

# HIV transmission within marriage: findings from Tanzania

*A thesis submitted in partial fulfillment of the requirement for the degree  
of Master of Public Health*

**By**

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**Declaration:**

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Signature.....

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## Abstract

Married people constitute 55.5% of all people with HIV in Tanzania, while they make about 33% percent of The Tanzanian total population. Due to close association between marriage and having children, HIV infection among couples has direct link with increase number of children born with HIV and AIDS orphans in Tanzania. These two problems are of public health concerns currently and estimated to get worse in the future. Married people almost all belong to productive and reproductive segment of the population, hence morbidity and mortality of this group has unbearable economic, demographic and social consequences from the family level to the country at large. This thesis therefore focuses on the influence of marriage on HIV transmission and factors associated with HIV transmission among married people in Tanzania, and to suggest possible and feasible solutions. The study questions are:

1. What are the reasons for HIV transmission among married people in Tanzania
2. How Marriage influences the spread of HIV?
3. What are the perceptions of society towards marriages in the context of HIV acquisition?
4. What measures (solutions) should be taken to make marriages safer?

The literature review was done through reviewing of English published studies done on HIV/AIDS among married couples in Tanzania and neighboring countries, this was complemented by systematic reviewing of scientific publications on the subject. Author's experience and opinions were used wherever necessary.

The findings show that, extra-marital sexual relationship, non-condom use, sex violence, early marriage and high rate of sexually transmitted infections among married people in Tanzania found to be major reasons for the spreading of HIV within marriage. Marriage, despite of emphasizing on fidelity as a religious institution prohibits use of condoms, expose young women to early marriage, and trans generation sexual relationships; subject married women to widow inheritance and widow cleansing; provide safe haven for sex violence and gender in equality.

**Conclusion:** Marriage is in fact a risk factor of acquiring HIV in Tanzania, especially among women. Albeit there are opportunity of making marriage and life within marriage protective against HIV as expected, since HIV risk perception is high among couples and in general community.

**Recommendations:** Marriage is potentially risky in Tanzania, the government and policy makers in collaboration with other stakeholders including religious leaders need to harmonize their efforts targeting this emerging high-risk group, and to stop doing business as usual.

**Key words:** HIV transmission, marriage, Tanzania, married people or couples. Gender in equality, early marriage, sex violence, polygamy, extra-marital sex.

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## List of abbreviations

|         |  |
|---------|--|
| AIDS    | Acquired Immune Deficiency Syndrome                |
| AMREF   | African medical Research Foundation                |
| ANC     | Antenatal Clinic                                   |
| ART     | Anti Retroviral Therapy                            |
| ARV     | Anti-Retroviral                                    |
| CRR     | Center for Reproductive Rights                     |
| GDI     | Gender related Development Index                   |
| GEM     | Gender empowerment Measure                         |
| GNI     | Gross National Income                              |
| HIV     | Human Immunodeficiency Virus                       |
| IEC     | Information, Education and Communication           |
| KDHS    | Kenya Demographic and Health Survey                |
| MHIC    | Muhimbili Health Information Center                |
| MOH     | Ministry of Health                                 |
| MTCT    | Mother to child transmission                       |
| MUCHS   | Muhimbili University of Health Sciences            |
| NBS     | National Bureau of Statistics                      |
| NPHA    | National Policy on HIV and AIDS                    |
| OR      | Odd Ratio  |
| PMTCT   | Prevention of mother to child transmission         |
| RR      | Relative Risk                                      |
| TACAIDS | Tanzania Commission for AIDS                       |
| TAMWA   | Tanzania media women association                   |
| TDHS    | Tanzania Demographic and Health Survey             |
| THIS    | Tanzania HIV/AIDS Indicators survey                |
| TPHC    | Tanzania population and house census               |
| TRCHS   | Tanzania   |
| UN      | United Nations                                     |
| UNAIDS  | The joint United Nations program on HIV/AIDS       |
| UNDP    | United Nations Development program                 |
| UNFPA   | United Nations Fund for Population                 |
| URT     | United Republic of Tanzania                        |
| USAID   | United States Agency for International Development |
| VCT     | Voluntary Counseling and Testing                   |
| WB      | World Bank   |
| WHO     | World Health Organization                          |

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## Chapter 1: Introduction

*Few are the studies on the perception and preventing attitudes towards HIV/AIDS of men and women in stable heterosexual relationship, its interface with moralities regarding marriage and roles taken up by partners. However, recent epidemiologic data show the need for an urgent approach on the heterosexual part of the population (Maia et al. 2008, p.2).*

Since first AIDS cases were detected in Tanzania in 1983, its dynamic has changed from concentrated epidemic to present situation of generalized epidemic with National HIV prevalence of 7% (1,400,000) higher among women than men with prevalence of 7.7% and 6.3% respectively (THIS 2003-2004). Although the epidemic is generalized, but there are groups that due to nature of their occupations or demographic characteristics and biological factors, have been identified as high risk groups and special attention on prevention programs developed, these include, sex workers, long truck drivers, military personnel, fishermen, youths (ages 15-24), and health workers (URT 2003). These groups from the beginning of the epidemic until now have had high HIV prevalence among them, for example Studies done to estimate prevalence of HIV among sex workers by AMREF (1997) along the major truck stops and towns (cited in Garbus 2004, pp.25-6) have shown this group to have a high HIV prevalence of up to 60%, while the study in Dar es Salaam showed that 50% of the bar workers were HIV positive (URT 2003). No one would think about infection among married people, no one either would believe that marriage could be playground for HIV to the extent that it has been observed in Tanzania.

Throughout my career working in HIV and AIDS programs and projects in Tanzania including testing and counseling people for HIV, and treating AIDS patients as a medical doctor, I had noticed ascending trend of proportion of married people who were HIV positive. Later on it was confirmed through epidemiological research reports that married people constitutes more than fifty percent of HIV infections in Tanzania (THIS 2005). This report rose attention of people from different walks of life because marriage as an institution was regarded and expected to be “holy” and respected sexual union, indeed marriages were regarded as protective against HIV infections by many people in Tanzania so long as both couples were HIV negative during wedding day (Mchimbiri 2004; author’s experience). This report compelled me to pursue with this study to try to find out what is happening in Tanzanian community, whether this represents absolute increase of HIV prevalence among married people or due to selection bias, and to find out what are main reasons for HIV infection among married people. Gender, education, HIV awareness, polygamy, sexual violence, extramarital sex, concurrent sexual relationships, pre marital infection, condom utilizations, and religion believes will be described because have been associated with epidemic in many countries and in Tanzania as well (TACAIDS 2003, cited in URT 2003).

This thesis is intended to act as an eye opener to Tanzanian community in general, policy makers, religious and community leaders, HIV program managers and government officials, to re-organize preventions programs focusing married people, and re-visit and review existing laws and policies pertaining marriages. This retreat is of paramount important now considering high rocketing in number of AIDS orphans due to deaths of their parents caused by AIDS and increase number of children born with HIV from increase number of infected mothers within marriage.

## Chapter 2: Background

### 2.1 Tanzania geo-politics and Demography

Tanzania is the largest country among countries forming east Africa community, others are Uganda, Kenya, Rwanda and Burundi, it occupies about 9450,000 Sq km. According to Tanzania population and Housing Census (TPHC) report of 2003, the country population was estimated to be 34.5 million (main land), recent data according to Population reference bureau (2007), Tanzania population is estimated to be 38,700,00, of whom 53.1% are between 15-64 years of age, and 44.3% below 14 years old. 17,658,911(51.18%) are women and 16,910,321(49.02%) are men, with sex ratio of between 95-99 men per 100women. Tanzania became independent on 1961, and since then it has been enjoying peace and political stability compared to other eastern African countries.

The Tanzanian population was expected to increase at high rate proportionally to its general fertility rate of 5.7 (TDHS 2004-5), but the rate has been slower than expected mainly due to AIDS. According to United Nations (UN) report on population and social affairs (2003), AIDS was expected to reduce life expectancy by 17% between 200-2005, 14% between 2010-2015 and by 7% between 2045-2050 as shown by table below (table 1).

| Period    |              |                              |                      |           |              |                              |                      |           |              |                              |                      |
|-----------|--------------|------------------------------|----------------------|-----------|--------------|------------------------------|----------------------|-----------|--------------|------------------------------|----------------------|
| 2000-2005 |              |                              |                      | 2010-2015 |              |                              |                      | 2045-2050 |              |                              |                      |
| With AIDS | Without AIDS | Reduction in Life Expectancy | Percentage Reduction | With AIDS | Without AIDS | Reduction in Life Expectancy | Percentage Reduction | With AIDS | Without AIDS | Reduction in Life Expectancy | Percentage Reduction |
| 43.3      | 52.1         | 9                            | 17                   | 46.5      | 54.1         | 8                            | 14                   | 63.3      | 67.8         | 5                            | 7                    |

Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat. *World Population Prospects: The 2002 Revision. Highlights*. New York: February 2003 <<http://www.un.org/esa/population/publications/wpp2002/wpp2002annextables.PDF>>

### 2.2 Social Cultural & Economics situation

There are more than 126 tribes in Tanzania, each with its own language, but almost all people can speak and understand Kiswahili, an official National language. There are three major religions, Christian (40%), Islam (35%), (25%) follow traditional religions, and remaining 5% belong to other religions and none believers (wikipedia), According to Tanzania Reproductive and child Health survey (TRCHS 1999/2000, cited in Garbus 2004, p.40), about 66 percent of women and 58 percent of men ages 15-59 are married (currently in unions), the population of married people is 11, 385,000 (33%) of the general population. 11 percent of women and 5 percent of men were divorced, separated, or widowed. 23 percent of women and 37 percent of men have never married; and women head that 27 percent of urban and 21.7 percent of rural households (TRCHS 1999/2000).

Tanzania demography and health survey (TDHS) report of (2004-5) showed that almost half of women married before age 18 and two-thirds married before age 20. Compared with TDHS (1996) results, the median age at first marriage for women in Tanzania has remained more less the same at slightly over 18 years. Men do marry considerably later than women. The median age at first marriage for men ages 25-59 was 24, almost six years later than the median of 18 for women. About nineteen percent of men aged 25-49 years old were married by age 20, compared with 69 percent of women ages 25-49. These statistics show the magnitude of the problem of early marriages especially among girls in Tanzania (TDHS 2004-5)

Median age at first intercourse for women age 20-49 is 17 years. 50% of women age 15-19 have had already started sex, while 46% of them were married. This percent rose to 92% for women age 20-24, with 67 percent of them married. The median age at first intercourse among men was about 18. In general an average men entered into marriage six years later than women, albeit they started sexual relations more less at the same age (TDHS 2004-5). This information indicates that delaying marriage does not necessarily mean delay sex debut of girls.

