HIV/AIDS Prevention in Uganda
- a Success Story

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We have had the unique opportunity to write our thesis in Uganda, where we were fortunate to experience a vastly different culture to that of our own and introduce ourselves to the African way of life. Through the development of our work, there have been many people who have shared their knowledge and thoughts about the difficult circumstances of HIV/AIDS in Uganda. For us this has been valuable information, and we are very grateful for their cooperation. We also want to show gratitude to the people close to us, for being a great support during this process, and everyone that has contributed to make this thesis possible.

We hope the reading will be enjoyable!

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Abstract

The purpose of this essay was to examine which marketing tools have contributed to Uganda’s accomplishments in the prevention of HIV and AIDS. We wanted to investigate whether or not marketing as a phenomenon actually can contribute to a better good, and how it is possible with non-profit marketing, where there are no goals of making financial profits, to reach out with proper knowledge to an entire population.

We chose to work within qualitative methods, and we have carried out our research by performing several open interviews with people who work with the difficulties of HIV/AIDS in Uganda. We also conducted a number of interviews with the citizens of Kampala, capital of Uganda, to get a different perspective of the marketing of HIV/AIDS.

Our theoretical framework consists of two main headlines, which are Marketing to Change Behaviours and Communication Tools. Under the first heading we discuss how it is possible to make people change certain behaviours, and what ways in carrying out the information will make people take action. Under the second headline, we explore the different tools that can be used to market a non-profit message for implementing behavioural change.

In the empirical data, we are presenting the voices of our interviewees, using the same two main headlines as in the theoretical framework. The discussion question if there has been any change in the behaviour regarding HIV and AIDS amongst the Ugandan population, and how to proceed to encourage behavioural change. The other central discussion concerns the tools used in the prevention of HIV/AIDS in Uganda, to be able to decrease the number of new infections.

In our analysis, we are discussing around the different marketing tools that have been used in the successful prevention against HIV and AIDS in Uganda and which have been more or less efficient. This discussion is completed in a conclusion, where we confine the main marketing tools that have been the key factors in the prevention information of HIV/AIDS. We are finally giving our recommendations about what tools we consider Uganda can implement to perform better in order for the disease to decrease even more.
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1. Introduction

In presenting this thesis an understanding of the background of HIV and AIDS, and our views concerning the situation in Uganda will be established. The purpose of the paper will be specified, as there will also be a discussion of the problem, with emphasis on a marketing perspective.

1.1 Preface

In the past, marketing was a powerful tool to persuade customers to acquisition. However, several authors over the years have enlightened different aspects of marketing theory in different directions, but few of them refer to the prevention of HIV/AIDS. In this thesis we want to examine if it is possible to broaden the views of the marketing concept in the direction of a non-profit context, with HIV/AIDS and the nation Uganda as the observed objects.

1.2 Background

HIV – Human Immunodeficiency Virus – is a virus as Croteau et al. (1993) and Hudson et al. (1988) state, which affects the body’s immune system. The virus is mostly spread through sexual intercourse, but can also be carried on by open wounds and through blood transfusions. If the disease is not treated, the immune system will collapse, which is called AIDS – Acquired Immune-Deficiency Syndrome.

HIV and AIDS is a global problem, which increasingly affects more and more people each day according to Ainsworth (2005). Since AIDS was first discovered, around 20 million people have died and today 60 million around the world live with the disease. O’Leary (2002) claims that HIV/AIDS and its implications constitute a severe developmental problem, in the worst affected countries. The most exposed are those situated in the third world and underdeveloped countries, where they do not have access to sufficient education, information, and health care systems.

For a long time, Africa has been the most affected region, where the problem restrains the welfare as well as the social and the economical development de Walque (2007) claims. As much as 65 % of the world’s infected population lives in the sub-Saharan region in Africa. Since the disease was discovered, many myths about HIV and AIDS have over the years been circulating in Africa and Wahren & Wahren (2007) mention that the president of South Africa, Thabo Mbeki, has denied that HIV causes AIDS, and his Health Care Minister in 2006, advocated garlic, olive oil, and lemon as a cure against the epidemic.

Even those who are not infected become affected by the epidemic, as many children are left as orphans when their parents fall fatally ill from the disease according to Auerbach & Coates (2000). Africa receives a large portion of the world’s aid and there are many active help organisations within the region states Kavuma (2007).
Despite this, the disease is continuing to spread. Even if Africa has come a long way in its prevention against HIV/AIDS, Wahren & Wahren (2007) show a text written in a Sexually Transferred Diseases clinic in 2006 which we believe shows that Africa still has a long way to go:

"You can not cure your aids by having sexual intercourse with a virgin or an albino."

One country in this continent that has been harshly affected, but who has accomplished to diminish the effects of the disease in recent years is Uganda. Parikh (2007) emphasises that this is extremely rare for any nation in the world to accomplish.

### 1.2.1 HIV/AIDS in Uganda

"I urge married couples to take personal responsibility to avoid risky sexual behaviour that could contribute to an upsurge in new infection and increase the burden of the epidemic. Abstain, be faithful and those who cannot practice these two should use condoms."

Yoweri K. Museveni
President of the Public of Uganda (2007)

In the Country Progress Report of Uganda the United Nations General Assembly Special Session on the Declaration of Commitment on HIV/AIDS, often called the UNGASS (2008) declaration, states that the disease spread rapidly in the 1980s in Uganda, with heterosexual contact being the central infection route. By the early 1990s the epidemic had its peak with 18% being infected in rural areas and up to 25–30% in urban areas. Between 1992 and 2000 a decline of HIV prevalence was observed, according to Uganda’s National HIV & AIDS Strategic Plan – UNSP (2007), and by this, Uganda became the first African country to begin to show a sustained decline in its national HIV infection rate according to Epstein (2007).

Since the year 2000, the HIV epidemic of Uganda, has been characterised by stabilisation of the HIV population at a level ranging from 6–7% as it is written in UNSP (2007). However, there is anecdotal indication of an apparent increase in the prevalence of HIV during the last few years, but this evidence is not yet compelling.

While the epidemic is still on the rise in most African countries, as de Walque (2007) argues, Uganda is one of the few countries in the world that has been doing well in fighting and preventing the epidemic. In realising this, there is a high potential in learning from the tools Uganda have implicated. Therefore we are interested to acquire more knowledge of the subject, with an emphasis on a marketing angle.

### 1.3 The importance of the Problem

As Epstein (2007) writes, the world wide AIDS epidemic is ruining families, villages, and businesses, and leaving behind an immense sadness that will linger for generations. The overall impact of AIDS on the global population has not yet reached its peak, and current projections imply that by 2015, the total population will be diminished by
115 million less through the devastation of AIDS, according to UNAIDS (2006). As Ruxin et al. (2005) state, AIDS is part of a development issue and most countries in high-prevalence areas experience extreme poverty. This is complicating the struggle against HIV/AIDS even more because low developed nations do not have the same prerequisites as developed countries.

Despite the frightening facts about the widespread disease, Uganda is a nation which stands out among the African countries, as it has managed to decrease the number of people getting infected by HIV by more than 50 % as stated by Asamoah-Odei et al. (2004). In the context of the prevention of HIV/AIDS, we want to examine if marketing as a device is useful and influential in reaching out with information to help an entire population in the fight against the horrible epidemic.

We are interested in exploring how the small nation Uganda, in the east of Africa, has been able to stand out in a large continent struggling with the same problem, by looking at actions made to inform the population about the disease. Since the highest risk groups are not only a minority as in the West, as Parikh (2007) states, it concerns millions of people. This is a complex task to carry out, and throughout this thesis an investigation will be undertaken to how it has been done.

### 1.3.1 Our Approach Concerning the Problem

The HIV/AIDS situation has been accentuated in many academic articles and reports, however focus do not contain a marketing viewpoint with Uganda as a central object. Therefore, this thesis will give a specific outlook of the problem and struggle in the nation from a marketing perspective by analyzing how Uganda has been successful in preventing the disease. An examination as to why the people in Uganda have processed the information about HIV/AIDS more so than the rest of Africa will be undertaken, and furthermore, observing how the marketing of HIV/AIDS has been used as a component for this country’s accomplishment.

According to Hultén et al. (2008) an expanded view of marketing is about adapting to the structure of the current situation in society. Uganda is a country of low development and their society is dissimilar to the west and terms as the authors refer to as vital in marketing such as life quality, spontaneity and emotion is not, in our concern, applicable in the HIV/AIDS marketing in Uganda.

According to Kotler & Andreasen (1996) marketing has for a long time only been related to business purposes with profit as the central focus, but Domegan (2008) indicates the dimensions are expanding into different views of marketing Katsjoloudes (2002) describes that non-profit organisations have an intention of reaching those in needs; providing access to and information about services, which is one of the valid functions of non-profit marketing. Jarlbro (2004) states commercial marketing to often encourage people to do something, like making a purchase, while the non-commercial marketing often wants people to take action.

In our approach we focus on non-profit marketing and our ambition is to investigate
whether or not this as a phenomenon actually can contribute to a better good. We want to investigate if it is possible with non-profit marketing, where there are no goals of making financial profits, to reach out with proper knowledge to an entire population. Since Uganda has been a great example of fighting back HIV/AIDS, we want to know how they could be prominent in Africa, where this seemed impossible, by analysing how the non-profit marketing has been used to prevent the epidemic from spreading even more.

As Earl (2000) underlines, it is possible to use techniques of marketing in a way that could have an important and beneficial impact on the public. Therefore will we examine what methods and tools that have been used in the fight against HIV and AIDS in Uganda. By doing this, we want to evaluate the key implementations of the preventions of the disease with communication efforts in focus, which has lead to our intention with this thesis.

1.4 Aim

Our purpose is to examine which marketing tools that have contributed to Uganda’s accomplishments in the prevention of HIV and AIDS.

1.4.1. Research Question

Is it possible to apply the marketing tools which have been used in Uganda to other countries in Africa with similar conditions?

1.5 Limitations

We have limited our research to only examine the African country Uganda. We will only focus on HIV/AIDS, and not get deeper into other sexual transmitted diseases that can be an indication of the spread of the virus, as Auerbach & Coates (2000) notify.

We do not want to write about marketing from a business approach, with an economic winning purpose, but instead out of a non-profit perspective.
2. Methodology

In this section we will describe what kind of approach and research method we conducted when producing this thesis. We will show how the empirical and theoretical data were collected as well as criticism about the chosen techniques. In the end an evaluation of the quality will be given.

2.1 The Research Approach

According to Neuman (2000) a researcher can approach the building and testing of theory from different directions, depending on the initial position of the study. A researcher can start by testing existing theories or by collecting empirical facts as Ruane (2006) exemplifies. Patel & Davidson (2003) explains the central core of the matter regarding scientific work is how to relate theory to the reality, and three ways are presented to achieve this; deduction, induction and abduction. The latter is the approach we chose to work by while implementing the study.

2.1.1 Abduction

In our research we used both a deductive and inductive approach, which is what Patton (2002) refers to as abduction. In the following text we will explain induction and deduction separately to give the reader an insight in what the both conceptions mean and later on introduce how we have combined these two into the abductive approach.

When using a deductive approach, the researcher starts with theory to prove relations in real situations as Olsson & Sörensen (2007) stress and this is coherent with what Patton (2002) claims. This is also emphasised by Neuman (2000), who states a researcher begins with an abstract to continue with concrete empirical evidence. The researcher deduces hypotheses from the theory that he or she wants to be empirically studied, both Bryman (2002) and Svenning (2003) state.

The inductive strategy refers to discoveries in reality to connect with broad principles to finally bringing them together in a theory, Olsson & Sörensen (2007) state and Neuman (2000) agrees with this description. The researcher tries to make sense out of a situation without pre-existing expectations from for example a theory, Patton (2002) confirms. An inductive analysis starts with an observation and then the researcher builds or modifies a theory from the collected empirical facts as Neuman (2000) argues.

We commenced our research process by making a deductive approach as we started out by finding theory to enhance our knowledge about the subject, and out of this theory we formed a base for the thesis in form of a theoretical framework. Consider the fact that we had never studied the connection between HIV/AIDS and marketing before, we needed to support our theories with empirical data.
When the empirical information was collected we analysed it to see how to best communicate information about HIV/AIDS in Uganda with our chosen theoretical background. By doing so we discovered new perspectives of the subject and here the inductive approach became present instead of the deductive. The mixture of these ways of conducting a research is what Patel & Davidson (2003) and Patton (2002) refer to as abduction, which we consider has been the most representative approach to what we have done.

### 2.2 Qualitative Method

We have chosen a qualitative method to write this thesis, which gives the research a personal depiction of events first hand through observations, the spoken word and the authors’ individual experience, as it is suggested by Olsson & Sörensen (2007), whose arguments are coherent with Patel & Davidsson (2003). We chose this type of technique as we believed this research was best observed in its immediate environment to be able to present the behaviours and experiences of the subject matter in an accurate perspective. Our desire was to get new perspectives of the subject which had not previously been brought up in the specific context chosen.

The characteristic of a qualitative method is its richness of information about a smaller group of people or cases as Patton (2002) states and as Olsson & Sörensen (2007) argue closeness to the subject exists. What is distinguishing this method is the strength of the word instead of statistics, as Allwood (2004) claims. We have documented real events, observed behaviours in reality and recorded what people have said, together by studying written documents, which is based around Neuman’s (2000) definition of the qualitative method. What has been central for us is the access to the individual respondent and her way of picturing the world.

We were aware of the criticism of a qualitative study due to the lack of reliability in this type of method as Ryen (2004) states, and Allwood (2004) together with Patton (2002) are saying, an interview will not lead to a broad viewed representation of the reality. Since our intentions were to reach a deeper and better understanding about the marketing strategies in the preventions of HIV/AIDS in Uganda, we considered a qualitative method as the most appropriate. Our ambitions were to get close to what people believe and consider the truth about the subject, and to do so we let them speak freely about it. We did not want to produce a generalized knowledge or compare different elements in this thesis. We have let all of our respondents’ voices being heard and not summarised them into over-all opinions and statements. We did not wish to make a research that could be made again with the same result, instead we wanted this thesis to be exclusive in its approach. This means our result is not applicable in an all-purpose, but instead points out and proves tendencies. With this said, we still want to declare the possibility to use our result in other related circumstances, in a broader spectrum, but with caution of simplification.
2.3 Data Collection

As Patton (2002) and Olsson & Sörensen (2007) suggest, there are two kinds of data collection in a qualitative method; primary data which includes interviews as well as direct observations, and secondary data which consist of written documents.

2.3.1 Primary Data

We collected our primary data through qualitative interviews with organisations working against HIV/AIDS and also by speaking to citizens of Kampala. What a researcher is trying to achieve by using a qualitative interview is, according to Ryen (2004), to mirror the reality that exists. Consequently during the interviews we have been able to observe behaviours in the existent surroundings which we believe add to our understanding regarding the studied matter.

The interviewer according to Trost (2005) should listen and ask questions and Creswell (2007) describes a good interviewer as a listener rather than a speaker. Olsson & Sörensen (2007) emphasise the importance of letting the respondent finish the sentence. When making a qualitative interview, Ryen (2004) mentions the questions should not be leading the interviewed person to answer in a certain way and this is developed further by Creswell (2007) and Berg (2004) who are writing the structure of the interview should be designed out of a few open ended questions.

We designed our questions from this standpoint and only asked a few broad open questions, which the persons being interviewed could freely discuss around without being interrupted. Therefore our respondents became co producers in the discussion instead of observers. The reason for us using this arrangement was that we did not desire to put words and ideas in the interviewees’ heads by asking closed questions, as we then believe the respondents’ truthful thoughts would not be heard. We consider our way of performing the interviews coherent with what Ryen (2004) accentuates, which is for the interviewer to play a neutral part and appear as an interested listener, without valuing the performance.

To further describe our way of working in the context of interviews, the term low standardised structure can be used, which is additional to what is mentioned above and according to Ryen (2004) distinguished by the interviewers’ use of language, the fact that questions can be asked in any possible order and additional questions are widely used. Trost (2005) and Berg (2004) continue to exemplify how the construction of an interview can be more or less standardised by determining if the questions asked are the same, from interview to interview and thereby also if the situation is identical. The reason for us using low standardised structure was, that each interview was unique and the outcome of the discussions was lead by the interviewees and not by us, in order to get a more truthful and accurate description of our interviewees’ realities. When necessary we asked additional questions if we felt something needed to be discussed further or be made clearer, but we were careful not to disturb or interfere the discussion and make the interviewee answer in a certain way. As a result, we did not get secluded or held back by a standard form of questions, which lead to discussions initiated by the persons’ interviewed.
When making an interview, many authors give examples of different aids to use for making the study easier and more valid. One specific technique we chose to utilize was an audio recorder. Using this kind of device during the interviews is something Trost (2005) together with Ryen (2004) think is positive, since you can listen to the discussion many times. They argue that the interviewer can listen to the respondent’s intonation and choice of words and also be critical to their own personal performance, and as Patton (2002) emphasises what has been said cannot be changed. Trost (2005) also claims some negative effects by using an audio recorder, such as the time consuming aspect of rewinding and listening to the tape, and that the body language gets lost. Although, Creswell (2007) recommends the use of adequate recording procedures, as he says, it can be difficult taking notes while interviewing and therefore recording the discussion can solve this problem.

We believe that by using an audio recorder we achieved a much better understanding of the interviews. If we failed to hear or understand something during the interview we listened to it again to make sure what the respondents actually said. Since it is recorded we are not able to change what was said, which we believe increased the validity of our thesis. The interviews have been performed face-to-face, where we have had a close and personal contact, observed behaviours and caught features such as the interviewed person’s body language and emphasizing of words. Therefore we consider the audio recorder more as a complement to the original interviews. We believe the positive aspects by using an audio recorder are greater than the negative ones and for that reason we chose to use this kind of device to achieve a good result.

