• Condom promotion should be strengthened to ensure uninterrupted supply of good quality condoms and improved distribution especially at the community level, and appropriate targeting of high-risk groups.

• The roll out of HCT based on various approaches should emphasize risk reduction among HIV infected and uninfected individuals, couple testing with disclosure of test results to partners and increased coordination of stakeholders.

• Safe male circumcision should be rapidly rolled out and integrated into other components of the HIV prevention package, initially in regions with high HIV prevalence and low prevalence of male circumcision.

• HIV prevention among HIV-infected people should be given added impetus through integration into all HIV and AIDS treatment, care and support programmes. Socioeconomic, gender, cultural and other underlying factors influencing HIV transmission and vulnerability should be taken into account in all HIV prevention endeavors.

• Strategic information for HIV prevention should be strengthened through improved monitoring and evaluation and surveillance to provide more comprehensive data, better reporting and information on the quality of services.

• Regular aggregation of monitoring and evaluation data and dissemination to stakeholders should be done to promote better data utilization. Monitoring of impact of HIV prevention based on HIV incidence should be explored.

• Tracking dynamics of MARPs through biological and behavioural surveillance, size estimation and tracking the sexual behaviour of HIV-infected individuals should be instituted.

The above analysis has been made on the national level. It is obvious from the regional diversity of the epidemic that those who wish to undertake BCC interventions, especially those that focus on primary audiences, undertake a situation analysis in their localities. Their interventions have to focus on the drivers of the epidemic in their own catchment areas.
Chapter 3: Behaviour Change Communication for HIV Prevention

As explained in the first part, BCC interventions have to proceed from a correct understanding of the risk profiles of the primary audience, the risk behaviour that expose them to the risk of infections and the factors associated with their involvement in the risk behaviour. This spells out the requisite behaviour change, as well as the kind of communication which is needed to address them. The BCC interventions have to reach the secondary audience whose contribution is necessary for making it easier for the primary audience to effect changes in their behaviour. This section outlines the generic interventions deemed appropriate at the national level. Each change agent has to start with the local epidemic and obtain a good understanding of its dynamics and drivers in order to decide on the appropriate set of BCC interventions.

Lack of HIV risk knowledge, and low and inconsistent condom use

Despite enormous IEC efforts to create awareness about HIV transmission since the first case was discovered in Tanzania in 1983, studies like the 2007-08 Tanzania HIV/AIDS and Malarial Indicator Survey (THMIS) confirm that lack of comprehensive knowledge is still a problem.

High-risk sexual behaviour refers to aspects of a person's behaviour, lifestyle, or environmental exposure, which renders an individual susceptible to HIV transmission or infection.

In Tanzania, as in many other parts of the continent, there are several critical factors that explain high-risk behaviour by individuals and groups of people, these include:

- Lack of comprehensive knowledge about HIV transmission which affects an individual's sexual behaviour.
- Low and inconsistent condom use. Studies show that not all individuals with knowledge about HIV transmission take precaution to use condoms correctly and consistently.

Factors that increases one's chances of engaging in high-risk behaviours include:

- Being a member of a mobile population. This includes people who frequently travel for employment to places such as plantations, mining areas, fishing villages, markets, and construction sites. It also includes those who work in trucking, and those who go to seminars. This population has a higher-than average tendency to engage in high-risk sex when they are away from their permanent homes.
- Excessive alcohol and drug consumption. Since intoxication often leads to impaired judgment, it is also associated with high-risk sexual behaviour that increases one's vulnerability to HIV infection.
- Adolescent sex. According to studies, having sex at an early age increases one’s chances of HIV infection in Tanzania because adolescents often lack knowledge of reproductive health and lack parental support or supervision.
- Poverty. Poverty is an issue in that it often leads adolescents to indulge in sex (often cross-generational) for money or material benefits.
- **Idleness among youth.** Teens that don’t have jobs or other positive outlets for their time and attention often turn towards experimenting with sex.

- **Gender inequalities.** Gender inequities and gender-based violence, in the form of coerced sex or rape, increases the risk of HIV infection particularly among girls and women.

One of the major challenges is to not only close the gap between knowledge and behaviour for many of these high-risk groups, but to also effect changes on cultures which tolerate promiscuity, sex for money, gender-based violence and excessive drinking.

**The drivers of high risk behaviour**

Some individuals, particularly those who are part of a mobile population or are adolescents, have unprotected sex because of lack of comprehensive knowledge of HIV and how one can be infected.

Some indulge in unprotected sex under the influence of excessive alcohol.

Some girls and women indulge in high-risk sex because of monetary or material gain.

Others, particularly girls and women who are coerced into sex or rape, are victims of gender inequalities that support this behaviour.

Supporting factors include:

- Casual sex as a result of peer pressure.
- Societal acceptance of casual sex.
- Non enforcement of laws that limit alcohol consumption, especially for drivers; non-enforcement of laws that limit opening and closing time for bars.
- Guest houses that offer convenient services for individuals who engage in casual sex.
- Lack of parent-youth communication (communication gap), lack of strong moral foundation within families, bad examples from those who are supposed to be role models.
- Women who are coerced into sex or rape fear retribution if they file charges against perpetrators.

**Objectives**

Increase the number of mobile populations and youth who have comprehensive knowledge about high-risk sexual behaviours and are willing to go for testing and counseling

Increase incidences of consistent condom use among mobile populations, commercial sex workers and youth

Reduce incidences of alcohol-induced sexual encounters among mobile populations, commercial sex workers, and youth
Engage the community to actively advocate for protection of young women from having sex with older men.

Engage community, non-governmental organizations and community-based organizations that prevent HIV transmissions to actively advocate for enforcement of laws that help to protect girls.

**Key desirable behaviours**

- Mobile populations, commercial sex workers and youth start addressing the risks involved in their sexual behaviour, including receiving testing and counseling services.
- Wearing a condom correctly each time one has sexual intercourse for safety against HIV/AIDS and sexually transmitted infections.
- Those involved with excessive intake of alcohol correctly use condoms each time they have sexual intercourse even after drinking.
- Demand creation of Health Seeking behaviour.
- Community leaders, parents, teachers, religious leaders and non-governmental organizations start talking openly and taking action to discourage early sex.
- Parents, teachers, community leaders, religious leaders, political leaders and role models start advocating for the enforcement of laws protecting girls and women from coerced sex and rape.
- Parents, teachers, community leaders, religious leaders and role models increase their communication with youth regarding their risky behaviours.

**Target Audiences**

Target 1: Provide comprehensive HIV knowledge among at-risk populations

- Primary: Truckers, miners, fisherman, businessmen and women, traders, farm and construction workers, excessive drinkers, commercial sex workers, young women aged 15 to 24 years old.
- Secondary: Bars, guest house and shop owners, brothels owners, close friends, parents, teachers and guardians.
- Influential: Peers, policy makers, community leaders, law enforcement officials.
- Supporting/facilitating: Non-governmental organisations, community-based organisations, mass media, programme managers, field officers and health officers.

Target 2: Correct and consistent use of condoms

- Primary target: Truckers, miners, fisherman, businessmen and women, traders, farm and construction workers, excessive drinkers, commercial sex workers and women aged 15 to 24 years old.
- Secondary: Bars, guest house and shop owners, brothels owners, close friends, parents, teachers and guardians.
Target 3: Reduce incidences of alcohol-induced sexual encounters
- Primary: Excessive drinkers
- Secondary: Bars, guest house and shop owners, brothels owners, close friends, parents, teachers and guardians.
- Influential: Peers, policy makers, community leaders and law enforcement officials.
- Supporting/facilitating: Non-governmental organisations, community-based organisations, mass media, programme managers, field officers and health officers.

Target 4: Communities advocating for protection of youths from early sex
- Primary: Men and women aged 15 to 24 years old, parents, teachers, village heads and opinion leaders.
- Secondary: Community local governments, non-governmental organizations, faith-based organizations and community-based organizations.
- Influential: Role models and peers.
- Supporting/facilitating: Mass media, drama artists and musicians

Target 5: Communities advocating for better law enforcement to protect girls and women against rape
- Primary: Parents, teachers, non-governmental organizations, faith-based organizations and community based organizations
- Secondary: Elders and youth
- Influential: Policy makers and law enforcement officials
- Supporting/facilitating: Mass media, drama artists and musicians

Key behaviours
- Mobile populations, commercial sex workers and youth start addressing the risks involved in their sexual behaviour, including receiving testing and counseling services.
- Wearing a condom correctly each time one has sexual intercourse for safety against HIV and sexually transmitted infections.
- Target audiences for alcohol abuse correctly use condoms each time they have sexual intercourse even after drinking.
- Community leaders, parents, teachers, religious leaders and non-governmental organizations start talking openly and taking action to discourage early sex.
– Parents, teachers, community leaders, religious leaders and role models start advocating for the enforcement of laws protecting girls and women from coerced sex and rape.
– Parents, teachers, community leaders, religious leaders and role models increase their communication with youth regarding their risky behaviours.

**Message Concepts**

- “Avoiding high-risk behaviours helps you to stay safe from HIV and other sexually transmitted infections. Also knowing your HIV status helps you to stay safe and to avoid new infections.”
- “Wearing a condom each time you have sex gives you peace of mind because you are protected from infections; it helps you to live longer and to realize your dreams.”
- “Wearing a condom helps you enjoy sex because you do not worry about the possibility of infection.”
- “Protecting young women from early sex helps them to stay safe, live longer and realize their dreams.”
- “Advocating for protection of girls and women from coerced sex and rape helps to build a decent and HIV free society.”

**Channels of Communication**

- Interpersonal (one-on-one, peer influence, small groups)
- Community-based/community mobilization
- Workplace initiatives
- Faith-based initiatives
- Political-based initiatives
- Artists (drama, film, music)
- Mass media, newsprint, TV, internet, radio, electronic and print media
- Social networks

**Monitoring and Evaluation**

**Outcome indicators**
- Number of individuals within target groups reporting they have not indulged in high-risk sexual behaviour in a specified period of time.
- Number of individuals within target groups reporting they have received testing and counseling in a specified period of time.
- Number of individuals within target groups reporting using condoms last time they had sex.
- Number of individuals within target groups reporting using condoms every time they had sex within a specified period of time.
– Number of community leaders, religious leaders, parents, and non-governmental organisations reporting they have had a meeting to discuss how to stop early sex among adolescents in a specified period of time.

– Number of parents, teachers, community leaders, religious leaders and role models who have taken specific actions toward advocating for the enforcement of laws protecting girls and women from coerced sex and rape.

**Impact indicators**

– Decrease in cases of individuals in target groups prevalence rate with new infections of HIV or STIs.

– Increase in cases of individuals in target groups reporting they have not had unprotected sex while drunk in the specified period of time

– Decrease in the number of youths reporting they have not had sex in the specified period of time

– Increase in number of communities reporting they have started addressing the issue of protecting adolescents from early sex.

– Increase in the number of young women aged 15 to 20 reporting they have not had sex in a specified period of time.

– Increase in incidents of parents, teachers, community leaders, religious leaders and role models advocating for enforcement of laws protecting girls and women from coerced sex and rape.

– Increase in incidents of policy makers and law enforcement officials addressing the issue of laws protecting girls and women against coercive sex and rape.

