

***Usitembee nao: Women's sexual health communication networks
in rural Tanzania***

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Abstract

ANNE HILLMAN: *Usitembee nao*: Women's sexual health communication networks
in rural Tanzania
(Under the direction of Dr. Lucila Vargas)

Physical, cultural, and economic factors have increased Tanzanian women's vulnerability to HIV/AIDS infection. Although health communication campaigns have aimed to reduce infection rates and educate people about sexual health topics, little research has been done on the effectiveness and suitability of these campaigns in rural areas. Multiple in-depth interviews with 20 Tanzanian women from a rural village revealed factors that influenced how mass media health messages were perceived and how they fit with local health communication networks. Local belief systems and an adherence to male-dominated gender roles might have negatively influenced the effectiveness of health messages. Magazines and other mass media, though valued, were not seen as adequate replacements for declining traditional, community-enforced sexual health communication practices. The women felt that mass media messages should be supplemented with seminars and traditional performances and should incorporate more technical information about HIV/AIDS, physical pleasure, raising families, and other topics.

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Nashukuru mno.

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Table of Contents

List of Tables.....	vii
List of Figures.....	viii
Chapters	
I. Introduction.....	1
Research Justification.....	5
Thesis Outline.....	7
II. The Setting.....	10
Tanzania.....	10
Health Communication in Tanzania.....	14
Matiru Village – The Research Site.....	15
III. Literature Review.....	24
Sexual Health Knowledge.....	24
Health Communication.....	25
Gender Relations.....	31
The Influence of Modern Education on Sexual Mores.....	34
IV. Methods.....	36
Limitations of Study.....	46
V. Faith	52
Christianity	52

	<i>Uchawi</i>	57
VI.	Life Lessons.....	61
	The Mamas.....	61
	Mabinti	74
VII.	Health-Focused Magazines.....	80
	Currently Available Magazines.....	81
	<i>Nataka kujua kuhusu</i>	83
	HIV/AIDS and STIs.....	84
	Other Information Women Want to Learn.....	86
	Other Teaching Methods.....	90
	Behavior Change.....	91
VIII.	Conclusions.....	94
	Contributions and Further Research.....	99
	Appendices.....	102
	References.....	109

List of Tables

Tables

1. Interviewee Demographics.....37

List of Figures

Figures

1. Map of Tanzania.....11

Chapter One – Introduction

Fatuma¹ stared down at her folded hands as she sat on a grass mat and leaned against the room's mud brick wall. I perched tentatively on the edge of the empty bed frame she shared with her daughter, accepting the need to sit in silence. What could I say to my friend who, at 24, had miscarried for a second time? To a degree miscarriages were almost expected by women in rural Tanzania. Though everyone could see the growing bulge of Fatuma's stomach, no one openly acknowledged that she was pregnant. When I moved to Fatuma's village to work as a Peace Corps Volunteer, I quickly learned never talk to about a pregnancy until the outcome is certain. Who can say if the baby will live or die?

The only pregnancy Fatuma successfully carried to term was the one she didn't initially want. When Fatuma was 18 and studying at secondary school in the district capital, one of the boys from her home village of Matiru got her pregnant. If a girl became pregnant, she was automatically expelled from school. Though her parents had already died, her siblings still lived in Matiru. She moved into her family's old, decaying house and gave birth to Alice. Alice's father finished school; Fatuma did not.

Out of wedlock pregnancies happened with enough regularity that the villagers seemed to accepted it. Because Fatuma was known to be intelligent, she was still given leadership roles in the village. She assisted the village health officer during monthly

¹ All names of people and specific towns have been changed.

clinic days and was part of the HIV/AIDS education theater troop that performed throughout Matiru. Having a child out of wedlock had its repercussions, however. It limited her options for finding a future husband; she was unlikely to become anyone's first wife. Her miscarried child was the product of well-known affair with one of the local men who guarded the timber forest. When he learned that she was pregnant, he followed local customs, and took her as his second wife.

As I sat with Fatuma I considered the ironies of the situation. When she was studying she didn't take precautions to protect herself and became pregnant. She was kicked out of school, returned home, and became a sexual health educator in the village. Through skits and songs developed with community and church groups she taught others about the dangers of unprotected sex and promiscuity. Simultaneously, she was involved in an adulterous relationship. When a pregnancy limited her options by forcing her to quit school, she gave birth to a healthy daughter. When a desired pregnancy would ensure a marriage to a well-off husband, she miscarried.

I sat on the edge of her bed, pondering what influenced Fatuma's decisions. What did she know about sex before getting pregnant? What did she want from her relationship with Alice's father? I knew reproductive health information was available, but did she have access to it? Did she care? As I considered these questions I took a closer look at the newspapers that served as her make-shift wallpaper. Fatuma's walls were lined with the free health education newspapers that she was supposed to distribute to the village youth. The papers blared, "Choose to protect yourself!"

Not all stories of sexuality, pregnancy, and youth in Tanzania are as unfortunate as Fatuma's. In the end, even Fatuma's story ended well. The forester still married her after she lost the baby. She now lives in a new house with a tin roof in the center of town. After one more miscarriage she gave birth to another daughter. She achieved financial security and motherhood, two Tanzanian indicators of success and happiness. When speaking with her during my research trip to Matiru, she seemed happy with where life had led her though she was hesitant to talk about her past. She did not want to bring up actions that were seen as unseemly.

I first befriended Fatuma when I was living and working in her village as a Peace Corps Volunteer from 2001 until 2003. Our relationship continued when I visited the village while I was serving as a Volunteer in Dar es Salaam in 2004. When I returned to Matiru in December of 2006 to conduct interviews for this thesis, Fatuma's youngest child, Hannah, was almost two years old. Hannah's half-sister, now 9, had moved in with her paternal grandmother.

Like many countries in sub-Saharan Africa, Tanzania is in a state of flux. Most of the population lives in rural agricultural towns and villages. They cook over open fires but have access to cell phones and shortwave radios. Schools are being built, the economy is being liberalized, and the political system is becoming more democratic. As Tanzania slowly moves towards the Western notion of "developed," aid organizations and foreign governments have moved into the country to implement more development projects, mostly focusing on combating the spread of HIV/AIDS.

Approximately 7% of the total population of mainland Tanzania, which excludes Zanzibar, is infected with HIV. One of every 13 women has tested positive for the

disease; one in eight men have. In Iringa region, where Matiru is located, the infection rate is the second highest in the country—13.4% (“Viwago vya maambukizi”, 2006).² The Tanzanian government estimates that only 1 in 5 cases of HIV/AIDS are reported (Government of Tanzania, 2007), so the rates may be much higher. Tanzania’s government openly acknowledges that HIV/AIDS is a serious problem in the country. “The epidemic has evolved from being rare and new disease to a common household problem, which has affected most Tanzanian families” (Tanzania, 2007).

To combat the epidemic, HIV/AIDS and sexual health education campaigns use a variety of methods to spread their diverse messages. Some discuss abstinence during traditional skit and dance performances. Multimedia approaches use television, the internet, and magazines to target youth populations with facts about condom use and life skills. HIV prevention methods and moral values are incorporated into nationally broadcast radio soap operas. Organizations disseminate different information about sexual health issues. But who do these messages reach? What do Tanzanians think about these health communication strategies? How do Tanzanian women, who are at higher risk than others, react to these strategies? How do they fit with traditional methods of sexual health information transference, such as initiation ceremonies? Initiation ceremonies and circumcision practices vary from tribe to tribe. The research site is populated with the Hehe and the Bena. In the case of the Hehe, circumcision of the inner labia accompanies initiation ceremonies. For the Bena, circumcision was performed only on girls who grew up in mixed Hehe-Bena communities. For both, initiation was an important practice for

² Other sources give different prevalence rates. UNAIDS says the prevalence rate is 6.5% for people between 15 and 49 years (UNAIDS, 2007). It is difficult to give an exact percentage because many cases are not reported.

teaching about sexual health. This practice is now declining, affecting traditional methods of sexual health communication.

Through in-depth, face-to-face interviews with 20 women of various ages in the rural Tanzanian village of Matiru, I studied how traditional sexual health communication practices among these women are changing and why. I also examined how rural Tanzanian women react to modern health communication materials and how these methods affect and are used with traditional communication methods. I interviewed each woman up to three times, depending on her availability. The interviews focused on the women's life histories, how and when they first learned about sexual health, and what health topics they wanted to learn more about. I also gave the women copies of currently available health periodicals to look through and comment on. I then analyzed the data using a combination of open coding and ethnographic methods.

Research Justification

There is hardly any research establishing the effectiveness of various IEC [information, education, and communication programs] run in rural Africa...Research facilitates the development of effective strategies and campaign techniques. Without it, it is like shooting in the dark—we have no idea where we are aiming and whether or not we are successful. (Nzyuko, 1996, p. 228)

Because of the high prevalence rate of HIV/AIDS in Tanzania (approx. 7%) millions of dollars have been put towards developing and implementing sexual health communication programs. Despite these attempted interventions, prevalence rates of HIV and other sexually transmitted infections are increasing. This may be because the health communication strategies in use are not suited to the specific populations they target. As Nzyuko (1996) says, not enough research is being done in the field, especially in rural

Africa. Though more research has been conducted in the intervening 10 years, the effectiveness of health communication strategies in rural Tanzania is still not fully understood. Researching the receivers of the communication and using their input to develop the messages and the medium through which they are delivered improves the likelihood that projects will succeed (Soola, 1995). My research does just that.

Women seek sexual, reproductive, and other health information from a variety of sources and these sources have changed since colonization and independence (Allen, 2001). New technologies and new schooling methods have influenced information availability. These new sources of information and modes of communication have been blamed for changing sexual mores. However, very little literature mentions how health communication and health messages in the media specifically affect these mores. Moreover, very little research has been done on how media-focused health communication strategies affect other health communication practices.

Health education and HIV/AIDS information and media campaigns often send conflicting messages about sexual behavior and sexual health (Dilger, 2004; Muturi, 2005). The research does not specify which messages and media cause these conflicts, insinuating the need for further research on reactions to specific media. Additionally, the research focuses primarily on school-aged adolescents and does not focus on the reactions of women in rural Tanzania to health communication materials and messages. Because women are more vulnerable to HIV infection than men, it is important to see their reactions to health communication messages. “If the goal of AIDS communication is to prevent the further spread of the disease among women in Africa, then

understanding the perspectives of this audience would be a vital first step.” (Barnett, 2004, p. 124) This research takes that step.

Additionally, studies note that women’s lived experiences color how they use and react to health communication (Parrott, 2004b) but there is little research on this topic (Barnett, 2004; Nzyuko, 1996). By discussing life experiences and reactions to health communication with women from rural Tanzania, my research will help health education communicators effectively target their messages at some rural female populations in Tanzania. This will make their communication strategies and messages more relevant to and useful for the targeted populations.

Although the conclusions of this research are not generalizable, its broad findings may be transferable to villages that are similar to Matiru. It is important to remember that Tanzania is populated by more than 120 different tribes and each has specific cultural traits. My study focuses on a specific population of rural Hehe and Bena women. The Hehe and the Bena are the largest tribes in Iringa region, which has the second highest rates of HIV/AIDS infection in the country. Additionally, these groups are infrequently researched, further justifying the use of this population.

Thesis Outline

My thesis begins with background information on the study site, then discusses belief systems and life lessons that influence how the women perceive health information. I present this information first so that the reader understands what issues factor into the women’s reactions to and perceptions of health communication materials and methods. The thesis closes with a summary and an analysis of their reactions, suggestions, and questions about health-focused magazines and other communication

methods. The ideas mentioned by the women can be used by health communication planners to tailor their communication strategies to rural villages similar to Matiru.

Chapter two, The Setting, begins with a brief political history of Tanzania, its current economic status, and its currently available health communication. I then describe the specific research site, Matiru. In addition to an account of the resources available in the village, such as a small health clinic and a primary school, I present a summary of the typical work schedule for a village woman. Chapter three is a summary of relevant literature, including previous research on health communication, sexual health knowledge, and gender relations in Tanzania and neighboring countries. Gender relations partially determine how women use the sexual health information they receive. This literature guides my research, supports my research claims, and shows how my data compares to other situations in Tanzania. Chapter four explains my methods and their limitations. Working with a group of women I already knew had both advantages and drawbacks that colored and improved the data.

Chapters five and six describe different factors that influence how health communication materials are received in the community. Chapter five presents the different, overlapping belief systems that are present in the village. All of the women I spoke with are Christians but still believe in the powers of witchcraft. I discuss how these somewhat deterministic beliefs influence how the women perceive health information. Chapter six, Life Lessons, outlines the typical health lessons the women received at different periods of their lives and how these lessons have changed for younger generations. All of the women over the age of 30 learned about sexual health at specific points in their life: puberty, during the marriage process, and as they began raising a

family. Health lessons changed both in content and source for the younger generations and factor into younger generations' changing sexual mores.

In chapters seven and eight I discuss the women's comments on and reactions to currently available health-focused magazines and health communication methods.

Although the women like the magazines, they think the magazines need to be supplemented with other forms of communication, like seminars. They also sought more information about science and their bodies than the current magazines provide. Using their comments, suggestions, and questions to me, I develop my own suggestions for health communication designers.

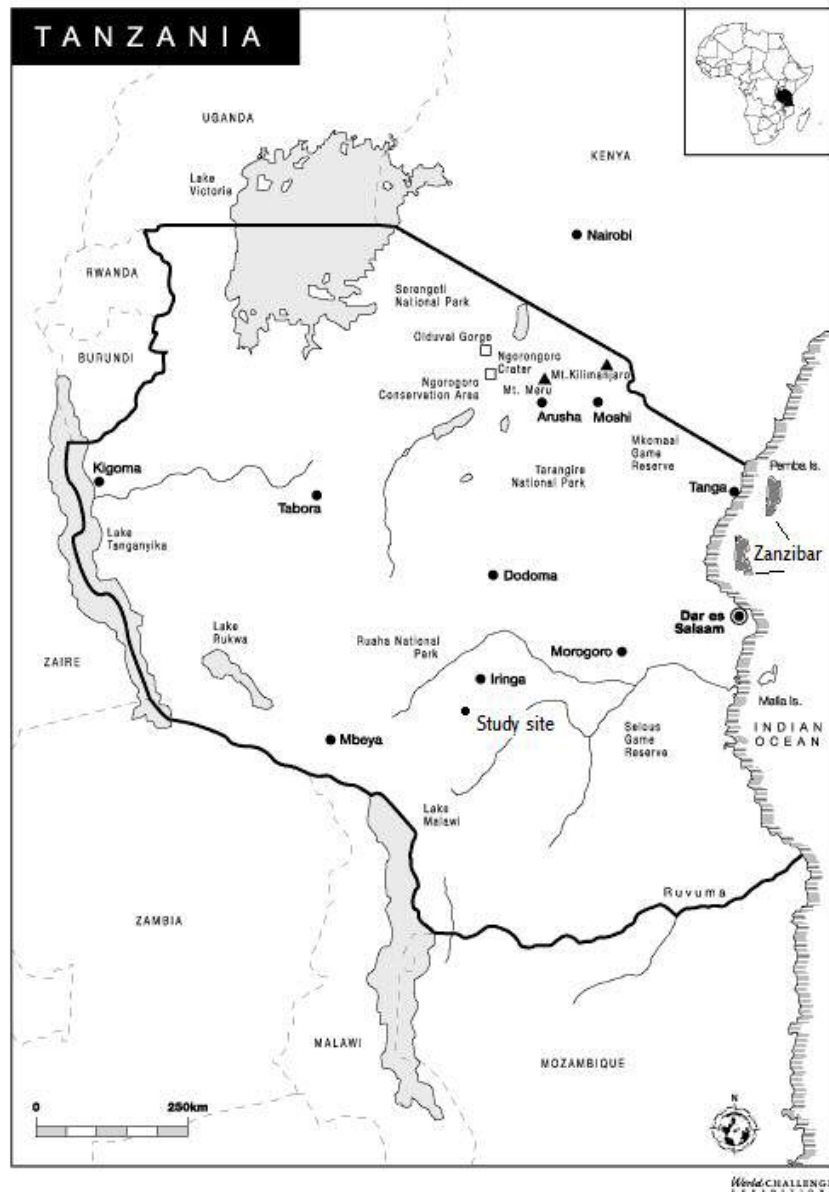
Chapter Two – The Setting

Tanzania

Tanzania (then called Tanganyika) gained its independence from Britain in 1961 and joined with the island nation of Zanzibar to form the United Republic of Tanzania (see Fig. 1) in 1964. Julius K. Nyerere, the first president, implemented a unique form of socialist rule called *ujamaa*, or family-hood. Under *ujamaa* people were grouped into villages with communal food stores, free schooling, and free health care, when available. They also learned Swahili, a Bantu trading language. Though many criticize Nyerere's policies and their effects on Tanzania's economy, he did manage to unite Tanzanians with a common, African tongue and create a sense of unity between the more than 120 tribes. Some argue this unity was at the expense of the expression of cultural and religious differences between groups (Liljeström, Masanja, Rwebangira, & Urassa, 1998). They claim that tribes are seen as non-existent at the national level, but they remain a significant identifier at the local level (Liljeström, et al., 1998). When people register at a hotel or make a report at the police station, they are still requested to identify themselves by tribe. Likewise, most rural Tanzanians still speak their tribal languages and follow local customary laws.

Under Nyerere's rule, Tanzania severed connections with the West in the 1970s (Grosswiler, 1997; Ng'wanakilala, 1981). He tried to create a media and a communication system that was unique to Tanzanian culture, not a mirror of Western or Soviet media. He wanted Tanzania to be culturally autonomous rather than dependant on

Figure 1 – Map of Tanzania



Source: <http://www.world-challenge.co.uk/members/popups/Tanzania.htm> with added labels.

Cold War powers. Nyerere viewed media as a development tool that used horizontal communication and appropriate technology to disseminate necessary information. Instead of creating a television network on mainland Tanzania, the area of the country excluding Zanzibar, Nyerere used a video system to deliver information that would be useful for village life directly to the villages. The AM radio network was used for adult and health education campaigns. These campaigns pushed traditional African values, such as a focus on self-reliance, community, and family (Grosswiler, 1997) and were used to promote national unity (Ng'wanakilala, 1981). The radio programs also taught basic skills such as mathematics, money management, agriculture, and Swahili (Ng'wanakilala, 1981). Despite these attempts to use AM radio to unify and educate the country, later critics say it failed, in part due to technical problems. Even when foreign money was used to set up transmitters in the 1980s, "when donated equipment went wrong, there was usually no money readily available for repairing it" (Ngatara, 1995).

In 1985 Nyerere stepped down as president and his vice president, Ali Hassan Mwinyi from Zanzibar, took his place. Mwinyi began to liberalize the economic and political systems (Grosswiler, 1997). On July 1, 1992 he launched a multiparty system and liberalized the press. Private television and radio stations were introduced in 1994 (Ngatara, 1994). Though many new, private newspapers and media outlets emerged, initially some argued that the government allowed this only to please foreign donors (Ngatara, 1992). Some criticized the new media outlets for primarily reaching only the urban population and not providing quality programming: "TV is full of ancient American soap operas or dancing Congolese musicians" (Lusekelo, 2001, p. 12). This has since been supplemented with *telenovelas* imported from Mexico and dubbed in English,

English-language news reports from BBC, al Jazeera, and Russia Today, music videos from the U.S., and locally- produced Tanzanian hip-hop and choir videos. Outside of Dar es Salaam, most people do not speak English, so most of the television sets, which are in restaurants and bars, are tuned to music videos and sporting events.

