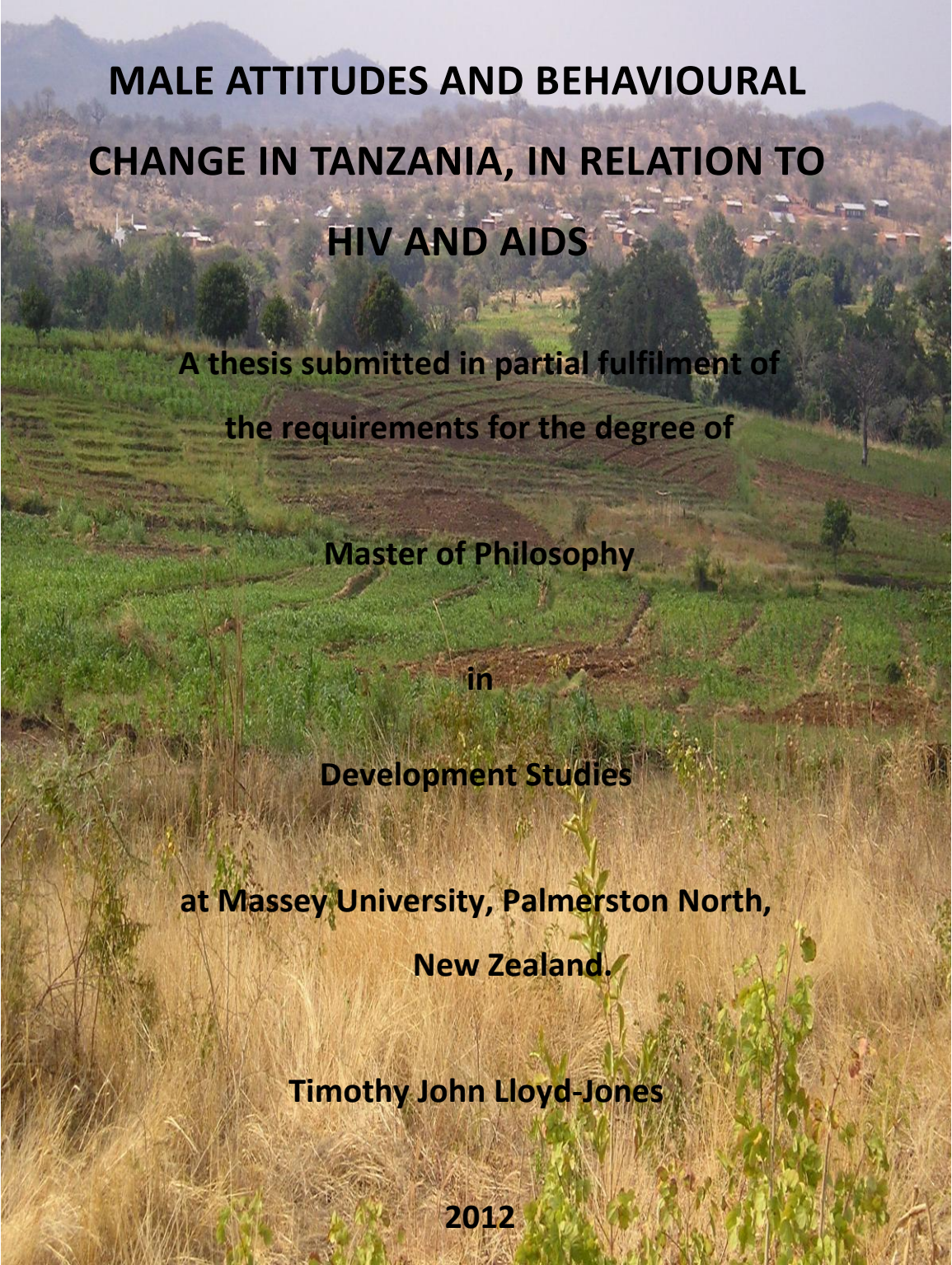


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**MALE ATTITUDES AND BEHAVIOURAL
CHANGE IN TANZANIA, IN RELATION TO
HIV AND AIDS**

**A thesis submitted in partial fulfilment of
the requirements for the degree of**

Master of Philosophy

in

Development Studies

**at Massey University, Palmerston North,
New Zealand.**

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ABSTRACT

Although there has been some encouraging progress towards combating the Human Immunodeficiency Virus (HIV) and the resulting Auto Immune Deficiency Syndrome (AIDS) in recent years, AIDS continues to cause premature death and hardship for many families. Sub-Saharan Africa accounts for 68 percent of the worldwide HIV infections, an estimated 22.5 million people (UNAIDS 2010:2). This thesis examines the relationship between men's attitudes and behaviour in relation to HIV and AIDS. It is important to focus on men in the battle against HIV because men often control women's sexual and reproductive health. Grieg (2005:1) and other commentators believe the socialization of boys and young men to be a major factor in the spread of HIV/AIDS. The ways in which boys and young men are socialised are strongly influenced by prevailing cultural norms.

Fieldwork was carried out in the Iringa region of the United Republic of Tanzania during June 2008. Interviews and focus group discussions were conducted with men of different ages and socio-economic backgrounds. Results showed that culture and influential role models strongly influence men's attitudes and behaviour in relation to HIV and AIDS. This thesis confirms other research for example Silberschmidt (2001), who argued that sub-Saharan Africa is undergoing an identity crisis as changes in society have eroded men's traditional role as hunter and provider. Many men are facing feelings of inadequacy, inferiority, lack of self-esteem and depression. Faced with these feelings of disempowerment,

many men often resort to alcohol and extra-marital relationships, which increase the prevalence of HIV. One of the challenges facing those involved in reducing the spread of HIV is to help men face up to these feelings of inadequacy and develop a healthy lifestyle, despite changing social and economic conditions in 21st century sub-Saharan Africa.

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Tanzania

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ACRONYMS AND ABBREVIATIONS

AIDS	Auto Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
FGM	Female Genital Mutilation
GAD	Gender and Development
HIV	Human Immunodeficiency Virus
KAP	Knowledge, Attitude, Practice
MAP	Men as Partners
MDG	Millennium Development Goal
MTCT	Mother-to-Child Transmission of HIV
MUHEC	Massey University's Human Ethics Committee
NACP	National AIDS Control Programme
NGO	Non-Governmental Organisation
PLA	Participatory Learning and Action
PLWA	People living with HIV/AIDS
PRA	Participatory Rural Appraisal
SADC	Southern African Development Community
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
UN	United Nations
UNAIDS	United Nations Agency for Control and Prevention of AIDS
VCT	Voluntary Counselling and HIV Testing
WHO	World Health Organisation
WID	Women in Development
WFP	World Food Programme

GLOSSARY OF TERMS

Discrimination.	Unfair or bad treatment directed at those that belong to, or are perceived as belonging to, a marginalised group, such as people living with HIV/AIDS. Discrimination reinforces social stereotypes and inequities and, for populations marginalised on more than one basis (for example homosexuals living with AIDS), it has a harmful multiplicative effect. Discrimination based on “race, colour, sex, language, religion, political or other opinion, natural or social origin, property birth or other status” is prohibited under international human rights law (The Universal Declaration of Human Rights, Article 2).
Food insufficiency	The condition of not having a quantity of food available to meet the hunger or nutritional needs of an individual at any time in the past twelve months.
Gender	A social and cultural construct; the widely shared expectations and norms within a society about appropriate male and female behaviour, characteristics, roles and relationships.
HIV	Human Immunodeficiency Virus: a retrovirus that damages the human immune system thus permitting opportunistic infections that eventually cause fatal diseases. The causal agent for AIDS.
HIV prevalence	Total number of persons with HIV infection alive at any given moment in time.
Incidence	An epidemiological term that refers to the number of new cases of a disease occurring in a population during a given period of time, usually a year.
Opportunistic Infections	The many parasitic, bacterial, viral and fungal infections, which are able to cause disease once the immune system has been damaged. These are the most common clinical manifestations that establish the diagnosis of AIDS. They are characterised by an aggressive clinical course, they resist therapy and have a high rate of relapse.

Pandemic	A pandemic is a disease prevalent throughout an entire country, continent or the whole world.
Sexual Risk-Taking	Practices or circumstances that are likely to expose an individual to the risk of HIV transmission through sexual intercourse without a condom with a person infected with HIV. These include having multiple sexual partners, having a relationship with an older and experienced partner (intergenerational relationships) where the younger partner is also likely to lack control over condom use and other aspects of the relationship, and other intimate relationships where the partner, and not the individual, makes decisions regarding sexual matters.
Stigma	A loss of status and the social sanctioning of prejudice, domination and inequity based on membership in a particular group. Stigma arises when a community or authority links social differences to negative stereotypes and categorizes these “others” as different from and inferior to themselves. HIV- related stigma developed out of an early association of AIDS with already marginalized populations- the poor, ethnic minorities, women, homosexuals, sex workers and IV drug users- as well as the association of AIDS with death.
sub-Saharan Africa	This region encompasses the forty-seven countries including the southern African countries.
Vulnerability	The risk of being exposed to HIV infection, including due to social factors and determinants in the external environments, which are beyond an individual’s control. Women and girls are a population group with an elevated vulnerability to HIV infection as a result of unequal gender relations and entrenched gender inequity and sex discrimination.

Source: Carter, I. (2004:56-7) and International HIV/AIDS Alliance (2006:62-5)

Chapter 1: Introduction

The Human Immunodeficiency Virus (HIV) and the resulting Auto Immune Deficiency Syndrome (AIDS), present a challenge to the global community of a magnitude equivalent to a World War.¹ How each member of our world responds to this challenge depends on his or her circumstances, knowledge of the situation and how he or she views their responsibilities as a member of the global society. Certainly, the virus has spread around the planet to the extent that everyone, irrespective of age, ethnicity, or wealth, has the potential to contract HIV.

The Human Immunodeficiency Virus (HIV) is a particularly difficult virus to fight. There are at least three known strains and numerous sub-strains (HIVAIDS Care 2012). It is also mutates rapidly, making developing a vaccine particularly difficult. Although the virus cannot survive long outside of body fluids and is easily killed by simple disinfectants, it is still spreading around the world at an alarming rate. There are a number of reasons for this. Firstly, it is predominantly spread by sexual activity and intravenous drug abuse (UNAIDS 2006). People are naturally shy about discussing these activities. Collecting reliable statistics on aspects such as sexual debut, number of sexual partners, use or non-use of condoms etcetera can be difficult. Researchers sometimes use proxy indicators such as the number of condoms sold, to make an 'educated guess' on condom

¹ It is estimated that since 1981 there have been nearly 30 million AIDS related deaths. (UNAIDS (2010) ['Unite for universal access'](#): Overview brochure on 2011 High Level Meeting on AIDS')

usage. Other statistics have consistently proved to be unreliable for example males tend to over report the number of sexual partners and females tend to under report (Nnko, Boerma, Urassa et al. 2004). However gathering as accurate data as possible is very important to help those who design HIV prevention strategies.

This thesis will explore how the socialization of boys and young men, and men's associated attitudes, affects the spread of HIV. Many commentators believe this to be the root of the problem; the conditioning of men by the norms and cultural practices that surround them (Greig 2005:1). HIV and AIDS are serious development issues, not only for developing nations but also for more developed states. This thesis shows that HIV and AIDS are more than just a health issue. Rather, factors such as gender inequality, migration, drug abuse, certain cultural practices and poverty increase vulnerability to HIV infection. These issues have far-reaching social and economic impacts at household, community and national level. When infected with HIV people's ability to secure sustainable livelihoods is reduced and economic development restricted. This study from Iringa in the Southern Highlands of Tanzania focuses on men's attitudes and the linkages between poverty, culture, socialisation of boys and young men, HIV and AIDS.