Tanzania is one among the poorest countries in the world, with 2002 Gross national Income (GNI) of US\$290 (WB, 2002), About 36% of the population living below the basic need poverty line (URT, 2002). In recent years, the economy of Tanzania has been growing steadily at the rate of 5-6%. The backbone of economy is agriculture, with tourism and mining sectors booming contributing 15% and 30% respectively (URT 2002)

### **2.3 Health Care system & Financing**

Soon after its independence in 1961, Tanzania installed economy based on socialistic principles, hence health service delivery was under control of the central government and it was free of charge at all levels. Structurally the health care system comprises of three levels, primary, secondary and tertiary levels; at the primary level, there are dispensaries, health centers, and district hospitals, this level is responsible for delivering primary health care. The secondary level comprises regional hospitals, which provide both basic and specialized services. There are six tertiary hospitals, which are responsible mainly for specialized services (Garbus 2004)

According to Tanzania Global Fund country Coordinating Mechanism (CCM) as cited in Garbus (2004), there is severe shortage of human resource in the health sector, and is a major concern in Tanzania. It was reported recently during the Health Sector Review (2007) as priority issue for the coming years, roughly about ten thousand additional Full time equivalents (FTEs) health workers mainly counselors of various types are urgently needed. This problem can be explained partly due to hiring freeze policy that was imposed in effect in all sectors as part of the IMF structural adjustment measures to Tanzania. This policy has been partially relaxed for the health sector.

Access to health care is constrained due to geographical distance to facility, poor and impassable roads during rain seasons, and lack of vehicles for transportation (TBS 1999-2000). According to report of center for Reproductive Right (CRR) of 2001, most public dispensaries do not have enough funds to buy facilities and provide better services

including salaries for employees, and the poorer of the poor cannot afford to pay for private facilities where services are relatively better.

In 1995 the ministry of health (MOH) introduced cost-sharing policy for health services, as part of structural adjustment measures, previously free health care services 100% paid for by the government, now require fee payment. Anti natal care services (ANC) and family planning services are exempted from user fees. Often, no fees are imposed on pregnant women, children under five, TB drugs, ART, or the very poor (Hales at el. 2003). However, other areas of reproductive health (e.g., treatment of STIs) are not exempted (URT 2001/02). This policy has made it difficult for the poor to acquire medical treatment; many are unable to afford doctors' consultation fees of Tsh 500, or more expensive diagnostic tests, which can cost up to Tsh 120, 000 (CRR 2001).

## **2.4 HIV/AIDS situation, Globally and in Tanzania**

It was estimated that by the end of 2006, more than 33.2million people in the world were living with HIV/AIDS (UNAIDS 2007). Sub-Sahara Africa is the worst affected part of the world, with estimation of 25 million people living with HIV, and approximately 3 million new infections occurred in 2006 alone, since epidemic arrived in the continent in early 1980s it has killed 2.1million and around 2 million children under 15 years of age are living with HIV, and orphaned more than 12 millions others in Sub-Saharan countries alone (UNAIDS&WHO 2005).

Tanzania average national HIV/AIDS prevalence is 7% (TACAIDS, NBS&USAID 2005), with the most affected age group adults aged 15-49. Women have a higher prevalence rate (7.7%) than men (6.3%) (TDHS 2004-5). Tanzania HIV/AIDS Indicator Surveillance (THIS) report showed that by the end of 2004, 1.9million individuals in Tanzania were living with HIV (THIS 2003-4). Almost 10% of the children under 18 years old are single or double orphans due to AIDS. Report of Poverty and Human Development (PHD) of 2005 showed that in Makete district where the prevalence of HIV is among the highest, about 24% of the children are orphans due to AIDS.

According to Population Division report (2003) of United Nations, AIDS has increased number of deaths in the country by 11%. In the year 2000 there had been 807,000 AIDS deaths in Tanzania, and it was projected additional 5 million deaths by 2050. HIV has reduced life expectancy to 44 years as opposed to the projected 56 years without AIDS; it is therefore expected to reduce population size up to 15% by the year 2050 (UN 2003)

HIV/AIDS has resulted in welfare losses equivalent to 47.2 percent of the gross Domestic product (GDP). The epidemic continues to impose a heavy burden on the health care system. Households affected by AIDS are experiencing significant reductions in income and increase in health expenditures (WB 2003).

Mother to child transmission of HIV (MTCT) is raking number two next to heterosexual as a major way of transmission in Tanzania which account up to 6% of the National prevalence according to CCM report (2004). With General Fertility Rate (GFT) of 5.7 which is among the highest in Africa, this attributable fraction of MTCT to the National HIV prevalence is likely to increase in the future, and the fact that in Tanzania it is estimated between 30-40% of HIV positive pregnant women infect their children, but

only 30.5% among married people are aware about Prevention of mother to child Transmission (PMTCT) the existing programs (TDHS 2004).

Major route of HIV infections is through heterosexual contacts accounting for over 90% of new HIV infections in Tanzania, followed by MTCT, whereby the mother passes the HIV-virus to the child during pregnancy, at time of birth or through breastfeeding this route is estimated to account up to 6%(TACAIDS, NBS&USAID 2005). Because there is direct link between heterosexual transmissions and MTCT, it can be inferred that, heterosexual transmission is responsible for up to 96% of all HIV infections in Tanzania

A study done among AIDS cases reported in 2000, heterosexual transmission was the primary mode of infection (77.2 percent), MTCT accounted for 3.4 percent of AIDS cases; transmission via infected blood/blood products accounted for 0.4 percent. For 19 percent of cases, the transmission mode was not stated (MoH, 2001).

This thesis therefore addresses determinants of HIV infections within marriage in Tanzania, it also tries to find out and describe what and how marriage as an institution influences these determinants, lastly it identifies challenges for addressing HIV/AIDS among couples in Tanzania and gives recommendations on how better the problem can be tackled.

The thesis is presented in five main parts. The first is describing the problem of HIV among couples in Tanzania, its magnitude and its implication to the families, societies and country at large. The second considers factors that influence the spreading of HIV among married people in Tanzania, comparing with never married, divorced or widows by using information from reviewed literatures. The third describes the influences of marriage on HIV transmissions; it tries to find out how marriage as an institution plays role on HIV transmissions among couples in Tanzania. The fourth part describes challenges that are faced on addressing HIV and AIDS within married people in Tanzania. The fifth part is discussion, conclusion and recommendation in which key findings are summarized and suggestions are given for interventions.

## **Chapter 3: Problem Statement and study objectives**

### **3.1 Problem statement**

HIV is the number one killer of adults in Tanzania, since it was first reported in the country early 80s, it was estimated that by the end of 2005 it had taken approximately 140,000 lives of Tanzanians (UNAIDS 2007), left behind grieves, desperations and destitutions among families societies and country at large. HIV/AIDS is a unique and serious disease due to the fact that it attacks the productive and reproductive segment of the community, at the family level, it usually attack both parents, some times and children.

According to THIS (2003/2004) report, of all AIDS cases reported in Tanzania, 55.6% (784,000) were married. The report showed that those who were in union (married and cohabiting) had a HIV rate of 7% and 8% for women and men respectively, compared to that of general population, which was 6.3% for men and 7.7% for women. 8% of HIV positive married couples are discordant, women in polygamous unions showed higher rates (10%) of infections compared to those married women who were not in polygamous relationship with (7%) infection rate (THIS 2003-4).

In the neighboring country of Uganda, current studies show that the highest infection rate is now amongst married females 15–49 years old (5.9%), compared to that of females who were not married which is 2.7%. The same studies show that overall, 6.4% of Ugandan adults (15–49 years) are infected with HIV, with more infections among women (7.5%) than men (5.0%). Among young people 15–19 years, the prevalence rate among women is 2.6% as compared to only 0.3% among men (Kibombo, Neema and Ahmed 2007).

The HIV/AIDS pandemic represents great threats to love, harmony, tranquility and peace within families, and it is in fact one among major reasons for domestic violence, and women abandonment by their husbands (Maman 2002). Stigma associated with HIV/AIDS causes panic and disharmony among couples which leads to reduction or total elimination of love within marriage and in general community at large. Morbidity and mortality among couples disrupt plans, decelerate progress and erode gains of the families.

The economic consequences of HIV/AIDS among couples, or commonly referred to as bread earners of the families has been extensively documented, Mwanza cohort study (1995) indicated that, total of direct medical and funeral costs due to morbidity and mortality caused by HIV/AIDS, is much higher than annual per capital income of household. Households affected by HIV/AIDS suffer the loss of productive labour, income and food reserves. The combination of morbidity and mortality of family's bread earner due to AIDS, is associated with diversion and withdraw of labour and task shifting within families which mainly results into low productivity, diversion of servings and assets including capital assets for productions are depleted to meet medical and burial costs (Barnet and Rugalema 2001).

The epidemic does not affect men and women equally, women are more susceptible and vulnerable than men as it was reported by researchers from Muhimbili University college of Health Sciences (MUCHS) in Dar es Salaam and Johns' Hopkins University, who in collaboration investigated the attitude and experiences related to

partner violence and HIV serostatus disclosure of women who attended VCT services at Muhimbili Health Information Centre (MHIC), that when a woman is tested HIV positive the possibility of domestic violence from husband or his relatives was common in Tanzania. Wife and her children abandonment, stigma and discrimination, abusive languages and divorces have been common problems to married women. In case of death of a man partner due to AIDS leaving behind a woman and children, property grabbing from relatives of the man has been excised widely in Tanzanian community which denies woman and her children their future prosperity and hence increases their susceptibility and vulnerabilities to HIV and AIDS (Garbus 2004). Women are also biologically more susceptible for HIV infections than men due to anatomical structures of their genital organs.