Currently, the World Bank reports that Tanzania (pop. 38.4 million) is one of the poorest nations both in the world and in Sub-Saharan Africa. The gross national income per capita in 2004 was only US\$330, less than a dollar a day (World Bank, 2005). In Sub-Saharan Africa, the average GNI is US\$600 (World Bank, 2005). In 1994 the gross domestic product was US\$4.5 billion and increased to US\$10 billion by 2004. Forty-five percent of the GDP consistently comes from agriculture. According to the Tanzanian National Census conducted in August 2002, 77% of the population is rural (Government of Tanzania, 2003). Using factors such as life expectancy, GPD, and literacy rates, the United Nations Development Programme ranked Tanzania 164 out of 177 on the 2005 United Nations Human Development Index (United Nations, 2006). When looked at quantitatively, Tanzania is the fourteenth worst place to live in the world. This ranking does not take into account the fact that Tanzania, unlike many of its neighboring countries, is not at war nor is there violent political repression within the country.

The UN and the World Bank also compile data on information and communication technologies. According to the World Bank, only seven in every 1,000 Tanzanians use the internet compared to the Sub-Saharan average of 20 of every 1,000 (World Bank, 2005). According to Hamilton (2006), 94 of every 1,000 people have mobile phones. In 2005, twenty-five percent of the country had mobile phone coverage (World Bank, 2005). This is increasing every day as the four major mobile phone

companies, Vodacom, Zantel, Tigo, and Celtel, vie for dominance. Fourteen percent of households have a television (World Bank, 2005). The percentage of households with working radios with a power source is not provided. Although non-print communication technology resources are limited, according to both the UN and the World Bank, 30% of Tanzanian adults are illiterate (United Nations, 2006; World Bank, 2005), though the rate is lower for people under 40. In a country with limited access to communication technologies and high illiteracy rates, communication strategies are important components of development projects.

Health Communication in Tanzania

Communication-focused health education projects use different types of media to disseminate information to rural and urban populations in Tanzania. According to the Communication Initiative (2006), an on-line database that catalogues communication projects around the world, more than 40 communication-based Tanzania-specific projects have been initiated since 2000. Of these, about 60% are health-related projects, focusing primarily on HIV/AIDS and sexual health. Of the 24 health-related, Tanzania-specific projects listed on the Communication Initiative web site, seven used drama, theater, and/or other traditional media as the main form of communication, seven used modern mass and multimedia, six relied on interpersonal communication, three focused on radio, and one used Information Communication Technology (ICT) (Communication Initiative, 2006).

Non-governmental organizations (NGOs) also target rural areas through media campaigns. Schools, health workers, and community-based development workers

distribute health-focused newspapers and magazines, such as *Amua! (Decide!)* (Population Services International, 2006) and *Fema* (Cheza Salama, 2006). Other groups, such as ANGAZA, travel from village to village showing videos about sexually transmitted infections (STIs) and safe sex. In most rural villages, a monthly clinic day is held in which nurses from the district center come to weigh the children. During these visits they distribute information about family planning and display posters about health and nutrition.

Much of the funding for these projects comes from external sources. SIDA, the Swedish International Development Agency, alone gave US\$4.2 million to HIV/AIDS projects in 2004, including funds for an HIV/AIDS television show and the promotion of educational theater groups (SIDA, 2006d). The United States Agency for International Development (USAID) in Tanzania, which had a \$65 million budget in 2005 (USAID, 2006b), is incorporating a national mass media youth communication campaign into its \$15 million HIV/AIDS prevention program (USAID, 2006a). According to Melkote and Steeves (2001), most contemporary communication and education campaigns deal with HIV/AIDS because of the seriousness of the pandemic. These campaigns involve multimedia, multi-sectoral approaches that include peer-to-peer counseling, which reinforces the messages, and social marketing campaigns of condoms.

Matiru Village – The Research Site

I first moved to Matiru in December of 2001 as an Environment Volunteer with the United States Peace Corps. Matiru's village government requested Peace Corps to place a volunteer at the site who had knowledge about environmental and health issues. I

had previously taught both topics. The following research site description is a recollection of my two years at the site, from 2001 until 2003, and observations made during visits in 2004 and the research period of December 2006 to January 2007.

Matiru (pop. 2,774³) is a rural agrarian village with no electricity and no running water located about 25 kilometers from the district capital along a major dirt logging road. It is divided into five subvillages, three of which are centrally clustered around the primary school. Two of the subvillages are separated from the main village by fields and valleys. From the furthest points in the village, it takes school children about an hour and a half to two hours walk to school each day, each direction. Many of the families who live in the peripheral areas are trying to relocate to more central places. Each of the subvillages has at least two pump wells, though they occasionally break and are not deep enough to easily draw water during the end of the dry season.

All of the government-provided social services are based in the main, central subvillage. At the center of the subvillage is the village government office, though it is usually locked. The office is a spacious brick building with decaying cement floors that is partitioned into four smaller rooms and a large meeting area. The walls of the office are plastered with health posters from UNICEF and other organizations and political posters supporting CCM, the dominant political party. People used to gather there for monthly government meetings. In 2005 the office was partitioned into two sections. One small room is still used for government business. The other section serves as a house for the nurse who works at the local clinic.

³ This figure was given to me by the village executive officer who read it off of a statistic sheet given to him by the district government. The data is presumably drawn from the national census, but village-level census data is not available online.

For a year an international NGO helped a group of women open up a “questions” office in the building. The office served as a resource for village women to ask legal questions and to seek advice. In conjunction with this office, the villagers formed a theater group that traveled around the village performing skits, songs, and poetry about HIV/AIDS. Their main messages focused on preventing the spread of the disease and about its dangers. After the NGO stopped monitoring and funding the project, the theater group stopped touring, the office closed, and the room became part of the nurse’s quarters. The project never became self-sufficient.

The village’s small health clinic, staffed by a nurse and a doctor, opened in early 2005. The building consists of a doctor’s office, a nurse’s office, a store room, a medicine room, and a sleeping room. The walls of the waiting area outside are lined with posters from UNICEF, the government-led Green Star family planning campaign, and health-focused NGOs. They include notices about vaccinating children, the importance of prenatal care, advertisements for edutainment cartoon strips, and other messages. The clinic has basic medicines but no equipment other than a bed and basic measurement tools, like a thermometer, a scale, and a stethoscope. The clinic provides services and medicines to the village and surrounding areas. Villagers either pay 5,000 TSH (about US\$4.20) for a year’s worth of services, or 1,000 TSH per visit (about US\$0.90). If help is needed in the middle of the night, the clinic guard will wake up the doctor or the nurse and they will help the patient.

Each month the clinic hosts two “clinic days.” Every mother is required to bring her children, aged four and under, to be weighed so their growth can be charted. The growth charts help the health workers give proper treatment to the children. They know if

the children are dropping weight or growing steadily. Additionally, the doctor and nurse provide free vaccinations, birth control pills, and Depo-Provera birth control shots. Each month the health workers teach about a different health topics. In 2006, lessons included nutrition, family planning, good breast feeding practices, and discussions of common diseases. Before the clinic was built, clinic days were run by visiting nurses and held at the village government office. In addition to medical services and short health lessons, the day gives women from different parts of the village a chance to talk and sell small foods, like fried dough and bread. The clinic and the offices are located next to the soccer pitch and the old communal grain storage building dating from Nyerere's attempt at forced socialist villagization.

Further down the wide dirt path that cuts through the village is the primary school. More than 660 students attend kindergarten and grades one through seven in the 11 room school building. Children are supposed to begin school at age seven, though actual entrance age varies. More children have entered the school since the elimination of primary school fees. All students from each grade level are in one class. Class size ranges from 90 students for one teacher, primarily the lower standards, to 30 students per teacher in the upper standards. In 2006 the first grade class had 206 pupils and was taught in sessions by three different teachers.

The school currently employs nine teachers, two of whom are studying at various institutions in Tanzania and not teaching. A local woman teaches the kindergarten students for part of the day. Each student is expected to wear a uniform and shoes, though many do not have shoes. They provide their own notebooks and pencils. Each morning, before classes begin, students clean the school and help the teachers with their household

chores, like farming, gathering firewood, and carrying water. Misbehavior, tardiness, and, occasionally, wrong answers are punished through beatings with a thin stick on the backs of legs or hands. Very few textbooks are available to the students and some classrooms lack sufficient desks. Until recently, very few of the students continued on to secondary school. Within the past two years, however, more secondary schools have been built, school fees have been reduced, and more children are continuing their educations, including many girls.

The primary school houses a small library. Most of the library is filled with models and science demonstrations built by the a former teacher and art projects built by students. The shelves hold a few books written in Swahili and donated books written in English. These are supplemented by approximately four years worth of *Newsweek* magazines donated by Peace Corps Volunteers. Sometimes students look at the pictures or teachers use them for practicing their English. The library also has a supply of health communication materials, including sexual health books produced by the German aid agency GTZ and *Femina* (now called *Fema*), an entertainment-education magazine that uses Tanzanian pop culture to discuss health issues in Swahili and English. The library also has copies of *Si Mchezo!*, a healthy lifestyles magazine written in Swahili and targeted at youth in the region where the village is located. Though the library has a system for checking out materials, very few people ever use it. Many villagers are in their fields when the library is open during school hours. The woman who attended a librarian training seminar six years ago moved to the district capital and never worked in the library.

The yearly calendar of the villagers is determined primarily by the weather cycles. The rains usually start in mid-November or early December and continue until mid-April. From late September until the rains start, people concentrate on preparing their fields by plowing them by hand and occasionally burning off old growth. The villagers farm by hand with a heavy hoe called a *jembe*. Once the rains begin, they plant field corn, beans, and potatoes. In February, they plant sweet potatoes and local tubers. Each family supplements their farm crops with produce such as greens and tomatoes from their gardens in the valleys and some grow millet and wheat. The gardens are irrigated by streams year round. After the rains end, the corn is allowed to dry on the stalk and is harvested in July and August.

During the rainy season, a village woman's typical day involves hauling water and eating a small breakfast in the morning before going to the farm fields. She works on the farms, sometimes along side her husband or in groups with other women, until mid-afternoon. After returning from the fields she cooks corn mush (*ugali*) and beans or greens for her children and herself. In the afternoons, the children and the mothers usually spend time gathering firewood from local forests and tree plantations, hauling water, feeding livestock if they have them, and socializing. The men often go to the *vilabu*, centralized areas with many small mud buildings where people serve local liquor. Most of the major *vilabu* also include small stores with basic goods like soap, tomatoes, oil, and kerosene. When the sun sets, around 7 pm, women leave their other work to cook dinner and socialize before going to bed. During the dry season, women work in the gardens but have more time to socialize and complete small projects, like weaving baskets and grass mats.

In traditional Tanzanian society, among most of the 120 different ethnic groups, women and girls do all of the cooking, water carrying, and firewood gathering. This is especially true in Matiru, which is populated by the Hehe and Bena groups. Despite this, many women also actively participate in small women's groups, livestock raising projects, and church groups. Most people in Matiru attend the Catholic Church, the Assemblies of God Church, or the Lutheran Church. There are also congregations of Anglicans and Seventh Day Adventists. In the past decade, an increasing number of Catholics have converted to either Assemblies of God or Seventh Day Adventism. Church activities and religion, including local religions, are important elements in many people's lives. Services are conducted in Swahili. Almost all of the villagers speak Swahili and their tribal languages, Kihehe and Kibena.

All of the villagers farm corn, beans, potatoes, and other crops for their personal use. Some supplement their incomes by raising livestock, running small business, selling excess crops, and working in the neighboring timber forests. They use this money to buy essentials, such as soap, kerosene, and cooking oil from local stores and to pay for their children's school expenses, such as buying uniforms and paying secondary school fees.

Many of the residents have access to radios and a bar, which opened in December 2006, occasionally shows religious and fictional videos on a generator-powered TV. Approximately twenty of the residents have battery-powered cell phones that can be charged either at the district capital or at a new local store that has a solar panel. Occasionally shopkeepers buy newspapers when buying other supplies in the district capital. Matiru is connected to the district capital by an unreliable daily bus that frequently does not run during the wet season or is too full to pick up passengers from

Matiru. People travel to and from Matiru, the district capital (about 25 km away), and other neighboring villages by bicycle and foot.

Health communication enters the village in a variety of ways. In the past, health workers brought pamphlets written in Swahili with them to distribute during clinic days. The doctor and nurse currently distribute similar pamphlets on STIs, HIV testing, mother-child HIV transmission, family planning, and miscarriages. When Peace Corps Volunteers, like myself, live in the village, we distributed Swahili-language health-focused newspapers, magazines, and booklets such as *Amua!*, *Si Mchezo!*, and *Femina*. Excluding two four-month periods, Peace Corps Volunteers have lived in the village since 2000. Other NGOs who work in the region also distribute Swahili health communication materials at village events. Most people under the age of 40 can read.

Through these health materials, interpersonal communication, public performances and announcements, and experiences of watching villagers die from the disease, the women in Matiru learned about the seriousness of the HIV/AIDS epidemic. As Salma, a woman in her early 20s from Matiru, expressed,

Ukimwi ni gonjwa ambalo haliepukiki ehe hata kama utafanya kila bidii itafika kipindi utaangamia tu. Mimi katika hili swala la ukimwi... wakati mwingine wapo wengi wapo wengi wanalo hilo gonjwa, hata kuzaa hawawezi, kwa sababu wameshapatwa na huo ugonjwa kwa hiyo ni swala ambalo linatisha.

AIDS is a disease which is unavoidable, even if you make every effort you will perish. For me, the question of AIDS...sometimes there are many people who have this disease who, even to give birth, can't. Because they've already gotten it. This disease is a question that is frightening.

Salma was afraid of AIDS because she thought it would prevent her from participating in one of the most basic and necessary life stages for a Tanzanian woman—giving birth.

Later she commented it prevents people from marrying as well. She, fatalistically, thought infection was inevitable.

Most people in Tanzania and in Matiru knew that HIV infection rates were increasing and that they need to be aware of the dangers of the disease. This awareness did not necessarily cause people to get tested. Ndavalonge, a woman in her late 30s from Matiru, said she thinks about half of the people in Matiru would get tested for HIV. Some see the importance of knowing their status, others think knowing can lead to more problems, she said. Ndavalonge:

Maanake wao wanasema hivi, ye akienda kupimwa, akielezwa kama yeye ana virusi vya UKIMWI, anaogopa. Anaogopa anasema hivi, anakuwa na wasiwasi juu ya maisha yake. Halafu pengine ataweza kuanza kutapanya mali ovyo... na wengine wanasema hivi, wakiniambia nina virusi vya UKIMWI, naona ni bora kunywa sumu au nijiue tu. Kila mtu na maelezo yake.

That is to say, they say this, that if he goes to get tested, if he is told he has HIV, he is afraid. He's afraid and he says he worries about his life. Then, sometimes, he can start to squander his wealth without caution... And others say this, "If they tell me I have HIV, I think it's better just to drink poison or to kill myself." Every person has his own explanations...

People understood that HIV/AIDS was deadly but did not understand the benefits of getting tested. They used the deadliness of the disease as justification for living in ignorance. Women told me they saw no benefit in knowing when they would die, and they did not know about possible treatments. Messages about the importance of testing have not yet effectively reached all of Matiru.

Chapter Three - Literature review

Sexual Health Knowledge

Tanzanian women obtain sexual health knowledge through a variety of different channels, depending on the tribe. Many studies focus on how sexual information and mores were historically passed to girls during initiation and circumcision ceremonies (Ahlberg, 1994; Allen, 2001; Katapa, 1998; Tumbo-Masabo, 1998). When external influences, such as missionaries, forced traditional initiation rites to change, social conversations about sexual morals and exchange of sexual knowledge were limited, leading to changes in sexual behavior (Ahlberg, 1994).

Currently, formal structures of education, both traditional (initiation rites) and modern (school system), are not major sources of information about reproductive knowledge among some of the tribes in rural Tanzania (Allen, 2001). Most formal sexual education is taught at the secondary school level, but very few students go beyond primary school (Matasha & Ntembelea, 1998). Students in Mwanza, Tanzania said they primarily discuss sex informally with their peers but would be open to discussions with teachers and health workers (Matasha & Ntembelea, 1998). Informal information networks are important sources of sexual knowledge for women in certain areas of rural Tanzania (Allen, 2001). Likewise, in northern Tanzania, most health information comes from relatives, friends, schools, media, and religious organizations (Dilger, 2003). This becomes problematic because each source often presents contradictory messages about preventing STI transmission and competing messages about sex and sexuality (Dilger,

2003). Studies showing levels of factual knowledge about sexual health in Tanzania are limited however information about neighboring counties might be relevant. One study showed that factual knowledge about sex was limited among South African youth (Harrison, et al., 2001). However, researchers note that, although gaining sexual knowledge is important, “knowledge is not a sufficient condition for behaviour change” (Airhihenbuwa & Obregon, 2000, p. 12-13).

Health Communication

The U.S. Department of Health and Human Services defines health communication as the “art and technique of informing, influencing, and motivating individual, institutional, and public audiences about important health issues” (Parrott, 2004b). It is the dissemination of messages intended to inform people, to persuade them, and to manipulate them to produce different behavior (Barnett, 2004). Most current health communication focuses on behavior change (Ford, et. al, 2003; Obregon, 2003).

NGOs and other organizations use a wide variety of communication strategies and methods to reach target populations. These include radio, magazines, dramas, newspapers, posters and pictorial messages (Pillsbury & Mayer, 2005). Pictorial information is not always universally understandable, however, because pictures and images are culturally coded. Though posters are both useful and vital in areas that are not easily reached by mass media, such as television, radio, and newspapers, it is often difficult to visualize some abstract concepts. Designers must be wary because drawings and pictures can be incorrectly decoded and may include details that distract the viewer from the main messages (Pauwels, 2005). For example, the doctor at the research site

frequently shows women a poster promoting family planning. One half of the poster shows a distraught family with many children running around unclothed. The other shows a prosperous family with only two children. The doctor said that the poster is well received, except most of the women who see it comment that the poor woman has pomade in her hair. If she is so poor, how can she still afford pomade?, he said the women ask. The picture is unconvincing because the designer did not notice small details that the intended audience honed in on.

Many of the current health communication strategies do not effectively induce behavior change and halt the spread of HIV (Ford, et al., 2003). This may be because the theories and models of health communication that are in use are being applied in contexts different than for what they were designed (Airhihenbuwa & Obregon, 2000; Barnett, 2004). Models for communication usually come from American researchers with little input from Africans (Barnett, 2004; Kivikuru, 1989; Mlama, 1994). Health communication strategies rarely involve knowledge from field experiences and are based on frameworks that are not flexible enough to be applied to different regional and cultural contexts (Airhihenbuwa & Obregon, 2000). The communication strategies and their use of media need to be responsive to the specific conditions and living situations in each village they are serving (Kivikuru, 1994). Many models are based on the assumption that the receiver of the material is a “rational” decision-maker not influenced by emotion (Airhihenbuwa & Obregon, 2000). These models “were designed to address health prevention from an individual, linear, and rational perspective... they seem inadequate for communicating HIV/AIDS prevention and care messages in Africa” (Airhihenbuwa & Obregon , 2000, p. 8).