In a global comparison, Sub-Saharan Africa is most affected by HIV, accounting for over 60 per cent of all recorded cases (UNAIDS 2010:2). There are various reasons why this region has been so severely affected.

Sub-Saharan Africa has one of the highest levels of poverty, as measured by the Human Development Index (HDI); there are a large number of predominantly male migrant workers and some countries have a history of polygyny (Ntozi and Zirimenya 1999:193). Within the region, it is principally young people between the ages of fifteen and twenty-four which account for new infections (UNICEF 2006). Women, because of physiological differences and gender inequalities, are more at risk than men and young women are disproportionately affected; 75 per cent of HIV- positive fifteen to twenty-five year olds in sub-Saharan Africa are female. However, men play a significant role in the spread of infection, as in sub- Saharan Africa unprotected heterosexual intercourse accounts for the majority HIV infections (UNAIDS 2009:2).

Research aim, questions and objectives

This research aims to further understanding of men's attitudes and behavioural change in relation to HIV and AIDS in a Tanzanian context. Specifically the main research aim is to understand the role men play in the spread of HIV in sub-Saharan Africa.

The research will focus on exploring the links between individual, family, community, cultural, economic and political factors, influencing HIV preventative behaviour. In order to inform the main research aim the research focused on one main question:

What factors influence the attitudes and subsequent behaviour of

Tanzanian men regarding HIV and AIDS?

Governments and NGOs have come to realise that faith plays an important part in the control of HIV/AIDS (Geissler 2006:10). This research aims to explore further the link between faith, HIV and AIDS.

Primary research was conducted with men in Iringa, Tanzania using semi-structured interviews and focus group discussions during a period of two months in 2008. See Chapter 4: The Research Process.

Background to HIV and AIDS in sub-Saharan Africa

Doctors in the USA first became aware of a new and dangerous disease in 1981. Later, doctors named the disease Acquired Immune Deficiency Syndrome (AIDS), because it attacks the immune system and weakens natural defences. However it was not until 1984 that scientists in France and the USA identified the Human Immunodeficiency Virus (HIV), which kills the T-helper cells and eventually leads to AIDS (Whelan 2003:8). It is now known that someone can be infected with HIV for ten or more years before developing AIDS.

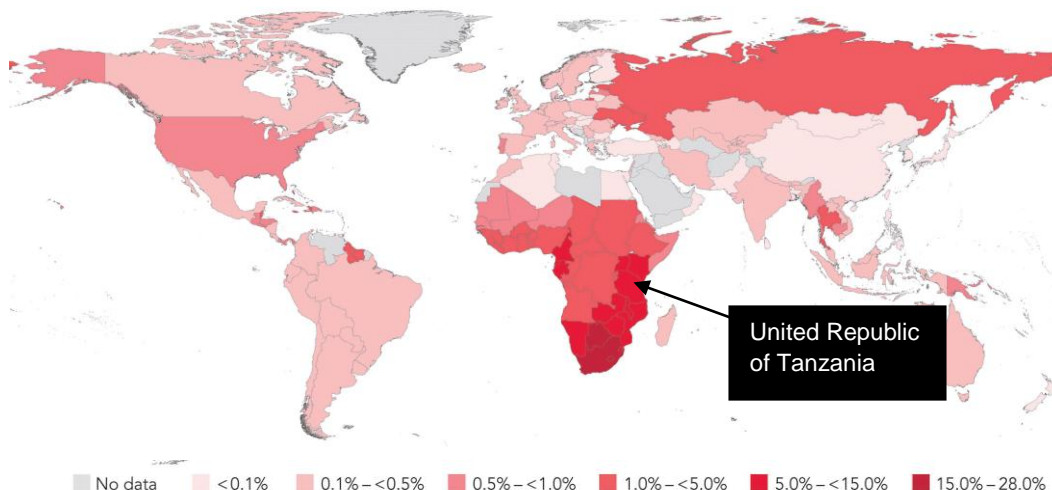
At the same time as HIV and AIDS were identified in the West, the disease was spreading fast in the developing world, especially sub-Saharan Africa. In fact people had been dying for a number of years of a disease they had called 'slims disease', because victims became very thin, before it was identified as AIDS. In the developing world HIV is predominantly spread by heterosexual sex (Hanson-Bourke 2004:12). Although HIV is a global phenomenon, as illustrated by Figure 1 below, shows sub-Saharan Africa is

enduring most of the pandemic.

Figure 1: Map showing distribution of the number of people living with HIV.

2010: A global view of HIV infection

33.3 million people [31.4–35.3 million] living with HIV, 2009



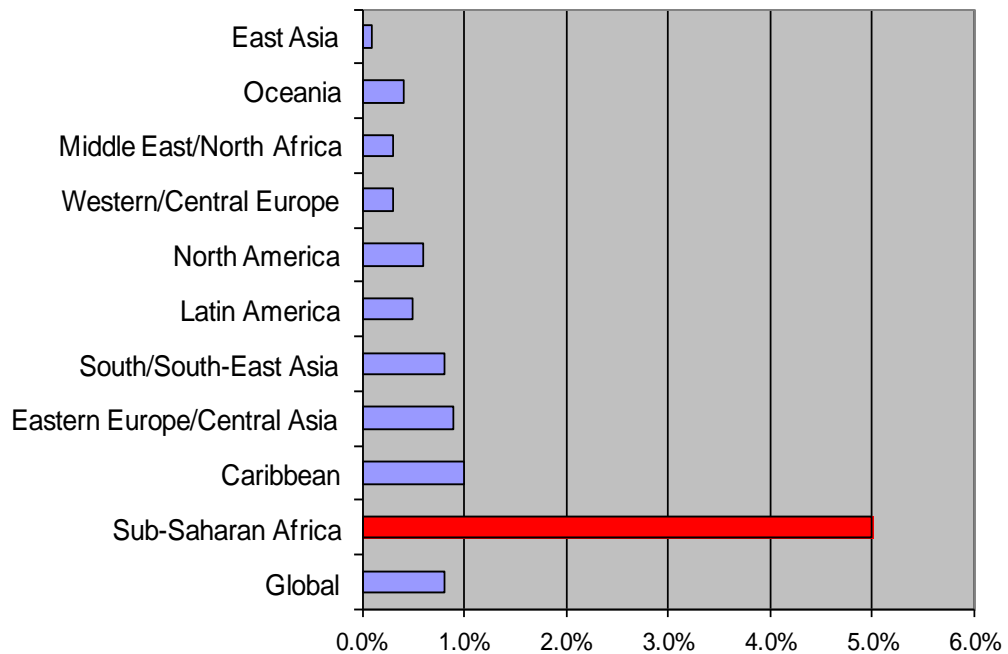
Source: Source UNAIDS Retrieved on 16/10/11 from http://www.unaids.org/documents/20101123_2010_HIV_Prevalence_Map_em.pdf

With only 11 per cent of the world's population, in 2009 sub-Saharan Africa accounted for 68 per cent of those living with HIV/AIDS, an estimated 22.5 million people (UNAIDS 2009:2). Figure 2, graphically illustrates the burden that sub-Saharan Africa carries, compared to other regions. The percentage of adults estimated to be living with HIV/AIDS in sub-Saharan Africa is 5 per cent, compared to other regions, which are close to, or below, 1 per cent.

There are a number of factors, which contribute to sub-Sahara's vulnerability to the disease. The interaction of biological, psychological, social, gender, environmental, economic, political, cultural, ethical, legal,

historical, and spiritual factors all play a part in influencing the spread of HIV/AIDS.

Figure 2: Percentage of Adults estimated to be living with HIV by region, 2009.



Source: Kaiser Family Foundation Retrieved on 06/06/07 from http://www.kff.org/hiv/aids/upload/7391_09.pdf

Development agencies and organisations, both governmental and non-governmental, involved in tackling the disease are becoming increasingly aware of this complexity and how it shapes intervention strategies (UNICEF 2005:5, UNAIDS 2005). Acknowledging this web of interconnectedness means that no single intervention is going to be appropriate for the multiplicity of contexts in which HIV and AIDS present themselves. Multiple and complex links also mean that those individuals and communities affected by HIV and AIDS need a range of different support services, both informal community-based and more formal professional services, to mitigate the impact.

While acknowledging the many diverse contexts and wide-ranging issues involved, it is also recognised by those working in HIV prevention and treatment that those infected with HIV have much in common. Those who are HIV positive commonly express the feelings of disempowerment, stigma, helplessness and rejection (Scambler and Paoli 2008:1850). Due to the stigma and shame surrounding HIV/AIDS, the pandemic has been surrounded by silence and denial. This inability to deal with the pandemic openly has increased the rate of spread. For those who live in sub-Saharan Africa, these issues of stigma, shame and denial, confront individuals, communities and countries daily. Encouraging an atmosphere of openness and honesty in relation to HIV/AIDS is seen as one important strategy in reducing the spread of the virus.

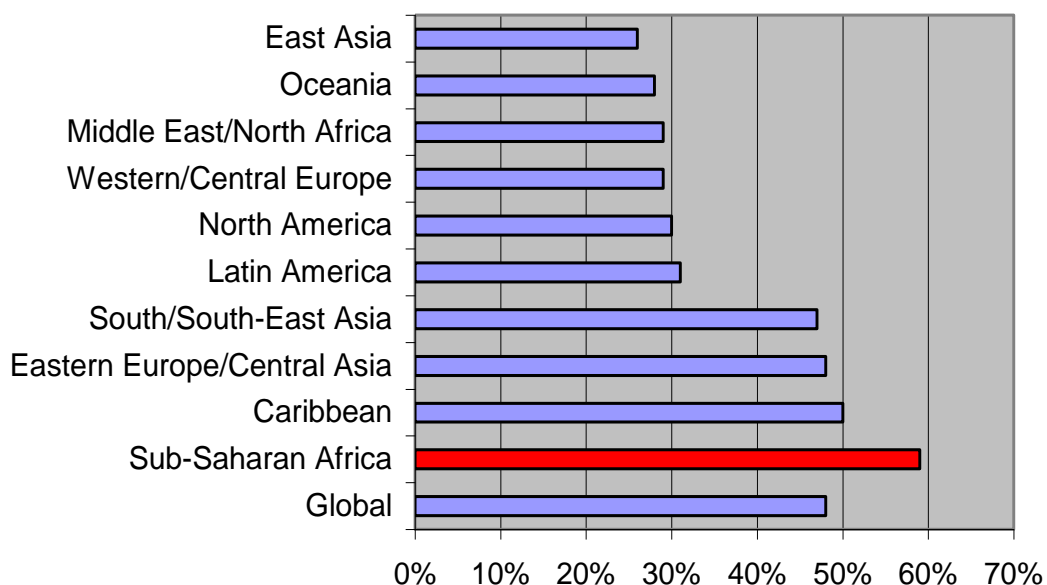
Young people between the ages of fifteen to twenty-four are particularly at risk of HIV. Nearly 10 million men and women aged fifteen to twenty-four are living with HIV in sub-Saharan Africa and half of the 3.4 million new infections per year, occur in this age group (UNICEF 2006:37). Young people are vulnerable for a number of reasons. Adolescence is a time when young people take risks in many aspects of their lives, including sexual relationships. Risk taking at this stage is a product of the development of individual identity and the perception of invulnerability (Mann and Tarantola 1996 cited in Awasubo-Asare 1999:128). Early sexual debut, multiple sexual partners and unprotected sex, increase the risk of contracting HIV/AIDS. It is interesting to note that the median age of reported first sexual intercourse for American high school students and Ugandan men and women were very similar at generally sixteen to

seventeen years (Konde-Lule et al. 1997). Sexual activity amongst adolescents places them at high risk of HIV infection and pregnancy. Other factors that increase the vulnerability of young people to HIV are gender inequity, lack of education and knowledge about HIV, poor access to health services and lack of good peer support. Those young people who have an existing sexually transmitted infection (STI), or inject drugs, or are involved in sex work or are men who have sex with men, are particularly at risk from HIV (UNAIDS 2009:3).

