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'Eating a Ripe Banana with Its Skin On': Health Education Campaigns against STDs and HIV/AIDS in Mbozi District, Tanzania, 1980s-2010

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Abstract

This historical study assesses health education campaigns against sexually transmitted diseases including HIV/AIDS in Mbozi district, Tanzania, between 1980 and 2010. Archival and oral data collected in Mbozi from 2008 to 2010 reveal that the campaigns have not had the intended impact of preventing the spread of the diseases. This is in part because the campaigns do not take into account the prevailing socio-economic and cultural contexts. Nevertheless, there is an increase of public awareness of sexually transmitted diseases and a slight change of sexual behaviour. Thus, to improve on the current campaigns, the stakeholders who are involved in intervention campaigns against sexually transmitted diseases should take into account the socio-economic and cultural environment.

Résumé

Cette étude historique évalue les campagnes de sensibilisation contre les maladies sexuellement transmissibles, notamment le VIH/SIDA dans le district de Mbozi, en Tanzanie, entre 1980 et 2010. Les données d'archives et de sources orales recueillies à Mbozi de 2008 à 2010 révèlent que les campagnes n'ont pas eu l'impact escompté qui était de prévenir la propagation des maladies. Cela est en partie lié au fait que les campagnes ne prennent pas en compte les contextes socio-économiques et culturels existants. Néanmoins, l'on observe une conscience croissante du publique vis-à-vis des maladies sexuellement transmissibles et un léger changement de

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comportement sexuel. Ainsi, pour améliorer les campagnes en cours, les acteurs impliqués dans les campagnes de lutte contre les maladies sexuellement transmissibles devraient tenir compte de l'environnement socio-économique et culturel.

Introduction

> Although government and Non-Governmental Organizations exhort us to use condoms during sexual intercourse, we do not normally use them because they reduce sexual pleasure. Instead, we like 'flesh for flesh' [referring to sex without a condom]. Using a condom is like eating a sweet with its wrappers on, or eating a ripe banana with its skin on (IDI Mwasomola, Tunduma, Mbozi).

As implied by the above quotation which was taken down in Mbozi district in 2010, governments and other organisations have faced challenges in their educational campaigns against sexually transmitted diseases (STDs) in Tanzania in particular, and in Africa as a whole. The challenges in question revolve around the absence of connection between the STD-related campaigns and the social reality reflected in sexual values and desires, and the economy. The campaigns have overemphasised the change of individual sexual behaviour, without considering the socio-economic and cultural factors which make individuals vulnerable to STDs. Thus, it is argued in this paper that health education campaigns against STDs, including HIV/AIDS, have largely been ineffective because their design did not take into account the local social realities. STDs, also known as sexually transmitted infections (STIs), incorporate a number of diseases which are transmitted through sexual contact. These include HIV/AIDS and a group of diseases, which traditionally have been referred to as Venereal Diseases. STDs are classified according to their major symptoms of genital ulceration and discharges. Hence there are Genital Discharge Syndromes which include chlamydia, trichomoniasis, gonorrhoea, bacterial vaginalis, yeast and candida albicans infections. In women chlamydia could infect the uterus thus resulting in a pelvic inflammatory disease (PID). There are also diseases which produce ulcers in the genitals which are referred to as genital ulcer diseases (GUD). Some examples of GUD include syphilis, chancroid, herps simplex, lymphogranuloma venerum (LGV) and Granuloma inguinale (Hunter 2003).

Health education campaigns involve the dissemination to the public of preventive information and knowledge on STDs. The knowledge includes the risk factors for the diseases and categories of people at high risk, available medical treatment, and the complications and consequences arising from non-treatment of the diseases (Darrow 1997:

88). The health education campaigns, however, face one major problem, namely that of a mismatch with social reality. Yet, little effort has been made in Tanzania in particular, and in Africa in general, to evaluate the campaigns against the diseases at regional, national or local levels. Some pioneering evaluation efforts that have been made in post-colonial Africa have been synchronic, general and have focused on the change of people's sexual behaviour, especially on condom use among female sex workers, thus neglecting other social groups (for example, Nguyen and Sama 2008; Barnett and Whiteside 2002). This paper assesses STD education campaigns across all social groups in Mbozi district for a period of nearly a quarter of a century. Specifically, it focuses on the following three questions: (i) What has been the trend of STDs in the district since the 1980s? (ii) How have educational campaigns been conducted in the district between 1980 and 2010? and (iii) What has been the outcome of the campaigns in terms of changing sexual behaviour of the residents of the district since the 1980s? From these questions we could learn lessons which could be applied in the current efforts to combat STDs, including HIV/AIDS.