Communication strategies developed in the United States ignore the community-focus of many groups in Africa (Barnett, 2004). It is questionable if these theories are relevant “in cultures where individual decisions are the result of group norms whereby being individualist is going against the grain” (Airhihenbuwa & Obregon, 2000, p. 7). Often these strategies are ineffective because health communication is seen as an interaction between the message and the individual rather than the message and the community (Airhihenbuwa & Obregon, 2000).

In some instances, health communication messages about STIs reach the targeted populations, but the recipients do not understand them (Muturi, 2005). The messages are not properly targeted. “It is important to know what the target audience believes in order to make a persuasive argument” (Pillsbury & Mayer, 2005, p. 365). To understand what the audience believes, the communicators must understand the audience’s culture (Airhihenbuwa & Obregon, 2000; Dilger, 2003; Muturi, 2005; Okigbo & Meister, 2000). Humans live by interpreting meaning through culture, which affects the perceived meaning of the communicated messages (Muturi, 2005).

Cultural beliefs are seen as in opposition to scientific health knowledge (Airhihenbuwa & Obregon, 2000), so culture is seen as a barrier to effective communication rather than as an asset. Cultural norms and emotions influence decisions about sexual behavior; thus, individuals may not follow the patterns of decision making on which the theories are based. Additionally, it is important to understand cultural characteristics and gender relationships that influence effectiveness of communication strategies (Ford et al., 2003). The messages in the strategies must also be tailored to the language and culture of the receiver (Pauwels, 2005). “The failure to integrate health

messages effectively into locally established communication networks has been the cause of much misunderstanding and has resulted in programs irrelevant to the needs and goals of rural people” (Riley, 1990, p. 312). The messages are more effective if they are incorporated into both modern and traditional media (Mlama, 1994; Okigbo & Meister, 2000; Riley, 1990). Currently, research is lacking on the effects of culture on the development and effectiveness of health communication strategies (Parrott, 2004b).

Unless health information campaigns engage the audience in a dialogue about the underlying problems (Muturi, 2005) and culturally shaped experiences of sexuality (Dilger, 2003), they are not effective. This is especially true for programs focusing on HIV/AIDS (Dilger, 2003). A move toward promoting discussion about sexual health topics instead of just promoting behavior change is necessary, since behavior change often proves to be short-lived (Ford, et al., 2003). Dialogue with the community will help determine the best communication strategies (Ford, et al., 2003; Obregon, 2003; Soola, 1995) and may prevent conflicting sexual health messages from different sources. Additionally, health messages in the media that are reinforced through interpersonal communication and dialogue more effectively cause behavior change (Agha & Van Rossem, 2002; Mohammed, 2001) and information retention (Kivikuru, 1994). This was shown through studies about a radio soap opera broadcast in Tanzania in the mid-1990s. The show incorporated sexual behavior change messages into the story line. Listening to the show increased the likelihood that people would openly discuss sex-related topics, which are traditionally considered taboo in Tanzanian society (Mohammed, 2001; Vaughan et al., 2000).

AIDS information campaign designers need to address the conflicting messages that are broadcast from different campaigns about sex and sexuality (Ahlberg, 1994). Because many of the religiously-based information campaigns promote abstinence and monogamy, a culture of silence has risen up around sexual behaviour and mores—sex should not happen so it should not be discussed (Ahlberg, 1994). Thus, the audiences, especially adolescents, receive messages from some sources that promote talking about AIDS and being open with sexual partners while other campaigns promote silence. Campaign designers also need to recognize that how specific messages about AIDS are read and understood varies based on geography (Barnett, 2004), social networks, gendered communication (Parrott, 2004b) and religion (Parrott, 2004a). Although links between spirituality and religion and health behaviors are well documented, few people have researched how this link influences health communication (Parrott, 2004a), especially in Africa.

“Health communication programs could further benefit from learning how much value women place on messages from intimate others and interested others, the weight women give mass media messages versus interpersonal communication, and women’s ability to act on messages they hear” (Barnett, 2004, p. 124). More women’s voices need to be heard. Though women’s views are now included in much research, they are often devalued by a research process to which the women are unaccustomed. (Barnett, 2004). HIV/AIDS prevention programs need to address the female sexual agency and desire rather than enforcing females’ subordinate sexual decision-making powers (Pattman, 2005).

When health information campaigns are planned, they should focus on more than individual behavior change and biological information (Ford et al., 2003). The campaigns should try to change the social environment in which HIV is spreading and help people to learn about alternative life choices (Ford et al., 2003). They should also recognize that no matter what the message is, personal experiences and communication behaviors will affect responses to health communication materials and people's willingness to act on health information (Parrott, 2004b). People evaluate messages based on their experiences and decide if they are relevant to their lives (Barnett, 2004). Furthermore, women mediate the health messages they receive based on gendered interactions (Barnett, 2004; Parrott, 2004b).

Many of the current health-focused media in Tanzania take heed of these suggestions and incorporate social change messages into the magazines. *Fema* and *Si Mchezo!* are widely distributed and well-known health magazines created by the Health Information Project. *Si Mchezo!*, which means "Not a Game!," starts each issue with a personal story of triumph then connects the story to larger social problems. Instead of just talking about health issues, both magazines include sections on making money, relationships between men and women, gender roles, and cultural issues. Each month, *Fema* focuses on a specific region of the country and the cultures and practices that are unique to that area. The magazine writers seek to educate people about regional differences and similarities as they educate people about health issues, further uniting the diverse nation.

Gender Relations

Gender identities, gender roles, and gendered interactions influence sexual behavior, agency, and relationships. Gender identities are neither inborn nor products of socialization, they are things people do and perform (Pattman, 2005). The link between biological sex and gender identity is built into the Swahili language. The word for woman (*mwanaamke*) literally translates as a person who is a wife. Wife (*mke*) stems from the word for vagina (*uke*). The word for man (*mwanaumume*) stems from the same construction (*mume*-husband; *ume*-penis). Ideas of fecundity are part of the language and tied to identity (Liljeström, et al., 1998). Most of the research on gender, sexuality, and relationships in Tanzania and other parts of east and southern Africa focuses on youth and students. Though my study does not focus on adolescents, this is the primary research to work from. Because of the limited data, I will also draw on research from neighboring countries which reflect on probable Tanzanian norms.

The female and male Tanzanian secondary school students who participated in one study constructed each other as opposites and said that the interactions between the sexes are limited (Pattman, 2005). “Sexuality was spoken about in ways which tended to cement gender polarized identities” (Pattman, 2005, p. 510). In societies such as in East Africa where desire is seen only as heterosexual, gender identities are very polarized (Pattman, 2005). The dichotomy between female and male wherein females are seen as submissive and there is little common ground between the genders, makes it more difficult to negotiate sexual relations, reducing female sexual agency (Lesch & Kruger, 2004; Pattman, 2005).

Accepted gender inequalities in larger society determine girls' subordinate role (Chambua, et al., 1994; Harrison, et al., 2001; Pattman, 2005). In northern Tanzania, "both men and women consider hierarchical gender relations to be legitimate" (Dilger, 2004, p. 37). Females and males both function in accordance with male dominance (Dilger, 2004). Because the boys are seen as the leaders of the relationships, girls see it as boys' role to initiate romance (Harrison, et al., 2001; Pattman, 2005). Boys initiate sexual relationships by "proposing love," even to girls they do not know well (Pattman, 2005). Youth embrace this idea of "romantic love" because they see it as legitimatizing sexual interactions—if they love each other, sex is acceptable (Ahlberg, 1994). Interestingly, the word "to love" in Swahili—*kupenda*—also means "to like." There is no distinction.

The adolescent Luo boys of northern Tanzania who participated in group interviews, however, admitted to using "romance" and sweet words only as a way to get girls into bed and to prove their own masculinity (Dilger, 2004). Lying is also part of the subtle forms of pressure and coercion that are often elements of heterosexual relationships in South Africa (Lesch & Kruger, 2004) and Tanzania (Chambua, et al., 1994). Women's lack of autonomy and authority is compounded by a lack of communication with their partners (Barnett, 2004). Adolescent girls are put into submissive positions that often make them susceptible to early pregnancy (Chambua, et al., 1994).

The adolescent girls' submissive position and lack of agency is compounded by financial aspects of many relationships. Girls start having sex because of peer pressure and desire for the material goods their partners provide (Dilger, 2004; Harrison, et al., 2001; Pattman, 2005; Rwebangira & Liljeström, 1998; Tumbo-Masabo & Liljeström,

1994; Wizara ya Afya, 2006). Modern girls are expected to have boyfriends who take care of them emotionally and materially when they are young (Dilger, 2004; Rwebangira & Liljeström, 1998). This economic transfer is seen as acceptable in sexual relationships (Dilger, 2004; Pattman, 2005), but boys see it as entitling them to more sexual freedom and unhindered ejaculation (Dilger, 2004). Further, this economic relationship and female dependency is emphasized as the cause for high female infection rates by some AIDS campaigns (Wizara ya Afya, 2006). This emphasizes women's powerlessness and ability to control safety measure like condom usage (Wizara ya Afya, 2006) and further reduces their agency (Dilger, 2004; Pattman, 2005). Sex is not an act under a woman's control and thus she is psychologically disempowered (Lesch & Kruger, 2004).

Socially enforced gender roles influence how women view their sexual behavior as well. For some South African women, these social forces shape sexual identity more than the women's own desires for sexual pleasure (Lesch & Kruger, 2004). In East and Southern Africa, female sexuality is repressed while male sexuality is openly encouraged (Pattman, 2005). Whereas men can talk about their sexual experiences to prove their manhood, women are expected to represent themselves as good, hence non-sexual (Pattman, 2005). Women are susceptible to social pressure, influenced by local religious norms to remain virtuous (Spronk, 2005). However, the modern woman in Nairobi is supposed to lose her virginity early to prove her status while simultaneously preserving her positive feminine reputation as someone chaste and virtuous (Spronk, 2005). This societal contradiction leads to an internal paradox: being sexually active makes the women feel confident and more womanly because she can attract a man, but it also introduces feelings of guilt for not remaining pure until marriage (Spronk, 2005).

These imbalanced gender roles are recognized by writers of health communication materials in Tanzania. One striking example is a pamphlet issued by the Tanzanian Ministry of Health. The pamphlet, which is distributed at health clinics around the country, teaches women why they are more susceptible to STIs than men. It highlights physical reasons, such as the large area of permeable skin inside the vagina; economic reasons, such as women sleeping with for economic resources and survival; and cultural reasons, such as men having control over sexual situations and condom usage (Wizara ya Afya, 2006).

The Influence of Modern Education on Sexual Mores

The modernization of Tanzania includes mandatory schooling for primary school-aged children. Because mothers think their daughters are learning about puberty in the schools, the school system often replaces customary initiation practices. However, the schools do not teach the students the same information about sexual health and sexual mores that initiation ceremonies usually provide (Liljeström, et al., 1998). This leaves adolescents unprepared for sexual relationships (Liljeström, et al., 1998). In some cases, the modern school system teaches children about biological information that traditional initiation ceremonies do not. The girls' parents usually do not have this same information, which changes the teaching relationship between parent and child (Liljeström, et al., 1998). Additionally, the modern education system does not give girls knowledge of their own bodies or cultural values, such as their importance in the family structure (Puja & Kassimoto, 1994).

Modern education is blamed by some as the cause of higher divorce rates and early pregnancies (Katapa, 1998; Tumbo-Masabo, 1998). Women are educated and empowered by schools and the push towards modernity, thus they do not respect traditional family structures (Katapa, 1998; Liljeström, et al., 1994). Education is also blamed for out-of-wedlock pregnancies (Katapa, 1998; Tumbo-Masabo, 1998). Studies of the Nyakusa in Tanzania show that older women think girls' supposed love of money, and hence involvement in economically-based sexual relationships, is caused by modern schooling and leads to early pregnancies (Katapa, 1998). Education also leads to a later marriage age and changes traditional lifecycles for women (Liljeström, et al., 1998; Tumbo-Masabo, 1998). This has led mothers from the Mgogo tribe in Tanzania to circumcise their daughters at an earlier age before their values are polluted by modern education (Tumbo-Masabo, 1998).

Chapter Four - Methods

I arrived at the study site, my former Peace Corps village, with one major goal—to complete my thesis research. But for some reason that goal wasn't as clear to everyone else in the village. Every time I ran into a new person, after the typical string of greetings, the conversation went something like this...

Villager: Are you really Anna?

Me: Yes, it's really me.

Villager: Good. At first I thought you were the new volunteer and I thought, fancy that, all white people look the same.

Me: No, I'm really Anna.

Villager: So, you've come back to visit?

Me: Yes, but also to do research and ask questions about health. I'm studying again.

Villager: Oh, so you've come to work here again and teach about health?

Me: No, I'm here to learn.

Villager: Ah... and you'll teach, too?

Many of these conversations ended with a look I've become used to, a look that affectionately means they think I'm nuts. The idea that I would come back to the village to learn from those I used to teach didn't seem to make much sense—the American, the former development worker, came back to ask questions but not to bring pigs or to teach seminars? Very odd. But, there I was, back after three years of wandering, studying, and changing, wondering what this return trip would be like.

I returned to a village that once was my home to ask questions I never had reason to ask before. During the ensuing month in the village I conducted face-to-face, in-depth interviews with 20 women aged 18 to mid-80s. They had varied pasts, religions, and

Table 1. Interviewee Demographics

Interviewee	Approx. Age	Marital Status	Other wives?	Other Members of Household	Religion	Education/Literacy	Times interviewed
Monica	18	Single	-	Lives at secondary school	T.A.G.	Some secondary school	2
Salma	20	Single	-	Mother; siblings already married	7th Day Advent.	Primary school, sewing school	2
Virginjon	21	Single	-	Mother; sister and father during school breaks	T.A.G.	Some secondary school	2
Veronika	23	Engaged	-	Parents, 5 younger siblings	7 th Day Advent.	Primary school, sewing school	2
Faraja	24	Only wife	No	Husband, 3 children (1 child is not hers)	Catholic	Primary school	2
Fatuma	27	Second wife	Yes – one	1 child; sometimes husband and other child	Catholic	Some secondary school	2
Adelaide	Mid-30s	Third wife	Yes – two	2 children; sometimes husband	Non-practicing	Primary school	3
Yosefina	Mid-30s	Only wife	No	Husband, 5 children	Catholic	Primary school	3
Federika	Late 30s	Abandoned	Not known	1 child during school breaks	Catholic	Primary school	3
Goleta	Late 30s	Only wife	No	Husband, 5 children (3 of her own, 2 orphans)	Catholic	Primary school	3
Ndavalonge	Late 30s	Widowed, Only Wife	No	5 – last has different father	Catholic	Primary school, some nursing school	2
Sandina	Late 30s	Widowed, First Wife	Yes – one	4	T.A.G.	Primary school	3
Benedeta	Early 40s	First wife	Not known	6	Catholic	Primary school	3
Elizabeth	Early 40s	Only wife	No	1 child; another child and husband during school breaks	T.A.G.	Primary school, sewing school	3
Mama Kipara	Early 40s	First wife	Yes – two	8 children including 1 grandchild	Catholic	Primary school, health seminars	2
Mariam	Early 40s	First wife	Yes – two	1 child; sometimes husband and 2 other adult children	Lutheran	Primary school	1
Edina Longo	Late 50s	First wife	No	Unable to have children	Catholic	Some primary school	1
Mzee Mgogo	mid-70s	Widowed, First Wife	Yes – one	2 grandchildren	Catholic	No schooling, illiterate	1
Mzee Jirani	mid-70s	Widowed, Only Wife	No	Unable to have children	Catholic	No schooling, illiterate	1
Bibi Mdeme	Early 80s	Widowed, First Wife	Yes-one	2 grandchildren, one is mentally disabled	Catholic	Schooling unknown, literate	1

N.B.: T.A.G. is Tanzania Assemblies of God

family situations (Table 1). Twelve of the women were Catholics, four belonged to the Tanzanian Assemblies of God Church, two were Seventh Day Adventists, and one was Lutheran. Sixteen of the women had been or were married, seven in polygamous relationships. Five of the women were widows. Everyone over the age of 23 was married and either had children or could not have children. Women are expected to marry in their late teens or early 20s and have children within the first year of marriage.

Most of the women I knew when I lived in the village as a Peace Corps Volunteer. This purposeful sampling led me to information rich cases (Patton, 2005) and gave me another way to learn about my friends' and acquaintances' lives. These women introduced me to their friends and told others about my project. More women wanted to participate than I could accommodate and this snowball and emergent sampling gave me access to women I never would have met (Patton, 2005).

My interviews with the village women were supplemented by interviews with the doctor and nurse who have lived in the village for almost two years. The interviews lasted less than 30 minutes and focused on what types of health information they share with the women, the health media they distribute, and what questions women tend to ask. The data gained in these interviews informs my interviews with the women from the village. They gave me a better sense of what health communication the women have frequent access to and how health communications and information are presented. By comparing what the doctor and nurse said they taught about to what the women said they learned about, I got a better sense of what health information the women were absorbing during these clinic days and other visits to the clinic. For a full interview guide, please see Appendix A.

Interviewing women with whom I was already familiar, or who at least knew of me, had both advantages and disadvantages. Because the women already knew and trusted me and were aware of my penchant to say whatever was on the top of my mind, they were open, honest, and willing to ask questions about typically embarrassing topics. I felt a bit like Dr. Ruth as I answered questions about responding to a boy's advances, how to deal with a husband's disease-causing, philandering ways, and different methods of masturbation. The women said they couldn't ask anyone else those questions because women do not talk about sex and relationship issues among themselves or with men. For some reason, because I'm an educated foreigner, they assumed I knew much more about sex and relationships than I necessarily do. Though this belief might be misguided, it led the women to provide me with rich data about what sexual health information they seek. However, they also still associated me with my previous role as a Peace Corps Volunteer.

When I worked in the village as a Volunteer I often taught seminars or helped organize self-help and livestock groups. Many of the interviewees, after I explained what I was researching and why, thought I would help them start health information learning groups. Luckily, since a new Volunteer was there, I could say that she might lead groups and the expectation was lessened. The magazines I provided to each participant, the chance to ask questions, and my reputation proved to be motivation enough to participate even though I could not provide long-term help. I did not provide monetary or other compensation. Knowing this did not prevent some women from asking me if I would resume my role as a Volunteer and help fund another pig project, though.

Once the women understood that I was there to interview them about their lives and health magazines, we arranged times to talk. I interviewed each woman up to three

times, depending on their schedules. Usually the women remembered our appointments, but as is frequent in Tanzania, we often had to reschedule. The interviews, once they took place, lasted from 20 to 70 minutes, depending on how talkative the interviewee was and the number of interruptions. We met in a variety of private places, from living rooms to empty fields to empty rooms in other people's houses, but this did not prevent people from stopping by to ask a favor or kids from crying and distracting their mothers. Sometimes we were alone, but oftentimes we were joined by small children, the women's friends, or the occasional screaming cat. Though I intended to hold one-on-one conversations with the women, two women preferred to be interviewed together. I conducted all of the interviews in Swahili. I admit that during the first interviews, my Swahili was hesitant; I felt like I had developed a stutter and forgotten all of my vocabulary. Despite this, I still gathered important data and successfully conveyed my questions to the women. As the interviews progressed my language skills returned and the conversations went more smoothly, though some ideas were undoubtedly still lost in translation.

