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DO INSTITUTIONS MATTER? EXPLAINING HIV PREVALENCE VARIATIONS ACROSS REGIONS IN TANZANIA

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ABSTRACT

This work researched on the institutions for implementing policies for HIV prevention in Tanzania. It was designed to explain why HIV prevention services are producing contrasting results across regions in Tanzania. Two sampled cases were used for the purposes of this study: high HIV Prevalence case (Njombe region) and high to low to "reversing" HIV prevalence case (Kagera region). The study employed institutionalism as a frame for analysis. Moreover, the study relied largely on qualitative methods for data collection and analysis. Three methods of data collection were employed; documentary review, in depth interviews and focus group discussions. Respondents for the interviews included government officials from National AIDS Control Program, Tanzania AIDS Commission (TACAIDS) and the Prime Minister's Office-Regional Administration and Local Government (at district level downwards). Other interviewees were from Civil Society Organizations. Participants for the FGDs were drawn from the study villages and included ordinary citizens. The findings of the study show that the enforcement of institutions is constrained by growing clashes between the formal and formal rules on one hand and between formal and informal rules on the other hand leading to unfavorable conditions which in turn affects people's acceptance attitude towards HIV prevention services. In addition, performance of the institutions is constrained by limited capacity indicated by shortages of human, financial and infrastructural resources. The study concludes that institutions matter, but their actual performance with regard to policy implementation depends on local conditions under which they operate.

Contribution/ Originality: This study contributes in the existing literature with regard to theory. It highlights the gap between institutionalism perspective of policy making and implementation together with actual practice of policy implementation in Tanzanian context. Public policy becomes public policy if it receives legitimacy of both, government institutions as well as communities.

1. INTRODUCTION

Policy theories inform that both formal and informal institutional contexts significantly shape conditions within which a policy is implemented thereby influencing policy success or failure. Institutions are capable of generating and implementing prescriptions that defined along lines of a legitimate participant; the kind of acceptable agenda as well as prescribing sanctions in case of deviations (Thoenig, 2011). Individual/actors responsible for actual implementation of the policy are also empowered and controlled by these institutional contexts. Institutions influence the conduct of "public administration not only by stating what they have to do when and how" but also by shaping "the imagination of the actors about alternatives and solutions in new contexts"

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(Thoenig, 2009). Institutions shape decisions about resource allocation, leadership position as well as policy outcome (Patterson, 2006).

Tanzania has established an extended institutional framework to prevent and control HIV epidemic. One of the earliest efforts by the government was establishment of a National Task Force in 1985 (URT, 2000; Garbus, 2004; TACAIDS, 2009). The Task Force, whose members were selected randomly from different organizations, played an advisory role to the government (TACAIDS, 2009). In 1988, the Task force was transformed into the National AIDS Control Programme (NACP) under the Ministry of Health. In its attempt to confront the growing epidemic, NACP developed three Medium-Term Plans for the period between 1987 and1991, followed by the second and third medium-term plans for the periods from 1992 to 1996 and from 1998 to 2002 (Garbus, 2004; TACAIDS, 2009). However, despite combined efforts, the short-term and medium-term plans between 1986 and 2002 failed to reverse the trend of the epidemic at national level (TACAIDS, 2003; TACAIDS, 2009).

Following failure of the early days' efforts to control the epidemic, it was felt that the special unit located in the Ministry of Health had insufficient capacity. To provide institutional leadership for the country's national response to the epidemic, the Tanzania Commission for AIDS (TACAIDS) was established by the government by an Act of Parliament (Tanzania Commission for AIDS Act no 22 of 2001) in 2001. Placed under the Prime Minister's Office, TACAIDS's role is to intensify the national response through strategic leadership, policy guidance and coordination of the public, voluntary, private and community efforts (TACAIDS, 2009). Since its establishment, TACAIDS has implemented three National Multisectoral Strategic Frameworks (NMSF), the first one was implemented from 2003-2007, the NMSF II was implemented from 2008-2013 and the third NMSF was implemented from 2013 to 2018. Tanzania adopted its current HIV and AIDS Policy in 2001, about 18 years after the first case of HIV was reported in the country in 1983. The policy is divided into four thematic areas that include the following: Cross cutting Issues, Prevention, HIV and AIDS Care and Support and lastly, Social and Economic Impact Mitigation. Furthermore, to give a legal effect to the National Policy on HIV and AIDS of 2001, the parliament adopted the HIV/AIDS (Prevention and Control) Act of 2008. The Act was signed into law on the 4th April 2008 by President Jakaya M. Kikwete.

Under the current institutional framework, HIV prevention services have been implemented throughout the country. Approaches towards prevention of HIV have been broadly categorized into two: biomedical approaches and behavioural approaches. Biomedical means of HIV prevention include condom use, treatment of sexually transmitted diseases (STDs), HIV testing interventions, and safe blood transfusion. Others include therapy to reduce perinatal transmission (prevention of transmission from mother to child) and anti retroviral therapies (ART). Behavioural approaches, on the other hand, seek to reduce high risk practices such as unprotected sex, early sexual debut, multiple sexual partners, inter-generational sexual relations, sharing needles for drug use and the like (URT, 2005; URT, 2009; TACAIDS, 2012). In their application, HIV prevention interventions either target specific groups or can be used as a mass based approach.

Implementation of policy on prevention of HIV transmission under the presented institutional framework is reported to have made notable strides particularly in reducing the overall HIV infection rates at national level. However, such decline in HIV infections at national level does not seem to reflect what transpires in terms of HIV infection rates across specific regions. While HIV prevention services seem to be effective in terms of reducing HIV infection rates in some regions, infection rates in other regions remain significantly high and are on the increase. For example, in the period between 2008 and 2012, infection have increased between 1.5 -2 percent in 7 out of 21 old regions. In Kigoma, for example, infection rates increased for approximately 2.3 percent from 0.9 percent in 2007 to 3.4 percent in 2012. In Ruvuma, infection rates increased from 5.4 percent to 7.0 percent during the same period (THMIS, 2007/2008; THMIS, 2011/2012). Increased infections rates are also reported in Arusha, Kagera, Kilimanjaro, Mtwara and Rukwa regions (UNDP/URT, 2014). Even in cases where HIV reductions have been reported, impressive reductions have occurred in more urban areas than in non-urbanized ones. In urban areas, HIV

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prevalence declined for approximately 3 percent from 10.9 percent in 2004 to 8.7 percent in 2008 and further declined to 7.0 percent in 2012. On the contrary, in rural areas, HIV prevalence declined for only 1.3 percent from 5.3 percent in 2004 to 4.7 percent in 2008 and 4.0 percent in 2012 (THMIS, 2011/2012). All this implies that prevention services are working differently across regions in Tanzania.