The paper is guided by a bio-social perspective on disease (Nguyen and Sama 2008). This framework situates diseases and the people's responses to them within the socio-economic, cultural and political contexts of a society. Thus, this paper analyses the socio-economic and cultural environment of Tanzania generally, and Mbozi district specifically, with the aim of ascertaining whether these contexts have enhanced or hindered the health campaigns around STDs. By adopting this theoretical framework, the paper departs from the behavioural and psychological models, which as Whiteside and Barnet (2002) point out, have been predominant since the 1950s, and have focussed on individuals and the change of their sexual behaviour.

Methodology

This paper is based on archival research conducted at Mbeya Zonal Archives (MBZA), and in Mbozi district between 2008 and 2010. In the archives, I consulted documents such as STD registers and medical reports that provided information on the prevalence of STDs, and successes and problems associated with the campaigns. In addition to the above mentioned sources, I conducted interviews in Mbozi district with key informants who had specialised knowledge regarding STDs and health educational campaigns. These informants included medical doctors and the District Coordinator of STIs and HIV/AIDS Control Programme (DACC). The medical personnel informants furnished me

with information on the successes and challenges of the campaigns. Besides these key informants, I selected a few people from the general public. These were randomly chosen, but I had to ensure gender and age representation. The general public supplied me with their assessment of the campaigns. In conducting the interviews, interview guides were used. This being a qualitative historical study, I used a comparative historical approach for analysing the information. This approach entails comparing research findings from Mbozi with other findings elsewhere in Tanzania, Africa and other parts of the world. Ethical clearance for this research was granted by the Mbeya Medical Research and Ethics Committee.

Mbozi District

Mbozi district was created in 1964 and is one of the eight districts of Mbeya region in Tanzania. The district shares a border with the Republic of Zambia and Rukwa Region to the West, the Republic of Malawi and Ileje district to the South, and Mbeya Rural district to the north-east. It also extends north-westwards to Lake Rukwa where it borders on the Chunya district (see Appendices 1 and 2). Mbozi is generally a rural district, but with some large and rapidly expanding towns such as Vwawa, and Tunduma. The district is mainly inhabited by Bantu-speaking peoples, especially the Nyiha and Nyamwanga. These inhabitants are mainly agriculturalists.[1]

Mbozi district has the largest population in Mbeya region. In 1978 the population of the district was 233,418,[2] but ten years later it had increased to 330,282,[3] and in 2002, it was estimated to be 493,576.[4] The district's annual population growth rate is estimated to be 3.1 percent, which is higher than the 2.9 percent national average.[5] This high population growth is attributed to the high fertility rate and immigrants from other parts of the country.[6] The immigration and general people's movement into the district is facilitated by good transport networks. The district is crossed by a tarmac highway and the TAZARA railway both running from the port of Dar es Salaam in Tanzania to Kapiri Mposhi in Zambia.

Mbozi district has had high prevalence of STDs in Mbeya region; it is the second most affected by STDs, including HIV/AIDS in the Mbeya region. This high prevalence is partly attributed to a long history of intense social intercourse among people of diverse origins and cultures. Such interaction is thought to have been conducive for multiple partner sexual relations, hence the high prevalence of STDs. It is because of the high level of prevalence of STDs that I chose the district for the research on health education campaigns.

The prevalence of STDs in Mbozi Since the 1980s

Statistics and discourse on STDs show a high prevalence of STDs in the district since the advent of HIV/AIDS in the1980s. For example, the district report of 2001 ranked STDs the sixth out of the top ten listed diseases afflicting out-patients over five years old.[7] Three years later another report noted that HIV/AIDS/STIs were among the five major health problems that caused high morbidity in the district; thus, the district accorded high priority for combating them.[8] The overall picture of HIV/AIDS shows that cases have been increasing since the diagnosis of the first case in the district in 1986. In 1998, 435 patients were tested for HIV with 311 (71.5 percent) testing positive. In the same year 937 blood donors were tested for HIV with 130 (14 percent) testing positive. One year later, in 1999, 616 patients were screened for HIV. Of these 384 (62.3 percent) were positive while 232 (37.7 percent) were negative. Among 602 blood donors who were tested 107 (17.8 percent) were positive.[9] And five years later in 2003/4 HIV infection figures from antenatal clinics of Ruanda locality showed a higher prevalence of HIV than the Mbeya region's rate of 15.7 percent. The Ruanda HIV rate was 0.2 percent higher than the regional rate, while Igamba's rate was 5.2 percent lower than the regional rate.[10]