The first set of interviews focused on the women's personal stories and health education histories. It was important to understand the participants' personal biographies and experiences because they influenced how the women perceived and used health communication materials (Parrott, 2004b). During this initial interview, I asked about the women's families, their experiences growing up, local customs, and how they learned about menstruation, sex, pregnancy, and other topics. I initially tried to conduct this interview using very vague questions that allowed the women to decide on their own what stages in life were the most important, but that style of interview was very

unproductive. The women didn't seem to understand what information I wanted and frequently looked confused, so I changed tactics. When I started asking specific questions about events like beginning menstruation, school health lessons, and how they met their husbands, they answered directly. Some of my questions were met with a fair amount of giggling, though. It took me a while to realize that, in Swahili, "met with", "talked to", and "saw" could all be euphemisms for "had sex with." However, because of my rapport with the women, I was able to successfully navigate my way through the euphemisms. These interviews showed how and when sexual health information entered the women's lives. For a full interview guide, see Appendix B.

At the end of the interviews I gave each woman a copy of *Amua!* newspaper, *Fema* or *Si Mchezo!* Magazine, and a few photocopies of articles from *Fema* and asked them to look through them. The periodicals included articles and stories on HIV/AIDS prevention, life skills, healthy decision making, and other health issues. They were donated by Femina Health Information Project and Population Services International, both located in Dar es Salaam. I chose to distribute these particular magazines and newspapers because I knew copies of them had been available in the village for a number of years.

Each woman was interviewed for a second time at least a week after the first interview so they would have time to look through the health materials. I intended to focus these interviews on the women's reactions to these materials—did the materials meet their informational needs? What did they really want to know about? Then I hit my first major snag. Most of the women had very little time to look over the magazines. In addition to weeding the fields, many of the women were also planting trees in the nearby

timber forest. After working until early afternoon, they had to do household chores such as hauling water and bathing children. Who had time to read? Therefore, most direct discussions about the health materials were brief. It quickly became obvious that the women liked the magazines and would like to have more access to them, but couldn't really talk about them in-depth. I decided to change tactics and try a new line of questioning. "If you could write these magazines or ask questions of the writers, what topics would you focus on?" I queried (Appendix C). Most of the women were unaccustomed to being asked what they wanted and how they would tailor magazines to their needs. I became frustrated with some of the women's tendencies to list topics they had already read about instead of thinking up different ideas. This frustration is captured in a fieldnote I wrote after talking to Fatuma.

Getting answers from her is like pulling teeth! She only says it's good to teach about the stuff she already knows about and/or she read in the magazines. She isn't producing any new answers. In fact, she was hesitant to say anything really. The whole time we talked she had a stubborn, holding back look on her face. She has never been the most open person, but this was a bit extreme. I think what I mostly got out of this interview is that some people have a tendency to repeat official statements and opinions rather than expressing a willingness to explore new ideas about what might work and what might not.

Fatuma did not seem to be to be thinking about her answers. She had been avoiding the interview for a week and only consented to talk again because she knew I was getting annoyed and had to leave the village soon. This might have caused the lack of depth to her answers. Other interviews were much easier to conduct.

I conducted both rounds of interviews in tandem. I had begun the second round with some of the women while I conducting the first round with others. The overlap of interview types and the concurrent analysis of my data and my notes informed and

refined my data collection (Charmaz, 2000). After conducting a few interviews, I knew which questions were well received and which often led to confusion. I changed some of my questions and went back to interview a few of the women for a third time to confirm or refute some of the ideas women put forth (Patton, 2002). I wanted to know if others believed in magic curses and genies or the detrimental effects of birth control, topics that emerged during some of the initial interviews. After eight women answered consistently, I stopped my questioning and started wondering if I should be interviewing the genies as well.

I asked all participants for oral consent before the interviews.⁴ At the onset of the interviews I read the oral consent script (Appendix D). I explained that the research concerned their personal experiences and reactions to health materials. It would be used for my master's thesis and to help make health communication materials more useful and relevant to community members. Each woman was promised confidentiality and given the option to back out of the interview at any time. Confidentiality was ensured through the use of pseudonyms and through the storage of interview data, tapes, and field notes in a secure location.

I read the oral consent script to the women and explained the aims of my research to them before arranging the interviews. Despite these explanations, I'm not sure if all of them understood what the oral consent script meant. They said they understood the Swahili, but not necessarily the ideas behind it. A few asked direct questions—what exactly do you plan on doing with the information? Will others know what I say? You're studying journalism; will this all be in the newspaper you distribute here? Others

⁴ Written consent was not obtainable from the older women, who I interviewed for background purposes, because they could not read. Written consent also would have added a level of formality to the interviews that would make broaching health topics more difficult.

consented straight away even when they looked unsure. Only one woman, after hearing the consent form, refused. Others asked for the audio recorder to be turned off at certain periods. All of the women seemed to understand that I would not share their stories with others, though they double checked multiple times and sometimes tried to find out what others said. I did not quench their curiosity about their neighbors, however, and properly followed all consent procedures and ethical research methods.

The sounds of pounding rain, screaming children, and yelled greetings mixed into the audio recordings of all of the interviews. After some of them, I jotted down notes as the women eagerly listened to their own voices on the recordings, many for the first time. They all seemed pleased with how the interviews sounded. They also wanted to read the transcriptions of their interviews; it seemed novel to them to have their words typed out.

For the participants' privacy I planned on having the interviews transcribed in Dar es Salaam, the largest city in Tanzania, by people who had no connection to the research site. An incoming university student agreed to transcribe the interviews. I only wish he had followed through. He accurately completed about half of the transcriptions. Instead of reading and translating transcriptions, for the other half of the interviews, I listened to the recordings and took notes as I transcribed and translated them on my own. When looking at this situation positively, I could say reviewing and transcribing the interviews on my own improved my analysis. However, because Swahili is not my first language, it is possible that sometimes I misheard the words and transcribed them incorrectly, possibly changing the meaning slightly.⁵

⁵ The transcriptionist's failure to follow through on his promises even after he was paid also left me a bit disgusted. I hope my frustrations with the transcriptionist did not color some of my readings of the data. Frustration with one aspect of the research process has the potential to influence others.

After transcription and translation, the interviews, fieldnotes, and supporting health communication documents were analyzed using ethnographic and grounded theory coding methods (Emerson, Fretz, & Shaw, 1995; Strauss & Corbin, 1990). Strauss and Corbin's open coding involves "naming and categorizing data of phenomena through close examination of data" (Strauss & Corbin, 1990, p. 62). By examining the data to identify patterns, notable stories and experiences, cultural themes, and other information, I placed the data into categories. The coding process forced me to constantly review the meanings I saw in the data, consciously or not (Charmaz, 2000). Coding was also affected by my specific background and experiences, changing how I interpreted certain statements and memories (Emerson et al., 1995).

The research and coding was influenced by Charmaz's (2000) constructivist grounded theory methods as well. "Constructivism assumes the relativism of multiple social realities, recognizes the mutual creation of knowledge by the viewer and the viewed, and aims toward interpretive understanding of subjects' meanings" (Charmaz, 2000, p. 510). She stresses that data are reconstructions of experiences not experiences themselves. These reconstructions are created by both the researcher and the participant together; the results are a rendering of the participants' realities by the researcher. My role in creating the data cannot be ignored.

After open coding, I related categories to each other and to their subcategories (Strauss & Corbin, 1990) as well as to the literature (Cresswell, 2007). These patterns and relationships created themes that I further interpreted according to my own views, hunches, insights, and knowledge (Cresswell, 2007). From these themes I used inductive

processes to “create rather than discover theory” (Emerson et al., 1995, p. 167) about an ethnographic observation of sexual health communication in rural Tanzania.

Limitations of study

As with all studies, my own prejudices and biases colored my research. My connections with the women of Matiru built through two years of living and working in the village and subsequent visits affected my interpretations of their experiences both positively and negatively. My past experiences and relationships influenced the questions I choose to ask and how the answers were rendered (see Charmaz, 2000). This prior knowledge was helpful in directing my questions—I knew to ask Fatuma about her previous pregnancies, Ndavalong about her relationship with her husband, and Mama Kipara about the seminars she attended. I also knew when certain interviewees were lying in order to seem more “pure.” For instance, I was around when Virgeni told her mother she had sex two years ago though she denied it in the interviews. Although I could not be certain how often this happened, I knew that lying and giving answers that seemed more “appropriate” was culturally acceptable.

I am an outsider who was eventually accepted as an honorary member of the community, though two years ago, and a permanent outsider. I will never be Tanzanian, yet this status gives me a unique standpoint for interpreting the data. The data can be interpreted from both emic and etic perspectives (Patton, 2002). To understand both it is important to try to immerse oneself in the culture and try to think, see, and feel as one from that culture—become one with them as much as possible (Patton, 2002). I already began crossing the insider/outsider line at this site. However, during my analysis I have

been keenly aware of the tensions between the two perspectives and tried to see how each colors the data (Patton, 2002).

However, my intimate knowledge of the site and the interviewees also probably caused me to be biased towards certain participants and to value their answers more. I can't deny that I cared more about Elizabeth's and Sandina's answers than I did about Mama Kipara's or Yosefina's. I was more excited about interviewing them and pushed the interview questions further, though since I knew them well I didn't have to coax. The answers were deeper and more interesting and I probably looked for more meaning in them. This intimacy with the site caused me to ignore details as well. I had to remind myself to ask about events we experienced together. I never thought to take notes about settings or house decorations because they were so familiar to me. Despite this, my relationships with the research participants and my comfort level at the site helped me gather richer data than would be available at a new site. The women opened up to me because they trusted me.

My nationality and ethnicity probably affected the women's answers as well. Although the women were familiar with me, and in some cases were my friends, I am still a young, white American. The women could not think of me outside of my previous role as a development worker. This identity caused some of the women to view me as an expert in sexual health. It also caused certain assumptions about my vulnerabilities and proclivities.

After my first interview with Sandina we stayed in her sitting room to talk. Beneath a crumbling poster of the former president, she asked me questions about sexual urges and behaviors. In addition to her other questions, she wanted to know why *wazungu*

(white people) did not have as many sexual urges as Africans. It took me a while to convince her that not only do we have the same urges, we even fulfill them. Despite this, she still seemed to think I was above certain problems. During our second interview, as we sat in the kitchen frying dough over the fire, we talked about AIDS infections.

S: Ina maana hawa wote yaani

A: Hao wote!!

S: Wote!! ...

A: Mtu yoyote, hata mimi.

S: Anna, hamna

A: Inawezekana kama nafanya hiyo ngono ovyo hata mimi naweza. Hata mimi napenda kufanya.

S: Umepima?

A: Eeh, nimepima.

S: Ukaona salama?

A: Mnhh.

S: Nasema Anna hamna kuathirika...

A: Sijaathirika lakini ninaweza....

S: So the meaning is everyone [can be infected]...

A: Yes, all!

S: All!

A: Any person, even me.

S: Anna? You? No way.

A: It's possible if I have unprotected sex then even I can get it. Even I like sex.

[She looked at me incredulously.]

S: You've been tested?

A: Yes, I was tested.

S: You saw you were clean?

A: Yes.

S: Like I said, you, Anna, couldn't be infected.

A: I'm not infected, but I *can* be...

Because I am an American, my identity is always associated with wealth, a sign of power, and thus not with problems associated with poverty, like AIDS. My personal identity might have influenced her belief as well. Sandina knew my personality and how I interacted with people and thus may not have thought I would engage in risky sexual behaviors.

Power dynamics between me, the researcher, and the interviewees need to be considered when interpreting data (Airhihenbuwa & Obregon, 2000; Shefer, 2002 cited in Lesch and Kruger, 2004). My original role in Matiru was as a Peace Corps Volunteer. I was considered, to a degree, to be an outside expert. Having taught some of the women about sexual health topics and my association with mainstream health lessons – use condoms, don't have sex outside of marriage—some of the interviewees may have given me answers that they thought I wanted to hear.

Independent of the identity that they ascribed to me, the women may have tailored their answers in ways they deem to be more socially acceptable. Matasha and Ntembelea (1998) noted in their study of sexual behaviors among students that “it is also recognized that shame, or the desire to give socially acceptable answers, may lead to under- or over-reporting of certain behaviours” (p. 577). This desire to give the “right answers” was especially obvious during certain interviews. For example, Elizabeth asked me to turn off the recorder when she listed the questions she would want to ask health writers. She wanted to make sure her questions were good enough before I wrote them down. Ahlberg (1994) says research on sexual health is difficult because the researcher must rely on reported behaviors and stigmas might change what participants say. This desire to seem socially acceptable probably came through in my research as well when women denied discussing boys during their adolescence and shied away from answering questions about experiences with men. Additionally, “the meaning and experiences” the women shared “will always be influenced by the context within which they are conveyed” (Lesch & Kruger, 2004, p. 468).

The women's memories about their experiences were conveyed in a research context that they did not fully understand. Although they knew the word, *utafiti*, none of them had participated in research projects before. They questioned where the information would go and wondered if they would see the results in the form of a newspaper or report. Only the doctor and a couple of the primary school teachers instantly knew what research was and that I was "in the field." I am uncertain as to how this affected my data. The women seemed less inclined to help me because they saw the benefits of their answers and more because they wanted to talk to me.

The data are also limited because much of it is based on the women's memories. The details were not always retained. The memories themselves might have changed over time and their recollection might have been influenced by my questions or comments. Memories are not necessarily reliable data, but they highlight what the women valued enough to remember.

Practical limitations of time and money affected my study as well. Because I had only two months and limited resources for completing my fieldwork, I interviewed only 20 women. Additionally, if the interviews had occurred during the dry season, between May and August, the women would have had more time to read the magazines and give more feedback. My research schedule did not make this possible. The respondents were also often distracted by small children, pounding rainstorms, passing visitors, and the like. A baby cry cannot be ignored and the interruptions became part of the experience.

Despite the research's limitations, I still gathered valuable, reliable qualitative data. Because of my rapport with the women and my familiarity with the site, they shared information with me that they said they could not tell other women. They related stories

that gave insight into the changing communication networks in the village. The interviews also gave the women opportunities to ask questions they were too embarrassed to ask of others. The in-depth, face-to-face interviews provided a forum for the women to share their experiences and learn from mine.

Chapter Five – Faith

Most Tanzanians claim religious faith. Estimates say about a third of Tanzanians are Muslim, a third are Christian, and a third follow other religions, including traditional beliefs (University of Pennsylvania, 2007). Most people who live in coastal regions and on Zanzibar follow Islam because of the Arab influences. Missionaries spread Christianity to the interior of the country. Almost everyone in Matiru attends a Christian church. Oftentimes, though, people who say they follow Christianity or Islam still hold on to traditional beliefs in witchcraft, or *uchawi*. *Uchawi* takes many forms, from long lasting curses to instant killings. All of these belief systems influence how women in rural Tanzania react to health issues and influence how they perceive health-focused magazines.

Christianity

While a Peace Corps Volunteer in January of 2003, I returned to Matiru after a vacation to Zanzibar. My head still filled with palm trees and hammocks, I inquired after the local gossip, not thinking much could have happened in my two week sojourn. “*Wote wazima*—all are healthy,” replied Ndaivalongwe in standard form. She paused. “*Kasoro Virgeni*—except Virgeni.” Virgeni was the daughter of another close friend. She was 17 years old and studying at the secondary school in the district capital. Ndaivalongwe explained that while I was gone, Virgeni had gone crazy. She was speaking nonsense,

talking about bombs, and calling for people who had moved away years ago. Her parents couldn't control her so they took her to the district hospital about 75 kilometers away.

Concerned for Virgeni, but also for her mother, Elizabeth, I went to visit them at the hospital a few days later. Virgeni lay on a bed in the psychiatric ward, catatonic and drooling from the sedatives. The doctors knew no other way to treat her. After a week in the hospital her parents brought her home. The sedatives seem to have solved the problem, she was no longer rambling incoherently, and the doctors refused to test her for other problems. But she still wasn't back to normal.

At home, she spent most of her time lying in bed, staring at the wall, as neighbors stopped by to pay their condolences. Her mother fed her porridge with a spoon and waited. We all waited, but nothing changed. Then one day, about a week later, she just started walking. Silently, she stood up and walked out of the house. She didn't shake, she wasn't weak, and she didn't look around her. She just walked out of the courtyard and up the dirt path. Her mother grabbed her, not understanding what was happening. Together with another woman, she helped her silent but pliant daughter sit on a grass mat in the sun. I think that must have been it for Elizabeth. Her daughter had gone from a bright, slightly giddy teenager to a husk of a human. Virgeni was no longer there and the doctors couldn't help. But Elizabeth thought the pastor at the church could.

When Virgeni was rambling she sometimes talked about a boy at school and mentioned that he was something other than a friend. Elizabeth suspected something had happened between them as Virgeni, in her dazed state, referred to him as her fiancé. Such an indiscretion as sex before marriage indicated that Satan was at work, Elizabeth told me. As a devout member of the Tanzania Assemblies of God Church, a branch of the

evangelical church, Elizabeth believed that the only way to cure her daughter was to call the pastor and have her exorcised. Virgeni's sexual misbehavior caused this disease, so asking for God's forgiveness and calling the demon out could cure it.

I didn't go to their house on the day of the exorcism. I was familiar with the strange languages and cries that constituted praying in the Assemblies of God church. The intensity of their belief made me uncomfortable and the idea of exorcism seemed ludicrous. I went back the next day, and Virgeni talked to me. She admitted to her mother that she had had sex with the boy at school and that she regretted it. She never spoke of it again.

Four years later Virgeni and I sat in a bare living room talking about sexual health issues and her life history. Since her illness she's never quite been the same. She doesn't notice other people's reactions to her behavior; it's almost as if some of her inhibitions are gone, but she's keenly aware of other social expectations. She knows her mother told me about her confessions of sexual encounters, but during the interview she said she always refuses advances. Every question I asked concerning moral opinions on sex produced a church inspired answer—wait until marriage and avoid temptations. The church saved Virgeni and in return, Virgeni wholeheartedly espoused the beliefs of the church.

Virgeni and Elizabeth's story highlights some of the relationships between religion, health, beliefs, and sex, all of which affect how sexual health information is received. They, and many others in the village, believe that religious doctrine and faith in a Christian god should determine how you behave. If you falter, that faith can heal you

both emotionally and physically. In fact, Virgeni's mother originally joined the Assemblies of God Church because she believed being saved would cure her own illness. She says the conversion healed her and from that day forward she has followed the teachings of the church. Many of the interviewees, all of whom follow different forms of Christianity, say they have faith that God will guide them in the right direction and determine their futures.

God's plan led Salma, a woman in her early 20s, from Catholicism to the Seventh Day Adventist Church. She dutifully goes to church twice each Saturday and she dutifully waits for God to bring her a fiancé. Though she's ready to be married, and the boy she likes sent her text messages expressing his interest in her, according to religious and local traditions, she cannot answer him. The boy must always pursue the girl, she explained to me patiently. My proactive self wanted to prompt her into action...

A: Kwa hiyo unaweza kutuma message ukasema kwamba itabidi akupigie wewe?

S: Inawezekana lakini sasa kwa sisi hapa, yaaani, kwa mtu wa mungu tunaambiwa hivi kama ni mpango wa mungu hata kama tulivyosema hata awe na aibu vipio itatokea tu ataongea vizuri hawezi kuishia hivyo tu.

A: Kwa hiyo unasubiri? Huogopi atasema kwamba hajapenda?

S: Aha-che nasubiri kama atakuja, kama itaishia hivyo hiyo. Basi itakua hivyo.

A: So... can you send him a message that says he'd better call you instead?

S: It's possible...but for us here, I mean, for a person of God and faith, we are told that if it's God's plan, even if—like we talked about—even if he's shy it will still happen. He'll speak up. It can't just finish here.