In Tanzania marriage is expected to bring children, without whom the marriage is considered as unsuccessful which might lead to divorce, domestic violence, polygamy, or extramarital sexual relationship mainly by man trying to find children elsewhere (Mchimbiri 2004; author's experience), this implies that HIV infection among couples is directly connecting to the rising number of orphans and children born with HIV, these two (AIDS orphans, and children born with HIV) are currently considered to be major public health problems that impose serious challenges to the already over stretched health system (TDHS 2004). UNAIDS&WHO (2006) estimated that by the end of 2006 there would be about 1.1 AIDS orphans in Tanzania, and percentage of orphans attributed by AIDS rose from 4 percent in 1990 to 42 percent in 2001; it was projected to increase to 54 percent by 2010 if the current trend of epidemic remains unchecked especially among couples in Tanzania (UNAIDS&WHO 2006).

Previous studies have identified some of the factors which might explain the skewing of HIV transmission between men and women in Tanzania; gender, economic dependence of women, culture, norms, taboo, Polygamy, religion believes and attitudes towards HIV/AIDS, low awareness among married people on VCT, poverty, domestic violence, condom use, stigma and concurrent multiple sexual partners have been mentioned and associated with epidemic and gender differences on HIV transmission (TACAIDS 2005), little has been done to explain the rise in proportion of prevalence of HIV among married people in Tanzania

HIV infection within marriage in a country like Tanzania where major mode of transmission is through heterosexual contact can be explained mainly due to pre-marital infections, or due to infidelity within marriage (Mahraj and Cleland 2005). HIV prevalence is highest among youths especially young women aged 15-24 which is 6.4 – 9.7%, and 2.8- 4.3% for young men (Lyamuya 2005), this high prevalence among youth is an indication of premarital sex practices, infections acquired during pre marital stage might be passed to the spouses through sex within marriage. To estimate proportion of infections within marriages that is attributed by pre marital infection is difficult because premarital HIV testing and disclosure, like any other HIV testing is voluntary (NPHA 2005), and there is no documented information available which shows percentage of spouses who were HIV positive before and those who were infected within marriage, therefore, current prevalence of HIV/AIDS among married people is a gross data.

The discussion above does not give clear picture on what are the major factors for HIV infections among married people in Tanzania, while Marriage doctrines assume the "holiness" of the marriage, that is an institution within which should be no HIV

infections through heterosexual among concordant HIV negative couples unless one or both were infected before marriage; another school of thought considers factors within marriages including infidelity to be responsible for HIV transmission among couples. Despite of all these thoughts, it is not clear to what extent infections among married people are due to pre marital infections, infidelity or both.

This study therefore intends to identify and analyze factors influencing the spreading of HIV among married people in Tanzania. It tries to analyze factors that had been mentioned previously to be associated with the spread of HIV-among women if they too contribute to the epidemic within marriage in Tanzania. As much as it is possible premarital and intra-marital factors are differentiated and analyzed separately.

### **3.2 Study questions**

1. What are the reasons for HIV transmission among married people in Tanzania?
2. How does marriage influences the spread of HIV?
3. What are the perceptions of society towards marriages in the context of HIV acquisition?
4. What measures (solutions) should be taken to make marriages safer?

### **3.3 Objectives**

#### **3.3.1 General objective**

The general objective of this study is to identify and describe factors that influence the spread of HIV among married people in Tanzania, to describe influence of life within marriage on HIV transmission, and formulate appropriate recommendations for prevention.

#### **3.3.2 Specific Objectives**

1. To describe factors that influence HIV transmissions among married people in Tanzania
2. To describe the influence of marriage on HIV transmissions in Tanzania.
3. To describe challenges for addressing HIV prevention among married people.
4. 4. To formulate appropriate recommendations for interventions.

By describing the above objectives, this study will give valuable information to the government of Tanzania, specifically to policy makers for reviewing the current HIV/AIDS policy in order to pay more attention to married people. Program managers will have information for better planning, implementation, monitoring and evaluation of intervention programs. Religious leaders and tribes leaders who are responsible for wed locking, to mainstream HIV/AIDS and review the common practice of testing couples just before wed locking, and lastly but not least to the general population and couple in specific to understand clearly the association between marriage and HIV infections, and appropriate measures for prevention.



### **3.4 Methodology**

The literature review was done through reviewing of English published studies done on HIV/AIDS among married couples in Tanzania and neighboring countries, this was complemented by systematic reviewing of scientific publications on the subject. Author's experience and opinions were used wherever necessary.

#### **3.4.1 Key words**

Search strategy: The following key words were used to search for the information; HIV transmission; Married people or Couples; Tanzania; sex violence; polygamy; Gender; Early marriage; condoms; STI; Stigma; HIV/AIDS awareness; multiple sex partners; widow inheritance; widow inheritance; and in combinations.

Searching engines that were used are: PUBMED; Go ogle scholar; Go ogle general searching engine; KIT & VU Libraries; and previous students thesis were referred for clarification whenever need raised. Some websites relevant to this study were visited, for example; WHO; UNDP; United Republic of Tanzania; WB; Wikipedia; Scientific Journals and research papers were also reviewed.

#### **3.4.2 Definition of used terms**

Marriage: Marriage means the voluntary union of a man a woman intended to last for their joint lives (The law of marriage Act, 1971) for the purpose of this thesis this includes cohabitation.

A monogamous marriage is a union between one man and one woman to the exclusion of all others. AND polygamous marriage is a union in which the husband may marry to another woman or women (The law of marriage Act, 1971)

Married people/couples: People who are currently married (or in cohabiting relationship) and unmarried means: never married, divorced or widow (Mchimbiri 2004)

Premarital sex: It refers to sex done by non-married person who is under age of 18 years that is legally permitted for marriage.

Cross generation sex: Sexual relationship involving man and woman that have age difference of ten years and above.

High-risk sex: unprotected sex with non-married or non-cohabiting partner (TDHS 2004-5).

Extra marital sex; for purpose of this thesis, it refers to sex done by a married person with a person who is not his/her spouse.

Multiple sexual partners: for purpose of this thesis, it means having more than one sexual partner at different time interval

Concurrent sexual partners; for purpose of this thesis, it indicates having more than one sexual partners at the same time interval.

Discordant couples; a situation where by one partner is confirmed to be HIV negative and another one is HIV positive (Thomton et al. 2004), the same meaning of the term is referred in this thesis

Single and double orphan: a child who lost single and both parents respectively (TACAIDS 2001)

Life within marriages; for purpose of this thesis it describes time period of people who are in marital union

### **3.4.3 Limitations of the study**

The fact that the reviewed literatures and publications were mainly in English and published ones, might led to the missed information that are in other languages like Kiswahili which is Tanzania's official national language. There might be many studies that are not available in the websites because are not published in the peer-reviewed journals, a situation that is common in a country like Tanzania. There not enough similar studies done in the country hence some references were from neighboring countries, which might not mimic the same picture for Tanzania community. Though there are number of quantitative studies done on HIV infections among IDUs in Tanzania like the study done by McCurdy et al. (2006) in Dare es Salaam indicated prevalence of 57% among IDUs, no available information yet on to what extent this mode of transmission contributes to HIV transmission to married people, hence this currently emerging important mode of transmission was left out in this study, like wise no published information was available on HIV and MSM in Tanzania, this is because practicing MSM is prohibited by law, and is a taboo which is not accepted and tolerated by community members, though author while was working as a medical doctor met MSM who were either married or co-habiting, attributable fraction of this mode of transmission was also missed out in this study, though there is possibility for them to link between MSM and to the general population, including their wives. Despite all these shortcomings, information obtained is expected to give clear picture of the subject in Tanzania.

## **Chapter 4: factors that influence HIV transmission among couples**

Guilhem described factors for disease acquisition as:

The situation resulting from a set of individual factors (biological, cognitive and behavioral), programmatic (prevention, education, control, and care programs, as well as political will), social (related to economic and social issues) and culture (submitting to moral standards and beliefs, hierarchies, power relation and gender issues), interdependent, and with mutual influence, taking up different weight and meanings over time and determining the level of susceptibility of individuals and groups regarding health issue. (Guilhem 2005, pp. 63-64)

This chapter narrates reasons from that were identified to contribute to the spread of HIV among married people, mainly in Tanzania. For clear understanding these factors are divided and discussed under the following sub-headings: Individuals factors; programmatic factors; cultural factors. It should be remembered that, all factors that apply to the general population also apply to couples, here for the sake of convenience; only those factors that have direct influence at pre-marital an intra-marital stages will be mentioned and explained.

### **4.1 Individual factors**

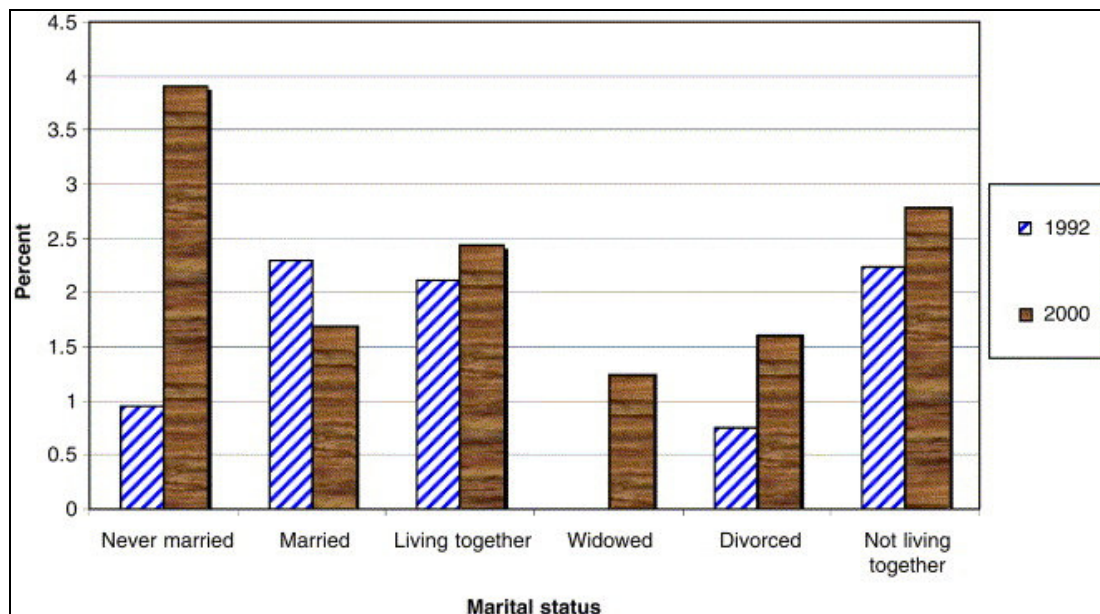
Individual factors are those that that are contributed by a person directly, they can be under control of a person, like behavior: semi control like cognitive: or out of control like genetical factors.

