Exploring factors associated with women's vulnerability to HIV infection as compared to men in Tanzania.

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Tanzania

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Exploring factors associated with women's vulnerability to HIV infection as compared to men in Tanzania.

A Thesis submitted in partial fulfilment of the requirement for the degree of Masters in Public health (MPH).

By Mary Kassimbi Rwegasira
Tanzania

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Where other people's work has been used (either from the printed source, internet or any other source) this has been carefully acknowledge and referenced in accordance with departmental requirements.
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Signature.....

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Becoming a scholar is a like gathering raw materials and putting them together in a required shape. It takes a team of dedicated people to work together and turn everything into reality. I have been blessed with such a team working with me on my school journey at the Royal Tropical Institute.

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ABBREVIATIONS

ACORD	Agency of Research and Cooperative in Development
ADB	African Development Bank
AIDS	Acquired Immunodeficiency Syndrome
CBO	Community Based Organisations
FP	Family Planning
GBV	Gender Based Violence
HIV	Human Immunodeficiency Virus
HSV	Harpers Simplex Virus
IMAGE	Intervention with Microfinance for AIDS and Gender equality
MCP	Multiple Concurrent Partnership
MoHSW	Ministry of Health and Social Welfare
NGO	Non-Governmental Organisation
NMSF	National Multi-sectral Strategic Framework
PMTCT	Prevention of Mother to Child HIV and AIDS Transmission
RH	Reproductive Health
RHS	Reproductive Health Services
RTI	Reproductive Tract Infections
SAT	Southern African AIDS Trust
STI	Sexually Transmitted Infections
SSA	Sub Sahara Africa
TACAIDS	Tanzania Commission for AIDS
TGNP	Tanzania Gender Networking Programme
UNAIDS	United Nations Joint Programme on HIV and AIDS
UNICEF	United Nations Children's Education Fund
URT	United Republic of Tanzania
USAID	United State Agency for International Development
VCT	Voluntary Counselling and Texting
WHO	World Health Organization

GLOSSARY

Agency-refers to an actor/individual or group's capacity to act independently and make their own purposeful rational choices for their own lives (Samman et al 2009)

Concurrency- "Overlapping sexual partnership where sexual intercourse with one partner occur between two acts of intercourse with another partner" UNAIDS, 2010, p.2

Comprehensive Knowledge to HIV- Comprehensive knowledge of AIDS is defined as "(1) knowing that both condom use and limiting sex partners to one uninfected partner are HIV prevention methods, (2) being aware that a healthy-looking person can have HIV, and (3) rejecting the two most common local misconceptions—that HIV/AIDS can be transmitted through mosquito bites and by supernatural means" (TDS-2010 p.214)

Empowerment- Is the "process by which people take control and take action in order to overcome obstacles" (SAT, 2011, p.6). In the gender perspective, the term refers to the process whereby women mobilize their collective efforts to understand, identify and overcome obstacles against gender oppression and discrimination in order to bring about equal relations in equality and equity.

Gender- refer to the different socially constructed roles and opportunities associated with being a man or women and the interactions and social relations between men and women, it determines what is expected, permitted and valued in women or in a man in a determined context.

Gender equality-It is a situation whereby there is no discrimination on the bases of person's sex in accessing to resources and services. Both men and women are free to make personal choices for personal development without any limitations imposed by rigid gender roles and responsibilities.

Gender equity- Fairness treatment and distribution of resource to females and males according to their respective needs in terms of rights, benefits, obligations, and opportunities. Equity is the means to reach equality.

Gender based violence- This is the broad term referring to any act or conduct that is perpetuated ageist a person's will based on the socially ascribed differences between men and female. Gender based violence therefore include and not limited to, sexual violence, physical violence,

psychological violence, social and economic violence and traditional harmful practices such as female genital cuttings.

Gender mainstreaming-It is a process of making women's as well as men's concerns and experiences an integral dimension of design, implementation, monitoring and evaluation of policies, programmes in all political, economic, and societal undertakings so that women and men benefit equally with the ultimate goal of achieving gender equality in all planning, implementation, monitoring and evaluation of all programs.

Man (men)
This refers to an adult human male (Concise Oxford Dictionary-Tenth Edition; The free dictionary.com/man). In this study, the term was used to refer to men from 15 years and above.

Multiple concurrent partnership- Having more than one sexual partner at a time and/or moving quickly from one sexual relationship into another one.

Sex- refers to biological/physiological differences of men or women

Vulnerability- In the context of HIV infection, "vulnerability refers to the likelihood of being exposed to HIV because of a number of factors or determinants in the external environments which are beyond the control of a personal or social group" (UNAIDS, 2005 p8). In this regards, women and girls from poor communities specifically from patriarch societies are more likely to be vulnerable to HIV because of structural factors.

Woman (women)- Refers to an adult human female (Concise Oxford Dictionary-Tenth Edition). The term is further explained by the free dictionary as "any adult human being who is biologically female and who is capable of bearing children" (www.thefreedictionary.com/woman). The term woman is also used to identify a female human regardless of age, for example "women's rights" en.wikipedia.org/wiki/Women. In this study the term was used to represent women who can acquire HIV at any age due to social-sexual relations between to sexes. Mainly these are women from 15 years and above. But, depending on the use, it can also refer to women below 15 years especially if discussing about sexual abuse/rape and timing of sex education to women.

ABSTRACT

Back ground and problem: The HIV prevalence among women in Tanzania has been proportionately high from 2% and above in all age groups as compared to men. At the age range of 15-24 years the prevalence among women is 4% while for men from the same age group is 1%. It is estimated that younger women of 15-24 years in Tanzania accounts for 45% of the new HIV infections in the general population of 15-49 years. Several social cultural, structural and programmatic challenges contribute to the high prevalence of HIV among women.

Objectives and methods: This thesis explores the influencing factors and challenges contributing to women's vulnerability to HIV in Tanzania. It also looks at current integrated gender empowerment and HIV programs and provides recommendations based on evidence from informed-interventions. Through literature review, the framework adapted from Eaton et al was used to organise and analyse factors increasing risks of HIV to women, and the gender empowerment model helped to analyse the current gender empowerment programs in Tanzania.

Findings: In Tanzanian context, women's lack of control over their sexual desire and fertility, economic dependence on men and lack of decision making of their personal lives are major factors putting women at high risk to HIV. However, all these factors have interactions with structural factors, specifically social, cultural, economic and programmatic factors which affect women's strength to control their sexual desire and search for information in light of HIV infection.

Conclusion and recommendation: Women's vulnerability to HIV in Tanzania is the subject of complex unequal social, cultural and economic relations between men and women. Unequal relations to economic control results in unequal power relations in heterosexual partners and, the loser in terms of HIV risks is one who controls less; usually these are women.

Gender transformative empowerment programs when coupled with economic support to women have shown better results in transforming gender relations. Gender empowerment in HIV programs should be informed by community based participatory gender and HIV situational analysis and CBOs/village committees and council should be among implementing stakeholders.

Key words: HIV and AIDS, Gender relations, vulnerability, decision making, empowerment interventions,

Word count:12,929

INTRODUCTION:

Worldwide data estimates that 66% of HIV infection is among women (UNAIDS 2010) and women from southern African countries are mostly affected. In South Africa for example, 21% of women are living with HIV as compared to 7% of men (UNAIDS 2012).

In Tanzania HIV prevalence is 5.7%, with women more affected than men(6.8%women compared to men 4.7%) (NBS 2011). This increase of HIV prevalence among women has consequences at the personal, community and national level. At the personal level, there is an increase of ill-health. At the community and national level Calore (2013) has found from her studies in different countries including Tanzania that one-in four deaths of pregnant women in poor countries is due to HIV, this makes an estimate of 994/100,000 deaths due to HIV positive pregnant related causes. Currently Tanzania has a Maternal Mortality Rate of 454/100,000 live births if HIV is not considered. Other consequences including the rising number of children living with HIV and AIDS, infected by their mothers estimated to be 1.5 by the year 2010(UNAID & WHO 2006),half of them were in the street (Garbus 2004).All of these are public health concerns at national and global level. Also, they are all concerned with gender relations, thus, gender has become important to health in order to address fairness in health equity (DFID et al 1999)

The mentioned above consequences and concerns have been my area of concern for more than five years working as National HIV and Equality Advisor for an International organisation. My role was to mainstream gender andHIV in the core organisation programs (Integrated livelihood, women rights and water facility programs). The particular interest was ensuring participatory gender and HIV community action plans were developed in each program village and mainstreamed into core program activities. Community action plans aimed at reducing women's vulnerability to HIV through increasing women's participation in decision making and control of resources and products from their labour. These could then increase their capacity to make rational decisions concerning their sexual matters.

However; this has been a challenging process. In most villages women remained sexually controlled by their partners despite some improvements in decision making in some social arenas (Concern 2010) 'unpublished report'. This challenge is an area of my motivation to search more deeply about "Why women are sexually submissive to men? and, what causes women's vulnerability to HIV more than men?"

Evidence-informed interventions will be used to recommend how Tanzania can address factors that increase women's vulnerability to HIV. However, this study is not in the best interest of addressing consequences of Women's vulnerability to HIV

CHAPTER ONE: BACK GROUND INFORMATION.

This chapter summarises Tanzania profile. It also talks about social cultural & economic situations as far as gender is concerned. It summarises the general situation of women and HIV, and talks about the health sector and its challenges in responding to gender and HIV. It ends by highlighting some public-private partnership challenges in providing gender oriented HIV and AIDS services.

1.1. Tanzania profile

The United Republic of Tanzania (URT) commonly known as Tanzania is the country in East Africa bordered by 8 countries: Zambia, Malawi and Mozambique to the south, Democratic Republic of Congo, Burundi and Rwanda to the west, Uganda and Kenya to the north, and the Indian Ocean to the eastern part. Tanzania is approximately covering 945,087 square kilometres. It is divided into 150 districts that serve as the central administrative unit to implement and coordinate public services under local government authority and reporting to the central government authority. The district is formed by divisions, further subdivided into wards and villages. The village is the primary level of government administration (NBS 2011). The population of Tanzania is estimated to be 44.9 million (male 21.9m and female 23.0 m), with a growth rate of 2.85% and a birth rate 37.7/1000. Life expectancy is 53.14 (NBS 2012).

Tanzania continues to be politically stable and scores better than other East African countries in terms of civil liberty and political rights; however, women's rights need to be continuously guaranteed in order to enable them to participate freely and benefit from economic activities (ADB 2011).