An increase in respect of other STIs is also recorded. In 1997 a total of 692 STIs was recorded among the youth and adult out-patients. Of the total, 261 had GDS, 96 GUD, 173 syphilis, 30 PID, and 132 had other STIs.[11] Four years later another government hospital report noted 6,451 cases of GDS (3,336) and GUD (3,115) among in-patients.[12] Yet in 2004 out of a total of 5,353 expecting mothers who attended antenatal clinics and tested for syphilis, 491 had the disease.[13] Again in January 2005 the district recorded among the out-patients 3,441 cases of GDS, 3313 GUD and 1515 PID.[14] This high prevalence of STIs in the district has made it imperative to institute health education campaigns as one of the strategies for combating the diseases.

Health Education Campaigns in the Era of HIV/AIDS

The advent of HIV/AIDS has revived massive health education campaigns on STDs, which focus on changing individuals' sexual behaviour. The campaigns have been given impetus due to the high prevalence of HIV/AIDS, a lack of vaccine and effective cure of HIV/AIDS (Bonga 1999: 177). Furthermore, the campaigns against STDs have been intensified following a number of studies that have established the link between the high prevalence of HIV/AIDS and the high prevalence of other STDs[15] such as gonorrhoea and syphilis to mention but a few. Thus education is deemed

to be essential for the behavioural change[16] needed for the control of the diseases. Yet the campaigns have registered only modest achievements in altering sexual behaviour as the following assessment indicates.

Among the achievements of the health education campaigns in Mbozi district had been not only the increase in the number of patients seeking medical treatment for STDs in various health facilities but also a slight change in sexual behaviour. The district, under the auspices of the District's HIV/AIDS Coordinator (DACC) conducted a number of seminars, peer education programmes, film shows, and drama as well as disseminating information through other media such as radio, billboards, pamphlets, etc.[17] An example of a billboard with messages aimed at the prevention of HIV/AIDS follows below.



Figure 1: A billboard on protection against HIV/AIDS, Mlowo Dispensary, Mbozi district, June 2010. Photo by Musa Sadock. Translation: Sexual Indulgence has made me miserable. Take Care of your health, and your family: protect yourself from HIV/AIDS by ceasing casual sex, treating sexually transmitted diseases, being tested for HIV and using condoms.

Over the years the messages in the mass media as exemplified by the above billboard had emphasized that people should protect themselves from STDs by changing their sexual behaviour, by being monogamous, abstaining from pre-marital and or extra-marital sexual relations or using condoms. Detailed analysis of condom-use, and pre-marital or extra-marital relations in Mbozi district are provided in the coming sections of this paper. Campaigners promoting monogamy, abstinence

and condom-use, often summarise their messages in a slogan, namely, ABC: A standing for Abstinence, B for Be faithful, and C for Condomise (see an example of an ABC message below).



Figure 2: Bill board on ABC, Mlowo Dispensanry in Mbozi district, June 2010. Photo by Musa Sadock. Translation: Think before you decided. HIV/AIDS, mmh! Abstain, Be faithful to one sexual partner. If you fail use a condom.

Apart from insisting on monogamy and condom use, the campaigns have focussed on the treatment of STDs. Free testing and the treatment of STDs are offered. Such free medical services, alongside other campaigns against the diseases, have been possible through massive support from the Ministry of Health and donor countries, especially the USA through the United States Agency for International Development (USAID) and Germany via its organisation, the Deutsche Gesellschaft fur Technische Zusammenarbeit (GTZ).

The concerted efforts of the above-mentioned campaigns partly explain the slight decrease of the HIV/AIDS/STD prevalence in Mbeya region as a whole and Mbozi district in particular.[18] For example, in the 1990s and early 2000s HIV prevalence rates for Mbeya region generally and Mbozi district in particular declined. The rate for Mbeya region declined from 20 percent in the early 1990s to 15 percent in the late 1990s, while that of Mbozi district declined from 14 percent in the 1990s to 11 percent in the early 2000s (Jordan-Harder et al., 2000).