#### **4.1.1 Condom use**

Condom use is one among the three pillars of HIV prevention strategies; others are abstinence, and be faithful, together they form ABC strategy that Tanzania adopted and included in its National HIV/AIDS policy (NPHA) of 2001, and Tanzania HIV/AIDS Multisectoral strategic Framework. Condoms are scientifically approved to be efficiency and effective method of prevention with effectiveness of up to 80% for male condoms (Weller et al. 2003). In general condom use is low in Tanzania, a study showed decreasing use with increasing age. Kapiga and Lugalla (2003) revealed that men ages 20-24 and women ages 15-19 years had the highest rate of condom use, and that condom use was increasing among men who were never married and lowest to married men and women (Kapiga &Lugalla 2003).

As indicated previously, the commonest means of HIV transmission in Tanzania is through unprotected sex with an infected individual, there fore condom use has great role to play (if used correctly and persistently) on HIV prevention. According to TDHS (2004-5), about 99.4% of never married women engaged on high risk sex (sex with non-married or non- cohabiting partners) 12 months prior to the study, 37.1% reported to use condoms, compared to 14.2% of married women who reported to engage in high risk sex during the same period only 26.8% reported to use condoms. Similar trend appeared to

men, while 100% of never married men do engaged in high-risk sex 46.4% used condoms, among married men 42.2% did have high-risk sex and only 40.6% used condoms. This trend shows that there is a tendency of married people not using condoms wherever they do have sex in comparison to their never married counterpart. This might put them in higher risk of getting HIV than never married people despite of lower proportional of married people who are practicing high risk sex, this might be one reason for high HIV infection among married people in Tanzania. Mchimbiri (2004) reported that, in Malawi condom use was increasing among unmarried men but had not increased among married men, in fact she found decrease in condom use among married men (Fig.1).



**Fig.1. Proportion of men using condoms by marital status and year of survey: source. *Social Science & Medicine*: 6(5): March 2007: p.1102-1115.**

Knowledge of condoms is very high in Tanzania with 92 percent of women and 96 percent of men who had ever had sex knew about condoms (TDHS 2004-5), albeit there were differences on ability to obtain them based on the geographical locations, urban dwellers with higher possibility of obtaining them compared to rural dwellers. 80.5% of never married women and 79.7% of married women knew sources of obtaining condoms, while 89.4% and 90.5% of never married men and married men respectively knew about sources of obtaining condoms (TRCHS 1999, cited in TDHS 2004-5, p. 38). This data excludes knowledge of sources of condoms as the reason for difference on condom use between married and never married people in Tanzania; it is possible that there are other reasons that need to be unveiled.

Another study by Ukwuani et al (2003) indicates that, condom use was more common among women (but not men) who lived in clusters where HIV/AIDS testing, counseling, and treatment were provided. The researchers found that although education improved condom use, but knowledge on HIV and risk perception of acquiring HIV

infection were more associated with use of condoms. The result of this study suggests that individual HIV risk perception is a better determinant of condom use than knowledge HIV/AIDS in general, and on where to obtain condoms, this in fact concurs with previous result that shows almost the same level of awareness on where to obtain condoms between married and unmarried people in Tanzania.

While exploring level of acceptability of condoms in married life, the result from TDHS (2004-5) indicated that, 74.6% of married women agreed that woman could propose use of condom if husband has STI, while 84.6% of married men believed that woman could propose use of condom if her husband has STI. It was reported that many women supported proposition of condom use when husband confirmed to have STI than if he has confirmed having extramarital love affair. (TRCHS 1999, cited in Garbus 2004, p.44) These findings indicated the level of acceptability of condoms use within marriage and how it can be useful to prevent HIV among married couple considering the fact that a healthy looking person can have HIV and only 14% of Tanzanians know their HIV status (THIS 2003-4).

#### **4.1.2 Extramarital sexual relationships**

Extra marital sexual activities and concurrent sex multiple partners had been associated with explosion of the epidemic in Sub Sahara Africa, much so in Southern and eastern African countries (Halpein and Epstein 2004). Latif et al. reported that:

Seventy-five married men found to be positive for HIV-1 in Harare, Zimbabwe, were interviewed in order to define behaviors associated with acquisition of infection and to determine factors associated with transmission of infection to their wives. The majority of infected men reported sexual intercourse with multiple heterosexual partners and female prostitutes, and gave a history of sexually transmitted diseases. (Latif et al. 1989, p.4)

In Tanzania the epidemic among couples can be associated with concurrent multiple sexual partners. Seven percent and eleven percent of married women and men respectively had had two or more partners in the year prior to the study, including their partners (TRCHS 1999, cited in Garbus 2004, p. 44). The same study showed that men tend to have had more partners compared to women by twenty-five and twenty-nine percentages for unmarried and married men respectively. Analysis of Mwanza cohort study's data revealed up to 40% of married men had had extra marital sexual relationship; only 3% of married women had had extra marital sexual relationships (Garbus 2004). This big difference between men and women on numbers of sexual partners from community based study can be attributed partly by over reporting of men and under reporting of women on their sexual partners, a situation that has been reported from other similar studies (Nnko et al. 2004), but suffice here to give reliable picture on the situation.

Many factors can be associated with this high rate of concurrent multiple sexual partners in Tanzania like poverty, gender, religious and traditional beliefs, peer pressure, desire to have children (Boerma et al. 2002). Others are: high mobility among urban, rural, and mining areas, much of this movement is dominated by men, in eastern and southern Africa it has been facilitated by a well-developed infrastructure for

transportation that has stimulated economic growth. Recent retrenchment associated with structural adjustment measures, which has often pushed young men out of rural areas to urban areas where there are more economic opportunities (ILO 1997: cited in Garbus 2004, p.12). Migrant labors separate men from their families, place them in close proximity to 'high-risk' sexual networks, and may result in having increased number of sexual contacts. Concurrently, it may also lead to women's reliance on sex to supplement their incomes while their male partners are away for long period of time and do not give enough economic support back home (POLICY project 2001).

#### **4.1.3 Polygamy**

Africa has the highest rate of polygamy in the world; Polygamy in Africa gets support from some religions (Traditional religions and Islam), which allow polygamous marriages. Africa is profoundly and incurably a believer, religions form fabrics of individuals and cultural lives (wikipedia 2008).

According to TDHS (2004-5) the percent of women who are in polygamous union is 25% and that of men is 10%, a decrease from 29% for women and 15% for men from 1996 TDHS report. Women of age 45-49 were found to have highest rate of being in polygamous unions than that teenagers with 38% and 22% respectively; In general, polygamy showed close association with duration of marriage, hence older women compared to younger ones were more likely to be in polygamous unions (Garbus 2004).

The highest level of polygamous unions was found in the Southern highlands zone, were not by coincidence HIV prevalence is the highest in Tanzania, with prevalence of 13.4% and 13.5% for Iringa and Mbeya respectively, which is about twice of the national HIV prevalence (7%). None educated women reported to be more likely in polygamous union with 39%, than educated ones who had completed primary education 22% (THIS 2003-2004).

Women in polygamous unions showed higher rates of HIV prevalence of ten percent than married women who were not in polygamous union with seven percent (TACAIDS, NBS&USAID 2005). THIS (2003-4) showed that those who were in marital union at the time of the survey had seven and eight percent prevalence rate for women and men respectively. In Kenya the prevalence among polygamous marriages was 17.9% compared to 10.1% of the monogamous marriages (KDHS 2003).

Polygamy and extra-marital sexual relationships both expose a man or woman to concurrent multiple sexual partners. While extra-marital sex is informal, immoral and literally not accepted form of concurrent multiple sexual relationships, polygamy is morally and legally accepted form of concurrent multiple sexual relationships disguised as marriage. It should me remembered that concurrent multiple sexual partners had been associated with explosion of epidemic in sub-Sahara Africa, and many researches had confirmed high prevalence of HIV among people in polygamous union too.

#### **4.1.4 Sexual Violence**

Sexual violence is widely exercised in Tanzanian community especially among married people and some time is accepted as normal and way of teaching women discipline and cordoned by some religious leaders (Mbwambo 2001). Researchers from Muhimbili

University College of Health Sciences in Dar es Salaam and Johns Hopkins University revealed that HIV-positive women, compared to HIV-negative women were 2.7 times more likely to have uncounted episodes of violence from a current partners, this indicated strong association between HIV- status of women and violence of their husbands (Garbus 2004).

About 30 percent of women who participated reported at least one episode of physical violence like, punching, slapping and arm-twisting within three months prior to the study. The study found that, young HIV-positive women (ages 18-29) were ten times more likely to report violence from their husband than HIV-negative women of their age, the study also found that over a quarter of the women interviewed confessed that violence was a big problem in their lives (Garbus 2004).

The above findings that confirm a link between HIV serostatus of women and partner's violence can be explained by two way phenomena: first, HIV positive man partner who knows his serostatus, tends to be violent hence infect his partner during non consented sex that is likely to result into bruises, second, most violent men tend to have multiple sexual partners, to be excessive drinkers, careless, reckless and negligence and therefore ending up having sex with multiple partners without using condoms, factors that make them more susceptible to HIV infections (Dunkle et al. 2004).

## **4.2 Programmatic factors**

These are factors that are not under control of individuals rather are determined by government system and country policy, for example: political will, prevention and control programs, health care system and social support (Guilhem 2005).

### **4.2.1 Prevention and control programs**

Since the beginning of the epidemic, preventive programs targeted specific high risk groups, like, youth in school and higher learning institutions, youth out of schools, people with multiple partners and sex workers, drugs substance abusers, and for people living with HIV/AIDS (NPHA 2001). These groups were considered to be at high risk and therefore special IEC materials and other campaigns were designed according to their specific needs (TACAIDS 2005). People in marriage were not considered to be among high risk groups hence there were no plans in place to address their specific needs, like couple counseling before wedlock, discordant couple counseling, condom use within marriage, and IEC with specific messages that target married people. While addressing the AIDS conference at Rome in December 2006, a UNAIDS senior adviser, Karen Stannecki said that; married women were more likely to become infected than unmarried women in Asia and much more in Sub Sahara Africa, she emphasized a need for change on preventive approaches to pay more attention to married women (Catholic news service 2006).