I.2. Social Cultural & Economic situation

Tanzania is comprised of more than 126 tribes speaking different languages but all united by Kiswahili as the national language. It is a patriarchy society with approximately 66% women and 58% men aged 15-59 are in marriage unions. Households are headed by men either through nuclei or polygamy family structure (Garbus 2004). Approximately one quarter of households are female headed, many of them being widowed due to AIDS (TGNP, 2007). Female literacy is 67% as compared to 79% for men. More than 75% of Tanzania population live in rural areas surviving on traditional agriculture mainly done by women (NBS 2011).

1.3. General situation women and HIV in Tanzania

In Tanzania the first case of Acquired Immune Deficiency Syndromes (AIDS) was detected in 1983. Since then, its dynamic has changed from concentrated epidemic to currently generalised epidemic with national

prevalence standing at 5.7% and varying prevalence in sub population groups. For example, the Human Immunodeficiency Virus (HIV) prevalence among women is higher by 2% compared to men (URT 2007; NBC, 2011).

Heterosexual contact has been identified as the important route of HIV transmission constitutes about 80% of all new infection, followed by mother to child transmission of HIV accounting about 18% and 2% is contributed by other route like homosexuality, blood transfusion, unsafe injection etc (URT 2007;UNAIDS 2012).

In Tanzania, HIV transmission is linked to high risk groups and behaviours like injecting drug use, early sexual debut, sex work, concurrent sexual partners, mobile households eg in mining and fishing areas and long track drivers and recently among wealthier group (URT 2007). However, still women in these high risk groups have higher HIV prevalence than men counterparts. For example, HIV prevalence among injecting drug users in Tanzania is 57% for women and 27% in men (TACAIDS 2009). Therefore further explanation is needed in order understand why women are more vulnerable to HIV than men.

1.4. Health sector's response to HIV and AIDS

1.4.1. Levels of health services provision.

The health system of Tanzania is comprised mainly of three levels: primary level, secondary level and tertiary level.

Primary level: comprised of dispensaries and health centres. A dispensary serves the population of 10,000 living within 5Km. It provides general primary health care including, Voluntary Counselling and Treatment (VCT) and Family planning services but, Anti Retroviral Therapy (ART) services are not available at this level except in few selected dispensaries. The health centre works within the population of 50,000 and provides higher level of primary health care as compared with the dispensary. VCT, ART, treatment of some opportunistic infections and Prevention of Mother to Child HIV Transmission (PMTCT) services are offered at this level.

Secondary level: comprised of a district hospital as the first referral and serves up to 250,000 population. CD4 count for HIV and management of complicated opportunistic infections is done at this level. Also, it provides back-up surgery and obstetric emergencies

Tertiary level: Includes regional hospitals and advanced specialised services (URT, 2009).

1.4.2. HIV and AIDs policy

Tanzanian health system is well organised in a way everyone can access HIV services at primary care level. Reproductive Health (RH) and HIV policies allow anyone who needs services to access it (URT 2010). But there are many challenges facing younger people especially girls in accessing HIV services. Culturally, unmarried younger people are not expected to engage in sexual activities, so if she/he acquires STIs or HIV infection, it become difficult for her/him to seek services. Issues related to privacy and health care providers' judgemental and negative attitudes affect the quantity and quality of HIV services provided to younger people (Mbemba et al 2012).

1.4.3. Human resource for health and provision of HIV and AIDS services

Tanzania is faced by a shortage of health personnel of all cadres specifically in the public health sector. The problem is worse in rural area where health personnel are not comfortable to live due to poor socio-economic and bad infrastructures (Kwesigabo et al 2012). World Health Organisation (WHO) recommends doctor-patient ration to be 1:10,000, but, current ratio is 1:23,000 for doctors and nurse-patient ratio is 1:6000 (URT, 2009).

Furthermore, the health care infrastructure is overstretched in coping with additional demands for treatment of HIV opportunistic infections and provision of ART services (URT 2007). The gender responsive HIV/STIs hospital-based services are affected by both the number and quality of staff. Doctors may tend to just prescribe drugs and ignore the concept of health education and counselling for HIV prevention, re-infection and adherence on drugs (URT 2009). HIV and AIDS awareness rising, gender based VCT services, youth friendly adolescent sexual reproductive health and HIV impact mitigation are done by Non-Governmental Organisations (NGOs).NGOs are note organised by one body (e.g government) and not covering all country. This affects equity in accessing HIV services.

1.5. Challenges in Public-private partnership in responding to gender and HIV.

Tanzania has well written policies (eg 2003 National health policy, 2010 National HIV policy and community development policy) and their strategic plans emphasising the importance of multi-sectrol collaboration in responding to HIV and AIDS with a gender lens (URT 2009; URT 2010). However, experience from the district response has shown lack of integration planning in the execution of districts, wards and village level response to HIV and AIDS. Non-health NGO/Community Based Organisations (CBOs) and health planning officers appear to be working in isolation at all levels of HIV and AIDS program implementation. There is low

progress on integrating gender into HIV and AIDS programs in comprehensive local government council plans (URT 2007).

CHAPTER TWO: STUDY OVERVIEW

This chapter presents the problem statement, justification, aim and objectives, methods, key words and study's conceptual framework.

2.1. Problem statement

HIV incidence and prevalence among women and girls from African countries including Tanzania has been disproportionately high as compared to men and boys. Estimates show that 66% of HIV infection worldwide was among women aged 15-24 years and most of these women were from Sub Sahara Africa (SSA)(UNAIDS 2010). Fifty eight percent of all people living with HIV in SSA in 2011 were women, 92% HIV positive pregnant women were from SSA. Furthermore, prevalence data indicates that 13 women in SSA become infected with HIV for every 10 men and in some African countries like South Africa, 21% of women are living with HIV compared to 7% men of the same age group (UNAIDS 2012).

In Tanzania the national HIV prevalence among the sexually active population between 15-49 years of age is 5.7% with females having a slightly higher rate (6.8% females and 4.7% males) (URT 2007). Data from National AIDS Control Program under the Ministry of Health and Social Welfare (MoHSW) estimates that younger women aged 15-24 account for 45% of new HIV infections in the general population of 15-49. For men of the same age, they account for 26% new HIV infection (NBS 2011). These results suggest that new infections among younger women in Tanzania are almost twice as much as compared to men.

The higher HIV prevalence among women as compared to men is partly due to their biological factors. Women's biological susceptibility to HIV increases with the increase of gynaecological infections such as lesions in the vagina and cervix (Rodrigo et al, 2010). The presence of STIs and Reproductive Tract Infections (RTI) in females increases up to ten fold the risk of becoming infected by HIV positive male sexual partners (Turmen 2003), and the immature cervix for younger females further increases their susceptibility to HIV (Cohen et al, 2005).

Nevertheless, gender inequality norms have been mentioned to be the major and most powerful factors which increase the risk of HIV to women compared to biological factors. In his conclusion for example Shannon (2012) stressed that women's vulnerability to HIV are complex and encompass factors of structural, culture, social and economic nature perpetuated by patriarchy and inequality norms. Culture which allow males to have multiple sexual partners, control family resources and sexual decision making while insisting women obey men and husbands, magnify

women's dependency on the men's economy and decision making through intergenerational sexual relationship and sex exchange for money and goods, which in turn undermines the women's strength to negotiate safer sex (Randrigo, 2010; Shannon 2012).

2.2: Justification

The latest gender profile analysis that was conducted in Tanzania in 2007 stressed for the great need to reflect on women's equity issues from a human rights perspective. It also concluded that, the status of most women in matters of access to and ownership of assets is governed by patriarchal social customs and traditions which marginalise women due to out-of-date laws and regulations of the government. Also, the analysis added that at local Government Authority/districts and community level, gender analysis is not fully understood or carried out unless there is support from NGO. Gender issues related to HIV are not brought forward from the community to policy level advocacy (TGNP & SIDA, 2007). The HIV National Multi-sectoral Strategic Framework (NMSF) adds that women might be aware about measures needed to reduce risk of HIV, but putting their knowledge in practice has been a challenge for most women in Tanzania (NMSF 2007)

This study therefore intends to critically explore how structural factors like law and regulations, patriarchy social customs and traditions undermine women' rights of equity to health and equality in matters related to sexual decision making. It attempts to analyse how other factors like personal, interpersonal and biological factors are affected by structural and programming factors leading to increased women's HIV vulnerability. Also, the study reviews evidence-based, effective interventions related to women/gender empowerment and HIV worldwide, and formulate recommendations on the future programming and advocacy strategies in Tanzania.

2.3. Overall Objective

To explore factors and challenges associated with women's vulnerability to HIV infection as compared to men in Tanzania; analyse current interventions which integrate both gender and HIV in development projects and based on identified best practices, provide recommendations for future improvement of gender and HIV responses.

2.3. 1. Specific Objectives

i. To examine socio-cultural and economic factors related to women's vulnerability to HIV infection as compared to men.

ii. To describe the challenges of safer sex practices and negotiations faced by women in Tanzania.

iii. To identify and analyse current response to women's vulnerability to HIV, particularly looking at how gender relations and HIV are addressed by the development programs.

iv. To provide recommendations for future improvements in responding to gender and HIV issues through development programs and health services in Tanzania.

2.4. Methods

This study consists of a literature review whereby both published and grey materials were reviewed and analysed to answer study objectives. Multiple search engines were used to locate appropriate online materials for review; these include Scopus, pub Med and Science directly accessed through Google scholar and VU library. WHO, UNAIDS, UNICEF, UNFPA, USAIDS, and AIDS Alliance websites were used to search evidence-based studies for effective intervention on women and gender empowerment as well as HIV/AIDS programs. Reports from international organisations dealing with gender empowerment in HIV and AIDS interventions in Tanzania were reviewed and compared with evidence-informed interventions. These organisations are Engender Health and Concern Worldwide. Also, relevant Tanzanian government websites were used to search relevant information.

Key words: Gender relations, culture, HIV and AIDS, women, men, vulnerability, decision making, sexual behaviours, risk perception, norms, value, empowerment interventions, power relations. Delimiters: Years 2000-2013, Geographical Areas: Tanzania, SSA, Africa, outside Africa. Language: English.

2.5. Conceptual Frame work

Through the literature review several conceptual frameworks for factors influencing HIV vulnerability were searched, no single identified published framework was found to be a perfect fit for this study without some modifications. Among the ones researched, three HIV/AIDS conceptual frameworks were found relevant to analyse factors of HIV vulnerability but, only one was selected based on the research topic and objectives as follows.