**Multiple and concurrent partnerships**

Multiple concurrent partnerships (MCP) is a situation whereby sexual partnerships overlap in time; either when two or more partnerships continue over the same period, or when one partnership begins before the other terminates.

In an HIV context once one person in MCP is infected with the disease, everyone in the network is exposed to the risk.

MCP in Tanzania is driven by complex social-cultural male and female gender norms. MCP has its roots in the socially acceptable practice of polygamy, male dominance and treating sex as a form of recreation.

MCP is also supported by other factors including travel, mobile employment and peer pressure.

There are different forms of MCP, namely:

– Intergenerational sexual relationships (commonly known in Kiswahili as *fataki*)

– Married men cohabiting with other women (commonly known as *nyumba ndogo*)

– Casual sexual partners (one night stands for fun or *kujirusha*)
– Transactional sex where money is exchanged
– Polygamy, whereby a man will take on multiple wives at the same time.

**The evidence**

According to the 2007-08 Tanzania HIV/AIDS and Malarial Indicator Survey (THMIS), 27% of men and 3% of women reported having more than one sexual partner in the previous 12 months.

HIV prevalence increases with the number of sexual partners over a lifetime.

For those with one lifetime sexual partner, HIV prevalence ranges from 1.4% to 3%.
For those with 10 or more lifetime sexual partners, HIV prevalence ranges from 11.4% to 21.5%

About 29% to 16% of married or cohabiting men and women reported having extramarital sex 29% to 16% of men and women aged 15 to 49 reported having casual sex.

According to the 2007/08 THMIS, 8% of young women had sexual relationships with men 10 years older or more.

According to National Multi-Sectoral HIV Prevention Strategy (2009-2012) about 3% of sexually active young women and 27% of sexually active young men reported they had more than one sexual partner in the previous 12 month.

**The drivers for the MCP behaviour**

Many youths are engaged in MCP because of money and material gains while other factors include lack of partner communication, sexual dissatisfaction, among married couples, male dominance, misconception that men cannot control desire, polygamy, prestige, status, alcohol abuse, sex for drinks, emotional/physical abuse, domestic discord, neglect, peer pressure and lack of role models in the society.

Locations for this behaviour fall into three settings. First, it is most prevalent in entertainment locales such as bars, clubs, brothels, local video theatres, and entertainment centers. Second, it occurs at transit locations such as highway stop-over, public transport areas and at weigh bridges. Finally, MCP behaviour happens in employment settings such as construction sites, mining areas, plantations, mobile markets and schools.

Supporting causes include the lack of parent-youth communication (communication gap and the lack of positive role models.

Specific issues to be addressed include: access to knowledge about HIV, parent-youth communication, addressing peer pressure, alcohol abuse, casual sex and enforcing laws protecting young women against older and married men.
Objectives

• Increase incidences of consistent condom use among MCP.
• Engage the community to actively advocate for a significant reduction of trans-generational sex.
• Engage religious and community leaders to help reduce family conflicts originating from MCP.
• Reduce the number of new multiple concurrencies.

Target Audiences

Target 1: Wearing condoms in each sexual encounter.
- Primary: Married couples aged 20 to 50. Male and female youth aged 18-24 years.
- Secondary: Bars and guest house owners, brothels owners, close friends, parents, teachers and guardians.
- Influential: Peers, policy makers, community leaders, law enforcers.
- Supporting/facilitating: Community-based organisations, non-governmental organisations, mass media, programme managers, field officers, and health officers.

Target 2: Addressing trans-generational sex through communication.
- Primary: Community leaders, parents, teachers, guardians, religious leaders.
- Secondary: Youth.
- Influential: Faith-based organisations, community-based organisations, non-governmental organisations, and role models.
- Supporting/facilitating: Mass media.

Target 3: Helping to reduce family conflicts.
- Primary: Community leaders, role models and community-based organisations.
- Secondary: Men and women.
- Influential: Community members, teachers, parents, non-governmental organisations, faith-based organisations, community-based organisations and role models.
- Supporting/facilitating: Human rights advocates, policy makers, mass media, law enforcers and researchers.

Target 4: Addressing the issue of multiple concurrent partners among youth.
- Primary: Youth above 18 years old.
- Secondary: Parents and teachers.
- Influential: Role models, peers, non-governmental organisations, faith-based organisations.
and community-based organisations
– Supporting/facilitating: Mass media

Target 5: Increasing couples’ communication about their sexuality and sexual satisfaction
– Primary: Married couples and cohabiting partners
– Secondary: Faith-based organisations and traditional leaders
– Influential: Influential religious and community leaders, non-governmental organisations and community based organisations
– Supporting/facilitating: Mass media and drama artists

Target 6: Reducing the number of new multiple partners
– Primary: Young adults who are about to get married.
– Secondary: Faith-based organisations, community and traditional leaders as role models.
– Influential: Non-governmental organisations and mass media, role models, drama artists and peers.
– Supporting/facilitating: Religious and community leaders, and health workers.

Key desirable behaviours

• Wearing a condom correctly each time one has sexual intercourse for safety against HIV and sexually transmitted infections.
• Community leaders, religious leaders, parents, and non-governmental organizations start talking openly to discourage MCP.
• Community leaders, religious leaders and role models start addressing family conflicts which may lead to MCPs.
• Parents, community leaders, religious leaders, peers start discouraging the youth from engaging in MCPs.
• Couples start communicating frankly about their sexuality and sexual satisfaction.
• Young adults start making choices to stay away from polygamous marriages.

Message Concepts

• Wearing a condom every time you have sex gives you peace of mind because you are protected from infection.
• Condoms help you to live longer and to realize your dreams.
• Wearing a condom makes you enjoy sex because you do not worry about the possibility of infection.
• Protect young women from older men so that they can stay safe, live longer and realize their dreams.

• Sticking to one life partner helps you to remain financially stable and to be a good example in the community.

• Promote family values by encouraging married couples to not stray from their spouses.

• Help couples talk frankly and openly about their sexuality and sexual satisfaction so they can live happier and more fulfilling sexual life.

• Help couples solve their family problems through communication so they can live happier lives and support their children.

• Support young women to have one life partner so they can reduce chances of HIV and sexually transmitted infections and live longer.

Channels of communication

• Interpersonal (one-on-one, peer influence, small groups)

• Community-based/community mobilization

• Workplace initiatives

• Faith-based initiatives

• Artists (drama, film, music)

• Mass media

• Social networks

Monitoring and evaluation

Outcome Indicators

– Number of MCPs and youth reporting using condoms last time they had sex

– Number of MCPs and youth reporting using condoms every time they had sex within the last three months

– Increase in cases of community leaders, religious leaders, parents, and NGOs reporting they have had a meeting to discourage MCPs in the last three months

– Increase in community leaders, religious leaders and role models reporting they have addressed family conflicts which may lead to MCPs in the last three months

– Increase in incidences of parents, community leaders, religious leaders and peers reporting they have discouraged youth from having MCPs in the last three months

– Increase in number and incidence of couples reporting they have communicated frankly about their sexuality and sexual satisfaction in the last three months.
– Increase in number of young adults reporting they have avoided engaging in multiple concurrent partnerships in the last three months.

**Impact Indicators**

– Decrease in the number of cases of MCPs and youth with new infections of HIV or sexually transmitted infections
– Increase in cases of MCPs reporting they have not had sex with partners other than their spouses.
– Decrease the number of family conflicts
– Increase in the number of youths reporting they have not had sex with people other than their partners
– Increase in number and cases of couples who report they are now communicating frankly about their sexuality and sexual satisfaction
– Decrease in number of couples reporting they have had sex outside their marriage
– Decrease in number of women who have relationships with a husband who has MCP

**Sexually Transmitted Infections (STI)**

Interventions for STIs have been considered essential in HIV prevention programmes. However, the general public, and young people in particular, tend to be ill-informed about STIs.

Prevention and treatment of STIs for HIV prevention in Tanzania is integrated into routine health service delivery and is available in about 60% of public hospitals, health centres, dispensaries, faith-based organizations and private health facilities (Tanzania Services Provision Assessment).

**Drivers**

- There is an absence of adequate services for youth and high-risk groups regarding care and treatment of STIs.
- Almost half of patients with STIs do not seek prompt and adequate treatment from qualified health providers. Some opt for self medication by purchasing drugs over the counter.
- Some providers, especially private facilities, unlawfully offer STI medications without prescription.
- There is insufficient screening for STI’s (syphilis) during ANC clinics.
- People have unprotected sex because of lack of comprehensive information about HIV and AIDS and STIs.
- When used, condoms are not always used correctly and infections still occur.
- STI patients shy away from seeking treatment in hospitals, hence they stay untreated and potentially infecting others.
- STI’s symptoms are not managed correctly by health providers, especially around the choice of medication, dose and duration.
• There is a shortage of qualified health workers to provide appropriate and adequate treatment as well as Post-treatment preventive counseling.

Objectives

• Increase the number of patients with STI’s who seek appropriate diagnosis, treatment and counseling
• Increase the number of pregnant women who are correctly screened and treated for STI’s
• Increase the number of STI patients attending health care facilities who receive appropriate advice on preventive counseling including condom use, partner identification and who are referred for HIV testing and treatment.
• Decrease over-the-counter sale of drugs to STI patients.
• Increase the number of qualified health providers

Key desirable behaviours

• Single people who are infected with STIs promptly and confidently seek appropriate treatment at a health facility.
• Spouses/partners who are infected are promptly seeking appropriate treatment together.
• Pregnant mothers at ANC clinic are demanding for STI’s services including screening for syphilis.
• Patients receiving medication at a health facility are complying to the prescribed dosage and duration and are adopting preventive measures.
• Health care workers are providing safe, confidential and non-judgmental STI management services including prevention counseling.
• Providers, especially at private drug stores and pharmacies, are only offering STI medications to individuals with prescription from qualified doctors.

Message concepts

• Whenever you detect any abnormal symptoms related to your reproductive organs or functions, go to your nearest clinic to seek appropriate treatment. Any hesitation may make the disease worse, and you might infect your partner.
• Untreated STIs can facilitate HIV infection or even reduce your fertility potentials.
• Avoid fear and worries because you are entitled to prompt treatment and confidentiality from health providers.
• Health care providers are there to help you and they will always protect your private information. You will get appropriate, confidential and non-judgmental treatment that will address your illness and reduce the risk of HIV infection.
• Being infected with STI’s does not mean you have AIDS. When you delay your treatment, you are more likely to increase the chances of being infected with HIV. When you go to a clinic, you will not be forced to test for HIV.
• It is important to address STIs even if you do not want to test for HIV. Your provider will discuss ways to prevent further infection including HIV.

• Take all prescribed medication as recommended to make sure you completely treat the disease.

• Talk to your provider about ways to protect yourself from STI’s infection. You and your partner can remain free of STI’s.

• Take your partner with you for treatment of STIs. It is important for both partners to be treated or else re-infection may occur.

• Take all medications as prescribed by your doctor. Ask your provider about ways to practice safer sex so that you will not be infected again.

For pregnant women

– Ask your provider at antenatal care clinics about STI screening. You might be infected with STIs that can affect you and your child. Testing will help you get proper treatment and protect you and your child.

For health care workers

– Help patients who are diagnosed with STIs, with quality, safe, confidential and non-judgmental treatment.