According to Neuman (2000) the researcher should not present all the detailed notes from the interview in the report, but rather provide the reader with sufficient information and knowledge from the meeting. We have not written the whole interviews in our thesis, but chosen parts that we consider most relevant for the understanding of the text, but the full text interview can be found in the appendix at the end of our report.

### Selection

Trost (2005) mentions that the selector of respondents for qualitative interviews should strive to get as many different perspectives as possible, which also Ryen (2004) confirms. One ambush that easily occurs is to interview people who are relatively alike and therefore have more or less the same point of view. The selection should represent a variety of people but not too many who diverge from the selected frame of choice. Patton (2002) explains, by using a variety of sources, the observer can minimize the weakness of any single approach. In the selection process Ryen (2004) explains the researcher does not only have to decide who is going to be a part of the project, but also an environment where the purpose of the thesis really can be examined which also Berg (2004) maintains.

We started out with interviewing UNICEF and TASO, two of the leading non-profit organisation working with HIV/AIDS in Uganda followed by two more interviews, with the Ugandan AIDS commission and the AIDS sector of the Swedish Embassy. During these interviews we found out that the organisations working against HIV/AIDS in the country, including the government, work together in alike manners, but
focus in different areas and therefore we felt satisfied with the information given from this viewpoint. However, we did not consider this organisational perspective to be enough. As an outcome we wanted to get a deeper understanding of how the people exposed to the messages apprehend the given information and decided to talk to a number of citizens in Kampala to obtain their perspective of the subject and get a view of their knowledge and perceptions of the matter to understand what tools are successful. Since we had a restricted amount of time in Uganda and for the thesis overall, we were not able to perform a larger number of interviews. On the contrary, we consider, with the above said and with our time limitations, we performed as many interviews as according to us was needed for our thesis to be valid and of good quality. We also believed that for us a bigger selection would not be better, since we think the importance was not the number of interviews, but the information they presented.

2.3.2 Secondary Data

Secondary data consists of previously made research, according to Bryman (2002). Since the subject we chose to write about was not in the traditional marketing spectrum, we had to find other theoretical frameworks to broaden our former marketing knowledge, which would suit our subject. A different approach of marketing, as we see it, is more necessary when it comes to inform about HIV/AIDS than for example marketing a product in a business purpose.

In our research, books related to HIV/AIDS and the prevention in general existed, but the difficulty was to find literature focusing on the marketing regarding the disease. To get a better understanding about the subject matter, we used articles we found relevant for the thesis by using the Internet and the University of Kalmar’s library database for academic research. Here we obtained specific texts about the area in which we were exploring. We used the most relevant parts of traditional theory and complemented with substantial articles to get a suitable frame for our aimed purpose, according to us.

2.4 Research Quality

When writing a thesis, perfect reliability and validity is almost impossible to achieve according to Neuman (2000) which also Berg (2004) agrees with. In our qualitative study, the reliability was not of great essence for us as we believe it was not of importance to achieve the same results as we did, if the study was to be made again. Instead we tried our best to produce such a valid report as possible.

2.4.1 Validity

The most important way to create trust for the reader of a qualitative research is the way the authors present the evidence according to Neuman (2000) and the significance is the authenticity; to give a fair, honest and balanced description of the persons studied. To do so Olsson & Sörensen (2007) exemplify it is important to
carefully plan the observations and structure the collected information, which Berg (2004) confirms. We have after each interview, written them down, word by word to prevent too much of our own interpretations to occur. By doing this we mean the empirical data was not taken out of its right context and as a result misunderstandings were reduced.

Trost (2005) writes the difficulties in being completely objective in an interview and emphasizes how one's own values should not affect the respondents. Even Ryen (2004) says excessively subjectivity should be avoided. We have tried to be as objective as possible but we are aware, since we have previous preferences and sometimes been integrating in the discussion, that subjectivity to some extent will always occur. Neuman (2000) and Olsson & Sörensen (2007) advocate the essential in trying to understand the respondents’ way of thinking, and why they think like they do. The most important aspect is to give a truthful picture of the observed people which Berg (2004) exemplifies. We consider our thesis well-founded since we have interviewed people in their natural environment, with all writers present during the performance. We believed this lead to a better validation about what was said, how the interviewees said it and what he or she meant. By doing so, we have not taken the interviewees’ statements out of its context which otherwise could lead to false understanding.
3. Theoretical Framework

In this chapter we will present our theoretical framework under two main headlines, Marketing to Change Behaviours and Communication Tools. We will portray what we believe are the most relevant existing theories, from different authors, regarding our chosen subject.

3.1 Preface

Domeagan (2008) brings up the widely accepted perception that social problems have underlying behavioural causes. In the context of HIV/AIDS, Ruxin et al. (2005) specify there has been a shift in the prevention strategies in recent years towards trying to change behaviours and according to Holtgrave & Kelly (1996), HIV-related risk actions can be modified successfully with behavioural interventions which also Auerbach & Coates (2000) emphasise. To be able to implement behavioural change, we see marketing as a powerful device to use. Therefore the core of this chapter refers to how marketing is used to make changes in behaviour and as a second part, what communication tools can be applicable to achieve this in Uganda.

3.2. Marketing to Change Behaviours

New aspects of the marketing theory have been progressed and refined over the years, as Domegan (2008) claims, and a matured view of marketing, according to Formoso et al (2007), describes the process of behavioural change. Earle (2000) argues the use of skills from marketing can be applied to effect social change, to benefit individuals or society at large. Kotler & Roberto (1989) insist that marketing principles can be useful to advance a social cause, idea or behaviour. Basil & Brown (1997) suggest the possibility to apply marketing theories and methods to improve the health of individuals.

Communications is about building an understanding and encourage change according to Radtke (1998), and Solomon (2007) declares how receivers constantly are bombarded by messages inducing them to change their attitudes. As said by Jarlbro (2004), many information campaigns can achieve an increase knowledge and change attitudes, but only a few have an actual effect on people’s behaviour. Ewles & Simnett (2003) state that people are often at different stages of readiness to change over issues and as Berry (2007) states, changes in behaviours can occur when values and attitudes are shifted. Often attitudes and behaviours are so deeply embedded in the individual that information alone will not change them as said by House & Walker (1993) and Croteau et al. (1993) say that reduction of health risk is never a matter of “simple” behaviour change. Ewles & Simnett (2003) continues by saying that social and economical circumstance can prevent people from carrying out new health behaviour, even if they would like to.
3.2.1 Social Environment

Knowledge about HIV/AIDS can be present, but without an understanding about the social environment and respect of values held by individuals in the community, efforts of preventing the disease and related behaviours will be ineffective, as House & Walker (1993) state. According to Berry (2007) people make behavioural decisions on the basis of their values. Ewles & Simnett (2003) signify that major determinants of health are social, economic and environmental aspects and Streefland (2003) explains this by saying how someone’s image of a specific epidemic is shaped by how he or she socially and economically is positioned. A person’s lifestyle appears indirectly from the society’s formation and the individual position in it Jarlbro (2004) explicates.

Culture can also be used as a navigator of our actions Magala (2005) states and can be broadly defined as the learned beliefs, values and norms common to a group of people as said by Berry (2007). There is a growing recognition that the way people react to illness is rooted in their broader health belief systems, which in turn are culturally determined. Further described by Croteau et al. (1993) when promoting changes in behaviours as intimate as sexual expression, a persons’ cultural context cannot be ignored.

Social class is an element which influences behaviour as it strongly affects norms and beliefs, and therefore manners, indicate Hoyer & MacInnis (1997). Ewles & Simnett (2003) explain how we are more likely to be influenced by individuals in our own social class than by those in other classes, and they clarify by writing that this occurs because members of the same social class interact regularly among themselves, both formally and informally. Croteau et al. (1993) give further details about this and mean all behaviours, including that related to HIV and AIDS, arise within the context of the individual’s membership in a particular social group.

An additional aspect of the social environment is education which determines the response to information to increase knowledge, and in turn affects health outcomes de Walque (2007) considers. Education has shown to be important when it comes to risk judgement as Dahlén & Lange (2003) declare, as risk only exists if there is knowledge of it. If we do not know the risks in question it is risk free. Jarlbro (2004) and de Walque (2007) verify this by mentioning that the use of condom to prevent the risk of transmitting sexual diseases, has been shown related to educational levels. According to House & Walker (1993) the only effective method of reducing the transmission of HIV is education.

3.2.2 The Source of Information

Under most conditions the source of a message can, as Solomon (2007) writes, have a big impact on the likelihood of the receivers accepting the message, which Jarlbro (2004) agrees with by saying a message will not be received if using the wrong sender. The characteristics of the source play an important role, clarified by Hoyer & MacInnis (1997), when influencing the receivers’ beliefs and behaviours. Further
Ruxin et al. (2005) argue, when discussing HIV and AIDS, the message itself is of less importance, taking into account by whom it is communicated.

To look at it from another perspective, the same message can be brought out in identical ways, but be understood differently depending on whom the message derives from, according to Solomon (2007). Jarlbro (2004) states that research in health communication frequently shows the importance for the population in having faith and trust in those communicating the message. Credibility can also be particularly persuasive when people have not yet learned much about an item or formed an opinion of it, Solomon (2007) exemplifies.

Jarlbro (2004) develop this further by declaring that the choice of source depends on the group of people aimed to be reached out to, and sometimes the most powerful source is not the most effective one. Studies have shown how the social distance between the sender and the receiver can lead to misinterpretations of the message. Croteau et al. (1993) stress, individuals to whom the information is targeted, may be unwilling to place trust in messages delivered by professionals who exhibit different beliefs than themselves.

It may be possible, Ewles & Simnett (2003) write, to take help of significant people who are regarded as opinion leaders or trendsetters, such as political figures, religious leaders or pop stars. Croteau et al. (1993) describe how trends and innovations often are initiated by a relatively small segment of opinion leaders. Basil & Brown (1997) mention one of the most used strategies for invoking identification, is to use a celebrity, since it has been shown that exposure to media personalities over time leads people to develop a sense of intimacy and identification with a certain celebrity. Solomon (2006), Jarlbro (2004) and Hoyer & McInnis (1997), all agree about the positive effects by using a celebrity source.

According to Auerbach & Coates (2000), the more sensitive a message is for the population, the more equal, culturally insightful and appropriate the source needs to be. To Jarlbro (2004), the advantage by using this kind of source, is that the sender and receiver are at the same cultural level and the source can therefore formulate the message at a suitable level. The most successful AIDS projects, Epstein (2007) says, have tended to be conceived and run by Africans themselves or by missionaries and aid workers with long experience in Africa, in other words, by people who really know the culture. A likeness and recognition attract, and we tend to like other people similar to us, Dahlén & Lange (2003) state. We look for people alike to us and are also more prepared to listen to what they say.

An additional facet to sources is peer-education and Jarlbro (2004), Croteau et al. (1993), and House & Walker (1993) advocate this as an equal method for dispensing information. This is also something Ruxin et al (2005) suggest by saying that involvement of the vulnerable populations themselves, for instance through peer outreach, is critical to winning trust to the people aimed to reach. They underline that on a district level in the nation the communities themselves can bring about the changes in for example sexual and gender norms, which is also coherent with
Streefland (2003). To Croteau et al. (1993), the advantage is the potential credibility and trustworthiness of peers in delivering prevention messages. Ruxin et al. (2005) exemplify this by describing that people living with HIV are a particularly important resource and can bring valuable personal experience and a compelling perspective, as well as special motivation to various aspects of AIDS work.

**Word of Mouth**

Word of mouth is people talking to one another instead of professional marketers making the communication, according to Sernovitz (2006) and Blythe (2003). Personal communication from friends and other important people is a powerful form of communication, according to Evans et al. (1996). Sernovitz (2006) refines this by illuminating that there is considerable evidence that people are more likely to respond to what they hear from family, neighbours, and friends than from impersonal, distant sources like the mass media, billboards, and leaflets when spreading information about HIV and AIDS.

As Lundberg (2008) mentions word of mouth is seen as more trustworthy than traditional marketing communication since there is no profit gain behind the sharing of such information. Katsioloudes (2002) emphasises, word of mouth is a valuable source for any non-profit organisation, and Solomon (2007), Pickton & Broderick (2001), Blythe (2003) and Evan et al. (1996) all agree that word of mouth is one of the most, if not the most, powerful communication channel when it comes to influence behaviour.

Word of mouth is perhaps not considered as a marketing communication medium in any conventional sense, yet it should because of its sheer force and impact that can involve anybody and everybody as Pickton & Broderick (2001) stress. This is confirmed by Bruhn (2003) who states that word of mouth communication is a phenomenon that can have just the same behavioural effect on the recipient as active direct marketing. Marketers may want to encourage peoples' word of mouth communication, according to Evans et al. (1996), since this helps to spread awareness beyond those people who come into direct contact with the campaign. Simply by placing information in people's environments, marketers can increase the probability that the information will be communicated to other people.

Pickton & Broderick (2001) together with Rosen (2000) claim that a great deal of word of mouth communication is from people who are dissatisfied and will spread the bad news among their immediate family, friends and workmates. Blythe (2003) brings into view that bad news often travels twice as fast as good news; leading to a great part of word of mouth is in fact negative.

**3.3 Communication Tools**

Good communication is fundamental to successfully promote health according to Ewles & Simnett (2003), and Berry (2007) states communication towards health can take different forms. Formoso et al. (2007) declare it is possible to utilize tools, techniques and concepts derived from marketing principles to influence a target audience to voluntarily accept, reject, modify or abandon behaviour, which is further enlightened by Piotrow et al. (1997) who states marketing methods has
been suggested to be the most effective way to change knowledge, attitudes, and behaviours. According to Katsjoloudes (2002) good marketing strategies begin by paying attention to the receivers.

### 3.3.1 Target Groups

Mathur et al. (2005) explains that market segmentation is one of the most important strategic marketing decisions. The significance of dividing a population into different segments or define ones target groups, cannot be emphasised enough writes Katsjoloudes (2002). Jarlbro (2004) stresses that the basic idea of segmentation is simple; divide a population, market or audience into groups whose members are more like each other than members of other segments. Although it is not obvious that people of the same gender or in the same age is a homogenous group, especially not concerning health related issues.

Wanger (2002), together with Solomon (2007) and Jarlbro (2004), are emphasising that an vital goal for marketers is to approach different costumers in different ways, and when it is concerning people’s health, the identification of the consumers’ needs are, according to Ewles & Simnett (2003), of significance. This is confirmed by Peattie & Peattie (2008) and Katsjoloudes (2002) who both state it is important to understand the targets’ needs, attitudes, and current behaviour.

Hoyer & McInnis (1997) claim there are different abilities to process a message for an individual and these abilities are depending on for example knowledge and experience, education, age and monetary resources and this is coherent with Dahlén & Lange’s (2003) opinions. Therefore there are, according to Mathur et al. (2005), numerous ways for segmenting the market, ranging from simple demographics to behavioural, attitudinal, and lifestyle variables. Although Berry (2007) suggests it is not always necessary to only choose one target group for the marketing communication, since it could be interesting to influence several at the same time.

### 3.3.2 Traditional Marketing

Modern mass media in general constitute an important source of health information, as said by Fennis (2003) and Basil & Brown (1997) assert that mass communication affects judgments of societal risk. Katsjoloudes (2002) argues how non-profit marketing can reach a large audience using advertising, and Ruxin et al. (2005) believe communicating basic information about AIDS through the mass media and other public channels is important. Bessinger et al. (2004) state the use of mass media can be instrumental in promoting condom use as a way to prevent HIV.

**Print Media**

Katsjoloudes (2002) is declaring that non-profit organisations tend to rely on print vehicles more frequently than other types of media and according to Berry (2007) several researchers have argued that providing information in written form is more effective than via spoken communications. Although Radtke (1998) claims print, by
its very nature, to be a one-way medium, since the print materials do not allow real-time interactions with audience members.

Jarlbro (2004) means print is positive since many people can receive the message and Katsjoloudes (2002) states this type of media to have an ability to broadcast messages, but both agree that it is achieved at a high cost. According to Radtke (1998) print media is a wide spreading technique and therefore easily accessible to most audiences. Jarlbro (2004) accentuates that wide spread media should only be used when having large target groups, because smaller and more compact groups need more detailed messages.

Although Radtke (1998) states that print media has limited use with illiterate population and therefore Ewles & Simnett (2003) claim that if possible, the message should be expressed in both pictures and words. Earle (2000) also argues the importance of using a language the audience understands.

Active Media

Many non-profit organisations take advantage of the opportunities to carry out their message through active media, writes Katsjoloudes (2002). According to Jarlbro (2004) it is very useful when wanting to get people’s attention, and to keep them aware of the situation. She continues by saying that in the connection with HIV/AIDS and other kinds of risk information, fastness is an important quality. When considering what media to use, TV together with radio, stand out when looking at this feature.

Berry (2007) describes that nowadays, active media enables information on a whole range of health topics to be conveyed straight into the homes of a large proportion of the population. According to Katsjoloudes (2002) announcements which are brought out by these media can reach large audiences and inform the public about the organisation's programs and services. Even Jarlbro (2004) stresses the importance of this way of giving out information, since many people can be reached. Radtke (1998) asserts the positive aspects of using active technologies, that it is especially effective when working with illiterate populations.

According to Radtke (1998) radio can be seen as an easy and fast way to obtain information while getting something else done. Katsjoloudes (2002) stresses the opportunity for non-profit organisations to reach out to their determined segments through aiming its efforts at different radio stations. But as Ewles & Simnett (2003) and Hallin & Hallström (2003) underline, the radio has a lack of visual material and body language. Radtke (1998) writes how audio is less useful when the message that needs to be conveyed relies heavily on detailed information, like statistics, or financial data. In these cases, print is said to be better to use.

Fennis (2003) believes television may be effective in creating awareness, knowledge gain, belief change, attitude change and sometimes behavioural intentions with regard to health-related issues. Ewles & Simnett (2003) bring out the advantage of utilizing TV, since they can be used to convey real situations otherwise inaccessible.
Multi Channels

Basil & Brown (1997) stress that only one single media has no measurable effects on personal or societal concern. This is coherent with Dahlén & Lange (2003) and Berry (2007) who say by using many different media, increases the probability to cover all the people in the target groups. Many researchers, according to Jarlbro (2004), Bessinger et al (2004) together with Solomon (2007), claim the importance of using a combination of different media, if wanting the message to bring attention and set off behavioural change.