The first HIV/AIDS conceptual vulnerability model was about "Interaction of the feminist theory and HIV: A conceptual model of vulnerability" This model was applied in Kenya and Uganda to analyse women's vulnerability to HIV. It emphasises issues about women's HIV knowledge, powerlessness, cultural practices, sexual behaviours and perception of risk. It lacks government structural issues like policy and strategies, programmatic factors, biological issues and interpersonal factors, thus the framework was not considered in

this study. The second model was "Proximate determinants conceptual frame work for factors affecting the risk of sexual transmission of HIV". This is the framework for HIV research which puts more emphasis on social, cultural and economic factors and their influence on biological determinants and intervention outcomes like antiretroviral, opportunistic infections and STIs treatment. Issues of policies, interpersonal factors, family and community factors and accessibility factors are less described in this model; therefore it was difficult to apply it to this thesis

The third conceptual framework is one which guides this thesis which. It has been adapted from Eaton et al (2003) and modified according to the current situation of the factors associated with women's vulnerability to HIV in comparison to men. This model was used in South Africa to explore HIV and risky sexual behaviours among younger people. It includes most of the factors except biological and biomedical factors were omitted. Some modifications have been carried out to capture biological factors and their relationship to other factors. Also, arrows in the original model are depicted in a one-way process showing the influence of broader social conditions to the individual and their immediate environments as if individuals and their environments do not have any influence on broader social conditions. Therefore, this has been modified.

Also, there is another conceptual framework to analyse gender empowerment processes in HIV and AIDS programs or stand alone projects for gender empowerment in Tanzania. This framework model has been adopted from UNAIDS & UNFPA (2005). It is comprehensive and appropriate and no modification was required. The model has been used to assess how gender empowerment and HIV/AIDS interventions are integrated to reduce women's vulnerabilities to HIV infection in Tanzania compared with the evidence-based interventions. Thereafter, recommendations were provided based on evidence.

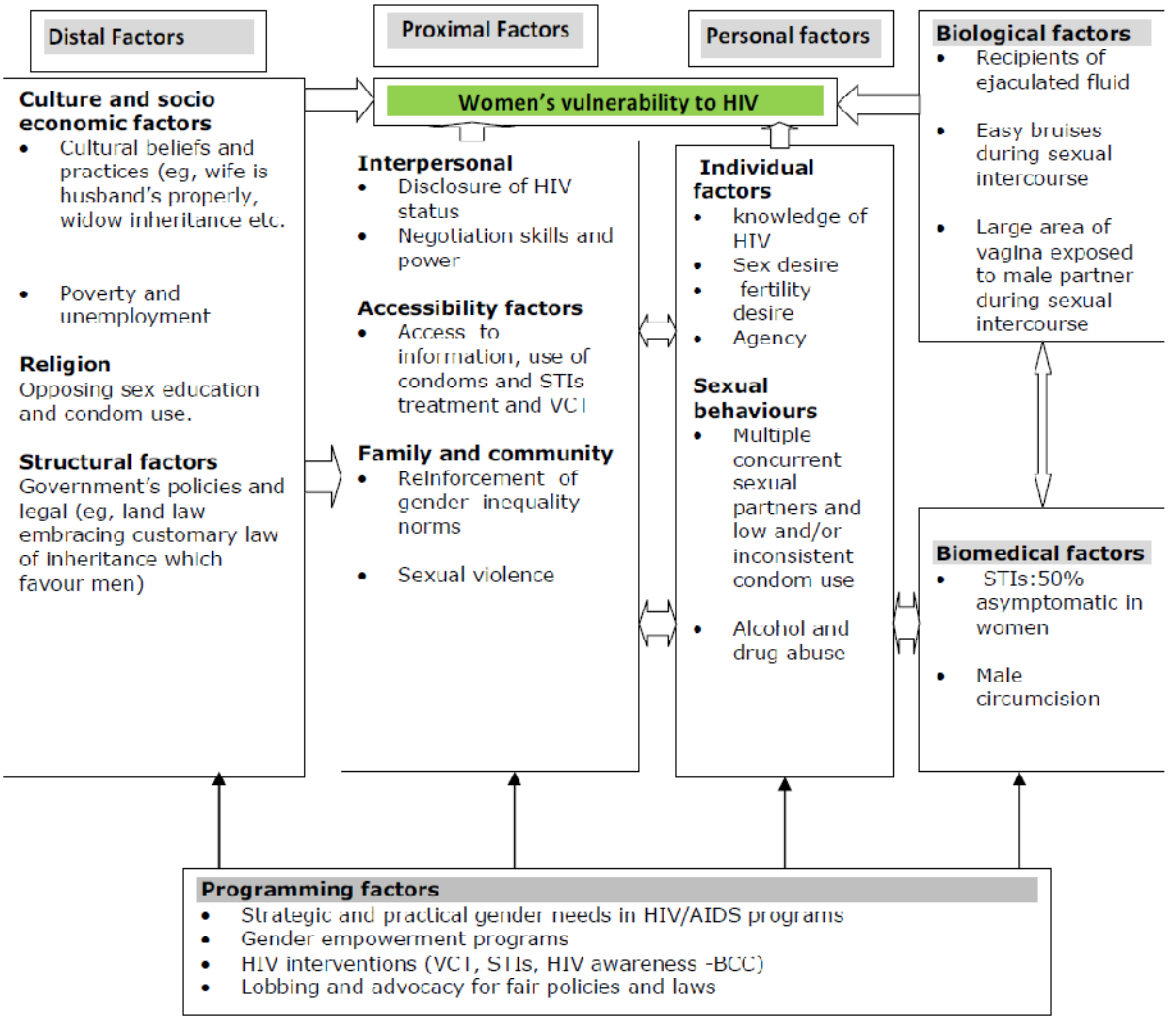
Explanation of conceptual frame work of the women' vulnerability to HIV

As mentioned above, this model has been adopted from (Eaton et al (2003), and to guide analysis and understanding of the factors associated with women's vulnerability to HIV as compared to men.

There are three categories of factors interlinked together in complex interactions; these include personal factors, proximal factors and distal factors. Personal factors are related to the individual as a person and his/her sexual behaviours. Proximal factors are those factors which can affect individual personal behaviours and health yet, they are controlled by another person and they are determined by mutual understanding and negotiations.

They include interpersonal, accessibility, family and community. Distal factors are those related to culture, economic, religion and structural or contextual factors including government policies, laws and strategies. These factors have powerful influence on the first and second categorical factors. Biological and biomedical factors are independent but can be indirectly affected by all factors. Programming factors affect all categories of factors.

2.6.1. figure 1: Conceptual framework to explain women's vulnerability to HIV as compared to men



Adapted from Eaton et al (2003).

CHAPTER THREE: ANALYSIS OF THE FACTORS AND CHALLENGES CONTRIBUTING TO WOMEN'S VULNERABILITY TO HIV

This chapter applies the framework of the analysis for women's vulnerability to HIV to explain factors which increase women' risk to HIV compared to men. These factors include: Biological, biomedical, personal, proximal and distal factors. Worldwide experience and examples have been cited followed by SSA, Southern Africa, and then narrowing to Tanzania.

3.1. Biological factors

As it has been already introduced in the problem statement, biological factors associated with women's vulnerability have been documented all over the world. Many authors Blum (2007); Rodrigo et al (2010); and Onipede (2011) describe women's vulnerability to HIV in relation to their heterosexual position. For example, women are recipients of semen from infected partners, their reproductive organs and their large vaginal areas are exposed to sexual partners' secretion during sexual intercourse and the contact of semen to vaginal epithelium lasts a bit longer as compared to male sexual partners. Furthermore, women easily get bruises especially if sex is forced or if they are raped. This situation worsens in the presence of any lesions in the vagina such as untreated STIs/RTIs(Turmen 2003).

African women's biological vulnerability to HIV also arises from their reproductive roles. Women have greater risk of HIV infection than men through blood transfusion and blood contact during pregnancy and delivery. Tanzania was cited as an example among countries with high HIV prevalence (5.7%) in SSA yet with extremely limited blood screening for HIV and other STIs; only 35.7% of blood bank was screened in 2007 (SAT 2011). Additional to that, about 50% of pregnant women in rural Tanzania are at risk for blood contamination during home deliveries or unsafe delivery rooms in rural health centres and dispensaries (Kruger 2011). Although biological factors are unchangeable, improving service deliveries may reduce HIV vulnerabilities related to women's biological roles. For example, educating women to know their bodies can empower them to take precautions (Higgins et al 2010.

3.2. Biomedical Factors

Sexually Transmitted Infections (STIs) and Reproductive Tract Infection (RTIs)

STIs and HIV are synergistically related, mutually influenced by each other and transmitted through common roots (White et al 2008). RTIs are accelerate by changes in the vaginal flora during pregnancy and the postnatal period resulting in loss of lactobacilli which protect women from

RTIs including bacterial vaginosis (BV), trichomonas and candida (Taha cited in White et al 2008).

Studies among pregnant women from Zimbabwe and Uganda have found that Herpes Simplex Virus (HSV-2) alone facilitates HIV by 25%-35%, followed by bacterial vaginosis 17.2% (Ward & Ronn 2011). Both infections may be asymptomatic in females thus, with poor STIs/RTIs screening, early treatment might be missed resulting to increased women's vulnerability to HIV. For example, a study conducted among HIVpositive women in Tanzania found that pregnant women had multiple infections: 33.6% had HSV-2, 17.5% had candidiasis, and 23.9% had trichomoniasis and/or bacterial vaginosis. However, 50% of these women were asymptomatic
(Msuya et al 2009). While Asymptomatic STIs/RTIs remains important risk aspect of HIV, no evidence identified through literature review indicated routine screening for asymptomatic STI/RTI among women in Tanzania.

STIs and RTIs accelerate HIV acquisition and transmission through disruption of genital inner membranes, increased HIV load in plasma, rapid recruitment of HIV targeted cells to the genital tract, and genital ulcers in both partners facilitate blood to blood contact (Ward & Ron 2011). In an HIV infected person, there is an increase of HIV genital shedding which in turn increases concentration of HIV in genital secretion (Msuya et al 2009). Such situations increases female to male HIV transmission by 10% but, due to women's biological position and social reasons like coercive sex, the risk of male to female HIV transmission of this nature may go up to 30-40% resulting to higher HIV incidence and prevalence among women as compared to men (SAT 2011).

Male circumcision

Male circumcision is defined as complete removal of entire fore skin of the penis (UNAIDS 2007). Uncircumcised HIV negative men are at risk to acquire HIV during unprotected penetrative sex due to multiple reasons associated with presence of penile's foreskin. Foreskin has less protective cells, it tears easily during intercourse, it has high density of Langerhans cells that are more attracted to HIV, it provides a favourable HIV environment and, in the presence of STIs there is an increase of the foreskin's epithelium shedding and sores which act as the door for HIV (Acon 2009)

All over the world HIV prevalence has been observed to be low in the male circumcision communities as compared to non-circumcised male communities. A systematic review and meta-analysis from 28 published studies conducted in Sub-Sahara Africa concluded that 50-60% of men could be protected from heterosexual HIV transmission because of circumcision

(UNAIDS 2007). In South Africa the protective effect was 61%, in Kenya 53% and Uganda 51% (Wambura et al 2009).This 60% reduction in men' HIV acquisition due to circumcision could indirectly reduce women' HIV acquisition but, circumcision in HIV infected men does not provide protection to their female partners (Wawer et al 2009). Also, due to 60% risk reduction, men could feel protected and take this advantage to negotiate unsafe sex; in-turn this would further undermine women's strengths to negotiate condom use, and women might be blamed in bringing the infection to the family in case it happens (PSI et al 2011).