Figure 3 illustrates the number of women as a percentage of adults living with HIV by region. It shows that in sub-Saharan Africa women account for 59 per cent of all people living with HIV. Young women are particularly at risk from HIV for a number of reasons. Physiologically they are more susceptible and although they have a reported lower number of multiple partners, they are at risk from their partners. (Konde-Lule et al. 1997).

One of the reasons that young women have a higher HIV prevalence and incidence than young men is that they are often considerably younger than their sexual partners (Kelly 2003). Young women may find it difficult to have control over when and with whom they have a sexual relationship. For example, Manzini (2001:50) and Buseh (2004:359) found that 10 per cent of young women aged fifteen to nineteen in South Africa and 18 per cent of female secondary school students in Swaziland reported being coerced during their first sexual experience.

Figure 3: Women as percentage of adults living with HIV/AIDS by region, 2009.



Source: Kaiser Family Foundation Retrieved on 06/06/07 from http://www.kff.org/hivaids/upload/7391_09.pdf

HIV and AIDS have caused a catastrophic increase in the number of children who have lost one or both parents. The World Health Organisation (WHO) and UNAIDS, the United Nations agency for HIV and AIDS, estimated that by the end of 2007 the number of children in sub-Saharan Africa orphaned by HIV and AIDS was 11.4 million (UNAIDS/WHO 2007:8). Children orphaned by AIDS are defined as children aged 0-17 years that have lost one or both parents to AIDS. These stark statistics point to the need to identify appropriate interventions for controlling the pandemic. Figure 4 shows children being cared for at a Tanzanian orphanage, the majority of whom would not be there if it were not for the HIV and AIDS pandemic.

Figure 4: Children at a Tanzanian orphanage.



Source: Author

The United Republic of Tanzania has been severely affected by HIV. From a prevalence of 8.8 per cent in 2003, it has now declined slightly to approximately 6 per cent (UNGASS 2010:1). The following section first discusses the general background to the United Republic of Tanzania and looks at the development of HIV and AIDS in Tanzania.

General background to Tanzania

The United Republic of Tanzania is a large country with a land area of 945,000 km² and stretches from the Indian Ocean in the east, to Lake Tanganyika and Lake Nyasa in the west. The country shares borders with eight other countries (see Figure 5).

This means that through various forms of migration there is significant movement of people within the country and across borders, which increases the spread of HIV/AIDS. Total population is approximately 45 million; Dar es Salaam, the largest city, has about 4 million people (World Bank 2012). Approximately 75 per cent of the population live in isolated rural areas with poor infrastructure and are engaged in subsistence agriculture. The main cash crops are coffee, tea, cotton and sisal. Tourism is becoming increasingly important.

Figure 5: Map of United Republic of Tanzania.



Source: 1997 MAGELLAN Geographix <http://www.maps.com/>

Following independence in 1961, the country followed a policy of African socialism under the leadership of President Julius Nyerere (Hyden and Karlstrom 1993). Opposition to Nyerere started to grow in the early 1980s due to worsening economic conditions and after he resigned as president in 1985, the door was open for radical reforms. In 1986, the government embarked on social and economic reforms. Between 1986 and 1992, the Tanzanian shilling was devalued, trade restrictions were lifted, subsidies were removed and public expenditure reduced. These reforms led to a fall in real incomes and for many, a subsequent fall in living standards (Meertens 2000).

Cuts in public expenditure led to a fall in health and education services and Tanzanians were forced to adapt to these changing economic and social conditions. This led to a rise in the number of informal small businesses, as households sought to raise the necessary cash to pay for previously free public services (Tripp 1992). Tanzania continues to struggle to compete in the world export market as most of the population are widely distributed in rural areas that lack adequate communications, health and education facilities. The following section traces the development of HIV and AIDS in Tanzania and the responses of government and non-government institutions.

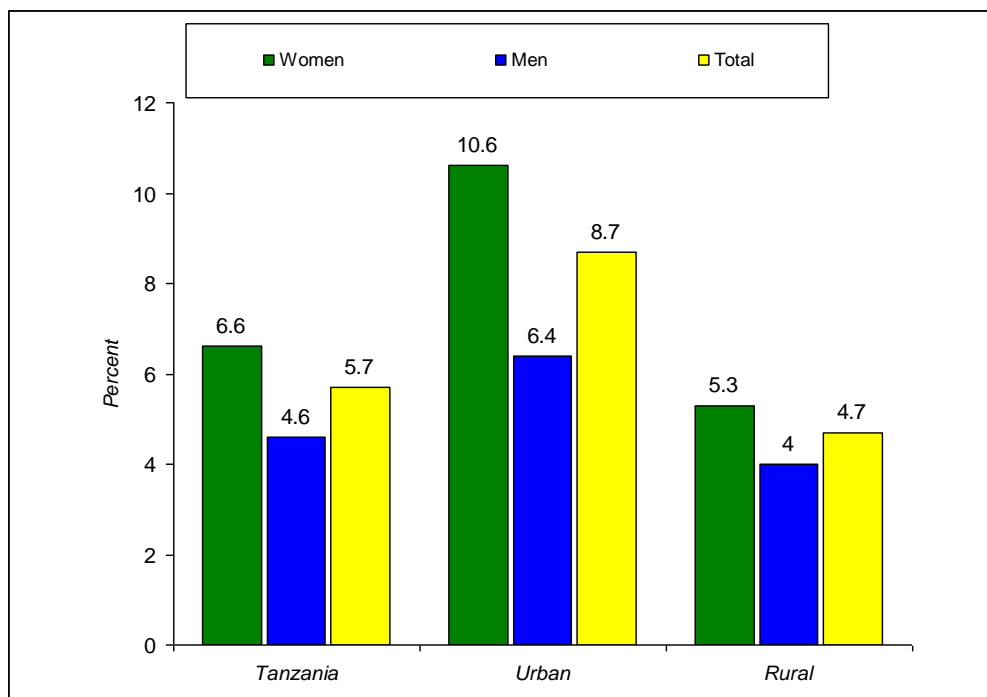
Tanzania, HIV and AIDS

AIDS were first identified in the Kagera region of Tanzania in 1983. (Garbus 2004:1). At the end of 2009 UNAIDS estimated there were 1.4 million people living with HIV in Tanzania. This is a prevalence of 6.5 per cent (see Table 1 on page 32). This compares with Kenya (6.1 per cent) and Uganda (6.7 per cent) and sub-Saharan Africa in total with 5 per cent (UNAIDS 2006). Tanzania's HIV prevalence has declined slightly in recent years. The 2007-2008 Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS), which tested 15,000 men and women for HIV, estimates the general HIV prevalence to have fallen slightly in 2007 – 2008 to 5.7 per cent, with 6.6 per cent for women and 4.6 per cent for men (THMIS 2007-2008).

Figure 6 illustrates the higher HIV prevalence for women in both urban and rural areas. Prevalence in at-risk groups are much higher and women are particularly vulnerable (Pettifor 2005). In Tanzania HIV is mainly spread through heterosexual activity (NACP 2005:5).

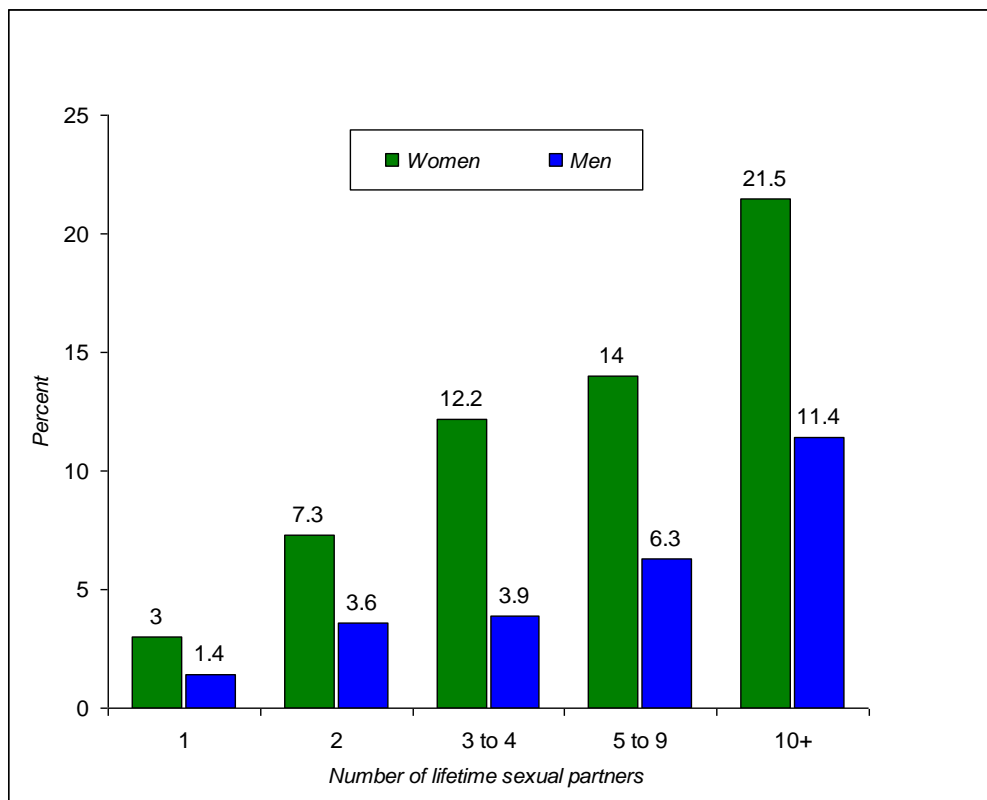
As Figure 7 illustrates, HIV prevalence increases as the number of lifetime sexual partners increases. Men and women with ten or more lifetime sexual partners are seven times as likely to be HIV positive as those with only one lifetime sexual partner.

Figure 6: HIV Prevalence in Tanzania 2007-2008.



Source: THMIS 2007-2008

Figure 7: HIV Prevalence by Lifetime Number of Sexual Partners.



Source: THMIS 2007-2008

Poverty, alcohol and other drug abuse, and certain cultural and traditional practices also, foster the spread of HIV. In some areas of Tanzania the sharing of wives, wife inheritance and 'widow cleansing' rituals are still practised. Widow cleansing often involves the brother-in-law having sexual relations with his brother's widow. Some men also believe that having sex with a virgin will cure them of the disease. Social factors such as gender inequality, transience, loneliness, and sexual violation such as rape, also contribute to the spread of the disease (Parker 2001). Finally, the stigma of HIV and AIDS lead to fear, shame and denial (Alubo 2002). All of the above can be major obstacles in the prevention and treatment of the disease.

The pandemic is having a devastating effect on social, political and economic life. HIV and AIDS are affecting all communities in Tanzania and are exacerbated because most of those with HIV and AIDS are living in poverty and often lack good health, adequate water, food, shelter and education (Klepp 1997). Figure 8 below shows children collecting water from a muddy water hole.

