HIV/AIDS INFORMATION FLOW AND ACCESS: EXPERIENCES FROM BABATI DISTRICT, TANZANIA

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Abstract

This paper is based on an empirical study of the flow and access to HIV/AIDS information in the Babati District of Manyara region in Tanzania. The study integrated both qualitative and quantitative research designs. A sample of 131 respondents comprising of 50 male and 81 female was conveniently selected from three villages in Dareda ward. Primary data was collected using face to face interviews, focus group discussion, dissemination workshop, and in depth interviews with key informants. Findings revealed that the provision of HIV/AIDS information in the study area is undertaken by multiple agencies including: the district council, village governments, private and public health institutions, civil society organizations, schools, faith based organizations and other community-based organizations. The data showed that access to HIV/AIDS information is through radio; television and video show programmes, newspapers, oral presentations in schools and clinics, and various types of meetings. Other delivery methods include posters, songs, dances, and dramas. The findings revealed that, while information on HIV/AIDS prevention was available, limited information was available on care and support of people living with HIV/AIDS (PLWHA). Furthermore, access to current and up to date information on all aspects of HIV/AIDS was found to be problematic. Generally, HIV/AIDS information system and structure at local level was found to be inadequate. Major challenges that limit access to and flow of HIV/AIDS information include low levels of education, language barriers, lack of information and library services, limited access to radio, television programmes, and newspapers. Family structures were also found to inhibit the free flow of HIV/AIDS information between parents and children.

1.0 INTRODUCTION

1.1 Background to the Problem

HIV/AIDS is now the number one overall cause of death in Africa, accounting for more than 6% of the disease burden in some cities and the fourth cause of death worldwide. It strikes the most economically productive members of the society, the young adults. In 2003 WHO Report, it was estimated that between 6.4% and 11.9% of Tanzanians aged 15-49 years were HIV positive. However, according to the National Aids Control Programme (NACP), only 1 in 5 cases is reported, which implies that far more people are infected with the disease. According to NACP 2001 Surveillance Report, heterosexual sex accounts for 78% of all cases, mother to child transmission ranking second at 5% and for the remaining cases the mode of transmission are not stated. NACP 2001 Report, showed that five districts, including Babati, had, unusually, high HIV prevalence among

blood donors. 33.9% of all blood donors in Babati district were found to be HIV positive in the year under review. In the past HIV/AIDS policy in Tanzania emphasized prevention which included the provision of information about the causes, prevention, transmission, and consequences of the disease, yet the expected attitude and behaviour change has not been realized.

1.2 Problem Statement

This paper addresses the question whether individuals in Babati district have adequate access to HIV/AIDS information in view of the increasing rates of transmission reported by NACP (2001). This is despite the fact that HIV/AIDS policy in Tanzania has emphasized the provision of information about the causes, prevention, transmission and consequences of the disease. Yet, even within this context, the expected attitude and behavior change that could have led to a reduction in the transmission rates has not been realized. This paper therefore, is a critical analysis based on empirical research of the issues of access and availability of HIV/AIDS information within the social-cultural context of Babati district in Manyara region. The objective of this paper is therefore to analyze first, the extent to which people in the study area are informed about HIV/AIDS and secondly, to examine factors that influence access to this information.

1.3 Literature Review

A study by Sudha (2005) revealed that information provision is a major step in the fight against HIV prevention, to fight fear, prejudice, and myths. Ignorance about the disease and how it is transmitted, and misconceptions about HIV positive people can generate fear and prejudice, hence, the source of stigma of people living with HIV/AIDS. Ndeki and Ulepp (1994) and Sudha (2005) revealed the major sources of information as mass media including radio, television, posters, newspapers, friends, health workers and religious leaders. Wougnet (2003) and Kichbusch (undated) observed that, although it is believed that sufficient HIV/AIDS information is available, the increased social economic stratification in the communities creates differential access patterns and rates. For example, because of women's low social economic status in most rural African societies, women have insufficient access to accurate information on HIV/AIDS transmission, prevention, diagnosis and treatment services. The traditional family structures also preclude efficient flow of information among members of different age groups and gender including the unwillingness to talk about sex in homes.

Additionally, the wide spread poverty reduces the possibilities of the larger segments of the population from accessing correct information and education about sexual health matters and medical services. At the same

time poor resources limit the capacity of the public sector to support the health services, thus reducing the flow of information. Finally, high rate of illiteracy among the general population contributes to reduce access to information.