The overall prevalence of male circumcision in Tanzania is 70%. In high HIV prevalence regions like the Iringa region (HIV prevalence 18.2%), the male circumcision is low (37.7%), and in low HIV prevalence like Zanzibar (HIV prevalence 1%) male circumcision is high (96.9%) (TACAIDS et al 2008; Wambura et al 2009). With the high rate of multiple sexual partners for example among younger people aged 15-24 (39% for male and 22% for women) and low condom use (<50%) (Jessica et al 2012), coupled with unequal power relations on sexual matters (Shannon 2012), uncircumcised HIV infected men in Tanzania can be among the major factors of increasing risk of HIV infection among women. The same applies for circumcised men who refuse to take any precautions by believing that they are safe put their female partners at high risk of HIV (PSI et al 2011).

3.3.PERSONAL FACTORS

3.3.1. Individual factors

Knowledge of HIV

A study commissioned by USAIDS in 23 Sub-Sahara countries found general knowledge about HIV and AIDS for both men and women aged 15-49 was above 95% in all countries. However, knowledge about condom use to prevent HIV was higher among men as compared to women and differed from one country to another. For example in Chad 27.4%women and 60% men, and Rwanda 80% women and 89% men had this knowledge. Women with secondary school education had better knowledge on condom use and HIV prevention because of exposure to information (Mishra et al 2005).

In Tanzania general HIV knowledge is estimated in the DHS 2010 report to be around 98% among men and women of 15-49 ages. Knowledge of condom use to prevent HIV is similar for women and men of this age group: 71% for women and 70% for men. However, condom knowledge is lower among women of 15-24ages than men in this group: 59% for women and 77% for men (NBS 2011).This suggests that norms which prevents women from talking about sex prevents them to access HIV information or to admit that they possess this knowledge.

Women (15-24) with no education have less knowledge on condom use (48%) as compared with educated women of the same age (70%). The knowledge of condom use to prevent HIV infection correlates with the HIV prevalence between the two sexes. At all age groups except 15-24 women have about 2% higher HIV prevalence compared to men; at age 15-24 HIV prevalence among women is 4% as compare to 1% of men of the same group (TACAIDS 2008). This reflects what has been said in the problem statement that; 45% of new infection rate in the general population of 15-49 years in Tanzania is attributed to women of 15-24 years compared to 26% of new infections from men of the same group (NBS 2011). This signifies that, empowerment interventions to prevent women vulnerability to HIV should start before the first stage of sexual debut usually at 10 years (Kirby 2002), and they should ensure younger women with no education are targeted.

Sex desire

Sexual desire is the motivational state to have sexual intercourse with an intimate person; it is about sexual pleasure and satisfaction, and when it is accompanied by fertility desire then it refers to the needs or wishes of individuals to reproduce (Schuler et al 2009).

Unfortunately, women's desire to have sex is much controlled by culture, social and situational factors than for men. Women in many African countries may have desire to have sex but they fear to initiate it to their partner due to cultural norm which prevents them from expressing their sexual needs (Chen et al 2001). In turn, this increases women's vulnerability to HIV through making them reluctant in soliciting HIV information, and/or responding to men's sexual advances without thinking about HIV precautions. In Malawi for example, a younger woman explained that once one has experienced sex, and for any reason she has been deprived from it for some time, once a man touches her she feels hot and would respond immediately (Weiss et al 2000).

In Tanzania men are socially empowered, encouraged and expected to initiate sex with their female partners and are believed to have stronger sexual desire than women. Contrary, women are expected to respond to men's sexual advances. However, USAIDS (2011) conclude from its study done in Tanzania and Malawi that such cultural tendency encourages men to engage in concurrent sexual relationships thereby increasing risk of HIV transmission to female partners.

Fertility desire

Fertility desire is an individual's need or wish to reproduce. Like the general population, fertility, even in the HIV paradox individuals or couples have a desire for children (Nattabi et al 2009). Study of HIV positive patients with discordant partners from Switzerland reported 47% women and 38% men had a desire to have children in the future (Panozzo et al 2003). In the United State, 28% and 29% of HIV positive younger people (below 40years) said they desire and expect to have children in future, (Chen et al 2001).

In the African culture, Tanzania inclusive, the fertility desire is driven by both individual needs and social expectations (Bankole 2010). In Tanzania for example women are expected to bear children and men to provide material and economic support to the family. Women's social respectability depends on the number of children she has and the capacity to raise them for the sake of family sustenance (USAID 2011). The number of living children and the age of the individual shapes the fertility behaviours of the couples despite knowing that they are both HIV positive or discordant couples and/or the wife knows her husband is not faithful; this has major implications on heterosexual HIV transmission especially for woman who have to bear children regardless of the HIV status of her partner. (Chen et al 2001).

Agency

Agency refers to an actor/individual's capacity to act independently and make their own purposeful rational choices. Structural patterns and arrangement affect person's agency and these include economic structure like materials and individual's assets such as land, housing, servings and capabilities like good health, education and good employment. Social structures are like norms, customs, traditions, social belongings, sense of identity, and leadership. Others are psychological feelings such as self-esteem and confidence (Samman et al 2009).

Women' agency is more likely to be affected by both economic and social structures. Mumbai and Bhende studies' from India found that adolescent girls had limited movements as protective measure. Girl could be beaten by her father, mother and her older brothers to discipline her to conform to this norm as a measure of preparing her as the good mother once she is married. Boys instead were respected, had time for leisure and movements, given opportunity to participate and/or consulted by parents in important family decisions. Also, boys had assurance from parents as family property inheritors (Weiss et al 2000). Such cultural norms translates into unequal power relations through creating women's psychological and economic dependence on men hereby affecting women's agency leading to poor

decision making in matters related to their sexuality and HIV and AIDS (Samman et al 2009).

Furthermore, social norms which insist on the culture of silence and women's obedience to men are likely to suppress women's agency despite how economically powerful they are. In Kumas Ghana for example, women were observed to be economically empowered and powerful. They controlled large markets and employed men in their businesses. However, they were sexually and socially submissive to their husbands simply due to social norms that prevent women from communicating their sexual concerns with partners such as initiating talk about sex and condom use as protection (Mason 2005). Also there is the limitation in bargaining power for the female partner who faces much more negative influences at the breakdown of a relationship. For example, a woman may be blamed and socially discriminated when a marriage breaks down (Sen 2007). Such social influence makes it difficult for women to refuse sex in marriage or insist on consistent condom use because of fear of violence (USAID 2011).

Nevertheless, gender based social inequality norms when coupled with economic dependency worsen the condition for women to make decisions about their health risks including HIV. A cohort study carried out among sex workers in two regions of Tanzania found that 97% of female commercial sex workers had had no more than primary school education thus, they couldn't find formal employment. The options for their income included farming on male owned land, housemaid, bar-made and commercial sex; the jobs that are fuelled by sexual exploitation as well as undermining the capacity for safer sex negotiation and condom use (Otwater et al 2000). In such situations women's agency are suppressed by their economic vulnerability, they might not be able to dictate terms for sex exchange including the decision to use condoms because of their economic dependence to their partners (Jewkes et al 2003). In such conditions, women's vulnerability to HIV is worsened.

3.3.2. Sexual behaviours

Multiple concurrent sexual partners and low and inconsistent condom use

Concurrency is defined by UNAIDS as "overlapping sexual partnership where sexual intercourse with one partner occurs between two acts of intercourse with another partner" (UNAIDS 2010, p.2). Multiple concurrent partnerships (MCP) is simply having more than one sexual partner at a time and/or moving quickly from one sexual relationship into another.

MCP with low and inconsistent condoms use has been mentioned in many studies conducted in Africa to be the major drivers of HIV infection in the

region (Mishra et al 2009). Newly infected HIV people in marriage and cohabitants were estimated to be 60% in Zambia, 62% in Kenya and 78% in Malawi (UNAIDS 2010).

Tanzania's DHS (2010) reported that 4% of women and 21% men (15-49 years) had sex with two or more partners in the last 12 month (NBS 2011). Another study estimated prevalence of multiple sexual partnerships in Tanzania to range from 2.7% to 3% for married women and 25% to 40% for married men (Saleem et al 2008). Although there is lack of data in Tanzania to estimate condom use in extramarital relationships, evidence informed systematic reviews approximate only 5% of consistent condom use in long term extramarital relationships (Foss et al 2007), this means women in marriage are at high risk of HIV due to their partners' infidelity.

Gender inequality norms prevailing in Tanzania were reported to suppress women's strength to challenge their partner's concurrent behaviour. USAID found in its study carried out in Tanzania and Malawi that those women who enquire too much about their husband's sexual behaviours may risk physical violence in their relationship because men's MCP is socially regarded as normal practices. Other factors mentioned to increase women' vulnerability to HIV include economic vulnerability specifically of women, mobility especially of men, social pressure and alcohol (USAID 2011).

Alcohol and drug abuse

Alcohol has been perceived as one among the major underlying factors of risk sexual behaviours related to HIV. Morojele et el reviewed 50 studies on the association of alcohol and HIV/AIDS risk behaviours in SSA found HIV and alcohol use were associated by 68%. Also they found adolescents who engaged in sex with multiple partners and rarely used condoms were more likely to consume alcohol compared to those who opted for abstinence (Marojele et al 2013). In South Africa, alcohol and drug use were associated with increased odds of STIs and HIV through forced sexual intercourse (Shanoon 2012).

In a study conducted in Malawi and Tanzania, participants commented that alcohol use facilitate multiple sexual partnerships through providing an avenue of meeting sex partners. To make it clear, one male respondent described the situation as "When you are lit up there is darkness in your eyes and everything becomes bright and beautiful" (USAID 2011, p.16). Evidence suggested low prevalence of safer sex precaution like condom use when one does sex under the influence of alcohol or other substances and, men are more likely to drink and ignore condom use than the female partner (SAT (2011). All these factors were also mentioned in Tanzania as reasons which increase women's vulnerability to HIV (TACAIDS 2008)

3.4: PROXIMAL FACTORS

3.4.1: Interpersonal factors

Disclosure of HIV status

The HIV status disclosure has been at the heart of the global goal to prevent new HIV infections and treat those who are infected. Many studies conducted among ante-natal women from different African countries reports the average disclosure to a stable partner to stand at 49% (WHO 2004), and this takes place from two months after receiving HIV positive results to nearly four years (Medlay et al 2004).

