HIV/AIDS in Ngorongoro District

Report for Ereto-NPP

17th October 2002

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TABLE OF CONTENTS

Glossary

ELCT	Evangelical Lutheran Church in Tanzania
FGM	Female genital mutilation
IEC	Information, education, communication
MTCT	Mother to child transmission
NAAP	Ngorongoro AIDS Awareness Programme
NMMU	North Maasai Medical Unit
PHC	Primary health care
PWC	Pastoralist Women's Council
TBA	Traditional birth attendant
UWT	Umoja Wanawake Tanzania
VCT	Voluntary counselling and testing

1.0 Aim

1. The output of the consultancy will be a report contributing to the design of a new phase of the project where addressing HIV/AIDS issues among pastoralists will be an important element

2.0 The context

2. Because HIV/AIDS is a multi-sectoral issue, and not merely a health issue, the practical implications for established NGOs that are not focused on human health are difficult to establish. By commissioning a HIV/AIDS specific report into future project plans, ERETO-NPP has taken a first step to dealing with HIV/AIDS as a multi-sectoral issue.

3. The mainstreaming of HIV/AIDS into development is the concept of responding to HIV in development sectors where the impact of HIV might not otherwise be addressed. It must be emphasised that mainstreaming is not the same is simply "adding on" HIV focused work. UNDP draws a comparison with attempts to mainstream gender, suggesting, "Mainstreaming gender has been a way of forgetting about it". If the mainstreaming of HIV/AIDS is not to suffer the same fate, then any future project needs to critically assess both what it can do to reduce future infections and mitigate the consequences for those people affected by the disease. Thus, there are two options for the future. Either, to mainstream HIV/AIDS into future plans for Ereto-NPP without taking on specific HIV/AIDS work. Or, to integrate HIV/AIDS activities into a future Ereto-NPP phase.

3.0 Methodology

4. The TOR specified that information be gathered at a range of administrative levels, from national to local, using information from a wide range of sources.

5. The interviews and organisations are summarised in Appendix 1.

6. Focus group discussions were held with 35 individuals over 2 days using 4 single-sex focus groups. The focus group discussions were preceded by short individual questionnaires, administered in KiMaasai, on HIV/AIDS awareness and knowledge.

7. The two district hospitals were visited, and interviews conducted with Doctors in charge, PHC team members, a Doctor of the Flying Medical Service, and a Doctor currently conducting an epidemiological survey of Ngorongoro District.

8. Policy documents at a range of scales were studied, and the literature was reviewed for any Maasai- or pastoralist-specific examples of HIV/AIDS interventions and consequences.

4.0 Analyse the cultural and livelihood context of the spread of HIV/AIDS: **Identify the main causes of HIV/AIDS and its spread within the communities through discussions with a broad spectrum of community members and administrators**

9. In common with most of sub-Saharan Africa, the primary mode of transmission of HIV among the population of Ngorongoro District is via

heterosexual sex. High individual fertility means that mother to child transmission (MTCT) will be an important element of the future transmission of the disease. HIV+ infants have already been identified at both Wasso and Endulen Hospitals.

Factors affecting transmission

10. There are a number of factors that make the risk of HIV transmission particularly high among the Maasai:
    - Polygynous marriage is the norm
    - Early (pre-pubescent) sexual debut for females, with strong social sanctions for non-participation
    - High levels of sexual networking within and outside of marriage
    - Very low levels of condom knowledge and use prior to the HIV/AIDS pandemic, combined with strong cultural obstacles to condom use[1]
    - High levels of untreated STDs among all age groups, with little or no social stigma attached to STDs
    - High fertility, low levels of hospital based deliveries, and prolonged breastfeeding all contribute to an environment favourable for MTCT
        - Women continue to be sexually active throughout their reproductive lifespan. For example, a woman can continue to bear children after she has been widowed, the children still belong to her dead husband's patriline and are not socially stigmatised
    - Non-consensual sex is commonplace
    - Very low levels of correct HIV/AIDS knowledge
    - Blade sharing for male circumcision[2]

Gender aspects of HIV transmission

11. Women show a different pattern of HIV infection to men due in large part to physical vulnerability[3].
    - Risks are heightened for girls and young women, including:
        - Immature cervix with thinner mucous membrane
        - Higher risks of STD and other infections
        - Rapid intercourse increases risk of injury of mucous membranes

(from Baden and Wach, 1998)

12. It is difficult to separate the social and physiological causes, especially in a context where young girls and women have little control over the context in why they have sex.

Common misconceptions (primarily by NGOs and IEC providers)

13. FGM as a major source of transmission. The majority of girls are circumcised individually, and most reports are of single blade use for each girl.
14. Widow inheritance as a common practice among the Maasai. This is extremely rare, although widows are able to continue to be sexually active and bear children.

Contextual factors

15. Relatively low medical service coverage

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[1] For example, sperm are considered an essential pre-requisite to female physical maturity "*they make the breasts grow*".

[2] Although it should be noted that male circumcision, *ceteris paribus* reduces the risk of heterosexual HIV transmission.

[3] Due to the physiology of genital mucosa (infected male semen contains higher concentrations of the virus); the surface area of the female genitalia is larger; and, semen is in contact with female genitals for longer.

16. Very limited voluntary counselling and testing (VCT) facilities in Ngorongoro District
17. Low levels of school attendance

5.0 Data

18. To date, there are no published data on the prevalence levels at the population level in Ngorongoro District. There is currently an epidemiological study being undertaken by Dr Magoma[4], but the data have not yet been published. Based on very early results, Dr Magoma estimated that prevalence rates among women attending for antenatal treatment were 5-6%.

19. Wasso and Endulen hospitals test for HIV, but the data are not representative of the population as a whole because the sample is self-selecting (hospital patients).