A: So you're waiting? You're not afraid that he won't like it?

S: I'm waiting. If he comes, if it ends here... [she shrugs] That's how it will be.

And so she patiently waits for God to determine the next move. If she and others think God will determine their paths in life, especially their romantic paths, I wonder how open they are to health education magazines that say to determine your own future. Veronika said she trusted in God to bring her a husband, but she also said she was inspired by the

magazines' stories of youth who brought themselves out of poverty. Are a belief in God's will and a desire to take control and improve your own conditions contradictory?

The power of the magazines' behavior-changing messages, which focus on remaining faithful to one partner, waiting to have sex, and using condoms, are both reinforced and negated by religious lessons on proper behavior. For example, the Catholic Church is notorious for its specific lessons on sexual behavior. All of the Catholic participants mentioned the Church's prohibitions on birth control and condom use. Fredrika explains that because she was married in the Catholic Church, she can never leave her husband though he abandoned her two years before. Ndavalonge talks of being excluded from church community activities because she had an extramarital affair. Despite the severity of some of the Church's teachings, the Church also brings community members together and encourages mothers to talk to their daughters about STIs and be moral examples to them, reported many of the women. Some of these moral lessons and behaviors coincide with popular methods of AIDS prevention, such as waiting until marriage to have sex and not sleeping around.

Other Christian churches teach similar lessons. Veronika recounts what she was told at a Seventh Day Adventist seminar for youth.

V: Wanafundisha vijana na wanavyotakiwa kuishi.

A: Kwa mfano nini?

V: Kutunza miili yao, kwa kutofanya mambo ya ngono....kijana anayotakiwa kuyaepuka mambo hayo tusiwe...usipende mambo ya kwenye vikundi.

A: Anhaa.

V: Halafu ufanye kazi kwa juhudi ili kuepukana na tamaa hiyo ya ngono.

A: Anhaa kufanya kazi nyingi kuepuka vishawishi?

V: Mnha kwamba mawazo yatakuwa kwenye kazi.

A: Unaona ni kweli?

V: Ni kweli.

V: They teach youth how it is they should live.

A: Like what?

V: To take care of their bodies, to not do things like have sex.... Youth who want to avoid things like this [sex], we shouldn't...you shouldn't like to hang out in groups [with the opposite sex]...

A: Ah...

V: And work really hard to avoid the desires of sex.

A: Ah... if you do lots of work you'll avoid the temptations?

V: Mhhh... it's that your thoughts will be on work.

A: You think this is true?

V: Yes, it's true.

Many of the Christian organizations want the youth to remain abstinent, an idea consistent with much of the health-focused communication. In these instances religious organizations reinforce the magazines' messages. However, at the same seminar Veronika was told that women who use modern birth control pills must get cesarean sections if they ever give birth. Churches feed community unity and reinforce healthy messages while occasionally spreading inaccurate information. For better or for worse, the churches seem to have the power to influence the entire community with both positive and negative messages and inspire faith that can heal.

Uchawi

When Adelaide talks about *uchawi*, or witchcraft, she doesn't look hesitant or shy. She does not wonder if I'll doubt what she says. Adelaide does not question the existence of genies or curses; she's experienced them both:

Mwenzangu alifanya biashara... alisema itabidi natumikia majini. Yawe kama maume ya kwangu, mawili. Nikaona hapo siwezi, na akaua mtoto kwa ajili ya biashara, ndio nikaona siwezi kuishi naye, ndio nikaamua kuachane.

My [first] husband did business... he said, "I had better be served by genies, mine should be male, two of them." I saw that I couldn't—and he killed my child for the purpose of business. I saw that I couldn't live with him, so I decided to leave him.

Adelaide had told me before, in detail, about her husband's genies. When she first told me the story years before, I wasn't sure if I had understood her. I brought my Swahili-English dictionary to her house to confirm my translation. I had understood her correctly—she spoke of genies.

The genies looked like humans but had goat hooves for feet. Her husband bought them so they would steal from his competitors and improve his business. She explained that because both genies were male, when the husband was not home, they would molest her at night. Eventually, her husband had the genies kill her child to save money on expenses. Adelaide could not handle the situation and left him. Years later, after becoming the third wife to another man, she came down with a long-term illness. After doctors with modern medical training could not help her, she determined she was cursed. She is not sure who cursed her, but she recently visited the witch doctor to find a cure.

Although others are more hesitant to admit to it and despite adherences to forms of Christianity, all of the women I interviewed confessed to a belief in witchcraft. Some diseases are caused by God, I was told, but others are the work of magic. *Uchawi* caused Mzee Jirani's three month-old child to die and her womb to become barren. *Wachawi*, practitioners of witchcraft, can use lightening to cause miscarriages. A witch who worked as a primary school teacher seduced Elizabeth's husband then cursed him with impotence when he left her. People die suddenly or have lingering illnesses because they have been cursed. The women say they cannot explain how witchcraft works, only *wachawi* themselves understand, but they know it can affect one's health.

If people are cursed, only a witch doctor can heal them. Adelaide explains how a person knows if she has been cursed and how to treat it.

Ad: Kama umelogwa itabidi utumie kinyegi. Kama ni homa ya kawaida tu ukienda hospitalini, ukitibiwa unapona.

An: Kama umelogwa, unajuaje umeloga au una homa ya kawaida?

Ad: Baada ya kuugua, muda mrefu, hata ukipata matibabu ya kila aina hata ya hospitali, unabadalisha hospitali hii au ile, hakuna mafanikio yoyote kupata nafuu. Ndio unajaribu kwanza kwenda kwa mganga. Maana, kuna wengine kweli wanasema wanaongea uongo, wengi wanaongea ukweli kama ulivyo. Na ukifwatalia utapona. Ndio unajua kweli nimelogwa ... unaenda kwenye mganga fulani, akupikie ... unakija nyumbani utaona nafuu. Saa nyingine, kama usiku, kila siku wanakuja, wanakusumbua. Lakini kama umeishaenda kwenye mganga, ukapata dawa, utaona wanaogopa... wanaishia nje hawaingia ndani kutesa usiku.

Ad: If you've been cursed, you need to use local treatments. If it's a regular illness, if you go to the hospital, if you get treated you get better.

An: If you're cursed, how do you know?

Ad: After you fall ill for a long time, even if you get treatments of every type at the hospital. You change hospitals, this one or that one. Still there are no signs of improvement. So you try a local doctor. Some tell lies, some tell the truth....You know if you've been cursed...if you go to a certain doctor....he makes you a medicine, you go home and you are better. Other times, like at night, they [wachawi] bother you. But if you've already gone for the witch doctor, you've gotten medicine, you'll see that they are scared. They stop outside and don't go inside to disturb you at night.

Sometimes the traditional doctors make cuts in the patient's skin and rub in different local medicines. These cuts heal and the scars serve as protection against the curses.

Others mix different plants and roots together to make medicinal teas. Once the cursed person starts taking the medicines, the spirits of the *wachawi* can no longer visit their homes at night and perpetuate the illnesses.

Adelaide had just returned from visiting the witch doctor to seek a cure for vaginal sores. Thinking it was a typical illness, she sought help from three different hospitals and health clinics first, but the doctors never provided her with effective

treatments. After two years of failed treatments, the illness had worsened and she could no longer walk long distances or work in the fields. Though she had only been taking the witch doctor's medicines for three days, she said she felt a bit better. Her curse was lifting.

Such beliefs have potential ramifications for the effectiveness of sexual health magazines which are written from a western medical standpoint. Women who believe that others can curse them at any time may think they do not have control over their own health status. Curses are out of their control, so even if they take care of themselves they can still fall ill. Likewise, they may not be receptive to scientific explanations of illnesses and preventions because they blame some illnesses on witchcraft that they cannot explain. This may prevent them from seeking medical care from hospitals as well. On the positive side, however, the women still trust in the powers of traditional medicines, such as herbs and roots, that may in fact be very beneficial.

Local beliefs in Christianity and *uchawi* affect how the women perceive sexual health information. According to Salma, some Christians refuse to read the magazines because they openly talk about sex and condoms, which is discouraged in their congregations. Faith in supernatural powers takes control over and responsibility for sexual health out of the women's hands, making them less receptive to behavior change and sexual health messages spread through magazines and other forms of health communication.

Chapter Six – Life Lessons

I interviewed women from three different generations on how they learned about sexual health. All of the women over the age of thirty received similar formal and informal lessons as they went through puberty, got married, and began raising their families. Their daughters, who came of age in the past decade or so, and the younger women I spoke with received somewhat different sexual health lessons. The following chapter outlines how and when women from the study site typically learned about sexual health and how this has changed for their daughters' generation.

The Mamas

Puberty

Unyago—Initiation

Elizabeth was at school when she started bleeding. She had no idea why.

Nimetoka shuleni nikajisikia damu zinatoka nikaenda nyumbani nikalala asubuhi nikamwambia mama kuwa, “Mimi naumwa.” Mama hakunielewa. Nikasema sasa, sijui nisiende. Akasema kwani kuumwa huko unaumwaje? Nikasema damu hizi zinatoka sielewi ni nini? Aah akasema usiende shule utabaki hapa hapa ... ndani kama uko chumbani. Nikakaa, akasema sasa usiwe unatoka nje. Yeye akaenda kumwambia shangazi nyumba ya jirani akaja ilikuwa jioni siku hiyo. Akamuita, akanifundisha namna ya kuvaa, kuzuia na kitambaa.

I left school, I felt the blood coming out. I went home and slept and in the morning I told my mother, ‘Mama, I’m sick.’ She didn’t understand me. I said, ‘I don’t know. I shouldn’t go.’ She said, ‘Why? What’s wrong?’ I said, ‘This blood is coming out. I don’t understand what it is.’ ‘Aah,’ she said, ‘Don’t go to school, stay here...inside this room.’ I stayed; she said ‘Don’t go outside.’ She went to tell my aunt, who lived next door. She came that evening and taught me how to wear cloths to prevent the blood [from showing].

Elizabeth remained alone in the room for three days. She ate, cooked, and slept alone. On the fourth day she was taken away from the village, into the fields and trees, where a group of older women awaited her. “They laid me down, they said lay down so we can look if really you did [start menses]. I lay down because I didn’t understand. I lay down and other woman positioned me like this.” As she recounted the story, she spread her legs wide, exposing her vagina.⁶ And then, she explained, they began to cut her inner labia, the skins around her clitoris.

They held me down as they did it, Sandina explained, recounting her initiation. They pulled off my clothes, held me down, and covered my face with a cloth. I didn’t know what was going to happen and it hurt when they cut off the skin. The pieces were like this, she said as she pointed to the top joint of her finger. They left the middle there. In other places, they cut out everything until the area is just open. After they cut, they spread medicine on the area to help it heal. It hurt when they did it. It hurt me. “They cut it because if it remains there, it will drain your health, they say. It’s something to remove... When you grow, it grows so you have to cut it.”⁷

Not all of the women in Matiru were circumcised during initiation, or *unyago*. Though circumcision was required for all Hehe girls, Bena girls did not necessarily go through the process. The Bena women who grew up in mixed Hehe-Bena communities were circumcised. Those who grew up only with other Bena were not. All of the women, however, received similar lessons about interacting with men, sex and pregnancy, showing respect for others, and caring for their bodies. Some women were given the lessons on the day of their circumcision. Others were allowed to heal for a few days before being taught. Many of the Bena women sat alone for seven days before receiving

⁶ *Wakanilaza. Wakasema lala tuangalie kama kweli wewe umefanya hivyo uko hivyo. Nikalala, kwa sababu nilikuwa sielewi, nikalala mwingine akanikalia hapa (anaonyesha).*

⁷ “Kitu kikikaa kwako, kitakunyonya afya, wanaposema wao. Ni kitu cha kutoa... Unavyokua, kinakua ni maana tunavyokitoa.” Sandina’s entire explanation is drawn from her words, however, Sandina does not tell linear stories. I used her own words but rearranged them for clarity.

the lessons and gathered a piece of firewood each day to represent the seven days of menstruation. The firewood was used as a visual representation to teach the girls about menstruation. All of the women I spoke who were more than 30 years old told me similar stories about the initiation process and the lessons they received.

Ten to 20 women usually gathered to lead the girls through *unyago* into adulthood. Through songs, dances, and poetry they passed on cultural and health lessons. A woman would sing a song about wearing cloths inside underwear to make sure the menstrual blood was not visible. Another woman would sing a different song or give an explanation to make sure the lesson was understood. In this style, the girls were told that they had become adults. As adults, they could no longer play with the younger children and must always show proper respect to other community members.

The main lesson the older women stressed was that the girls could no longer talk to or play with boys. “They taught me that since I have already had my first period, I should not like to go about with boys,” said Ndaivalonge. “That is to say, if I go with men, I can get pregnant.”⁸ The older women constantly repeated: do not talk with men or walk with them or be around them until you are married. The girls were taught what sex was but only so they knew to avoid it. The younger women I spoke with did not go through the initiation process and did not mention it or circumcision until I mentioned it.

School and friends

The health lessons Elizabeth and her contemporaries received at school focused on cleanliness—how to wash clothes, sweep the house, and bathe properly. They did not

⁸ *Walikuwa kunifundisha wakati ukiwa umeishavunja ungo, usio na kupendelea kutembea na wanaume. Maanake ukitembea na wanamume, utaweza kupata mimba.*

learn about puberty, sex, or pregnancy because these lessons were taught in private during *unyago*. The older women did not want girls who had not entered puberty to know anything about the changes that would take place or what would happen if they had sex. The adult women felt that girls should not learn about sex when they are too young and without accompanying warnings that explain the dangers of sex.

After girls experienced *unyago*, they were told not to talk to their younger classmates about the process. Sandina said she was told not to warn the younger girls because then they would be afraid of the process and refuse to go. They were only to befriend other girls who had also started their periods because they were also adults. Though they could talk to the other girls about *unyago* and their bodies, they were encouraged not to talk about boys. Of the older women I interviewed, only Ndavalonge admitted to talking to her friends about boys. She was even brazen enough to tease men directly.

A: Mlizungumza kuhusu wavulana?

N: Wavulana? Wavulana? Bas, ni kweli tulikuwa kuzumgumza. Maanake sisi wakati tulikuwa shuleni tulikuwa wakorofi....tulikuwa wajanja! Kwa mfano, kuna siku, tulikuwa na usanyiko, tulisherekea sikukuu ya Sabasaba. Sasa pengine, utakuta mwanamume mwegine akaona labda msichana anampenda, labda, nani, sehemu za siri yanavimba sana... kuna siku tulimtania... sijui kama utaelewa... tulikwambia kwa kilugha. Alitukimbiza! [anacheka]

A: Did you talk about boys?

N: Boys? Boys? Okay, it's true, we talked about them. That is to say, when we were at school we were troublemakers....we were jokesters! For example, one day, we were all gathered together to celebrate Sabasaba [a political holiday]. Sometimes, if you see a man and maybe he's looking a girl he likes, maybe, his private areas swell up a lot. That day we teased him...we told him so in kibena [local language]. He ran us off! [laughter]

Ndavalonge openly recalled her experiences, but she was quick to reprimand herself. She knew that her behavior was not acceptable by local moral standards. Ndavalonge was

also more willing in general to admit to her faults and how she deviated from cultural norms and expectations. I think part of her openness was due to our close friendship. Though Ndavalonge is bolder than most of the women in the village, I think her admittance to talking about boys might be a bit more honest than other women's stories. Other women said they occasionally discussed love proposals from men but that was all. I wonder if they simply do not want to admit to talking about boys because it might reflect badly on their characters.

Marriage

Courtship

During initiation the girls were told that after a few years they would be married. They would meet boys, the boys would decide they liked the girls and the girls would be pursued. Elizabeth said the women taught her not to talk to a boy about love until they were preparing to marry some time in their late teens or early 20s.

Mnaweza mkazungumza kama mnaongea mambo ya kawaida lakini sio kuhusu mapenzi eeh mambo mengine tu mnaweza mkaonge kama anakuuliza kitu kizuri unaonge lakini sio kuhusu mapenzi hayo ndiyo walinikatalia kabisa wakasema mwiko mkali kabisa binti kukaa na kuongea na mwanaume kuhusu mapenzi labda mpaka aje atakapoongea kwamba wewe nakuoa, ninapenda kukuoa atafika nyumbani kwa mzazi, kama hapa atakuja kama wewe ulipokuja hivi halafu atasema mimi ninashida hii nah ii labda baba atakaa kile chumba kingine kama hicho mimi nipo huku ataongea atasema mimi nakupenda halafu kama mimi naitasema haya basi ataleta barua kwa wazazi ... atakuja kuleta tena mahari halafu ndio mtafunga harusi. Mkifunga harusi ndio mtaenda kufanya mambo ya ndoa.

[Men and women] can talk to each other if you are talking about normal things, but not about love. Other things only, like if he asks you something good you can talk to him but not about love. Yes, they [her parents and the old women] completely refused, they said it is strictly prohibited for a girl to sit and to talk to a man about love. Maybe until he comes and says I want to marry you. He'll arrive at the parent's house and he'll say I have an issue to discuss. Maybe the father

will sit in another room while I'm here and the man will tell me he loves me. Then, if I say yes, that's it. He'll bring a letter for the parents...they'll plan the bride price...he'll bring it, you'll have a wedding. Then, if you get married, you can perform the "act of marriage" [sex].

Flirting is not acceptable until the man asks to marry the woman. The woman is told to wait until the man initiates romantic interactions. However, if a woman in rural Tanzania decides to take an active role in pursuing a relationship, she is considered dirty. As Salma explained,

kwa sisi huku, ikitokea hivyo, binti ukijirahisi kama hivyo, sasa ukaachika, na jambo kama hilo kwamba binti anajirahisi? au ni muhuni sana? ni malaya sana? Kwa hiyo jambo kama hilo hata kama umependa vipi ni ngumu.

for us here if it is like this, [a girl responds to a boys' advances and calls him], a girl cheapens herself, then you cause [the advances] stop. [He questions,] "Is she cheapening herself? Is she morally declined? Is she a prostitute?" So things like this, even if you really like him, are hard.

Boys pursue girls, men pursue women. As soon as women start to take pro-active roles, they are seen as cheap. From the courtship on, men take the lead and control the relationships, even for today's modern youth, like Salma.