Bessinger et al. (2004) agree by suggesting that campaigns using multiple media channels may be most effective in improving sexual health knowledge. Jarlbro (2004) states no general campaign strategy is likely to achieve the demands of HIV/AIDS prevention. A wide range of different campaigns, using different communication strategies and messages targeted at different audiences, will have to be employed to help curtail the spread of HIV/AIDS.

3.3.3 Relationship Marketing

Although the mass media are generally effective at reaching a large number of people in a shorter time, evidence propose interpersonal channels to be more effective in promoting precautionary sexual behaviours, Basil & Brown (1997) declare. All organisations are based on relations and they only have to make them visible and meaningful for the people, presumed it is what the people want, as Grönroos (2007) writes, and Berry (2007) declares communication as a key aspect of all relationships, whether these occur in family, educational, work or social settings.

Berry (2007) defines a relationship as a process in which the participants create and share information with one another in order to reach mutual understanding. A relationship consists of at least one meeting or situation where the client coordinates with the organisation, Storbacka & Lethinen (2000) and Grönroos (2007) claim. They continue by telling how feelings, knowledge and action are exchanged between the client and provider during the meeting and this exchange demands for both parties to participate. A relationship strategy is often used by non-profit organisations, Radtke (1998) suggests. Katsjoloudes (2002) also discusses this when saying that marketing is not a crass and exploitative activity for the non-profit organisations. It is means of fostering the interaction between the organisations and the clients, information-giver and information-seeker, in a way that it is beneficial to both, or as Storbacka & Lethinen (2000) says: “It takes two to tango.”

The key to all relationships, according to Gordon (1998), is people. The people at the front line of organisations should be able to communicate with the people in a manner that recognises them, remember their contact history and understand their current issues, predict anticipated behaviours and suggests appropriate responses, solutions or suggestions. A genuine two-way process is frequently transactional in its nature and the people involved both influence and are influenced by the other
participants according to Berry (2007).

Gordon (1998) writes that with cultural differences the formation and maintenance of relationships can be difficult. The language can also be a barrier which needs to be overcome Ewles & Simnett (2003) describe. Therefore they believe it is essential to have an atmosphere of trust and openness between yourself and your clients, so they are not intimidated. Furthermore the clients’ familiarity with the corporation is another way of gaining trust, Grönroos (2007) writes. The pros of having a relationship for the user is that they feel secure; they have a feeling that they can trust the organisation, and Berry (2007) strengthens this statement by saying that empathy and trust are important for building positive relationships and this is particularly important in health care situations.

Radtke (1998) is stating since a relation demands eye contact, which is one of the most direct ways to connect with other persons, a face-to-face strategy is the most effective way of gaining trust. Face-to-face meetings or events convey closeness about an issue or message, since things happens in real time Gummesson (2002) states, and because of this, the face-to-face strategy is one of the best ways to engage individuals to work through complex or conflicting attitudes, opinions, and beliefs about an issue, problem or concerns. When discussing HIV and AIDS Ruxin et al. (2005) indicate that a spread of knowledge through for instance community networks is more efficient, than through formal channels.
4. Empirical Data

The purpose of this chapter is to demonstrate the studied reality. The two main topics from the previous chapter are remained to give an indication of the empirical elements connected to the theory. To make the reading easier to follow, this section will begin with a short presentation of the interviewees.

Interview objectives

Name: Dirk Buyse  
Position: Chief Children and AIDS Section  

Name: Robert Nakibumba  
Position: Public Relations Officer  
Organisation: The AIDS Support Organisation – TASO

Name: James Kigozi  
Position: Communication and PR Officer  
Organisation: Uganda AIDS Commission

Name: Ulrika Hertel  
Position: First secretary Health and HIV/AIDS Advisor  
Organisation: Embassy of Sweden, Kampala


4.1 Change Behaviours

“HIV/AIDS is death” Henry Albert Oyukui

One million people have died from AIDS in Uganda, a country of 30 million, and there is over a million people infected, Dirk Buyse informed us. Over the past 25 years HIV/AIDS has affected everybody. Every family and every household are affected; it is influencing all – the rich, the middle class and the poor. As Robert Nakibumba stated, there was no accurate knowledge about how HIV/AIDS was caught and transmitted from one person to another, and people started stigmatising each other. By 1990-91 everybody in Uganda was affected and had lost somebody to the disease, an aunt, child, sister, or mother.

“When I hear HIV/AIDS I think about dying and loosing somebody.” Florence Berabura
4.1.1 Action for Change

Dirk Buyse explained Uganda as the first country in Africa to decrease the number of HIV infected. The rate in the country was close to 20% ten years ago, but today it is around 6%. Early the disease received attention from the president, and instead of ignoring it, he demanded action against it. As a result, Dirk Buyse continued, the Ugandans are generally more open about HIV/AIDS. People talk forthrightly about it and an individual could openly state their uncle died from the disease, and not make it mysterious by saying he died from pneumonia for example.

“You can talk about it; you have to talk about it!” Henry Albert Oyukui

A strategy emphasised in Uganda, Robert Nakibumba notified us, which encouraged behavioural change in the country, was the ABC-strategy. The given message was Abstinence, Be faithful, and Condom use and as he argued, it is very practical because it has made people aware of the information.

“If you have a boyfriend and are not married, use a condom. If you are married, be honest and faithful to your partner. Wait, but if you can not wait, use condom.” Josephine Nantongo

Dirk Buyse uttered that he has lived in many countries in Africa, and can see a change in behaviours, and Robert Nakibumba expressed behaviour change has occurred in Uganda because of the given messages of ABC. This is confirmed by James Kigozi when he stated that the results of the ABC-campaigns prolonged young peoples sexual debut and more young people are abstaining until the age of 20, 21. Ulrika Hertel informed, Uganda has been effective when it comes to adolescents, who have started to protect themselves, and as a result infected youths have decreased.

“To protect myself I am waiting for the right time.” Muhem Mboga

4.1.2 Cultural Difficulties

Kampala has the highest rate of knowledge about HIV and AIDS, Robert Nakibumba told us, but ironically, the rate of infected is higher there than in the countryside. Is the knowledge not being translated into behaviour change? Or is it because people can live longer with HIV/AIDS since it now can be managed, he questioned himself. In Uganda, James Kigozi told us, most of the people know about HIV; how it is transmitted and how it can be avoided. Therefore the biggest challenge is behavioural change, which is revealed by culture.

“After loosing relatives I know what it is.” Florence Berabura

The women culture in Uganda is especially a challenge James Kigozi declared. Women are not treated as equals to men, but as subordinates. As Robert Nakibumba expressed, women have to obey their husbands, and therefore they cannot act upon the information they receive. This was also emphasised by Ulrika Hertel who told us,
how women are treated is the biggest problem in controlling the HIV infection rate. The women often have knowledge about the disease, but cannot put the awareness into action, because of the culture. Their husbands do not allow them, for example, to go to a testing centre or practice safe sex, James Kigozi uttered. They cannot initiate condom use, even if they know their husband has been with other women. Therefore behaviour change is the biggest problem in our society when it comes to the prevention of HIV/AIDS, he emphasised.

Another immense problem is the vulnerability of women, as they are infected easier than men, Ulrika Hertel enlightened. On the other hand they obtain information better compared to men, and as Robert Nakibumba informed us, there are 65% women versus 35% men that visit TASO, although they are given the same information.

In Uganda, it is common to get married around the age of 18, Ulrika Hertel informed us. When married, children are usually wanted, and therefore condom use is no longer necessary. Although, if the husband has a woman on the side or uses a prostitute, then what will it matter if his wife is faithful, she might get infected anyway, Ulrika Hertel exclaimed. At the same time, it is difficult for a married woman to tell her husband to use condom, as it indirectly indicates mistrust.

“If you are married you cannot trust each other, you need to protect yourself.” Florence Berabura

It is not common to have more than one wife in Uganda, Ulrika Hertel stated, nevertheless it occurs on the countryside. What is more common is to have one or two partners alongside the marriage. There are no indications that Africans have more partners in average during a lifetime compared to other parts of the world, she accentuated, on the contrary. Europeans or Americans have many more, although often only one at a time. Africans might not have more than two or three, but they have their partners simultaneously, which makes the infection spread extremely fast. It is enough if one individual in that network is infected for it to have the same impact.

4.1.3 Increase of Knowledge

“At first people didn’t know the cause of HIV/AIDS. In the small villages people died from a combination of all different diseases and they believed it was witch-craft that caused them.” Kyomcikama-Rosette Dekool

Ulrika Hertel expressed the necessity to understand what level of knowledge and education the target groups have. In Kampala, around 80-85 % of all adolescents know how to protect them selves from HIV, but in the northern Uganda, only around 3 % of the population has that knowledge. “There are these huge differences!” she burst out. In Kampala people are more informed, and they know more, but out in the countryside or in a village it is a completely different matter.

“I have seen relatives and friends suffering and die.” Henry Albert Oyukui
Ulrika Hertel continued by explaining, it is still common to think; she looks nice, she cannot have HIV. Dirk Buyse claimed those who are negative should be educated to stay negative, and Ulrika Hertel stressed the sexual education is not extensive in the schools and therefore it is important to encourage people, when they for example are at a health centre seeking health care for one or another reason, to get tested, so they know if they are HIV positive or not.

“I think the best way of getting information is through hospitals.” Sarah Oleru

Many people might get the information, but it is much easier to reach those who are educated, because they have a better understanding James Kigozi accentuated. Dirk Buyse stated that for his colleagues at UNICEF who have been educated and travelled around the world, there are no issues to discuss HIV, but in general it is quite difficult.

“The young generations are getting more and more information. I grew up without knowing about HIV/AIDS, I only got a little bit of information from the school.” Kyomcikama-Rosette Dekool

4.1.4 Influential Senders

In the beginning of the 1990’s around 18 % of Uganda’s population was infected, and in some parts of the country it was over 30 % Ulrika Hertel declared. She told us there are different explanations to why Uganda has managed to decrease HIV, and one is that the president spoke openly about HIV/AIDS very early. That has meant a great deal to the country, as attention was brought to the matter on the political agenda, which made people aware, Ulrika Hertel affirmed. This is not the case in many other countries, where the word HIV is not even uttered. Robert Nakibumba agreed with this by saying the president’s openness in talking about it and his recognition of Uganda’s problem, made many efforts regarding HIV/AIDS to take place.

Dirk Buyse emphasised this as well by mentioning that when there is a problem, we need to talk about it. The president said: “HIV attacks my country so I need to speak about it.” He urged this to every leader in the country; religious, political and civil service leaders. This is the strategy to use if wanting to reach the mass, Dirk Buyse advised. Almost all Ugandans go to the church, mosque, or cathedral, and the pastors talk about HIV/AIDS. Compared to Europe, they can talk about this in these places. Robert Nakibumba explained that HIV message is given to you in church, mass or at local government meetings, and the leaders are talking openly about it.

James Kigozi continued in the same focus and uttered: “I think in the case of Uganda we are very fortunate to have committed political leadership when it comes to HIV.” He told us that he has seen the issues of HIV in other African countries, where he has lived and worked. Although it is not the same type of political commitment as in Uganda but instead a great deal of apathy at the top where HIV is not prioritised. One of the major advantages in Uganda is that the government realised HIV was a
serious problem, and took it as a main concern he accentuated.

For example in South Africa, as Dirk Buyse stated, when Nelson Mandela declared one of his sons was dying from AIDS, it was a horrific statement since HIV and AIDS is not accepted there. In Uganda this is not taboo and people are much more open minded about the disease.

“HIV/AIDS is not a difficult subject to talk about because I am aware and therefore it is ok.” Kyomcikama-Rosette Dekool

Another explanation, which was brought to attention by Ulrika Hertel, is that famous persons went out and expressed that they were infected. Musicians and other artists gave the disease a face, and this was significant because of the stigma. It also made other people reveal that they were infected. It is still a lot of stigma in Uganda, but they talk more openly about it now, which has probably been one of the explanations why people obtained knowledge about HIV.

“HIV/AIDS can be discussed with family and friends, it helps the young kids how to be careful, they need to know.” Josephine Nantongo

4.1.5 Personal Engagement

Using local leaders speaking the local language was suggested by Dirk Buyse as the most efficient way of communicating to the Ugandan population. That is because they are trusted, understood and familiar with the people and a part of this as James Kigozi enlightened us is to work together with people living with HIV.

“You can get information from friends that are HIV-positive” Josephine Nantongo

The most effective way for TASO, Robert Nakibumba indicated, has been to use the people living with HIV and AIDS to give HIV/AIDS messages. These people have formed drama groups and through music, dance, and theatre they communicate to the local population using the local language in the villages. This has been irreplaceable he emphasised, because it advertises that; “I am HIV positive, but it is not the end of the world. I have gotten support, and I am now working and can educate my children.” People listen to that, he accentuated.

4.2 Communication Tools

“I got my information of HIV/AIDS through educational centres, radio and TV. But there are also women groups, counselling, prevention for unborn child and youth information.” Kyomcikama-Rosette Dekool
4.2.1 Written Materials

Robert Nakibumba said that every organisation has their own brochures, but also share information among each other when producing communication materials. That is because it is expensive to produce, and therefore different organisations do materials for specific areas of the disease. Dirk Buyse revealed that UNICEF works with flyers, but the use of billboards is limited. James Kigozi told us Uganda AIDS Commission uses materials such as posters, brochures, and leaflets.

“Billboards in Kampala are an effective way to reach out to people.” Kyomckama-Rosette Dekool

Ulrika Hertel informed us that Straight Talk Foundation produces magazines which are present in almost every school in Uganda, which they are handed out once a month. Their focus is HIV/AIDS, and the magazines are targeted to different groups, such as Youth Talk, Teachers Talk, and Parents Talk. Robert Nakibumba declared that TASO uses newspapers to discuss about HIV and AIDS issues. They use pictures in their materials, but a picture alone does not inform enough. The most effective way for TASO has been to use a combination of pictures and written information, to better support the message. Dirk Buyse declared that UNICEF sometimes uses comic books as an information source.

Robert Nakibumba enlightened us about the many languages existing in Uganda, and therefore TASO translate their written information. Dirk Buyse claimed that UNICEF’s printed materials are translated into the local language.

4.2.2 Radio as an Effective Tool

“Everybody listens to the radio a lot.” Rose Namawejje

The best way to reach out to people is through radio, Dirk Buyse told us. UNICEF has at the moment a project in a specific region in Uganda, where they give away rewindable radios, because the lack of electricity. Radio is an extremely important and powerful tool. Ulrika Hertel agreed when saying, numerous people in Uganda listen to the radio, not always their own, but they have access to one.

“I listen to the radio a lot, most people do. We enjoy radio. It is the main media in Uganda. There is information in newspapers, but some cannot read.” Florence Berabura

James Kigozi updated us that Uganda AIDS Commission mostly uses the radio, and at the moment there are over 140 local stations active in Uganda. “That is our best tool” he highlighted. Ulrika Hertel declared that the radio programs include everything concerning HIV/AIDS; how you protect yourself, and what to think about. It is not always a message, but can be a funny anecdote or a story, just to bring it to attention. James Kigozi told us that in most of the villages you could find people with small handsets listening to the radio, when they pick firewood for example.
“The information comes from radio and TV. Radio is the best; I listen a lot to the radio. It is good information, because you don’t want to die, so you listen to what they have to say about HIV.” John Kizitig

Ulrika Hertel stated that there is an extremely large number of languages spoken in Uganda, and that Straight Talk Foundation has radio shows sending in thirteen different languages. Robert Nakibumba explained that in the radio TASO speaks the local tongue.

Ulrika Hertel told us that TV is not at all common in the countryside, and James Kigozi declared television has the least effect, since the rural areas do not have electricity and therefore the TV is restricted to urban areas. Robert Nakibumba on the other hand informed us that TASO have TV talk shows in English discussing HIV/AIDS issues.

“The information goes through radio and TV. It is wise to pass through radio because it would cover wide areas. It is easier through radios than TV because in smaller communities they don’t have electricity and they can’t afford a TV, but the radio cost only 3 000 Ugandan shillings (≈ 12 SEK, authors’ remark). You might buy the radio to listen to music, but then automatically when the adverts come you get information about HIV.” Henry Albert Oyukui

4.2.3 Relations

“The ones carrying out the information need to be convinced about it. It should be a chairman and chairperson in the villages, who can go around and talk to people. Local counselling is good and they should have meetings in the villages.” Kyomcikama-Rosette Dekool

One important aspect Dirk Buyse stressed is the training of peer educators, who should be trained on one condition; spread the word and reach the people. TASO has trained various community workers regarding HIV/AIDS, Robert Nakibumba let us know. “We have about 4 000 community volunteers”, he enlightened, and those people are seen as the organisation’s ambassadors in the communities. TASO disseminates information through community volunteers, who will spread information in the villages. Robert Nakibumba also stated training of community volunteers as a very strong strategy.

Work related to communities take the form of small meetings, James Kigozi described that Uganda AIDS Commission has small meetings in the communities where they communicate face to face with people. Robert Nakibumba told us their approach in the communities is to involve people; “We share a lot of love and compassion to people so they feel confident to come.” Dirk Buyse notified us there are local village help teams in Uganda, who reach out to the communities.

Ulrika Hertel enlightened us about the existence of youth centres in Uganda, where youths can receive counselling and get tested for HIV. The employees at the centres are educating the youths on how to prevent HIV/AIDS. It is possible to talk about sexuality and youth health problems; everything from head aches to puberty. They
can speak to persons who can give support and advice, but most of all is it a place to come and meet other youths.

As Robert Nakibumba informed us, TASO has 11 service centres around the country, and when working in those districts they speak the local languages since the majority of the people do not know English. Dirk Buyse said there are many tribes in Uganda, and most of them have their own language. When UNICEF recruits for local offices, they want to recall the local languages, because their can be large voids between languages, even for Ugandans, he accentuated.