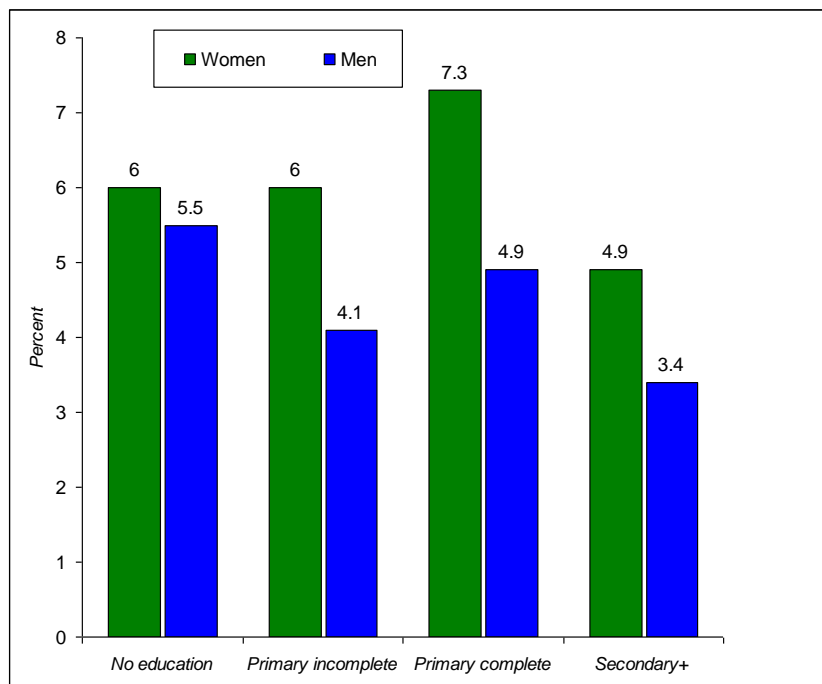
Figure 8: Children collecting water in rural Tanzania



Source: Author

Figure 9 below demonstrates that in Tanzania, HIV prevalence is higher among women and men who have no education or have only completed primary education.

Figure 9: HIV Prevalence by Education in Tanzania.



Source: THMIS 2007-2008

Those living in poverty usually have a low status in society, lack infrastructure and government services. Therefore, it is impossible to address HIV/AIDS without addressing these issues (Garbus 2004). Table 1 on page 32 below, highlights some of the demographic, social and economic indicators of the United Republic of Tanzania in 2006. It describes a large and rapidly growing population, of which almost sixty per cent are living on less than two US dollars per day. In 2006 there were approximately 1.4 million people living with HIV, of which 70 per cent were aged 25 to 49 years old. Table 1 also highlights that 81 per cent of young men (15-24 years) had sex with a casual partner within the last twelve months, compared to 36 per cent of young women, and approximately 10 percent of young people had sex before fifteen. These statistics highlight need for research into men's attitudes towards women and sexual relationships. Figures 6, 7 and 8 show that those who are most at risk from HIV are young women who live in an urban situation, who have more than 10 lifetime sexual partners and who have little or no education.

Tanzania, along with other sub-Saharan countries, suffers heavily from the effects of the HIV pandemic. The Tanzanian government and non-governmental agencies have been actively involved in trying to combat the spread of HIV. Since 1983, the national government has initiated a number of programmes to combat the disease. The main emphasis of these activities has been to promote the increased use of condoms. However, as Bond and Dover (1997) point out, relying entirely on condoms to reduce the spread of HIV is not sufficient. Figures in Table 1

showing just under half of young people aged 15-24 used a condom last time they had sex with a casual partner, is consistent with other research. Although the prevalence for HIV has dropped to 5.7 per cent, reducing it further requires a greater effort on the part of government and communities to address the issues of gender inequality, the socialization of young men and ingrained traditional belief systems (THMIS 2007-2008).

Table 1: Demographic, social and economic indicators for the United Republic of Tanzania, 2009.

DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS		
Estimated Population	43,739,000	
Population Growth Rate	2.9%	
Life expectancy at birth	Men – 57	Women - 59
Human Poverty Index	Rank – 65	Value – 35.8
Human Development Index (HDI)	164	
Percentage of people living with less than US\$2 a day	59.7%	
Per Capita Gross National Income, ppp, Intl dollar rate	US \$ 660	
Per Capita Government Expenditure on health at Intl dollar rate	16	
HIV AND AIDS ESTIMATES		
Number of people living with HIV	1,400,000 [1,300,000 – 1,600,000] ¹	
Adults aged 15 to 49 HIV prevalence	6.5 [5.8 -7.2] %	
Women aged 15 and up living with HIV	710,000 [640,000 – 780,000]	
Deaths due to AIDS	140,000 [110,000-180,000] ²	
Children aged 0 – 14 living with HIV	110,000 [43,000 – 210,000]	
Orphans aged 0 -17 due to AIDS	1,100,000 [910,000- 1, 200,000]	
Percentage of young people aged 15- 24 who correctly identify ways to prevent HIV	Men 49.0%	Women 44.0%
Percentage of young people aged 15 -24 who had sex with a casual partner in the past 12 months	Men 81.0%	Women 36.0%
Percentage of young people aged 15 -24 who had sex before 15	Men 10.7%	Women 10.1%
Percentage of young people aged 15 -24 who had used a condom last time they had sex with a casual partner	Men 47.0%	Women 42.0%

1 Among the 1.4 million people living with HIV/AIDS, 70 percent are 25-49 years old; 15 percent are 15 - 24 years, and 60 percent of new infections occur among youth aged 15-24 years.

2 Although 140 000 deaths were attributed to HIV/AIDS in 2009, it is estimated that only one in five cases are actually reported, grossly understating the extent of the pandemic.

Source: UNAIDS website Tanzania.

<http://www.unaids.org/en/dataanalysis/epidemiology/epidemiologicalfactsheets/>

The main coordinating authorities for combating HIV are the Tanzania AIDS Commission (TACAIDS) and the Zanzibar AIDS Commission. Local and international funds are managed through the Tanzanian National Coordinating Mechanism and multisectoral AIDS committees have been established at district, council and village levels, supported by Regional Facilitating Agencies. Some villages have formed local by-laws to reduce high-risk sexual behaviour, for example public meetings, celebrations and weddings are to finish before dark. Mwaluko et al. (2003) note that these interventions have been insufficient to restrict the spread of HIV/AIDS and that more intensive control efforts are needed. United Nations (UN) support has been streamlined by establishing a joint UN team on AIDS, which is responsible for developing a joint programme of support and joint budget of pooled resources (UNAIDS 2007).

The Tanzanian national government has demonstrated political commitment at the highest level. In June 2006, the First Lady of Tanzania launched an in-school and out-of-school HIV/AIDS programme, aimed specifically at young people. However, commitment and capacity at the middle levels of government remain weak. There is a shortage of qualified personnel to coordinate and implement effective interventions and to bring about the desired change (UNAIDS 2007). HIV/AIDS awareness amongst the general population is high, but low perception of personal risk, misconceptions and myths continue to be barriers to prevention, treatment and care. Up to now, most interventions in Tanzania have taken a generalized approach and failed to take into account specific cultural or environmental issues. Women, young people, migrants and sex workers

are most at risk, yet their specific needs have largely been ignored and there have been few interventions designed around their specific situations. There is a need for more data on the drivers of the pandemic, to help provide accurate information for more specific interventions, and target high-risk groups. For example, the increasing problem of HIV transmission amongst intravenous drug users in Dar es Salaam and Zanzibar (Garbus 2004:50), has yet to be addressed.

Tanzania has ratified its commitment to provide universal access to antiretroviral therapy and support those living with HIV and AIDS. However, the government still lacks the capacity to implement this, especially in the more remote rural areas, where health services are often limited. In 2006, the UN placed twenty-two volunteers to help strengthen health capacity at the district and community level (UNAIDS 2007). The Joint UN team also helped plan the programming and implementation of the Annual Action Plan for 2007, as well as develop the second version of the National HIV/AIDS Multisectoral Strategic Framework on the Mainland for 2008-2012 and facilitate the mid-term evaluation of the Zanzibar HIV/AIDS Multisectoral Strategic Plan (UNAIDS 2007). According to the 2007-2008 Tanzania HIV and Malaria Indicator Survey (THMIS) HIV prevalence in Tanzania have dropped from 8.1 per cent in 1995, to 5.7 per cent in 2007-2008 (THMIS 2007-2008). Within the country, Iringa region is the worst affected, with infection levels ranging from 10 to 25 per cent, with a mean prevalence of 15.7 per cent (THMIS 2007-2008). This high prevalence in the Iringa region highlights the importance of this study

project.

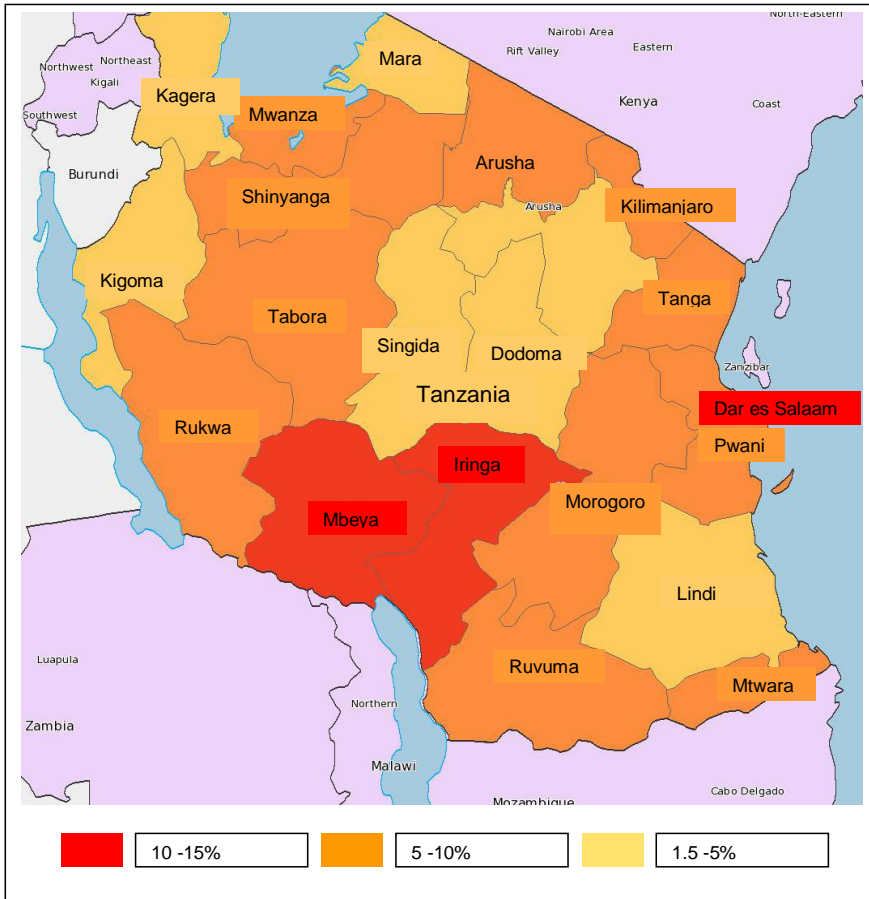
Iringa region, HIV and AIDS

The Iringa region extends over an area of 57,000 square km, with a 2005 population of approximately 1.5 million, resulting in a mean density of 27 people per square km (Tanzania in Figures 2006:19). The Iringa region is an important agricultural area, producing tea, coffee, maize, potatoes and beans. The tea estates in Mufundi and Njombe districts (within Iringa region) employ a large number of migrant workers. The busy main trunk route from Dar es Salaam to Malawi, Zambia and Democratic Republic of Congo traverses Iringa region (see Figure 5). Large numbers of long distance lorry drivers, migrant workers and traders, many of whom have casual sexual encounters, exacerbate the spread of HIV. Figure 10 shows the prevalence of HIV by region in Tanzania for women and men aged 15 to 49, based on 2004 data. Iringa, Mbeya and Dar es Salaam have the highest prevalence at 10 to 15 per cent. Iringa region has the highest HIV prevalence in Tanzania, with 15.7 per cent of women and men aged 15 to 49 HIV positive (THMIS 2007-2008).