The purpose of this paper is twofold namely; One, to provide an explanation to the variation of HIV prevalence across regions in Tanzania, in which the paper argues that these variations in HIV results across regions in Tanzania are a function of institutions behind HIV Policy implementation; two, to highlight the gap between institutionalism perspective of policy making and implementation together with actual practice of policy implementation in Tanzanian context. Institutionalist theorists have argued that it is only government institutions, which give public policy three distinctive characteristics, namely, legitimacy, universality and coercion. That public policy can only be considered as public policy if and only if, it is legitimized by government institutions. However, unlike this argument, which still holds truth, in essence though, this paper argues that communities' legitimacies matter when it comes to HIV policies and intervention. Public policy becomes public policy if it receives legitimacy of both, government institutions as well as communities.

2. METHODOLOGY

2.1. Study Areas

The study was conducted in two regions of Tanzania namely; Kagera region and Njombe region. The decision to undertake the study in Njombe and Kagera regions was based on reported levels of HIV and AIDS prevalence rates. Njombe is the leading region with the highest infection rate in the country at 14.8 percent. Kagera region was included in the study for two reasons. One is that the first case of HIV was reported in this region and the region experienced a full blown pattern of epidemic before it managed to reduce the rate of infections. Two, the region is now marked among eight regions where infection rates have been increasing from 3.7 per cent in 2004 to 4.8 per cent in 2012 (THMIS, 2007/2008; THMIS, 2011/2012). From these two regions, two districts were selected namely; Makete in Njombe region and Muleba in Kagera region. These were purposefully selected with a guiding criterion of local HIV prevalence. Similarly, purposive sampling was used in selection of wards and villages. The only criterion that was considered during the selection process was again based on the local HIV cases. In Makete district, the sampled ward was Iwawa and the sampled village was Iwawa village. In Kagera region, the sampled ward was Muleba and the name of the village was Kaigara.

2.2. Sample and Sampling Procedure

The population of the study consisted different categories of respondents from different policy implementation levels. The first category of respondents comprised key informants, mainly, government officials from the Ministry of Health and Social Welfare particularly the National AIDS Control Program (NACP) and Tanzania AIDS Commissions (TACAIDS). Also included in the study were officials from the Prime Minister's, Office Regional Administration and Local Government (PMO-RALG). Specifically from the regional level the respondents included; Regional Medical Officer (RMO) and Regional AIDS Control Coordinator (RACC). From the local government level respondents included heath officials and HIV Coordinators from district (District Medical Officers (DMOs), District AIDS Coordinators (DACC), Village AIDS Committee members and some village health personnels (nurses/clinical officers).

Other respondents for the study included three officials from Civil Society Organizations involved in HIV and AIDS related activities such as mitigating the impact on HIV, providing education for prevention of the disease and the like. The said respondents included Elizabeth Glasier's Pediatrics Foundation (EGPF); Service Health and Development for People Living with HIV (SHDEPHA); and National Council for People Living with HIV and

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AIDS (NACOPHA). Lastly, the study also contacted ordinary citizens in the identified two rural districts. The sample size for the study was 83 respondents drawn from the mentioned population.

Table-1. Summary of the respondents of the study.

Level	Institutions/Population	Number of respondents
National	NACP Headquarters	1
	TACAIDS Head quarters	1
NGOs	SHDEPHA	1
	NACOPHA	1
	EGPF	1
Regional	RACC Office	2
	RMO Office	2
District	DACC Office	2
	DMO Office	2
Village	Health Workers	4
	Village AIDS Committees	2
Community	PLHIV	4
	Ordinary citizens (30ppl per village x 2)	60
Total respondents		83

The presented categories of respondents were obtained through purposive sampling procedure. The procedure was used because the study required including some specific population categories (PLHIV, youths, women and men) as well as some key informants from different levels involved in implementation of HIV and AIDS policy and programs. The degree of involvement in the HIV and AIDS interventions was used as the main criterion for eligibility and inclusion in the study. This criterion was used to identify the intervening sector, institutions as well as individuals. Purposive sampling was also used in selecting 60 respondents (ordinary citizens) in the rural areas who volunteered to participate in six (6) Focus Group Discussions. In the course of selecting the respondents, two criteria were considered, age and gender. In the actual conduct of the discussions, respondents were divided along age and gender lines (women, men/elders and youths). The age and gender differentiation was important for this study as it has been established that women and adults between 15-49 years of age have been hit hard by the disease (THMIS, 2007/2008; TACAIDS, 2012; UNAIDS, 2012). It was important that their views on effectiveness of institutions for HIV policy implementation were collected. Inclusion of elders in the study allowed the researcher to get their views on traditional and cultural practices facilitating spread of the disease as well as their views on how such particular practices impact on performance of institutions for policy implementation.

2.3. Data Collection

Data was collected from both primary and secondary sources. Secondary data were collected through documentary review. Documentary review aimed at evaluating scope and focus of HIV preventive services in the existing policies, laws, strategies, guidelines and frameworks governing HIV prevention efforts within the national response on HIV and AIDS at different levels. In terms of scope, documentary review for the study was limited within three categories; national, institutional and local government levels. At national level, reviewed documents included documents such as the National HIV and AIDS Policy, HIV and AIDS Act, national Multisectoral frameworks, Tanzania HIV/AIDS and Malaria Indicator Surveys as well as other related strategies addressing HIV/AIDS in Tanzania. At institutional level, (MDAs, NGOs and the WHO/UNAIDS) and local government level (district councils, wards and villages), the review included various sectoral policies, guidelines and implementation plans.

Emancipatory research approaches which included focus groups discussions and in depth interviews were used in collection of primary data. Focus Group Discussions (FGDs) were used to collect data from ordinary citizens in selected villages. In each study village, three FGDs were held. Each FDG group consisted of 10 participants. The

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groups included a group of women, group of men/elders and group of youths (18-25yrs). Separation of participants was done in order to allow comparison across groups of different age groups, sexes and different involvement levels to HIV/AIDS interventions. It was anticipated that perception on extent of coverage of proposed HIV Prevention services as well as on performance of institutions in delivery of the said services differ across groups under studied contexts.

In-depth interviews were used to collect primary data from officials (policy implementers) in the Ministry of Health and Social Welfare, National AIDS Control Program, Tanzania AIDS Commission (TACAIDS) and the Prime Minister's Office, Regional Administration and Local Government (at district level downwards). In Njombe region, the researcher conducted 9 in-depth interviews and three FGDs with ten participants in each group (youths, women and elders/men), making a total of 39 respondents in the region. In Kagera region the researcher conducted 9 in-depth interviews and three FGDs with ten participants in each group (youths, women and elders/men), making a total of 39 respondents in the region. In depth interviews were also used to collect data from the three identified Civil Societies which have their Headquarters in Dar es Salaam. Similarly interviews with the officials from the National AIDS Control Program (NACP) and Tanzania AIDS Commissions (TACAIDS) were conducted in Dar es Salaam.