The National policy on HIV (2001) has suggested amendment of penal code for criminalization of those who deliberately infect others. This measure is intended to control deliberate (a person knows s/he is HIV positive and decide to have unprotected sex without informing a partner) transmission of HIV by irresponsible people in Tanzania, like man who marries other women after deaths of his wives due to AIDS

while he is aware of his HIV positive status and possibly is on ARVs treatment, without prior informing his new partners, this is a common phenomena in Tanzania (Authors experience). This amendment is on process, when passed and implemented effectively is expected to reduce infections among married people as well, because women who are forcefully inherited and cleaned together with those partners who suspect danger of getting infections from their partners, may have legal protection. This amendment also is expected to punish those irresponsible people who infect others deliberately, hence increase people's responsibility especially men to their wives (authors opinions).

National policy on HIV/AIDS states that all HIV testing should be voluntary unless stated otherwise (NPHA 2001). Some religion dominations impose compulsory testing and disclosure to its followers before wedlock to control pre-marital infections, this practice is getting stiff opposition from human rights and HIV activists groups condemning it of violation of human rights, while government opposes based on it's HIV policy of Voluntary counseling and testing.

With current trend of HIV infections within marriage, which directly leads to the increase in number of orphans and children born with HIV, early consensus that puts these facts into consideration among these groups is of paramount important if the battle against the scourge has to be won.

### **4.3 Health care service utilization factors**

Utilization of health facilities is an important factor not only for treatment and care for people with AIDS, but also plays a crucial role on HIV prevention. ARVs reduce infectivity power of a person with HIV, and early diagnosis and treatment of STIs has been confirmed to reduce both susceptible and infectivity of HIV up to three folds (NPHA 2001). Hospitals, clinics and dispensaries can be used for rising awareness and distributions of condoms and IEC materials.

#### **4.3.1 Sexual Transmitted Infections**

STIs and HIV have mutual and synergistic relationship; they do enhance each other in both susceptibility and disease progression. HIV as an entry point can use presence of ulcers caused by STIs. The study showed that ulcers of genital parts due to STI could be used as an entry and exit points by HIV, hence increase HIV susceptibility and infectivity up to 50% (White et al. 2008). On the other hand Plasma level of viruses has been directly or indirectly linked with STD through altering the cytokine milieu, which in turn may both increase infectivity of HIV-1 and disease progression. HIV-1 infection destroy immune system, hence it increases susceptibility to other STIs and increases the severity of some infections and possibly reducing the response to treatment as well (Garbus 2004). Study done in Mwanza, Tanzania showed that, effective treatment of STIs resulted in decline in HIV incidence up to 40% (Plummer 1998).

Surveillance done among pregnant women attended antenatal clinic (ANC) in 2002 indicated that, overall 12.4 percent of ANC attendees were co infected with HIV and syphilis, 86 percent of them were married, among those co infected 89 percent lived in an urban area, 60 percent were ages 25-34 (URT 2001-3). This high rate of both HIV and STIs among married pregnant women not only signifies unsafe sex practices, but also



is an indication of low utilization of health care services among married people especially women.

The reasons behind for low utilization of health care facilities among married women might be due to less control over decision making when it comes to issue related to their health, like, use of condoms, and when and where to go for health care service when they fall sick, this is catalyzed by lack of economic power which compels them to request money from their husbands when they want to go to dispensary or Hospital. The study in Uganda found that many women were afraid to access HIV/AIDS services for fear of being physically assaulted or threatened by their husbands or partners (Human right watch 2003), therefore scaling up early diagnosis and correct treatment of STIs among couples can have dramatic and long lasting effect on spreading of HIV among married people in Tanzania.

#### **4.3.2 Discordant couples**

According to THIS (2003-4), 8 percent (62,720) of HIV positive couples in Tanzania are discordant. In a report of the research done in 1995 by Grosskurth (cited in Garbus 2004, p.33) indicated that discordant couples are at the highest risk of infecting each other. The study found that, 96.7 percent of couples who participated were concordant-negative (both were HIV negative) at the beginning of the study, 0.9 percent were confirmed to be concordant-positive (both partners were HIV positive) at the beginning of the study, 1.2 percent were confirmed to be discordant with the male partner being HIV-positive, and another 1.2 percent were discordant with the female partner being HIV-positive at the beginning of the study. After three months of close follow up it was found that, Individuals living with HIV-positive partners were more likely to be HIV-positive (women: OR: 75.7, 95% CI: 33.4-172; men: OR: 62.4, CI: 28.5-137). The rates of sero conversion among discordant couples were 10 per 100 person-years (py) and 5 per 100 py for women and men respectively, (RR: 2.0, CI: 0.28-22.1). sero conversion among concordant-negative couples were far less, 0.17 per 100 py and 0.45 per 100 py in women and men respectively (RR: 0.38, CI: 0.12-1.04).

The same study unveiled that individuals living in discordant relationship are at greater risk of infection compared with individuals in concordant-negative couples (RR: 57.9, CI: 12.0-244 for women; RR: 11.0, CI: 1.2-47.5 for men). This result indicated that men were more likely than women to introduce HIV infection in concordant-negative partnerships. In discordant couples, incidence in HIV-negative women was twice as high as in men (Garbus 2004).

It was reported earlier that in Sub-Sahara Africa, infection within marriage largely is due to, either premarital infection or infidelity within marriage (Maharaj 2005). Information that distinguishes clearly attributable fraction of each, would indicate how much of the infections within marriages are due to premarital infections and if premarital testing would be of any benefit considering the fact that many couples have had unprotected sexual relationship before getting into the unions (Authors thoughts). But from the above statistics on condom use which show low condom use among married people compared to never married people, it might be inferred that intra marital attributable fraction on HIV infection among couples is greater than that of premarital

infections, but still there is a need for prospective cohort study to ascertain percentages contributed by each.

It is worth to repeat here that, is not yet established epidemiologically what is the proportion of discordant couples is due to premarital infections and that due to intra-marital infections. Programs that target to identify discordant couples and prevent infections among them need to have this information in order to choose most effective and efficiency approaches. This information is also important for religious leaders who do HIV testing to their followers before wed locking to know if is of any merit, lastly to the government if should think of mandatory testing policy before marriage policy.

### **4.3.3 Antiretroviral Therapy**

Antiretroviral therapy (ART) is a treatment using Antiretroviral (ARV) drugs to treat AIDS, it's goal is to reduce amount of Viruses in the blood (Viral load) and to increase number of CD4 that protect against opportunistic diseases so as to improve and prolong life. ARVs can also reduce chances of both vertical and horizontal infections, and therefore has special role to play on prevention HIV transmission among couples.

It was estimated that, there were about 440,000 AIDS patients who were in need of ARVs by the end of 2005 in Tanzania, initial government target was to provide free ARVs to 220,000 (50%) to meet "3 by 5" targets, later the target was reduced to 44,000 patients. Only 19,600 were receiving free ARVs by November 2005 (URT 2005). Recent figures showed by the end of 2007 between 80,000 to 120,000 patients were receiving ARVs ( ).

According to URT (2005), insufficient entry points like VCT services, PMTCT and TB and sexually transmitted infections services due to high cost might be among the reasons for failure to reach targets, treatment literacy among health sector employees and community is still low and stigma and discrimination against people with HIV and AIDS is rampant.

PMTCT-plus is an initiative that was introduced in order to extend PMTCT services to the family level; plus means including mother and "father" in care and treatment. The aim of this initiative is to keep parents health and alive so that they take care of their baby, this would in the long run reduce number of orphans and infants mortality, because the death of mother has confirmed to have direct effects on child survival (CHG 2004).

PMTCT-plus provides ARVs treatments to the mother as well after the dose that was intended to prevent transmission to a baby; it also gives counseling and psychosocial supports to the father as well. Increased coverage of PMTCT- plus would mean increase in number of couples on ARVs in Tanzania. There are number of reasons that might result to low up take of this service in Tanzania. Even where service is available women may not make full use of it due to "cascade effect", that means: client use of service, at initial contacts, goes to counseling, testing, collecting results, starting treatment, and receiving infants treatment and counseling, this cascade decreases in intensity at each step of the processes (CHG 2004).

Other barriers that prevent ARVs up take among married people in Tanzania are; denial of HIV infections, male partners' opposition, stigma associated with HIV/AIDS, women's fear of disclosure, lack of awareness on ARVs among couples, especially on

PMTCT, concern about taking drugs during pregnancy, and fear of being found out if taking drugs (THIS 2003-4; CHG 2004; TDHS 2004-5).

#### **4.4 Gender**

Gender and HIV infections has been studied and documented extensively around the global, and nearly all studies have shown strong relationship between gender in equality and HIV/AIDS susceptibility and vulnerability (UNAIDS 2002-3, Sa and Larsen 2007). More than 61% of people living with HIV in sub-Saharan Africa are women and young girls (UNAIDS&WHO 2006). Women and girls have relative risk of up to four times compared to that of men and boys counterpart (PAHO 2007). Gender has been reported to contribute on dynamics of HIV incidence within marriage, a retrospective study done in Moshi, Tanzania, to examine multiple dimension of gender in equality on increased women's risk of getting HIV using, Economic, social and physical factors as forms of exposure, indicated that a woman is at higher risk of getting infected if her partner is older than 10 years, economic contribution of her partner to support children is very low, and she experienced coerced first sex before the age of 18 years (Sa and Larsen 2007). All these factors seem to play significant role in HIV transmission within marriage in Tanzania because of cross generation marriages, poverty which renders men economically less capable to support families and wide spread of violence against women as described below.

The report indicated that, majority of women are powerless, they don't have power to negotiate safer sex with their husbands or partners because of sub ordinate nature of women, they are denied of their basic human rights like education, economic opportunities, health care, and lack on decision on issues related to sexuality.

Discrimination and violence against women put them at high risk of being infected by HIV compared to men (UNFPA 2004). Polygamous union is a good example of low status of women and gender inequality, many women would not like to be in polygamous marriage, because most men never consult their wives before they get married to new wives (author's experience), but they are compelled to accept because of poverty, cultural/traditional and religious values, lack of education and social/economic empowerment, these factors individually or in combinations contribute to marital norms that discriminate and oppress women and render them susceptible and vulnerable to HIV and AIDS (Mshana M et al, 1998).

Many women lack autonomy with regard to decision making on HIV testing. Male and female informants frequently referred to the need for women to "seek permission" from partners prior to HIV testing, and if tested they are obliged to disclose the results to their husbands. Men, however, generally made the decision to test on their own without soliciting prior consent and are not obliged to disclose the results to their wives (Mbwambo 2001).