**4.2.4 Reaching the Right People**

Ulrika Hertel held that particular messages and special initiatives need to be reached out with to different target groups. Everybody cannot receive the same type of information, it has to be specific or targeted information, that is an intentional message to the explicit group, she continued.

James Kigozi told us that the Uganda AIDS Commission has specific messages for specific groups. In for example primary schools, the given messages basically emphasises life skills and they do not talk about sex or condoms with children at this age he stated. Later in colleges and Universities, the full information is given because these people are sexually active.

“I got the knowledge of the disease from primary school at 10-11 years old. We got good information and they were advising us.” Sarah Oleru

**High-Risk Groups**

Robert Nakibumba told us how TASO is targeting people at high-risk, and look into how to reach these specific groups with the HIV prevention messages. By high-risk, he meant ex-prostitutes, but also people who do not have jobs, since they more often will use commercial sex.

This was also exemplified by Ulrika Hertel, when said, high-risk groups such as prostitutes, need specific information. The military is another of these groups, which have not been put enough effort into. They are an exposed group, since they are away from their families and often revert to prostitution and younger generations. In Uganda the fishing communities are also widely discussed, Ulrika Hertel claimed, since they are away from their families and use prostitutes. At the same time get limited access to information because of the their time at sea. Therefore it is important to reach out to them as well, because they are more infected than the average Ugandan, Ulrika Hertel affirmed.

Dirk Buyse brought up a high-risk behaviour called cross-generational sex, which are young girls who are dating old men for purely economic reasons. It is very common in Africa, and is not considered as prostitution. It is not love, Dirk Buyse described, since that man probably has a wife or even two; it is just to have some fun. For the girl
it is convenient because she gets for example the latest phone.

Ulrika Hertel also talked about the issue cross generational sex. Women get infected with HIV by having sex with older men, who are already married and have had many partners. The women do not always have to be very young, they can be around 25-30 years old, and they have a man who is much older. The woman might have two men, one who gives her a mobile phone, clothes, jewellery, etc, and at the same time a boyfriend who she actually likes.

“I talk to my younger sister, mostly about cross generational sex. Young girls get themselves a “sugar daddy” to get expensive gadgets, such as mobile phones. Some girls do it to get nice things, but some are forced and let the men pay for their semester at the university, otherwise they wouldn’t have been able to study. The daddies are married people and they just have fun, and you don’t know their HIV-status. Some think that, he is a nice man, he does not have HIV.” Kyomckama-Rosette Dekool

Married Couples

In the Ugandan culture the woman has to obey her husband, Ulrika Hertel informed us, and therefore it is easier to reach out to younger persons before they get married because later it will be too late. Although, Ulrika Hertel said, it is harder with the information to married couples, and other tactics should be used. It is common that only one spouse in the marriage is infected, and in that case it is important to be aware of the situation.

“It is difficult in marriages because of the paternal.” Florence Berabura

Important Regions

Dirk Buyse informed us that UNICEF targets special districts or specific regions in Uganda where they have the worst socioeconomic indicators, since their budget would not allow them to engage all over the country. In the case of Uganda they are focusing their attention in the north, where there has been a prolonged conflict for many years. This was also discussed by Ulrika Hertel, when she confined the health situation in the north as really, really bad. It is a lower health status compared to the rest of the country, and there are no health centres. Robert Nakibumba eductated us that TASO focuses on prevention, especially in the conflict and post-conflict areas. As Ulrika Hertel stressed; “One can never cover the whole country.”
5. Analysis

In this part of our thesis, we will bring together the collected theory with the studied reality, to discuss our own thoughts concerning the HIV/AIDS problems in Uganda.

5.1 Preface

Whilst living in Uganda and observing the marketing against HIV/AIDS, we have discovered that the spread of the disease is based on behaviours and therefore the biggest challenge is the immense problem of changing people’s way of acting. Our approach has consequently been how marketing can achieve this. In Uganda it has shown that the disease is not restricted to specific social groups, or belongs to certain economical conditions; it is a disease of the whole population. This makes the prevention marketing to achieve behavioural change even more complex.

When we first came to Uganda we were shocked by the poverty and low development throughout the country. One example is the capital Kampala, where there are no streets lights and numerous people in the city centre live in huts without proper walls or roofs. What we have realised is that people struggle to find food and fresh water for the day and face many other issues than HIV/AIDS, such as malaria, diarrhoea, and infant mortality. Their first priority can be to survive the day, and in our belief’s, this is yet another aspect which make the prevention marketing against HIV/AIDS more difficult. With this said, we want to point out that marketing HIV/AIDS in a country like Uganda is not the same as marketing the disease in for example the west.

Despite these observations made, Uganda is a country in Africa which has had an infection rate around 20 %, but has managed to decrease the number of HIV-infected down to approximately 6 % in only a few years, which shows an occurrence of behavioural change. Throughout our research, we monitored several non-profit marketing tools that have been used to make this change in behaviours take place and these are presented below.

5.2 Sources

Solomon (2007) and Jarlbro (2004) claim that the source of information is of great importance for the receiver to accept a message or not, and the choice of sender should depend on the people aimed to be reached out to. From the interviews with organisations working with non-profit marketing, we found out that in Uganda, the president went out very early in the epidemic and recognised HIV/AIDS as a serious problem that needed to be addressed. According to us the president is representing the people of a country, and as mentioned before HIV/AIDS is a disease concerning the whole Ugandan population. By underlining this, we signify having the president, who is an important person in a nation as a source of information, made it possible to reach out to a great part of the general public of Uganda.
Another aspect we observed and experienced while living in Uganda was a high level of hierarchy. For example when contacting organisations active in the prevention work against the disease it has been difficult to reach the right people without having the right contacts. We have experienced that Ugandans do not listen to just anybody and a person with authority is highly respected. Everywhere we have been in the nation and whatever we have done we have always noticed the institutionalisation in society. Systems which make it impossible for people to act over their social and cultural parameters. We mean that who carries out the message shows to be very important in Uganda. If the leader of the country, who has a high authority, declares it is approved to talk about HIV/AIDS, we believe that people will listen to what he states and respond much more compared to if the message was given by any source.

The president urged other formal leaders in Uganda to acknowledge the problems of HIV/AIDS, according to Dirk Buyse. Because of this, Robert Nakibumba informed us, religious and community leaders also brought attention to the subject. These leaders’ actions have, according to us, played a big role in the prevention of HIV/AIDS in Uganda. Although we consider this was made possible because the president started to speak openly about the disease, and therefore the subject became relatively freely discussed and not such a big taboo as in other African countries.

We claim that Uganda, by using the president as the initial source of information, have created a foundation for the prevention of HIV/AIDS. Behavioural change has occurred, but we state by vastly relying on the president as a source of information in today’s Uganda is not enough.

5.2.1 Communities

Auerbach & Coates (2000) write that the more sensitive a message is the more equal to the people the source needs to be. After performing our interviews in Uganda, we have reached the conclusion that the use of local citizens in communities has been a main device to carry out the information about HIV/AIDS. This is something we consider as an effective way of working, since the locals have the same background, language, and are a part of the same social context as the receivers. Because of the sources alikeness with the recipient, they have a greater understanding of how to approach them in the right way concerning the sensitive subject of HIV/AIDS.

Grönroos (2007), Berry (2007), Ewles & Simnett (2003), and Radtke (1998) all discuss the value of generating reliance to commit in a relationship with an organisation. Robert Nakibumba stated: “Our approach in the communities is to involve people; we share much love and compassion with people and they feel confident to come.” According to us this statement shows that the non-profit organisations have come a long way in gaining trust from the Ugandan population. We claim that trust and mutual understanding can be created if the message is given by someone known to the receiver and the message will be taken more seriously and become acted upon.

Several organisations in Uganda are even using HIV-positive people to give out
information in the communities, which we consider an irreplaceable source. He or she can describe out of personal feelings and experiences how it is to live with the disease, and the receivers will be given information out of a realistic point of view.

5.3 The Use of Media

Katsjoloudes (2002) is stating that non-profit organisations tend to rely on print vehicles more frequently than other types of media. In Uganda, this has shown not to be the case. When conducting this research, a clear message was given from our interviewees; radio is an effective tool when preventing HIV/AIDS in Uganda. We have seen, after talking to a number of people in the capital Kampala, and by observing behaviours’ during our stay in the country, the importance of radio as a significant tool in the marketing of HIV/AIDS. We have recognised that many people in Uganda have access to the radio and most importantly listen to it in a large extent. Wherever we have been in the country in Kampala, out in the villages or at work places, the radio has always been present. It is cheap to purchase and has during the past years in Uganda been of essence in the action to get a grip of the epidemic.

A negative aspect of using the radio as a marketing tool, which Ewles & Simnett (2003) bring out together with Hallin & Hallström (2003), is the lack of visual aspects and body language. We believe these down sides are concurred by the positive features, such as wanting to reach illiterate people, as Radtke (1998) mentions. Uganda is a country with a low level of development, and as Florence Berabura told us: “Everybody cannot read.” Considering that Uganda is a country where illiteracy exists, we state this problem can be overcome by using the radio.

According to Jarlbro (2004) printed information can be positive in the aspect of reaching large audiences. In the case of Uganda, we believe this is a good feature since HIV/AIDS concerns the whole population, although we would like to bring into focus by using this method, no security will be assured that the given message will be read. As mentioned before illiteracy occurs in Uganda, and therefore we consider that billboards and printed information should be used together with other types of media.

Fennis (2003), together with Ewles & Simnett (2003), believe that the media television may be an effective source of information regarding health related issues. When looking at the HIV/AIDS situation in Uganda our opinions are not coherent with these authors. Many parts of the country do not have access to for example electricity; therefore we do not consider TV an effective tool for spreading information about the disease in the nation.

5.4 Extending Behavioural Change

Formoso et al. (2007) state the possibility to utilize tools, techniques and concepts derived from marketing principles to influence a target audience to voluntarily accept,
reject, modify or abandon behaviour. A concept emphasised in Uganda, Robert Nakibumba notified us, which encouraged behavioural change in the country, was a marketing method called the ABC-strategy. This strategy was aimed to influence people to gain awareness and knowledge of how the infection was spread and as an outcome behaviours related to HIV/AIDS were changed.

In Uganda, a decrease in people becoming infected by HIV since the beginning of the 1990’s is a fact, but we have seen that even though people have knowledge about the disease, action against it is not always taken. From the time when the HIV/AIDS rate had its peak, a fast decrease has been shown, but are now stabilised since a few years. As we see it, the behavioural changes must be further developed to be able to decrease the numbers of infected even more and to stop it from turning and escalating. We have discovered several causes that can explain this stabilisation of HIV-infected in Uganda, which will be discussed below.

5.4.1 Word of Mouth

When interviewing the citizens of Kampala we noticed that the people having most knowledge and seemed to be most aware of HIV and AIDS, were the ones having someone in their close surrounding infected or who had died from the disease. Pickton & Broderick (2001), Blythe (2003) and Salomon (2007) state that word of mouth is an extremely powerful communication medium when it comes to influence behavioural change. Henry Albert Oyukui and Florence Berabura, told us that they have seen relatives suffer and die, and because of this they have obtained knowledge about HIV/AIDS. This shows how important family and friends are as a source of information when discussing HIV/AIDS. Not until the disease has entered their lives do they take in the information properly, and not until then the biggest behavioural change will appear.

Rosen (2000) and Dahlén & Lange (2003) draw attention to the negative sides of word of mouth, which is that bad news tends to travel fast. What we believe is a difficulty when discussing word of mouth, is the fact that it is uncontrollable. It is not possible to know what a person will tell their family and friends, and although word of mouth is a powerful medium, it is not always said to occur in a positive way.

What we have seen while living in Uganda is that many people believe HIV/AIDS derives from witchcraft and this phenomenon is spreading through people talking to one another. During a visit to a church, we observed first hand when a lady in her testimony, told crying and screaming about how her neighbours put a spell on her, and that she had been bewitched. We consider this side of word of mouth as extremely negative since people’s words and thoughts are spread without proper knowledge about what they are in fact expressing.

Word of mouth is not seen today, after talking to organisations active against HIV/AIDS in Uganda, as a device that can be utilized for the cause of the prevention. It is acknowledged, but not to a large extent managed intentionally, we argue that it is one medium that can support a further decrease in the infection rate.


5.4.2 Target Groups

According to Jarlbro (2004), Mathur et al. (2005), and Katsjoloudes (2002), it is important to define ones target groups. During our interviews with Dirk Buyse, James Kigozi, Ulrika Hertel and Robert Nakibumba, we found that specific groups are identified in the matter of the prevention, such as women, high-risk groups and youths.

We do not think that it is possible to use only one method to communicate with the whole population and Uganda has already been undertaking many different tools in order to succeed over the HIV/AID epidemic. According to us an entire nation is too multifaceted to be seen as an equal group. A sensitive subject like HIV and AIDS should therefore be directed in diverse ways to different segments, in order for the information to be best received. One example we have observed in Uganda is the targeting towards the new acknowledged phenomenon of cross generational sex, where older men are dating young girls. In Kampala we were exposed to billboards picturing a middle aged man saying; “Would you let this man date your teenage daughter? Then why are you dating his?”

Although the people we interviewed told us segmentation have been conducted in Uganda concerning HIV/AIDS, we noticed during our research how this element can be improved even further. We imply how focus needs to be renewed to other important segments than the ones they target today. The organisations’ division of the population is good, but in our opinion, not good enough, since we consider important groups do not get enough attention.

5.4.3 Redirecting the Focus

As de Walque (2007) states; the responsiveness to information is dependant on education, and we agree that education is a component to why people understand and grasp information given to them, differently. James Kigozi confirmed the author’s declaration by saying it is easier to get through to people who are educated because they have a greater understanding.

With this knowledge in our hands, we think that the educational aspects need to be reflected upon when bringing out a message concerning HIV/AIDS. We want to emphasise, that being aware of the situation in Uganda, where there are great educational differences and therefore various levels of knowledge among the different segments of the population, a key aspect is to give the correct message to various educational intensities. After conducting our research, we know the organisations responsible for the non-profit marketing are aware of the occurrence that educated people take in given information easier. Although, we do not consider this knowledge is captivated into the actions for the prevention in Uganda. These facts needs to be acted upon and implemented and should definitely not be ignored or set aside to further decreasing the infection rate.

Another aspect that we want to highlight is the fact that women have shown to be
the gender that receives information about HIV/AIDS best, Ulrika Hertel and Robert Nakibumba revealed. When discussing this further with our interviewees, we discovered that although they receive the information better, they are not always able to control their own health and behaviours. As Croteau et al. (1993) declared if behaviours as intimate as sexual expression are to be changed, a persons’ cultural group context cannot be ignored. According to both James Kigozi and Ulrika Hertel, when it comes to HIV/AIDS and behavioural change, culture is a big barrier, the female culture especially. We signify this is not an easy task to attack and believe that the culture aspect is a great difficulty when engaging in the subject of HIV/AIDS.

Since the culture in Uganda consider women as subordinates to men, it has lead to the impossibility for numerous of women to act upon the information they receive. What we have seen is that women, in a larger extent, are more prioritised than men, in the prevention of HIV and AIDS in Uganda. We consider this should unquestionably be continued, but as we see it to mainly target women is not sufficient. Because the primary focus is laid on the women, not enough behavioural change has occurred, and the prevention of HIV/AIDS is constrained.
6. Conclusions

With our conclusions, we would like to highlight the most important aspects of the prevention against HIV/AIDS in Uganda, acknowledged throughout our research, and together with this, our purpose of the thesis will be discussed. In the closing stages, we will give our recommendations of how to improve the prevention in the nation and the possibility to apply this in other countries, through the use of certain marketing tools.

6.1 Preface

HIV/AIDS is a widespread mortal disease and Uganda has been severely affected since the beginning of the epidemic. One million Ugandan people have already lost their lives and countless more are affected by this horrible infection. Consequently the prevention in the nation has been, and still is in the present day, an immense challenge.

Uganda has already come a long way in bringing attention and awareness to the population about the infection. As a result behavioural change has occurred, which has been one of the most important aspects when it comes to preventing HIV/AIDS from spreading. In our opinion, the country stands out as an admirable example in the fight against HIV/AIDS, but with this said, we still believe further change and awareness can and needs to be developed in Uganda, to ensure the decreasing trend to continue, and reduce the amount of people becoming infected.

Our aim with this thesis was to examine which marketing tools have contributed to Uganda’s accomplishments in the prevention of HIV and AIDS. As an outcome, we want to present the most successful marketing methods used in the country regarding the prevention. We will also discuss aspects we believe additionally can develop the non-profit marketing against the epidemic.

6.2 Successful Marketing Tools

During our research we have observed three main marketing tools that we have distinguished as crucial elements in the prevention against HIV/AIDS in Uganda. The first aspect we want to acknowledge that Uganda has done extraordinarily is the use of influential sources. The president of Uganda recognised early on the problems of the epidemic and started to speak about the disease. As an outcome, local and religious leaders brought attention and awareness to the subject and made it an accepted topic to discuss. This recognition from a top layer in the nation made HIV/AIDS a relatively open subject to discuss even among the Ugandan people, even though it still is a sensitive subject. Although the president was a fine initial source, we believe the recognition needs to be continued to maintain and develop the prevention of HIV/AIDS.
The second successful communication tool we want to highlight is the radio. Many people have access to radios, and most importantly listen to it regularly, and therefore it covers large numbers of the population. Possessing a radio goes over the economical and social layers of the population and as a consequence everybody can be reached by its information. Another aspect of the media radio is that people with low levels of literacy are able to take part of the information, and since illiteracy occurs in Uganda, we consider radio as a good way to reach them as well.