3. CONCEPTUAL AND THEORETICAL ISSUES

This study applies the institutional theory of policy making and implementation as its analytical guide. As a theory, institutionalism makes two major arguments or assumptions. First, the argument is that "institutions matter" (Przeworski, 2004; March and Olsen, 2006; Fukuyama, 2007; Acemoglu and Robinson, 2008). Institutionalism believes that politics and policy making take place in the context of institutions (Dye, 1981; Parsons, 1995). According to them, there are two major ways that institutions may influence policy and political actions. One, institutions, as entities, compose the largest part of political landscape and all policy governance related issues occur in or through institutions (Bell, 2002). Because of this position they occupy in the policy process, institutions are capable of constraining and superimposing conditions for mobilization, access, and influence (Amenta and Ramsey, 2010). Two, institutions influence policy by shaping powers and preferences of actors thereby limiting some forms of action and facilitate others (Przeworski, 2004; March and Olsen, 2006). It is claimed by the institutionalists that institutions create a greater regularity of human behavior rather than would otherwise exist. According to Osoro (2004) although institutions can be constraining for individuals, they can be facilitative for the community. It is common knowledge that communities would be better off if people followed rules rather than it would otherwise be or in absence of rules.

The second argument put forth by institutionalists is that institutions are endogenous (Przeworski, 2004; Immergut, 2011) meaning that, "each institutional arrangement can function only under some conditions; that the effect of particular institutions depend on the conditions under which they function" (Przeworski, 2004). In other words, while institutionalists agree that institutions matter, they, however, understand that their effectiveness is not automatic. Rather, institutional effectiveness depends on both their internal context and their external contexts (Blondel, 2006; Bratton, 2007; Fukuyama, 2007). The same institution may function variously under different conditions.

Literature on institutions is vast and competing with regard to aspects pertaining to institutions. Nonetheless, from literature, there are at least three meanings that scholars attach to the concept. Firstly, institutions are viewed as rules of the game (North, 1990; March and Olsen, 2006; Hyden, 2008; Amenta and Ramsey, 2010) secondly, institutions are identified with game players (Lawson, 1985; Thoenig, 2011) and thirdly, institutions are viewed as equilibrium of both (Aoki, 2001).

For economic institutionalism theorists, institutions are viewed exclusively as "rules of the game" (Hall, 1986; North, 1990; March and Olsen, 2006). North (1990) for example, defined an institution as "rules of the game in a

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society or, more formally, are the human devised constraints that shape human behaviour." Hall (1986) also viewed institutions as "The formal rules, compliance procedures, and standard operating practices that structure the relationship between individuals in various units in the polity and economy." For Hyden (2008) institutions are rules that are upheld by society over a long enough time to make a difference in an individual actor. The "rules of the game" can be formal or informal. Formal rules/institutions are such as constitution, property-rights rules, contracts and so forth. These are literally easily established, abolished or changed (Fukuyama, 2007). Informal rules/institutions, on the other hand, are derived from society's norms, belief, values, traditions and habits and in contrast, these are hard to be manipulated (Fukuyama, 2007).

For political theorists, institutions are viewed as "players of the game" rather than rules or procedures. To them, institutions are first and foremost organizations (Blondel, 2006). The argument put forward for this stance by political theorists is that rules and procedures that economic institutionalists emphasized on can only be recognized and applicable if, and only if, they are recognized and legitimized by an authoritative organization (Blondel, 2006). Therefore, in political context, "institutions are primarily organizations" (Blondel, 2006). Also it was argued by Thoenig (2011) that organizations, which are charged with handling public affairs ought to be regarded as institutions rather than instruments. The view is best presented by Lawson (1985) who defined institutions as "structures with established, important function to perform; with well specified rules for carrying out those functions; and with a clear set of rules governing the relationships between the people who occupy those roles." Organizations are important because they generate and implement prescriptions that classify how the game has to be played (Thoenig, 2011).

Those who have taken an equilibrium position see institutions as encompassing both rules of the game and players of the game. World Bank (2003) for example, views institutions as rules and organizations, including informal norms that facilitate coordination of human behaviour. Rules can be formal or informal (Hyden, 2006;2005). Informal rules evolve from norms to traditions and formal rules are from regulations, laws as well as constitutions and they are highly difficult to change. Organizations include government agencies, parliament, firms, police, court and civil society (Aoki, 2001). For analysis purposes, the study views institutions as rules that facilitate coordination for policy implementation together with actual execution of policy objectives. Rules can be formal or informal. Consideration of informal rules in this study is important because they play an influential role to formal rules and sometimes even replace them.

4. LITERATURE REVIEW

Researches have substantiated the impact that a country's institutions have on policy outcomes (Przeworski, 2004; March and Olsen, 2006; Acemoglu and Robinson, 2008; Green, 2008). Currently, questions of 'how and under what conditions institutions make a difference in policy implementations' have been a paramount concern (Przeworski, 2004). Concerns arise due to the fact that institutions, though might have a similar design, do not function uniformly across different contexts. Institutions are endogenous, that is, their forms and functioning depend on the context under which they emerged and endured (Przeworski, 2004). Therefore, similar institutions may succeed under some conditions but fail under the other conditions. Such conditions may be internal, for example, resources, configuration of the organization and so on or external, for instance, how the target population reacts to some proposed rules for managing new HIV infections (Przeworski, 2004; Blondel, 2006).

This paper assumes that institutional effectiveness matters in determining performance of HIV policy across regions in Tanzania. It holds that where institutions for HIV policy implementation have been effective, there have been low HIV infection rates. In contrast, where institutions have been ineffective, HIV infections remain higher or they are on the increase. Conceptually, institutionalism theory reasoning enables the identification of three variables of institutional effectiveness that are subjected to empirical examination. They include enforceability of rules, resources at disposal of organizations in-charge of policy implementation and actors in the organizations.

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As rules of the game, institutions serve at least two purposes: first, to constrain individual preference and instead, promote realization of collective actions; and two; promote sense of predictability in organizations' activities and consequently, to outcome(s) of collective actions (North, 1990; Green, 2008). However, achievement of "the rule of the game" predetermined goals is determined by the extent to which such rules are enforceable in society. When exploring factors for variations in institutional strength, Levitsky and Murrilo (2009) point out that enforceability is one of critical determinants. In this context, enforcement is taken to mean degree to which formal rules (written rules), in practice, are complied with. Levitsky and Murrilo (2009) conclude that some institutions are weak because actors who create them do not enforce them, whether intentionally or unintentionally. They (*ibid.)* called these organizations "window dressing institutions." In the same vein, Engerman and Sokoloff (2008) also propose enforcement of institutional rules or provisions as critical to success of whatever institution that exists. They (*ibid.*) place one condition to effective enforcement of rules such that rules or provisions being enforced should, first and foremost, be accepted (acceptability of the rules). In HIV prevention policy implementation, acceptability concerns are of paramount importance. Provisions for HIV prevention can only be effectively complied with by individuals and society if they accept them as legitimate or appropriate.