Table 1: HIV testing and result data, Wasso Hospital, January 1999 – June 2002

6 month period	Total VCT[5]	HIV+		
		Total	Country of origin	Age range
Jan-June 2002	121	29	52% Tanzania 48% Kenya	18 months – 61 years
July-Dec 2001	82	33	45% Tanzania 55% Kenya	3 years – 51 years
Jan-June 2001	89	22	55% Tanzania 45% Kenya	5 years – 50 years
July-Dec 2000	60	24	71% Tanzania 29% Kenya	3 years – 55 years
Jan-June 2000	27	14	86% Tanzania 14% Kenya	25 years – 46 years
July-Dec 1999	19	5	60% Tanzania 40% Kenya	20 years – 36 years
Jan – June 1999	25	5	100% Tanzania	30 years – 50 years

20. Comparable data were not available for distribution at the time of the visit to Endulen Hospital, as the Doctor in Charge was absent[6].

21. The very high levels of cross-border population movement with Kenya are an important element in the future development of the epidemic in Ngorongoro District. Seroprevalence levels in Kenyan Maasailand (Narok and Kajiado Districts) are rising rapidly. For example, in neighbouring Kajiado District in Kenya, rates of 18% seroprevalence have been cited. The relatively high proportion of HIV+ Kenyans who are being tested at Wasso Hospital is testament to the geographic mobility of the population.

22. It is likely that the age at infection for Maasai girls will be substantially lower than in other ethnic groups, even though young women aged 15-24 are the fastest

[4] With collaborators from University of North Carolina at Chapel Hill, funded by the Rockefeller Foundation. Anonymous testing of blood of women attending antenatal clinics provided by Wasso Hospital, Endulen Hospital and the Flying Medical Service started Sept 2002 - check.
[5] Voluntary Counselling and Testing
[6] Total numbers of HIV+ patients recorded at Endulen Hospital: 2002 – 21; 2001 – 2; 2000 – 16; 1999 – 4; 1998 – 7.

growing segment of sub-Saharan African population with HIV. The early age at infection for Maasai girls will have an impact on

- future fertility levels, due to a combination of
    - death of girls before they have their first child
    - reduced fertility among HIV+ women

23. The presence of an untreated STD is a major co-factor in HIV transmission. STDs are a major cause of morbidity among the Maasai population, with pre-pubescent girls (aged from 8 years) frequently presenting with symptoms. There are no published data on STD prevalence, although these data are being collected as part of the study by Dr Magoma. Hospital-based data on STDs cannot be used to estimate levels of STD among the general population because of very high levels of self-treatment using either over-the-counter generic drugs or traditional medicine. There is little social stigma attached to having a symptomatic STD among the Maasai, although attempts at anonymous partner tracing and treatment have proved futile (Dr Zurre). The result is high levels of untreated STDs, incomplete treatment, and high levels of re-infection.

24. To date, there does not appear to be a rise in typical opportunistic infection levels such as TB, although it should be noted that typically TB levels are relatively high among the Ngorongoro District population.

25. A prevalence rate of 6% among the general population in mid-2002 against a background of increased risk, and the S-shape of an epidemic curve, show that HIV prevalence is increasing rapidly among the population of Ngorongoro District, and will continue to do so for several years. The perceived absence of AIDS-related deaths (which will always lag behind HIV incidence) contributes to the low visibility of the disease in the district at the moment. Some AIDS deaths have been recorded at the district hospitals, although levels of personal knowledge of people affected by the disease remain very low.

26. Specific types of rural areas with a high vulnerability to HIV/AIDS have been identified. Ngorongoro District is represented by two of these categories

1 Regions susceptible to drought and food insecurity, in which rural households rely on migration as part of their livelihood strategy, are highly vulnerable to HIV/AIDS
2 Rural areas that are sources of migrant labour to urban areas.

27. Communities can be grouped into 3 categories in terms of HIV/AIDS impact[7]

1 pre-impact communities
    - HIV infection may be present but the impact of the disease may not yet be visible
2 early impact communities
    - the impact of the disease is visible, but community coping mechanisms still work
3 full impact communities
    - the impact of HIV/AIDS is markedly visible and traditional coping strategies are on the brink of collapse

28. The current situation in Ngorongoro District is of a community that is pre-impact, but will move rapidly into an early impact community. The possibilities for interventions will vary depending upon the stage of the epidemic. For example, in pre-impact areas, education and identification of vulnerable people are very

[7] Based on GTZ (1997) "HIV/AIDS as a cross-sectoral issue for technical cooperation"

important. In full-impact areas, then there is a need for mitigation and alleviation projects.

6.0 Consequences of the spread of HIV/AIDS on pastoralist production systems, livelihoods and gender relations

29. To date, there is no empirical evidence on the effect of HIV/AIDS on pastoralist production systems. Effects seen in other sub-Saharan African communities suggests that the process of response to the pandemic will be one of "experimentation and adaptation", especially over time as more individuals within a household/family become ill. The effect on the household/family will be cumulative, as resources are depleted over time. HIV/AIDS represents not only a health threat to the individual, and a social and economic threat to families and communities, but also destroys widespread gains in health, education and development. Finally, it is often difficult to define responses as short or long term e.g.: removal of a girl child from school is a short term strategy that will probably have lifelong consequences for her health and well-being.

6.1 Generalised responses

30. Evidence from elsewhere in sub-Saharan Africa highlights that strategies that do no involve the use of cash are the ones most often adopted, including
- intra-household labour re-allocation
- withdrawal of children from school
- diversify food production at the household level (assuming there is labour available for the diversification)
- reduction in the scale of food production

31. Effect on the family (general UNAIDS model) include
- loss of members, grief
- impoverishment
- change in family composition
- change in adult and child roles
- loss of labour
- forced migration
- stress
- inability to parent and care for children
- loss of income (impact on health and education)
- demoralisation
- long-term pathologies (increased depressive behaviour in children)
- increase in the proportion of multi-generation households, where the "middle" generation is lacking

32. The specific effects will vary, dependent upon a family's
- exposure to the disease
- economic and demographic situation prior to the emergence of the disease

Thus, the households most vulnerable to the effects of the disease are those that are already vulnerable (poor, small households – particularly if female-headed)

6.2 Potential responses in Ngorongoro District

33. This section is in essence of my own judgements, based upon what has been noted in other sub-Saharan African communities experiencing the pandemic. There appears to be no literature that refers to the effects of HIV/AIDS on pastoralist production systems. Thus, this section takes what we know about the impact of the epidemic in other communities, and tries to suggest what would be the likely impact on Maasai livelihoods.