UNDP measures gender inequality by using the unweighted average of three component indices: life expectancy, education, and income, It uses Gender-related Development Index (GDI) scale to measure gender in equality, Gender Empowerment measure (GEM) scale to measure level of women empowerment which indicates active participation of women in economic and political life, it tracks gender disparity in income earning, percentage of senior officials and managers posts and share of parliament seats

held by women, these are indication of economic independence. Values for both scale range from 0 (lowest value) to 1 (highest value). UNDP calculated Tanzania's GDI value at 0.467 for 2004, ranking it 62 out of 156 countries for which UNDP calculated a GDI, and it ranked Tanzania 44th out of 93 countries in the GEM scale, with a value of 0.597 for 2004 (UNDP 2004).

The Tanzania's ranks both GDI and GEM reflect how wider the gape of inequality is between men and women. This gender gape is reflected to the skew picture that exists in HIV prevalence, susceptibility and vulnerability between women and men. In Tanzania gender in equality is kept widely open by many reasons include, culture, low education, poverty, religions which persistently have rejected the idea of women to become religious leaders (Christian), and support polygamous marriages (Islam and traditional religions), and poor government plans on implementation of women empowerment policy (TAMWA 2006)

## **Chapter 5: The influence of marriage and life within marriage on HIV transmission**

This chapter describes how marriage as an institution, and life within marriage can influence transmission of HIV among married people in Tanzania. It tries to find out whether marriages put couples in low or high risk of getting infections. It intends to give an answer as to what extent marriage as an institution and life within marriage support or hinders couples to fully practicing preventive measures. It should be noted here that marriage varies from tribes to tribes and from religion to religion, so its influence on HIV transmission also is complex.

### **5.1 Marriage**

According to wikipedia marriages is described as: “Marriage typically requires consummation by sexual intercourse, and non-consummation (that is, failure or refusal to engage in sex) may be grounds for an annulment, that contraceptive intercourse does not consummate a marriage”(Wikipedia 2003). This philosophy has been a strong base for many religious leaders to oppose any type of contraceptive method, especially use of condoms among married people (IRIN 2007).

The impact of consummation philosophy within marriage might explain the reason for the low level of contraceptive uptake among couples in Tanzania. While knowledge on contraceptive is above 90% in general population, only about half of married women ever used any contraceptive method out of whom only 10% used condoms, comparing to unmarried women “who are not influenced directly by marriage philosophy of consummation” 58% ever used contraceptive methods out of them 30% used condoms (THIS 2003-4).

A study done by Sleaf (2001) in Tanzania showed that widows or divorced women were three times as likely to be HIV positive compared to those who were single or currently married. This finding shows direct relationship between marriage and becoming HIV positive among women. The fact that unmarried and currently married women had low risk compared to divorced, widows and those women who were married for a long time, it might be inferred that, the longer the women is exposed to marriage life, the higher is the chance of getting HIV infections in Tanzania.

The philosophy that marriage is not complete without unprotected sexual intercourse; it creates loopholes within marriage that can be used by irresponsible partners, “usually men” to infect their partners. These ideas of “ Consummation by unprotected sexual intercourse in combination with gender inequality might act as negative forces on HIV prevention among married people in Tanzania. Despite of preaching on infidelity and abstinence by religious leaders, but still couples do commit adultery as it has been shown previously, consummation philosophy may need different look and amendment to protect rather than pre dispose people to HIV infection in Tanzania (Author’s opinion)

Intrinsically marriages is expected to involve young woman and older man, this age difference in Tanzania goes to the level of trans-generation relationship where by the husband is older than ten years (TAMWA 2006), the younger the woman is, the higher is the chance of being infected if the husband is HIV-positive, this is because her immature

sex organs are not capable to endure well matured and over exposed sexually old man's pressure, it might be easy to get bruises which can be used as an entry point by HIV. Their relative low education and economic dependence make them less likely to negotiate sex (NFPA undated). Prevalence of HIV among married girls aged 13-19 years was found to be twice as much as their unmarried age counterparts (Sleap 2001).

The findings of a study done in Moshi Tanzania showed that older and powerful (physically, socially and economically) HIV infected males are infecting a disproportionate number of younger sexually active women, because either these girls are unable to negotiate safer sexual practices within relationship, such as condom use, because of their sub-ordinate position in the relationship (Sa and Larsen 2007).

Marriage as an institution seem to favor unprotected sexual intercourse through its philosophy of consummation, it also favors trans generations sex "intrinsicly", both these factors put marriage on high risk group, on other hand its principle of fidelity among couples makes marriage to contribute positively on prevention of HIV infections. From statistics that showed only 16 percent of people who interviewed believed in infidelity, and high HIV infections among couples, it can be assumed that, may be infidelity has overpowered fidelity.

## ***5.2 Marriage, widow inheritance and widow cleansing***

Widow inheritance is a common practice in Tanzania like many other countries in the region, widows whose husbands have died, are obliged by customs to be inherited by deceased's brothers, the aim is to keep fully together especially wealth of the deceased should remain within the paternal family, regardless of the causes death or how many wives inheritor has, It might be possible that these persons might have already inherited or have more than one wife. This normaly is done with or without consultation with women to be inherited, in case she refuses to be inherited, can be chased away with her children and loses her rights of possessing properties left by her late husband. This inheritance some time do affect unmarried women too, a man whose wife has died or has become incapacitated due to chronic disease can be given a sister of his late or sick wife to be his new wife and to take care for her sister's children (UNAIDS 2002-3)

This practice of widow inheritance not only violet human and women rights, but also is a good conductor of HIV transmission from deceased person to inheritor and to his wives, or from inheritor to widows because it does not consider testing for HIV prior to inheritance. In a study done among 92 widows from Luo tribe which resides in Tanzania, Kenya, Uganda and Northern Sudan indicated that 47(51%) were already and other 34 (37%) were planning to be inherited, only 2 (2.3%) refused on the basis of HIV prevention (Okeyo & Allen 1994). Recent data shows decrease in tendency of inheriting widows in many communities in Africa, but still remains to be of public health problem in Tanzania (THIS 2003-4).

Widow cleansing is a ritual resembling widow inheritance and normaly they go together, women is required to have a sex with either a village cleanser or relative of her late husband before she is accepted in the society, without which she is thought to be unholy and "disturbed". It is believed that she can cause the whole community to be haunted by evil spirit caused by her husband's death. In many instances woman under go both, before she is inherited, first must be cleaned (Broken Bodies-Broken Dreams

2006). The cleansing sex should not involve condom with which is regarded as not real cleansing, even women who are aware of risk of HIV transmission do obey this ritual practice due to community pressure. In many societies which practice these rituals, normally fear of flouting tradition outweighs fear for HIV/AIDS (Nytimes 2005).

Widow inheritance and widow cleansing largely transmit HIV infection to women, while only one man is involved, “a cleanser” in case of cleansing or “inheritor” for inheritance there are many widows who are involved in both occasions, more over cleanser or inheritor normally have one or more wives who can be infected or infect widows through their husband. Both these two rituals only apply to people who are married; they put them at higher risk of HIV infection than never married people, in other words to avoid HIV infections through these ways a woman should remain unmarried.

### ***5.3 Marriage and Violence***

Violence against women is a global problem, and its prevalence in Tanzania is as high as any other Sub-Sahara African countries, where violence is highest in the world (McCloskey et al. 2005). Studies done in some of the southern African countries has shown that, about 48% of Zambian married women experienced violence from their intimate partners, out of whom 26% reported experiencing violence within the past 12 months prior to the study. In South Africa the situation is more less the same, 10 % of married women reported exposure to violence from their husbands within the past 12 months prior to the study, and 25% reported lifetime exposure (McCloskey et al.2005).

Partners’ violence is very common in some countries in Sub-Sahara Africa that it is accepted as justifiable by around 50% of the women themselves, as researchers from MUCHS (cited in Garbus 2004, pp.38-39) found that, many informants, men and women agreed with some form of violence and accepted that it was fine for husband to slap or whip his wife so long as does not cause permanent physical injury. Violence is of public health problem in Tanzania because places a serious health burden on women and their children, and its role is amplified through its connection to the rising tide of HIV. A study done in Zaire showed that, woman could not ask to use condoms due to fear of violence from her husband, even if she knew that her husband has a sexual relation with another women (Garbus 2004).

Violence against women is very much tolerated by the community especially when occurs within marriage woman cannot refuse to have sex with her husband, and if she does, the husband might beat her and community would not side with her as this is regarded as legitimate punishment (TAMWA 2006). There are some reports of hesitance of government institutions like Police and judiciary institution on handling violence reported by women against their husbands just because they are married (Author’s experience). Marriage creates life within marriages a right place for practicing violence, because it offers protection of some kind for people who practice violence to be tolerated by community, law enforcing institutions and victims themselves. Marriage favors violence that in turn favors HIV infections.

#### **5.4 Early Marriages, sex debut and school dropout**

Many studies have confirmed the relationship between early sexual debut and high HIV prevalence (TDHS 2004-5). Early marriages not only are associated with early sexual debut, but also early school drops out among young girls in Tanzania. Data collected by TAMWA showed strong correlation between early school exit, teenagers' marriages, pregnancy and HIV/AIDS (IRIN 2006). The statistics showed between 20% and 40% of girls were married before reaching adulthood as the result of Tanzania's Marriage law. The report-identified girls as young as 11 years, withdrawn from school to be married off. At this young age scientifically their genital parts are not capable to endure sexual activities without rapture and allow entrance for HIV. Poor girls are motivated by pride of having husbands because unmarried woman is less respected in the community, in Tanzania, unmarried woman is given a cynical nick name "Nungayembe" literally means less respected woman (authors' experience). Parents are attracted by wealth of bride, especially very poor parents who some time use their daughter for getting money, ultimately the young married girls loose control on their sexual lives and put them at higher risk of getting infected (IRIN 2006).