Institutionalism approach also places huge emphasis on actors within organizations. The assumption is that linkage between actors/individuals and institutions is reciprocal (Guy, 2012). While institutions are expected to constrain actors' actions or preferences in the organization, individuals also shape institutions within which they function. Tsebelis (2002) for example, speaks of the veto players, that is, any political actor who must agree for legislation to pass. They can be partisans or institutions. Veto actors affect outcomes of policy through their impact on the process by which policies are designed, approved and implemented (Spiller *et al.*, 2003). Most institutionalists agree that it is, in fact, actors/individuals at lower level of bureaucracy like street-level bureaucrats that generally determine what the law or policy means to citizens (Lipsky, 1980; Guy, 2012). As Guy (2012) correctly put it "the lower level echelon employees—often have substantial discretion over how implementation occurs and who actually gets what from the government." For this matter, institutional effectiveness has a lot to do with not only skills of individuals at the street level, but also their number and adequacy. For example, with regard to implementation of HIV prevention services, people will have more contact to health service personnel at the local level. Therefore, the number, adequacy and skills of these personnel determine accessibility levels to services.

The human resource is just a single dynamic in determining institutional effectiveness in policy implementation. Other resources such as adequate financial resources and physical resources, that is, infrastructures are equally important. For example, by using an example of institutions for choosing leaders through elections, Przeworski (2004) described how resource condition led to variations in functioning of the electoral system in two countries.

5. RESULTS AND DISCUSSION

5.1. Case 1: High HIV Prevalence: Njombe Region

Njombe is the hardest hit region in Tanzania. Currently, the region is leading in terms of HIV infection at 14.8 percent prevalence (THMIS, 2011/2012) with 103,910 of its 702,097 population living with HIV (URT, 2013). Prevalence rate is higher among women at 15.4 percent than men at 14.2 percent (UNDP/URT, 2014). HIV prevalence within districts in the region is also reported to be high, ranging from 8.6 percent in Makete district to 18.5 percent in Njombe Town Council in 2014 (URT, 2013). Table 2 elaborates.

Findings from the study indicated that enforcement of rules for preventing HIV in Njombe region is problematic, both as measured in terms of their availability as well as acceptability. Respondents identified several factors that they believed contributed to the high HIV prevalence in the region. When these factors are carefully interrogated, they narrow down to weaknesses in enforcement of rules for prevention of HIV as well as weaknesses in organizations charged with the responsibility of implementing the policies.

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Table-2. HIV Prevalence by district-2011/2012.

Council	HIV prevalence
Ludewa DC	9.5%
Makete DC	8.6%
Njombe DC	13.7%
Wanging'ombe DC	*
Makambako TC	*
Njombe TC	18.5%

Source: URT (2013).
*Included in Njombe DC.

One factor that was believed to contribute to the regional higher HIV prevalence was poor availability of services for HIV prevention. On one hand, most participants were able to identify almost all services that are advocated in the HIV policy and frameworks for HIV prevention purposes. In fact, many of them could easily name most of them. On the other hand, they argued that most services were unavailable at the facilities nearest to their communities. According to them, only some services, most behavioural interventions, were provided at dispensary level. Table 2 provides summary of services that were delivered at the nearest health facilities.

Table-3. HIV prevention services at the nearest health facility - Makete district.

	Behavioural interventions		Biomedical interventions					
Group	Condoms	HIV Education	ARVs	VCTs	PMTCT	Male Circumcision	STD Treatment	Blood Safety
FGD 1-Males	v	v	*	v	v	*	*	*
FGD 2-Females	v	v	*	v	v	*	*	*
FGD 3-Youths	v	v	*	v	v	*	*	*

Note: Key v=means service is available.

As it can be gathered from Table 3, most of provided services at the nearest health facilities to the communities were behavioural services. All groups indicated that condom promotion and distribution as well as education for HIV prevention were provided in the health facilities nearest to their communities. On the other hand, only some biomedical interventions were indicated to be provided in the health facilities. Services such as male circumcision were offered at health centers and district hospital. There were also other services that were only offered at the district hospital. They included ARVs and safe blood transfusions. ARVs are provided only in the district/regional hospitals and not in the dispensaries that were closest to the communities. Participants suggested that safe blood transfusion service was a difficult service to find even at the district hospital. The service was said to be irregularly offered and sometimes one would require a referral to Ikonda Mission hospital or Mbeya Regional Hospital (Interview with VHP-02, Makete district Njombe region). Dispensaries are facilities widely present in rural areas. In Njombe region, for example, out of 241 available health facilities, 209 are dispensaries (URT, 2013). The fact that some important services are not provided in these facilities literally means that services are not physically present. To most people, district hospitals are too distant to reach easily such that getting there involves costs that unfortunately create barriers to accessibility. In addition to service availability concerns, participants also mentioned several factors contributing to higher HIV prevalence in Njombe. As it shall be seen in the subsequent sections, these other factors suggest that even for available services, they have not been adequately utilized by people because they are conflicting with dominant cultural traditions of people in Njombe region.

5.2. Low rate of Male Circumcision

Medical Male Circumcision has been associated with lowering the risk of HIV transmission. However, the rate of male circumcision in the region was only 49.2 percent, less than the national average at 72 percent (THMIS, 2011/2012). Despite availability of services in the region, participants in FGDs suggested that some cultural practices in the region were to blame for the low prevalence of male circumcision in the region. It was explained

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that such practice was not culturally acceptable among Wakinga ethnic group in Makete district. Wakinga believe that a circumcised male breaches Wakinga norms. To be able to attend some rituals, one has to be complete. Removal of the foreskin during circumcision is equated to one being incomplete and therefore, cannot be allowed to attend any special Wakinga superstitious prayers to dead family members (known in Kiswahili as *mizimu*). Some villages with such practice in Makete district were named to be Lupombwe and Ukwama. Sadly, Ukwama village is one of the villages with the highest HIV infection rates in Makete District. Furthermore, some participants associated reluctance to undergo male circumcision with superstitions and witchcraft. Some believed that the skins removed during circumcision are used for superstitious rituals by witchdoctors.