– It’s unethical to share patient information with others without proper authorization. Your job is to provide service and encourage patients to protect themselves. Breaching confidentiality might lead to disciplinary actions including a possible suspension.

– Counsel clients on preventive practices that will enable them to avoid re-infection.

For medical providers

– Only offer STI medications to clients who have a prescription. Providing STI medication to people without prescription is a criminal offense and you could lose your license.

For law enforcement officials

– Help enforce the law by stopping the sale of prescription drugs to those without a prescription.

Monitoring and Evaluation
Outcome Indicators

– Number of patients with STIs reporting at health facilities for diagnosis, treatment and counseling according to national guidelines.

– Number of STI patients attending health care facilities who received appropriate advice on condom use, partner notification and who were referred to HIV testing and treatment.

– Number of patients who seek appropriate STI treatment together with their partner.

– Number of pregnant women attending antenatal care that are screened and treated for STIs.

– Number of drug store and pharmacies reporting a reduction in patients seeking STI treatment without prescription.
Impact Indicators

- Decreased percent of new STI infections
- Decreased percent of targets who admit they have had unprotected sex.
- Decrease in percentage of HIV infection.

Parent to child transmission

Overall, findings from the 2007-08 Tanzania HIV and AIDS and Malarial Indicator Survey (THMIS) indicate that eight in ten women and seven in ten men age 15 to 49 years know that HIV can be transmitted from mother to child through breastfeeding.

However, only 53 percent of women and 44 percent of men know that HIV transmission risk can be reduced if the mother takes special drugs during pregnancy.

Knowledge of both these facts is comparatively higher among women with higher education (completed primary and secondary or more education) and those in the fourth and fifth (highest) wealth quintiles, but it is lower among women age 15 to 19, those who have never been married and those who have never had sex.

Urban/rural differentials exist between women and men especially in believing that the risk of mother-to-child transmission can be reduced by the mother taking special drugs during pregnancy. Among women, 70 percent of urban residents compared with 47 percent of rural residents are aware of these special drugs (THMIS).

Drivers

- Many pregnant mothers avoid antenatal care visits for fear that their HIV status will be exposed and that they will be rejected by their husbands.
- There is not a lot of trust in the confidentiality of health care providers.
- There is a lack of knowledge among people living with HIV and AIDS on what is to be expected from antenatal care regarding PMTCT.
- There is embarrassment that one is HIV positive and pregnant.
- Many pregnant women do not return to antenatal care after the first visit and hence they miss out on continued health care and services.
- ARVs are not enough for all pregnant mothers.
- Parent to child transmission of HIV occurs throughout the country, particularly in rural areas where stigma is high and there is a shortage of antenatal care medical services.
- Supporting causes include gender inequalities (gender violence), poverty, long distances to antenatal care in most rural areas, peer influence and lack of positive influence from role models.

Specific issues to be addressed include:

- All pregnant mothers, especially those with HIV, be assured that advantages of visiting antenatal care clinic outweigh their fear of embarrassment or rejection by spouses.
– Health service providers are motivated to adhere to confidentiality.
– Patients are informed about what to expect at antenatal care clinics regarding PMTCT.
– Pregnant women are motivated to go to follow up visits after their first visit so that continue to receive antenatal services.
– ARV drug availability to pregnant women, especially those with AIDS, are a matter of priority.

**Key desirable behaviours**

- Women with HIV, who are planning to have babies, are willingly and confidently visiting antenatal care facilities of their choice.
- HIV-positive pregnant women are visiting antenatal care facilities regularly for counseling after their first visit.
- Both husbands and their HIV-positive wives have knowledge and are educating others about essentials of PMTCT and encouraging them to seek antenatal care services.
- Health service providers at antenatal care facilities are motivated to offer professional services, including observance of clients’ confidentiality.
- The government and other relevant organizations are making the availability of ARVs a priority to HIV-positive pregnant women.
- Peers and counselors are helping HIV-positive pregnant women to visit antenatal care facilities on time and regularly.
- Religious leaders, elders, doctors, health and field officers, are helping HIV-positive pregnant women to visit antenatal care facilities on time and regularly and also to cope with their condition.
- Non-governmental organizations and mass media are addressing key PMTCT issues throughout the country.

**Message concepts**

- Despite your HIV-positive status, you can have a HIV-free baby if you visit an antenatal care clinic on time, regularly and adhere to the medical advice throughout your pregnancy.
- Getting counseling and treatment with ARVs throughout your pregnancy and during breastfeeding can help you achieve your dream of having a healthy baby who is HIV free.
- Attending an antenatal care clinic with your husband or partner helps ensure that both of you receive all of the necessary information you need to ensure you give birth to an HIV-free baby.
- Men: Knowing the status of your pregnant wife or partner will allow you to get the appropriate counseling needed to ensure your unborn child is free from HIV even after birth.
- Health service providers: Help to encourage more pregnant HIV-positive women to attend antenatal care clinics by keeping their information confidential. Exposing medical information of your patients is unethical and may lead to your dismissal.
• Government: Make ARVs available to pregnant HIV-positive women so that they can achieve their dream of giving birth to an HIV-free baby. Save the lives of unborn babies and help reduce child mortality rates.

• Peers and counselors: Help encourage pregnant HIV-positive women to seek antenatal care services promptly and regularly to save lives of unborn babies.

• Religious leaders, elders, doctors, health and field officers: Help HIV-positive pregnant women to visit antenatal care clinics on time and regularly so they can cope with their condition and give birth to an HIV-free child.

• Non-governmental organisations and mass media: Help to address key PMTCT issues throughout the country because the survival and health of many unborn babies depends on your contribution.

Channels of communication

• Interpersonal (one-on-one, peer influence, small groups)
• Community-based/community mobilization
• Workplace initiatives
• Faith-based initiatives
• Artists (drama, films, music)
• Mass media
• Social networks

Monitoring and Evaluation

Outcome Indicators

– Number of HIV-positive women and their husbands reporting they are willing to attend antenatal care as soon as they are pregnant.
– Number of HIV-positive pregnant women reporting they are attending antenatal care services regularly.
– Number HIV-positive pregnant women reporting they are attending ANCs with their husbands.
– Number of antenatal care health service providers reporting they are trusted by their HIV-positive pregnant patients.
– Number of HIV-positive pregnant women accessing ARVs at antenatal care clinics.
– Number of peers, counselors reporting they have been helping HIV-positive pregnant women to seek antenatal care services.
– Number of religious leaders, elders, doctors, health and field officers reporting they are helping HIV positive pregnant women to visit antenatal care clinics.
– Incidents of coverage of key PMTCT issues by non-governmental organisations and mass media.
Impact Indicators

– Percent increase of HIV-positive pregnant women who attend antenatal care regularly and with their spouses.
– ARV availability is made a priority for HIV-positive pregnant women.
– Percent increase of babies born of HIV-positive women who are HIV free.

Medical Male circumcision
Tanzania is still in the process of making preparations for the introduction and roll-out medical male circumcision. This has been shown to reduce the risk of HIV acquisition by about 50 – 60 per cent among men. Follow up studies in those places where this intervention is in operation indicate that there are misperceptions among those who have been circumcised that lead them to take risks in their sexual behaviour that reduce the protective effectiveness of the circumcision. This is an area to watch out for and for BCC to preempt.

BCC will therefore have a role in promoting medical circumcision, and for reinforcing risk reduction after people have been circumcised.

Gender issues
The gender dimensions of HIV and AIDS should be recognized. Specific measures have been taken towards this end. These include publication of Gaps in Policies and Laws that perpetuate Gender based violence in Tanzania, and Gender Operational Plan for HIV Response in Mainland Tanzania (2010 – 2012).

Women are more likely to become infected and are more often adversely affected by the HIV and AIDS epidemic than men, due to biological, socio-cultural and economic factors. The greater the gender discrimination in societies and the lower the socio-economic position of women, the more negatively the latter are affected by HIV. Therefore, more equal gender relations and the empowerment of women are vital to successfully prevent the spread of HIV infection and enable women to cope with HIV and AIDS.

Inequality in gender operates in many ways, most of which reinforce each other and also promote the spread of the epidemic.

Inequality in personal relations
Women in many different cultures are systematically assigned inferior social and economic roles. This makes them less powerful in their relationships with men. As a result, they are often unable to resist men’s sexual demands.

They cannot negotiate safer sex or refuse unsafe sex – even if they know that their partners engage in high risk behaviour. Some men may not want to use a condom, or they may want numerous sexual partners. According to UNAIDS, up to 80 per cent of HIV-positive women in long-term relationships acquired the virus from their partners. In its most extreme form, this inequality results in violence against women - rape, sexual assault and beatings. It is most often perpetrated by the woman's partner. Studies of women in all regions show that about half of them have been physically abused by an intimate partner.
**Inequality before the law**

Unequal property, custody and support laws in some countries mean that women’s rights are often determined by their father and/or husband. Widows are in a particularly weak position: after losing her husband to AIDS, a woman may also lose her home and land, and even be blamed for her husband’s illness. This can force widows to resort to ‘survival sex’.

**Education and health**

Women are also disadvantaged because of lower levels of literacy – due to a lack of investment by governments and families in the education of girls. They are therefore less able to access information and education about HIV and AIDS. Health services often fail to provide facilities for women, particularly reproductive health care.

**Women as care givers**

The burden of caring for sick family members falls more often on women and girls than men, thus increasing the females’ workload and diminishing their income-generating and schooling possibilities. Where orphans are taken in by the extended family, it is the women who provide most of the care.

**The special vulnerability of girls**

The average age of infection for women is much lower than for men. HIV prevalence in the 15–24-year-old age group is twice as high among females as among males. Young girls are especially vulnerable in a number of ways. Until her body is fully physically developed, a girl’s reproductive system is more likely to be torn during sex, making her more vulnerable to sexually transmitted infections (including HIV). There is also the persistent myth that sex with a virgin will cure a man of the virus, and the belief that younger females are less likely to be infected. Young women are also the least able to assert themselves or protect themselves from the sexual advances or coercion by older men. This can result in sexual exploitation.

**The challenge men are facing**

In order to reduce the vulnerability of women to HIV infection, and the spread of the disease, we must look at ways of making men and women more able to negotiate their relationships on a basis of equality. The ILO Code of Practice on HIV/AIDS and the world of work stresses the fact that, “men have an important role to play in adopting and encouraging responsible attitudes to HIV/AIDS prevention and coping mechanisms.” This does not mean blaming men, or ignoring the pressures on them to behave in certain ways. On the contrary, it means improving our understanding of masculinity – the characteristics of male behaviour and the many factors that shape it, and rejecting the many stereotypes that surround it.

Men also have expectations and burdens placed upon them, which contribute to their vulnerability. Just as women are often expected to remain within the home, and assume the main responsibility for child care and domestic labour, men are expected to be the chief provider of income through work - however dangerous, dirty or unpleasant. This can be a source of pride, but also of stress. Men are unable to spend much time with their children. They may travel within their country, or even abroad, to find work. Or they may have to take jobs that mean they are away from their families for long periods – as is the case
with seamen or truck drivers, for example. In many societies, men are also expected to be powerful and strong, and not to show or talk about feelings. They may also believe that they should know about sex and what to do, though they may not. When men do not admit to NOT knowing, it makes it harder for them to receive information about AIDS.