Elizabeth followed the cultural courtship instructions—she didn't pursue her husband or speak to him about relationships, *he* sought *her*. She recalled all of the details—he was a teacher at the local primary school. Though he had seen her before in the village, it was not until she met him on the old road through the woods that he took notice of her. She was walking with her friend on the way to town when they encountered him on the path. They all chatted for a while and as she and her friend continued on their way, she saw him gazing after her. "He was looking at us," she said. "And we thought, that guy, I don't know, what's he looking at?"⁹

⁹ *Yeye akawa anatuangalia, sasa tukafikiri huyu mtu, sijui, anaaangalia nini?*

Elizabeth began assisting the first grade teacher soon after and he became more interested in her. He went to her house and met her parents. As she escorted him away from her home, he said he loved her and would she have sex with him in the woods? “I said, ‘You’ll hurt me! I don’t want to!’ He said, ‘Okay, if you don’t want to, fine.’ He left and went home. Later he brought me a letter and again said, ‘I love you, let’s live together.’ I said, ‘Okay, let’s live together and get married.’”¹⁰

The Wedding

As the wedding approached, the older village women taught Elizabeth how to live with her husband. “Have good manners and submit to him, your husband. Don’t be strict with your husband and respect your mother-in-law. Then my mother told me if your husband needs your body, don’t refuse him. Agree to it.”¹¹

Most of the lessons the women received around the time of their weddings focused on sex and respect. Sex was encouraged, except during menstruation. Ndaivalongwe remembered being told if she has sex during her period, her husband’s penis would become limp and he would be impotent. Fredrika and Benedeta giggled when I asked about the wedding lessons and declined to say more than “how to have sex.” Bibi Raheli refused to tell me any details about wedding lessons because I did not yet have a fiancé. The older women also told the brides what to expect when they became pregnant. They told them the warning signs, such as nausea and cravings, and said they would learn

¹⁰ *Nikasema utaniudhi, sitaki! Akasema haya kama hutaki, basi. Akaondoka, akaenda nyumbani. Basi akaniletea barua. Tena akasema mimi nakupenda tu tuishi. Nikasema haya tutaishi wote, tutaonana baadae.*

¹¹ *Kwamba uwe na tabia nzuri umtii, mume wako. Usiwe mkali kwa mume wako. Mama mkwe, nae umuheshimu. Halafu mama akaniambia, mume wako, akihitaaji mwili wako, usimkatalie ukubali.*

the other details later. Tanzanian women are expected to become pregnant within the first year of marriage. The brides also learned how to clean the house properly and the necessity of cooking every meal for their husbands, unless they are sick or traveling. Sandina's lessons also came with warnings—you'll meet with hardships and annoyances, but as a wife, you must bear them.

Married Life

Elizabeth lived with her husband for two years before he cheated on her. He started sleeping with another primary school teacher. They walked together and talked together like a couple, Elizabeth lamented. Everyone knew about it. Before he started cheating, they raised their child together in a house on the school grounds. Elizabeth had become pregnant with their first child, Virgeni, within a few months of their marriage, as was expected of her by society. They loved each other and were happy. Since his affair, however, "he's upset with me. He doesn't want to love me, even now [almost 20 years later]. I have no happiness with him because of him."¹²

Elizabeth's history is not atypical. Most of the women I spoke with told stories of abandonment. Sandina's husband, after 12 years of what she describes as an intensely positive physical and emotional relationship, took a second wife and started ignoring her. Mama Kipara compared her life to that of a pig's—her husband lives with his other wife and only visits her to impregnate her because bearing children is necessary in Tanzanian society. Fredrika has not seen her husband in over two years. The women do not seem to like their situations, but they feel they can do nothing about it.

¹² *Akanichukia. Hataki kunipenda mpaka sasa. Sina furaha naye kwa sababu yake.*

After six months of marriage, Ndavalonge's husband went to live in a different city and only returned to visit her a few days a year.

A: Kwahiyo ulijisikiaje kuhusu hii?

N: Kwa kweli, kuhusu hii, sikusikia vizuri kwa sababu kuna wakati nyingine ni sawa, sisi ni binadamu. Unaweza pengine kuona kuna muda unapenda sana kumuona mwenzio, lakini uwezo kumona haipo. Kwa hiyo, pale unakosa amani. Pengine unakuwa na mawazo me-e-engi... Basi tu! ... Kusema ukweli kipindi nilisikitika sana.... pengine hatumii hata kitu chochote vya familia...nusu mwaka mzima imeisha hakuna kutoa sabuni wala hela cha kusagia au nguo ya mtoto.... Namuliza, kwani uko uliko unafanya nini? Sawa, nafanya kazi...nafanya nakula mi mwenyewe.... Kuna muda nilifikia hata kumtaarifa wafi, mimi bora nikinywe sumu kuliko maisha magumu kama haya...

A: How did you feel about that?

N: Truthfully, about this, I didn't feel very good because there are periods... we are human...Sometimes you can feel you really want to see your husband, but the ability to see him isn't there. So you lack peace. Sometimes you have so many thoughts, but that's it! Really, during that period I was saddened... Sometimes he didn't send anything for his family. Half a year finishes and he doesn't give soap or money to grind the corn or clothes for the children.... I asked him, 'Why are you there? What are you doing?' 'Fine, I'm working,' [he says], 'I work and I use it myself...' There was a period when I even told my sister-in-law, it's better if I drink poison than to live a life like this...

Not only do the women regret the lack of attention, they feel their husbands' behaviors are hurting their families. They are no longer providing for their children. None of the women mentioned being able to change their situations. If their husbands left, they had no choice but to accept it. Women are taught during their weddings that men have control and that they must show them respect, even when the men do not show them respect in return. The women seem resigned to this lack of power and do not question it.

Sex

Just as the men have the power to decide if they will live with their wives or provide for their families, they have the power to make decisions about sex. Though

every relationship is different, there are conventional teachings. If a man asks his wife to have sex, she should never refuse, explained Benedeta and Fredrika. She can say she is tired or on her period, but to refuse outright might invite suspicions. The husband might assume the wife is sleeping around. If a woman sleeps around it is *mwiko*, or bad behavior. If a man sleeps around, it is simply expected and accepted. “Men can’t go for very long without sex, so if he’s not coming by the house, he’s sleeping around,”¹³ explained Benedeta. Even Goleta, who describes her relationship with her husband as mutually respectful, says it is expected and normal for men to sleep around. What can you do? One thing the women indicate they cannot do is try to get their husbands to use condoms when they have sex together.

Benedeta says that condom usage depends on each couple, but if a woman asks her husband to use protection, he will suspect she is sleeping around.

Inategemeana na wamanifu wao pale nyumbani, kama atampa, kama anamelewa mke wake, kusema anatembeaje, lakini sio rahisi, atakuuliza kwa nini unaomba? Kwa nini unastuka nini?.....Maana sisi wanawake hatuna nguvu zaidi za wanamume. Sasa, kama ni mume wako atakuuliza, kwa nini unaomba kondom? Kwa nini, una wasiwasi gani? Umetembea nje au?

It depends on how much the couple trusts each other at home, if the man will give the woman a condom [to use], if he understands his wife...but it’s not easy. He’ll ask you, “Why are you asking to use one? Why? What are you alarmed about?” I mean, we women don’t have more strength than men. If you ask your husband, he’ll ask you.... “What are you worried about? Have you gone outside of our marriage or what?”

Men can question women but women cannot question men. Benedeta’s comment on condom use also followed a typical speaking pattern.

When discussing relationships between men and women and husbands and wives, all of the interviewees carefully stated that every relationship is different and every

¹³ *Wanamume hawawezi kwenda bila ngono. Kama hapitii, anaenda nje.*

couple has their own arrangements. Within minutes, they invariably would make a generalization about the way men treat their wives. “Of course the men will cheat on you, that’s normal,” said a majority of the women. “Ask your husband to use a condom? Why would he agree to that?” All of the women I interviewed expected the men to control and drive the relationships and to have sex outside of the marriage. And yet all of them viewed marriage as a necessary thing.

I find it hard to absorb this information, analyze it, and present it without a personal and cultural bias. When I hear the women talk about their marriages, I rarely hear them use terms of affection. When speaking of the negative aspects of affairs and polygamy, the women complain that their husbands give their money and resources to other women. Sandina says that she and her four children would receive as much sugar as her co-wife and her one child. Though Ndavalonge sought sex outside of marriage to compensate for her husband’s absence, she often focuses on his neglect of his family, not of her affections. The women speak of relationships more as arrangements and less as romantic affairs. I think I’ve seen too many Hollywood movies to be able to look at this situation objectively and as a cultural relativist. The lack of affection and mutual respect strikes me as unhealthy though many Tanzanians I have spoken with seem to think nothing of it. They do not seem concerned that Swahili has only one word, *kupenda*, for like and love; they do not distinguish between the concepts.

The women I spoke with accept their marriages but do not necessarily like them. They feel powerless to change their situations. I know from experience that this is not true in all Tanzanian marriages. Some couples live together and raise their children together without extramarital affairs. In these relationships, the women have just as much

say as the men when decisions need to be made. However, I have met fewer women with relationships like these than I have women who are married but, in literal or figurative senses, live alone.

These imbalanced relationships, wherein the women run the houses but the men wield the sexual and fiscal power, are accepted as normal by the women I spoke to at the study site. This may be why most of the women did not understand the sections of the magazines that focused on gender and relationships. The Swahili word for gender, *ujinsia*, meant nothing to them beyond a person's physical sex. The Swahili word for relationships, *mahusiano*, was only seen as primarily referring to sexual interactions. The women did not seem to think that gender roles could be questioned or that relationships could refer to a larger pool of interactions. They did not see themselves as capable of inciting change in their relationships because dichotomized gender roles were too ingrained in the lessons they received from the older generations of women and examples they saw in other relationships.

Friendships

Women, for the most part, keep their sex lives to themselves. They do not ask each other about their relationships with their husbands, and they do not usually give each other advice. Fredrika seemed surprised that American women bother to talk about sex. Why would should we discuss our sex lives, she wondered, when you already learned about sex through experiences at home? Sex as a pleasurable activity was not discussed. However, I do not think this silence about sex sits well with all the women.

While I interviewed Sandina, she mentioned sex with her husband often enough to indicate that she enjoyed her sex life before he took another wife. As we closed the

interview, I asked if she had any questions. At first she only mentioned wanting to know different ways to deal with her sexual urges now that her husband had passed away. I turned off the tape recorder thinking a short explanation of masturbation would shock her enough, but I inspired a rush of questions and stories. She told me in detail about her favorite sexual positions and acts, she inquired about how white people have sex, and wanted to know about my own personal experiences. Sandina seemed ready to explode. She had always wanted to talk about the joys of sex, but she had no one to join her in the conversation. She pointed to parts of her body and mine and used gestures to indicate where she liked to be touched. I answered her questions and let her talk, but I was admittedly jarred. Conversations with Tanzanian women about sex never usually get beyond acknowledging that oral sex is possible. I wasn't sure how to react. The experience made me wonder if other Tanzanian women were also seeking confidantes for talks about sex. The silence about sex, though culturally mandated, may not be individually desired.

Although the women kept their experiences private, many of them mentioned talking with other women about STIs that might affect their children (GOLETA 18). The importance of talking about STIs and UKIMWI with other women was stressed by all of the women I interviewed, but some of them felt they did not know enough to really talk about it. Fredrika made frequent mention of the need for more health seminars so they could properly advise each other about protecting themselves. However, advice giving among adult women is rare.

A: Kwa hiyo, watu hawaangaliane? Kwa mfano, kama unajaribu kufanya kitu cha hatari?

F: Kwa kuongelea, labda inapatikana mmoja, unaweza kupata mwazi anaweza mmoja akaja kukuambia. Lakini sio wote, hawawezi kuwaambia. Moja, moja tu.

Ni yule, kusema labda majirani yako au wao wanakupenda zaidi lakini wengine wanaweza kuwaacha tu. Wanaona ni vibaya, wanakuangalia tu, hawawezi kusema.

A: Do people look after each other? For example, if you are trying to do something dangerous, does someone talk to you?

F: To talk about it, maybe you can find one person. You can get an open person who can come and tell you [advice]. But not everyone, they can't all tell you. One only. A person, maybe who is your neighbor or who loves you a lot, but many can only let you be. They can see you are doing badly, but they can't say anything.

Women only accept advice from close friends, but this does not mean women are not talking about other people's problems. Sitting in houses and in public spaces, I frequently listened to the women gossip about affairs, illnesses, deaths, and other village events. As Elizabeth said, they may not give each other advice, but they certainly talk about their bad behaviors behind their backs. For example, the women were quick to tell me about Ndavalonge's extramarital affair as soon as I entered the village; they wanted to make sure I knew I was living with a woman who misbehaved according to cultural standards.

Mabinti

In their mothers' eyes...

When Elizabeth's daughters, Virgeni and Happy, hit puberty, Elizabeth taught them to wear cloths in their underwear to prevent the blood from showing, just as her mother had done. However, because circumcision was criminalized and the women were afraid to take the girls into the woods even for lessons, her girls did not go through *unyago*. Elizabeth had to teach them the other lessons as well. She recalls,

Tukawafundisha kwamba wawe na tabia nzuri wasiwe na tabia za kujamiana na wanaume ovyo. Kwanza niliwakatalia kabisa kuhusu tabia za kujamiana na wanaume mpaka waaje wamalizeshule halafu waje waolewe wapate mchumba wakipata mchumba watafunga harusi basi ndio wataanza kufanya mambo kama hayo... Tuliwaeleza wa damu

inatoka kwa sababu waawe tayari umeshakua mtu mzima... ukitembea namwanaume hii damu haitatoka tena ina maana labda utakua umeshika mimba...haitoki labda tena ukishajifungua ndio inatoka mpaka miezi tisa...

We taught them to have good manners and not to have behaviors like having sex with men carelessly. First, I disallowed them to have sex with men until they finished school then when they get married. When they get a fiancé and have a wedding, then they can start to do these things... We told them that the blood means they are already an adult and if they go with men then this blood will stop and it means maybe you are pregnant... The blood won't come again until you've already given birth, until nine months...

Elizabeth passed to her daughters the lessons she learned from the older village women, but she did not reinforce the ideas through dances and songs. It was a family discussion instead of a community event. The girls learned basic information and moral lessons about their bodies and sex but did not receive community reinforcement of the ideas, except at church. The lack of community reinforcement may be why many of the girls in Virgeni's generation reportedly do not follow the cultural expectations of abstaining from sex until marriage. All of the women I interviewed, old and young, said youth these days are having more out of wedlock sex than other generations.

Although the mothers said they taught their daughters about puberty, sex, and abstinence, some of them said their lessons were unnecessary because the girls already knew. The girls learned about puberty at school when they were too young, complained Benedeta. She and Fredrika spoke at length about the dangers of teaching youth about sex and condoms at school. Knowledge leads to experimentation and once the girls know the joys of sex, they will never stop having it. Benedeta and Fredrika expressed more extreme views than most of the women. They frequently and adamantly opposed youth learning anything about sex other than to avoid it.

Other women said they thought it was important to supplement the school's scant puberty lessons with more information. Although Goleta had her mother-in-law teach her daughter about wearing cloths during her period and how to get pregnant, Goleta herself taught her daughter about sexually transmitted infections.

G: Mimi nikakae naye nikamuelezea (kuhusu magonjwa)...utembe kama hii, uwe na tabia nzuri, usionyesha kwa wenzio, kuna magonjwa mengi yamejikoteza. Kwa hiyo, ukijiangalia wakati unatembea.

A: Kwa hiyo, wewe huoni aibu kuongea na mtoto kuhusu ugonjwa kama haya?

G: Sitaona aibu. Kama sitamwambia atajifunza kutoka nani? [anacheka] Siwezi kuona aibu.

G: I sat with her and explained to her (about diseases)...walk like this, have good manners, don't show yourself to others, there are many diseases around, so look after yourself when you are going about.

A: So you aren't embarrassed to talk to your child about these diseases?

G: I will not be embarrassed. If I don't tell her, who will she learn from? [laughter] I can't be shy.

Goleta, Elizabeth, and other mothers see the importance of being open with their daughters, at least enough to protect them. Fatuma, who became pregnant in secondary school and now has a nine-year-old daughter, is especially emphatic that her daughter needs to learn about the dangers of sex as soon as she is old enough. Not enough youth understand the dangers. If they only have a small amount of knowledge, they start to experiment, these mothers expressed. Adelaide emphasized that their children are vulnerable so they as mothers must stand up for them. Most of the mothers seem to be trying to compensate for the lessons their daughters are not receiving from *unyago*. Some of the daughters, though, think they still are not learning enough.

What the Youth Say

Elizabeth's daughter, Virgeni, recalled the lessons her mother taught her when she started her period about six years before: wear cloths to hide your blood, don't have sex

until marriage. These lessons were not new to her. She had learned the same basic facts about puberty and sex at school the previous year. Short lessons on puberty had begun to supplement health lessons on cleanliness and nutrition. The other four youth with whom I spoke said the same things. They learned basic information about puberty and pregnancy from their mothers and primary school teachers. The two girls who continued onto secondary school, Monica and Virgeni, said they learned more details about reproduction during the second year of secondary school. The young women also admitted to another source of sexual health information that their mothers denied—their friends.

Virgeni's friends in secondary school gave her love advice, though the advice focused on avoiding love until she's ready to be married rather than seeking it.

V: Tulikuwa tunazungumza jinsi ya _ _ _ _ ya _ _ _ _ kujiepusha na wanaume... na njia ipi ni nzuri ya kutumia wakati wewe ukiwa umeshaolewa na uko na mme wako, utapanga na unapanga njia gani ambayo itakuwa nzuri kuliko.

A: Lakini wengine hawajasema aah! _ _ nampenda mtu au mtu amesema amenipenda

V: Kuna baadhi ya watu walisema, lakini tulikuwa tunawashauri kusema kwamba si vizuri wakati uchanganye mapenzi na masomo.

V: We discussed how to....to.... keep ourselves away from men.... And what is best to do when you are already with your husband, you plan what path is best to take.

A: But others didn't say that they liked a certain person or a person said he likes her?

V: There were some that said this, but we were advising them, to say that, it's not good to mix love with studies.

Virgeni seemed very keen on coming across as a well-behaved youth who always listened to her parents. Though I knew she had already experimented with sex, and she was aware I knew, she never admitted it. She wanted to seem like the cultural ideal—a pristine young woman who would never even think about having sex. I received similar answers from both Veronika and Salma, though I do not know about their sexual pasts.

All three of these young women also share another trait—they are very religious. They belong to evangelical churches, Assemblies of God and Seventh Day Adventist, which adamantly oppose premarital sex. On the other hand, Faraja and Monica both admitted to having sex. Faraja even lived with her husband before they wed when she was 21. Religious beliefs influenced how the young women spoke with me and, reportedly, with each other about sex.

Women received a proscribed set of lessons about their sexual health and behaviors. From puberty on they were taught basic lessons about their bodies and pregnancy and taught only to have sex after marriage. Each generation of women was taught about their role as subordinate caretakers and that men have the dominant roles in relationships. The lessons were the same for all of the women, but the younger women learned about the topics through different means. The older women learned about puberty and sexual mores through community-led initiation ceremonies and from groups of women at the time of marriage. The younger women learned the same lessons from school, magazines, their friends, and their mothers. Although the messages were similar, they were not reinforced by the community.

This lack of community reinforcement may have had both positive and negative effects on the younger generations' sexual behaviors and beliefs. The younger women may have started experimenting with sex earlier and been exposed to more STIs because the abstinence messages were not reinforced by the community. Cultural lessons about gender roles were also not being reinforced in a formal way, which may be seen as positive, though the younger generations witnessed the subordinate decision-making roles

of their mothers and grandmothers. The changing communication networks between women might have affected the women's sexual mores and behaviors.

Chapter Seven – Health-Focused Magazines

I sat in Salma's living room staring at the walls as she listened to the recording of her interview. Eventually I grew tired of trying to read the small print of the South African real estate ads that papered the room. Knowing the cost of luxury homes in Johannesburg did not change my discouragement. None of the women I interviewed for a second time had had any time to read the magazines I had given them. Their excitement at receiving the glossy, colorful copies of *Fema* and *Si Mchezo!* did not seem to motivate them to do more than flip through them. I recognized that the women were very busy in their farms and working in the forest, but I was still frustrated. Few of the women had ideas on how to tailor the magazines to their needs either. The magazines are great, they seemed to chorus, we just need more. Morose from another uninspiring interview that differed so greatly from our first interaction, I began to examine the decorations hanging from the ceiling. Salma had tied together scraps of cloth from her sewing business and strung them along the corners of the room. In the center, she hung cut up copies of *Si Mchezo!*, the health magazine I wanted her opinion on.