5.3. Low Condom Use

In addition to low male circumcision rate, participants indicated low condom use as another contributing factor to high HIV prevalence. Condom use is known to prevent unwanted pregnancies but also prevent transmission of STDs as well as HIV virus. Nevertheless, participants suggested overall rate of condom use in the region to be very low. For cultural and traditional reasons, most women especially those who are married do not use condoms. Culturally, marriage is an institution meant, among other things, to produce children. Condom use would, on the other hand, make that aspect difficult. Besides, married women are expected to be faithful to one partner, the husband. A married woman insisting on condom use risks herself to be seen as unfaithful by the husband. Furthermore, participants also suggested that the problem widens by relative absence of female condoms in the communities. According to them, usually it is only male condoms which are distributed. Youth participants indicated that low condom use among the male youth was because it was claimed that condom reduces sexual pleasure, said in Kiswahili as *inaondoa ladha ya mapenzi*; translated that condom use removes taste/pleasure.

In addition, findings from this study showed that some religious teachings contribute to people's shaky attitude towards condom use. Some participants recalled the manner pastors and priests taught them to abstain from sex until they are married or remain faithful when married. In the FGD with the youth, some participants claimed to be taught in churches that condom use is a sin because it promotes promiscuity and goes against God's commandment on reproduction. On top of that, some participants suggested that sometimes information on condoms and condom use delivered by religious leaders in houses of worship were said to be misleading. One youth from FGD remembered how one Muslim cleric taught that condoms are made using pork's (swine) skin and thus, it is forbidden (*kha'raam*) to touch them. Another recalled how a pastor informed them that condoms do not prevent HIV at all, but they only prevented them from unwanted pregnancies. According to the priest, participants recalled that, in the first place, those who made condoms, made them for purposes of preventing unwanted pregnancies and that condoms were not meant to prevent HIV transmission.

Furthermore, apart from providing some misleading information that affected people's attitude towards condom use, some faith-based institutions prevented people from accessing them. At Ikunda Mission Hospital, which is used as a referral hospital by many in Makete district, condom distribution is done by a doctor's prescription (Interview with ACC-03,Makete district Njombe region). Generally, HIV comprehensive knowledge in the region was found low. Only 38.7 percent of women and 51.8 percent of men had comprehensive HIV knowledge (THMIS, 2011/2012). It is not surprising to also note that a significant number of population in Njombe region does not support HIV education including condom use. Only 54.5 percent of women and 66 percent of men supported education about condom use to avoid AIDS particularly among the youth (THMIS, 2011/2012).

5.4. Polygamy and Multiple Partnerships

Participants in FGDs disclosed that multiple partnerships were a common practice not only in Makete district but in the region in general. That was contrary to what is promoted in the HIV/AIDS campaigns about reduction of number of partners (single-partnership) as a way for one to protect him/her from the virus. In Njombe region,

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11.8 percent of men are in over two wives polygamous marriages (THMIS, 2011/2012). It has been established that acceptance level of this particular service differs between the two dominant religions in Tanzania. While single partnership is a religiously acceptable practice among Christians, polygamy, on the other hand, is an acceptable practice to Moslems. Instead of insisting on reduction of sex partners, Moslems would insist on faithfulness amongst several partners. However, further analysis into this issue suggests that in Njombe region, difference in acceptance level of single partnership against polygyn does not end in religion alone. Findings from this study revealed that in fact, more people are in informal polygamous relationship than those who have made it formal. According to THMIS (2011/2012) about 25.4 percent of men in Njombe region have multiple sex partners, which is higher than the national rate at 21 percent.

Apart from cultural and traditional factors contributing to multiple/polygamous relationships in the region, participants in FGD associated practices of multiple partnerships with cold weather. Njombe is one of the coldest regions in Tanzania. The temperature in the region ranges from below 0 degrees Celsius (^{0} C) in May/June to about 20^0 C in the months from October to November and long rainy seasons that range from 600 millimetres (mm) to 1,600mm per annum (URT, 2013). According to participants, because of the cold weather, most people found it difficult to sleep alone at night. So they looked for partners to keep themselves warm. It was highlighted that in Njombe region, most people work in soft timber and tea plantations. This implies that they spend considerable time away from their families. In such situations, they search for temporary partners to 'keep them warm.'

It is known that two or more bodies laying tightly together produce more warmth than one body. To survive in cold conditions requires one to have special warm clothing such as thermal wear, heavy blanket and the like. However, those may not be affordable by many people thereby given prevailing high poverty levels in Njombe region. Perhaps sleeping with a partner is considered as the cheapest way. Therefore, strategies to promote single partnership as a measure to reduce HIV transmission should be implemented with an understanding that it should go beyond one's religious affiliations and culture.

5.5. Low HIV Knowledge and Behavioural Change

Proper HIV knowledge equipped an individual with the tool to prevent oneself from getting infected. Participants in FGDs indicated that although HIV education on HIV prevention has been provided, it has never been satisfactory. The THMIS (2011/2012) indicates that 38.7 percent of women and 51.4 percent of men in Njombe have comprehensive knowledge about HIV and AIDS. According to the participants, HIV education has not been provided widely because of health workers' inability to get to the hard to reach villages because of poor road infrastructure, shortages of funds and inadequacies in their numbers. As a result, transition of generation that has not been adequately provided with HIV education.

5.6. HIV Prevalence Figures are Inflated?

Low HIV education and reluctance to behavioural change seem to be creating a new problem in the region; denial about seriousness of the disease. In a very surprising way, male participants in FGD in Makete district denied that Njombe region was the most affected region in Tanzania. According to them, Njombe region's HIV statistics were inflated particularly at Ikonda Mission Hospital. This was their hypothesis, Njombe region is surrounded by two other regions, which have high numbers of HIV infection rates, namely, Iringa region (9.1 percent) and Mbeya region (9.0 percent). Because of stigma, most people do not attend CTC services in the facilities nearest to their homes. They prefer to travel far to remove the possibility of meeting people they are familiar with such that their HIV status is hidden. Apparently, they claimed that most people from Iringa and Mbeya regions prefer to go to Ikonda Mission Hospital for their CTC clinic. Since people do not reveal their true addresses during hospital registration, they are considered as Njombe residents and consequently, that distorts the regional HIV figures.

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Several researches have substantiated that stigma forces HIV patients to by-pass the nearest health facilities and travel far (Akin and Hutchinson, 1999; Klemick *et al.*, 2009). However, the influx of patients from Iringa and Mbeya in just one out of ten hospitals in the region cannot be claimed to be the only problem. As indicated in the presented discussion, there is no behavioural change among the population. Most people still engage in risky behaviours that put them in danger of getting HIV or transmitting the virus to uninfected individuals. Furthermore, for cultural and traditional reasons, services that have been made available for preventing services are not utilized. Denial that there is a real problem just complicates the situation even further. In a state of denial, chances are that most people will continue with risky behaviours.