1.4 Research Questions

The empirical study on which this paper is based addressed the following two research questions:

- What is the extent of flow of HIV/AIDS information at local levels?
- What factors influence access to HIV/AIDS information at local levels?

2.0 RESEARCH METHODOLOGY

2.1 Research Context

Research was conducted in Babati district and field work focused on Bermi, Loto and Seleto villages in Dareda ward.

2.2 Sample

Sample study was drawn from a population of villagers, students, employees of hospitals, schools, and other training institutions. Convenient and purposive non-probability sampling techniques were employed. Purposive sampling enabled researchers to obtain a sample that includes the major socio-economic characteristics found in the communities which were assumed to influence access to HIV/AIDS information. A sample of 131 respondents consisting of 50 (39%) males and 81 (61%) females was selected.

2.3 Methods of Data Collection

Primary data for the study was collected through face to face interviews, Focus Group Discussions (FGDs), in-depth interviews, key informant interviews, participant observation, and dissemination workshops. Face to face interviews were conducted with Local Government Authority officials at district and village levels, CSOs officials, and religious and local leaders.

Secondary data was mainly from the district, wards, villages and institutional records and statistics on HIV/AIDS.

2.4 Data Analysis

Data analysis employed quantitative and qualitative techniques. Data obtained from focus group discussions, observations and key informant interviews were analyzed using qualitative techniques.

3.0 FINDINGS

3.1 *HIV/AIDS, Information Programmes, Activities and Providers*

HIV/AIDS programmes, activities and providers in Babati district are undertaken by the District Council, village governments, civil society organizations and a number of other agencies such as schools, health facilities and religious institutions. The HIV/AIDS activities implemented by the district council include: advocacy meetings, training of trainers, workshops for HIV/AIDS facilitators, and development of community plans. Other activities were, financing village activities, condom promotion and supply, provision of HIV kits in blood transfusion centers and identification/support of orphans and PLWHA.

Activities implemented by village governments were: establishment of village/sub-village HIV/AIDS committees, presenting HIV/AIDS as key agenda item in village meetings and sensitization using village youth groups. Others were attending seminars on HIV/AIDS. For example village leaders, representatives from NGOs and CBOs, traditional elders, and religious leaders attended seminars organized by district officials and Dareda hospital in 2003 and 2004 respectively. Dareda Hospital and the School of Nursing and Midwifery implemented the following activities: incorporated HIV/AIDS in the school curriculum, health education campaign in the neighboring villages, conducted seminar for village leaders in 2005, distributed brochures and made video presentations; stocked library with current information on HIV/AIDS and employed seven qualified HIV/AIDS counselors in 2005. The hospital also started providing retroviral drugs at the hospital in July 2005.

At Dareda Secondary school HIV/AIDS activities included: inclusion of the issues about HIV/AIDS in the civics and biology curricula, seminar attendance by two teachers on how to integrate HIV/AIDS in civics curriculum, workshop facilitated by doctors and nurses (once per year) organized at the school using oral, video and discussions, formation of student's HIV/AIDS committee which meets once per week, distribution of brochures and discussion on the use condoms in forms III and IV. Others were sensitization activities through drama, songs, and poems with HIV/AIDS themes during school baraza and the graduation day. St. Joseph Dareda Vocational Training Centre implemented the following HIV/AIDS activities: organized workshop once per term facilitated by a medical doctor and seminar attendance by one teacher. Local Initiative Support Organization (LISO) a local NGO based in the area implemented the following HIV/AIDS activities: worked with village HIV/AIDS committee and collaborated with ISHI campaigns using video presentations. LISO also organized HIV/AIDS primary school activities and provided booklets and

brochures on HIV/AIDS at its resource center. Seloto primary schools integrated HIV/AIDS information into the science (health section) curriculum for class VI and VII since 1998, organized talk facilitated by doctors and nurses about the disease and with LISO organized a one-afternoon event of drama, poems, and songs on HIV/AIDS. Two teachers attended a seminar on the disease. The Diocese of Mbulu Catholic Church implemented the following HIV/AIDS activities: organized a seminar for participants from various groups. HIV/AIDS information was also communicated through brochures and choir and drama by a special parish group at village and sub-village levels.