After she finished listening to the recording, I asked her about them. "What do you do with the magazines when you are done with them?" I inquired. She said she shared them with friends sometimes. I pointed to the ones on the ceiling. "Oh those!" She laughed, understanding that I thought they were the magazines I had given her. She quickly explained that they were old copies of *Si Mchezo!* given to her by friends from

the district capital that no one else was interested in reading. “You can’t always find someone else to give them to,” she said. “People, especially religious people, don’t want to read them because they talk about sex. When you finish with them, you turn them into something else.” She spoke to me like this was obvious. “I made decorations, she patiently explained. Other people use them to roll cigars.”

Currently Available Magazines

Although currently available health-focused magazines were not always used as reading material, most of the women I spoke to said they are valuable teaching tools. The photographs seemed to draw people into the magazines and make the topics covered seem more relevant to their lives. Unlike songs or seminars, people can take magazines home with them and read them at night. Because a person can read them at leisure, the ideas stick with them better, said Fatuma. Magazines cover topics in-depth and do not hide embarrassing information about sex, said Monica. However, most of the women I spoke with said that they like reading the magazines, but they do not usually share them or talk about them with others. The magazines are for their own private enjoyment and, sometimes, they serve as personal inspiration.

Some of the magazine articles focused on how different youth pulled themselves out of poverty by starting their own businesses and following their dreams. These tales often served as inspirations to the younger readers I spoke with. As Veronika said,

Nimejifunza kwamba yani kama kijana yani ukiwa na maisha magumu ukiwa na juhudi ya kufanya kazi unafanikiwa katika maisha. Kama wenzetu, nilivyosema, kwenye magazeti, walikua na hali ngumu lakini saa hizi wanasema wana unafuu na pia wana matumaini ya kuishi...[Ni bora kuandika kama hizi] kwa sababu inatia changamoto kwa mtu ambae anasoma na pia anaweza akajifunza kitu

kama yeye ajasonga mbele. Anaweza akajifunza kupitia wale wasichana ambao wametoka kwenye magazeti.

I learned that if a youth, I mean, if you have a hard life, if you exert effort to work hard, you are successful in life. Like them, as I said, in the magazine, they had hard conditions but now they say they are better and they have hope to live... [It's good to write about this] because it challenges the person who reads it and she can learn something like if she improves herself she can go forward. She can learn this from the girls in the magazines.

The stories encouraged her to work hard, make plans, and follow her hopes for the future instead of being resigned to her current conditions. These stories seemed especially important to the younger women I spoke with. Virgeni, Monica, Veronika, and Salma all mentioned whichever inspirational story in they read in their different magazines, noting that if these young women could help themselves, then they could, too.

The young women in the magazines took control of their lives. This differed greatly from the typical village life path in which a woman waited for a man to propose, got married, and raised a family. The stories suggested that the women have agency over their own lives, which also meant they have agency to affect their health status and prevent infection. These stories might have had a greater effect on younger readers because the younger women have had more access to non-traditional alternatives. Two of the young women attended secondary school and two attended sewing courses in the district capital. They had friends from the towns, had read the magazines, and had received more extensive educations at younger ages. They knew about alternatives and were inspired by young women who sought out those alternatives. This might be seen as a success for the magazines. The magazines effectively convinced the young women that they could seek their own paths and choose their own destinies, though only to a degree. The same women who were inspired by the stories of success still said that they trusted

God to lead them in the right direction. Along with seeking their paths, these women as well as the others I spoke with were also seeking more information about their bodies and their health.

Nataka kujua kuhusu...¹⁴

I went to visit Sandina shortly after Christmas. As she hurriedly prepared herself to go work at her small store, she told me her husband had died. Elizabeth had included this fact as a footnote to one of her greeting-filled letters about a year before, so I wasn't surprised. "*Pole sana*," I said; "that's too bad" is the standard statement for sympathy. When I had received the news I wasn't very surprised—people frequently die in the village—and I didn't feel much sympathy. Sandina had always spoken of her husband with a bit of distaste because he gave more money and attention to his other wife. She told me about his death casually as she dressed in the adjoining room.

"He was sick a long time," she shouted through the curtain. "For the last month, he was so sick he just lay in the house while I took care of him."

"What was he sick with?" I asked with trepidation as she came back in the room. I had grown cynical; any time I heard of a long term illness I suspected it might be AIDS.

"*Homa tu*," she said, using the generic word for a feverish illness. "And," she continued in her straight-forward style. "His other wife died, too, about a month later."

"His other wife died."

"Yes. Their daughter is with her grandmother," she said nonchalantly.

¹⁴ I want to know about....

I was used to her Sandina's atypically direct nature but taken aback by her seeming lack of concern. "Um, Sandina, aren't you worried?"

"Worried? About what?" she asked as she sat on the couch.

"Sandina, have you been tested?"

She knew I meant had she been tested for HIV and looked a little puzzled. "Why would I get tested?"

I tried to phrase my words carefully though I knew I would be blunter than any Tanzanian. "He was sick a long time then died. His other wife died. Don't you wonder if maybe they had something you could catch? Don't you think you should know?"

"Anna!" she laughed. Hidden in her laughter was her shock that I mentioned the possibility out loud. "Why, Anna? Why should I know? I go to church, I pray, I don't go with men. What good would it do me to know? What difference would it make? Come, let's go to the shop."

HIV/AIDS and STIs

The conversation about testing ended there that day, but Sandina hadn't forgotten it. When I returned after a few days to interview her about her life, she asked about the importance of being tested. She later wanted to know what it meant to "live with hope,"¹⁵ the new slogan for how to live positively with HIV and sustain a high quality of living for as long as possible. She thought it meant living with a belief in God. Sandina had the same question as many of the other women in the village: What good does it do me to know my status?

¹⁵ "*Kuishi na matumaini*" is a frequent refrain in current AIDS literature.

Three years ago much of the information on HIV/AIDS that was available in Matiru focused on scaring people into avoiding the disease. “AIDS kills, steer clear of it” and “protect yourself” were frequent mantras in AIDS-focused skits and songs. The messages seem to have sunk in—all of the women I spoke with understood the importance of learning about AIDS and its dangers. But they also seemed to think that if a person was infected, she was doomed. Knowing one’s status would not improve her situation. The women did not seem to understand the science of AIDS and the benefits of being tested, but they did understand that because many of their husbands slept around, they needed to know more about HIV/AIDS and STIs. The women talked to each other and me about the problems caused by AIDS using what little information they had.

Salma explained that people in the village talk about the disease without really knowing what they are talking about. That makes AIDS one of the most important things to discuss in magazines, she said.

Nafikiri somo ambalo lingetakiwa kwa hapa ni somo linalohusu ukimwi.. Eeh hilo ndio lingekuwa zuri zaidi...kwa sababu masomo kama hayo imekuwa vigumu watu wengine kuyasikia au kuyaelewa... Au, hata asikie tu, yaani, ni watu wanavyoongeaongea lakini hawezi kujua kama ukimwi unaanza na nini? unatokana na nini? na mwisho wake ni nini? Hawezi kuelewa.

I think the lesson which is needed here is about AIDS. This would be the best to learn about....because lessons like these are hard for some people to listen to or to understand....Or even if he just hears it, I mean, people talk and talk about it, but a person can’t know, like, if AIDS starts with what? Or, what does it come from? And how does it end? He can’t understand that.

Salma explained that people talk about AIDS without knowing answers to important questions about it. They haven’t received complete lessons and more magazines are needed to fill these educational gaps.

The Health Information Project, which produces *Fema* and *Si Mchezo!*, noticed this need and now produces booklets focused on AIDS in society, how to live with hope, and the values of being tested. Some of the booklets use personal stories to talk about living positively with HIV/AIDS. Others give more direct explanations of what the disease does and how the symptoms can be dealt with and lessened. The women seem to strongly prefer direct information about HIV/AIDS and medical facts about the disease from experts. Most of them said scientific explanations were more useful than personal stories, though the stories were interesting. Unfortunately, the booklets are only available in limited supply, though I distributed 15 or so of them in the village and noticed people's positive reactions to them. These are the types of magazines they want more of.

The women seemed to have genuine interests in learning more about HIV/AIDS, but sometimes I wondered if they listed it as their primary interest because it was an obvious answer. When I asked the women what they would include in a magazine written just for Matiru, I often had to prompt them and help them search for topics of inquiry, except HIV/AIDS. Everyone mentioned AIDS without prompting. The women wanted magazines and other forms of media that taught them about HIV/AIDS through direct, straight-forward explanations. Although they saw the value in personal stories, they were more interested in learning about the science of the disease and ways to treat its symptoms. The women sought this information so they could have more educated conversations with their friends about the disease's dangers. Some of the women I spoke with mentioned other topics they wanted more information on as well.

Other Information Matiru Women Want to Learn

Some of the women mentioned information they wanted to know about their bodies, their health, and their families' health. Their suggestions for magazine article topics are drawn from their direct requests and from questions they asked me about their personal situations. A health magazine written for the women of Matiru, and may be similar villages, should include sections on science, physical pleasure, relationships, family matters, and money issues in addition to in-depth information on HIV/AIDS.

Science—In addition to scientific lessons on HIV/AIDS, women wanted to know other facts about how their bodies function. Salma asked why female circumcision was dangerous because she did not know about the different parts of the vulva. Veronika wanted to know more about menstruation and irregular periods. Monica and Fatuma were interested in reproductive health lessons. Sandina wanted to know what caused menstrual cramps, she had heard it was because she was not with a man. She also wanted to see diagrams about physical bodies, much like those found in science textbooks.

As the women learned about and experienced their own bodies and heard about others' experiences, they wanted to know the biological science behind their bodies' changes and needs. Some of the women had learned a little about this in school, but most of them had never seen a biology book. They were aware that the information existed and wanted access to it so they could better understand themselves and their physical bodies.

Physical Pleasure—One reason Sandina wanted to see diagrams of women's bodies was so that she could better understand how to make herself experience an orgasm. Since her husband is dead, she said, she is seeking methods to give herself

pleasure without having sex. Similarly, Monica wanted to know how to avoid giving into her sexual desires. Mariam pursued the same line of questioning—“How do I get my daughter to stop sleeping around? She already knows the joys of sex, so what can replace that?” Other women, in casual conversation, said they had heard about alternatives to vaginal sex, like oral sex and using hands, but did not really understand how the alternatives affected their bodies and their partners. The women were unsure of what caused their physical pleasure and wanted to know how to increase it. Sandina practically asked for a sex guide. Though some women were very curious about their bodies and physical pleasure, the more conservative women thought sex should only be discussed in magazines for people over the age of 18. Such matters were not universally appropriate. These queries showed that women were curious about their own bodies but unsure of how they worked.

Relationships—Every issue of *Fema* has a section focusing on relationships between men and women and gender issues called *Mahusiano na Ujinsia*—Relationships and Gender. Most of the women I spoke with did not understand the meaning of these words and what this section encompassed nor had they the time to read it thoroughly. Although they did not understand the words, many of them asked me questions about interactions between men and women. For example, Elizabeth had me turn off the recorder and write down the following question:¹⁶

A man, after being wed a few years, starts to look for other women and then brings problems back into the home. For example, he brings STIs into the relationship and he gives away his money to the other women instead of to his family. What can be done about this? It destroys lives and the development of home life. How can lives be

¹⁶ Elizabeth was concerned that she would not ask the “right” question, so she did not want it to be recorded directly. She asked me the question in Swahili, rephrasing it as she went. I translated the question as I wrote it down, so the complete, original Swahili is not available.

planned together if this is the case? How does a wife get her husband to get treated for STIs?

This question was drawn directly from her personal experiences, but she thought other women might be in similar situations. Other interviewees asked about pursuing men and talking to them about STIs. None of the women directly requested a magazine section on relationships and gender, but they did have questions about these topics as related to their own lives.

Family Matters—In addition to wanting to know about their romantic relationships, the women also wanted to learn more about caring for their families. Although the mothers with young children learned about taking care of small children and treating common diseases from the doctor and the nurse at clinic day, others did not. The women wanted to know general information about caring for their entire families and specific information on raising teenagers. Even when reading current magazines, Fatuma sought out certain articles that talked about family issues. “I saw that these articles are about [family]...because I have a family so it’s necessary that I care for my family.”¹⁷ For Tanzanians, having a healthy family is just as important as having a healthy body, but to care for one’s family, it is necessary to have money.

Money Issues—In Tanzania health care and health quality are inextricably linked to money. Without money families cannot buy nutritious food supplements, like leafy green vegetables, or pay for medicines and health care costs. Because of this, an article about seeking early medical treatment in order to prevent higher treatment costs later caught many of the women’s attention. Four of the women specifically wanted to know about money matters and how to find new sources of income. This is already an element

¹⁷ *Niliona hilo linanihusu... kwa sababu nikiwa na familia inanibidi niijali sana familia.*

of the magazines. *Si Mchezo!* has a section entitled *Mambo ya Fedha*, or money matters. The village women want more suggestions like the ones already provided on how to make money and use it wisely in the village context.

Other Teaching Methods

Magazines are not the only available method of teaching about health issues. Health warnings are posted on sign boards and walls around the village. Outside of the clinic a sign reads “Life is a gift, don’t lose it”¹⁸ and another says “AIDS kills!”¹⁹ Posters in bars advise to get tested for AIDS.²⁰ Many of the women said these signs were unhelpful. The signs give warnings without providing explanations. They spread negative messages instead of positive advice, said two of the women. According to these women, the sign boards are not effective health communication tools.

Health lessons are also taught via live skits and songs, *ngoma* or traditional dancing and drumming, radio programs, and seminars. Although the women like the openness of the magazines, many of them felt direct, live communication methods are necessary supplements. Virgeni said,

Mengineyo ya kusema, niliomba kwamba waandishi, waandishi wanaoandika haya magazeti waweze kutufikia ili kwamba wana.....wananchi pamoja na wanawake wawe na muda kuzungumza nao na kuwa na muda wa maoni na mapendekezo yao waliyonayo binafsi. Si vizuri kuandika tu katika magazeti na kuacha hivi hivi. Na pili tuliomba haya magazeti yaweze kutufikia vijijini kwa wingi kwa sababu, yaani, ni vigumu sana kuyapata haya magazeti kama haya.

¹⁸ *Maisha ni zawadi. Usiyapoteza.*

¹⁹ *UKIMWI unaua!*

²⁰ *Pima afya yako* – it literally means test your health, but the phrase is always meant to imply get tested for AIDS.

Another thing to say is, I want the writers of these magazines to be able to reach us such that citizens together with women have time to talk, a time for talking about their personal observations and suggestions. It's not good to just get the magazines and to leave it at that.

Virgeni felt that without conversations about the magazines, their messages were not as effective. People who read the articles sometimes need more explanations than what is provided and need to understand the lessons in certain context. Direct communication and seminars with experts make the messages more meaningful and lasting and incite people into action. Because of this, Fredrika, Benedeta, Yosefina, and Goleta plan on starting a *Fema* club together. They will discuss the magazines and ask the new Peace Corps Volunteer and the local health workers questions about the articles.

The women say they want direct, live communication about health issues. They want to learn about sexual health via village meetings featuring *ngoma*, seminars with experts, and structured group meetings. They do not, however, frequently talk among themselves about sexual health issues in informal settings. This maybe because discussing such sensitive topics in a formalized way, such as during a seminar, makes the topics less personal and thus less embarrassing. The seminars and dances may also feel like comfortable learning options because they are reminiscent of traditional teaching methods. The older women learned about puberty and sex through songs and skits performed during *unyago*. It may seem natural to learn about other sexual health issues through the same methods. The traditional communication methods also appealed to the younger women. Perhaps this is because they have been exposed to these methods throughout their lives as well. Although the women appreciate and are interested in the magazines, this modern form of communication has not completely replaced traditional methods.

Behavior Change

The main goals of health-focused communication are to educate people about diseases such as HIV/AIDS and convince them to change their behaviors in order to reduce infection rates and improve their health conditions (Ford, et al., 2003; Personal Observation, 2007; Obregon, 2003). The women recognize this aim and support it, but do not necessarily think any of the communication methods, including magazines, signs, and songs, are effective. Most of the women made similar remarks as Benedeta.

A: Watu wanafwata ushauri ya magazeti?

B: Anaoelewa zaidi anaweza kufwata ushauri ya magazeti lakini kuna wengine wanasema “ah-ah! Mbona haya wanasemaga kila siku.” Analiacha hapo hapo halafu anaendelea na nani.... Na nani yake tena. Anaendelea tu kutembea tena lakini huko kuna wengine anasikia hivyo anaogopa kweli anasema “Ah, hiyo nilisikia hii, nifwate hili hili. Niwasikie.” Hata wakiimba kwa nyimbo, wanasikia, wanafwata. Lakini wao, bas. Hawa wanasema wanasikia kila siku...

A: Do people follow the advice of the magazines?

B: Those who understand better follow the magazine's advice, but there are others who say “Ah-ah! This is what they say every day!” He drops it right there and continues with... with his ‘things’ again. He continues to walk about again but others listen to them and are afraid. They say, “Ah, this I hear, I’ll follow these advice. I’m listening to them.” Even if they are singing songs, they listen. But the others, they say they hear this everyday...

Benedeta says that some people ignore the messages because they are too common and have over saturated the environment. People are tired of hearing that they should not sleep around and that AIDS kills, so they no longer listen to advice. Veronika, who is in her early 20s, says this is especially true of her own generation. Many people do not heed the lessons because they have given up hope, she says. Despite the belief that the messages are ignored by many people, all of the women were adamant that health educators must continue spreading them. As Elizabeth said,

Bora waendelee kwa sababu watu ukiacha kabisa itakuwa mbaya, tena ila. Waendelee mtu tu akatae mwenyewe, lakini huku bado anasikia ushauri.

It's better if they continue [making the magazines] because people... if you stop completely, it will be bad, a fault. They should continue; a person can refuse [to follow the advice] on their own but still they can at least hear the advice.

As Elizabeth and others said, the health communication methods are necessary even if not fully effectual. In fact, the women think there need to be more of them, especially seminars. Abandoning the issue is not a solution either.

The women of Matiru seek a multi-faceted media campaign that teaches them about a variety of health issues. The media campaign should combine seminars, traditional media, and magazines to teach about AIDS, biology, physical pleasure, child rearing, and money management and generation. If these issues are not addressed through a variety of media approaches and accompanying interpersonal communication, their messages will not be as effective and people will not adopt healthier sexual behaviors.

Chapter Eight—Conclusions

In a small, rural Tanzanian village women sat and talked. They fretted about the heavy rains and how they might affect the crops that year. They gossiped about the woman in the next village who left her husband; the husband refused to give her their four-year-old son until she brought back the dishes she took. They braided each others' hair as they nursed their children and asked me questions about riding in airplanes and living in the United States. When we were alone and I conducted interviews about their pasts and their sexual health knowledge, the women's questions changed. Instead of asking about the luxuries of western life they inquired about their bodies, their children, and their fears about HIV/AIDS.

HIV/AIDS prevalence rates in Tanzania are increasing, especially among women, though most cases are not reported. Magazines, community groups, NGOs, church leaders, and others are successfully raising awareness of the disease and other sexual health issues, but some women still have questions. The women I spoke with are unsure about how the symptoms of the disease can be treated and the importance of getting tested. Although schools, modern media, traditional media, and other health-focused communication methods have attempted to answer these questions, the answers have not reached the women at the study site.