Therefore, what can be gathered from these findings is that there are serious clashes between institutions in the region as rules. On one hand, the formal institutions are clashing between themselves - rules advocated for HIV prevention by the government against rules by religious institutions. Religious institutions do not support many of the interventions advocated for HIV prevention as signified by their deliberate efforts to provide misleading information to their followers and even preventing people from accessing them. Condoms are distributed in religious own health facilities only by doctors' prescriptions. On the other hand, the formal rules are clashing with the informal rules. Because of cultural and traditional factors, people do not utilize most services that could help them to protect themselves from getting infected such as male circumcision. Acceptability of services is seriously challenged by clashes between formal and formal rules and between the formal and informal rules, which, in turn, affected level of people's attitude towards some services for HIV prevention. On top of growing clashes between formal and formal rules and between formal and informal rules in the region, there is also denial of seriousness of the epidemic in the region. Apparently, people in Njombe do not believe on statistics indicating their region being the hardest hit of all regions in the country.

5.7. Case 2: The High to Low to "Reversing" HIV Prevalence: Kagera Region

The first case of HIV in Tanzania was first reported in this region in year the 1983 at Ndolange Mission Hospital in Muleba District. Soon thereafter, the region experienced a major outbreak of pandemic (Kwesigabo, 2001). In just four years, HIV cases increased from 3 cases in 1983 to 1,663 in 1987 (URT, 2000). In 1987, the Kagera AIDS Research Project (KARP), which aimed at investigating dynamics and spread of HIV in Kagera divided the region in three zones based on observed HIV prevalence, high prevalence zone, medium prevalence zones and low prevalence zone (Kwesigabo, 2001; Frumence *et al.*, 2015). The rate of HIV infection in high prevalence zone in the region such as Bukoba urban district was reported to have reached as high as 32.8 percent among hospitalized patients and 24.2 percent in general population in 1987 (Kwesigabo, 2001). In the medium prevalence zone, which consists semi-urban areas such as Muleba district and low prevalence zones such as Karagwe district, HIV infection reached 10.0 percent and 4.5 percent in 1987, respectively (Kwesigabo, 2001).

However, for the past 15 years, Kagera has experienced a significant decline in HIV infection in all three zones. In high prevalence zone, HIV incidence is reported to have declined from 24 percent in 1987 to 18 percent in 1993, to 13 percent in 1996, and to 8.2 percent in 2004. In the medium prevalence zone, HIV occurrence declined from 10 percent in 1987 to 6.8 percent in 1996 and to 4.3 percent in 1999. In the low prevalence zone, HIV incidence declined from 4.5 percent in 1987 to 2.6 percent in 1999 (Frumence *et al.*, 2015). Decline in HIV prevalence is supported by a downward trend in the regional statistics. Surveillance reports indicate that Kagera region managed to reduce HIV prevalence from 3.7 percent in 2004 to 3.4 percent in 2008 (THMIS, 2007/2008; THMIS, 2011/2012). Sadly though, an increase of 1.4 percent has been reported in 2012 and now HIV prevalence in the region has reversed to 4.8 percent (THMIS, 2011/2012).

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5.8. Explanation on Decline of HIV Prevalence in Kagera Region

5.8.1. Behavioural Change Factors

Behavioural change is capable of altering the course of epidemic and thus, contributes to HIV downward trend. The observed decline in HIV in the region was due to behavioural change resulted from observing the agony brought by HIV and AIDS. Most participants in FGDs and in-depth interviews indicated that having witnessed how disastrous HIV can be, the grief as well as agony that both individuals and families experienced, triggered adoption of safe behaviour to most people in the region. Almost all participants indicated to have lost a family member, a relative or a friend and/or at least knowing a family that has suffered the loss of their members. AIDS was a real threat and everyone knew he/she was susceptible to the scourge. Participants in FGDs explained that while HIV prevalence was at its peak in the region, there was a sudden increase in condom use and sticking to one partner as most people feared from ending up in the same fate. In-depth interviews with one AIDS Control Coordinator in Kagera region disclosed how fear from HIV and AIDS forced people to change their risky behaviour(s). He narrated during interviews that,

> "Wahaya do not burry their loved ones in public cemeteries. Instead, they lay to rest their loved ones in their farms or just around the household. The number of graves just on the door steps was a constant reminder of a relative succumbing to AIDS and a warning to those remaining relatives of what awaits them if they do not play safe" (Translation: Interviewee ACC-05, Muleba district Kagera region).

In addition, participants also explained how communities encouraged people to get married early and stay in their marriages as a mechanism to shield themselves from HIV transmission. During interviews with one village elder in Muleba district, he narrated how community reacted to HIV by promoting early marriage to youths and the manner it contributed to decline in HIV transmission. According to him, elders in the communities thought that if youth got married early and remain faithful to their partners, they will be protected against HIV transmission. As a result, most people decided to get married early so as to reduce chances of engaging into premarital sex. Previous studies on HIV declining trend in Kagera region appear to be supportive of elders' claim. In the discussion of findings from the study "*Trends of HIV Infections in Kagera region of Tanzania 1987-2001*, Kwesigabo (2001) narrates that,

> "The proportion of individuals getting married and those marrying at an early age was found to rise in all the study areas…these behavioural changes may have been responsible for the observed changes in HIV prevalence and incidence. Marriage at an early age on one hand and sticking to those partners may, on the other hand, explain the lowered transmissions in the study areas. Early marriage decreases the likelihood or duration of premarital sex, which, if not practiced safely, may predispose individuals to an increase risk of infection."

Furthermore, participants in the study indicated that practices of multiple sexual partners among men and women (married and non- married) became uncommon compared to era before HIV was discovered in the region. Before AIDS, people actually did not fear from sexually transmitted infections because they knew such diseases could easily be cured and thus, they engaged in unsafe multiple relationships. However, arrival of AIDS in the region and fear from being associated with getting sick from the virus was reported by many to have forced people to change their attitudes towards such malpractice. Participants in focus group discussion argued that an increased awareness among people that if one partner got infected would put another at risk, turned couples as "each other's keeper." Findings from in-depth interviews revealed that currently, incidences of separation and divorce are becoming very common particularly in families where one spouse is infected and the other is not or where both partners are infected.

Related to decline in multiple sex partnership, there was decline in other bad marital practices such as inheriting widows. It was reported because of fear from catching HIV virus, less and lesser people agreed to the practice. One male participant in focus group discussion in Muleba district remarked that, *"Even if it is your own*

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brother, it is insane if one agrees with this practice nowadays with AIDS everywhere" (Male participant FGD, 26 March, Muleba district Kagera region). Widow inheritance widows as a practice required a brother to inherit his deceased brother's wife.