The Tanzania marriage Act 1971 states that:

The minimum marriage age under the Marriage Act 1971 is 18 for males and 15 for females. Courts may permit underage marriage of parties who have reached 14 years of age if specific circumstances make the marriage appear desirable. The Penal Code provides that persons of "African or Asiatic descent" may marry or permit marriage of a girl under 12 years of age in accordance with their custom or religion so long as the marriage is not intended to be consummated before she attains 12 years. The Marriage Act only specifies the free consent of marrying parties for validity, and dispenses with the need for the guardian's consent if the have attained 18 years of age. (URT 2008, p.12)

This Marriage Act 1971 has been receiving criticisms from many human's rights and HIV/AIDS activists who express their concerns on its age claiming that is too old to outlived its usefulness with emerging challenges including that of HIV prevention. Women activists accused government of delaying on making amendments that would result in changing this law of marriage, especially provision that allows girls under 15 years to get married (IRIN 2007).

The influence of marriage on school dropout for young girls raised government concerns, which made the president of Tanzania, His excellence Jakaya Kikwete to address this problem during one of his monthly address to the Nation. He gave data that showed an increase of the number of girls school drop out from 32,469 in the year 2005 to 44,742 in 2006. In his speech confirmed that, those who became pregnant others were as young as 11 years old and he called for immediate solution for this problem (IRIN 2007). From the above discussion it is becoming clearer that, marriage in Tanzania has direct negative influence on education of young girls and early sex debut, this factors have direct link with HIV infection among young women who drop out of the school showed high HIV prevalence than young women who are in the school (Barnett and Whiteside 2007).



## **Chapter 6: Challenges for addressing HIV prevention among married people in Tanzania**

This chapter tries to find out reasons that hamper preventive efforts targeting married people in Tanzania, again should be remembered that all those factors that prevent addressing HIV to the general population also might apply to married people, here only VCT uptake, religion affiliation, HIV risk perception, and attitude towards condom among married people are discussed, because they closely related to an increase of HIV among couples as reported by TACAIDS (2005). Gender in equality is an important factor on addressing HIV within marriage in Tanzania, that deserves also to be discussed under this chapter, but is not included here because has been discussed in the previous chapters.

### ***6.1 Voluntary Counseling and Testing (VCT)***

HIV voluntary counseling and testing has been a corner stone for prevention strategies in many countries, especially those with big burden of HIV infections in Sub Sahara Africa, post test counseling as an essential component of VCT gives education and skills on risk reduction strategies necessary for HIV prevention among adult who are sexually active. VCT can be used as gateway for accessing ART centers for those who are HIV positive and are eligible for treatment (WHO 2004).

In general VCT up take is low with only 14% of Tanzanians adults ages 15-49 have ever tested for HIV at least once in their lifetime (TDHS 2004). Compared to never married and divorced or widows, married women have lower rate of VCT up take despite the fact that they have opportunity and access for testing during ANC visits as it was reported in TDHS (2004) that, percentage of married women who attended ANC and were offered VCT services during period of survey only 11.9% tested and received results, while percentages of never married and Divorced or widows who did test and receive result at the same period were 18.7 and 19.3 respectively. A study done in Kisesa ward in Mwanza Tanzania indicated that, among women who participated in the study and accepted offer of VCT services, 49% never married and another 49% were divorced or separated (Wringe et al. 2008).

This low rate of VCT up take among married women can be explained due to narrow decision space of women that exists within marriage on many issues specifically pertaining with HIV/AIDS. Women in marriage need to ask permissions from their spouses before testing as it was reported in Wringe et al (2008), which showed that VCT up take was higher among women and men whose spouses also had undergone VCT. The fact that majority of couples do not know their sero-status and that of their partners, it might create false believes that they are HIV negative or may have virus, situations that might influence negatively their behaviors on practicing safer sex and hinder their decision on accepting preventive strategies.

### ***6.2 Couples' perceptions on Condom use***

Condom use has been one among important strategy of HIV prevention adopted by government of Tanzania through ABC strategy (NPHA 2001). Though condom is

accepted by large population as an important tool for prevention, its acceptability and uses still very low within marriage. Caryar and Adetunji (2000) report (cited in Maharaj and Cleland 2005) revealed that married people regard condoms as in appropriate within marriage and that it is only for pre-marital and extra marital sexual acts. Reports from many studies show unacceptability of condoms within marriage due to its close associations with promiscuity, unfaithfulness and illicit sexual activities (Maharaj and Cleland; Mchimhiri 2007; Maia 2008).

In Tanzania, acceptability of condom use within marriages is getting stiff opposition from religious leaders as reported by afro news (2008) titled “ Tanzania Church still opposes Condom, Sex education”, it quoted an Anglican church leader urging government of Tanzania to burn all advertisements for condoms condemning them to stimulate and encourage under age sex, infidelity and immorality. Another reason for opposing condom use within marriage is desire for children, normally expectations of couples, their parents, in-laws and society are to see children are born soon after wedding, many young wives are under pressure to bear son (UNFPA undated), condom is perceived to interfere with these expectations and is regarded as intruder within marriage life; also it is implicated with reduction of sexual pleasure by majority of people interviewed (Mchimhiri 2007).

There is a positive sign of condom acceptability among married people in Tanzania as it was noticed during TDHS (2004) study, participants who replied to a question whether people in marriages can use condoms if one has STI, 88.6% women said wife can refuse having sex, while 74.6% said she can propose use of condoms. 92.8% and 84.6% of men agreed that woman can refuse sex and can propose condoms respectively. These responses did not state clearly if also is applicable if a women suspect her husband to have extra marital sexual affairs, because HIV infected person does not necessarily to have STI.

### **6.3 Religion**

Religion is part and parcel of lives of majority of Tanzanians as most of them are followers of different religions; major religions in Tanzania are Christian, Islam, and traditions religion (Wikipedia 2008). For many years has been difference on opinions between religious leaders mainly from Christian and Islam on one hand, and government and HIV/AIDS activists on the other hand, about HIV prevention strategy, specifically on condoms use and sex education in primary school. While government and other HIV activists believe and advocate ABC strategy and sexual education in primary schools as best ways for HIV prevention, religious leaders do support only AB and oppose C and sex education in schools (Afro news 2008).

In Senegal Imams (Muslim’s leaders) were interviewed about their perceptions on HIV infection whether is a punishment from God; they unanimously agreed that it is a punishment from God to those who get it by having sex with some body not married to, albeit they said, God does pardon every one (Ansari 2008). This concept of punishment from God has been one among the causes of stigma associated with HIV/AIDS, non-disclosure for those tested HIV positive and non-use of condoms. Condom use has been a controversial and focus point of discussions during many HIV prevention forums around the world, especially within marriage; opposition from religious leaders to condom use

has been rising concerns, in fact, has been seen as obstacle to HIV prevention efforts (Caldwell 1999).

An Australian political scientist was quoted by Sue valentine saying: “It’s not that people don’t know what to do to prevent HIV/AIDS, but rather that prejudice and stigma, disguised as morality, tradition and religion, prevent societies responding effectively to the epidemic” (Valentine 2004, p.98). Therefore success of any preventive program that targets married people would very much depends on how much the couples are embedded to their religion. Research done in Mwanza Tanzania showed that, people who believe in traditional religions were less likely to utilize VCT services, compared to Muslims, Christians were less likely to accept and use condoms (Wringe 2008).

Married people do commit adultery despite it has been forbidden by religion, and religious leaders continue to emphasize fidelity and oppose condoms despite the fact that they know that people do commit adultery without suggesting alternatives measures for those who disobey religion. These scenarios create gape that allows HIV transmission among married couples. Until when this gape is filled or narrowed religions will continue to be regarded as an obstacle for prevention of HIV in Tanzania.

#### ***6.4 HIV risk perceptions within marriage***

For many years the HIV/AIDS epidemic has been seen as disease of unmarried people and therefore many preventive strategies were focusing to premarital and extra-marital sex infections. Mchimbi (2007) reported that in Malawi, the government policy, programs and community perceptions and statements do associate the use of condoms with sex workers and with infection outside marriage. Because of these, many HIV prevention programs are targeting the so called “high risk groups” and exclude people in marriage. Communities in Sub Sahara Africa regard people in marriage at low risk of getting HIV, and Married people themselves regard HIV as an alien disease (Maharaj and Cleland 2005). Marriage was considered by many people to be protective (Population Brief 2007), hence it is common in Tanzania for people to decide to get married or be advised by parents to get married as soon as possible in order to avoid premarital multiple sexual relationships that can expose them to STIs and HIV infection (Sultana et al. 1990: Author’s experience).

A study done in 2002 on “Vulnerability to HIV/AIDS in married heterosexual people or people in a Common law marriage” reported that majority of married people were believing in their partners, 24% of women who participated in the study said that they trust in their husbands, others were quoted saying that “I see no need of condom, I have one partner”. Though the report showed that sizeable number of women showed concerns on HIV infection, but they relied on love and relationship, they thought that condom is incompatible with marriage (Maia, Guilhem and Freitas 2008).

The result of a study on risk perception in married people showed positive change in people’s perception about marriage and risk of getting HIV infection, participants were asked if they do believe that married people do have sex with their spouses only, the responses were as follows; only 13% women and 16% men agreed with the statement that, married men do have sex only with their wives, and only 16% of all participants believed that married women do have sex with their husbands only (TDHS 2004).

This new perception on risk perception within marriage provides opportunity for addressing HIV within marriages in Tanzania; it provides an entry point for discussion with couples, an important entry point that for many years since the beginning of the epidemic was missing. It appears as if community is realizing that acquisition of HIV is not a matter of which group a person belongs, rather than how she or he behaves. The fact that community accepts the reality that majority of married people do have extra marital sexual relationships is a good sign that might be used as stepping stone for preventive programs that aim married people.

## **Chapter 7: Discussion, conclusions and recommendations**

### **7.0 Discussion**

HIV transmission in Tanzania is changing its direction and infecting more people in marriage. Higher numbers of couple are living with virus than before and more others would be infected in future if current trend of transmission will continue uncontrolled (UNAIDS 2006). Large proportion of couples among people infected with HIV in Tanzania seems to relate with marriage life; that in Tanzania marriage appears to put couple in high risk of HIV infections.