6.2.1 Increasing levels of food insecurity

34. Food insecurity will increase:
- as people sell livestock (assets) for medical treatment (both traditional and modern).
- Decline in available labour for cultivation
- Decline in available labour for livestock management
- Attempts to diversify food sources e.g.: use of wild foods, but this is unlikely, given the Maasai contempt for gathered/hunted food
- A change to lower-maintenance food crops
- Reduction in the area of land cultivated
- Attempts to use oxen/ploughs to replace lost labour (although such machinery is currently illegal within NCA)

6.2.2 Rising levels of impoverishment

35. Impoverishment will be driven by:
- sale of assets (livestock / capital/ investments / property/materials goods) either to buy medical care or to replace lost labour
    - potentially negative impact on livestock prices if many people try to sell their animals
    - the medical care might be modern or traditional For example, there are reports of a woman in Endulen who is selling a herbal cure for AIDS.
- particularly for female-headed households with either few assets or little control over asset sale – there are few income diversification strategies for female-headed households (*viz* beer houses in Endulen village)
- increased levels of loans and obligations between and within households, and possibly the emergence of the use of money lenders
- decreased consumption (health, education, food) in order to reduce expenditure
- attempts to secure paid work (adults and children) – see migration
- increased reliance on "charity" or the emergence of begging (from tourists?)
- inheritance following adult death of assets (primarily livestock) by young children who are unable to manage or keep these resources, which might then be appropriated by other relatives or clan members.
- a decline in the availability of young men for long distance trading may result in more localised livestock trading activity
- reduced effectiveness of livelihood production systems, including:
    - unable to trade cattle over long distances for better prices
    - less able to graze over long distances for optimal herd performance
    - loss of accumulated livestock knowledge e.g.: disease management, as this knowledge is held by men

6.2.3 Migration

36. Increased levels of migration to urban and peri-urban areas for paid employment

37. These migration streams are already well-developed for young men e.g.: Mererani mines, guards work in Arusha and Mwanza
38. The return migrants have already been identified as a key source of infection within the rural community.

6.2.4 Child and orphan support

39. - Traditionally there are high levels of child fostering/adoption, particularly for Maasai women with sub-fertility. Such networks will become increasingly burdened over time, for example, as all of the children from one household head with several wives are cared for by fewer wives. The outcomes for orphaned children are negative relative to non-orphaned children, *inter alia*
    - Lower school attendance
    - Poorer nutritional status
    - Less expenditure per child (health and education)
    - Higher labour demands
    - Worse living conditions/ housing – possible homelessness or migration to an urban area to beg
40. - The family and community support of orphaned children is likely to be the only sustainable source of support, given the lack of residential institutions.

6.2.5 Housing

41. The traditional organsiation of a household is that it is composed of *enkaji*, each *enkaji* belonging to a married woman. Rising levels of orphanhood following the death of a co-wife, will mean that new living arrangements will emerge, possibly with a single woman having responsibility for more than one *enkaji*.
42. Building and maintaining housing is a major element of women's productive work. Rising demands on time, for example to care for orphaned children, will probably result in a decline in the quality of housing

6.2.6 Female headed households

43. Women identified to be at high risk of infection include those women who do not have an identifiable household head (separation, mistreatment, alcoholism, desertion). These women are often dependent upon long-term sexual partners for support (practical and emotional), but have relatively little bargaining power in how/ whether to have sex
44. The number of such households will increase rapidly.
45. The loss of a male household head due to HIV/AIDS would lead either to the devolution of decision-making power to a son or male relative, or possibly to the development of new (female influenced) forms of decision-making.

6.2.7 Community-level responses

46. Over time, the ability of the community, household and family to provide sources of support (physical, emotional, financial) will decline.
47. It is possible that CBOs will emerge with the specific mission to provide self-help to mitigate the consequences of the disease.

6.2.8 Services and infrastructure

48. Skilled personnel (teachers, administrators, health workers) are often at high risk of HIV transmission
    - Time spent away from family
    - Disposable income for purchase of sex
49. The implications of a declining workforce for services will include, amongst others,
    - larger class size,
    - increased absenteeism
    - poorer service quality
    - declines in long term service gains
50. Development of water resources – tends to require highly skilled water engineers for design and some maintenance. It has been noted that the loss of even a small number of highly trained engineers can place entire water systems and significant investment at risk. Engineers may be susceptible to HIV infection because of the need to spend time away from home.

6.2.9 Income generating activities (excluding livestock)

51. To date, these are limited in Ngorongoro District, generally operate on a very small scale, and include
    - Vegetable
    - Honey
    - Beadwork
    - Wet season butter-oil and cheese making for women
52. It would be unrealistic to suggest that income diversification projects could function sufficiently well to provide alternative income sources for families and households affected by HIV/AIDS.
    - The local market is small, and the district/regional markets are difficult to access.
53. Evaluation of such projects in other areas of sub-Saharan Africa has tended to conclude that such schemes tend not to derive enough income to justify the effort.

6.2.10 Introduction of limited zero-grazing techniques[8]

54. In order to overcome the shortage of labour for grazing and herding, each family (wife?) with a zero-grazed cow would have constant access to the milk production.
55. Such an intervention would require training in zero-grazing techniques, but does have the advantage of not requiring long distance herding, and of providing a reliable source of milk for each woman and her dependants.
56. If such a scheme were to be integrated alongside existing projects such as the Ewoloto project, then female calves could be given to another family in need in order to make the project sustainable.