In most cases, HIV behaviour change, in general, population has been linked with a programmed intervention of some sort. That had, in early years, not being the case with regard to Kagera region. For significant period when AIDS was out of proportions, there were apparently no systematic and coordinated programs that could have been linked with sudden change of behaviours among people around that time. Instead of change of behaviours been triggered by interventions, it was fear from HIV that forced people to change their risky behaviours. This implies that sometimes, behaviour change is not a result of a programmed intervention. In the discussion of findings from the study that examined the trend of HIV and AIDS in Kagera, Kwesigabo (2001) argued that there were other factors apart from policy interventions that explained downward trend in areas that he had studied. He was of the assumption that fear from HIV was forcing people to change their risky behaviours. He narrated that,

> "The absence of any significant colleration between HIV seroprevalence trend and healthcare policies suggest that other factors are more influential than national policy in determining such trend and, by extrapolation, trend in AIDS prevalence. This implies that in areas where no specific interventions for HIV/AIDS exist, other factors may be responsible for the observed trend.....It may be also be pointed out that, the mere presence of an HIV epidemic in an area with its enormous consequences such as grief and agony experiences at both individual and community level, on their own, may have indirect effects on the trends of the epidemic" (Kwesigabo, 2001).

Furthermore, contrary to an increased belief that early marriages promote HIV transmission, it is interesting to note that at some particular times, the same practice can be linked with HIV prevalence declined.

5.9. The Role of Government

Findings from the study further revealed that prompt government response and commitment in the fight against HIV in Kagera played a great role to the observed decline in the region. The government established the National Task Force in 1985, just three years after the first case of HIV was reported in the region. The Task Force played an advisory role to the government pertaining to HIV epidemic. In 1988, the Task Force was transformed into the National AIDS Control Programme (NACP) placed under the Ministry of Health. The NACP established an extended structure at regional (Regional AID Control Coordinators) and district level (District AIDS Control Coordinators) to coordinate efforts to combat spread of HIV. Again, since Kagera region was the epicenter of the epidemic, these structures were heavily endowed with resources by the government to see that the epidemic was controlled. Key informants revealed during in- depth interviews that NACP were very instrumental in the region since its establishment. They organized massive public campaigns through billboards, meetings, seminars and workshops to raise awareness among people on HIV. The platforms were also used to distribute free condoms and taught people about its proper use.

On top of investing on institutional structures, the government also invested heavily on awareness campaigns particularly among youths who were in educational institutions. The researcher was informed, during in depth interviews with key informants, that in early 1990s, the government adopted a special policy that allowed Kagera region to introduce a special curriculum "Education on HIV and AIDS" in primary schools. Two teachers from each primary school in the region were trained to implement the said special curriculum to primary schools in the region. The special education may have, without doubt, increased HIV awareness levels among children in the region and equipped them with necessary skills to prevent themselves from HIV transmission.

Furthermore, participants in the study also linked the government decision to be more open and strengthen its relationship with non-government organizations with the observed HIV decline in the region. Participants explained that on the onset of HIV, numerous NGOs were established locally and others from outside the country

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keenly engaged in HIV related activities in Kagera region. The first NGOs such as AMREF, RED CROSS and RAC and Kanisa Katoliki na UKIMWI (KAKAU) started their operations in the region as early as 1989. By 1993, there were around 13 NGOs involved in HIV related activities in different parts of the region (Kwesigabo, 2001). They were involved in training of peer educators, provided HIV education, distribution of free condoms as well as home-based care and HIV counselling. Others were involved in mitigation of HIV impact by providing support to HIV patients, HIV orphans and spiritual counselling. The government was reported to be very open and supportive to NGOs' activities on HIV. That helped in expansion HIV prevention services in more areas in the region than would otherwise have been if the government was to act alone. For example, many participants in the study exemplified government and NGOs' relationship in expanding ART services. Personnel from NGOs personally visited HIV patients in the residents to provide them with needed drugs so as to ease the suffering. Effective ART has been known to reduce chances of an individual transmitting the virus to other non-infected individual(s). HIV/AIDS/STIs Surveillance reports indicate that number of clients enrolled in ART in Kagera region increased. The number increased from 13,880 patients in 2010 to 15,312 in 2011 to 20,511 patients in 2014 (HIV/AIDS/STIs Surveillance Report Number, 22, Number, 23; (URT, 2014)).

5.10. The Role of Research Organizations

Observed decline in HIV prevalence in Kagera region is also linked with the role played by research organizations in the region. Apparently, proportions of HIV and AIDS epidemic in Kagera region attracted many researchers, both from within the country and outside the borders who wanted to investigate as well as understand the nature and dynamics of HIV/AIDS epidemic. One of the research organizations that was commonly indentified in in-depth interviews with key informants was Kagera AIDS Research Project (KARP). KARP was established in 1986 as a bilateral collaborative research project between governments of Tanzania and Sweden. It has been operational in the region since then. The project is constituted by researchers drawn from different disciplines (multidisciplinary project). That followed realization that AIDS could not have been effectively understood from a single discipline. In its inception, the project had aimed at understanding proportions of AIDS epidemic, factors associated with transmission of the virus in the region and its consequences in the general population.

There are several ways that AIDS research endeavors may have contributed to the observed declined in the region. One is that, through research, political, economic and socio-cultural factors, practices and behaviors that fuelled transmission of HIV were indentified. Findings were instrumental to both the government and other actors engaging in HIV prevention and mitigation activities to plan about programs as well as interventions to curb further spread of the virus. Two, early information gathered through researches has been used by the government to design its national HIV policy, NMSF and other instruments (Killewo and Sandstrom, 1994; Kwesigabo, 2001; Lugalla *et al*., 2004).

5.11. Explaining the "Reverse" in HIV Prevalence

After several years of observed HIV prevalence decline in Kagera region, currently, reports indicate that the trend is reversing. The 2011/2012 THMIS report shows that HIV prevalence increased from 3.4 percent in 2007/2008 to 4.8 percent in 2011/2012. Findings from this study indicated several factors that can be attributed to such reversing trend.

5.12. Enforcement of Rules for HIV Prevention

It was argued before in this paper that people's cultural, norms and traditions play a great role to an individual's acceptance of particular HIV prevention services. If it happens that cultural practices and belief clash with the proposed HIV strategies, chances are that acceptance levels will be very minimal. Historically, Kagera is a non-circumcised region. Efforts to promote male circumcision were strengthened after the onset of HIV. However,

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participants in FGDs in Muleba district suggested that because of some cultural reasons, adult male circumcision in Kagera region is still very low. Male circumcision rate in the region is only at 38.9 percent (THMIS, 2011/2012). Again, despite government interventions to promote the practice for purposes of preventing HIV transmission, the rate has been very low compared to national rate. In fact, the trend has remained so over the years. For example, in 2007/2008, only 38.2 percent of males were circumcised in the region. In 2011/2012, the rate is reported to be 38.9 percent, suggesting that there have not been any significant increase. Some participants in FGDs in Muleba district associated low male circumcision rate with religious reasons that male circumcision is anti-Christian.