The third marketing tool we have recognised having an impact on the citizens of Uganda is the ABC–strategy, which promotes Abstinence, Be faithful and Condom use. This marketing method was mentioned by all the organisations interviewed and was even brought up by several of the people in Kampala. The fact that many of the citizens knew about this strategy, made us consider it has been a great way of enlightening the people of Uganda about how to protect themselves from HIV/AIDS.

### 6.3 Can the successful tools be used in a larger extent?

After living in Uganda we have observed how these three methods have stand out and been present in the nation. They are used from the organisational side, but we have also seen how the people exposed to these tools have received the information and started to act upon the given messages.

We mean that each nation is unique with there special culture, people and prerequisites and therefore we state it is difficult to apply, how Uganda has been working and what tools they have effectively used, to other countries with the same problems. We have understood, after collecting information about the issue of HIV/AIDS that not all tools are applicable in the same way everywhere. Even successfully used methods in one country can have the opposite effect somewhere else. For example, in the bordering country Tanzania, the people do not listen to the radio to the same extent as in Uganda and consequently in Tanzania the radio is not an effective tool when carrying out prevention messages concerning HIV/AIDS.

With this said we still want to declare after being close to the problem and experienced it first hand the importance of having the leadership of the country as a support in the prevention against the epidemic. Uganda has been fortunate to have a committed president that have been open and brought HIV/AIDS into focus early on and as a result the people of the country have been able to get awareness about this immense problem. Without the president’s early openness we state that the tools mentioned above, would not have had the same effect as it did in the prevention in Uganda.

We do not see Uganda’s prevention as a flawless model of how the problems of HIV/AIDS can be solved or how the number of infected can be decreased, but we consider the president together with the government’s actions as a prerequisite to be able to fight the disease everywhere. By being close to how the disease has been successfully prevented, we speak out that having the government together with influential and authorised people to bring the problem to surface, is vital to be able to get a grip of
the prevention from all angles. Other African countries, which struggle with the same problems, need the nation leaders as a starting point. Without the support from the government in a severe question like HIV/AIDS, which is a nation wide problem, we believe it does not matter how much efforts is given to the prevention both from organisations and marketing attempts.

6.4 Recommendations

Because of the discussion above we do not dare to give a generalised recommendation for all the African countries, in the marketing prevention of HIV/AIDS. However we have come to the conclusion that even though Uganda has decreased the numbers of infected we believe it is possible for the nation to improve their tools in the marketing against the epidemic even further.

Despite the successful marketing tools shown above, our research has revealed that knowledge has not always been implemented into behavioural change in the case of HIV/AIDS in Uganda. Therefore we now want to shed light on a number of aspects we believe are of significance for continuing the fight against the deadly disease in the non-profit marketing context. These aspects are not shown, as we see it, to be carried out in the right line of attack in the nation, and we wish to give our beliefs about why and how they can be improved. We are aware that the HIV/AIDS situation in Uganda relies on donors and therefore we have had the economical aspect in mind when formulating our recommendations.

6.4.1 Segmentation

As we see it an essential marketing tool that should not be neglected is segmentation. This is especially vital in the situation of Uganda since, as we have mentioned before, HIV/AIDS is a concern of the whole population, and not exclusively explicit groups. In our research it has been shown that differentiating of groups is performed, but in our concerns’, not in the present day in a sufficient approach.

Education is recognised as an indication of how well people receive information, and therefore we see it as an excellent way of segmenting the Ugandan population. Although we consider this knowledge not utilised in the non-profit marketing of HIV/AIDS in Uganda. For example, why not try and target the lower educated people in a different way, as they tend to receive information in a diverse pace and manner. To further decrease the numbers of infected in Uganda, we believe the organisations’ knowledge about receiving information versus educational level needs to be acted upon more intentionally.

Finding out the appalling truth about the women’s position in Uganda, made us realize that men are another segment that needs to be seen as a focal point in changing the behaviours of both genders as part of the prevention against HIV/AIDS. The attention that exists on women should continue, but to not restrain the progress and achievements made in that area, men needs to be targeted more aggressively. We accentuate it is beneficial for the future progress of the prevention,
to try and get men to understand, that a change in attitudes and behaviours towards how to protect themselves against HIV/AIDS, is personally good for their own well being. By accentuating this we believe men will be more willing to protect themselves against HIV and AIDS, and as a result, the women’s health will also improve. We consider that by attacking the problem from this viewpoint, a difference can actually be made.

If this is done successfully, a next step is to try and change the attitude towards women’s right to their own behaviours and health. We know that culture is deeply rooted and its values and beliefs can be quite a challenge to influence. We do not mean for the Ugandans to entirely change their culture, but instead being informed in a convincing way about the dangerous parts of their lifestyle and make them adjust the harmful aspects of their culture, such as neglecting to take precaution when having sexual relationships.

**6.4.2 Word of Mouth**

We have seen a tendency among the citizens of Kampala, which is quite frightening; the persons best informed about the disease and having the most knowledge about protection are the ones who have had family or friends infected by HIV/AIDS. We believe this shows how powerful the medium of word of mouth is. The people closest to us, are the ones we rely on the most, and therefore their information is taken into great consideration. We believe word of mouth can be partly influenced, and therefore to some extent worked with as a marketing device. In the case of Uganda, we believe this aspect needs to be taken into consideration, for enabling a further decrease in the rates of HIV/AIDS.

In Uganda today, word of mouth is known to our interviewees to spread information about HIV/AIDS, but it is not seen as a controllable marketing device in the prevention. A lot of untrue facts are spread through this powerful medium, such as myths, and according to us this needs to be changed intentionally. It is not possible to entirely control the phenomenon, but we believe the negative aspects can be decreased through marketing, for example through spreading true encouraging anecdotes about HIV/AIDS, carried out by sources such as peers and community workers. We are convinced this can raise a greater awareness and knowledge of the problem among the Ugandan population.
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Appendix


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Robert Nakibumba, Public Relations Officer, The AIDS Support Organisation – TASO 20080410

James Kigozi, Communication and PR Officer, Uganda AIDS Commission 20080414

Ulrika Hertel First secretary Health and HIV/AIDS Advisor, Embassy of Sweden, Kampala 20080418

Sarah Oleru, Rose Namawejje, Muhem Mboga, John Kizitg, Henry Albert Oyukui, Florence Berabura, Josephine Nantongo, Kyomcikama-Rosette Dekool, Charles Sebunya 20080420
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There are 180 staff members of the UNICEF in Uganda and around a 100 of them here in Kampala, which is the country office. We also have field offices. Three of them in the northern region towards Sudan and one in the eastern region called Karamodja. UNICEF works here in Uganda with education, protection, HIV/AIDS. There are like five technical sectors. I go to the field usually one week a month. There are around 1800 people working in the fields.

Last year we had a budget of 80 million dollars. That may sound a lot but, personally it is little. If you look at the needs in this country, it lives 30 million people, so that’s why we don’t work everywhere. We can’t say we work at every school in Uganda, in every health centre. So when UNICEF agrees to work in this country we sign a contract with the government that defines what we do and where we do it. In Uganda there are regions where the socioeconomic conditions are worse than the national average. So usually UNICEF targets in every country special districts or specific regions of the country where they have the worst socioeconomic indicators and focus on these, since our budget won’t allow us to work in the whole country. In the case of Uganda it is the north, where there have been a prolong conflict for many, many years. That is a region where, for twenty years, people have been in a really bad conflict. And so the people not living there any more must move to big towns and camps and live there as refugees that displace people. So we work in the north because that region is really bad. This conflict has destroyed all the infrastructure, roads, and schools. So now we are trying to rebuild that region, or first one.

The second one is in the east, called Karamodja. The Karamodja region is also quite special, very bad socioeconomic indicators. The people who live there are nomadic, cattle, even the climate environment is very harsh. They don't have food, they move around their cows, they cross the boarders to Kenya, they all have guns, it is a very special region. It has the worse socioeconomic indicators in terms of health and education. So we work in the east and a few districts in the west on the boarder to Congo.

We sign a five years program cooperation document with the government based on our analysis. 2005 did UNICEF together with the government an analysis and based in that we signed what UNICEF is doing for five years. We sign this with the government saying what we are doing – five technical sectors – and where – north, east, west – and that is described in the document. What are the situations, and based on that what are the needs, what should we do, what should we not do.

I have only been here at UNICEF in Uganda for one year, so it is too short to answer if I have noticed any change in the attitudes and behaviour in the population. But I lived here before, 2002 and 2003. I have lived in many countries in Africa, and I can see a change. The Ugandans are generally more open about HIV/AIDS. For example, here in Uganda, over the past 25 years, there are one million people who have died in a country of 30 million and there is over a million people infected. That means that every family and every household is affected. And it is everybody, it can not be said as a disease of the poor, it is causing all – the rich, the middle class, the poor.

HIV/AIDS here has affected everybody and the people talk about it, for example they tell you openly that my uncle died from the disease, they don’t make it mysterious and say he died from pneumonia. That is probably why Uganda has made more progress because there is a problem and we need to talk about it, including the president. He said, HIV attacks my country so I need to speak about it. So he speaks about it and he said every leader in this country, religious leader, political leader or civil service leader need to talk about it. So the topic became quite open and was discussed and people were quite open about it. And I think that is true, because I know my houseboy who works at my home talk to me about that he is HIV-positive, and if you compare this to other countries in the region here locally in eastern Africa people won’t say those things. They say he died after a long disease. When Nelson Mandela in South Africa declared that one of
his sons died of HIV it was a horrific statement, and in South Africa it is since they don’t talk about HIV and AIDS. While here it is not taboo and people are much more open here. What the taboo is here is to talk about sex and to talk about sexuality. But that is not specific to Uganda, it is in most African countries. It is very rare for people to talk about their sexuality, but even here they’re trying to change that. It still is a difficult topping.

What happened is, I think it is all documented. Uganda was the first country in Africa, the first to reserve HIV, because the HIV rates here were close to 20% ten years ago and nowadays it is around 6%. So it is a successful case and one of the things was the leaders of this country engaged against HIV/AIDS. Any leader in this country, on local government level, on regional level, has to mentioned HIV. Even the president. Some people say he is taking too much credit for himself, but that’s a big difference from many other countries where no one wants to speak about it. You know HIV is linked to sexuality, which is a difficult topic. Homosexuality here in Uganda is not allowed and it is punished, so here of course most transmissions of HIV is through heterosexuals and not like in the US and in Europe there is homosexuality and it is riskful for HIV, but you can’t talk about it. It is impossible. There were a representative here from UN AIDS who himself was gay and who had organised a workshop for gay people on HIV/AIDS and it was a scandal. And up to date they talked about it and he had to leave.

So there are a lot of difficult topics, but it depends on who you talk to, like my colleagues here who have been educated in two steps and travelled around the world, there is no issues. But in general it’s quite difficult.

UNICEF is an agency for children and women, so we focus about children. When talking about children and HIV/AIDS, they call it the four p’s. First there is the prevention of mother to child transmission, from the pregnant women to the child. It is the most common cause of HIV infection of a child in Africa, 95% of the child who are infected is from their HIV-infected mothers. The second p is paediatric care as above. So when the child is HIV-positive it needs care and support. Then it is the final prevention in adolescence, the third p, which is adolescence and the fourth p is protection, care and support of orphans and vulnerable children. Because in this country there are a million orphans and vulnerable children because of HIV and AIDS. So what ever is done as a campaign or as work around children and AIDS is around the four p’s. The primer prevention in adolescence, one issue was of those who were already infected. That is the problem, we need to handle and provide care and medical treatment. The other issue is those who are negative, can we keep them negative. So we look at the children and see what is the age of their sexual debut. Let’s say it is 15 or 14 years, the question is those who are younger than that, that’s what they call the window of hope. Those who are negative and below that age, they should be educated so that they stay negative. So prevention and window of hope for young children, prevention for adolescence and youth was very important in the countries’ strategy.

What does UNICEF do? We focus on two of these four p’s, we focus on the pregnant women and on paediatric care and support and we focus only on those districts. Basically who we work, we get money from commerce. And get about 6 million dollars for HIV/AIDS a year here in Uganda and I think, you know we have national committees, are you aware of that? National committees for UNICEF, so basically we have UNICEF in helping countries like us here but then we have UNICEF offices in Belgium, France and America. They are called National committees in industrialised countries, rich countries, so their role is to raise awareness, education of the public like you and to raise funds.

For us it is very interesting because the Scandinavian countries are quite active on HIV AIDS children and AIDS especially the Norwegians, Norway. Last year they did a gala and they raised in one night 40 million dollars, they had a TV marathon, a gala and I don’t know what and in one day they raised 40 million dollars of what we receive 4 or 5 million dollars.

In general the national committees of the Scandinavian countries are very active and I don’t know if you know, in the statistics there is a target which says that each country should dedicate 0.7% of its GDP (Gross Domestic Product) to operation and development AIDS and you know, the ones who comply with it is usually the Nordic countries and Holland. But
if u go to the US it's a joke they may devote 0.1 %. We get money from NY which comes mostly from governments the government give money to the UNICEF NY, but they also have a relationship with national committees of UNICEF so we receive money from Germany, France, Norway.

My first job is to get money, it is not if u work for UNICEF that u just arrive and you just have to plan and spend and reach results for children in Uganda, no u have responsibility also too to find money, I don't know if u realize that? Part of all job here is first of all to find money so we operate around 6 million dollars. To do all these four p's it's too little money, too little, so that is why we have to make choices, if u have that amount what can we do we have decided to do two things mother to child transmission, the pregnant and the paediatric care and support. So we have quit a big problem in the north and in the east and the west which basically means that pregnant women when they come for antenatal care they are constant consulted on HIV, they are tested for HIV if they are positive they should know. Then they are given drugs which reduce the transmission chance from the mother to the baby. Even when the child is born and is positive then it also needs care and support. These infections it may need anti prevented treatment, so we focus on those two in the strategy districts in the north eastern Uganda but that choice is purely based on money. If u want to do everything it's also difficult so there is many needs in this country, there is trusting all the government, there is financial donors such as SIDA, the American government, so u have to choose and focus and discuss with government, that is how we choose. So we have a quit big operation going on 6 million dollars a year.

How much money I would like to have? That is a good question. You see, maybe this is my personal opinion, I don't think that I should. You know if you look what the money needs for Uganda for HIV. That's why they have a nationally strategic plan it is around 500 million dollars a year. And yeah I would want that at least 50 % of that money goes for children so lets talk about 15 % of 300 million dollars, so 75 million dollar. The question is not where if that money should come to us, the question is weather the money is in the country and weather it service the children. Uganda has not a problem of money, Uganda has the problem of knowing what to do with the money and spend it well, it sounds strange but it is the truth.

HIV is the biggest donors in this country is the Americans, this year they are giving 283 million dollars, 283 million dollars!! for HIV in this country in one year. So what we try to do is not to spend all the time on campaigns or what u call it, service delivery in those districts, what we do to make sure these Americans spend their money in a good way and include the needs of children in that great money pot. That is a different way of saying: how much money do I need. We would be comfortable I had 10 million dollars here, very comfortable, it would be better, but I wouldn't complain too much and focus too much on it I would rather look like to see what the Americans do with their money and can I make sure that they are spent correctly and children are included. It is very strange, children often get neglected, because for treatment, I don't know, it is complicated u know, paediatric drugs, it is not like an adult, an adult accept a tablet, but a child needs a syrup. A syrup may not exist so they might cut the tablet of the adult in two or in four which is not correct. So there are issues, for an adult the diagnosis is easy it takes a test, drop it, a blood drop, antibody test, but for a child this test does not work, I don't know if u know but the test for HIV which we do is a blood test which gets antibodies so If I get infected with HIV my body reacts and produce antibodies, so when u do an HIV test, that is what u measure and these antibodies can go through the placenta.

These antibodies goes through the placenta, this means if the mother is HIV positive that antibody from the mother goes through the placenta to child, so when the child is born and I do a test, it is positive, yet it could be negative and this antibodies remain in the child's body for 18 months, so that means the test is not useful, I cant use it for a child, maybe the child is infected, maybe not. We don’t know.

So there are many reason why they say they can’t do anything for children, but it is not true, they can, because in Sweden if a child is HIV positive they will do the test, it is possible there, there are other tests, they are more complicated, but they exist and the child gets treatment. The child will be on treatment in Sweden, isn’t it? But here not. Here, if you are a child and born with HIV after 3 years, half of them are dead, they are dead! And nobody is doing anything about it. For me, my issues, should I have more
money in UNICEF? I could have 10 million it would be ok, I wouldn’t mind. But if I can influence the Americans, or if I can make sure that the government here when they talk to the Americans they say this is what we want u to do: Americans we want u to spend money on prevention of mother to child transmission, we want you to address the needs of children and it is also good no? and I don’t get the money myself, but it is ok.

So we also have a rule not just campaigns or window districts, we have a rule here in Kampala that you have to help the government to coordinate all these donors to plan, to have a national plan, when the …receive the donors to have peer ideas so we have a very important rule here at the national level we work with parliament on legislation for example the registration could say that maybe an adult have to pay, but if you are a pregnant woman or a child it should be free. Why not? That is legislation and parliament. So we have different rules, we have one rules in the districts, the campaigns as you are referring to, but we have a rule here in Kampala, and that doesn’t cost much money, it is just to sensitise people, donors, partners, help the government, coordinate legislation, it is extremely important for UNICEF.

When I talk about work in the districts we have a partnership contract with NGOs (non governmental organisations), they could be international or they could be local.

So we work with CRS Catholic Relief service, IRC International Rescue Committee
There are many NGOs, there are also local NGOs which you would never have heard of, local community based organisations.

The working districts. We work, if we work in the health centre maybe there is an infrastructure, there is a district hospital and there is health centre so we work through government structures which are in place so if u would visit a district in Uganda, maybe you should do that, you would find there is a district headquarters, a district hospital, and there are health centres, health centre four, health centre three, health centre two, this depends on what they can do small etc and big help centres, so we work through local government and their infrastructure and their staff. For sure, maybe in Europe what you know about hospitals or health centres they are very isolated, the link to the communities is small, but here in most African countries we find there is a community help workers, there are village help teams who reach out in the communities, so, we in general work for government infrastructure.