[8] See Kezaala & Bataringaya, 1998

7.0 Identify the main areas where communities can bring about a change to their practice and behaviour in order to cope with the HIV/AIDS threat and its consequences

57. The overwhelming response was that the community first needed to be told about HIV/AIDS in order that people could begin to respond to it. The responses to the questions on HIV/AIDS are testament to the extremely low levels of knowledge about the transmission of the disease in the district. At face value, with 100% of people having heard of the disease and 77% replying that they knew of a way to prevent the transmission of the disease, it would appear that knowledge levels are high. However, levels of detailed knowledge are very low and sketchy. For example, transmission routes suggested include: standing in spit, sharing a latrine, kissing, not praying, clothes, sweat and toothbrushes. There is an important distinction between "awareness", which may be superficial, and "knowledge", which is more detailed and thus more likely to lead to effective voluntary behaviour change.

Table 2: Summary of response to questionnaire[9]

	Percent of respondents (n=35)
Heard of HIV/AIDS?	100
Know a way to prevent getting the disease? - Sex partners - Condom use	77 77 11
Mosquitoes can transmit HIV/AIDS	52
Food can transmit HIV/AIDS	66
A mother can infect her baby In the womb At birth Through breastmilk	 77 60 74

7.1 The ABC approach

58. The ABC approach is advocated by the WHO and UNAIDS but its adoption would involve enormous and rapid changes in traditional Maasai lifestyle:

A **a**bstain
B **b**e faithful
C use **c**ondoms.

7.1.1 Abstinence

59. The social construction of maturity for both male and females involves the socially sanctioned sexual partnering of young girls (aged from 8 or 9 years to puberty) with the *murrani* (aged from late teens to mid twenties). After puberty, a young woman can then be married to a man who is considerably older than herself, and who will almost certainly already have other wives. Against such a background, any approach that advocates total abstinence without first discussing these cultural norms would fail. Cultural norms are not unchangeable or

[9] See Appendix 2 for a copy of the questionnaire

immovable, rather, a discussion within the community about such practices has to develop. In order for this debate to develop, people first need education about HIV/AIDS and its transmission routes.

7.1.2 Faithful

60. In a polygynous society, it is unclear exactly what this concept entails. The ELCT, for example, preach that a man remains faithful to all of his wives, and that individual wives remain faithful to that one husband.

7.1.3 Condom use

61. Logistics
    - Condoms are not easily available in Ngorongoro District at the moment.
    - Few shops sell condoms at all, and the social marketing campaigns seen elsewhere in rural Tanzania (e.g. Salama brand condoms) appear to be absent from this area
    - There are major logistical problems involved in the sale and/or distribution of
    - condoms, not least storage constraints (temperature affected).

62. Resistance to use
    - Condoms were virtually unknown to Maasai prior to the HIV/AIDS epidemic, as this is a population that has barely begun to use modern family planning methods. Therefore, condoms are viewed as associated only with the disease, and there are many misconceptions about condoms
    - 86% of respondents in the survey had heard of condoms, but only 29% of these people knew how they worked.
        - Knowledge about condoms is very low, not least because people exposed to the HIV IEC provided by the faith-based organisations have received many negative messages about condom failure rates
    - The impact on fertility as a result of condom use is perceived as a major drawback.

7.2 What can the community do for itself?

63. The overwhelming response was that, given some support (see below), the community could organise and mobilise itself to educate people about this issue. In the focus group discussions, suggestions about what the community itself could do in order to deal with HIV/AIDS included

64. The use of traditional organisational and power structures to inform people
    - *Laigwenani*
    - *Laibon*
    - Village Executive Officers

were all considered to be key people in mobilising community support. It was generally felt that this group should be educated first, not just in the disease specifics, but also in the need to have trained people to do the education.

65. There was a very strong sense that men and women should be educated separately, not least to avoid the embarrassment of dealing with such issues publicly.
66. Both men and women felt that it was necessary, however, to educated both sexes separately but at the same point in time, to prevent the disease being perceived as the problem of just one sex
67. There is little possibility for women to express themselves in a mixed group – important for any HIV/AIDS IEC – although this is how the Uhai Centre and the ELCT approach IEC in the area

68. Use separate blade or sterilise the blade for circumcision.
    - It was reported that female circumcision trends to involve individual girls and the use of a single blade, which would not represent a significant HIV transmission risk.
    - However, the use of a single blade that is cursorily cleaned between each boy does represent more of a risk.

69. Whilst there is a transmission risk from shared instruments, it must be noted that the chief route of HIV transmission is sexual.

70. Preventing the entitos and murrani from having sex
    - This suggestion was made frequently, but generally felt to be unworkable in practice. This is not least because the *entito* and *murrani* are not the only people involved in such decisions. For example, older woman often act as go-betweens, having been paid by the murrani
    - When a wife is entertaining either her husband or a lover, her daughters have to leave the *enkaji* for the night. It was felt that mothers had a duty to make sure that their daughters had a safe place to sleep, instead simply assuming that the daughter will go to find a *murran*

71. Test all of the young men who have been away for HIV
    - This approach has been suggested in other areas (for example, Hanang District). There are, however, major rights issues involved in such an approach, not least the right to confidentiality about test results.
    - Proposals for such an idea would not work, unless, for example, couples voluntarily tested before marriage (although in a polygynous marriage this would involve all of the wives to be tested).

72. Prevent returnees from marrying
    - A feeling that young men that have been away to work should not be allowed to marry Maasai women.
    - Given that such a large proportion of young men are currently migrating for work, the implications of trying to prevent young men from marrying are large. For example, if young men are prevented from marrying then the spousal age difference will increase as older men acquire more wives. Or, there will be rising levels of never women. It is highly unlikely, in my opinion, that such a strategy would be either workable or acceptable.

73. Build different houses
    - The inability of women to negotiate a refusal to have sex has been linked to the structure of traditional *enkaji*. The lack of lockable doors

means that women are unable to physically separate themselves from men.

- The norm of extending hospitality (a place to sleep for the night in a wife's *enkaji*) to any member of a husband's age set, is associated with forced sex.

7.3 Community responses to the consequences of the disease

74. Most of the responses identified by people were responses to the transmission of the disease. However, when the discussion moved towards how the community would cope with the outcome of the disease (high levels of morbidity and mortality), then responses were much more fatalistic

> *"What is the point of going to all of this effort if so many people are going to die?"*
>
> *"If I think about this disease, I will die of shock anyway, so what is the point?"*

75. However, given that most people with whom the focus group discussion were held had very low levels of knowledge about the disease, then it is unsurprising that ideas about responses to consequences of the disease were unformed.