Since the early 1980s, people's understanding of the virus and its impact on individuals and societies has improved. For those living with HIV and have access to Antiretroviral Therapy (ART), their life expectancy has increased. Yet, the impact of ART on sexual risk behaviour and transmission is still unknown. An initial study conducted in Uganda concludes that integrated ART and prevention programmes reduce sexual

risk taking behaviour and can reduce HIV incidence (Bunnell et al. 2006).

Figure 10: Percentage of women and men in Tanzania aged 15-49 who are HIV-positive, by region.



Source: HIV/AIDS Mapper Retrieved on 17/10/2009 at <http://www.hivmapper.com>

These integrated programmes included prevention counselling and proactive testing of sexual partners. There is evidence that voluntary counselling and testing (VCT) of HIV discordant couples dramatically increases the use of condoms, from less than 3 per cent, to greater than 80 per cent (Allen et al. 2003). Discordant couples are couples where one partner is HIV positive and one partner is HIV negative. However, there is still much to be done in bringing about the transformation in societal

norms surrounding gender equity and sexual behaviour that is at the root of HIV transmission in sub-Saharan Africa.

Structure of thesis

After briefly looking at the background to HIV and AIDS, with particular reference to Tanzania, this thesis goes on to trace how development approaches to HIV and AIDS have changed since HIV was first identified in 1984, in Chapter 2. Chapter 2 explores the way in which an individual's HIV preventative behaviour is influenced by different factors, such as individual, family, community, economic and political issues. This chapter then looks at issues such as how people acquire information about sexuality and reproduction, helping people to make informed decisions and in what ways this acquired information and knowledge can change sexual behaviour. Secondly, Chapter 2 investigates what factors and interventions lead to changes in attitude, positive behavioural change and reduced HIV infections, with a particular focus on men in the Iringa region of Tanzania. A comparative study conducted in 2002 between two sites in Uganda (Masaka and Rakai) and one in Tanzania (Mwanza), showed interventions promoting reducing sexual partners significantly reduced HIV infections (Low-Beer 2004) and this chapter explores how peer pressure and cultural expectations affect the number of sexual partners. The chapter also looks at issues such as developing social skills, gender roles and access to services. HIV and AIDS must be seen as part of these wider issues. It also explores how communities and faith-based organisations play a part in reducing the spread of the virus and how these organisations can create a greater awareness of the problem and reduce

the stigma attached to the disease. It will be explained how communities can reinforce positive changes in individual behaviour.

Chapter 3 explores how changing circumstances in sub-Saharan Africa have influenced men's role in society and their self-esteem. Silberschmidt (2001), Morrell (2007) and other authors explored how men's role as the main 'breadwinner' has been threatened by structural changes since European colonisation and how this has undermined men's self-esteem and forced many men to migrate away from home in search of employment. The result is that many men throughout sub-Saharan Africa are struggling to redefine their role and may resort to extra marital affairs in an effort to restore their self-esteem. Reaching these men and helping them regain their identity in gender equitable ways is seen by many as one of the keys to reducing HIV transmission (Barker 2000:3). More recently, much greater interest is being shown in incorporating men into gender development initiatives in an effort to reduce the vulnerability of both men and women.

Chapter 4, entitled The Research Process, first addresses how HIV and AIDS research has changed to integrate the understanding that HIV interventions need to incorporate the cultural traditions and sensitivities of the target group. HIV and AIDS research has generally applied holistic approaches, including both quantitative and qualitative data. This study seeks to address Tanzanian men's attitudes and behaviour towards HIV and AIDS. Therefore, in dealing with a sensitive topic and including young

men, the research process adopted an in-depth approach by applying qualitative methods. Two groups of men were interviewed, one from a local university in Iringa town and one from a rural village, 12 km from Iringa town, using semi-structured interviews and focus group discussions.

Chapter 5 presents the fieldwork data and highlights the young men's concerns about the severity of the HIV pandemic in Tanzania, which they spoke openly about, and what could be done to reduce the incidence of the disease. Two issues emerged in particular, firstly the influence of alcohol and secondly concurrent sexual relationships outside of marriage. Men suggested that schools and churches could take a more active role in equipping young people to deal with issues around HIV and AIDS.

In Chapter 6, the fieldwork data and its implications are discussed in detail, with particular reference to the material presented in Chapters 1, 2 and 3, drawing conclusions from the studies, and making recommendations.

CHAPTER 2: LITERATURE REVIEW ON BEHAVIOURAL CHANGE, HIV and AIDS

Introduction

This chapter seeks to draw upon existing research to determine why, despite increased level of knowledge of HIV and AIDS, men and women persist with sexual risk taking behaviour. Many studies show that HIV and AIDS knowledge and information is insufficient to bring about behaviour change (Bolton and Singer 1992, Carrier 1989, Clatts 1989, Herdt et al. 1991, Parker et al 1991, Schoepf 1992).

Many organisations working in the area of sexual and reproductive health have noted this gap between knowledge, attitudes and behavioural change. Attempting to fill this gap is seen as a priority for those working in the area of HIV prevention (Varga 2001). To become more effective, those involved in HIV prevention and control interventions need to take into account the social, cultural, political and economic factors surrounding sexuality and sexual decision-making. They also need to recognise that not only are people subject to these factors, but people also shape these social norms, to actively manage their own lives and identities (Dilger 2003). Any intervention should attempt to understand these different factors and allow them to determine the appropriate response, seeking to bridge the gap between knowledge and long-term behavioural change.

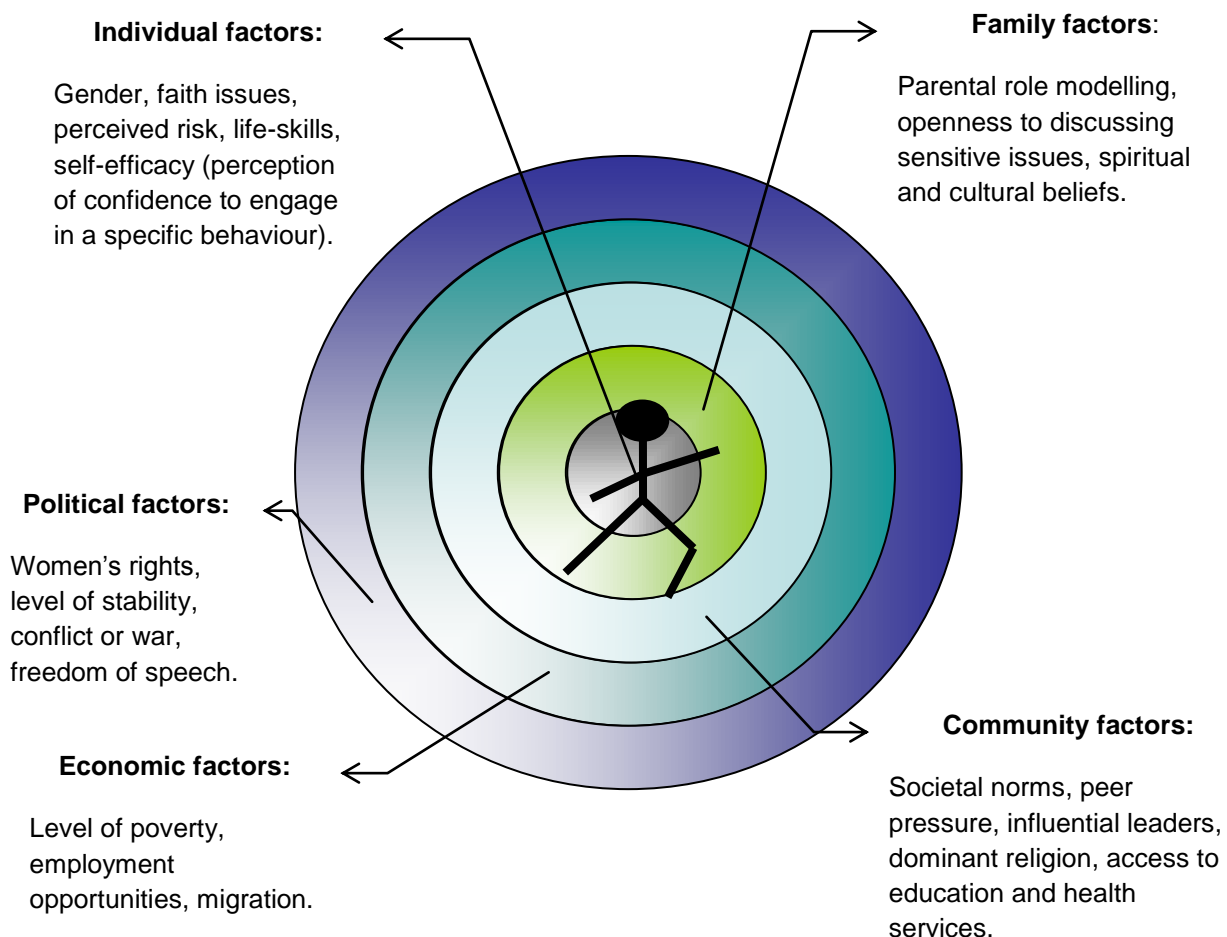
Understanding the means of transmission and methods of preventing the infection are still prerequisites to any risk-reduction behaviour.

Braithwaite and Thomas (2001) in a study focusing on a group of African American and Caribbean college women in the USA, found no significant relationship between HIV and AIDS knowledge and sexual risk taking behaviour, concluding that knowledge was not a direct indicator of behaviour. Furthermore, Mwaluko et al. (2003) conducted a longitudinal study in a rural population in Tanzania between 1994 and 2000. They found despite the continuing spread of HIV there was little change in sexual behaviour, and more than half of the men studied had more than one partner. Mwaluko et al. (2003) concluded that high rates of sexual activity, frequency of unplanned sexual encounters, and perceptions of invulnerability, place young adults at risk. All of these studies show that despite high levels of knowledge about HIV and AIDS, people may still have an inaccurate perception of personal risk. Consequently, understanding perception of risk is essential to promoting risk-reducing behaviour. When people are in denial about their vulnerability to HIV infection, they need to be equipped with the skills to assess and modify their behaviour.

Seeking to bring about behavioural change is a complex issue. People's sexual behaviour is influenced by different individual, social, cultural, economic, spiritual and political factors. The World Health Organisation (WHO 2003) identified several key factors, which might influence the extent to which a person with good knowledge of sexual and reproductive health might fail to change their behaviour. Either these might be individual aspects, or wider social issues (see Figure 11). Individually the person may lack the required life-skills to carry through a desired practice.