However, successes had been modest because of problems inherent in the campaigns. One such obstacle relates to the failure of the majority of the public to access information. Billboards and many other print media were limited to urban areas; thus a great number of people living in the rural areas could not access the information, the exception was in few dispensaries where pamphlets were available and billboards erected.[19] Seminars and drama which could have offset this problem were limited to few rural areas due to a lack of funds.[20]

Even in towns, the messages were engraved in dilapidated visual media such as billboards. Given their condition, the media failed to attract a big audience as they lacked the criteria that would have pulled the public to the messages. Darrow (1997: 89) lists the criteria as follows: first, the product (message) should appeal to the consumers, in this case the public; and second, the images shown must enlist excitement and interests to users.

The second problem was limited coverage of STD education to social groups. In general, the campaigns only targeted the youth, civil servants and sex workers.[21] Peer educators were at the forefront of campaigns directed towards sex workers and the youth. Between 1994 and 1995 intensive peer education program, dubbed 'Bar Workers Health Project' was conducted in the High Transmission Areas (HTA), that is, hotels, restaurants, bus-stops and bars along the railway line and road which run from the port of Dar es Salaam to Kapirimposhi (Zambia).[22] Other peer education programmes for sex workers and the youth were also conducted in Tunduma, a town at the border between Tanzania and Zambia. The programmes were run by an NGO called Action for Development Programme Mbozi (ADP-Mbozi).[23] Peer education was also conducted among pupils in primary schools. Yet, with the exception of primary school peer educators, concerns were raised about the lack of morality among some of the peer educators. One informant noted that 'some peer educators are as promiscuous as everybody, so much so that they have no moral authority to tell us about the need to change our sexual behaviours'.[24]

Third, the programmes did not cover all groups even in the same social category such as the youth. A case in point was the neglect of married youths and other couples in general. Despite the high prevalence of STDs, including HIV/AIDS among couples in Mbozi district,[25] there were, with the exception of a few messages on billboards and other media, specific STD educational programmes to cater for couples. Yet, the ABC

messages on billboards in Mbozi, in striking similarity with what Hughes and Malila[26] had found in other parts of Africa, were interpreted by adults and the married to be intended for unmarried youth and teenagers.[27]

The fourth problem was that the campaigns, to a large extent, ignored socio-economic conditions, especially poverty which put individuals at high risk of contracting the diseases or practising risky sexual behaviours that would lead to contracting the diseases. In Mbozi district, as in many other parts of Tanzania and Africa, poverty is inextricably linked with the spread of STDs (Iliffe 2006).[28] As one informant noted at Ndalambo township: 'Poverty forces some girls and women to engage in unsafe sexual relations with travellers in transit to and from Sumbawanga region. Consequently many of them get the diseases'.[29] This poverty in Ndalambo was not peculiar to that area, but also was widespread in other rural areas and towns found in the district, and had an effect similar to that of Ndalambo, that is of, forcing women and girls to engage in sex for money.[30] Realizing this link between the diseases and poverty, ADP-Mbozi started teaching entrepreneurship skills to the poor women and girls at Tunduma township aiming at improving their economic lot.[31] Additionally, small scale enterprises such as petty businesses were established for sex workers.[32] However, these kinds of initiatives had not been started in other parts of the district. The only resemblance of such projects, which were for orphans and people living with HIV/AIDS, existed in few wards of the district.[33] Moreover, the projects were too small to have a significant impact. Apart from poverty in urban areas, rural poverty especially of women forced them to engage in risky sexual practices. It was reported that some poor women engaged in risky sexual relations with men in order to get money for buying alcohol.[34] Thus, for these poor rural and urban women, the campaigns exhorting change of sexual behaviour were likely to fall on deaf ears.

The last obstacle is that there was a minimal change of risky sexual behaviour despite the campaigns. By stating this, it should, however, not be construed as denying the successes of the campaigns. Indeed, the campaigns led to the increase of public awareness and changes of risky sexual behaviour for some individuals.[35] Nevertheless, it is argued in this paper that the change of sexual behaviour in Mbozi district was not really so significant as indicated by the risky sexual behaviour such as multiple partner sexual relations among the married, unmarried and the general disregard of use of condoms.[36] The sections that follow elaborate on the issues.