3.2 Access to HIV/AIDS Information

The results of this study showed that HIV/AIDS information, though inadequate, was flowing to the community. However, access to this information is limited by a number of structural and individual socio-economic factors. The major sources of HIV/AIDS information reported by respondents include radio, health personnel, television, local leaders, peers, family members, NGOs, CBOs and schools. The dominance of the radio as a major source of HIV/AIDS information on the various aspects of the disease was partly explained by increasing access and affordability of radios in the rural areas. Television was mentioned as the second most important source of HIV/AIDS information. This was rather anomalous given that the study area had less than 10 television sets. However respondents could have got information by watching TV somewhere else other than in the study area. The health personnel was the third most important source of HIV/AIDS information. This was understandable because health personnel were required by their profession to provide such information especially to pregnant women. Leaders, peers, family members, NGOs, CBOs and schools were insignificant sources of HIV/AIDS information although, logically, one expected that since these were closer to the people they could have played a more prominent role in the provision of HIV/AIDS information. However, it was possible that these were themselves not informed and knowledgeable about HIV/AIDS. The study also indicated that although respondents generally receive information on various aspects (ie. prevention, treatment, care and support for PLWHA) they were more informed on HIV/AIDS prevention than for example on care and support of PLWHA. However, since many people in these communities are living with the disease, information on care and support of PLWHA will fast become critical and its demand and supply is more likely to increase in the near future.

Table 1: Sources of HIV/AIDS information by type of information N=131

Source of HIV/AIDS Information	Type of HIV/AIDS information Prevention	Treatment	Care of PLWHA	Support for PLWHA
Radio	81%	70%	65%	44%
TV	41%	34%	34%	28%
Health personnel	35%	32%	35%	34%
Leaders	29%	21%	24%	27%
Peer	28%	20%	13%	15%
Family members	22%	14%	12%	15%
NGOs	18%	13%	12%	12%
CBOs	5%	2%	4%	2%
Schools	2%	1%	1%	2%
No access to information	3%	13%	21%	34%

Source: Field Data (2005)

Findings have therefore revealed that, in the study area, a range of HIV/AIDS activities and programmes are being implemented by a variety of stakeholders, information about the disease is being made available and that 38% of the sample reported to have been affected by the disease. The implication of this is that HIV/AIDS information is flowing into the communities in the study area. The critical and perhaps a logical question is whether people are accessing this information and whether they are better informed about the disease? Results indicate that respondents were informed and knowledgeable about the general issues concerning HIV/AIDS. For example, on the aspect of how the disease was transmitted, 97% reported sexual intercourse, followed by blood transfusion (51%), and use of non-sterilized needles and syringes (49%). However, only 15% reported that the disease could be transmitted through mother-child, and only 5% reported sharing of needles and razor blades as possible ways of transmitting the disease. However, the sample selection provides one explanation for this relatively high level of knowledge, that is because a large percentage of them had secondary level of education. Respondents were however found to be less informed about HIV/AIDS prevalence rates in the district and neighboring villages. Only 18% of them knew that in 2001 Babati District was ranked number three with 33.9% of HIV/AIDS positive blood donors. Twenty one percent of the respondents knew that Dareda Centre, which is less than five kilometers from the study area, was

among the high transmission areas in the district. On condom use only 28% reported to know how to use them.

4.0 DISCUSSION

What determines access to HIV/AIDS information in the study area?

Information Infrastructure

The results of this study showed that a major obstacle to access HIV/AIDS information was lack of a developed formal information infrastructure for the general public. For example, whereas radio and television were reported as the two major sources of HIV/AIDS information, only 5 households have TV sets and only 7 video sets are available for business. Radio ownership among households was also limited. There was no regional or district public library and only small institutional libraries were reported to exist at the nursing and secondary schools. LISO, the local NGO, had only a small information resource centre. HIV/AIDS knowledge, information and experiences were therefore not widely shared and intense exposure was limited. To confirm this, one woman made the following observation, "most people in the area do no get information; they have no radios, television sets, and don't get newspapers". One female respondent complained, "I have never received any information on HIV/AIDS and my knowledge of this disease is limited". In the study area, appropriate and current information on condom use was also lacking. A respondent had this to say on condom use: "I don't believe it prevents the disease, therefore I don't like to use it". "I don't like to use it nor hear about it, I think it has a hole at its tip". Another respondent observed, "I have heard about condoms but have never seen one". Therefore in most cases people make decisions not based on adequate and accurate information on issues such as the use of condoms. Information on counseling and support services was totally lacking in the study area (however, Dareda Hospital employed seven counselors in 2005). As a result of lack of continuous and up to dated information on the causes, prevention, and modes of transmission of the disease and subsequently appropriate care, the stigmatization of PLWHA is likely to increase. As observed by a number of respondents, the cause of stigma was fear of contracting the disease, and as a result many of these people were isolated and discriminated.