8.0 Identify areas where the communities will need assistance in bringing about the desired change, and put forward ideas of how they can be assisted

76. The need for education that is both correct and culturally appropriate is reflected in the need to develop educational resources that could be duplicated and distributed for use by other organisations

8.1 Educational materials

77. Most of the educational materials are aimed at non-Maasai. This problem manifests itself in several ways

78. The language of HIV/AIDS in KiMaasai is generally felt to be very unsatisfactory. The most commonly used word is "biitia", which literally means "shrinking". Medical practitioners and Maasai alike find this word unhelpful, because shrinking or slimming is associated with lots of diseases, many of which have cures.

79. In discussions, it became clear that Maasai could conceptualise the immunity deficiency aspects of HIV, for which there was no cure, and readily drew comparisons with the impact on livestock of malnutrition, in which death results not from starvation *per se*, but from a disease that the livestock is too weak to fight.

80. The use of videos that portray non-Maasai living with AIDS reinforces the commonly held belief that the disease is not among the Maasai.

81. Only one video resource in KiMaasai was reported, called Saning'o. It was developed in the mid-1990s, and only used by a Roman Catholic priest in Endulen. It portrays a young Maasai man travelling to Arusha to trade his livestock. While in Arusha he uses a prostitute, acquires HIV, returns home and infects one of his

wives who then dies. The video is shown to the priest's students, but there is little discussion about the video afterwards.

82. Video shows are always very well attended by Maasai. There is a lot of potential in developing a series of videos along the lines of Saning'o, showing a series of scenarios associated with HIV/AIDS in a Maasai context.

83. Many of the video resources are from faith-based organisations, with varying emphases on, for example, condom use. The Uhai Centre (Roman Catholic) does not use a short condom video that it uses in other areas, because the health educators do not feel that it is appropriate for use in a Maasai context[10].

84. The use of a wooden penis model to demonstrate condom use is ridiculed because it is not "circumcised", and therefore not Maasai.

85. There are no paper-based resources in KiMaasai, although given the low levels of literacy, their usefulness is limited.

86. All mass media (TV and radio) sources in Tanzania transmit in either KiSwahili or English, again limiting their usefulness for non speakers of these languages.

87. The language used for training sessions has tended to be KiSwahili, with the exception of the PHC outreach teams, that tend to be composed of some Maasai

88. Most organisations tend to associated FGM eradication as a key element of HIV/AIDS IEC.

89. Any attempts to link HIV/AIDS IEC with issues of FGM eradication would be very counter-productive, and misguided, given the low levels of transmission potential involved in a clitoridectomy where a single razor is used for each girl.

90. In the Sonjo community, where more extensive FGM is carried out (including removal of the labia), then the issue is less clearly defined, as there would be potential transmission risks from the more extensive genital removal.

8.2 Existing organisations

91. Organisations that have already developed some Maasai-appropriate training resources
   - World Vision Canada: Longido HIV/AIDS Prevention and Control Project
   - Afya Bora
   - More generally, in Kenya, where HIV is at a more advanced stage in Maasai communities (Narok and Kajiado Districts), radio programmes are regularly broadcast in KiMaasai, and there are Maasai-specific education efforts. Any attempt to develop such materials in Tanzania would benefit from learning from the Kenyan experience. For example, recordings of the Kenyan KiMaasai radio programmes could be acquired and broadcast using mobile recorders in the district[11].

[10] In reality, this means that the educators, themselves non-Maasai, are not comfortable discussing condoms with Maasai.

[11] As radio broadcast would not be possible in KiMaasai in Tanzania's regulatory context where radio broadcasts must be KiSwahili or English

8.3 Exposure to Maasai People Living with AIDS (PLWA)

92. An approach used by the ELCT involves the identification, recruitment, training and employment of Maasai PLWA in order to work as trainers within their community. To date, ELCT has recruited 35 such people.

93. The belief that HIV/AIDS is a disease of non-Maasai is widely held, and exposure to Maasai PLWA would be a useful strategy.

8.4 Training of trainers

94. That Maasai would listen to (and believe) other Maasai, speaking in KiMaasai, was frequently listed as an appropriate response. The problems associated with non-Maasai doing any form of HIV IEC included

Negative assumptions about Maasai culture
Inability to use KiMaasai
Inability to understand the context of Maasai

95. The training of TBAs, for example, is an example of a targeted group approach

8.5 NGOs

96. Any educational materials could then be shared with other NGOs/CBOs needing these resources. These organisations include:

- NAAP
- PWC
- UWT
- Budaye
- Uhai Centre
- NMMU
- PHC teams
- ELCT

97. Materials could also be made more widely available to other Maa-speaking areas, although the relevant organisations would need to be identified, for example, via the ILO-INDISCO project in Simanjiro.

9.0 Report on efforts to tackle HIV/AIDS

9.1 National

98. Table 3 summarises the recent national policies dealing with HIV/AIDS. The most recent developments include

- an explicit acknowledgement of the multi-sectoral nature of HIV/AIDS, and the establishment of TACAIDS for this purpose
- a programme of decentralisation of HIV/AIDS activities to the Regional and District level

Table 3

Year(s)	Title	Agent	Aim
1985-1986	Short-term plan (STP)	Ministry of Health (MOH)	Mobilise and train health care workers about HIV/AIDS; establish blood transfusion safety standards
1987	National AIDS Control Programme	Government	Co-ordinate national responses

1987-1991	Medium Term Plan 1	MOH	Mass education to increase HIV/AIDFS awareness; condom promotion adopted as the principal strategy
1992-1996	Medium Term Plan II	MOH	Mass education to increase HIV/AIDFS awareness; condom promotion; emphasis on the involvement of other sectors outside MOH; decentralisation of AIDS control activities to the regions and district
1998-2002	Medium Term Plan III	MOH	Multisectoral, national response to address both risk factors for, and vulnerability to, HIV/AIDS and other STDs; emphasis on policy environment
2001	Tanzania Commission for AIDS (TACAIDS)	Prime Minister's Office	National multi-sectoral AIDS Programme