On top of having a big number of uncircumcised male populations, participants also suggested that there was a serious problem with regard to condom use particularly among youths. Condom use prevents not only transmission of STDs and HIV but also as a birth control mechanism. However, findings from this study revealed that not having children was very undesirable in the communities. Participants in the FGDs in Muleba district explained that every member in the community is expected to have children. If a person dies childless, some cultural rituals have to be performed during the burial so that his/her spirit will not come back to haunt the family known in Kihaya as *e'nchweke*. The rituals include burying the body with a banana stem in the grave. According to most participants, the desire to have children has forced many youth in the district to get married very early and refuse to wear condom because that would mean preventing chances of getting a child.

Besides, participants also described some sexual styles and practices during sexual intercourse, which make condom use very impractical. Participants indentified the *katerero* (others called it *kachaburi*) as the common style among Bahayas and other ethnic groups in the region.The nature of such sexual style literary implies non-condom use to both partners. Participants described condom use during *katerero/kachaburi* as impractical because it would prevent the satisfaction/pleasure intended in doing the style. These sexual styles have been practiced for decades. The styles were safe as there was no threat of HIV. But with the presence of HIV the story is different.

In addition, incidences of people engaging in multiple sex partnership have been coming back fast. Data from documentary review revealed that in 2007/2008, about 10.5 percent of men in Kagera region had over two sexual partners (THMIS, 2007/2008). The number declined fast to 4.3 percent in 2010 before it rocketed back to 11.4 percent (THMIS, 2011/2012). Sex network is known to contribute in fuelling transmission of HIV virus. When incidences of multiple sexual partnerships are linked with low condom use and low adult male circumcision, they can trigger an avalanche of new HIV infections.

Related to that is weak expansion of some services for HIV prevention in the region, which consequently, lead to their weak utilization by the intended target. Participants described that although services to prevent transmission of HIV of mother to child (PMTCT) was rolled out in the region relatively early compared to many other regions in Tanzania, the service has not been adequately utilized by pregnant women. PMTCT is delivered to HIV pregnant women during ante-natal visit in health facilities. In Kagera region, average ante-natal visit by pregnant women is below 50 percent. The Tanzania Human Development report indicates that only 46.49 percent of pregnant women in the region attend ante-natal care and only 53.8 percent of them give birth in health facilities (UNDP/URT, 2014). Low ante-natal visits imply that, among other things, most women do not get tested for HIV when pregnant and because of that, if they are positive, the likelihood that they will transmit the virus to their children either during giving birth or breast feeding is high. Participants described several factors contributing to low utilization of ante-natal care facilities in the region. Apart from cultural explanation that the woman is considered courageous if she delivers at home, factors such as distance to the health facilities were commonly identified. Participants argued that the government has not been able to expand the service to many areas in the district particularly in small islands in Lake Victoria. Apparently, most of these lands are heavily populated, but do not have access to health care facilities.

Therefore, what can be gathered from the ongoing discussion is that Kagera region has been exemplified for its achievement to lower HIV prevalence rates in Tanzania. This was a result of a range of behavioural changes

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triggered by fear from HIV among the population that had consequently led to the observed decline. Conventionally, implementation of some prevention programs in the population to reduce HIV transmission is linked with behavioural changes which, in turn, led to the decline in the rate of HIV infections in the population. However, in early days of HIV in Kagera region that was not the case or at least, the link is unclear. In contrast, fear from HIV played a major role to behavioural change. When systematic HIV interventions were finally introduced by some government and non-government institutions/actors, people were ready to embrace them. The trend is now reversing. Data suggest, among other things, increasing rate of risk behaviors in the region. This is partly because in the beginning, people only changed their behaviors following fear and agony brought about by the HIV scourge and because the era of HIV agony has passed, they have decided to normalize HIV and behave like in the pre-HIV era.

6. CONCLUSION

The purposes of this article were twofold; first to provide an explanation to HIV prevalence variations across regions in Tanzania, in which two cases were used; Njombe and Kagera. Njombe region was studied because is the leading region with highest HIV prevalence at 14%; whereas Kagera region is the HIV "reversing case". The article used institutional factors to explain these variations.

In the first case, findings showed that there are serious clashes between institutions in the region as rules. On one hand, the formal institutions were clashing between themselves - rules advocated for HIV prevention by the government against rules by religious institutions. Religious institutions do not support many of the interventions advocated for HIV prevention as signified by their deliberate efforts to provide misleading information to their followers and even preventing people from accessing them. Condoms are distributed in religious own health facilities only by doctors' prescriptions. On the other hand, the formal rules were clashing with the informal rules. Because of cultural and traditional factors, people do not utilize most services that could help them to protect themselves from getting infected such as male circumcision. Acceptability of services is seriously challenged by clashes between formal and formal rules and between the formal and informal rules, which, in turn, affected level of people's attitude towards some services for HIV prevention. On top of growing clashes between formal and formal rules and between formal and informal rules in the region, there is also denial of seriousness of the epidemic in the region. Apparently, as it is discussed in the findings, people in Njombe do not believe on statistics indicating their region being the hardest hit of all regions in the country. Again, given the fact that there is denial about seriousness of HIV in the region and growing clashes between formal and informal rules, which affect people's attitude towards some services, the possibility that people do not use health facilities cannot be ruled out.

With the second case, findings from the study revealed that it was the range of behavioural changes triggered by fear from HIV among the population that had consequently led to the observed decline. Conventionally, implementation of some prevention programs in the population to reduce HIV transmission is linked with behavioural changes which, in turn, led to the decline in the rate of HIV infections in the population. However, in early days of HIV in Kagera region that was not the case or at least, the link is unclear. In contrast, fear from HIV played a major role to behavioural change. When systematic HIV interventions were finally introduced by some government and non-government institutions/actors, people were ready to embrace them. The trend is now reversing. Data suggest, among other things, increasing rate of risk behaviors in the region. This is partly because in the beginning, people only changed their behaviors following fear and agony brought about by the HIV scourge and because the era of HIV agony has passed, they have decided to normalize HIV and behave like in the pre-HIV era.

The second purpose was to highlight the gap between institutionalism perspective of policy making and implementation together with actual practice of policy implementation in Tanzanian context. Institutionalist theorists have argued that it is only government institutions, which give public policy three distinctive

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characteristics, namely, legitimacy, universality and coercion (Dye, 1981). That public policy can only be considered as public policy if and only if, it is legitimized by government institutions. However, unlike this argument, which still holds truth, in essence though, the study findings revealed that theoretically, there is a gap between institutionalism theoretical thinking and actual practices of policy implementation in Tanzania. The study revealed that communities' legitimacies matter when it comes to HIV policies and interventions. Therefore, policy becomes public policy if it receives legitimacy of both, government institutions as well as communities. In fact, community legitimacy is even more important than otherwise.

In due regard, general findings from the study revealed that institutions matter, but their performance with regard to policy implementation depends on local conditions under which they operate.

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