Drivers

Lack of communication between men and women
- When men and women feel uncomfortable talking about sexual relations, they are less likely to use condoms with each other or in other relationships outside of the marriage. Men and women must deal frankly and openly with important issues such as fidelity, HIV counseling and testing, and sexually transmitted infections to ensure their protection from HIV infection.

Physical violence towards women
- Nothing destroys trust and confidence in a relationship quicker than physical violence. It is hard for a woman to respect her husband or boyfriend if he beats her. Beating a woman not only results in possible injury to her, but can also lead to divorce or conviction by a court of law.

Unsatisfied sexual needs
- Both men and women are more inclined to seek extra-marital sexual relations if their partner does not satisfy their sexual needs.

Insufficient money for supporting family
- If men do not provide enough money to keep their families well fed, clothed and housed, their female partners may seek financial support from other sources, including other men, in exchange for sex.

Money spent on girlfriends (or boyfriends), alcohol, drugs and gambling
- When a person spends large portions of his or her income on social activities, there is very often little left to support partners and families.

Transmitting a sexually transmitted infection that causes infertility
- The ability to have children is greatly valued by women and men. Men who have sex without condoms outside their regular relationships can pick up sexually transmitted infections that they then pass on to their regular partners. Even if the man never has any symptoms, the infection may be transmitted to his partner, and may make it impossible for her to have children.

Infecting a woman with HIV, who then gives birth to an infected baby
- Many couples learn that the man has been infected with HIV and passed the infection to his partner when she gives birth to a baby infected with the virus. Some families stick together, but many partners split up after discovering that their husband or regular male partner was unfaithful and transmitted the virus to them.

Message concepts (within the framework of harm reduction)
- The most effective way of protecting regular partners from HIV is to not have sex with other people. If that is impossible, then it is necessary to use condoms for every sexual act.
• Men and women should learn to trust each other. However, trust is not automatic; it is something that must be earned.

• Planning financially for the future and preparing a will are essential to protect the interests of partners and uninfected children.

• Men need to learn to respect all women and understand that women have the right to refuse sex. Men need to understand the harm they can do to women and to themselves when they abuse their power and take advantage of women’s vulnerability. Men should be encouraged to listen to the needs of women, take responsibility for their acts, and protect their loved ones.

Channels of communication

• Interpersonal (one-on-one, peer influence, small groups)

• Community-based/community mobilization

• Workplace initiatives

• Faith-based initiatives

• Artists (drama, films, music)

• Mass media

• Social networks

Alcohol Abuse

Alcohol abuse is not a risk factor for HIV infection in the way that having unprotected sex is. Its importance for HIV prevention lies in the fact that it is associated with involvement in high risk behaviour for HIV infection.

Alcohol can reduce an individual’s inhibitions and thus lead to high-risk behaviour. In places where alcohol is served, such as bars, discos and restaurants, sex workers may also be present. Alcohol can reduce a person’s resolve to avoid sex workers or use condoms. A person may intend to use a condom but forget if too drunk. Also, alcohol consumption can impair motor skills and reduce the likelihood of condoms being correctly used—if used at all. The use of alcohol can impair thinking and judgment. When people are under the influence of alcohol, they sometimes take risks they would not otherwise take. These can include having sex without using a condom. Even a single incident of sex without using a condom with a partner infected with HIV, can lead to infection.

Having sex with someone you meet at a party or bar presents a risk because those who regularly frequent bars or go to lots of parties often tend to have multiple sexual partners at the same time, or one after another. Commercial sex workers can also be found in some bars, discos or restaurants. The risk is high because it is impossible to tell by looking at a person if he/she is infected with HIV.

The 2007-08 Tanzania HIV and AIDS and Malarial Indicator Survey (THMIS) has shown that men who drink alcohol have HIV prevalence rates three times higher than those who do not drink (20% versus 7%).
THMIS reported that some young women (4%) and young men (2%) reported that they had sexual intercourse when drunk. Also, it has been reported that individuals who consume alcohol have less successful outcomes on antiretroviral therapy.

Women who drink alcohol have double the HIV prevalence rate than for those who do not drink (14% versus 7%).

The places with the highest number of reported incidents of drinking and high-risk sex are highway stopovers, commercial centres, mobile markets, and neighbourhoods with a high concentration of pubs, rural areas where excessive drinking is accepted and mining areas.

**Drivers**

People use alcohol:

- To socialize
- Because it is available and accessible
- Under peer pressure
- Out of boredom
- Because they are seduced by mass media advertising
- Because it provides temporary relief of pain, anxiety, depression and worries
- Because of the need to belong
- Out of habit

Excessive drinking is socially accepted/ tolerated in many parts of Tanzania as a means of relaxation. The reasons why people report that they drink excessively are varied. Some drink excessively to cope with family conflicts and other frustrations, others drink to feel important and to gain acceptance from peers.

People don’t make the connection that excessive drinking leads to poor judgment and unsafe sex.

**Objectives**

- Reduce incidences of alcohol-induced sexual encounters by highway truck drivers
- Reduce incidences of alcohol-induced sexual encounters by miners
- Reduce incidences of alcohol-induced unsafe sexual encounters by sex workers

**Key Behaviours**

- Get male truck drivers to wear a condom each time they have sex, regardless of how long they have known their sex partners.
- Get miners who are inebriated to avoid having unprotected sex even if their sex partners try to convince them otherwise.
- Get sex workers who are inebriated to always carry a condom.
Target Audiences

• Mobile Populations
  – Primary: Long distance truck drivers and sex workers
  – Secondary: Tan boys
  – Influencing: Truckers association
  – Supporting/Facilitating: Community organisations

• Miners
  – Primary: Miners
  – Secondary: Young miners (‘nyoka’ in Mirerani)
  – Influencing: Miners association
  – Supporting/facilitating: Community organisations

• Sex workers
  – Primary: Sex workers
  – Secondary: Go between/pimps
  – Influencing: Women associations and non-governmental organisations
  – Supporting/facilitating: Community organisations

Message Concept

• Truck drivers: Wearing a condom gives you peace of mind because you are protected from infection.
• Miners: You get the same pleasure and enjoyment when you use a condom and you stay safer.
• Sex workers: Wearing a condom helps to protect you so can achieve your life (or your family’s) dreams.

Channels of Communication

• Interpersonal (one-on-one, peer influence, small groups)
• Community-based/community mobilization
• Workplace initiatives
• Faith-based initiatives
• Mass media
• Social networks
Monitoring and Evaluation

- Outcome Indicators
  - Number of truckers, miners and sex workers reporting using condoms the last time they had sex
  - Number of individuals in target audiences reporting using condoms every time they had sex within a specified period of time.

- Impact Indicators
  - Decrease in incidence of sexually transmitted infections among targets
  - Decrease in the percentage of individuals in target audience who admit to having unprotected sex in a specified period of time.

Injection Drug Use (IDU) and Drug Abuse

Injecting drugs is one of the most direct ways of transmitting HIV and other infections, such as hepatitis. This is largely because needles and syringes are often shared between users and blood from one user often gets mixed up with the drugs and is then injected directly into the veins of another user.

Heavy drug-use reduces one’s ability to work, leading to less disposable income for purchase of drugs. Consequently, some injecting drugs users may turn to sex work as a means of supporting their habit. This increases the probability of the virus spreading to the general population. Approximately the same percentage of injecting drug users found in the general public exists within many workplaces. It is erroneous to assume that drug users, including injecting drug users, are unable to hold down a job. For example, some countries estimate that 5 per cent of male youths are injecting drug users. Since the activity is illegal, it remains largely hidden.

Sharing of equipment is widespread. It does not seem to be only a result of restricted availability, although there are great concerns that, where possession of equipment is illegal and police enforce the law, users are more likely to share needles and syringes with others, rather than carrying them on their person. In some places, a strong group culture has emerged among many injecting drug users, which stimulates needle-sharing and the joint purchasing and preparation of drugs.

The profile of IDU is that of jobless males, young people and sex workers who trade sex for drinks or drugs.

A greater proportion of intravenous drug using men than intravenous drug using women engage in the riskier needle use practices such as using used needles or sharing needles.

IDU influences high-risk sexual behaviour.

On average women IDU have twice the infection rates of male IDUs.
There is a greater HIV risk among IDUs, and bridging populations as needle sharing IDUs also do sex work to fund their substance use.

**Drivers**

- Poverty and lack of income generating activities push young people to drug use and, in turn, to sex to fund the purchase of drugs.
- Lack of money to purchase their own needles leads to needle sharing among some IDUs.
- There is a shortage of user-friendly services, such as testing for sexually transmitted diseases and HIV, counseling and treatment for youth and high risk IDU groups.
- There is a lack of knowledge about the dangers of sharing needles.
- Intravenous drug use occurs more frequently in urban areas such as Dar es Salaam, Arusha and Zanzibar than elsewhere in Tanzania.
- Supporting causes include the drug trafficking, peer influence, lack of positive role models and lack of a supply of clean needles to IDUs.

**Specific issues to be addressed include:**

- Provision of outreach services for IDUs, including supply of needles, establishment of drop-in centres, increasing the number of qualified health workers to provide services to IDUs.
- Encouraging IDUs to seek appropriate treatment from designated health centres and providers.
- Ensuring appropriate treatment is provided to IDUs as well as post-treatment preventive counseling.
- Encouraging consistent condom use among IDUs.
- Involving communities to tackle IDU.

**Objectives**

- Reduce the sharing of needles.
- Increase the number of IDUs seeking health services at drop-in centers
- Increase incidents of consistent condom use among IDUs
- Increase the number of IDUs who attend health care facilities to receive appropriate advice on preventive counseling including condom use, and who are referred for HIV testing and treatment
- Increase the number of qualified health providers for IDUs.
- Increase incidents of community involvement in addressing IDU problem
- Increase incidents of police involvement in stopping supply of drugs to IDUs
Target Audiences

- Primary: IDUs, sex workers and pharmacies that sell needles
- Secondary: Law enforcement officials, government and local government leaders
- Influential: Faith-based organizations, teachers and peers
- Supporting/facilitating: Non-governmental organizations, community-based organizations, mass media, programme managers, field officers and health officers.

Key Behaviours

**IDUs and sex workers**
- They are avoiding sharing needles because they are aware of the risks involved.
- They are willingly and confidently seeking health services at drop-in centres.
- They are using condoms consistently and correctly.
- They are attending health care facilities to receive appropriate advice on preventive counseling including condom use, and are referred for HIV testing and treatment.
- IDUs who are infected with sexually transmitted infections promptly and confidently seek the appropriate treatment at a health facility.

**Pharmacies**
- Pharmacy workers are counseling IDUs on proper use of needles and the need to avoid sharing.

**National and local government leaders**
- The police force is increasing effort to stop supply of illicit drugs to IDUs because they know the connection between IDU and HIV risks.
- The government and other organisations are taking steps to facilitate health services for IDUs.

**Peers**
- Peers are helping IDUs to stop sharing needles.
- Peers are encouraging IDUs to make sure they use condoms properly each time they have sex.

**Communities and NGOs**
- Non-governmental organisations, faith-based organisations, parents and local government leaders are taking action to address the prevalence of IDUs and accompanying high risk behaviour.