Many of the health-focused media I discussed with the women concentrated on teaching about healthy relationships, sexuality, paths to economic self-sufficiency, living

with HIV/AIDS, and HIV prevention. Our conversations focused on the magazines because they were easily obtainable. Although many of the magazines' articles contained positive messages about survival under Tanzania's harsh economic conditions, living a fulfilling life even when infected, and controlling one's own future, certain factors may have prevented the messages from being effectively received at the study site. My research supports past research on health communication which found that the health-focused media were not effective because they did not consider local cultures and communication patterns (Airhihenbuwa & Obregon, 2000; Muturi, 2005; Riley, 1990).

Traditional gender roles, wherein women are subordinate to men in most situations, determine interactions between women and men at the study site. The women of Matiru all express that they feel like they have limited control over decision-making within their marriages, including making decisions about sex. They were taught during initiation ceremonies and conversations with female relatives that men should take proactive roles in relationships and determine sexual interactions. These lessons were reinforced by example—younger women watched how their mothers behaved and followed suit. This meant that even though the women knew their husbands were probably sleeping around—all men do, they said—the women could not ask the men to use condoms. Women were taught to remain faithful even if their husbands were not. Few of the women I spoke with questioned this relationship, though some sought ways to improve it. They accepted that their husbands could determine their sexual health. These findings are similar to findings from studies on gender relations in other sub-Saharan African communities (Chambua, et al., 1994; Dilger, 2004; Harrison, et al., 2001; Pattman, 2005). This suggests that gender relations and how they affect women's agency

need to be considered when designing sexual health media in most areas of sub-Saharan African. These ingrained gender roles may negate the effectiveness of media messages about sexual agency as well as the messages about balanced gender relations.

All of the women I spoke with who were over 30 said they learned about these gender roles during initiation ceremonies. The women who led the ceremonies used songs, dances, poetry, and other traditional media to teach girls about becoming women. In addition to lessons about gender roles, the girls learned about caring for their bodies and keeping clean, the dangers of sex, and the importance of remaining abstinent. The young women were repeatedly told not to have sex with or even talk to men about love before marriage. The importance of the lessons and of the expected sexual behaviors was reinforced by a multigenerational group of women and never directly questioned during conversations between adult women. These same lessons were passed to younger generations of women as well, but by one or two family members or friends instead of a community of women. In other areas of Tanzania, communication between women is following similar trends; young girls are no longer going through initiation ceremonies (Liljeström, et al., 1994; 1998). This is partially because circumcision is now illegal and partially because the older women do not think it is necessary to teach the young girls in a group setting because they learn about puberty in school (Katapa, 1998; Liljeström, et al. 1998).

However, this lack of community reinforcement of sexual mores may be why many of the younger women are reportedly experimenting with sex at earlier ages both at the study site and in other regions of Tanzania (Katapa, 1998; Tumbo-Masabo, 1998). The older women I spoke with at Matiru, and even some of the younger women, said they

thought younger girls were not receiving the right information about sex and through the wrong avenues. Some researchers found that communication strategies that use traditional forms of communication, like initiation ceremonies, dancing, and singing, may be more effective than strategies that only rely on modern forms (Mlama, 1994; Okigbo & Meister, 2000; Riley, 1990).

Local religious beliefs may make the women less receptive to health magazines that encourage them to take control of their lives and their sexual health. Most of the women at the study site follow the teachings of Christianity and believe in witchcraft. In both of these belief systems external supernatural powers determine people's futures. Even if a woman takes care of her body, another person can curse her and make her ill at any time. God ultimately determines a woman's path in life. These belief systems suggest that women do not have control. Consciously or subconsciously these beliefs may alter women's sexual health behaviors and receptiveness to sexual health protection messages. Although the connection between health and religious beliefs is well documented, the effect of religious beliefs on the effectiveness of health communications is not (Parrott, 2004a). My research begins to fill this gap in the literature.

Despite the health lessons the women of Matiru received through traditional ceremonies, school, and friends, they still had gaps in their educations. They sought more information on reproductive health, biology, and mechanisms for sexual pleasure. The women also noted the connection between financial health and physical health. They wanted to learn other ways to make money in order to help themselves and their families and pay for medical treatments. Relationship problems were mentioned as well. Although the women did not seem to understand what the relationships and gender sections of the

magazines were trying to teach them, they had questions about relationships based on their personal lives.

The women saw the magazines as good tools for teaching about sexual health topics but felt they needed to be supplemented with seminars and traditional media such as skits and songs. This preference for traditional media has been found in other studies as well (Riley, 1990). Magazines were seen as advantageous because the writers were very open about sensitive topics, women could read the magazines at home at night, and they could learn from the pictures. Despite this, some of the women did not view the magazines to be as effective as live, face-to-face communication. Seminars and traditional media may be more appealing to the women because they are familiar methods of communication. They learned about periods and sex through songs, dances, and conversations, so it may seem natural to learn about HIV/AIDS and other sexual health issues in the same way.

My research supports the claim that devising health communication strategies for rural areas that incorporate magazines, interpersonal communication, and traditional media may be the most effective way to teach women about sexual health (Mlama, 1994; Okigbo & Meister, 2000; Riley, 1990). The women can learn about and become familiar with the issues through the magazines then supplement the information with conversations and seminars. The seminars would give women a chance to ask more questions and make sure they understood the writers' messages. Conversations would allow the women to discuss how the new ideas fit in with their current beliefs and lives. Formalized conversations with experts might be more comfortable for the women to

engage in since they are not used to discussing these issues with each other in informal settings.

Contributions and Further Research

My research largely supports the findings of previous research on health communication and sexual health issues in sub-Saharan Africa and introduces other important topics to consider when planning health communication campaigns for rural Tanzania. Previous research highlighted the importance of incorporating culturally appropriate health communication methods (e.g. Airhihenbuwa & Obregon, 2000; Dilger, 2003; Muturi, 2005) into multi-media health communication campaigns. Modern media, such as magazines and radio, can be effective but only when mixed with traditional media and interpersonal communication (Agha & Van Rossem, 2002; Mohammed, 2001). My research with the women of Matiru confirms these ideas and delves further into the specifics of print media. The women I spoke with said they preferred to learn through direct explanations, though personal stories can be inspiring. They highlighted that print media allow women to re-read articles in order to better process and absorb new information. This suggests more research should be done on what types, styles, and formats of print media are the most effective.

My research also highlights different factors that influence how women in Matiru perceive health communication messages. The women's perceptions of health messages are mediated by cultural and religious filters. Many studies in East Africa (e.g. Dilger, 2003; Rwebangira & Liljeström, 1998; Tumbo-Masabo & Liljeström, 1994) have confirmed the subordinate position of women and this negative effect on their sexual

agency. The same is true in Matiru and I suggest that these gender roles impair the women's ability to fully receive, understand, and act on the sexual health messages. This needs to be studied further, as does the effect of religious beliefs on the reception of health messages. My data shows that the women at my study site follow fatalistic Christian and indigenous beliefs. I believe that these beliefs negatively impact their acceptance of sexual health messages that promote empowerment and sexual agency. I was not able to find research supporting or refuting this claim; it needs to be pursued further.

My research fits into a large body of literature on sexual health and sexual health communication in sub-Saharan Africa. The similarities between my findings and other research on gender relations and intergenerational sexual health communication practices, like initiation ceremonies, suggest that my data on health communication strategies are transferable to similar communities. Although much research still needs to be done, I have filled a small hole in the pool of research on sexual health communication strategies.

The day before I left Matiru for the last time I went to say good-bye to Fatuma. I sat on the firm foam cushions of her living room couch as she mixed a pesticide into sacks of dried corn to protect her food supply for the next year. Her youngest daughter, Hannah, played outside in the courtyard with the Adelaide's and Ndaivalonge's children. Her eldest daughter, Alice, was living with her grandmother. The 25-year-old woman who used to live with the grandmother, Eva, had passed away from AIDS earlier that year.

“When are you coming back?” asked Fatuma.

“I’m not sure,” I replied for the umpteenth time. Many people had already asked.

“It depends on where I can get a job. The ticket fare is expensive.”

“When you come again, will you bring your husband?” she asked as she mixed the powder into the corn.

“Maybe. If God wants it.” I had given up explaining my views of marriage and taken the easy route. Placing the blame of my single lifestyle on God was much easier than explaining my reluctance to marry. “Will you still be here when I get back?”

“Who knows? If I’m alive, I’ll be here, farming.” She made the comment casually, matter-of-factly. Many of the women had said the same thing when asking about my return. We may be dead when you come back, they said. I used to roll my eyes when they made such comments. *Of course they’ll be here*, I thought. But when I returned to Matiru after two years of travel and school, not everyone was there. Eva, who I used to sing with at church and visit at her home, was gone. Sandina’s husband was gone. Things had changed. But I once again shrugged off her answer; I’m not good at dealing with such morbid, fatalistic ideas.

“Still farming? You don’t want to go back to school?”

“No, I’ll stay here. I have a house and a husband and another daughter. Maybe I’ll start a business. Maybe I’ll build another room on my house so you can stay here next time.”

“So I’ll see you when I come back?”

“Maybe, Anna. If God wants it, maybe.”

Appendix A

Question guide for health worker interviews

1. Please describe the work you do. (*Tafadhali, niambie kuhusu kazi yako.*)
2. When you go to the village for clinic days, what do you do there? (*Unakapoenda kijijini kwa siku ya kliniki, unafanya nini pale?*)
3. Sometimes, do you teach the women about health topics? Primarily about which topics? How do you teach them? (*Pengine, unawafundisha wanawake kuhusu afya? Zaidi zaidi, lenga kuu ni nini? Unafundishaje?*)
4. What topics are the women interested in learning about? (*Wanawake wanapenda kujifunza kusuhu mada gani?*)
Mostly what do women ask questions about? (*Zaidi zaidi, wanawake wanauliza maswali kuhusu nini?*)
5. If you distribute health communication (news, explanations, or announcement), what do you distribute? (*Kama mnagawa habari, maelekezo, au matangazo, mnagawa nini?*)

Appendix B

Round One Interview Guide

1. Please tell me a bit about your family and where you grew up. (*Tafadhali, niambie kuhusu familia yako na sehemu ulipokomaa.*)
Where do you live now? With whom? (*Unakaa wapi sasa? Na nani?*)
How many children do you have? All are alive? (*Una watoto wangapi? Wote ni uhai?*)
2. When you were a youth, how did girls in your village inform themselves about puberty, reproductive and sexual health? (*Ulipokuwa kijana, ulijiarifuje kuhusu ubalehe, afya ya uzazi na ujinisia?*)
Did people teach girls about sexual and reproductive health? Who? (*Watu waliwafundisha kuhusu afya ya ujinisia? Nani?*)
Which topics did they teach about the most? (*Zaidi zaidi, walifundisha kuhusu mada gani?*)
What did you learn about health at school? At home? (*Ulijifunza nini kuhusu afya shuleni? Nyumbani?*)
Did you talk with your friends about health? Boys? (*Ulizumgumza na wenzako kuhusu afya? Wavulana?*)
3. Did girls participate in initiation ceremonies when you were young? If so, please describe them. (*Ulipokuwa mtoto, wasichana waliingia unyago? Kama ndiyo, tafadhali, ueleze ulikuwaje.*)
Were you all circumcised? (*Mlikeketwa?*)
4. I would like to learn about your relationship with your husband. Where did you first meet him? (*Naomba kujifunza kuhusu uhusiano ya wewe na mume yako. Mlionana mara ya kwanza wapi?*)
When you got married, did the elders or others give you lessons? About what? (*Ulipofunga ndoa, wazee au wengine walitoa mafunzo? Gani?*)
5. If you have children, what do you teach them about health or puberty? (*Kama una watoto, unafundisha nini kuhusu afya au ubalehe?*)

Appendix C

Round Two Interview Guide

1. Let's look at these (health) newspapers and posters together. I'd like to understand what you think about the meanings of the messages/information. (*Tuangelie magazeti haya na picha hizi pamoja. Nataka kuelewa unaonaje maana ya habari.*)

Do they explain new information? Important things? (*Zinaeleza kuhusu mambo mapya? Muhimu?*)

What do they tell you about your body and your behaviors? (*Zinakuambia nini kuhusu mwili yako na tabia zako?*)

What do you think about the discussion of these types of topics in a newspaper? Is it appropriate for everyone to read? (*Unaonaje majadiliano ya mambo haya kwenye magazeti? Ni vizuri kwa wote kusoma?*)

Also, many times there are articles and stories about life skills. Why do you think so? Is this good or unnecessary? (*Pia, mara nyingi kuna hadithi na makala kuhusu staidi za maisha. Kwa nini, unafikiri? Hii ni nzuri au sio lazima?*)

Can you relate to these pictures, drawings, and stories? Is there a relationship between this information and your lives? (*Je, unaweza kuhusianisha na picha, mchora, au hadithi hizi? Unaona kuna uhusiano kati ya taarifa/habari na maisha yako?*)

What do these stories and articles make you think about? (*Hadithi na makala zinakusababisha kutafakari nini?*)

What type of people do you prefer to read about? From where? (*Unapendelea kusoma kuhusu hadithi ya watu wa aina gani? sehemu gani?*)

How does the health information in these materials compare to health information discussed in your community? Your family? Your church? (*Habari hizi za afya zinalinganizhaje na mada wanakijiji wanazozumgumza? Familia? Kanisani?*)

How is it possible to improve these magazines? (*Inawezekana kufanya nini kuboresha Fema au magazeti mengine?*)

2. If you could be a journalist and write *Fema* for the women from here, what topics would you write about? Why? (*Ungeweza kuwa mwaandishi wa habari na ungetaka kuandika Fema kwa wanawake wa hapa hapa, ungeandika kuhusu mada gani? Kwa nini?*)

3. Are the magazines enough to teach the community about health issues? What other methods would you like? (*Magazeti yanatosha kuelimisha jamii kuhusu mambo ya afya? Utapendelea wakitumia njia nyingine kama nini?*)

Appendix D

Oral consent guides

For the women at the site:

Niko hapa kufanya utafiti kwa shule kupata digri yangu ya pili. Nataka kuelewa matumizi na ufafanuzi wako wa njia za mawasiliano ya afya. Zaidi zaidi napenda kujua unaonaje na unatumiaje magazeti kama Amua! na mapicha kama zile za Green Star. Lakini ili nielewe vizuri matumaji, maoni, na hisi yako kuhusu njia hizi, pia nahitaji kukuuliza maswahili kuhusu maisha yako. Nitapenda kujua njia zingine za kupata habari za afya, pia. Kama hutaki kujibu swali lolote, usiwe na wasiwasi. Unaweza kukataa kujibu au kuacha kushiriki muda yoyote. Pia, ukipenda, uniulize maswali yoyote pia. Nitajaribu kujibu.

Utafiti itasaidia watu wanaoandika na wanopanga njia hizi za habari za afya. Wakielewa nyini wanawake wanataka na wanahitaji kupata habari fulani za afya au hampendi mambo fulani, wataweza kuwapa magazeti na mapicha bora.

Nitazungumza nawe mara tatu. Kwanza, tutazungumza kuhusu historia yako kwa kama nusu saa au saa moja. Halafu baadaye, tutaangalia njia za mawasiliano pamoja kwa nusu saa au saa. Nitaacha matangazo, magazeti nawe. Baada ya kuangalia majibu na kuwaza kidogo, labda nitakuuliza maswali mengi. Nitapenda kurekodi mawasiliano yetu kusikiliza tena baadaye lakini watu wengine wa kijiji au hata wilaya hawatasikiliza. Watu wa Dar es Salaam watanisaidia kuchapa. Pia, watu wa hapa hawataona ukumbusho wangu. Kwenye ukumbusho sitatumia jina lako la ukweli. Nitayafunga makanda na madaftari. Ukizungumza nami hutapata kitu chochote lakini maoni yako yatasaidia kuboresha njia za mawasiliano ya afya. Unayo maswali? Unakubali kushiriki? Unajali nikirekordi mazungumzo yetu?

I am here to do research for school in order to get my second degree (master's degree). I want to understand your uses and interpretations of health media/communications. Moreover, I'd like to know how you view and use newspapers like *Amua!* and posters like those that Green Star puts out. However, in order to better understand your usage, observations, and feelings about these materials, I also need to ask you some questions about your life. I'd also like to know other ways of learning about health. If you don't want to answer any question, don't worry. You can refuse to answer or stop participating at any time. Also, you can ask me any questions, too. I'll try to answer.

This research will help people who write and plan health media. If they understand what health information you want and need to receive, and what things you don't like, they can provide better newspapers and posters for you.

I'll speak with you three times. First, we'll talk about your history for about a half an hour to an hour. Then later, we'll look at health focused media together for a half hour to

an hour. I'll leave the newspapers and posters with you. After looking at my data and thinking a bit, I might ask you a few more questions. I would like to record our conversations in order to listen to them again later, but other people in the village, even the region, will never hear them. People in Dar es Salaam will help me type them. Also, people from here won't see my fieldnotes. In my notes, I won't use your real name either. I'll lock up the notes and cassettes. If you talk with me you won't get anything but your input will help to improve health communication materials. Do you have any questions? Do you agree to participate? Is it fine with you if I record our conversations?

Oral consent for the health workers:

Niko hapa kufanya utafiti kwa shule kupata digri yangu ya pili. Nataka kuelewa matumizi na ufafanuzi wa wanawake wa kijiji wa njia za mawasiliano ya afya. Nazungumza nawe kujua nyini mnawafundisha wanawake nini kuhusu afya na mnagawa vitu gani kuwasaidie kuelewa mambo ya afya. Kama hutaki kujibu swali lolote, usiwe na wasiwasi. Unaweza kukataa kujibu au kuacha kushiriki muda yoyote. Pia, ukipenda, uniulize maswali yoyote pia. Nitajaribu kujibu.

Utafiti hii utasaidia watu wanaoandika na wanopanga njia hizi za habari za afya. Wakielewa nyini wanawake wanataka na wanahitaji kupata habari fulani za afya au hampendi mambo fulani, wataweza kuwapa magazeti na mapicha bora.

Tutazungumza kwa nusu saa au saa moja tu. Nitapenda kurekodi mawasiliano yetu kusikiliza tena baadaye lakini watu wengine wa wilaya hawatasikiliza. Watu wa Dar es Salaam watanisaidia kuchapa. Pia, hawataona ukumbusho wangu. Kwenye ukumbusho sitatumia jina lako la ukweli. Nitayafunga makanda na madaftari. Ukizungumza nami hutapata kitu chochote lakini maoni yako yatasaidia kuboresha njia za mawasiliano ya afya. Unayo maswali? Unakubali kushiriki? Unajali nikirekodi mazungumzo yetu?

I am here to do research for school in order to get my second degree (master's degree). I want to understand how women from the village use and interpret health media/communications. I'm speaking with you to learn what you teach women in the village about health and what materials you distribute to help them understand health issues. If you don't want to answer any question, don't worry. You can refuse to answer or stop participating. Also, you can ask me any questions, too. I'll try to answer.

This research will help people who write and plan health media. If they understand what health information the women want and need to receive and what things they don't like, health communication designers can provide better materials.

I'll speak with you for a half hour to an hour. I would like to record our conversations in order to listen to them again later, but other people in the region will never hear them. People in Dar es Salaam will help me type them. Also, people from here won't see my field notes. In my notes, I won't use your real name either. I'll lock up the notes and cassettes. If you talk with me you won't get anything but your input will help to improve health communication materials. Do you have any questions? Do you agree to participate? Is it fine with you if I record our conversations?

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