Multiple partner sexual relations in Mbozi had multiple names and manifestations. The residents of the district referred to sexuality by different Swahili words: *kutembea ovyo ovyo* (having sexual relations with anyone), *uhuni* (sexual immorality) *starehe* (sexual indulgence) and *nyumba ndogo* ('small house' – denoting men`s extra-marital sexual relations).[37] In Mbozi district, multiple partner sexual relations were manifested in extra- and pre-marital sexual relationships.

The multiple partner sexual relationships in the district were associated with many factors, one of which was the decline in traditional norms which did not sanction such behaviour. In colonial times, it was customary to penalise any man guilty of adultery and or transmitting an STD to her partner. Among the Nyiha, a man who transmitted the diseases to another man's wife had to pay two cattle to the offended man,[38] and for the Nyamwanga, the fine was one cow.[39] This traditional sanction, however, began to fade in the 1960s and 1970s, partly because of the application of national laws, the increased influence of Christianity and western education, and the arrival of immigrants in the district from other parts of Tanzania who had diverse cultures, and the decline of the role of chiefs.[40] Partly as result of the waning of traditional sanctions, multiple partner sexual relations increased.[41] One informant noted that 'despite HIV/AIDS, «sexual revenge» was common'.[42] By sexual revenge he meant a situation whereby an offended man or woman also resorted to having sexual relations, more often without a condom, with the husband or wife of an offender[43] or any other partners. This infidelity, however, should not be construed as attesting to the sexual peculiarity of Mbozi residents, or denoting promiscuity that is unique to Africa. Adultery is common all over the world. As Susan Hunter observes:

> Men and women all over the world are adulterous; in 73 percent of cultures worldwide married men and women report that they have had other partners while married. In the 1970s women began catching up with men, although in most cultures more men take on new partners than women.[44]

Premarital sexual relations are common as well. The youth of today, lamented another informant, enter into sexual relationships prior to marriage.[45] They say that they want to 'try it out' before they get married. Put simply, they equate pre-marital relationships to the testing of a car before one buys it. Indeed, they have a saying that 'you cannot buy a car before testing it'. The danger, however, associated with such relationships is that participants in the relationships never test for STDs before entering into the relationships. Another danger is that many of them 'try it out'

on many sexual partners before they decide to get married. Thus, such behaviour increases the risk of getting and spreading STDs.[46] Like adultery, the youth behaviour of having multiple sexual partners before marriage is not peculiar to Mbozi district but universal. In 1996, one study in the US found a higher prevalence of STDs among the youth, which was partly caused by a higher rate of partner exchange.[47]

The afore-mentioned multiple partner sexual relations in the district persist despite the danger of contracting the diseases, especially HIV/ AIDS. When asked about this danger, the youths would compare the contracting of the disease to other risks happening in their daily lives. Indeed, the disease is likened to an 'accident', thus getting it depends on one's luck.[48] 'We have seen many examples of couples whereby one partner has HIV/ AIDS, while the other does not have it.' How can you explain, one informant queried, this difference in sero status, if not by sheer luck or lack of it?[49]

Regarding the availability and condom-use, in 2009 approximately 6000 condoms were distributed in the district through a project called Community Participation against HIV/AIDS (*Mwitikio wa Jamii Dhidi ya Ukimwi*). In addition to the project, many NGOs were active in the distribution of condoms in the district.[50] Despite the massive condom distribution, in general, condom use had remained low. For example, in 1996 a Demographic and Household Survey (DHS) in Mbeya region, where Mbozi district belongs, found out that only 25 percent of the surveyed men used condoms during sexual relations.[51] Indeed, many informants during this study noted that a great number of Mbozi residents did not use condoms during sexual intercourse on the grounds that condoms diminished sexual satisfaction.[52] 'Using a condom, the youth argued, 'is like eating a sweet with its wrappers on, or eating a ripe banana with its skin on'.[53] This finding on non-use of condoms because of lack of sexual pleasure in Mbozi district echoes findings from other parts in Africa. Good examples of such findings include Watikin`s and Kamwendo`s in Malawi,[54] a state that borders Mbozi district.