**Message concepts**

**IDUs and sex workers**
- Sharing of needles increases the risk of HIV infection. Use one needle by yourself throughout.
- Using drugs put you in the risk of having unprotected sex. Make sure you wear a condom each time you have sexual intercourse.
- Untreated STI’s can facilitate HIV infection or even reduce your fertility potential. Whenever
you detect symptoms, seek medical advice.
– You are entitled to prompt and confidentiality from health providers.
– Health care providers are there to help you and they will always protect your confidentiality.

**Pharmacy workers**
– Counsel each IDU who come to purchase needles (or condoms) on proper use of the same so that they may avoid HIV infection.
– You have a duty to save lives. You will have peace of mind if you save a life.

**Government and other organisations**
– Police: Help to stop the supply of illicit drugs to young citizens because the death rate of IDUs is five times higher than that of the general population. Saving lives is a shared responsibility.
– Government: Help to provide health care and necessary facilities for IDUs so as to save lives. Saving lives is a shared responsibility.

**Peers**
– Help your drug-addicted friend to stay alive by never sharing needles with him. Tell him to wear a condom properly each time he has sex. You will feel happy if you help your friends to stay alive.

**Communities**
– Take action and save addicted youths from HIV infection by talking to them about risky behaviours. You have a moral obligation to save lives in your community.

**Channels of communication**
• Interpersonal (one-on-one, peer influence, small groups)
• Community-based/community mobilization
• Workplace initiatives
• Faith-based initiatives
• Artists (drama, films, music)
• Mass media
• Social networks

**Monitoring and Evaluation**
• Outcome Indicators
  – Number of IDUs reporting they have not shared needles in a specified period of time
  – Number of IDUs reporting they have used condoms in the last time they had sex
  – Number of IDUs seeking health services, counseling and treatment
  – Incident of pharmacy workers reporting they have counseled IDUs who purchase needles or condoms
- Number police arrests of illicit drug suppliers
- Number of incidents of government officials addressing IDU issue
- Incidents of community involvement in addressing IDUs high risk behaviour

• Impact Indicators
  - Percentage reduction of sexually transmitted infections and HIV infections among IDUs in the area in the last six months
  - Percentage reduction of youths who are involved in using intravenous drugs
Chapter 4: Treatment

Tanzania began to provide care and treatment services for HIV and AIDS, including the provision of anti-retroviral drugs (ARVs), in October 2004 with a target of 44,000 patients for the first year. A total of 96 hospital facilities in the country were selected to initiate treatment services.

The Ministry of Health and Social Welfare (MOHSW) has continued to expand its efforts to ensure that all eligible patients are enrolled and provided with ART. However, utilizing Voluntary Counseling and Testing (VCT) services as the key entry point for care and treatment services will not be sufficient to enable and complete the enrollment of the estimated number of people eligible for ART.

Provider Initiated Testing and Counseling approach is being adopted to allow more people who visit health care facilities, mainly at the outpatient clinics and in-patient, to be offered HIV testing to determine their HIV sero-status.

Furthermore, the National HIV and Counseling and Testing Campaign, developed to mobilize more people for testing and to determine their HIV sero-status, was launched on July 14th 2007 by His Excellency the President of the United Republic of Tanzania, Hon. Dr. Jakaya Mrisho Kikwete.

New patients enrolled in HIV (care and treatment) on the Tanzania mainland from the start of the program up to June 2010 were 668,875. About half of them (345,006) are currently on ART.

The target was to provide ART for 440,000 patients by 2010. The figure above indicates a shortage of 94,994, or about 22%. However in 2010 only 384,816 patients were on ART.

The national indicators show that between 74% and 78% of adults with AIDS were on treatment at the end of their first year of treatment, with a corresponding proportion of children at 79% to 83%. In the second year, the proportion still under treatment at the end of year dropped to between 65% to 70% of adult patients and 72% to 77% of children. Currently, i.e. 2011, patients enrolled on Care on ART have totaled 412,108.

Another indicator shows that only about a third of patients attended a clinic throughout in the first year, indicating that adherence to ART is a problem (National AIDS Control Programme - Epidemiology Unit Monthly Progress Report, June 2010).

Drivers

Reasons for poor health-seeking behaviour among HIV and AIDS patients:

- Lack of knowledge of the availability of free treatment that prolongs life
- Mixed and competing messages over HIV treatment from traditional healers and faith healers
- Widespread misconception and rumors about antiretroviral drug (ARV) efficacy which generates confusion and mistrust.
– HIV stigma and discrimination at the family and community levels.

Supporting causes for poor health seeking behaviour which happens throughout the country include:
– Cultural norms and beliefs.
– Poor counseling due partly to the heavy workload on the part of health care providers.
– Lack of drugs due to poor accountability of service providers.

Specific issues to be addressed include:
– Providing appropriate information about the benefits of ART
– Addressing myths and misconceptions about drug therapy
– Improving the counseling of patients
– Ensuring constant supply of ARVs
– Addressing dietary requirements for patients

Objectives
• Increase the number of patients who seek care and treatment services
• Reduce misconception and mistrust of ARV treatment among skeptic patients
• Increase the number of patients who adhere to prescription, medical advice and treatment
• Increase the level of professionalism among ART health care providers
• Increase accountability among ARV providers
• Address the dietary issue among HIV patients

Target Audiences
• Primary: HIV patients, health care providers, and VCT counselors
• Secondary: Faith-based organisations (FBOs), community leaders/HIV committee, government and local government leaders
• Influential: Role models and artists
• Supporting/facilitating: Non-governmental organisations (NGOs) and mass media

Key

Key Behaviours

AIDS patients
– AIDS patients are willingly and confidently seeking proper information about care and
treatment from their nearest clinic.

– AIDS patients are accurately informed about services and treatments, such as ARVs.
– AIDS patients are attending a clinic and using ARVs as advised by health care providers.

**Health care providers**

– Health care providers are providing AIDS patients with proper medical advice and services, including proper prescription of ARVs.
– Health care providers following-up on the progress of their patients and are encouraging them to continue their treatment.

**VCT counselors**

– VCT counselors are referring HIV and AIDS patients to the nearest clinic for proper care and medical advice.
– VCT counselors are reminding clients that ARVs are generally the best option for AIDS patients and that ARV drugs are recommended by the government.
– VCT counselors are encouraging men to seek health care and ART because it is the best way to regain their health and prolong their lives.

**FBOs, community leaders/HIV committee**

– Community leaders and HIV committees are helping clients initiate discussions on HIV status with their closest family members.
– Community leaders and HIV committees are identifying trusted family members of patients to support them throughout their treatment.
– Community leaders and HIV committees are encouraging families with patients to openly discuss the issues of stigma and discrimination.
– Community leaders, and HIV committees are addressing the issue of proper diet for HIV/AIDS patients.

**Role models and artists**

– Role models and artists are helping HIV/AIDS patients to know that attending clinics and getting care will help them to live normal and longer lives.
– Role models and artists are showing HIV/AIDS patients examples of their colleagues who are now living healthy lives because they have chosen to adhere to proper medical advice and ARV treatment.

**NGOs and mass media**

– Mass media and NGOs are providing messages about the need for HIV and AIDS patients to attend clinics, get treatment and stay on their treatment.
– Mass media and NGOs are providing messages that assure HIV patients that ARVs are trusted; they are recommended by the government and can prolong life.
Mass media and NGOs are addressing the issue of accountability on the part of ARV drug providers/suppliers.

**Message concepts**

**HIV and AIDS patients**
- Seek proper information about HIV and AIDS care and treatment from your nearest clinic and avoid rumours and misconceptions about ARVs.
- Getting the right information on ARV treatment and following medical advice will help you to live a healthier and longer life, enabling you to fulfill your dreams.
- ARVs are recommended by the government for treatment of HIV and AIDS and they have been proven to prolong life elsewhere in the world. If you use ARVs properly you will live long.
- Even though you may believe in other methods of treating your illness, support them with adherence to the medical advice you receive from the clinic for the best results.
- Even though you see signs of health improvement, continue taking ARVs as prescribed by the clinic, otherwise your condition could get worse again.

**Health care providers**
- Provide HIV/AIDS patients with proper medical advice and health care services, including the proper prescription of ARVs and you will save lives.
- Show that you care by following-up the on progress of your patients and encouraging them to stay on their prescribed ART.

**VCT counselors**
- Help to save lives by referring HIV and AIDS patients to the nearest clinic for proper care and medical advice.
- Remind your clients that ARVs are the best option for HIV and AIDS patients, and that these drugs are recommended by the government and therefore can be trusted.
- Encourage men who test positive to seek health care and ART because it is the best way to regain their health and prolong their lives.

**FBOs, community leaders/HIV committee**
- Play your part by helping patients initiate discussions on their HIV status with their closest members of family.
- Save your community by identifying trusted family members of patients to support them throughout their treatment.
- Encourage families with HIV and AIDS patients to openly discuss the issues of stigma and discrimination.
- Initiate ways of ensuring that families and communities help HIV and AIDS patients receive...
the proper diet to support their medication

**Role models and Artists**
- Use your popularity to help HIV and AIDS patients to attend clinics and get the care they need to live longer.
- Show HIV and AIDS patients examples of their colleagues who are now living full lives because they have chosen to adhere to the medical advice given to them. You will have played your part to save lives.

**NGOs and mass media**
- Provide messages about the need for HIV patients to attend clinics, to get treatment and to stay on treatment. You have a big role to play to save lives.
- Provide messages that assure HIV patients about the reliability of ARVs and that they can prolong life if taken properly.
- Help to promote accountability on the part of ARV providers by exposing negligence, incompetence or corruption.

**Channels of communication**
- Interpersonal (one-on-one, peer influence, small groups)
- Community-based/community mobilization
- Workplace initiatives
- Faith-based initiatives
- Artists (drama, film, music)
- Mass media
- Social networks

**Monitoring and evaluation**
- Outcome indicators
  - Percentage of HIV and AIDS patients who are seeking information about care and treatment from their nearest clinic.
  - Percentage of HIV and AIDS patients who are accurately informed about their health status and treatment options.
  - Number of HIV and AIDS patients reporting that health care providers are delivering proper medical advice and services, including proper prescription of ARVs.
  - Number of health care providers who are motivated to follow-up on the progress of their patients and are encouraging them to stay on ART.
- Number of patients reporting that VCT counselors referred them to the nearest clinic for proper healthcare and medical advice.
- Number of patients reporting that community members of HIV committees helped them initiate discussions on HIV status with their closest members of family.
- Number of patients reporting that community members or HIV committees encouraged their families to discuss openly issues of stigma and discrimination.
- Number of messages sent by role models and artists encouraging HIV patients to visit clinics and get care and treatment.
- Number of role models and artists who are using the colleagues of patients as examples of those who have adhered to the medical advice given to them and have had successful outcomes.
- Number of messages sent by the mass media and NGOs about the need for HIV patients to attend clinics, to get treatment and stay on treatment.
- Number of HIV/AIDS patients reporting that families have started addressing their dietary issue.
- Incidents of mass media exposure of lack of accountability on the part of ARV providers/suppliers.

• Impact Indicators
  - Number of HIV and AIDS patients consistently attending clinics and using ARVs as directed.
  - Percent reduction in AIDS-related deaths of those who did not receive treatment.
Chapter 5: Care and Support

The concept of care and support extends beyond the physical health of a patient to cover social, spiritual, legal, psychological and economical needs of people living with HIV and AIDS (PLHA). Care provided to PLHA is not only needed at the clinics but also in their home environment, communities, workplaces and religious institutions.