Relevant life-skills include dealing with emotions and communication skills, decision making about relationships and sex, dealing with peer pressure to have sex, negotiating safer sex, unhealthy use of alcohol or other drugs, conflict resolution, problem solving and risk avoidance (Wiegiers and Scott 2004:21). Self-esteem affects people’s sexual behaviour and low self-esteem may lead to early sexual initiation (Spencer et al. 2002). Pettifor (2004) and Manzini (2001) highlight that adolescents who have early sexual activity are more likely to have multiple partners and are less likely to use condoms.

Figure 11: Diagram of factors influencing HIV preventative behaviour.



Source: Adapted from HIV/AIDS: The Society for the Scientific Study of Sexuality p.1.
Retrieved on 25/10/07 at <http://www.sexscience.org>

Figure 11 demonstrates that a person is subject to individual, family, community, economic and political factors, which may decrease or increase the risks of HIV transmission. For example, people caught in an environment of political instability, war and conflict may be subjected to sexual violence (Henttonen et al. 2008:122). Likewise, a person living in poverty may be tempted to engage in commercial sex to provide an income (Scambler and Paoli 2008:1848). Figure 11 highlights that people are subject to wider cultural and socio-economic factors that influence risk-taking behaviour. Parker and others suggest that more emphasis needs to be placed on the strong cultural, socio-economic and political factors that influence individual HIV preventive behaviour (Parker 2001:167). HIV preventive programmes need to consider these wider factors when planning interventions (Shahmanesh 2008:661).

The United Nations General Assembly Special Session on HIV and AIDS held in 2011 (UNGASS on HIV/AIDS) identified a number of targets relating to HIV and AIDS. They are firstly, that by 2015 there will be a reduction in sexual transmission of HIV by 50 per cent. Secondly, that policies and programmes that reduce young people's vulnerability to HIV are developed and that by 2015 overall HIV prevalence in young people is reduced by 25 per cent (UNAIDS 2012). However, progress towards these goals is very patchy. Although most people have heard about HIV and AIDS, there are still many widespread misconceptions on how HIV is spread and how it can be avoided.

In relation to the main thesis objective, which is to understand better men's role in the spread of HIV in Tanzania, it becomes important to look closely at the different spheres of influence on boys and men.

The next section traces the influence different development theories have had on approaches to HIV and AIDS policies and programmes.

Development approaches to HIV and AIDS

During the last twenty-nine years since AIDS was first identified, there have been considerable changes in approaches to dealing with the disease. Initially prevention programmes were strongly influenced by modernisation theories of development. The prevailing thought was that science and technology would solve all human social ills and inequalities. A belief in science had a dominating effect on successive development thinking for the next two centuries and still influences development policies in the twenty-first century.

Modernisation

Modernisation theory of development, which had a linear and upward path, with Africa and Asia as dark and undeveloped traditional societies at one end and learned Europe at the other end (Doherty 1993), other cultures and civilisations, were seen as inferior and backward (Hall 1992). Modernisation did not just concern itself with economic growth; it encompassed geography, social relations and politics. Social scientists too

were interested in modernisation theories; they wanted to try to answer the question as to how developing countries could become modern, industrialised states. They largely concurred that development was as a progression from primitive to advanced. Consequently, initial approaches towards HIV and AIDS were focused on scientific, medical solutions, rather than social approaches and behaviours. Neo-liberalism theories of development followed modernisation theories.

Neo-liberalism

The main characteristic of neo-liberalism, which came in the mid 1970s to the 1980s, was the privatisation of state owned enterprises. Neo-liberalism is susceptible to the same criticisms as modernisation theory; in that it is strongly western and does not allow for local differences. Some western development theorists fail to identify the root causes of underdevelopment in non-western societies, because of this strongly western bias, they believe in a one size fits all. Structural adjustment programmes imposed by the World Bank and the International Monetary Fund (Baylies 2000: 483) started in Tanzania in 1986. The outworking of this was the disbanding of state owned enterprises and the reduction of civil servants. The result was an increase in non-governmental organisations and civil society responding to development issues, including HIV and AIDS (Parkhurst 2001: 81). However, Baylies (2000: 485) argued that the HIV and AIDS pandemic posed such a threat to economic and social development in sub-Saharan Africa that there needs to be a unified response across all sectors, government and non-government, rather than fragmented responses across different institutions. Solutions to development must be contextualised to take into account cultural,

geographical, religious and economic differences (Broham 1995). HIV always presents itself in a very specific context; in a particular individual, surrounded by their own family and peers, in a community that will usually consist of a unique mix of cultures. National and international policies towards HIV and AIDS will also have an effect on an individual's response their situation. The understanding that responses need to take into account an individual's unique situation led to alternative development.

Alternative development

Alternative development is not really a theory, more a collection of complementary ideas and a critique on mainstream modernisation and neo-liberal development (Pieterse 1998:344). Characterised by bottom up, rather than trickle down, indigenous based civil society rather than state, small scale and appropriate technology, alternative development moves beyond economic growth as a model and recognises the limits to growth. Alternative development emphasises indigenous culture and values and adds new perspectives and dimensions to the development debate. It is not entirely divorced from the grand theories; rather it brings new perspectives and shows the powerful role of discourse. It often approaches development from a micro-level rather than a macro-level, for example, individual, family and community, rather than regional and national. Alternative development is a characteristic of post-development, which has a suspicion of grand overarching global solutions and universal applications. Post-development stresses difference, the acceptance of diversity and questions concepts such as 'progress and 'development' (Pieterse 1998:345). Alternative development practitioners promote small

scale, grassroots, locally focused, self help initiatives, which address the requirements of those most in need. Alternative development rejects a 'one size fits all', top down approach and favours participation and empowerment. Robert Chambers promotes participation and empowerment in his book *'Whose Reality Counts?: Putting the First Last'*, where he focuses on the poor and criticises development economists (Chambers 1997). Broham (1996) writes that alternative development is a 'broader more flexible vision of development, capable of addressing diverse Third World realities'. The move away from grand overarching theories of development, to a local participatory approach, has had an influence on HIV prevention and control. For example rather than practitioners saying 'You need to do this...' they might say something like 'We acknowledge that HIV and AIDS are a problem in your community, what do you think can be done to reduce this problem?' This approach empowers people to make decisions that are culturally appropriate for their particular situation. Lately a rights based approach to development and health care has come to the forefront.

Rights based response to HIV and AIDS

The International Cairo Conference on Population and Development in 1994 (ICPD 1994), initiated the term 'sexual and reproductive health and rights' (SRHR). The preface of the World Health Organisation's constitution states that 'the highest attainable level of health is the fundamental right of every human being' (WHO 2010). According to Simms (2011:233) it was the 'HIV and AIDS crises that clarified the connection between rights and health'. However, Simms (2011:234) goes on to argue that a rights based

approach to health care faltered in the 1990's when the Global Programme on AIDS (GAP) was replaced by the UN Programme on HIV and AIDS (UNAIDS) in 1996. The major donor for UNAIDS was the World Bank, which was primarily controlled by the USA. Simms (2011:234) asserts that the World Bank failed to realise the significance of the growing HIV pandemic and consequently failed to allocate sufficient resources towards HIV prevention and treatment. Lately the WHO has regained its influence in health care and instigated a more rights based approach which emphasises 'respect, protection and fulfilment of human rights' (Simms 2011:235).

According to Barroso and Sippel (2011:250) there is much to be gained by integrating SRHR and HIV and AIDS prevention and treatment. Firstly, clients are able to receive a wide range services at the same time. For example essential health services, such as pregnancy and childbirth care, family planning, can be combined with prevention and treatment of sexually transmitted infections, including HIV (United Nations Population Fund, 1994). Secondly, it can help to destigmatise HIV. People who are HIV positive are often marginalised and experience discrimination (Barroso and Sippel 2011:253). Overall a rights based approach to health care has gained considerable favour amongst development practitioners and intuitions in recent years. This should help achieve the WHO objective of the highest level of health for every human being (WHO 2010).

The following section looks at different theories of behavioural change

and how they have been applied to HIV and AIDS.

Theories of behavioural change and individual factors relating to HIV

Initially the major theories relating to behavioural change that were applied to HIV and AIDS were Eurocentric, top down and emphasised a single solution for everyone approach. For example the Theory of Reasoned Action (Fishbein et al 1994, Vandlandingham et al. 1995), the Health Belief Model (Rosenstock 1974) and the AIDS Risk Reduction Model (Polacsek et al. 1999, Schnell et al. 1996), have been used to guide HIV prevention programmes. The focus was on individual behavioural change, rather than taking into account cultural, economic, spiritual and political factors that influence sexual behaviour.

Rosenstock and Kegels developed the Health Belief Model in the 1950s and 1960s (Rosenstock 1974), to explain change and maintenance of health-related behaviour, once an evaluation of personal vulnerability and perceived severity of an illness was taken into account. According to Janz et al. (2002), a person will make efforts to modify behaviour when they regard the illness as a serious threat. After acknowledging the severity, a person must also believe that the options to reduce the risk of illness are feasible. This model includes variables that test what prompts people to engage in healthy behaviour (i.e. demographics, structural variables, and socio-psychological factors). This model also attempts to explain health-

related behaviours, especially in regards to HIV. The Health Belief Model comprises six key components: perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action and self-efficacy. Within the Health Belief Model each component is based on subjective perceptions because the theory hypothesizes that all action is directly associated with individual thought processes. However, people live within a society that has interdependent processes. Individual behaviour is strongly related to societal factors, for example sexual norms, peer pressure and social support. The Health Belief Model proposes that a change in one's beliefs about health may cause a change in one's health behaviours.

A number of studies have been conducted to measure the effectiveness of the Health Belief Model. For example, Steers et al. (1996) showed in a study on African Americans in the USA during the 1990s that perceived susceptibility, self-efficacy, and social support were the most important predictors of sexual behaviour change. However, none of the variables significantly predicted behaviour change for African Americans. Winfield and Whaley (2002), conducted a study amongst African American college students in the USA to predict condom use. The authors found that the only significant predictor of condom use was perceived barriers, such as fear of rejection, reduced sexual pleasure and inconvenience. Wulfert and Wan (1995) in a study in the USA, also found that the only significant variables in condom use were perceived benefits and perceived barriers of prevention behaviours. This means that although someone maybe aware of the health risks of unprotected sex, this in itself may be not enough to

cause a change in behaviour.

The *AIDS Risk Reduction Model* is a stage model of harm reduction that has been used to understand the social and psychological determinants of condom usage (Polacsek et al. 1999, Schnell et al. 1996). It comprises Stage 1, identification and labelling one's behaviour as risky; Stage 2, commitment to behaviour change; and Stage 3, actual change in behaviour (Burkholder et al. 1999, Catania et al. 1994). This theory proposes that the motivation to change to safe behaviour comes from the presence of a risk factor and the individual's perceived risk. Braithwaite and Thomas (2001:123) state that 'in order to reduce the spread of HIV, there must be belief that there is actual risk, and that this risk necessitates a change in behaviour'. Perception of HIV and AIDS risk can be related to various stereotypes that people create about people with HIV and AIDS. Catania et al. (1993) found that respondents, who held strong stereotypic beliefs, were less likely to label their own sexual behaviour as risky for HIV infection. An individual may not label one's behaviour as risky if HIV and AIDS are only associated with specific groups, for example injecting drug users, commercial sex workers, homosexuals. This stereotypic interpretation of HIV and AIDS risk minimizes the individual's assessment of possible infection. This may lead people to believe that unprotected sex is not a risk.