Another reason for the low condom use in the district relates to the general social misconception about condoms.[55] It is widely believed in Mbozi that condoms are likely to slip off the penis and remain in the vagina during sexual encounters.[56] Similar to Callaham's findings in a neighbouring state of Zambia, the unpopularity of condom use in Mbozi also revolves around issues of trust, women's fecundity and masculinity.[57]

Conclusion

To a large extent, health education campaigns in Mbozi have failed to prevent the prevalence of STDs. This failure is partly because the campaigns have mainly emphasised that
individuals need to change their sexual behaviour to the neglect of socio-economic and cultural contexts that impinge on the implementation of the campaigns, or drive individuals to risky sexual behaviours that lead to contracting STDs.

This being a brief historical survey of health campaigns against STDs; it leaves open many areas for further research. These areas may include a detailed study of peer education in schools and colleges, and local community participation in the campaigns. That said, we hope that this historical study may help stake-holders involved in interventions against the diseases to integrate socio-economic and cultural contexts in their strategies against the diseases. In other words, interventions against the diseases need to address the larger socio-economic and cultural issues prevailing in a particular society.

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Notes

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3. District Medical Office (DMO) Mbozi District Council: Comprehensive Health Plan for the year 2002.
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5. The Tanzanian census (2002), and Mbozi Socio-economic Profile 2010.
6. Mbozi Socio-economic profile 2010.

7. DMO Mbozi District Council Comprehensive Health Plan for the year 2001, p. 5.
8. DMO Mbozi Council Comprehensive Health Plan for the year 2004.
9. Mbozi Designated District Hospital Annual Report for the year 1999, 30 May 2000 p. 18.
10. National AIDS Control Programme (NACP) HIV/AIDS/STIs Surveillance Report No. 19 October 2005 p. 14.
11. Moravian Church in Tanzania: Mbozi District Designated Hospital Annual Report for the year 1997, 30 May 1998 p. 15.
12. DMO Mbozi District Council: Vwawa Government Hospital Annual Report for the year 2001.
13. DMO *Halimashauri ya Wilaya ya Mbozi, Idara ya Afya: Taarifa ya Mwaka 2004* (Mbozi District Council: Annual Medical Report for the year 2004).
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15. Regional Medical Officer (RMO) – Mbeya, AIDS/ STD Control Program: Plan of Operation 1994-1998, Mbeya Region, January 1994, p. 8.
16. Ibid.
17. Interview with Dr E. Kyara, District HIV/AIDS Council Coordinator, at Vwawa Government Hosptital, 8 March 2010.
18. Ibid.
19. Author's observation during field work.
20. Interview with M. Kwai, a member of Mbozi Council HIV/AIDS Control Committee on 10 April 2010.
21. I use the term sex worker to refer to a woman or girl who engages in sex for sale within an urban context. The Swahili equivalent term is *Malaya.*
22. Kyara, op cit.
23. Mwasomola, op cit.
24. Interviews with A. Nzunda at Vwawa on 21 June 2010, J. Mwamlima at Vwawa on 18 June 2010, J. Mwasenga at Ndalambo on 3 June 2010.
25. Interview with Dr J.M. Mwamwezi at Mbozi Hospital on 29 April 2010.
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30. Interview with J. Kasonso at Tunduma on 26 May 2010.