How to make the people come to the hospitals, that is a very important question. First of all there are help workers them self reach out to the community, sometimes services are provided in the in the village and not even in the health centres. Example for HIV they nearly once a month go to the villages and leave the health centres and they go to talk to them about HIV and offer them counselling and medicine, you have to talk to leaders, religious leaders, who can talk to the people and say: I know you are pregnant why haven’t you gone for antenatal care. I know you are sick. For sure one of the biggest issues is to create demand. It’s not just to try receiving economics there is also a demand. You have to create the demand and that you can do through radio, through sensitising of leaders, religious leaders who can this. So we have a section which is about that, called programs communications.

Radio, is the best way to reach people. Even in our project, in Karamodja at the border of Kenya with rewindable radios, because there is no electricity there or its too expensive.
Radio, people listen, and before the radio was monopolized by the states and there was only one radio, radio of Uganda. Now since 20 years/ 16 years radio is privatized so there are radio stations everywhere!!! It is the best way. Radio works!!

It is not who puts up the billboards, it is the government. There are flyers and all those things, but bill boards you put them up in Kampala, not in the village. In the village, that does not work. But yeah the program communications use all those media, leaders, people who go to church or the mosque so how do you use leaders to pass on certain messages. For example if you are pregnant you have to go to the health centre for you antenatal care. It is a simple message. If you are pregnant you should know your HIV status so if you pass these messages through leaders, through radio, through flyers, billboards here in Kampala.. if you go around you’ll see. There are bill boards about health and HIV. Right now there is a big bill board about children and AIDS. There are also big billboards if you go around Universities, you should check. At Makerere
there are billboards about cross generational sex, there are about young girls dating old men, for purely economic reasons. I go out with you, I give you a phone, airtime for my phone, it is not prostitution... I don't know what it is, it's called cross generation sex and it is very very common in Africa and maybe something you should look into, it's very interesting.

Cross generation sex and they started a big campaign PSAI it's a NGOs internationally co- operational service international. They started a campaign about Cross generational sex and it's created a lot of aid. But it is a very real phenomenon; you will find a young girl with old men. It's not love, that man probably has a wife or even two wives. That's just to have some fun. For the girl it's also convenient because she gets the latest phone, credits, maybe some chicken and chips and it is a very high risk behaviour. Because they don't protect themselves so for HIV it is a very high risk.

Here in Kampala most people speak English but if you go in the streets many people wont. It depends on their education. And then there is so many languages. There are so many tribes in Uganda, I don't know how many. Most of them have their own language. For UNICEF when we recruit for local offices we usually wanna recall local languages. For me, my rule I am a manager I sit here, my job is to get money, to plan it, to coordinate but we are a whole team of people. I know a few words of Ugandan, very basic. Which is the main local language, but there are so many. It is so easy, it is an important thing, language barriers are very huge. Even for Ugandans, we are recruiting people in the east Karamodja at the boarder of Kenya and it is very hard to find staff from there with the right qualifications, so we recruit people from other sides of Uganda and when they go there they don't know one word and they can't communicate with the people. But we try to recruit locally, we even give it as a criteria but it's very few people. If you could recruit locally you would do that, it's very important, because a Ugandan can be as much a stranger in his own country as me. If he just goes to another region he won't understand the language.

We do our written materials in local languages. You can use pictures, but a lot of material has to be translated. If the end user is a customer who are looking for health care or you use comic book. The most efficient way of communicating to the population is, well, to use local leaders in their local language, because they are trusted people. They know their people and they speak their language and it's the most important. Radio is extremely important.

Here in Kampala we have resource centre where people can come, it's like a small library where u can find information about children, children in the world, children in Uganda. So we get students who come here from local universities. Everybody can come, but the first criteria are you know that it exists. A man who is a taxi driver in the street may not be interested to come. Mostly there is more of an elite population who's more exposed or more interested so probably who you see walk in are international students, local students or people who are just intrigued. They can come there; they can sit there and take part of so much information and magazines. There are a lot of journalists who come (Uganda journalists) which is good.

If you want to reach new persons, you use the radio, it is not to write. We also don't want all the taxi drivers to walk in, you need to think of what you are trying to achieve. If you want to reach the mass here you go through leaders; religious leaders, political leaders and churches. Almost any Uganda will go to church, either if it is a mosque, cathedral or a protestant church. You have to go to church here. (KPC) That is how you reach people and radio. We don’t want them to come here. Pastors talk about sexual abuse and physical abuse. They can talk about sex!! (not like Europe) The problem is to talk about sexuality in Africa, but they are quit open minded. The pastors have been exposed and they are perfect; if you say: how can I reach people, just go there on Sunday (KPC).

In the field you would hope that it would be the same people coming back. I mean, if you talk about pregnant women, we want to see a pregnant woman at least 4 times during her pregnancy and we want her to come to deliver at a hospital, yet a lot of them deliver at home. They don’t come, so we want them to come back. Of course the ones who are not coming at all we want them to come also. It is the same with schools, we want the children to go to school and to stay in school, but they drop out, many times for stupid reasons. But of course there are a lot of people who don’t come at all
There is a system, first of all they will have a card, each pregnant women will get a card, so you know if she comes if she has been there before. And also they are registered in a register in a health centre. You can know if they have been there before.

You do training of peer educators to make the information of HIV to spread through the population. I train you on one condition, that you will spread the word. Train them to reach for the people. That is a very classical technique.

Uganda have had a HIV prevalence of 18 % 10-12 years ago, today it is 6 %. It is one of the few countries in Africa where they managed to stop it and to make it drop again. That is what Uganda is famous for. There are many things we talked about to make this happen. First of all: the leadership of the president and of all the leaders, religious leaders, local leaders who openly started talking about it. They made a strategy about how to keep children negative, the window of hope. There was a lot of making sure people knew their HIV status, counselling. Most people talk about is the leadership that actively engaged in the fight against HIV. That is a difference maybe with other countries in Africa.

In 2000 the rate had gone down from the 15 % to around 6,4 %. That was 2000, the start of the decade. It remains there, it has stagnated there, for quite some time to 6,4 – 6,5 %. In 2005 the country carried out what they called the National HIV/AIDS Zero Survey. The survey got out a form of preference and the rate got to be again a little bit higher then 6,4 % to 6,7 % in the country and it specified a few areas where the rates were specifically high. For example, here in Kampala, upper Kampala, the rate was quite high compared to other parts of the country. In northern Uganda, where there has been war for quite some time, the prevalence rate has been higher than other parts of the country. So they attributed that to the wars, exclusive counselling crowded together and a lot of challenging are there putting up HIV infections and in Kampala, surprisingly, because you asked about behaviour, knowledge, because that is what head offices are looking at – knowledge, people have knowledge or not about HIV/AIDS and Kampala had the highest rate of knowledge, best of HIV and AIDS. Ironically, the rate was higher. So, behaviour change was perceived because of the messages we are giving; emphasising being faithful with your wife if you have one, abstaining if you haven’t got one yet, using condom if you think you cannot be faithful or abstain – ABC strategy was emphasised, so the behavioural change of the country, it became a change of the country. I think when its coming up again to 6,7 % it brought a lot of questions and it made out a lot of people involved in research to think – why is that? Giving when there is knowledge, a lot of knowledge about HIV/AIDS in Kampala, the rate is high. Is the knowledge not being translated into behaviour change? Is it getting used to live longer with HIV/AIDS because this can now be managed? Less people die and more are living with HIV/AIDS than in the past. Because here the survey was looking at the preference, because preference means people living with HIV/AIDS at different time, but they will not recite incidence when new infections. So there are a lot of questions there. Behaviour change – yes there was tremendous behaviour change at the 1990s and 2000.
The prevention campaign we have right now are reregurated prevention strategy. Last year, we had a field question about HIV prevention among adults and it was going up and that show we had to look at prevention again, because HIV was again going up, so look at prevention again. We had this strategic plan, a five year strategic plan which we ended last year and started a new one 2008 and it is until 2012. And in that area we focus on prevention especially in the conflict and post-conflict areas because a lot of problems with HIV and AIDS are attend because of and even the people are going back home from these places will meet in freedom, the freedom after that and also be HIV/AIDS going up, so focus on that group rankly on people who are going to the camps and we are fighting the way of HIV preventing there. That’s one section of the people. We are also looking at children and adults at high-risk, for example high-risk in this case, how do people in ex-prostitution and commercial sex-worker, how do they get the HIV prevention strategy messages? We are looking at, in Uganda, people go and watch in video halls, local video halls, so many people go there and another high-risk group like who is normally attached to students and boys who are some of them are not yet going to school whereas people who don’t have jobs, sit there and in the beginning they go for commercial sex and that kind of thing. So we would like to focus on that, we are putting a strategy in place where we talk to the video owner of HIV/AIDS movies, a documentary there TASO and as they show that movie, they also put that clip of HIV and AIDS message together to that. Besides that we have other mainstream methods, we have regular talk shows counselling about HIV/AIDS issues, TV talks show discussing HIV/AIDS issues, newspapers discussing about HIV and AIDS issues and that is our focus and the things we are trying to look at.

We have brochures in TASO, every organisation has there brochures and we share information including materials for missions, including communication materials. It is expensive to make those materials so if another organisation is making materials of a specific area of the disease, we don’t do the same. So instead we can get something from them and we also feel that we can produce something. We are working on a documentary movie about HIV/AIDS and it is focusing on prevention among the, in a faith based organisation. A lot of people say when you are praying in church you are healed from HIV/AIDS, which we don’t think is true because it is not recorded of that effect.

We recall advocacy, networking and cooperation because we know that no single organisation can entirely address issues of the HIV and AIDS, you need support from others. There are so many people living with HIV and AIDS and one organisation like TASO cannot take care of all of them in the country, so we work with other organisations. It is hospice, if for example someone is specifically interested in paediatric care we refer the clients (we call them clients) who come to TASO to them. If you are due for anti produral therapy and you cannot receive it in TASO and there is another place where you can get it, we refer, but those people still come back to get counselling from TASO, so there has been a bureaucratic cooperation between TASO and other service organisations.

One thing is that TASO has 11 service centres in the country, which mean 11 districts, so all those has centres, working units which are coordinated by the headquarters here. Now for example we have service centres in Kolo, in the northern Uganda and the people who work there, they speak the local language. When they go to regular programs, community regular programs in those districts, they speak the local languages. The majority of the people don’t know English. But in the national television we speak English, but in the radio we speak the local language, so we don’t use a single language. And many of our information are translated into different languages.

We use pictures. A picture alone is just a picture, so we use a picture - a capture, picture and written information. What has been most effective for now is the combination. Supporting the message with pictures. But a picture alone, unless well coordinated, a picture alone doesn’t say enough, it needs to be supported by a message or a capture.

The most effective way so far, to us, has been using the people living with HIV and AIDS to give the messages to the community. People who are living with HIV/AIDS have formed drama groups and they through music, dance, and drama does the people living with HIV/AIDS go to villages and then they communicate to the local population using the local language. Through a song, through a dance, through a
skit, to us have been irreplaceable, cause the advertisement I’m HIV positive, I have gotten support, and I’m now doing work and educate my children. People do listen to that more, if you are HIV-positive it is not the end of the world. Drama groups have been useful. But also communication through other media channels; radio, to appear to other target audiences.

TASO is open to all people, not to a special group. The trend has shown that in the past years 1) it is more women then men, 65 % women versus 35 % men, 2) it has shown that the majority of the TASO clients, the people who come sick and want support in TASO, the majority of them are poor people. The ones who come to seek support in the communities are poor people in TASO. Children, those who come are normally, the children of the clients, the people living with HIV/AIDS who come with their children, they also get supported. That’s what I can tell you.

When TASO started in 1997 it was a community which attracted very poor people who was disconnected living with HIV/AIDS and stigmatised. And then our approach in communities was to involve people, we share a lot of love and compassion to people so they feel confident to come. Second, it was people who don’t have money, we give free service. Poor people who come will get a free of charge option. We were charging only 500 Ugandan shilling as a quality use of fee, just to make the people be responsible. That you get this and in the end it goes back to themselves. If someone needs a transport to take them home, and the people who didn’t have food could get a little bit of food. So it was the free service which people come to and it especially attracts poor people. A rich person can go to an expensive clinic to receive treatment from there, which a poor person don’t have. But we don’t close our doors; everybody can come to TASO and seek support. TASO has annual registration, who register annually. Every year we register about 25 people so it gets stretched. How we reach out to people who will not come. One: if you mention TASO people immediately know you are talking about HIV and AIDS management, because people know that TASO is the organisation that deals with HIV and AIDS. Already the communities know something about TASO and we reach out to them through their radios.

We have, like I said, we collaborations with organisations. AIDS information centre that tests people for HIV and AIDS to diagnose if they have HIV or not, refer them to test themselves. So it’s collaboration. Speak to the people and tell them what we offer, newspapers, magazines. So it is a channel of the population and a channel who speak to the ones who are internal. We want to have new people and help old ones.

We have trained so many community workers HIV management. We have about 4 000 community volunteers. So those people are ambassadors, are our ambassadors, in the communities. We disseminate information that is another strategy: through community volunteers, they disseminate information in the communities. Out of that we see people, in the end maybe some of them will come to receive treatment, some of them will go and get tested for HIV and AIDS so it’s a very strong strategy to train community volunteers.

In the prevention, one thing was that Uganda was open about HIV and AIDS, recognised it as a problem and looked for what are the practical issues of preventing HIV and attacking it, stuck to ABC Abstinence, be truthful and condom use, which is very practical and then the people saw the information. The leadership bought it and sent it down to other units, that’s why it got out sectored approach and they felt it had to work

If you have the leadership behind you it give you the direction maybe in other countries leaders don’t look at it as a problem so they don’t give it the attention so they come here to give it attention from AIDS control program Uganda AIDS mission to coordinate AIDS such organisations in the country to make sure that the for support HIV and AIDS, to use different sectors use the agriculture sector use the local governments use the rowidja sector, church everywhere you go, you go to a church and HIV message is given to you, you go to the mass and HIV information is given to you, you go to your local government meeting there is HIV messages are given to you so leadership is talking about it so the leaders are open about it. I don’t know why Ugandan leaders were more open about it, they recognised it as a problem. Then they knew that HIV was a threat a common problem that needed to be addressed. By 1990-91 I think everybody in Uganda lost somebody to HIV and AIDS an aunt, child,
sister, mother someone so the rate was to high at the beginning so it became every bodies responsibility so they recognised it and it get it attention so it don’t discriminate the president you loose somebody to HIV/AIDS, it affects U, U have lost two sisters, several ministers lost three brothers so probably because of the high rate it gave a lot of attention saying now we have to do something to stop this.

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Date: 2008-04-14

I am the spokesman for the commission, I also handle media and advocacy I do strategic partnership. I am Ugandan but not from Kampala. I have been working for the AIDS Commission for six years.

I have noticed change in attitudes and behaviours against HIV/AIDS in Uganda. Maybe I have to give you a small background, when the first cases was reported in Uganda 1982, now there was a lot of myths and controversy nobody new exactly what it was and all sorts of theories advanced so at the time people thought that HIV/AIDS was caused by which craft because the first cases where discovered in the fish villages near the Tanzania border and there was a myth that Ugandan traders were cheating in business and was therefore bewitched and that’s where it came about. Basically people that used to do business between Kenya and Tanzania so between Uganda and Tanzania, but as it moved on different case you have noted and it was no longer restricted to business. People that had some kind of business but three years later we have come to 1990, 1991 when we had the worst cases it got across the country an everybody no matter if you had wealth you had you had business weather you lived in the villages or in the urban areas. Because people how live in the urban areas occasionally go back to there villages and we have a situation where men come to work in towns and then they are coming to see the village so they will go back after some time and,  

So we get traces of HIV in both urban areas and rural areas between old people and young people, so it was that kind of trend but when the biggest campaigns where made advocacy and creative campaigns when they are made we noticed a trend especially among young people most of the young people especially the ones who where in school started to prolong their sexual debut so the first trend we noticed where that instead of getting so many cases between 12 and 14 no more cases where are going to the age of 20, 21, so it was that trend, because as a result of the campaigns we are making young people prolong their sexual debut and even more young people are abstaining and up till 20, 21 that’s usually the time in Uganda when somebody is leaving the University and getting married, starting to work that is also where we get a lot of cases, young who are just leaving the University and getting there first job maybe some are getting married then we are getting big problems there.

We have specific messages for specific groups for example primary schools we have messages that basically emphasises life skills we don’t talk about sex we don’t talk about condoms with primary school children then in colleges and Universities we give the full information because we know that these people are active. So for young people in primary school the messages are based on life skills so yes we have messages targeted to different groups.

We have a number of ways to reach out to people. The work against HIV/AIDS in Uganda the response is basically partnership based which is multi sectoral, meaning you have so many sectors and lots of strong partnerships between government and other organisations, especially civil society, in fact in most of the cases in Uganda when you talk about HIV/AIDS campaigns in like 75% of all the cases its civil society that is working there. Government basically puts in place and presents framework that other people use so you found a lot of work has been done at grass root by non governmental organisation, by the churches, by the networks, by young people, community organisations, so what we do as a group we sit with the governmental messages and then each part of the group specialises where they have there special advantage for example for so many organisations, so for them they specialise in that area and we find out that
they are addressing support programs for HIV organisations like TASO, then you find that organisations like the national committee of women living with HIV they are specialising on women, so we have that kind of partnership what is common is that we all work together we regularly have meetings where argue these messages. In the beginning everybody was working alone, as time progressed we noticed that we missing out on so many synergies we knew that we had to work together as a group because now we know what everybody else is doing. Now we are working together, but this did not happen until seven or eight year ago.