Whilst the *Health Belief Model* and the *AIDS Risk Reduction Model* provide

some useful constructs in predicting HIV prevention behaviour, their usefulness is restricted, due to their emphasis on individual behaviour over social and cultural factors, such as beliefs about normative behaviour within the cultural setting and role modelling behavioural change. These theories emphasise equipping people with knowledge about HIV and AIDS, in the hope that increased knowledge will lead to a change in sexual behaviour. However, studies consistently found that although knowledge about the causes, consequences, and methods of prevention of HIV infection are important, it is not enough in itself to stimulate change in behaviour (Fishbein and Guinan 1996, Kirby 1985, Stiffman et al. 1992). Other studies show that adoption of HIV preventative behaviour is related to both individual and wider social factors. At an individual level, it is related to self-efficacy (for example one's perception of confidence and ability to engage in a specific behaviour). HIV preventative behaviour is also related to belief in the efficacy of preventative behaviours, perceived social norms with respect to preventative behaviour, perceived barriers to the adoption of preventative behaviours and interpersonal communication about condom use with sexual partners (Bandura 1994, Dearing et al. 1994, Rosenstock et al. 1994, Vanlandingham et al. 1995). These findings suggest that for HIV prevention programmes to be more successful they not only need to take into account individual factors, but also include cultural, economic, spiritual and political factors.

There are a number of other models of behavioural change that are also applicable to HIV prevention. For example *Social Cognitive Theory* (Bandura 1994) emphasizes concepts such as self-efficacy, role modelling

of behavioural change, the consequences of alternative behaviours and beliefs about normative behavioural within a particular cultural setting. Diffusion Theory (Dearing et al. 1994) and Social-Movement Theory (Friedman et al. 1994) emphasize the importance of inter-personal communication, the opinion of trusted leaders, making the change compatible with cultural standards and community mobilization in promoting HIV prevention.

These models of behaviour change are not mutually exclusive and contribute necessary components to HIV prevention. In particular, perception of risk, perceived benefits, perceived barriers and self-efficacy have been shown to be important factors in reducing new HIV infections. However, most theories assume that individuals can be persuaded to change their behaviours, to reduce their risk of HIV infection. Altman (1994) and Bolton and Singer (1992), among others, however have shown that new knowledge and information about perceived HIV risk will be interpreted within the context of the existing culture.

Understanding people's knowledge, beliefs and behaviour related to HIV and AIDS, reveals areas where interventions may best be focused. While most people in sub-Saharan Africa have heard of HIV and AIDS, many people believe themselves not to be at risk. This perception of low risk of contracting HIV may be related to their level of education. Bankole et al. (2004) in their report on youth, HIV and AIDS in sub-Saharan Africa, found

that a young person's ability to avoid HIV is closely linked to education. They found that more highly educated adolescents understood that a healthy looking person could transmit the disease (Bankole et al. 2004). Knowledge of the three-pronged **ABC** strategy for HIV prevention and reduction; **A**bstaining from sexual relations, **B**eing faithful to one partner and protection via **C**ondom use, varies widely in the sub-Saharan region. Uganda, which has promoted the ABC strategy widely and has a high level of HIV and AIDS awareness, has started to see some declines in HIV prevalence (Asimwe-Okiror et al. 1997, Pettifor et al. 2005: 978).

While the factors influencing individuals' behaviour are reasonably apparent, the way in which these factors are translated into individual practice is less clear. In a study with Rwandan youth, Babalola (2002) found that factors relating to sexual abstinence include non-urban residence, younger age, Christian religion, not using alcohol, perceptions about peers' sexual behaviours, self-esteem, perceived self-efficacy to refuse sex with someone known for more than three months, perceived self-efficacy to refuse sex with someone truly loved, and attitudes towards premarital sex. The results of this Rwandan study helps those involved in HIV prevention understand what factors can help young people abstain from pre-marital sex, which in turn reduced their number of sexual partners and the associated increased risk of contracting HIV.

Those working in the area of sexual and reproductive health aim to

educate people about high-risk behaviours, or a particular 'risk set', which put them at risk of unwanted pregnancy and contracting STIs. There are a number of risk behaviours that can lead to increased possibility of risk of HIV infection. These risks include multiple sexual partners, needle sharing, alcohol and other drug use, and inconsistent condom usage. However, these risk sets are often explained to people only in scientific terms, and contextual, cultural, moral and other factors are largely ignored. Villarruel et al. (1998) conducted a qualitative study examining the HIV and AIDS knowledge, beliefs, and sexual behaviours of adolescents and adolescent peer educators in an urban environment. Adolescents stated the following reasons for engaging in sexual risk behaviours: blind faith in one's sexual partner, feelings of insecurity, feelings of dependency, and ineffective communication patterns. The female participants also stated that men have a tendency to have multiple partners.

Trust also influences sexual behaviour. A study conducted by Duncan et al. (2002) with thirty African American college students in the USA, found that negative views of condoms and trust issues interfere with their ability to engage in safer sex. It is interesting to note that trust was defined differently based on gender. Men related trust to whether they felt their partner appeared to be in good health, whereas, women perceived trust to mean that their partners were monogamous. In both instances, trust was based on an assumption that involved no communication. Therefore, perceived risk, perceived barriers about condoms, lack of communication and perceptions of trust influence an individual's sexual behaviour and

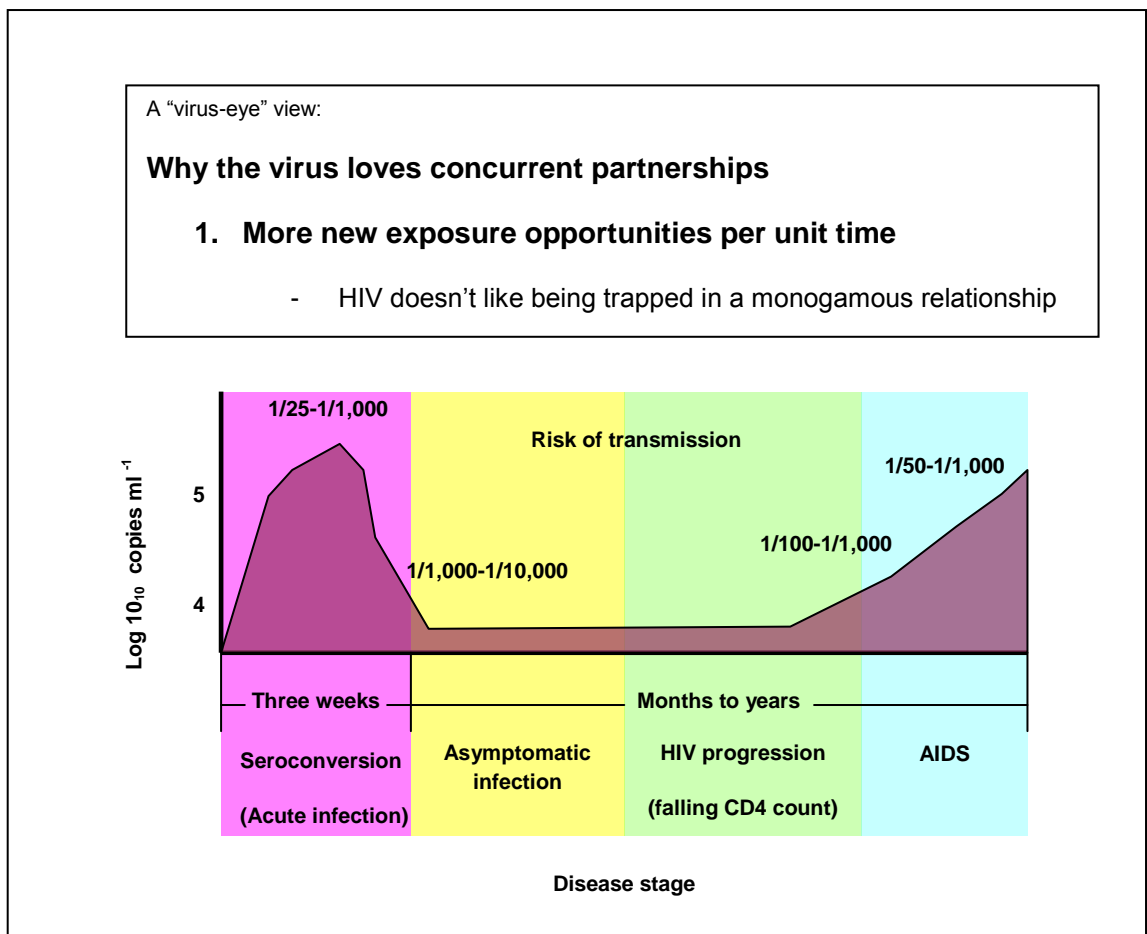
their ability to engage in safe sexual practices (Duncan et al. 2002).

Research shows that understandings of sexual risk are not simply adopted as they are taught (Mize 2002). Rather, as they are absorbed, they are modified to create group and individual understandings on the subject of sexual risk. People may have a good knowledge of HIV and how the virus is transmitted, but can still be involved in high-risk activities. Those working in the area of behavioural change describe this process as 'externalisation' (LeClerc-Madalla 2002). Recipients have yet to 'internalise' the risks, to the point where their behaviour is modified. That is to say, that AIDS is perceived as something that happens to others. An example of this is where people perceive AIDS to be a disease resulting from morality and lifestyle choices, such as transactional sex or drug abuse (Campbell 2003). Externalisation of risk is a key obstacle to effective behaviour change. If people cannot acknowledge the potential risks in their own situation, then they will assume that the information disseminated will not be relevant to their own context. This often leads to sexual decisions being made by using subjective risk criteria, such as a sexual partner's reputation, physical appearance, personal hygiene and family background (Varga 2001).

Additionally because HIV has a long period of asymptotology (the inability to see the symptoms), researchers found that there was no concern about the virus and people may continue in high risk sexual

relationships, unaware of the potential risk of contracting HIV (Villarruel et al. 1998). Figure 12 illustrates the varying rate of transmission of HIV over time, indicating the highest rate of transmission efficiency is in the seroconversion stage, within the first three to four weeks after infection. During this stage, a person may have a raised temperature and flu like symptoms, but otherwise appear healthy. In the second and third stages, the asymptomatic stages, which usually extend over a period of years, HIV progresses but the transmission efficiency is low. In the final stage, when symptoms of AIDS are displayed, transmission efficiency increases again (Galvin and Cohen 2004).

Figure 12: Transmission efficiency of HIV over time.



Source: (Galvin and Cohen 2004)

Understanding the link between perception of risk and traditional values and beliefs is important for HIV prevention. It is important to understand how information and education become adapted and evolve. LeClerc-Madalla (2002) observed that HIV interventions must incorporate people's own perceptions of the risks they face in everyday life to become more effective. It may be that people are aware of the risk of contracting HIV, but do not prioritise their sexual health. They might not see HIV as a threat to them personally. Research has shown that some people take a fatalistic approach to HIV (Kaufmann 2002, Gillespie 2006, LeClerc-Madalla 2002). This fatalistic approach to life HIV and AIDS may be expressed in a number of ways. Some may believe death is unavoidable, destined by God and always close. Some people believe that mosquitoes or witchcraft causes HIV and AIDS, and that nothing can be done to stop it.

If someone has poor self-esteem and limited employment opportunities, they may be less inclined to protect their sexual and reproductive health. Where life is hard and uncertain, people may try to take refuge in drink and drugs. They may feel that sexual activity is one of the few pleasures they are able to enjoy. In this way, sexual risk needs to be understood in the wider context of an individual's perspective on life (LeClerc-Madlala 1997, Swart-Kruger and Richter 1997, Varga and Makubalo 1996). Intervention programmes that take into account people's wider circumstances are more likely to succeed in reducing HIV prevalence.