31. Mwasomola, op cit.
32. Interviw with J. Mwakindu at Tunduma on 7 June 2010.
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36. A. Nzunda, op cit.
37. Interviews with M. Mwakibinga at Mlowo on 14 June 2010, J.Mwakondu, at Tunduma on 7 June 2010, E. Mkuto at Kamsamba on 26 May 2010.
38. Interview with Chief Jackson Nzunda at Vwawa on 18 June 2010.
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51. Jordan-Harder, op cit. p. 62.
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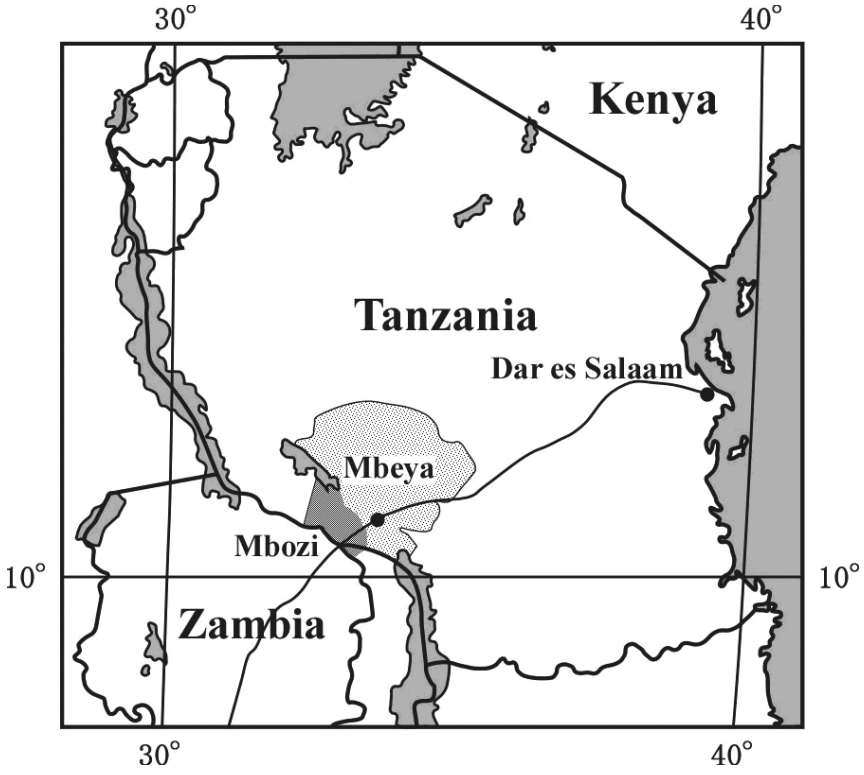
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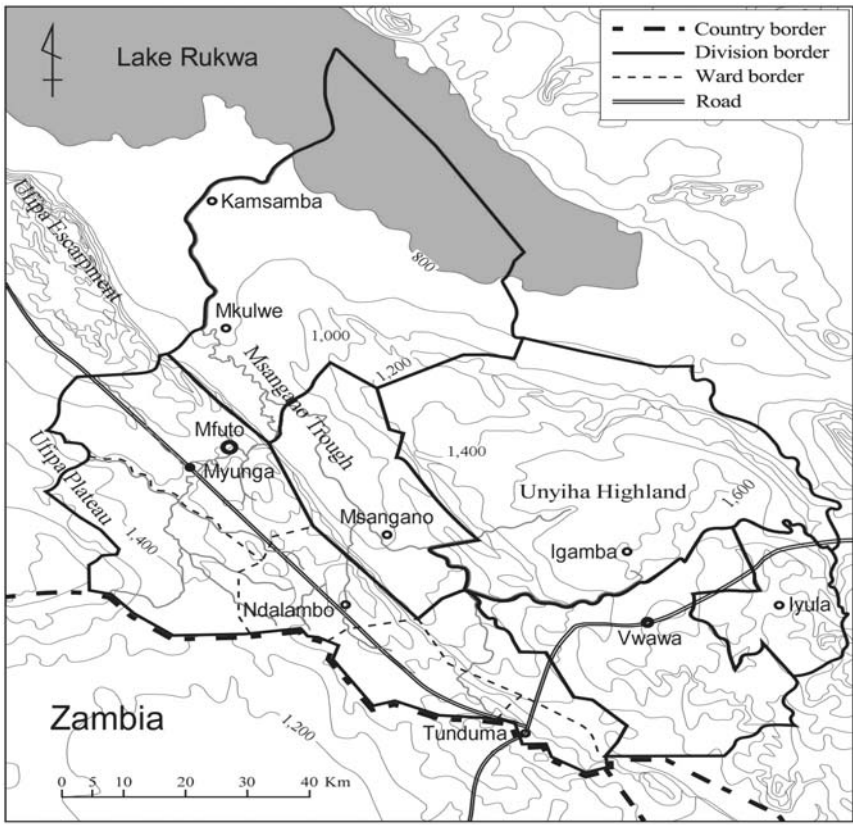
Appendices

Appendix: 1. A Map of Tanzania Locating Mbeya Region and Mbozi District



Source: J. Itani, *African Study Monographs, Suppl. 34*, March 2007, p. 5.

Appendix 2: A Map of Mbozi District



Source: J. Itani *African Study Monographs, Suppl. 34*, March 2007, p. 59.