We use quite a number of materials most of all we use the media, we use the radio mostly in the case of Uganda, cus we have so many local FM stations they are scattered globally at the last count over 140. That is our best tool, in the case of Uganda radio is the best tool, but we also have other avenues like posters, brochures, leaflets, like word of mouth, so we have quite a number but our key avenue is radio. We go to small meetings, community meetings where we talk face to face with people, we have worked with people living with HIV and go to address meetings there are so many times when we go out as technical staff and we go and talk to people specific groups, preschools, colleges, communities. That is part of my work. What they call the world aids campaign events in Uganda so we do a lot of that in fact starting next month and in December and we are going to different parts of the country doing that.

There are so many languages in Uganda and the main one Luganda is widely understood in the country an spoken so wherever you go in this part of the country U find that like 70-80% understand and it is the language of business, it’s the language of communication, so we don’t have to produce material in so many languages. We produce in English, in Luganda, there is another one in the western part Uankwele, then we do some in Swahili, there are about four main languages. Swahili is widely spoken in the northern and northeast parts of the country.

The television because has the least effect to communicate through. There are very few and restricted to urban areas, most of the rural areas don’t have electricity so television does not work, but for radios you know we have all these small radio sets which people buy very cheaply and there is also some organisations that actually distribute small radio sets which anybody can afford just about eight dollars, in most of the villages you find them, going to the way or when they pick firewood in the forest they have small hand sets so that’s the most effective way. The ones you wind up are going out of use.

Most of the people coming here are from other organisations, they are not individuals straight from, from, you know we deal most with partner organisations, because we are a coordinating body. So many that come here come from other partner organisations, but they come in more or less equal numbers we can’t say that more women or more men come.

In the case of Uganda most of the people almost 95% they know about HIV, they are informed about HIV the biggest challenge is behavioural change in Uganda, most of the people they know how HIV is transmitted how it can be avoided the know about some of the measures they have to take notified but the biggest challenge is behavioural change, people know that because of culture that is a subject that is revealed by, that is why I did my thesis, you know culture is the biggest challenge most of our communities, women especially the way they are treated they are actually treated as subordinates although she have all this information but she can’t actually act on it without the permeation from her husband so it is a big, big challenge, I did my thesis, I went to a community, I was very chocked from what I found because I had worked here for four or five years when I did my thesis and most of the people they have this information but they can’t act on it because the husband says no, the husband has not given his permission so the biggest problem in our society is behaviour change. The women have the information but can not put it into use because of culture their husbands don’t allow them for example to go to a testing centre they don’t allow them to partice in sex they can’t initiate condom use even if they know the husband has other women they can’t take an action and they can’t go back to their parents because it is found upon.

We have a system of working culture institutions in Uganda big group which we called media, culture and acts so this is one of the media sectors that we work with we have about eight
national kingdoms in Uganda and we use the heads of these institutions to campaign against negative cultural practices but as you know culture is something that is very, very difficult to change, people might still get the information but it is much easier in the case of people that are educated because they understand but when we go to the communities where most of our people live, somebody might get all that information but they still don’t change. And there is always a tendency for somebody to think that she looks nice she can’t have HIV so that is still very frequently.

You know I don’t like to say that we have succeeded here in Uganda, we have made some progress. I think in the case of Uganda we are very fortunate to have committed political leadership in the case of HIV, I have seen this in other countries like Kenya, countries I have lived in and worked in which I know, Kenya and South Africa. you don’t get the same type of political commitment you have here there is a lot of apathy at the top, people are not taking HIV as a priority they have other priorities and they think that HIV is something that can be handled by their health sector or what ever, so one of the major advantages we have had in Uganda is that one culturally, government realised that HIV is a serious problem and took it as a priority. Actually embark resources to work in the national response against HIV. It is taken as a priority. Two, ones the government puts in present in an everybody environment other people find it very easy to come and work alongside us. We have so many nongovernmental organisations both locally and internationally who are working in the response in Uganda and as I said in the beginning in the case of Ugandan response it is basically civil society not government that is building the work so you don’t get government to work alongside civil society so well for example in South Africa the democracy between the government and civil society is so big they are having a very big problem ones they say they want to do something the government says don’t do it. I saw it first hand because I studied it for my master and I could see it first hand every day, people say that the government is suppose to do this but the government is not there to do it so that has always been one of our major advantages, government knows it can’t get everywhere, it can’t get to the rural communities where most of the people live so it encourage buildings for taking partnership people can actually help instead of just saying, do like this the government says come and work as equal partners and the communities they say that we have a strategic national plan that was actually made by all stakeholders both government and non government organisations and we have a map here that shows where we are settled and where the gaps are and where people are building communities, so when I sit here now I can look in this and I can actually pin point an area where there is no service at all, so this is some of the reasons why Uganda have been able to make more progress then other countries.

We do follow the national strategic plan, because before we made that strategic plan once we could have meetings with all partisans both local and international nongovernmental organisations, the churches, the networks support for HIV so at the time when we came up with that document all partners had made an input so it becomes very easy for us to commit because they are our own document, everybody highlight it what they felt where the key issues we should address its very easy to follow for us

TASO is not a governmental initiated and it is one of the most successful in Africa, one of the people hat started TASO is actually serving at the Global Fund in Geneva, most of these initiatives are community included they are not driven by government, so I can never say that government has done more than other people in fact half of the effort that where good for government has been through policy, policy framework and things like that but actually initiating of programs has been done by non governmental organisations, networks on HIV these are the ones, these are our leaders in the Ugandan response.

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Free Translation

I handle the whole portfolio of money from Sida that comes to Uganda. We use to talk about the humanitarian organisations that give
humanitarian support, and these are working in the northern part of Uganda, where there have been conflicts. It has been a long civil war and still is, but now is there peace negotiations taken place in northern Uganda, but that is where the humanitarian help organizations have been working with the issues of refugees and more or less everything, like health, service and so on and HIV is a part of that. Up there have we been working or we mostly financing the UN organs and their coordination of what is happening in the humanitarian area up in northern Uganda, where you have a common UN support for health and HIV/AIDS in northern Uganda, and that is UNICEF, and there are WHO and UFK, these have a joint program, an emergency program about HIV/AIDS, more or less to give a greater support to the ones in the poor countries.

The health situation is really, really bad because of the crises that has existed in northern Uganda and where you have a much lower health status than in the rest of the country. There are no health centers that are working up there, all things like that disappeared during the civil war, so they have given their selves into the hands of the help organizations that have been there and been giving support and help, but that cannot be lasting. In one way it is good, but they can never cover everybody’s needs, so it’s a really bad health situation in northern Uganda. But now it is going a little bit better, since the conflicts are more or less over, at least the worst conflict and now are people leaving their camps for trying to get back to their old villages, although it is not much left of them. So now is it a great focus on building up new health centers and to bring out health staff; cause there are no ones who have started to work up in northern Uganda, for understandable reasons. So out of that perspective are we working together with the organizations, and I also think that we are giving support to a few humanitarian organizations which are not working with health and HIV, but for other causes, but I’m not too involved with that. In the rest of the country do we work with voluntary organizations in different kind of ways which are working with HIV/AIDS, but mostly do we support two organizations, with Sida money that is, one organization is named TASO who are very big and have been existing in Uganda for 20 years and have been functioning ever since HIV first started to appear in Africa and mostly in Uganda, and them have we been supporting for a long time, but they are not covering the whole country, which is impossible, but a pretty big part of the country, and they get what is called a core support from us, that is we give them money and they will decide by themselves how to use them, we don’t give specific directions about what kind or program to use the money for or what kind of region, instead we give them fully responsibility to what they want with their money, only if they give us their strategic plan, which they have for the next coming five years and what they will do and so on. And there is also another organization which is named Straight Talk Foundation, your both hear and see them a lot and they are also a non-governmental organization that works with HIV prevention and not just HIV/AIDS, but everything that is connected to sexual health and turn to youth. They work a lot through radio, that is through mass media, and they do magazines which are present in almost every school in Uganda, you can never cover the whole country, but they reach out to a lot of youth, I believe they do come out once a month these magazines, to pretty young children, ten – eleven – twelve, and the focus is about HIV, and then to older children, Youth Talk is the name of the magazine, and then they have another one for even older and also one for teachers, Teachers Talk and Parents Talk. They have different target groups and most important do they have radio shows that are sending in thirteen different languages which are spoken in Uganda, I don’t know the total amount of languages but it is an awful lot, and they have these radio shows in thirteen languages and many people in Uganda listen to radio, TV is not at all common in the country side, but radio do a lot of people have access to even if they don’t have their own radio, so that is a good way to make people listen, and they talk about everything that surrounds HIV/AIDS and how you protect yourself, what to think about, it is not always the message but can instead be a funny anecdote, a story, so people can talk, just to bring it to their intentions. They also have two youth centres or what you should call it, ungdomsgårdar in Swedish, even up in the northern Uganda in Gool and Kigou which have been really affected of the conflict, where youths can go and talk and get tested for HIV and talk to another person who can give support and advice. I also believe they are giving health care, but most of all is it a place come to and meet other youths like a youth centre. We do
also financing them, Straight Talk Foundation and have been doing so since 2001 I believe, and it is about prevention. We are also supporting another youth clinic which is situated here in Kampala, named Nagoro Teenage Centre, which takes in youths. They should only exist for certain geographical parts of Uganda, it is parted as in Sweden, but everyone has the right to come, and there are very many youths that are not living within this area who still comes to the centre since it has a very good reputation. Last year I believe they had 47,000 visitors or something like that in a year, only imagine. It should be to give service to youths in the age of 15 – 24, but are some younger are they allowed to come, but not if you are older since you do not longer counts as a youth, but there can you also get tested for HIV and you can get certain medication, I don't believe they give out anti AIDS medication, but they give for malaria, antibiotics, pretty basic stuff. They are situated right next to a health central, so they have the employees from there close to their centre, but they do also have their own staff who are educating the youths how to run HIV/AIDS and talk about sexuality, youth health problems, everything actually from head aches to puberty, like the youth centres in Sweden you can say, the same concept. This is something that been started up with Swedish funds, and a Swedish way of thinking, youth focused and not run by people with moral sticks, so they have the right kind of psychology, they are very famous, many youths know of them. It is Kampala, the city Kampala who run the centre, it is not a NGO but the Kampala city council, but they only pays for the halls and for electricity, all the cost for running the centre which is very good, but the salaries for the ones working there and their education and likewise, do Sida stay for. We have also financed them for a pretty long time, but we believe it is such a well working youth centre, so it is not only to decide to, no now shouldn't we do this any longer – you are on your own now, because it is very important for this kind of service. As you can see by looking at the number of youths who are coming to the centre, they think it is too many and they can not accept more people now, so it is important to build up new youth in other parts of the country, centres that are looking kind of the same as this one, but it is always the problem of money and priorities and yeah, it is difficult.

These are the ones we are giving support to in the type of projects or what you should call it, but then we are also giving budget support to the government, money that goes straight into the country’s fund which are marked to be used in the health sector. Although you can never really say, we can never fully decide that they should go to the health sector but it is to be read between the lines, and we can't control that every shilling is used in the health sector, but that is what job is about, I have a very close relationship to the ministry of health and through that try to see that their priorities will be good, that it will actually happen in reality and try to closely follow up, together with other donors, since all the donors are working very close together, not Sida by themselves and the Danish by themselves, but all together in a joint action trying to affect and make a good follow up and try to push some questions harder than others, which we consider are more important.

At the moment are Sweden trying to have a distinct profile in health connections, we are trying to run the issue about SRHR – Sexual Reparative Health and Rights, which is Sweden's big thing all over the world, with a great focus on youths; their health and also in the concept of SRHR are also mother care. In this country die a terrible number of women during their pregnancies, that first of all maybe wasn’t wanted, there are many unwanted pregnancies. They don’t have the access to contraceptives, which they can get hold of from this youth centre, there is where they can get help with contraceptives and also get the opportunity to talk about it. The media access is still very bad and women do get pregnant without wanting it, and when they are very young, tremendously many teenage pregnancies, which are often ending with, since abortion is illegal in Uganda, and then are they trying to make an abortion on themselves or finding a person that can go through with it for a lot of money, and they will lay somewhere and bleed to death. It is horrible and it is a big problem. Even the ones who want to have a baby, it can arise a lot of complications when they are to give birth, and they maybe die during or after the birth. These issues do Sweden work a lot with and we are famous internationally for our mother care. Sweden has the lowest mother mortality in the world and almost the lowest baby mortality too, and it is very high here so these questions are we trying to run hard, and then HIV/AIDS, that is prevention, so in HIV is it mostly, it is a lot of money for HIV/AIDS globally. Most of
all is it from globally funds, globally funds for HIV/AIDS, tuberculosis and malaria, where a lot of countries give a lot of money which are divided to countries in the world who have problems with these three diseases. Uganda get a lot of money, but most of it are used for AIDS medicine, which is of course very good and that have helped people from not dying of AIDS, it is not only in Sweden but also in Africa, but it is still not enough since there are so many that still are dying and who needs medicines, and more and more are getting sick by HIV. They have said that for every person who dies of HIV in eastern south Africa, there are six new that becomes effected of HIV, so it is hard to catch up even if you buy a lot of medicine there are a the time new persons who getting infected, therefore do they need to work with prevention.

Why Uganda has done better in their prevention against HIV/AIDS is a big question and I believe more countries should wanna know and be interested in to know more about than what they do. I was in South Africa yesterday and we had a meeting with representatives from south and east of Africa, since Sweden is about to write a new HIV/AIDS policy which is on its way. It is the assistant minister who has taken the initiative, so we sat there and discussed about just this, what it should be written and what is should contain for example. In the south of Africa, the problems are worse, there about 14-15 % are infected with HIV in South Africa, Zambia and even more in Botswana and Namibia and here it is about 6.5 % and that is a big difference. What the cause for that is possible to try and figure out, and there are a lot of explanations. They say here, or they believe that there are three main explanations to why they have managed to decrease it, because it was up in 18 % in the beginning of the 90ties and in some places in the country over 30 %. One thing was that the president went out very early and spoke about HIV/AIDS very openly, because attention was brought to the matter on the political agenda. That is not the case in a lot of other countries where they don’t want to use the word and it has meant a lot that people get aware, acknowledgement or what you can call it, pretty early.

The second explanation is usually said to be that famous persons went out and said that they were infected, that is musicians, artists who were infected and who dared, gave the disease a face and that was of great significance because of this with stigma and things and then people dared a bit more to tell they were infected. It is still a lot of stigma in Uganda, but I believe it is a lot less compared to south of Africa. Here you dare to talk a little more openly about someway it and that has probably been one of the explanations to why people got knowledge and thought more on HIV. You also say that apart from this a lot of promotion was dedicated to VCT, voluntary, counselling and testing to advise people to actually seek up health centres to get tested and then it was a lot of the people who found out they were infected and then they could protect themselves and start using a condom. So the three factors together had an effect on the new infected and it was very successful.

After that they have managed to keep it pretty stable, it has been kind of low, around 6,7-8 % and then it is a bit different, because in Kampala it is higher, here I think it is around 8-9 % and among women it is 13 %, so the number 6.5 % is in the whole country, but there is a lot more AIDS in the cities and among women. More percent of women are affected.

They have lived with it for so long now and the people who are young today they were, it hardly existed then, so they have grown up with this view of it since the president have been speaking about it the whole time. Then you also believe, but I guess you can discuss this, but it has been pretty tough campaigns here, ABC – abstinence, be faithful, use condom. What can you say, it has been controlled from USA and USA is a big actor when it comes to HIV/AIDS, most for medication, but also for research, but they have been promoting this device, at least since George Bush became president; abstinence and be faithful but on the other hand not condom use. That is something you don’t wanna talk about and the Americans have not brought it up, this is a fact globally too and it has led to huge problems. Now HIV/AIDS have got new infected, it started to go up in Uganda, they are increasing, goes up and down, so the trend is starting to end and that is discussed a lot what the reasons for this is, but I have to say that that campaign was successful since there are proof that adolescents are prolonging their sexual debut, with two years I think I read somewhere
and that is good. But other studies show though, when the study has been made again after a few years, that when these young people reach a certain age they still catch up and get infected in the same extent as the others. So sure, prolong your sexual debut, but it has no outcome on the number who gets infected at a certain age a few years after. So really, it is not a strong effect.

And then be faithful, it sounds very good on the paper, but it doesn't work that way in reality. Unfortunately, they have been pretty effective when it comes to adolescents, infected youths have decreased and they have started to protect themselves, but then they get married as a girl here at the age of 18 as an average for an Ugandan woman. As soon as she is married you would think it is okay, now I don't need to use a condom anymore cause I am married and now we will have kids. She has a husband who has a woman on the side or got to a prostitute, then what does it matter if she is faithful to her husband? It is a pretty mean message in the sense that you tell someone that you should: be abstinent. She may be abstinent till she gets married and then: be faithful. Yes she is, but still she gets HIV. You cannot take away that C, because it is extremely important; condom use for the woman. At the same time it is hard, as a married woman to tell your husband that he must use a condom, it is really hard because then she tells him indirect that she does not trust her husband. There are so many other factors that matter that you get infected in Uganda, but it is almost easier then to reach out to younger persons before they get married because then it is too late, then the woman has to obey her husband.

It is not that common to have more than one wife, but it actually still do occur, but I believe it is mostly on the country side. What is more common is that you have several partners, on the side, not many but you have more than one partner at the same time. This is what is discussed a lot at the moment, when it comes to Africa and why HIV is spreading so quickly in Africa and not in Asia and other parts of the world. And it depends a lot of these current conditions, because there is nothing that indicates that an African have more partners on an average during a lifetime, a lot less actually. They might only have two or three while an American have a lot more, but in Europe and in the west you often only have one at the time. You might have one for two years and then one for three and than it ads up and become many during a lifetime. Here you might only have two or three, but you have them at the same time and what that brings is that the infection is spread extremly fast, like this (wide gesture) and then it is enough if someone in that network, as you belong to even though you don’t think about it, is infected and then it is spread like fire. That is why people believe it has spread so quickly in Africa. Tradition is the wrong word, but that you have maybe two women and men too, you have your husband and then another man, a lover, that everybody knows about and it is nothing strange about that, but it is enough, and then he also has another one. It is something, when prevention is discussed nowadays and how to approach it, that they still have to focus on. Youths, sure, but also married couples where often one is infected, but the other part is still not infected and work to keep them uninfected.