9.2 Ngorongoro District

9.2.1 Medical services

99. There are two hospitals at the District level (Wasso and Endulen[12]), both of which provide, amongst other things
- outreach medical and health education services through the primary health care units (including fortnightly visits by the Flying Medical Service to 23 of the most remote locations)
- in-patient and out-patient services (including MCH and STD treatment)
- HIV testing

9.2.2 Administration

100. At the District level, it is now policy to integrate (mainstream) HIV/AIDS into all public speeches and statements[13].
- HIV/AIDS is integrated into district development plans, but to date no extra funding has been received from either the regional or the national administration to support any specific HIV/AIDS campaigns. TZS10 million was reported to have been made available to the district for the specific purpose of HIV/AIDS IEC projects, but these funds had yet to be disbursed.
- The future (2003) local government reform is hoped to bring with it a greater ability to decide on budget allocations at the District level.
- Free condoms are available at District Headquarters in Loliondo (although none has so far been used).
- There is a general sense of frustration relating to regional and national levels of government, and a perceived (probably real) lack of understanding about the challenges faced by a relatively remote rural district.
- The District AIDS Control Coordinator (DACC) is based in Loliondo. The primary activity of the DACC is to use the education of school children to diffuse HIV/AIDS knowledge to the rest of the community. No extra funds

[12] Both hospitals are funded substantially by the Austroproject.
[13] For example at the recent Uhuru Torch celebrations, the District Commissioner listed the total number of HIV positive cases by tribe as reported by Wasso Hospital.

were reported as having been received for HIV/AIDS intervention and education programmes.

9.2.3 NGOs and CBOs

101. Most HIV-related NGOs in Arusha Region are urban-based and centred, and have neither the capacity (funding, logistics, personnel) nor an interest in operating outside of the urban area. Informally, many of these NGOs are referred to as "briefcase NGOs" with little interest in primary intervention activities.

102. Perceptions and assumptions about the Maasai are so entrenched that it would be difficult for such NGOs to operate in a rural context. This is reflected both in the literature produced by such NGOs and in the opinions of the staff. For example, in an interview with Ms Nsiima (Director, Life Concern Organisation), the Maasai were described as "sexually reckless" and being "far too conservative and alone" for HIV/AIDS intervention programmes to work. Misconceptions are rife, for example, reference is made frequently to widow inheritance being a common practice among the Maasai[14].

103. There are no NGOs operating in Ngorongoro District whose primary aim is HIV/AIDS education and/or intervention[15]. However, several other NGOs have attempted to incorporate HIV/AIDS into their remit. It should be noted that the two largest efforts so far are by faith-based organisations that do not explicitly support condoms as an appropriate HIV intervention (Roman Catholic Church, Lutheran Church).

9.2.3.1 Uhai Centre

104. Based in Arusha town, the Roman Catholic organisation "Uhai Centre" is active in Maasai areas (including Ngorongoro, Monduli, Longido and Simanjiro). In 2002 so far there have been two outreach activities to Ngorongoro District. At these outreach workshops, men and women are educated together using videos on

- STDs[16]
- Christianity and AIDS
- Being positive about AIDS

105. Presentations are made in KiSwahili, which are then translated simultaneously. Questions are answered about condoms, but no practical demonstrations are given. The Uhai Centre does have a 5minute video about condoms, but it is not shown among the Maasai because it is not considered appropriate.

9.2.3.2 ELCT

106. The North Maasai Medical Unit (NMMU), which provides eye treatment (particularly for trachoma) in the district, is funded by the ELCT. Using the auspices of the ELCT AIDS Control Project, based at Selian Hospital, a HIV/AIDS

[14] Nsiima interview; Selian interview
[15] NAAP has been set up, but it has no funding or resources.
[16] Produced by the Tanzanian Ministry of Health

IEC programme was carried out in Ngorongoro District in 2001[17]. It should be noted that condoms are not strongly incorporated into this training programme, because the LECT only recommends condom use in the context of HIV-discordant married couples. The ELCT also concentrates much of its HIV/AIDS education on FGM eradication, which detracts from the overall HIV/AIDS message.

9.2.3.3 Pastoralist Council

107. The PC was reported as having relatively low standing within the community, and not particularly well-regarded for a number of reasons. The PC is seen as being very closely linked with NCAA. It has a theoretical ability to dispense funds but has a poor record of fulfilling its commitments. Thus a recent decision to spend TZS10 million in HIV/AIDS IEC, is greeted with a certain amount of scepticism that this funding will actually be made available..

9.2.3.4 NCAA

108. Has not carried out any HIV/AIDS interventions, either
    - among its own workforce, or
    - among the NCA population as a whole

109. The rates of infection among NCAA staff, particularly men separated from their families, are likely to be very high, although no data exist to substantiate this. Anecdotal evidence suggests that there have already been several AIDS-related deaths among people associated with NCAA. Many of the NCAA support staff are locally-recruited Maasai.

110. The Community Development Office at NCAA has no plans to integrate any HIV/AIDS activities in its work.

10.0 Examine the proposed ILO/INDISCO initiative for possible areas of co-operation and synergy

111. The proposal has, to a large extent, been superseded by the current study. If there are to be synergies between ERETO-NPP and the ILO-INDISCO project in Simanjiro, then the following work as outlined in the draft proposal remains to be done
    - identification of existing HIV/AIDS initiatives and interventions in Simanjiro
    - identification of factors singular to Simanjiro in a HIV/AIDS context e.g.: the presence of large populations of young men working in mines

112. The low levels of knowledge and awareness among the Maasai are not in doubt, as evidenced by
    - Kulzer's 2001 study in Simanjiro District[18]
    - the current small-scale survey
    - Moono's study in NCA

There is no need to replicate these data by doing further research to map out the levels of knowledge, beliefs and awareness.