Furthermore, the health care system itself is overwhelmed. The increase in the number of PLHA is greater than the increase in health care services. In addition, the health care system is designed to focus on treatment at health centers and clinics, leaving the patients on their own once they are discharged.

Although various people have a role to play in HBC, the family is the main player. The family is supposed to select one person to be trained on the specific elements in the care of the patient.

The community provides a supportive role in all aspects of care and treatment for the chronically ill including AIDS patients and their families. And HBC providers train and supervise volunteers and community resource persons to monitor HBC services in their catchment areas.

In relation to HIV and AIDS and chronically ill patients, formal Home Based Care (HBC) services were rolled out by the health sector in 1996 in eight districts. By the end of 2007, HBC services had been established in 71 districts of the Tanzania mainland.

Problems that HBC services face include:

- Inadequate continuity of care.
- Stigma hinders communication between those infected and care givers.
- Stigma limits drive to seek accurate HIV and AIDS information.

Specific issues to be addressed:

- Provide information and education on the care and support of people living with AIDS.
- Motivate AIDS patients to seek information on care and support.
- Motivate care givers to feel a sense of commitment towards providing care and support to HIV patients.
- Promote good work ethics to health care personnel.
- Establish support groups with communication skills to address issues on AIDS based on cultures, traditions and age groups.
Mobilize/promote innovative methods to help solve existing problems at the family and community level.

– Make the community realize that care and support for those living with HIV and AIDS is everyone’s responsibility.
– Empower committees, leaders (religious and opinion) to speak out about cultural practices that increase stigma and discrimination.
– Encouraging all stakeholders to network and work together.
– Provide legal support to PLHAs.
– Advocate for laws and bylaws against stigma and discrimination.

**Objectives**

- Increase the number of HIV patients seeking care and support at health centers of their choice
- Reduce the information and education gap
- Increase the motivation and commitment of care givers
- Increase health care givers’ adherence to work ethics
- Increase levels of effective communication skills among care givers
- Increase the involvement of FBOs and religious leaders in addressing care and support issues • Increase the number of innovative methods that help solve existing poverty problems at the family and community levels.
- Increase incidents of all stakeholders working together to promote care and support
- Reduce the number of PLHAs lacking legal support

**Target Audiences**

- Primary: AIDS patients, healthcare providers and home based caregivers
- Secondary: FBOs, NGOs, elders, stakeholders and human rights organisations
- Influential: Families and communities
- Supporting/facilitating: Mass media

**Key behaviours**

**HIV and AIDS patients**

- Organizations involved in care and support are providing enough information and education materials about care and support.
- HIV and AIDS patients are willingly seeking information and educational materials about care and support of AIDS.
Health workers/care givers

– Care givers are feeling a sense of commitment towards providing care and support to HIV and AIDS patients.
– Health care providers are adhering to their code of conduct and ethic.

Home based care givers

– Support groups are formed and equipped with communication skills to address issues involved in the caring for those with AIDS.
– The communications are appropriate given the culture, traditions and values of the community.

FBOs, NGOs, Human rights organisations, elders

– FBOs and religious leaders and elders are involved in addressing the faith and moral needs of AIDS patients.
– All stakeholders are coming together and are networking to ensure coordinated approach to addressing care and support.
– Legal organisations such as the National Organisation of Legal Assistance are supporting PLHAs who need legal help.

Families and communities

– Families and communities are coming up with innovative methods to help address the challenges to care and support within their areas.
– Families and communities are realizing that care and support for those living with HIV and AIDS is everyone’s responsibility.

Mass media

– Mass media are addressing issues of care and support through TV and radio news, feature programmes, and newspapers articles.

Message concepts

HIV and AIDS patients

– Seek information and educational materials about care and support of AIDS.
– Get information and education about care and support to empower you to demand services to which you are entitled.

Health workers/care givers

– The well being and happiness of PLHA depends on you. Take good care of them so they can contribute to the national development.
– Good care givers always adhere to their ethics and code of conduct. You can have rewards here and in heaven too.
– You are the most important person to PLHAs. Doing your work professionally enables you to fulfill one of humanity’s greatest achievements: saving lives.
Boost PLHA’s will power and you will help reduce deaths, new infections and stigma.

**Home based care givers**

- Our culture and customs support caring for the needy, including the sick. Taking good care of PLHA is good morally and culturally.
- You are the most important person to PLHAs. Doing your work diligently enables you to fulfill one of humanity’s greatest achievements: saving lives.
- Boost PLHA’s will power and you will help reduce deaths, new infections and stigma.

**FBOs, NGOs, Human rights organizations, elders,**

- FBOs and religious leaders and elders are involved in addressing faith and moral needs of HIV and AIDS patients.
- You are the most important person to PLHAs. You have a moral obligation to fulfill one of humanity’s greatest achievements: saving lives.
- Boost PLHA’s will power and you will help reduce deaths, new infections and stigma.
- Supporting PLHAs who lack legal help enables you to fulfill one of humanity’s greatest achievements: helping the poor and needy. Provide legal support to PLHAs and you will help reduce deaths, new infections and stigma.

**Stakeholders**

- Working together and networking to ensure coordinated approach to addressing care and support will increase efficiency and reduce costs.

**Families and Communities**

- You are the light to a brighter tomorrow for relatives living with HIV and AIDS. Moral and material support to PLHA is the key to their mental stability, healthy and happy life.
- Help come up with innovative methods to address challenges facing care and support within your areas. Innovation will make life easier to your task of caring and supporting PLHAs.
- Families and communities are realizing that care and support for those living with HIV and AIDS is everyone’s responsibility.
- You are the most important person to PLHAs. Show them love and you will have fulfilled one of humanity’s greatest achievements: saving lives.
- Boost PLHA’s will power and you will help reduce deaths, new infections and stigma.

**Mass media**

- Mass media are addressing issues of care and support through TV and radio news, feature programs, newspapers news and articles.
- You are the most important institution to PLHAs. Get involved in fulfilling one of humanity’s greatest achievements: saving lives.
- Boost PLHA’s will power and you will help reduce deaths, new infections and stigma.
Channels of communication

- Interpersonal (one-on-one, peer influence, small groups)
- Community-based/community mobilization
- Workplace initiatives
- Faith-based initiatives
- Artists (drama, films, music)
- Mass media
- Social networks

Monitoring and evaluation

- Outcome indicators
  - Number of HIV patients willingly seeking care and support at health centers of their choice.
  - Number of PLHAs, care givers reporting they have access to information and education about HIV and AIDS care and support.
  - Number of PLHAs reporting that care givers demonstrate commitment in their work and adhere to ethics.
  - Number of care givers reporting they are confident and feel competent in providing care and support.
  - Number (or incidents) of FBOs and religious leaders reporting they are providing moral support to PLHAs.
  - Number of community groups and families reporting they are coming up with innovative methods to solve existing poverty problems at family and community levels.
  - Number of stakeholders reporting they are working together to promote care and support within a year of intervention.
  - Number of cases in which human rights organizations have defended the rights of PLHAs.

- Impact indicators
  - Percent reduction of early PLHAs deaths.
  - Improved economic conditions under which care and support are provided.
  - Improved mental and physical health of PLHAs.
Chapter 6: Cross Cutting Issues

Stigma and Discrimination

The negative effect stigma and discrimination have on HIV prevention initiatives is several fold. Fear and concern inhibit people’s risk reduction behaviors and willingness to know their HIV status. HIV positive people do not access critical services or reduce unsafe behaviors for fear of raising suspicion about their HIV status.

Ramifications at the family and community levels are real; individuals hesitate to disclose their status to their family for fear of rejection and discrimination. Stigma associated with HIV often leads to discrimination and human rights violations against PLHAs and their families. Experts in issues of stigma and discrimination point to several causes of stigma and discrimination, the main of which include:

- Ignorance or insufficient knowledge, as well as beliefs and fears about HIV and AIDS.
- Moral judgments about people and assumptions about their sexual behavior.
- Associations with ‘illicit’ sex and/or drugs.
- Fear of death and other associated diseases.
- Linking with religion and the belief that AIDS is a punishment from God.

Widespread stigma and discrimination in a population can adversely affect both people’s willingness to be tested for HIV and their adherence to antiretroviral therapy. Reduction of stigma and discrimination in a population is thus an important indicator of the success of programs targeting HIV and AIDS prevention and control (THMIS 2007/08).

Also, HIV and AIDS are associated with taboos or uncomfortable behaviors, such as multiple partnerships. This inhibits communities from addressing risk behaviors. People often feel justified in their discriminatory treatment of HIV infected individuals, often based on wrong perceptions.

One of the first steps in reducing stigma and discrimination is creating “an open dialogue” about HIV and AIDS. In this, Tanzania has made great strides in the past few years. For example, President Jakaya Kikwete’s open support and promotion of HIV testing resulted in the greatest number of Tanzanians getting tested in the country’s history.

To assess the level of stigma, THMIS 2003-04 respondents who had heard of AIDS were asked several questions related to their attitudes towards people infected by HIV/AIDS. They were asked if they would be willing to care for a sick relative with AIDS in their own household, if they would be willing to buy fresh vegetables from a market vendor who has AIDS, if they thought a female teacher who has HIV but is not sick should be allowed to continue teaching, and if they would want to keep a family member’s HIV status secret:
About 90% of women and men are willing to care for a family member with the AIDS virus in homes.

About 75% of respondents believe that a female teacher with the AIDS virus who is not sick should be allowed to continue teaching.

However, only 57 percent of women and 65 percent of men express a willingness to buy fresh vegetables from a shopkeeper who has the AIDS virus and;

Less than half of women and 59 percent of men say that if a family member got infected with the AIDS virus, they would not feel it necessary to keep it a secret.

Stigma and discrimination are still widespread among Tanzanian adults because only about one in four women and one in three men interviewed expressed positive attitudes on all four indicators.

This level is almost the same as those observed in the THMIS 2003-04, and slightly higher than the level observed in the 2004 TDHS, though there are slight differences in wording between the surveys. In all three surveys, women are less positive than men in acceptance of all four attitude indicators.

Adults in urban areas are more likely than rural adults to have positive attitudes towards people with HIV and AIDS. For example, the proportion of women who express accepting attitudes on all four indicators was 37% in urban areas and 23% in rural areas; among men, the comparable figures are 50% in urban areas and 30% in rural areas.

Zonal variations indicate that women in Zanzibar exhibit the highest level of acceptance on all four attitudinal measures (34%), compared with other zones in Mainland Tanzania, while men in Eastern Zone are found to have the highest acceptance (46%).

The lowest acceptance is found among women and men in Central and Western zones. Differentials across regions are marked. Regions with low levels of acceptance on all four indicators include Dodoma, Mtwara, Shinyanga, Singida, Tabora and Tanga for women, and Tabora, Tanga, Shinyanga and Singida for men.

Only about one in five adults in these regions have accepting attitudes on all four indicators. On the positive side, women and men in Arusha (42%, 48% respectively) and men in Dar es Salaam (56%) are more likely than those in other regions to express accepting attitudes on all four indicators.