A study from Tanzania shows that 49.4% of HIV positive women were most likely to share the results with their parents and only 24.7% share their results with their spouses from 6 month onwards since they tested HIV positive (WHO 2004).

The most commonly reported barriers from African women not disclosing HIV status were fear of abandonment and divorce closely tied to loss of economic support from partner (WHO 2004). However, women's fears of HIV status disclosure were outweighed by a positive response from their spouses in Kenya and Tanzania. For example, 75% and 91.7% of women from Kenya and Tanzania who decided to disclose their HIV status to their husbands reported receiving kindness, understanding and acceptance following the disclosure of their status, also social support increased. About 3.5%-14.6% of women from the same countries reported violent outcomes including divorce, following disclosure of their HIV status, (Medlay et al 2004).
This result could mean that women's economic dependency on men influences the decisions they make as regards their health no matter the consequences. For example, women's worrying about economic deprivation from their husbands supersedes the danger of infecting their partners, re-infection in case their husbands are HIV positive and health benefits for their children (Moore & Oppong 2007).

Safer sex negotiating skills and power.

The effectiveness of condom promotion campaigns and programs for the prevention of HIV depends much on the skills of condom negotiation and willingness to use it among sexual partners (Siegler et al 2012). Talking about condom use in a stable/long term/regular relationship for example has been reported to be limited and awkward due to low HIV risk perception within long-term relationships, self-efficacy and lack of agency (Eaton et al 2003). In a perceived stable relationship both men and women tend to associate condom use with infidelity (Chimbiri 2007). They tend to talk about condom at a time of quarrelling when accusing the partner of bringing in HIV/STI infection and once condoms have been abandoned, it is difficult

introducing it again due to fear of conflict related to unfaithfulness (Eaton et al 2003). Condom negotiation is also difficult in both cross-generational sex and economic difference due to power imbalance (Samman et al 2009).

Programs promoting condom use in Sub Sahara Africa and Asia targeting sex workers and their clients and male transporters had shown significant success on increasing condom use (>70%) than programs targeting the general population where HIV is perceived low (even if it might not be true) condom use was relatively low (<5%). Successful condom promotion to key population (e.g sex workers) however involved combination of interventions like peer education, condom negotiation and decision making skills, health education, STIs treatment, provision of condoms to target group and income generation activities. These interventions facilitated agency and empowerment to female sex workers to negotiate condom use (Foss et al 2007).This finding reminds us that just telling women to use condoms and resist unprotected sex cannot work by itself, unless it is coupled by empowerment interventions.

Tanzania relatively has low use of condoms (<20%) despite social marketing and media campaigns supporting condoms (MEASURE DHS 2011). Female sex workers in Tanzania for example reported long term clients' refusal to use condoms (Outwater 2000). 48% of adolescent girls who participated in a sexual practice study reported refusal of their partners to use condoms, and that they wouldn't insist on it due to fear of breaking the relationship (Kazaura & Masatu 2009). Another study found that younger females were more likely to have unprotected sex than males (53.7% female and 38.7% male) because of the partner's refusal to use a condom. This study concluded that women's inability to convince partners to use condoms increases their vulnerability to HIV (Katikiro at al 2012)

3.4.2. Accessibility factors

Access to information on VCT/HIV, and STIs/RTIs services

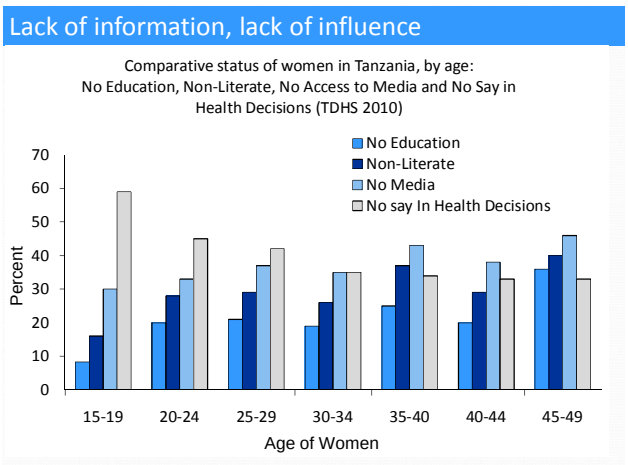
Knowledge and information about HIV and AIDS and other STIs and the formal education and skills have been evidenced as enablers of individual's ability to access and process health related information, and make rational decision from the information in order to solve her/his own health problems (Rinderman et al 2005). Evidence from South Asia and SSA has shown that women's lack of both knowledge and information on HIV and STIs and formal education increases their vulnerability to HIV compared to men and educated women. In Cambodia DHS, educated women in wealthier quintile were twice as likely to know how to prevent HIV infection, and they were four times as likely to have information for and the ability to cover costs related with HIV needs than women in poorest quintile (Krishnan et al 2008)

Findings from Kenya and Thailand have shown that unless a woman is pregnant which makes it easier her to access routine VCT/STIs/RTIs services through antenatal/PMTCT clinics, generally women are underrepresented among VCT/STIs seeking clients. Barriers connected to poverty, cost related services, gender related barriers for instance seeking permission from husbands to visit a doctor, stigma associated with HIV/STIs and perceived lack of confidentiality among health staff are among factors that prevent women to access services (Taegtmeyer et al 2006).

Although Tanzania has fair policy and guidelines for VCT/HIV services for all citizens who need them (MoHSW 2011), women, particularly those with no education and those in lower quintiles, are disproportionately not reached by HIV/STIs information in comparison with men (TACAIDS 2008), and this is due to unaddressed structural barriers like those mentioned above. For example, while NBS (2006) generalised that 98% of Tanzanian people aged 15 years and above have access to HIV/STIs information through various media including television, radio and print; NBS (2011) revealed that only 50% of women can access information through media compared to 67% of men. Female illiteracy is 32% compared to 16.9% for men, thus many women cannot read print (ADB et al 2005). For the women alone, only 24.5% women with no education and 21.7% of women in the lowest quintiles have access to television and radio compared to 75.7% of women with secondary school education+ and 72.7% of women in the highest quintile in Tanzania (TACAIDS 2008).

Furthermore, 52% of married women aged 15-24 years reported in DHS 2010 that they neither participated in decision making regarding their own health care nor major household purchases (NBS 2011).

Graph 1: To show how lack of information affect women's decision making in health issues



Source: TDHS, 2010

In the assessment study on standard operational procedures using national STI/VCT guidelines it was reported that the quality of STI syndromic management and VCT services were poor although with high coverage (97.7%). For instance, condom demonstration was very weak, contact tracing was offered only to 21.2% of the people at the facility and VCT services lacked proper information about informed consent and client shared confidentiality (URT 2009). Combination of all these weaknesses may not only reduce women's opportunity to fully access and utilize HIV/STIs service but also contribute to the increase of HIV risk through the misconceptions of STIs, HIV and condom use, hereby reducing the number of people who seek RH services specifically women (Mugisha et al 2011).

3.4.3. Family and community factors

Reinforcement of sexual gender norms

Power imbalance associated with sexual norms are learned from and internalised within the family and community. In Guatemala and Thailand for example Weiss et al found younger men are encouraged to have sex for their mental and physical health while girls are insisted to remain virgin until marriage and continue to be faithful in their marriage relationship. In Thailand, if a younger man did not visit sex workers, they would think he was impotent or homosexual and, if a girl was known to lose her virginity she would face high stigma through gossiping and pressure from boys to have sex with her. In Brazil parents would prevent their daughters from playing with a girl known to have lost her virginity (Weiss et al 2000). Through such informal sanctions, boys conform to sexual norms by pursuing forceful sex with girls and visit sex workers and girls turn to engage in anal sex as the means to preserve their virginity and preventing unintended pregnancy while increasing their risk to HIV (Blanc 2001).

In Ethiopia a study of social norms of virginity revealed that the emphases of virginity until marriage increased women's vulnerability to HIV once they initiated sexual practices within marriage because, women didn't have correct information about sexual matters. Also, they lacked power to negotiate safer sex even in a situation where their partners engaged in concurrent sexual partnerships (Molla et al 2008).

In Tanzania the concept of virginity until marriage is gradually losing its importance in some communities. Both parents and adolescents were positively supporting transactional sex by stressing that women's sexuality is a valuable commodity that should not be given away for free (Womayi et al 2009). The local initiation period in one community (Mtwara region) for example involves girls as young as age 8, teaching them about fulfilling sexual pleasure to their partners and handling men in a submissive manner. This norm and practice was reported to be associated with early pregnancy,

multiple sexual partners and increasing HIV prevalence among younger women in Mtwara (Bangser 2010).

Sexual violence

As already mentioned in biological factors, sexual coercion and rape are highly associated with HIV due to bruises in the genital tract that occurs during forceful penetration. Women are more likely to be violated sexually than men and most of sexual violence occurs within homes from their partners or male relatives (Onipede 2011). Katikiro and his colleague from their study of motivational factors and barriers to condom use in Tanzania reported that 44.9% of female experienced sexual violence as compared to 18.7% of men. Another study on sexual violence at first intercourse against women in Tanzania estimated 10-20% of women aged 15 years and above to have been raped at some time, and 29% of adolescents respondents report having had forceful sexual initiation (William et al 2008). 15.9% of adolescents who participated in Kazaura et al (2009) study reported forceful sexual intercourse and among them, 12.2% girls were raped. In these regards, it becomes difficult for women to escape from vulnerability to HIV especially during their teenage years because of sexual power imbalance.

3.5. DISTAL FACTORS:

3.5.1: Social-cultural and economic factors

Gender inequality and cultural believes

Socially Tanzania is a patriarchal society where men are known to use social, economic and cultural advantages to impose their sexual desires on their spouses and girlfriends; women respond passively based on cultural norms' standards thereby increasing their risks to HIV infection. For example, norms which emphasise that wife and offspring belong to husband give men power to control partners' sexuality while adding pressure to women to respond to husband/partners' sexual needs without questioning, and bear children based on husband's fertility desire (Liv 2005).

The cultural belief of wife inheritance which is still practiced in some communities in Tanzania worsens widows' lives through the grabbing of their property (TGNP 2007), and sexual exploitation and stigmatization which increases their risk of re-infection or newly infected (Evans 2011). Prevalence of HIV among widows, divorced and formerly married women in Tanzania is 20% versus 7% among currently married women. This variation is associated with their impoverished circumstances forcing them to engage in transactional sex (URT 2007).