113. The suggestion that the proposal could identify the number of people infected in the two areas is unrealistic. Such an endeavour requires not only ethical and

[17] The ELCT reports that 11,333 people were given full HIV/AIDS training as a result of this programme. In reality, it is unlikely that this number was reached.
[18] J Kulzer, 2001, Context of HIV/AIDS in Simanjiro District, Unpublished MSc Thesis

medical research clearance, but also a long-term epidemiological survey, such as that currently being conducted by Dr Magamo.

114. If a future phase of ERETO-NPP were to become involved in integrated HIV/AIDS activities, then in the sharing of culturally-appropriate resources with the ongoing ILO-INDISCO project would be desirable.

115. It is a very broad wish-list of proposed activities, and does not acknowledge that work has already been undertaken or is in the process of being done (*cf* Kulzer report, Magamo study)

11.0 How can a cultural specific approach to dealing with HIV/AIDS in Maasai areas feed into and complement the broad nationwide approach currently being developed in Tanzania?

116. The current National Policy on HIV/AIDS explicitly notes that there are "complex social, ethical, legal, **cultural** and economic aspects of the HIV/AIDS epidemic". However, in international documentation and "Best practice" documents, changing cultural norms and value are often accorded very little attention[19]. This is primarily because of

- the extreme difficulty involved in evaluating a change in culture.
- the complexities of trying to place a "one size fits all" (ABC) approach in so many different contexts. The development of culturally specific or appropriate approaches to dealing with HIV/AIDS is the next logical step

117. That there is a rationale for incorporating culturally-specific HIV/AIDS programmes is underscored by the fact that, although human biology is the same everywhere, sexual behaviour is the result of complex of socio-cultural values and economic and political conditions, which differs from one society to another and between different groups within a society.

12.0 Ereto-NPP and HIV/AIDS

118. In practice, despite a national commitment to multi-sectoral approaches to HIV/AIDS, clear definitions about what a multi-sectoral approach actually involves do not exist. There are no strategies on how to operate (and evaluate) them.

> *"Despite nearly unanimous donor support for multi-sectoral responses, these have not yet translated into practice"*[20]

119. Ereto-NPP deals with the most vulnerable people in Ngorongoro Division. These are the same people that will be most vulnerable to the impacts of HIV/AIDS.

[19] One exception is the GTZ (2001) publication "HIV/AIDS threat and prevention in marginalized ethnic groups" that deals with the Kxoe in Namibia.
[20] P.41 GTZ

120. ERETO-NPP is well-placed because it deals with issues of vulnerability in the Ngorongoro context, including an in-depth understanding of the socio-economic and cultural determinants of the population. The concept of vulnerability has important implications for the design of HIV/.AIDS activities, not least because vulnerability is strongly linked to the ability of an individual either to protect themselves from HIV transmission, or be in a position to cope with its consequences. The relationships are, however, extremely complex. For example, a wealthy (economically less vulnerable) man will acquired many wives, increasing his susceptibility to infection. Conversely, a poor (vulnerable) woman with no spouse will be highly susceptible to HIV transmission if she uses sex as one element of her survival strategy.

12.1 Factors internal to Ereto-NPP

121. Is HIV/AIDS acknowledged as a problem at the project level?

Are project staff aware not only about HIV/AIDS from a personal perspective, but also about linkages between what the project does and HIV/AIDS?

- Informal discussion with project staff demonstrated that HIV/AIDS at both personal and community levels is acknowledged. This is particularly due to the fact that the current Community Development Officer has a background in PHC.
- However, HIV/AIDS *per se* is not incorporated at any levels with the project currently
- There is a perceived need to identify if there are project-related situations that might inadvertently contribute to the spread of HIV/AIDS.
    - For example, if teams of people are used in the building of dams, where are these people (men) sleeping when they are away from home? Is the assumption made that men will be accommodated in adjacent *enkangs?* The concern of women about having to house temporary guests in a context of non-consensual sex has been noted above.

122. What will happen if there is a loss of project staff to HIV/AIDS?
    - It should be noted that project staff here refers to all staff, including drivers and support staff

123. What are the workplace policies for
    - HIV/AIDS prevention and care?
    - Non-discrimination of affected staff?
    - Absenteeism?
    - Will there be any increased expenditures e.g.: for health care?

124. WHO/ILO workplace policy best practice includes:
- no compulsory pre-employment or employee HIV/AIDS testing for employment or insurance
- medical and employee records remain confidential
- PLWA have the same rights, responsibilities, benefits and opportunities as other people with serious illnesses or disabilities
- HIV infection is not a cause of dismissal, as long as people are medically fit for available and appropriate work

125. Potential future actions
    - Provide fora for the discussion of HIV/AIDS issues for project staff
    - Identify a member of project management who is responsible for HIV/AIDS mainstreaming
    - The issue of HIV/AIDS can be placed into every training session. This raises the question of *how* to incorporate it. It is not sufficient to

simply have HIV/AIDS listed on an agenda at each meeting or training session. Such an approach will result in "fatigue".
- Assemble relevant info/documentation on HIV/AIDS and make it readily available to all staff e.g.: posters and leaflets produced by the MOH
- Provide condoms free of charge in a private place e.g.: toilet

126. As HIV/AIDS develops, and the Ngorongoro population becomes one in which the full impact of the epidemic becomes visible, then the output of ERETO-NPP will be affected.

Water resources/dams
- Will water sources be too far away for people to practically be able to take their livestock there?
- Will responsibility for collecting water fall to fewer women, therefore major implications in terms of the time spent on collecting water

Ewoloto livestock
- Will they be sold in order to provide cash?
- What are the ownership implications of Ewoloto livestock if the *de facto* owner dies?

12.2 HIV/AIDS integrated activities?

127. Ereto-NPP has a lot of goodwill, and has generated a lot of respect and good standing, even beyond the Division in which it is currently working, and is relatively well-known about in Loliondo division. ERETO-NPP is well placed in terms of its current structure to expend into dealing with the consequences of HIV/AIDS. In terms of HIV/AIDS prevention, ERETO-NPP is currently less well equipped. The key question here, is "Can ERETO-NPP cope with HIV/AIDS as an "added-on" topic, thereby extending the range of its activities to incorporate HIV/AIDS specific projects?"