There are perhaps other questions that are important today then 10 years ago, there is another focus, but this ABC campaign, if we talk about marketing, has been very successful in many ways. You could see it everywhere, there were a lot of billboards here with abstinence and be faithful. You can still see them, but I think today you see more about cross generational sex – older men and young women, because it is what you see today, the way women get infected through. That is, women get infected by having sex with older men, who are already married, and have had many other partners before and then they get infected that way. They don’t always have to be young, very young women, they can be around 25-30 years old, but still they have a man who is much older and she get advantages, for the transsexual sex, and she might have two different men, one who gives her a mobile phone, clothes and jewellery and things like that and then the other boyfriend who she really like. It is a lot of people who have more than one partner.

It is different partners who put up billboards. UNAIDS is with and then I also think it is PSI population services international. That is the organisations that are in charge of that, social marketing of condoms and then I believe there are these other American, there are very many American NGO who work here, I think it is them that are behind it. There are many organisations who work with HIV/AIDS here,
an awful lot, out in the districts too, that is local NGOs who work with HIV and I do not believe there is anyone who are in general of everything that exists.

There are so different target groups. There is the youths and you can try and reach them the way straight talk does, through newspapers, radio shows and the schools of course, even though there is a lot to do in that area. But the sexual education is not at all extensive in a good way in the schools. But they know pretty good how to reach the youth. Although, I believe it is harder with the information, as I mentioned, to married couple; where the disease is seen to be spread pretty quickly. Then I think it is harder, you have to have other tactics with them, youths are another group and it is not too easy. I am not all a marketing expert, I believe a lot in that it is important to try to make people, when they for example are at a health centre, when they seek health care for one or the other reason, try and encourage them to get tested and that they know if they are HIV positive or not. Because if you are married and only one is infected, the other person might not be infected yet it is very common that it is the case, you should know you are infected. You are not infected, ok, from now on we have to protect ourselves and start using a condom within the marriage, so that they know this. I think it is very important to reach out with this type of information and advise people to go and test themselves. I believe this is possible in connection with when they are seeking up a health centre in a different matter and give them that information there. Now I’m talking from a health perspective, I work within the health sector. Then there are other target groups who need particular information, it is for example prostitutes, precise information is need for that specific group. The military too is also one of these groups that I know haven’t been worked towards; it is a pretty exposed group. They are away from their families and they use young girls a lot. They are away from their families, as said, during longer periods and prisoners little for the same reasons. Then you also know that a lot happens in the prisons and yes, they are very vulnerable to get infected. Even from each other, men who have sex with men, which is happening within the prisons. Then, in Uganda there is a lot of talk about these fishing communities. There are a lot of fishing societies because there is a lot of fishing in the Victoria Lake. There are a lot of these communities that move around, not quit like nomads, but they move around a lot where the fishing is and they are also very vulnerable. For them it is the same thing, they are away from their families and use commercial sex workers and prostitutes a lot more. Also they do not get access to information as the rest of the people do as they move around so much and radio and TV does not exist and newspapers and stuff and it is important to reach out to these groups. Apparently they are, to a large extent, infected, much more than the average Ugandan according to certain studies, just the fishermen and they are many. Then I believe you have to reach out with particular messages and maybe special initiatives for the different target groups. Everybody cannot receive the same type of information, so it has to be specific or targeted information – an intentional message to the explicit group.

UNGASS is the UN, United Nations, that is all nations in the world have signed this declaration about HIV/AIDS and that was done in 2001, I think. The whole world has contributed to it and each country should hand in a report, a follow up and I believe it was handed in, or Uganda’s report was finished in December 2004 I think, and then there was a follow up meeting 2006 and there is going to be another one in a couple of years. It is a big meeting in New York in a couple of months, this summer I believe, the follow up of UNGASS and prior to the meeting, this report was carried out; the UNGASS report for Uganda, but all countries will present one. I don’t really know who the author is, but I guess it is the countries who are conducting them, but they probably get a lot of aid from the UN organs. Different organizations have helped writing it, TASO, AIDS Commission and the UN. Each country should have their own plan so on so on, and Uganda has signed as all the other countries and then you can follow up how it has been implemented.

How big part the government has in the stagnation of HIV/AIDS is hard to say because it is a multi sector and there are several ministries who work with HIV/AIDS and therefore, the Ugandan AIDS commission, who are some type of body, an agency or an institute who are suppose to be the coordinating institution. Yes, I guess that would be the right term for them for what they do, and it is some sort of a government institution. The problem with HIV/AIDS is that, since it is given
financed to 90% of external givers, it is not the own money, the countries own money are not dedicated much at all at HIV/AIDS and it is connected. It is like the hen and the egg, that is the government think that we get so much money from the givers and then we can take our own money and do something else, but it is totally wrong as they have to themselves look at where their priorities are and what they believe is important and then the givers can complement it. So unfortunately it is absolutely too little financing for HIV/AIDS from the nation, no doubt about it. Then on the other side, I believe they are pretty coordinated, Uganda AIDS commission have been given a lot of support from the givers to build up there capacity and that they coordinate themselves with these ministries who are involved, it is actually all ministries but some more than others such as the health, ministry of education, ministry of labor and gender, social development, because they work with AIDS orphans. It is different departments and ministries of local governments, yes they are several, but I believe that the government would need much, much more to take over the ownership again because they have given a lot to the external givers. It is so much money who falls in and unfortunately the government looses the ownership, or what you can call it, over the issue. They might priorities it on the paper, but now they have come up with a national strategic plan for HIV/AIDS and that is great. But it is also a product of the external consulters and given financed consultans who has been brought in and written large parts of it. It is good, but now it remains to see if it can be implemented, to keep the virus down. Because as it is said, it HIV is increasing at the moment, and that it is possible to implement the policy that is said to be put into practice. As said, Uganda has good plans, they are very good at creating plans, but it is the part of implementing them where they are not as good and to follow them up. There a lot can be improved. So it remains to see how the plan goes.

Kampala is Kampala, people are more informed here and they know more, but out in the country side or in some village it is a completely different thing.

Ugandan demographic health survey, it is made every fifth year and it is a big survey throughout the whole country that aims to look at the health situation in the country. Yearly follow ups are made, all programs do that are run in the country, and it is possible to see where they are now, how many new HIV infected and so on. But this is some sort of deeper investigation, where people are interviewed, survey throughout the country and this is not possible to do that often because it cost a lot of money, but it is made ever 5th year and it came out 2006, it was made 2006 and it contains a lot of information about HIV/AIDS; how many of the population who are infected, a lot of information about how much they know about HIV and then it’s also divided to different age groups, districts, education level. It contains that very important information that you need when you are looking at if the messages that are sent are working. Firstly then you need to look at what kind of knowledge and education do they really have. In Kampala I believe it is said that around 80-85% of all adolescents knows how to protect themselves from HIV. But if you go up to the northern Uganda or worse, if you go to Karamodja in the north east, where it is around 3 percent of the populations who knows how to protect themselves against HIV. There are these huge differences and then it is dangerous to only look at Kampala and believe that this is the whole of Uganda. If you want the whole picture is it out in the country. But there is of course an average too.

The biggest problem is that the women are so vulnerable. They are infected easier than men. They on the other hand receive information better than men, but since they have to obey their husband they cannot do anything with the information that they get.

Citizens of Kampala

Name: Sarah Oleru
Age: 18
Gender: Female
Profession: Cleaner

HIV/AIDS is about testing yourself and use condoms. I got the knowledge of the disease from primary school at 10-11 years old. We got good information and they were advising us. I am not familiar with any help organizations and I think the best way of getting information is through hospitals. To control the disease, we need to test the blood. I don’t listen much to the radio. I do not discuss this subject among friends
but I don’t think it is a difficult subject to talk about. It is transmitted through razorblades, injections, and sex without testing the blood.

Name: Rose Namaweje
Age: 19
Gender: Female
Profession: Saleswoman

HIV/AIDS is known to be a killer disease. I have received information from hospitals, HIV-counselling, HIV-organizations, and NGOs. The most information is coming from hospitals. I had to go and get HIV-tested, that’s why they told me. The information is enough, mostly good information. I talk to family and friends about it. Everybody listens to the radio a lot. (It was a radio right next to us, where we were standing)

Name: Muhem Mboga
Age: 25
Gender: Male
Profession: Driver

HIV/AIDS destroys the immune system. I first got the information from my parents and they advised me to be abstaining from sex until the time comes. Then I got information from school and also from TV and radio. The parents were the best advice. I don’t know any help organizations. To protect myself I use a condom and I am waiting for the right time. I don’t use condoms, since the right time hasn’t come yet. For me, talking about HIV/AIDS is sensitive, because it concerns my life. Sometimes I talk about it with my friends.

Name: Fredrick Kabunga
Age: 38
Gender: Male
Profession: Driver

HIV/AIDS is a virus that kills instantly. I can’t mention any help organizations. You protect yourself by using condoms.

Name: John Kizit
Age: 28
Gender: Male
Profession: Driver

You have to make sure to use condom when having sex. Everybody talk about it, nowadays you can talk about it, you have to talk about it. The information comes from radio and TV. Radio is the best; I listen a lot to the radio. It is good information, cause you don’t want to die, so you listen to what they have to say about HIV. I can’t say much about AIDS, but I need to use condoms. I can’t mention any help organizations.

Name: Henry Albert Oyukui
Age: 27
Gender: Male
Profession: Parking Guard

HIV/AIDS is death. I have seen relatives and friends suffering and die. Since I was a young boy I have seen suffering. The information goes through radio and TV. It is wise to pass through radio because it would cover wide areas. It is easier through radios than TV because in smaller communities they don’t have electricity and they can’t afford a TV, but the radio cost only 3 000 Ugandan shillings (ca 12 kr). You might buy the radio to listen to music, but then automatically when the adverts come you get information about HIV. It is not easy to talk about the subject. When some people have AIDS, people think they are witch-crafted. When they get the disease, they blame the people who gave the information about the risks because they should have continuing until it got the whole way through. If one person in the family dies, there is a message to the other one to not live the same as he did. If that person is still alive and around, he can say I’m heading towards the grave. In Africa, before they have seen it, they don’t believe it. TASO is a help organization which works here in Kampala.

Name: Charles Sebunya
Age: 28
Gender: Male
Profession: Driver

I don’t know any help organizations. I practice abstinence, faithfulness, and condoms.

Name: Florence Berabura
Age: 28
Gender: Female
Profession: Parking Guard
When I hear HIV/AIDS I think about dying and losing somebody. After losing relatives I know what it is. I protect myself. It is difficult in marriages because of the paternal. If you are married you can't trust each other, you need to protect yourself. If I am positive and if I have a good job, I can get money to keep going, compared to if I am poor. It is not easy. Open organizations is TASO and Mulago Hospital can assist you, even if you are poor. If you get sick, you go to the hospital, and no matter what disease you have, they always test you. The information is very good; it makes you aware of the disease. I listen to the radio a lot, most people do. We enjoy radio. It is the main media in Uganda. There is information in newspapers, but some cannot read.

Name: Josephine Nantongo  
Age: 30  
Gender: Female  
Profession: Receptionist

HIV/AIDS is a dangerous and incurable disease. Someone might even get it, even if he or she doesn't know about it. It can take one or two years before you know. You can get ill from it, but still don't know that it is HIV/AIDS. In Uganda we have counselling and we have separate HIV resource centres, like Mulago. And even in newspapers you can get information and friends that are HIV-positive. Centres and newspapers are the best ways of getting information. TASO is the number one help organization in Uganda, it is the biggest. There are many organizations. People can live longer if they get treatment. We have medicine to slow down the process, but not to cure. It is important to avoid being lonely when being infected. Don’t ignore people, don’t close yourself indoors. You have to go out, eat well, like vitamins; it helps you to live longer. Otherwise a premature death. If I say I’m going to die, I will die a premature death. You can discuss this with family and friends. It helps the young kids how to be careful, they need to know. There are many ways to protect yourself. If you have a boyfriend and are not married, use a condom. If you are married, be honest and faithful to your partner. Wait, but if you can’t wait, use condom. Even young people like 16 years old can have HIV/AIDS. Young people should abstain from sex, even with older persons.

Name: Kyomcikama-Rosette Dekool  
Age: 24  
Gender: Female  
Profession: Travel Agent

For me is HIV/AIDS a horrible disease. At first people didn’t know the cause of HIV/AIDS. In the small villages people died from a combination of all different diseases and they believed it was witch-craft that caused them. In the villages, you shared everything, so the disease was easily transmitted, although no one knew. People didn’t have money to go to the hospital and instead they used local herbs. Some people fooled the sick to buy expensive pills and medicine that couldn’t cure the disease, only to make business. They could also tell them that you’re whole family will die, cause your neighbours have put a spell on you, and if you pay me I can take it away. And the people paid a lot.

When, TASO, counselling, and the radio came a lot of untrue facts about HIV/AIDS were revealed. Nowadays it’s really cheap to get treatment and help. In student centres you can get tested for free and they can also provide some drugs. People have little money and organizations are there for those who need it. Condoms are still a problem in small villages. They don’t know how to use it and they don’t understand why they should use it. The information should come from aunts and uncles, cus it’s hard for parents to talk about it with their children. It’s good for the young generation, they getting more and more information. I grew up without knowing about HIV/AIDS, I only got a little bit of information from the school.

I got my information of HIV/AIDS through educational centres, radio and TV. But there are also women groups, counselling, prevention for unborn child, youth information, posters. TASO have training centres, where they educate people to inform other people. Villages do not have the same access to info centres and counselling.

We do not hardly talk about HIV/AIDS, cus all are aware of it. I talk to my younger sister, mostly about cross generational sex. Young girls get themselves a “sugar daddy” to get expensive gadgets, such as mobile phones. This can be cause by peer-group influence. For example,
peers that are experienced take you out one evening and have a lot of fun and in the end they introduce you to someone. Some girls do it to get nice things, but some are forced and let the men pay for their semester. Otherwise they wouldn’t have been able to study. It is just an adventure, not a good idea. The daddies are married people and they just have fun. You don’t know their HIV-status. Some think that he is a nice man, he doesn’t have HIV.

I don’t think HIV/AIDS is a difficult subject to talk about, but that is because I’m really aware, so it’s ok. I hate loosing relatives in HIV/AIDS. My father had HIV. We were living in a small village, but he sometimes lived in Kampala to work and he had a lot of women. He suffered for a long time. When you’re HIV-positive, you need to have good food, and it wasn’t in the village. And then my mother also got infected. My father died first, and then my mother. HIV/AIDS wouldn’t be here if we were aware and had access to medicine. Before a lot of people tried to cure themselves instead of going to the hospital, because they thought it was just any other disease. Now more people are aware and they rush to the hospital.

Billboards in Kampala are an effective way to reach out to people. The ones carrying out the information need to be convinced about it. It should be a chairman and chairperson in the villages, who can go around and talk to people. Local counselling is good and they should have meetings in the village. Can carry out free tests and if they are HIV-positive, they can get free treatment. Churches do also have a good counselling. If you have someone HIV-positive, the church will help.

When they fall sick, they do really “know” that they are HIV-positive, so they won’t get tested. But they are aware. If you get a boyfriend for a long time, you can go for counselling and also to test yourself, and they can inform you that it is still possible to have marriages and children if you are HIV-positive, the life is not ended.
<table>
<thead>
<tr>
<th>Wordlist</th>
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<tbody>
<tr>
<td>Adequate - sufficient, enough</td>
</tr>
<tr>
<td>Adolescence – teenage years, youth</td>
</tr>
<tr>
<td>Advocate – believer, supporter</td>
</tr>
<tr>
<td>Applicable – appropriate, relevant</td>
</tr>
<tr>
<td>Apprehend – capture, detain</td>
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<tr>
<td>Arbitrary – random, chance</td>
</tr>
<tr>
<td>Authenticates – validate, confirm</td>
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<tr>
<td>Authenticity – accuracy, realism</td>
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<tr>
<td>Authority – power, ability</td>
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<tr>
<td>Commence – begin, originate</td>
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<tr>
<td>Compelling – convincing, persuasive</td>
</tr>
<tr>
<td>Components – gears, mechanism</td>
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<tr>
<td>Concurrent – simultaneous, parallel</td>
</tr>
<tr>
<td>Contemporary – modern, current</td>
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<tr>
<td>Contribute – add, give</td>
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<tr>
<td>Deduce – reason, work out</td>
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<tr>
<td>Depiction – interpretation, representation</td>
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<tr>
<td>Distinguishing – unique, characteristic</td>
</tr>
<tr>
<td>Elicit – bring out, extract</td>
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<tr>
<td>Enhance – improve, add to</td>
</tr>
<tr>
<td>Evaluation – judgment, appraisal</td>
</tr>
<tr>
<td>Expectations – prospect, potential</td>
</tr>
</tbody>
</table>
Hypothesis - theory, suggestion

Immense – huge, vast

Inference – conclusion, assumption

Interpretation – understanding, analysis

Intonation – accent, modulation

Invoke – raise, call for

Linger – remain, stay behind

Misinterpretation – misunderstanding, false impression

Occur – happen, take place

Peer – equal, friend

Polygamous – several, many

Prerequisite – precondition, requirement

Promiscuous – loose, immoral

Restructuring – reform, reorganization

Secluded – isolated, sheltered

Spouse – partner, wife/husband

Stigma – shame, disgrace

Surveillance – observation, watch

Upsurge – rise, increase

Utilize – use, exploit
The University of Kalmar

The University of Kalmar has more than 9000 students. We offer education and research in natural sciences, technology, the maritime field, social science, languages and humanities, teacher training, caring sciences and social service.

Our profile areas in research are: biomedicine/biotechnology, environmental sciences, marine ecology, automation, business administration and informatics, but we have research proceeding in most subject areas of the University.

Since 1999, the University of Kalmar has the right to accept students in postgraduate studies and to examine doctors within the subject area natural sciences.

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