Poverty and unemployment

Economic and social imbalance has been pointed out in many studies to increase vulnerability of HIV among both men and women. Most women in Africa including Tanzania can only access productive property like land through their husbands (Onipede & Schmitt 2011). This situation forces women to stay in marriages even if they know that there is a risk to become infected with HIV from their husbands. Barnett argued that increased inequality of income put poor men and poor women at risk of HIV especially when sex is considered as a commodity without any social measure put in place to regulate power imbalance between sex partners. In this situation a sex partner who is poor is more vulnerable because she/he cannot demand condom use; in most cases these are women as compared to men (Bernett & Whiteside 2006).

In Tanzania unemployment is 5.8% among women as compared to 2.8% among men; the average earning of men is 1.7% times higher than women. Female-headed households (estimated to be one-quarter) face the high burden of care and have inheritance problems including access to land. 68% of producers in the agricultural sector are women. They would access land by farming from their husbands farms but never control the produce from their labour because land does not belong to them (TGNP 2007). Less than 10% of women can control what they produce from their own labour (ADB2011-2015). This situation causes most women to be economically dependent on men even for their own health issues including issues to do with sex. As the result, women become automatically vulnerable to HIV (Shannon 2012).

3.5.2: Religion

Some powerful faith groups still oppose sexual education and condom use in favour of sex abstinence alone promotion. Some condemn condoms to be unethical and against God's will (Jackson 2002).

Zou and colleagues conducted a study that looked at the influence of religious beliefs with HIV stigma, disclosure and treatment attitude in Tanzania. They found that 53.2% believe that those who have HIV have not followed the word of God and religious leaders encouraged their followers to believe that prayers could cure HIV. Such belief can build on pre-existing stigma to HIV positive women who are already stigmatized and blamed to bring HIV in marriage if they were the first to become ill. As the results, women may abandon conventional HIV and AIDS services and fear to disclose their HIV status (Zou et al 2009).

3.5.3. Government's legal, policies and strategies.

Tanzania has a positive, legal, institutional policy framework promoting gender equality but; some provisions are still disadvantageous to women's rights and economic empowerment which is fundamental in reducing their vulnerability to HIV. For example, the land acts No 5 of 1999 and the right of occupancy that is extensively used in Tanzania still accommodates customary law which is subjective to unwritten social rules and structures of the community from shared values and based on traditions, that automatically favour men (TGNP 2007). Customary law excludes daughters from family property inheritance by expecting that they will marry and inherit through their husband's line. However, this has not always been the case. In many marriages especially if a woman has no children or if marriage was not legal, it becomes difficult for a wife to inherit property from the husband's family.

Another example is a country's marriage law dated from 1971 and revised in 2002. This law allows girls at 14 years age to get married with parents/guardians consent but for boys it's 18 years. The law gives power to judges to permit marriage for girls of 14 to 15 years. As the result Tanzania is among the countries with the highest rate of child marriage in the world with estimates of some two out of five girls getting married before their 18th birthday and most married to older men (Mtengeti et al 2008).Also, the law is silent about domestic violence which is rampant in marriage. Connected to this, is the Sexual Offences Special Provision (1998) that has not taken marital rape into the consideration; marital cohesive sex has become normal in Tanzania but remained unchecked by law (HDT 2011).

Apart from other reproductive health problems facing married teen girls like those related to obstetric; these girls are highly vulnerable to HIV because their sexual and health rights are more likely to be violated by their partners due to sexual power imbalance (NBS 2011). Cohesive sex and marital rape have been reported to occur more among married 15-24 year olds than older women. This group also lacks information about HIV and STIs due to culture which prevents women from talking or accessing sexual information. Combinations of these factors make younger women to be at high risk of HIV compared to men.

As regards to empowerment strategies; Community Development Department is blamed for not doing enough for gender and HIV/AIDS opportunities and obstacles analysis yet, it receives the least resources from government to promote participatory gender and HIV analysis at community level and implement gender empowerment programs in government structure (TGNP 2007). The HIV NMSF is constrained by human resources and the capacity for district planning and community mobilization to address

gender vulnerability in HIV programs (URT 2007).All these are policy implementation issues which need to be addressed in order to reduce HIV vulnerability to women.

3.6. Programming Factors

Tanzania's national strategy plan for growth and reduction of poverty (MKUKUTA(ii) 2010) and the HIV policy and its NMSF 2008-2012 have undoubtedly included major elements of gender in their narrative plans and the awareness of gender budgeting within the government is obvious. However, gender is still not adequately internalised and mainstreamed in ministries and their departments, this affects cascading down processes of gender implementation (TGNP 2007).

The NMSF stresses those efforts for reduction of HIV vulnerability among women should start with gender responsive strategies and programming involving a multi-sectrol approach and community participation in order to enable them to find their own solutions to reduce their vulnerability to HIV (URT 2007). Yet, most of these commitments have remained in books. At the grassroots level, government lacks the capacity to conduct participatory gender and HIV situational analysis. Government's HIV and AIDS technical programs like PMTCT, ART, STIs/RTI are not strategically integrating gender needs; (for example, no routine screening for asymptomatic STI/RTI for women, couple counselling is not emphasised). Data disaggregated by sex are rarely available on a consistent basis from the ministries and programs. Health sector and NGOs plans for HIV are not harmonised. The job of gender empowerment in HIV programmes has been remained to NGOs; therefore short term donor dependent programmes, not equitably distributed, and questionable sustainability (TGNP 2007).

In September, 2011, Tanzania finalised its National Management Guideline for the health sector response to and prevention of Gender Based Violence (GBV). In its situation analysis, the GBV guideline revealed inadequate quality of services and insufficient support to GBV survivors due to poor quality of facility and minimal resources availability. Health care service providers are not trained to respond to GBV, they lack awareness on GBV as a human right issue and as a public health problem linked to HIV. Neither protocol nor guideline was available to doctors (MoSW, 2011). So far, no literature evidence has proved if the new GBV guideline is already operational; thus Tanzania is still facing a problem in responding to GBV and, this is among a major factor contributing to women's vulnerability to HIV.

3.7. Summary of factors contributing to women vulnerability to HIV in Tanzania

Based on background information about the challenges we face in Tanzania in controlling HIV prevalence among women; chapter three has deeply analysed underlying factors associated with women's vulnerability to HIV. Each of these factors identified were found to be underlined by women's lack of empowerment and poor decision making in matters related to their own lives specifically sexual matters. Gender empowerment strategy has been evidenced through informed-evidence interventions to reduce HIV vulnerability in women by intervening factors associated with HIV vulnerability summarised as follows.

Biological and biomedical factors

Biological factors are difficult to change but can be improved if biomedical factors are improved through service provision. Biomedical factors include untreated STI/RTIs, poor screening for asymptomatic STI/RTI among women and high prevalence of uncircumcised men. Training women to understand their bodies and HIV/STIs risk involved during sexual intercourse can help to some extent; but women's lack of decision making is sexual relationship may still hamper this aim.

Personal and interpersonal factors

Inability to control own sexual desire and fertility, economic dependency on men, poor decision making of personal lives, including health and sexual matters and lack of intercommunication skills specifically on HIV and AIDS and STIs issues are among the direct factors identified to increase women's vulnerability to HIV in Tanzania. However, all these factors have complex interplay of personal, social, cultural and economic factors (distal factors) that affect women's ability to make decisions about their sexual health and negotiate safe sex practices and access to services and information. This points to the need for multi-faceted strategies addressing vulnerability of women and service responses.

Distal Factors

These are factors associated with gender inequality norms which suppress women's social economic and decision making rights at the favour of men. For example, emphasis that women and offspring are men's property, women should be obedient and not argue with men, not to talk about sex, family properties are for boys and land is owned by men and inherited by boys etc. Others are unfavourable government policies and laws like marriage law allowing 14-15 year old girls to marry under parent/guardian consent. Tanzania Sexual Offense Act ignoring marital rape and not protecting unmarried couples. Also poor programming for gender responsive service delivery, lack of quality and quantity of health care providers and

lack of using community based gender issues for policy planning and advocacy are all affecting women's health through increasing their vulnerability to HIV. All these need adoption of empowerment strategies that could enable women to raise their voice and demand their rights through individual efforts or collective bargaining aiming at changing unfavourable laws and transforming gender relations.

CHAPTER FOUR: EVIDENCE-INFORMED INTERVENTIONS AND ANALYSIS OF PROGRAMS INTEGRATING GENDER AND HIV/AIDS IN TANZANIA

A multifaceted set of interventions is needed to address the influencing factors outlined in the earlier chapters. The factors emerging in chapter 3 point overwhelmingly to the need to develop programmes that lead to a better ability for women to decide on and negotiate relationships which are depending on a broader social, cultural and economic environment underlying power relations influenced by internalised norms and values of men and women. To address these programmes there is a need to focus on the empowerment of women and address gender norms and values of women and men. The empowerment model outlined in this chapter will help analyse current gender empowerment programs in Tanzania in comparison with evidence–informed interventions and thereafter make recommendations based on evidence.

4.1: Gender empowerment model: Preamble

The model emphasis on four interconnected intervention domains required to be simultaneously fulfilled for the well-designed program that integrates gender and HIV in order to address women's and men's vulnerability to HIV through transformative gender relations.

i. Expanding the material alternatives to choose from

These are economic opportunities and support provided by the program to reduce women's economic dependence on men in order to reduce transactional sex.

ii. Enhancing ability to make choices that are consequential

These include gender-sensitive awareness creation about safer sex, negotiation skills and provision of services or linking women and men with services providers.