In general there is acceptability of condoms in general population, as effective tool against spread of HIV, its acceptability within marriage is questionable. Clearly there is objection and hesitance in accepting condom use within marriage, neither men nor women are ready to introduce condom topic within marriage life. This resistance of condoms within marriage is the outcome of misconception and stigma associated with HIV/ AIDS. The disease is still regarded as an alien disease, which is not for married people. This concept based on misconception that it is only prostitutes and their clients, and those who are morally deviants are infected, as it has been preached by religious leaders (Ansar 2008), condom use is therefore associated to these groups. Most couples in Tanzania do believe that condoms can prevent from STIs and HIV infections, and are prepared to use condoms when a spouse has symptoms of STI, and definitely if a partner is confirmed to have HIV, but not if partner is suspected to have extramarital relationship which is an proxy indicator for acquiring HIV. Introducing discussion condom use in the marriage regarded as lack of trust, disregard of love to a partner and sign of less commitment in marriage, which is an institution that has been constructed with bricks of love, trust and sacrifice (Mchimbiri 2004), while actually the opposite is true. Unfortunately condom is associated with neither of these and hence is incompatible with marriage, is an intruder within marriage therefore no welcoming ambiance for condom by couples.

Most of the time life within marriage is guided by principles of couple's religion and they are expected to abide and obey these principles and regulations, of which societies judge the couple's success, if couples abide firmly to these principles is regarded as a respected couple and applauded, and couples who do not abide are considered as deviants. By coincidence these religious principles are against condom use and any other form of contraceptive within marriage. This guideline has been used as a scapegoat either by mistake or purposely, for not using condoms even with extra marital sexual relationships. My interpretation of this based on the theory of exclusiveness of sex within marriage is that; the guidelines meant to apply within marriage boundary, in fact it should go hand in hand with fidelity which is a basic marriage principle guideline of religion, these two compliment one another; that without fidelity then prohibition of contraceptive (condoms) should be questionable.

The findings of this thesis have shown that extra marital relationships is not uncommon in Tanzania, and most of Tanzanians are aware including married people, especially married women. The motive behind for couples' involvement in extramarital sexual relationships varies; while women seem to be driven by economic reasons, to supplement and fill gaps which has been left unfilled by their spouses, men are driven

by their sexual desire which is very much backed by masculinity, culture and gender in equality as it was reported by Mchimbiri A (2004). Extramarital sexual relationship (infidelity) is the reason most likely associated with higher HIV transmission among married people in Tanzania compared to pre marital infections. This inference is based on the findings that showed many unmarried people do use condoms when having high risk sex compared to married men and women despite high risk perception of HIV infection among couples (Smith & Watkins 2003, cited in Mchimbiri 2004). Low condom use by married people outside marriage can be explained by fear of being seen buying condoms, which is an indication of intention to commit adultery. This fear which creates barrier for acquisition of condoms among married people, mainly affects couples in rural areas, since in the villages where people live as one family, married person feels shy to buy condoms from shopkeeper or a health worker who is close relative, afraid of gossip because condoms is associated with unmarried people and extra-marital sex.

It is also possible that low use of condoms within marriage, makes couples uneasy and less skillful on how to use it, this makes it uncomfortable for them to use condoms even outside marriages where there is high risk of STIs and HIV infections. Although there is a sign of married couple to accept condom use especially in extra-marital relationships (TDHS 2004-5), There is nor sign for condom to be accepted and used within marriage, which is proxy indicator for use of condom any where.

Early marriage is very common in Tanzania (Garbus 2004), and it has been wrongfully understood by some parents that is protective against HIV, hence some parents has been arranging early marriage for their daughters to be married to older men, possibly to polygamous marriage for fear that girls would have relationships with multiple boy friends who are considered to be at high risk because are not married while the opposite is true, older men who have been exposed to multiple sexual relationships for long time with many multiple sexual partners are likely to have HIV infections than young boys who have recently started having sexual relationships, most likely have encountered less number of sexual partners (Path, undated). In Tanzania early marriage is common practice in rural areas compared to urban, but many programs that address early marriage are concentrating in urban areas (TAMWA, 2006)

Polygamy has been sensitive and controversial topic, simply because it is backed by some religions. Evidence from findings have indicated direct link between polygamy and HIV infections in Tanzania. Polygamous people being at higher risk of HIV infections than general population is not an coincidence, since there is triple risk of getting HIV among polygamous people; first like any other person who is married in Tanzania is at high risk, second like any person who is having multiple concurrent sexual partners which has higher risk than the previous one, and third because sex in polygamy marriage is non protective, therefore polygamy predispose a person to “unprotected, multiple concurrent sexual relationships”. hence being in polygamous relationships, though legally and morally acceptable in Tanzanian community, does not give any immunity to HIV infections so long as moral and principles of life within marriage as stipulated in religion and culture norms are constantly violated.

Polygamy becomes more dangerous when it is connected to STIs and discordant couples. STIs influence acquisition of HIV, which in turn increase susceptibility of STIs. Polygamous union facilitate this synergistic relation by increasing area of coverage by both infections, while in monogamous union infection is expected to affect one partner

and therefore has limited area of coverage in terms of number of people infected, in polygamous union is expected to be passed to all members of the polygamous union hence has wide spread effect (negative externalities). Polygamy is there for potential union for fast spreading of HIV and STIs in Tanzania that need urgent attention to stop further spread of HIV. Preventive programs that target people in polygamous union are likely to be more cost effective due to its positive spill over effects (positive externality).

Gender in equality and marriage are inseparable in Tanzania and Africa in general. It is very common for marriage to end into divorce as soon as a woman economically and socially becomes stable to resemble that of her spouse or even much better, because men are not comfortable to live with women who are economically and socially sound like men, the reason behind is fear of losing power of exercising dominance power over a woman (Author's opinion). Gender in equality in Tanzania is intuitively accepted within community especially within marriage as indicated by GDI and GEM scales of UNDP. Gender in equality creates conducive environment for sex violence, which from the findings is found to be associated with HIV infections among married people in Tanzania. In a nutshell, marriage might result to gender in equality and gender in equality might result to marriage, these two in combination or individually lead to sex violence, which in turn predisposes couples to HIV infections. In Tanzania efforts to correct gender in equality has been very slow process due to lack of commitment from the government officials (IRIN 2007). This effort are important now, since government and other stakeholders are joining forces together to fight the spread of HIV in Tanzania, a war that is not likely to be won if the gape of gender in equality will remain as wide as now.

Sex violence of any kind has been criminalized in Tanzania under sexual offense Act, 1998 commonly known as Sexual Offense Special Provision Act (SOSPA), under which any person convicted with rape or any type of sexual violence against women and children is suppose to be jailed between 30 years to life sentence. There has been some problems on its implementation, including, non reporting of violence by victims due to stigma associated with rape, and fear of long term imprisonment because many of the culprits are close relative of the victims. Despite of these problems a good number of people had been taken to courts and others convicted and given long-term sentence including lifetime imprisonment. But up to now author does not remember any case reported that involve married people because marriage does tolerate violence and hence it is a good heaven for culprits. Tanzanian community regards any sexual act within marriage is legitimate and there fore there is no sex violence within marriage. Marriage has been used to perpetuate sex violence while community and some times law enforcement organs remain quite and look at it through the window.

The influence of marriage on HIV transmission within couple varies, as a principle, monogamous marriage means one man and one women (The law of marriage Act, 1971), this principle is the same as be faithful (B) in ABC strategy of HIV prevention, question is whether this principle is well implemented and if not what measures are in place to enforce it. On other hand marriage as an institution, opposes any type of protected sex within marriage and intuitively support trans generation marriage, these two factors have been shown to contribute to the spread of HIV within marriage in Tanzania. Being a married woman in some societies where there are customs of widow inheritance and or widow cleansing is a qualification for these harmful rituals in terms of

HIV transmission. Although there is no available data to show how much these rituals contribute to the spreading of HIV within marriage, but based on the way they are carried out, it is obvious that its contribution is substantial.

Therefore despite good intention of marriage philosophy of addressing fidelity within marriage, it lacks proper system of evaluation and enforcement; hence its effect within marriage life is less visible and in fact it is overpowered by infidelity, as it has been revealed in the findings. Marriage in Tanzania supports many of the factors that contribute to the spreading of HIV within marriage.

Most of married women are worried about possibility of getting infections from their husbands and are starting raising their concerns on this; they agree that fidelity within marriage could no longer be guaranteed nowadays. Based on the findings that showed that men are more likely to bring HIV infections within marriage than women (Garbus 2004), their concerns are justifiable and legitimate, but challenge that faces women is how they can speak with their husbands on preventive measures like condom use within marriage. But the fact that there is HIV risk perception among married women, which was identified as very important determinant for condom use (TDHS 2004), is a positive step towards addressing HIV among married people in Tanzania. HIV risk perception among married people is also expected to increase VCT uptake among married couples from the current situation, which is considerably low that imposes big challenge on addressing HIV/AIDS among married people in Tanzania. Unfortunately high-risk perception among married people does not correlate with condom perception within marriage, still majority of married people perceive condoms as in appropriate within marriage, which is a paradoxical situation. This un-matched scenario can be partly contributed by difference on opinions between government and its allies on one side, and religions leaders on other side, this long lasting misunderstanding has been a draw back on addressing HIV prevention not only among married couples, but also in Tanzanian community as well.

## **7.1 Conclusion**

Marriage and life within marriage increase chances of acquiring HIV infections among married people in Tanzania instead of providing protection as expected, but there are opportunities of making marriage a better place for HIV prevention, if reality will be realized, accepted and faced, after all married people are aware about risk perception within marriage and community is realizing some facts about marriage and HIV transmission. Gender in equality, stigma, tradition and prejudice, which are undercover of marriage are socially constructed and malleable. Polygamy extra marital relationships and non-condom use, which are direct cause of transmission within marriage, are dependable factors, that can change if gender in equality; religion and stigma might are addressed. Early marriage, and sex violence are strongly supported by poverty and subordinate nature of women that are associated with HIV transmission in Tanzania. Weak or absence of preventive programs for married people has shown to contribute to high number of STIs among married women in Tanzania that facilitate the spreading of HIV. Religious leaders and are opposing scientifically proven better ways of preventions, therefore are influencing the spreading of HIV in married people in Tanzania.



## **7.2 Recommendation**

Marriage is potentially risky in Tanzania, the government and policy makers in collaboration with other stakeholders including religious leaders need to harmonize their efforts targeting this emerging high-risk group, and to stop doing business as usual;

- There is a need for government and religious leaders to harmonize efforts in order to have coherent message on better ways of protecting married people
- Special programs are needed to be developed that will advocate and promote use of condoms within marriage.
- To rise awareness on risk of HIV infections in polygamous relationships
- New programs to address the problem of infidelity are needed that will target the causes of infidelity.
- New efforts to address gender in equality starting at policy level.
- Marriage should be declared as high risk for HIV transmission, in order to receive special attention like other high-risk groups.

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