128. ERETO-NPP is well placed within the boundaries Ngorongoro Division to build networks of HIV/AIDS educators/trainers.
- This could be achieved using a similar model to that developed by the current Literacy and Communication Project (DANIDA-funded).
- Ereto-NPP is a large presence at most local markets, which could be used as focal points for training/education activities
- The well-developed networks of Vet Officers have a network of transport routes and target areas. It is not practical to suggest that the Vet Officers are trained to provide HIV/AIDS education or hand out condoms. Rather, these networks could be used by specialist HIV/AIDS trainers/educators, realistically reaching a large group of people using well-established and trusted networks.
- Ereto trains members of the community in leadership skills and community development, and therefore has experience in providing training to a wide range of people. Through specialist training programmes, using culturally appropriate materials (which are then made more widely available), could train groups of trainers.

129. Very few initiatives regarding the response of rural households and communities and to the HIV/AIDS epidemic have been evaluated for their effectiveness and virtually none for their costs to society. Any programme therefore needs systematic evaluation, including a definition of measures of impact and outcome (on a variety of timescales).

12.3 What issues would be raised by becoming involved in HIV/AIDS activities?

130. One of the issues surrounding HIV/AIDS prevention education is the linkages with other service providers, primarily health services.

131. If condoms are promoted as a HIV/AIDS behaviour intervention, then there needs to be practical back-up in terms of condoms being available (either free or at a subsidised cost). The logistical implications of condom provision have already been noted.

132. If VCT is to be dealt with in an education session, then there are issues about the ability of the district hospitals to cope with the projected volume in demand for VCT. VCT requires laboratory time and equipment. There are also cost implications for individuals wanting VCT. For example, ELCT in Arusha provides VCT for a couple at a low cost of TZS3,000 (reduced further for adolescents), costs of transport notwithstanding.

133. The PHC education is based at their outreach clinics and the hospitals. Any HIV/AIDS education would need to integrate with these efforts to avoid wasteful duplication of efforts. It is unrealistic to expect the PHC team (unless expanded in terms of size of staff) to do further HIV/AIDS education, given their limited resources and staff. NCAA, for example, has identified the PHC teams as being the team to provide training for NCA residents (using the TZS10 million allocated by the Pastoralist Council), but it is unlikely that the PHC would be able to deliver division-wide training.

134. If the issue of anti-retrovirals for the prevention of MTCT are to be included, then the current policy of non-provision of anti-retrovirals (e.g.: nevirapine) at the district hospitals would also have to be considered. Other hospitals in the region are provided nevirapine to HIV+ pregnant women e.g.: Selian Hospital.

135. STDs are a major co-factor in HIV transmission. There are high levels of chronic and untreated STD infection in the district. An education programme that incorporated the risk factor of an untreated STD would have to liase with primary health care providers in order to ascertain whether they had the resources to cope with an increase in demand for STD treatment services. It has been proven elsewhere in Tanzania that comprehensive treatment of STDs reduces the rate of HIV transmission.

12.4 Possible partnerships or support organisations.

PHC

136. The PHC teams would be an obvious starting point, but without extra personnel it is hard to see how either the Wasso or the Endulen PHC teams could cope with adding a targeted HIV/AIDS IEC programme into their work. PHC could provide the networks for such a programme, although at the moment the people they reach with their own IEC are a self-selecting group (outreach clinic attendees). If PHC were to be used as the starting point for an IEC programme, then thought would have to be given as to how it might be possible to arrange for larger groups of people to be reached at the outreach clinics. This might involve, for example, telling people that there will be HIV/AIDS presentations/videos/discussions at the next clinic session and that all members of the community can attend, not just those requiring the services of the PHC.

OXFAM

137. Oxfam already have networks in place within Ngorongoro District, but to do an IEC campaign would require extra personnel who are specifically trained (perhaps by an Ereto-NPP funded training scheme) to the HIV/AIDS job. Oxfam was not mentioned as an organisation might be well-placed to provide HIV/AIDS IEC, suggesting that as an organsiation they are not perceived as being integrated with issues of human health (although they are involved with food security issues). The new HIV/AIDS advisor post in their Regional Office in Nairobi might improve their ability to contribute to the necessary work.

Schools

138. Institutions already operating within Ngorongoro District include the schools, which should not be excluded from any wider programme. I am not suggesting that school children should go home and tell their parents about HIV/AIDS. Rather, the schools have an audience (including teachers) that can be easily reached, using culturally appropriate materials by specially trained trainers, rather than the current system of embarrassed school teachers choosing not to talk about the subject.

Churches

139. The faith-based organisations (primarily the RC church) in the area are another obvious starting place, particularly given their experience in doing HIV/AIDS awareness. However, the restrictions on condom promotion by such organisation precludes them from any comprehensive IEC programme.

Village Governments

140. The village level administration is, in my opinion, probably the best "institution" to begin working with, not least because of its comprehensive coverage and acceptability to the community as a whole. The major drawback to this network of influence is the widespread lack of female representatives.

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Appendix One

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Appendix Two

QUESTIONNAIRE

Drawn from 1999 Tanzania DHS questionnaire, Section 8

1 Have you ever heard of an illness called biitia or ukimwi or HIV or aids?
2 Is there anything that a person can do to avoid getting this disease?
3 What can a person do (free answer)?
4 Can somebody stop himself or herself from getting this disease by only having one sex partner?
5 Is it possible to get this disease from a mosquito bite?
6 Do you know what a condom is?
7 Will using a condom prot4ect somebody from getting biitia/ukimwi/HIV?
8 Is it possible to get this disease by sharing food with an infected person?
9 If somebody abstains completely from sex, are they protected from getting this disease?
10 Without giving me the name, do you know anybody / do you know of anybody has been affected by this disease?
11 Can a mother infect her unborn baby with the disease?
12 Can a mother infect her baby when she is giving birth?
13 Does breast milk carry the disease?

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