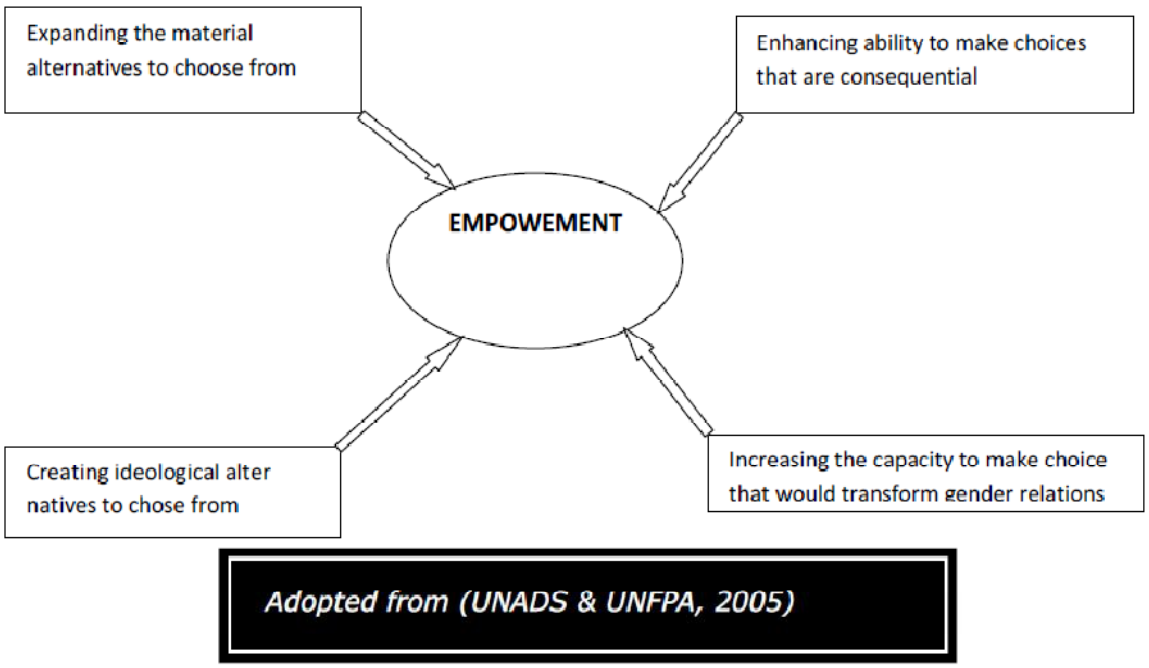
iii. Creation of ideological alternatives to choose from

This is about addressing social and gender inequality norms underlying HIV infection to enable women and men to challenge them.

iv. Increasing the capacity to make choice that would transform gender relations

This is about the creation of women's rights awareness, connecting them with legal networks and mobilising them to join together for collective bargaining when needs arise.

4.1.2: Figure 3. Empowerment model for analysis of gender empowerment for HIV interventions



4.2. Evidence-informed vis-a-vis current gender and HIV and AIDS programs in Tanzania.

In 2007, the World Health Organisation in collaboration with Instituto Promundo published the worldwide review study of evidence from program interventions seeking to engage men and boys in achieving gender equality and equity in health. Review assessed gender approaches and types of interventions applied by 58 programs from different parts of the world that engage men in sexual and reproductive health including preventing HIV and other STIs, using contraceptives, preventing intimate partner violence (IPV), parenting/fatherhood and men's health seeking behaviours among others. This review study report has been used as evidence to analyse current gender empowerment and HIV Programs in Tanzania.

4.2.1. Gender sensitive/positive approach

These are "*programs that recognise specific needs and reality of men based on the social construction of gender roles*" (WHO, 2007, p.4). In these programs gender is the means to development goals. Addressing gender norms, roles and access to resources in so far as needed to reach project goals.

The WHO and Instituto Promondo (2007) review found that 41% of programs that applied gender sensitive approach to transform gender

relations were likely to be effective in changing men's attitude than those programs who merely mentioned gender norms and roles in class sessions. The evaluated sixteen gender sensitive programs from Northern and Latin America and nine from SSA deliberately include boys and men in dialogue about the implication of gender and masculinity norms on women's reproductive health and emphasise clear efforts to change those inequality norms. However they were not so effective in transforming sexual and gender power imbalance as compared to those programs which added economic support to poor women (WHO 2007). The same applies for the intervention which used only economic support to women without focusing on transforming gender relations they didn't improve women's decision making in sexual relationship (Mason 2005). This call for using mixed approaches: gender education together with addressing women's economic constraints.

The international evidence above is supported by evidence from Tanzania where ACORD Tanzania gender-based HIV stepping stone programs were evaluated in 2006 after three years of its implementation. This program focused on reducing HIV vulnerability among younger girls and women through working with female and male peer community groups to challenge existing gender inequality norms associated with HIV vulnerability. Evaluation confirmed that although there was an increase of condom use from 10%-50% and discussion of sex matters among people under 35 years increased from 21%-44% in intervention group; HIV vulnerability to women remained acute due to women's economic vulnerability that was not solved by the program (ACORD 2006).

Programs involving men through combined peer group education, community outreach, mass and local media and HIV and AIDS service provision in developed countries (USA and Canada) have been proved to change behaviours among boys and men than those program using one approach peer group education (WHO 2007; WHO 2009).

In Tanzania a five year program of such nature is newly initiated in 14 districts but not yet evaluated. It is a five year program run by Engender Health (an international NGO); using Men Engage model adopted from USA and it is in the third year of its implementation. The program is known as CHAMPION-channelling Men's Positive Involvement in HIV and AIDS Response. It applies complex and mixed strategic activities under two components of the empowerment model namely increasing ability of community to make choices that are consequential (awareness creation on safer sex) and creation of ideological alternatives to choose from (addressing gender inequality norms). Married and cohabitating non polygamous couples are main target group through peer education. Other community members

are reached through community change clubs and meetings done by trained community leaders. In-depth community dialogue in one-on-one education, small group sessions, community events and meetings focusing on fighting gender inequality norms and preventing sexual and gender based violence are conducted at least once a week for 3-4 month in the program village(CHAMPION annual report 2011-2012).

Training to district health management team and health facility managers is conducted to build them with the capacity for monitoring and supervising VCT and PMTCT services. Facility staff from the programme areas are also trained on internal mainstreaming (CHAMPION annual report 2011-2012 'unpublished').

Successes and challenges

Through multiple activities the CHAMPION project has reached thousands of men and women in Tanzania. There is vivid evidence that the community appreciates this project. However, the annual report did not show mile stone evidence if the program is reducing gender power imbalance in sexual relationships. Also, CHAMPION project neither addresses the issue of women's economic dependence to men nor provides alternative economic choice for them. Also there is no evidence that the program emphasises women's collective bargaining or connecting them to legal service agencies where they could go for help when needs arise. Addressing women's economic vulnerability in HIV and AIDS interventions has been identified as the critical element to reduce women's vulnerability to HIV (ACORD 2006; WHO 2007; SAT 2011).

4.2.2. Gender transformative approach coupled with changing economic opportunity:

These programmes "*seek to transform gender roles and promote more gender-equitable relationship between men and women*" (WHO 2007, p.4). In these programmes gender is central to promoting gender equality and achieving positive development outcomes. They attempt to transform unique gender relations to promote shared power, control resources, decision making and support for women's empowerment.

Evidence from a number of reproductive health studies have shown that a multi-level empowerment strategy through community participation that address masculinity norms to preventing HIV infection when integrated with economic activities for women have greatest impact in improving women's quality of life (Wallerstein 2006). Also, Preston et al (2010) found from fourteen (38%) evaluated studies that community participation and empowerment in primary health care was a powerful tool to improve health outcome for the marginalised members of community.

The evidence-informed interventions of the gender transformative approach to reducing HIV vulnerability can also be traced from Kim and his colleagues' evaluation of the Interventions with Microfinance for AIDS and Gender Equality (IMAGE) from South Africa. This participatory Sister-for-life IMAGE programmes targeted poor women groups from rural areas. It provided them with financial support for Income Generation Activities (IGA) accompanied by skills building training for HIV prevention, gender relations, cultural norms, intercommunication skills and partner violence.

In phase two the programmes targeted the wider community. Through community participation strategies, boys and men were engaged in discussions aiming at improving gender relations and stop sexual violence against women. Review of these interventions found that women's opportunity through informal employment improved their capacity to participate in family decision making and ability to resolve their own health issues related to HIV vulnerability. Also, intimate partner violence was reduced by more than half in the intervention group (Kim et al 2007).

IMAGE programmes in Tanzania is run through a recently initiated program known as Women's Social Economic Rights (WSER). This is a three-year program run by Concern Worldwide, an International organisation implemented mainly under the auspices of European Union grant through Right Based and community participation approaches whereby gender and HIV and AIDS are non- negotiable cross cutting issues (Concern' WSER proposal 2012).The program is being implemented in forty villages in three districts through partnership with district councils, CSOs and community groups. It directly reaches approximately 42,000 households of both women and men through three aims: one: Improve women's economic returns on assets, two: Improve women's involvement in control over decision making in households and community, three: Advocacy and policy for gender equality improvement.

WSER's strategy of empowerment

This program applies three strategies: Expanding the material alternative to choose from (*economic return to asset*), creation of ideological alternatives to choose from (*challenging gender inequality norms*) and increasing the capacity to make choices that would transform gender relations (*advocacy and connecting women for collective bargaining*).

Economic return to asset

WSER supports women land rights through individually processing the certificate right of occupancy (Women headed households) or joint right of occupancy (married women), and supports economically vulnerable women's

community groups through farm inputs, processing machines, market skills, servings and credits and access to microfinance.

Challenging gender inequality norms
Through men's and women's peer groups and adolescents in schools, gender equality dialogues centred on challenging inequality norms are carried out. Topics include women's access to and resource control, engaging in income generation activities, equal decision making in family and community, sexual rights, equal right to education and governance.

Advocacy and collective bargaining
This is done through advocating for increased development implementation with a gender lens, connecting women with networks dealing with women's rights and facilitating both men and women to participate in village and district development planning while support women to hold positions at different levels. Also, the program commemorates annual international equality events in program areas in order to advocate for women's rights. Events include International Women's Day, female food hero during World Food Day, Sixteen Days of Activism, International Men's Day and World AIDS Day connected to reducing women's vulnerability to HIV.

Successes and challenges
This program is approaching towards the end of its first year implementation and has not yet provided its annual report. However, it is a well designed program which shows potential positive results. For example both men and women are involved in the program activities from phase one, and both sex are mobilised for advocating for women's rights. Also, connecting women with markets and microfinance can result in sustainable economic progress to women. However, WSER seems to put less emphasis on enhancing the ability to make choices that are consequential (*awareness creation about safe sex and services*). This may hamper efforts of empowerment for safer sex.

CHAPTER FIVE: DISCUSSION, STUDY LIMITATIONS, CONCLUSIONS AND RECOMMENDATIONS

Gender empowerment is easy to theorise but putting it in practice has been a challenging concept in Tanzania because of its complexity and demand of multidisciplinary skills and knowledge and multi-sectoral response requiring high political commitment and continuous resources. In light of different vulnerability to HIV between men and women and varying HIV prevalence between the two sexes, integrating the right-based gender into HIV and AIDS programs has become of paramount importance despite challenges we face in Tanzania.

This chapter discusses feasible measures which can be adapted in Tanzania to operationalize the evidence from informed interventions analysed in chapter four, in order to address HIV vulnerability factors summarised in chapter three. Conclusion and recommendation have been made based on the discussion.

5.1. Discussion

As it was summarised in section 3.7, the main factors identified to put women more at risk for HIV than men are those related with discriminatory social cultural rules resulting in gender inequality norms and practices which affect women's economic rights and decision making as regards their bodies and their sexual life. Also, government programs were found weak in responding to gender specific HIV/AIDS needs due to the little capacity that the government's staff have to undertake community gender and HIV situational analysis.