Gender inequities

Physical violence, the threat of violence and the fear of abandonment contribute directly and indirectly to women’s and young people’s vulnerability to HIV infection. Fear of violence is a barrier for women negotiating safer sex and discussing fidelity with partners.

Furthermore, fear of violence undermines seeking for treatment, including for STIs. Women may hesitate to test for HIV or, if hesitate, to receive test results because of fear of disclosing their HIV-positive status to their partners since doing that may result into physical violence, expulsion from home or social ostracism.

In many communities in the country, there are consistent differences between women and men’s roles, access to productive resources, and decision-making. Gender gaps between women in literacy, school enrolment, land ownership, and access to credit testify this imbalance in power,
• The imbalance in resource seeking opportunities drives young women to transactional sex. This vulnerability is intricately tied to social norms about femininity and masculinity which maintain the imbalance of power unfavorable towards young women and girls.

• Gender norms have implications for patterns of sexual relations (UNAIDS, 2005) as well as an individual’s attitude towards sexuality. For example, men are expected to dominate and women to be passive in decisions about sexual relationships. Within this situation, women are likely to experience little control or ability to negotiate change in sexual behavior.

• The masculinity norms, where men are socialized to exercise manhood by having more sexual partners as a way of exercising virility also drives the epidemic. In many cultures, in Tanzania, women have little say on men’s infidelity. A study on gender and generational struggles in Lushoto District noted that “though many women expressed concern about infidelity of their partners, they lacked control over the situation (Baylies and Bujra, 2002).

• Furthermore, many cultures still maintain harmful practices that render women and young girls vulnerable to HIV infection. These practices include: early marriages, female genital cutting, wife inheritance, dry sex, and initiation of girls.

• The power underlying any sexual encounter largely determines who can adopt protective behavior, and who is at greater risk of HIV infection (Baylies and Bujra, 2000)

• Early marriages: despite the legal minimum age for marriage at 18 years, the age at which marriage is allowed with parental consent is often lower (Mascarenhas, 2007).

• Female genital cutting (mutilation) is still carried out in 15 of the 21 regions on mainland Tanzania.

• Initiation rites of adolescent girls into womanhood often involve initiating sexual activity.

• Though a dying culture, in some communities, inheritance of a wife by the deceased husband’s relative is still practiced, often without knowledge of HIV status of the widow.

• In some communities, after the death of a husband, widows are disinherited of marital property, and left with responsibility of caring for children, thereby pushing them into poverty and risk of transactional sex (Landman et al., 2008).

• A study in Dar es Salaam found that only 57% of women who tested HIV-positive reported receiving support and understanding from partners.

• Sexual and gender-based violence is also common in Tanzania. For example, the abrasions caused through forced penetration of women facilitate entry of HIV. This also happens to young girls and boys, if they are forced to engage in sex, (WHO, 1995; Baden and Wach, 1998; UNAIDS, 2001).

• Orphaned girls have also reported being sexually assaulted by family members (REPOA, 2009). A recent study in northern Tanzania indicates that physically and sexually abused women are more likely to abuse alcohol, have more sexual partners, and report an STI (Ghebremichael, 2008).
Socio-economic factors

Cultural norms and behavior

Societal perceptions on how women and men behave in sexual relationships contribute to vulnerability to HIV. For instance, fear of being labeled promiscuous limits ability to learn about safer sex. According to NMHPS 2009-2012, a study in Rungwe District in Mbeya, showed that attempts by women and young girls to visit health facilities seeking information on STIs was challenged by communities stigmatizing them as “sinners” (Mbilinyi and Kaihula, 2000).

In many cultures, virginity is still the dominant framework within which young girls are encouraged to understand their sexuality. Within this context, they are encouraged to maintain the culture of silence surrounding their sexuality which prevents them from receiving information on HIV. Some cultural norms and behavior fueling HIV are:

- Inadequate information about stigma and discrimination.
- Low efforts in addressing stigma and discrimination.
- Violence against women.
- Local cultural practices e.g. widow cleansing and inheritance.
- Early marriages for young girls.
- Female genital mutilation.
- Address disinheritance of marital property which perpetuates poverty among widows.
- Men’s irresponsible sexual behavior due to cultural patterns of virility
- Mobility in all its forms which leads to separation of spouses and increased establishment of temporary sexual relationships.
- Promiscuous sexual behavior due to other manifestations of poverty.

Poverty and Wealth

- Over 50% of Tanzanians live below the poverty line which manifests in low or irregular incomes which creates desperation and labor migration. Migration and urbanization often leads to the disruption of family ties and traditional social practices and an increase in multiple-partner sex.
- Although the price of condom is low (average of 200 Shillings), many people especially in rural areas and urban peripheries tend to find it expensive. Also people with less or no incomes have less access to medical care, including that of STIs (UMCHT 2003).
- Poverty often leads women and poor men to taking risky actions as well as preventing them from taking protective action. Poverty and unequal economic rights between men and women often limits the bargaining power of women and girls and place them at greater risk of sex work.
- Poverty also limits women’s ability to access information. Furthermore, breast-feeding has gender and poverty dimensions (Seidel and Tallis, 1999). The option of exclusive bottle-feeding to reduce infection is often not viable to very poor women.
Nevertheless, data from 2007-08 THMIS indicates that HIV prevalence increases with wealth for both males and females. Although wealthy elites are also more likely to use condoms during sex, it is well known that it is difficult to sustain condom use.

**Key issues include:**

- Ensuring sustainable environment that mitigates underlying factors that drive HIV in Tanzania has to focus on all education and service provision, specifically ensuring availability of key information and education.
- Mainstreaming cross cutting considerations in all HIV and AIDS services: gender, stigma and discrimination, individual factors, harmful cultural practices, and socio-economic factors.
- Encouraging/empowering communities to address crossing cutting issues within their communities, including gender, stigma and discrimination, individual factors, harmful cultural practices, and socio-economic factors.
- Ensuring enforcement of HIV and AIDS Act 2008 to help address stigma and discrimination.
- Ensuring training for all cadres include modules on stigma and discrimination within service provision.
- Empowering the National Council of People Living with HIV and AIDS (NACOPHA) to carry out advocacy activities.

**Challenges:**

- Irrational stigma among populations, including health workers who deal with PLHAs
- Addressing practices that are deeply ingrained in cultures which enhance gender inequities and gender violence.
- Addressing poverty situations that promote risky behaviors.

**Supporting causes**

- Poor implementation of policies and enforcement of regulations
- Lack of commitment among stake holders responsible for encouraging behavior change and communication within the community.
- Poor education on communication and behavior change on issues surrounding HIV and AIDS.
- Differences in objectives among stake holders promoting behavioral change and communication on issues surrounding HIV and AIDS.
- Budget constraints.
- Lack of effective monitors to oversee link between various stakeholders.

**Specific issues to be addressed**

- Provide information and education materials about stigma and discrimination HIV and AIDS patients.
- Address stigma and discrimination across all interventions.
- Address social, economic and political gender inequalities including violence against women.
• Address negative cultural practices e.g. widow cleansing, gender violence and rape.
• Address men's irresponsible sexual behavior due to cultural patterns of virility.
• Address the issue of spouses who indulge in temporary sexual relationships due to mobility or migration.
• Increase community dialogue on cultural practices e.g. widow cleansing and inheritance by 20% within a year of intervention.
• Increase community dialogue on early marriages of young girls by 20% in the first year of intervention.
• Reduce female genital mutilation by 20% in the first year of intervention.
• Reduce disinheritance of marital property which perpetuates poverty among widows by 20% in the first year of intervention.
• Reduce men's irresponsible sexual behavior due to cultural patterns of virility by 20% within the first year of intervention.
• Increased by 30% community dialogue about the need to stop temporary sexual relationships in the first year of intervention.

**Stigma and discrimination**

• Primary target
  – PLHAs, NACOPHA
  – Healthcare givers
  – Home based caregivers

• Secondary target
  – FBOs, NGOs, elders,
  – Law enforcers
  – Human Rights organizations

• Influential target
  – Champions, role models, artists, policy makers

• Supporting/facilitating
  – Mass media, road banners

**Cultural norms and behavior**

• Primary target
  – NACOPHA
  – Community leaders
  – Religious leaders
  – Home based caregivers
• Secondary target
  – FBOs, NGOs
  – Law enforcers
  – Human Rights organizations

• Influential target
  – Champions, role models, artists, policy makers

• Supporting/facilitating
  – Mass media, road banners

Gender inequities
• Primary target
  – PLHAs
  – Men and women
  – Human Rights organizations

• Secondary target
  – FBOs, NGOs, elders,
  – Law enforcers

• Influential target
  – Champions, role models, artists, policy makers

• Supporting/facilitating
  – Mass media, road banners

Poverty and wealth
• Primary target
  – PLHAs, NACOPHA
  – Families
  – Community leaders

• Secondary target
  – Microfinance institutions (SACCOS)
  – Government, local governments
  – Mkurabita

• Influential target
– Entrepreneurs, role models, policy maker

• Supporting/facilitating

– Mass media, road banners

**Stigma and discrimination**

Key desirable behaviours

• Different societal groups are aware of, and have knowledge about, stigma and discrimination, and are demonstrating positive attitude towards PLHAs.

• PLHIV at community and national levels are confidently and actively addressing stigma and discrimination, particularly the way it impacts on HIV prevention, treatment and care & support.

• Health care givers and home based care givers are behaving positively towards PLHAs and are helping to change others to fight stigma and discrimination.

• FBOs, NGOs, elders, are initiating dialogue around stigma and discrimination among families and community members with a view to eradicating it.

• Law enforcers are enforcing the HIV and AIDS (Prevention and Control) Act 2008 to ensure PLHAs are not discriminated against.

• Human Rights organizations are highlighting issues and cases of stigma and discrimination against PLHAs with a view to eradicating it in society.

• Champions, role models, artists, are promoting the right attitudes and behaviors that help eradicate stigma and discrimination against PLHAs in society.

• Policy makers are addressing the issue of stigma and discrimination in all HIV and AIDS interventions.

• Mass media are addressing issues of stigma and discrimination against PLHAs through TV and radio news, feature programs, newspapers news stories, photographs and articles.

**Cultural norms and behavior**

Key desirable behaviours

• Community and religious leaders, as well as home based caregivers, are involving families and communities in continuous dialogue to address issues of inheritance of marital assets and property of women widowed by AIDS.

• Community and religious leaders are involving families and communities in continuous dialogue to address cultural practices and behaviors that promote HIV infections.

• NGOs and FBOs are involving families and communities in continuous dialogue to address issues of inheritance of marital assets and property of women widowed by AIDS.

• NGOs and FBOs are involving families and communities in continuous dialogue to address cultural practices and behaviors that promote HIV infections.

• Law enforcers are intervening to ensure adherence to human rights of PLHAs and women who are denied access to marital assets and property.
• Law enforcers are intervening to ensure workplace protection policies and employment laws, rights for welfare of orphaned children, and justice and civil rights for PLHIV in general.
• Human Rights organizations are monitoring and addressing human rights of PLHAs and women who are denied access to marital assets and property
• Champions, role models and artists are promoting the right cultural practices and behaviors that help to reduce HIV transmission, Policy makers are addressing issues of risky cultural behaviors that promote the transmission of HIV.
• Mass media, road banners are carrying messages that help to promote positive cultural practices and behaviors that help minimize or stop HIV transmission.