Among the major weaknesses of the existing information infrastructure in the study area are: inadequate information and providers, out of date and inappropriate information and limited information media (for example, only few people listen to radio programmes). Furthermore, campaigns such as ISHI only provide a one time pre-prepared information package with no

continuity and therefore people were not constantly reminded of the epidemic.

Cultural and Social Economic Parameters

The cultural and social economic factors that limit access to HIV/AIDS information at local levels included: the lack of reading culture, low levels of education, remoteness, and language barriers. Generally large proportions of people in the study area are illiterate and therefore cannot access information on brochures and other written documents because they cannot read. The expectation that other family members who know how to read will read these brochures for those who cannot read has not been realized because, this research revealed, there was very limited sharing of information on issues relating to sex in the families. According to the LISO Manager, the provision of HIV/AIDS information in the study area was faced with a number of challenges, among which was the lack of a reading culture even among those who are literate. He observed that literate people rarely go to the centre to read brochures, booklets and other available information materials. However the emerging consensus among respondents was that social and economic disparities lead to unequal access to HIV/AIDS information, thus further hypothesizing that the higher the social economic status (SES) the greater the likelihood of increased unequal access to HIV/AIDS information. The social consequence of this is the creation of information and knowledge gap among people with different levels of socio-economic statuses.

The Family Structure

Findings show that the family structure hinders the free flow of HIV/AIDS information, because it restricts sharing and communicating information on issues relating to sex across gender groups. Only 22% of respondents indicated family as a source of information on HIV/AIDS prevention. However, one could argue that perhaps family members were themselves not well informed and knowledgeable about HIV/AIDS. This study revealed however that many youths could not talk about HIV/AIDS or sex in the homes. For example it was reported to be a taboo for mothers and sons or fathers and daughters to discuss openly issues relating to sex. Yet discussing HIV/AIDS without talking about sex with adolescents and youths is leaving aside the most important aspect. Generally discussion on issues relating to sex between parents and children were reported to be indirect and superficial. Parents reported to telling children "to be careful because this disease was not curable". Therefore no real sharing of knowledge and information between parents and children on HIV/AIDS was taking place. The findings indicated that the family structure hindered the access and smooth flow of HIV/AIDS information between the various

categories of family members and yet the family remains an important and the primary socializing agency in an African society.

Financial Resources

Financing and the capacity to utilize funds at village and institutional levels were important variables that affected the flow of HIV/AIDS information. Data from the district showed that funding for the HIV/AIDS activities in the district was problematic and insufficient. As observed, proper, adequate, and sustained provision of HIV/AIDS information (generation, processing, dissemination, training etc) required a level of funding that, probably, could not be available from local sources. A fairly successful HIV/AIDS programme run by the Roman Catholic Diocese of Mbulu was supported through external donors from Germany and Austria. The findings showed that funding was an important factor in the availability and access to HIV/AIDS information.

Religion

Religious institutions in the study area focused their efforts in providing information on the causes and transmission of the disease, care, and support of PLWHA. The Diocese of Mbulu HIV/AIDS programme provides one of the best experiences in the district. However, in general, religious institutions have created a negative attitude among their members on accessing information relating to the use of condoms to reduce transmission. These religious institutions stifle free flow and access to comprehensive HIV/AIDS information by, for example labeling the use of condoms as irreligious and emphasizing abstinence which, a large proportion of respondents indicated, was not working.

5.0 CONCLUSION

Several conclusions are drawn from this study. First, HIV/AIDS information is provided in the district by multiple agencies including the district council through its various departments of health, education and community development. Other providers were village governments, private and religious health institutions, civil society organizations, schools, faith based organizations and other community groups. However these activities and programmes were not well coordinated. Second, the major sources of HIV/AIDS information were the mass media including radio, television, newspapers, but also the schools, clinics and leaders. Unfortunately most of these reach only an insignificant proportion of the people. Third, the methods of delivery include: a variety of mass media presentations (e.g video, radio and newspaper presentations), posters, oral presentations in meetings, clinics, and the popular media such as songs, dances and dramas. Fourth, in general HIV/AIDS information provision at

local level was found to be inadequate and not organized or managed except in the few institutions. Major challenges that limited access to HIV/AIDS information and its flow included: non-existence of formal information system, low levels of education, language barriers, limited (or no) access to radio, television programmes, and newspapers. Others were: family structures and religious belief systems inhibiting the free flow of HIV/AIDS information and limited funding to build local capacity especially in the design of local information content that is culturally acceptable and easy to understand. The paper therefore recommends that all major stakeholders address these challenges at various levels.

6.0 REFERENCES

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