However, the government is aware about the negative effects of prevailing unequal gender relations for both men and women's health particularly how the inequality gender norms increase the risk of HIV for women; yet addressing these problems are questionable. Despite the weaknesses in the strategic response to gender needs through government programs, Tanzania has a positive policy framework and guidelines promoting gender equality and encouraging multi-sectoral collaboration. This is an opportunity where evidenced-informed interventions could be adapted in Tanzania with minimal modification.

Gender transformative programmes through community participation strategy and education have been proved to reduce intimacy partner violence and increase women's participation in decision making in dealing with their own health and HIV issues in South Africa (Kim et al 2007), and from other SSA countries (Walleistain 2006; WHO 2007; Who 2009).Tanzania could build on gender transformative interventions that are

already taking place through NGOs (CHAMPION annual report 2011-2012 &, Concern WSER' proposal 2012-2015). Programmes may be started as the pilot and later scaled up based on resources available and experience gained by government and other stakeholders. However, it should be recognised that community participation and empowerment approach requires a long-term and consistent investment therefore it needs strong government commitment and coordination for the sustainability purposes (Preston et al 2010).

Through community based organisations and using participatory techniques, community members (women, girls, men and boys) would be facilitated to analyse gender and HIV and AIDS in relation to their daily lives. Through such analysis women and men would be supported to gain more information in gender equality, develop insights on its value and benefits to both women and men. This will enable them to challenge gender masculinity norms and cultural practices that increase risk of HIV for both women and men.

The goal is to reconstruct gender relations by changing men's attitude and gender roles in order to promote equitable relationships between men and women as it is recommended by WHO (WHO 2007).Therefore, the second aspect is to facilitate community members to undertake HIV risks and vulnerability analysis based on local, social and gender norms in order to enable them to understand and acknowledge the types of additional empowerment interventions and support required for groups/individuals that have been identified as vulnerable to HIV. Here the aim is to foster community support and approval from men/partners/husbands) for the microfinance support for income generation activities for women as the strategy of reducing women's economic dependence on men, hereby empowering them to meaningfully participate in decision making about their sexual matters (Kim et al 2007; UNAIDS & UNFPA 2005)

For this to happen and to be sustained, participatory community action plan at the village level would be developed to address the identified harmful norms such as gender based violence and other masculinity norms. Therefore, analysis and the community plan should involve community leaders (both government and religions), influential people, ritual passage teachers, women living with HIV, GBV survivors if known, women, men, girls and boys representatives, CBO/NGOs and front line government staff who work for the community (eg, health workers, teachers, community development etc). The gender and HIV community action plan developed should be included into the calendar of village's projects monitoring and evaluation plan meetings which usually take place on a quarterly bases in each village in Tanzania. The village council should report progress to the village assembly meeting and ward development council.

The above strategy should go hand-in-hand with awareness rising on gender equality and equity to the larger community. This should be done through peer group dialogues on masculinity and gender inequality norms, theatre arts (drama, poem extra), community outreach, and through community meetings. Equality related events (International Women's Days, Men's Day, Sixteen Days of Activism extra) have been used by my organisation to raise equality awareness in the districts and it yielded good results, so this may be adopted as well. Community trainings should also include topics on gender-sensitive awareness creation about safer sex, negotiation skills and the importance of couple counselling in sexual relationship (UNAID & UNFPA 2005). List of HIV services and service providers should be made available at community level. Such services include condom provision, VCT, STIS, PMTCT and ART.

Curriculum-based gender and HIV training is the best way to reach younger people at the appropriate time (WHO 2009), and that is why working with ministry of education is very crucial.

As part of advocacy, women and men should be mobilized to join hands for collective bargaining to advocate for change of unfavourable laws and government prioritization to implement its policy commitments. Also, women should be connected to legal and human right services (Walleistain 2006).

Addressing Gender and HIV would be better achieved through a national strategy through government ministries and departments and cascaded down to respective districts within health system reform process. Government staff at the district level working under ministries of Community Development Gender and Children, Health and Education should work hand–in-hand with expert NGOs to ensure gender and HIV and AIDs are integral parts of their plans and firmly mainstreamed in their program documents, workplace and in community level activities. It needs fund commitment from government for this to happen. It also needs to train government staff (eg health, community and education) on participatory community situational analysis for gender and HIV and AIDS and use the findings for planning, implementation and monitoring (TGNP 2007).Health staff needs additional training on responding to Gender- based Violence and on working together with police and human rights activist as honest brokers (MoHSW 2011).

5.2. Limitations

The major limitation of this literature review thesis was an inability to find enough program documents and reports (gray and online) from the social agencies dealing with empowerment programs in Tanzania. Also, pre-service

syllabuses for health staff were necessary to look at if gender component was considered, but I didn't find any through my web site searching. Therefore it was a bit challenging to come up with the range of analysis in chapter four.

5.3. Conclusion

Women's vulnerability to HIV in Tanzania is the subject of complex unequal social, cultural and economic relations between men and women. Unequal relations to economic control results in unequal power relations in sexual decision making between two sexual partners and, the loser in terms of HIV risks is one who control less; usually these are women.

The government policy and strategies illustrate understanding of this complex problem as a public health issue and human rights concern, but putting it in practice is a challenge. However, Tanzania has specialised international NGOs working with a number of civil society organisations and local government districts to address gender issues in HIV programs. From these programs there is big opportunity for the government to adopt and institutionalize gender empowerment interventions in its programs, particularly in health, education and community development. Gender transformative empowerment programs when coupled with economic support to women have shown better results in transforming gender relations.

5.4. Recommendations

Gender empowerment and addressing inequality issues is not only advocated for the sake of reducing HIV infection among women, it is also the centre of human, social and economic development as well as a human rights concern. The following recommendations aim at improving gender empowerment and HIV interventions already taking place in Tanzania in order to reduce women's vulnerability to HIV and provide equitable and desirable social services to all people.

- The ministry of community development and its departments should take the lead in the facilitation of community participatory gender and HIV situational analysis and work together with health and education departments to mainstream gender issues in their program plans.

- Implementation of gender and HIV and AIDS should as much as possible involve CBOs and existing community committees. These are community institutions well-grounded at the community level, trusted by community members and other stakeholders and seen as advisers and agents of social change.

- Adopt a gender transformative empowerment approach. This is an integrated comprehensive approach that has been evidenced to emancipate women from economic vulnerability which put them at risk for HIV.

- To increase the sense of responsibility and community ownership, gender and HIV and AIDS community action plans should be participatory, developed in each program village and be monitored and evaluated by both the implementing agency and village council.

- Responding to GBV in the health system is very crucial as it is responding to HIV and AIDS. This should not remain in writing rather; government should train health care providers and provide space at health facilities where GBV survivors could be provided with safety care.

- Health management information system should include sexual and gender based violence injuries, such information will complement the information collected through DHS.

- Screening for asymptomatic STIs and RTIs among women should be made routine. Silent STIs and RTIs infection increases the risk of HIV acquisition to women by up to 40% and in Tanzania about 50% of pregnant women have silent STI/RTIs infections.

- Policy makers should emphasise implementing policies they have already formulated, instead of keeping formulating new policies and leaving them in books.

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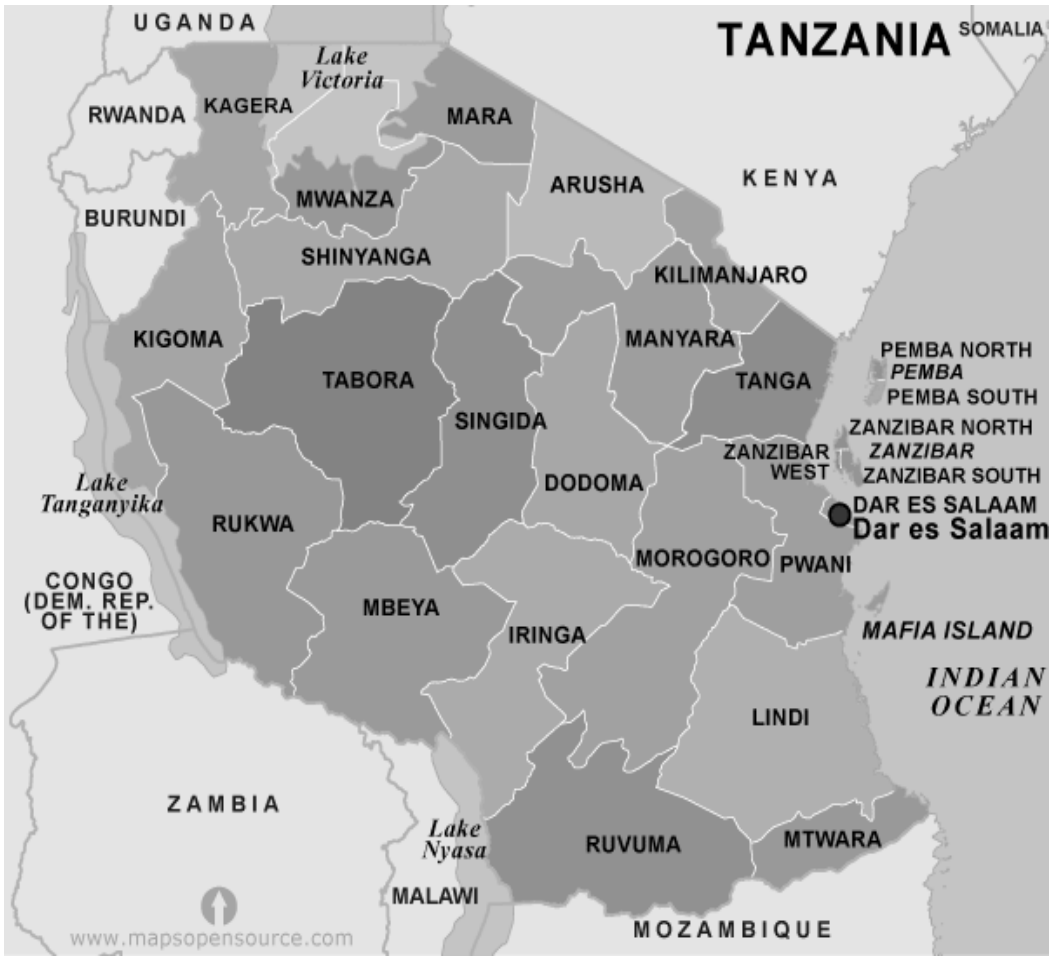
ANNEXES

Annex 1: map of Tanzania



Source: Tanzania website: www.tz.gov, viewed 29 July 2013