Gender inequities

Key desirable behaviours

• PLHAs are involved in promoting (speaking out about) gender equality, especially where it affects issues of HIV transmission, treatment and care & support.
• Men and women are actively engaged in community dialogue on cultural practices e.g. widow cleansing and inheritance which have effects in prevention, treatment and care & support.
• Men, women and human rights organizations are actively engaged in community dialogue on early marriages of young girls to address its effects in HIV prevention, treatment and care & support.
• Men, women, NGOs, FBOs, and law enforcers are actively engaged in dialogue and advocacy to stop female genital mutilation.
• Champions, role models and artists are also actively engaged in advocacy to stop early marriages, FGM and men’s irresponsible sexual behavior for their effects in HIV prevention, treatment and care & support.
• Law enforcers, human rights organizations and FBOs are actively engaged to reduce disinheritance of marital property which perpetuates poverty among widows and hence impacting on HIV prevention, treatment and care & support.
• Mass media and road banners carry messages that address gender inequities, particularly the culture’s impact on HIV prevention, treatment and care & support.

Poverty and wealth

Key desirable behaviours

• PLHAs, families, communities are actively engaged in promoting affirmative measures for PLHIV such as promoting them in public offices, providing them with more opportunities for training and allocating more representations to public decision making bodies so they can address poverty issues facing them.
• Microfinance institutions (SACCOS) are encouraged to support PLHAs in small loans schemes to help them address poverty and hence mitigate impact of HIV prevention, treatment and care & support.
• Government, local governments are deliberately including PLHAs in economic plans and opportunities to help them address poverty and hence mitigate impact of HIV prevention, treatment and care & support.
• Entrepreneurs, role models, policy makers actively creating awareness and calling for support for PLHIV who are engaged in poverty reduction activities.
• Mass media and road banners are carrying messages that help to address poverty particularly among PLHIVs.

Message Concepts

PLHIVs and PLHAs
• Seek information and educational materials about stigma and discrimination in HIV and AIDS to help you know your rights, gain confidence and feel better about yourself.
• Getting information and education about stigma and discrimination will help you demand as well as access services and rights to which you are entitled.

Health workers/Care givers
• The well being and happiness of PLHA depends on you; take good care of them, treat them with dignity so they can live a stigma free life and be happy.
• Good care givers always adhere to their ethics and code of conduct. You can have rewards here and in heaven too if you respect PLHIVs and treat them with dignity.
• You are the most important person to PLHAs. Doing your work professionally enables you to fulfill one of humanity’s greatest achievements: saving lives. Boost PLHA’s will power and you will help reduce deaths, new infections and stigma.

Home based care givers
• Our culture and customs support respecting the dignity of everybody, including the sick. Treat PLHIV with respect and dignity because it is what is morally and culturally expected of you.
• You are the most important person to PLHAs. Doing your work diligently enables you to fulfill one of humanity’s greatest achievements: saving lives. Boost PLHA’s will power and you will help reduce deaths, new infections and stigma.

FBOs, NGOs, Human rights organizations, elders,
• You are the most important person to PLHAs. You have a moral obligation to fulfill one of humanity’s greatest achievements: promoting the dignity of PLHIVs. Boost PLHA’s will power and you will help reduce deaths, new infections and stigma.
• Supporting PLHAs who lack legal help enables you to fulfill one of humanity’s greatest achievements: Helping the poor and needy. Provide legal support to PLHAs and you will help reduce deaths, new infections and stigma.
• Stakeholders: working together and networking to ensure coordinated approach to addressing care and support will increase efficiency and reduce costs.

Families and Communities

• You are the light to a brighter tomorrow for relatives living with HIV and AIDS. Moral and material support to PLHA is the key to their mental stability, healthy and happy life.
• Help come up with innovative methods to address challenges facing care and support within your areas.
• Innovation will make life easier to your task of caring and supporting PLHAs.
• Care and support for those living with HIV and AIDS is everyone’s responsibility because in our society everyone belongs to a community.
• You are the most important person to PLHAs. Show them love and you will have fulfilled one of humanity’s greatest achievements: saving lives. Boost PLHA’s will power and you will help reduce deaths, new infections and stigma.

Mass media

• Address HIV and AIDS cross cutting issues through TV and radio news, feature programs, newspapers news and articles and help mitigate the impact of prevention, treatment and care & support.
• You are the most important institutions to PLHAs. Get involved in fulfilling one of humanity’s greatest achievements: saving lives. Boost PLHA’s will power and you will help reduce deaths, new infections and stigma.

Monitoring and Evaluation

Outcome Indicators

- Number of HIV patients willingly seeking stigma and discrimination information at health centers of their choice.
- Number of PLHAs, care givers reporting they have access to information and education about HIV and AIDS stigma and discrimination.
- Number of PLHAs reporting that care givers demonstrate commitment in their work and adhere to ethics.
- Number of care givers reporting they feel comfortable providing care and support to PLHAs.
- Number (or incidents) of FBOs and religious leaders reporting they are providing moral support to PLHAs.
- Number of community groups and families reporting they are coming up with innovative methods to solve existing poverty problems at family and community levels.
- Number of stakeholders reporting they are working together to address cross cutting issues that impact on prevention, treatment and care & support. Or incidents of stakeholders coming together to address cross cutting issues.
- Number of cases in which Human Rights organizations have defended the rights of PLHAs.
Impact Indicators

- Improved economic conditions in communities and reduction in risky behaviors prompted by destitution.
- Improved mental and physical health of PLHAs.
- Percentage reduction of early PLHAs deaths

Capacity Building

Some capacity building activities will need to be implemented to enable those involved in the implementation of the National HIV and AIDS Programme in the country to adopt the BCC approach to health communication and to operationalize it effectively.

Capacity building will have to cover all the essential elements of BCC starting from conceptualization of a community problem/need through formulation of objectives, drafting of messages and delivery of the messages through commonly used channels to monitoring and evaluation. It will entail carrying out formative research to audience segmentation.

It may be necessary for the key players to undergo specialized training in health training instructions, in customized short courses or fully fledged undergraduate and postgraduate programmes.

In carrying out this activity it will also be essential to involve other partners who are in the business of communication campaigns, so that their interventions should be in the mold of BCC, and so that the people they work with can acquire this capacity.
Glossary of Terms and Concepts

**Advocacy:** Any attempt to influence public opinion and attitudes that directly affect the lives of people. A person or an agency can advocate for a particular cause or belief. The media may be used in advocacy to amplify an issue so that it is heard widely.

**AIDS:** Acquired Immunodeficiency Syndrome – the most severe manifestation of infection with the Human Immunodeficiency virus (HIV). There are numerous opportunistic infections and neoplasms which, in the presence of HIV infection constitute an AIDS diagnosis.

**Attitudes:** an individual's predisposition toward an object, person, or group that influences his or her response to be positive or negative, favourable or unfavourable.

**Audience:** the people to whom communications are directed. A distinction is made between target audience, primary audience and secondary audience. Target audience is the group that is intended to be the recipients of specific messages, and they often have common characteristic features such as demographic factors, risk behaviour or roles to play in facilitating behaviour change by others. The primary audience is the group of people most affected by the problem and whose behaviour needs to be changed. The secondary audience, in turn, is the group of people that can help influence the intended audience; it is not considered part of the problem.

**Audience profile:** a formal description of the characteristics of the people who make up a target audience, usually in terms of their family size, residence, education, religious and political beliefs.

**Audience segments:** a group of people who are enough alike on a set of characteristics of relevance for developing communication activities, such as a rural community and schooling status – in school or out of school youth.

**Audience segmentation:** division of a large group of people into smaller and more homogeneous
groupings based on shared characteristics for the purpose of communication.

**Barriers:**
Hindrances to desired behaviour change, either internal or external to the audience.

**Baseline:**
Information gathered about a target audience at the beginning of an intervention from which variations following the intervention are measured.

**Baseline study:**
The collection and analysis of data about a target audience and their situation prior to the intervention.

**Behaviour:**
The purposeful acts and actions of individuals or groups that can be observed, as opposed to reflexes.

**Belief:**
A belief is based on knowledge, opinion or faith.

**Channel:**
The conduit or route for delivering/sending messages.

**Communication:**
The use of messages to transmit meanings within and across various contexts through different channels and media.

**Concepts:**
Ideas that can be communicated to others.

**Creative brief:**
A document that includes information needed to develop messages for specific audiences.

**Enabling factors:**
Part of the PRECEDE analysis in the PROCEED – PRECEDE MODEL. These allow someone to perform a behaviour.

**Formative research:**
The information gathering activities conducted prior to developing health communication strategies and messages.

**HIV:**
A disease characterized by a gradual deterioration of immune function. During the course of infection, crucial immune cells, called CD4 T cells are disabled and killed and their numbers progressively decline.

**Immune Deficiency:**
A breakdown or inability of certain parts of the immune system to function, thus making a person susceptible to certain diseases that they would not ordinarily develop.

**Immune System:**
The complex functions of the body that recognize foreign agents or substances, neutralizes them and recall the response later when confronted with the same challenge.

**Incidence:**
The number of new cases occurring in a given population over a certain period of time.

**Infection:**
The state or condition in which the body is invaded by an infectious agent, such as a bacterium, fungus or virus, which multiplies and produces an injurious effect.

**Gatekeepers:**
People who have the responsibility, or who are perceived to have the responsibility for upholding moral standards in a community. They can help support a behaviour change goal if they agree with it or prevent its adoption.
if they don’t agree with it.

**Message:** the memorable, explanatory words or images that convey an idea – what you want people to know, feel or do.

**Objective:** the desired or needed result to be achieved by a specific time.

**Opportunistic Infection:** an illness caused by an organism that usually does not cause disease in a person with a normal immune system.

**PRECEDE – PROCEED MODEL:** a model developed by Green, Kreuter and others in the 1970s. The model stipulates that one has to start at the end – the desired state of health and quality of life and ask about the environment, behaviour, individual motivation, and administrative policy necessary for creating that desired state of health. PROCEED stands for policy, regulatory and organization in educational and environmental development. PRECEDE stands for predisposing, reinforcing and enabling constructs in educational/ environmental diagnosis and evaluation.

**Predisposing factors:** part of the PROCEED – PRECEDE MODEL analysis. These are the factors include existing beliefs, attitudes and values that influence whether a person will adopt a behaviour.

**Prevalence:** a measure of the proportion of people in a population affected with a particular disease at a given time.

**Reinforcing factors:** part of the PROCEED – PRECEDE MODEL analysis. It refers to a set of factors that encourage or discourage adopting a proposed behaviour.

**Serostatus:** results of a test for specific antibodies.

**STI:** Sexually Transmitted Infection – a contagious disease usually acquired by sexual intercourse or genital contact.

**Symptoms:** any perceptible, subjective change in the body or its functions that indicate disease or phases of disease, as reported by the patient.

**Syndrome:** a group of symptoms and disease that (together) are characteristic of a specific condition.

**Transmission:** the spread of a disease by contact with an infected person. In the context of HIV the virus can enter the body through the mucosa lining of the vagina, vulva, penis, rectum or the mouth during sex. The likelihood of transmission is increased by factors that may damage these linings, especially other sexually transmitted infections that cause ulcers or inflammation.