Most intervention programmes have focused on promotion of safer sexual

behaviour, largely relying on promoting the increased use of condoms. There is no doubt that condoms provide a high level of protection against HIV, when correctly used. However, research has shown that relying entirely on condoms to prevent HIV transmission is not sufficient (Bond and Dover 1997). In 1993 Uganda had an adult infection rate of 15 per cent, the highest in the world at that time (UNAIDS 2001). Uganda boldly embarked on a countrywide programme of truthfulness towards HIV and AIDS, led by President Yoweri Museveni. It emphasised sex only within a monogamous, faithful relationship. This, combined with increasing openness about HIV and AIDS at all levels of society, has proved successful in reducing HIV prevalence; in 2006 it had an estimated adult prevalence of 6.7 percent (UNAIDS 2007:17).

Some HIV prevention programmes have been criticised for being based on the assumption that sexual behaviour is based on conscious decision making, by rational individuals (Amuyunzu 1997, Butler et al. 1996). It may be that women, and some men, are coerced into sex, or engage in transactional sex, even though they are aware of the risks (Hewat 2008:152). They may not be able to negotiate risk reduction, or they prioritise other values over risky sexual behaviours, for example the priority of sex without a condom, as a demonstration of 'trust' in a partner or transactional sex as a source of income. Wider social issues that affect sexual behaviour include the effects significant adults have on adolescents, as they shape their values surrounding their sexual and reproductive health.

Family and community factors influencing HIV preventative behaviour

Parents, teachers, religious leaders and health workers have a strong influence on young people and can help support healthy decisions. Young people may encounter a range of competing ideologies from parents, peers and even a range of 'official' information from non-governmental organisations (NGOs), religious organisations and the government. Ultimately, young people filter all this information and develop their own strategy. Sometimes this results in high-risk sexual behaviour that will not safeguard their sexual health. Dixon-Mueller (1993) maintains that the framework for actions taken by an individual will be determined by the culture or society in which that individual lives. Cultural context includes norms regarding sexual partnerships, sexual acts, sexual meaning, sexual drives and enjoyment, and sexual knowledge and awareness. Understanding these norms, helps determine appropriate interventions that lead to positive sexual behaviour change.

Schools can assist young people by teaching them about HIV, AIDS and the life-skills necessary to reduce transmission of HIV. It is while enrolled at school that many young people become involved in sexual activity. However, most teachers are uncomfortable about teaching the subject of sexuality HIV and AIDS. A review of twenty-two varied school-based programmes in developing countries concluded that curriculum-based interventions that focus on specific behaviours that reduce HIV prevalence, such as abstinence, delaying sexual activity, fidelity and use of

condoms, are the most effective strategies in reducing HIV (WHO 2006:107). The South African Ministry of Education has a life-skills programme for schools, which addresses issues such as gender-based violence (Mlamleli et al. 2001). Young people can also be reached with information and life-skills through community groups and peer education. The WHO report (2006) on preventing HIV in young people, recommended using existing youth groups to be the most effective method of reaching young people. Figure 13 shows a group of primary school children in a village in rural Tanzania. Children like these need education and support, to help reduce their risk of contracting HIV.

Figure 13: Primary school children in a village in rural Tanzania.



Source: Author

Stigma, HIV and AIDS

The stigma associated with HIV and AIDS plays an important role in the reactions people have towards the virus and those infected with it. Those living with HIV and AIDS are often stigmatised because the disease is associated with sexual behaviour, and people are also fearful of contracting HIV through normal social contact. Leary and Schreindorfer (1998) argue that 'people are stigmatised when they are viewed as possessing characteristics that constitute a basis for avoiding or excluding them' (Leary and Schreindorfer 1998:15). The basis of social exclusion, with respect to their health, has been categorised by Leary and Schreindorfer into four categories: 1) it poses a threat to others' health and safety, 2) it deviates excessively from group standards, 3) it fails to contribute adequately to society, and 4) it creates negative emotional reactions in others (Leary and Schreindorfer 1998). HIV and AIDS meet all these criteria. According to Satterwhite (2002), HIV and AIDS-related stigma has increased or contributed to lack of control over the disease.

Negative beliefs and stigmatisation have created a foundation of fear, silence and denial. When such feelings are associated with HIV and AIDS, it can cause people to avoid such issues as prevention or protection from infection. Prevention efforts that recommend examination of individual sexual risk behaviours may be met with resistance, because individuals may not perceive themselves to be at risk, based on what they associate with the disease. For example, very few people want to know their HIV status and very few families are willing to attribute a family death openly

to AIDS (Urassa, et al. 2001). This process of stigmatisation causes people to disassociate from all they perceive to be related to HIV and AIDS. This disassociation can unknowingly increase their risk. Burkholder et al. (1999) conducted a study among heterosexual adolescents, which hypothesized a relationship between stigmatizing of people living with HIV and AIDS, and sexual risk behaviours through condom self-efficacy (such as one's perception of confidence and ability to use condoms correctly and consistently). They found that greater stigmatising practice was associated with greater behavioural risk for contracting HIV. In other words, the more people stigmatised others, the lower their condom self-efficacy, which in turn increased their sexual risk behaviours. For that reason, stigmatisation should be addressed, because HIV does not discriminate, everyone is vulnerable. Within African communities, the stigmas that are associated with HIV, contribute to the high infection rates. This stigmatisation of people living with HIV and AIDS can even be present in churches.

The Church, HIV and AIDS

Some churches have been teaching that 'HIV and AIDS is a punishment from God' (UNAIDS 2002-3:4) because the disease is associated with sexual behaviour, promiscuity, adultery or injecting drugs. However, the majority of Christian denominations disagree with this interpretation that HIV and AIDS are a punishment from God. The following quote from an interdenominational meeting held in Nairobi, Kenya in 2003 to discuss how the church can help with HIV and AIDS, gives a much more holistic understanding of the position of churches. Rather than condemning, it

seeks to display God's love and compassion for humankind.

The Christian Church in Africa is in a uniquely key position to address most of the aspects of the HIV/AIDS pandemic. It has extensive reach and its influence filters through most African communities. The church has a massive, yet often untapped, potential to successfully reverse the course of the pandemic. Its core values of love, care, support and justice have produced the nurturing and development of strong Church-run care and support programmes in many communities. At the same time, its promotion of abstinence before marriage and faithfulness in marriage, which can be strengthened, is an essential weapon to reduce HIV/AIDS prevalence and incidence in Africa. But sadly stigmatisation and discrimination still abound within the church, and seriously slow down, and sometimes reverse progress towards preventing and controlling HIV/AIDS (Pan African Christian AIDS Network Symposium on HIV/AIDS, Nairobi, 2003).

An individual's religiosity might play an important role in determining whether that person engages in sexual risk behaviours. Miller and Gur (2002:402) conducted a study that directly examined the role of religiousness on sexual responsibility. Miller and Gur's study comprised a lifetime history of cohorts' sexual intercourse, perception of risks when having sex, and use of birth control. The authors looked at three dimensions of religiousness: firstly, personal devotion and a sense of personal connection to God; secondly, personal conservatism, or a rigid or literal adherence to creed of religious denomination; and thirdly,

institutional conservatism, or fundamentalism of religious denomination. Results showed that religiousness was associated with a decrease in number of sexual partners. Personal devotion, in particular, was shown to have a negative association with lifetime sexual activity outside of a monogamous relationship. In other words, the greater personal devotion to God, the less likely one would engage in sexual activity outside of a monogamous relationship.

The above quote, from the Pan African Christian AIDS Network, recognises the potential of the Church in the areas of care and treatment of people with HIV and AIDS and also in the prevention and control of HIV. However, the above quote also suggests that there is much potential within the church that is not being realised and that there is much more that can be done, especially in addressing stigmatisation of those people living with HIV and AIDS that exists within the church.

Economic and social factors influencing HIV preventative behaviour

However, it is not only individual attitudes, cultural and religious beliefs that influence people's sexual behaviour. Poverty affects sexuality in many ways. For example, lack of education and information affects the accuracy of sex education, heavy work burdens and cramped living conditions affects peoples enjoyment of sex. Many sub-Saharan countries are among the poorest in the world and this poverty contributes to the spread of HIV.

Where people lack adequate food, water, shelter, education and health care, they are often unable to protect their sexual and reproductive health.

The interrelationship between HIV, AIDS, poverty and wealth status is complex. For example Gillespie and Greener (UNAIDS 2007:4) cite a number of studies that found a positive correlation between wealth and increased HIV and AIDS. Studies by Mishra (2006) and Kongnyuy (2006) found that richer urban men were more likely to have concurrent sexual partners than less wealthy men. Gillespie and Greener acknowledge that the link between wealth and HIV prevalence involve a number of different factors. Even though wealthier urban residents usually have greater knowledge of HIV prevention and greater access to condoms, they also have an increased number of partners, earlier sexual debut and greater alcohol consumption, than rural people (UNAIDS 2007b:5). These results highlight the risk of programmes designed to increase income, especially for men, as increased disposable income is associated with increased risk behaviour.

Economic underdevelopment and poor educational opportunities are widespread in many sub-Saharan countries, particularly in rural populations. However, there has been conflicting evidence regarding the association between educational attainment and HIV infection. Earlier studies in sub-Saharan Africa found that those with more education were

at increased risk of HIV infection, a fact attributed to more extensive travelling of more highly educated people and greater numbers of sexual partners (Fylkesnes et al 2001, Grosskurth et al. 1995, Hargreaves and Glynn 2002, Kilian et al. 1999). However later studies have found there is no evidence of increased risk of contracting HIV associated with education (Glynn et al. 2004). In a study of four African cities, from 1995 to 2003, looking at the associations between sexual behaviour change in young people and decline in HIV prevalence, researchers found high risk behaviours decreased amongst the more highly educated and urban groups. Sandøy et al. (2007) have recorded substantial delays in childbearing, increased use of condoms and fewer sexual partners, amongst more highly educated and urban respondents, indicating that higher education levels may assist, to some degree, in mitigating the spread of HIV. This increased condom use due to higher education, is probably due to the greater exposure that urban and more highly educated young people have to HIV awareness programmes and greater accessibility to health services and condoms.

In Tanzania, the relationship between HIV, AIDS and socio-economic status is also complex. There is a high incidence of HIV in the urban middle class, thought to be due to increased mobility and higher level of discretionary income (TAC 2006). This is confirmed by a survey of adolescents in Uganda, which reported a higher proportion of HIV prevalence amongst those residing in trading centres and trading villages, compared to those living in rural agrarian villages (Konde-Lule et al. 1997). However, the rural poor have restricted opportunities for employment

and entertainment. Furthermore, poverty and lack of economic independence among males and females can increase transactional sex and therefore increase the risk of contracting HIV. Poverty and the lack of employment opportunities may also cause a sense of fatalism, particularly amongst adolescents. For example, Kaufman (2002) found that earning potential was positively correlated with condom use, for both young men and women in South Africa. Strategies to increase employment opportunities, both in the rural and urban areas, may help improve people's sexual health.

Most countries in sub-Saharan Africa, with the exception of Gabon, are still predominately rural, although this is changing rapidly. In Tanzania for example, over three-quarters of the population live in rural areas (The United Republic of Tanzania, National Population Policy 2006:3). Under development in these areas restricts people's access to information and health services, which hinders people's ability to avoid HIV. The dissemination of information through newspapers, magazines, radio and television, is more limited in rural areas, and health and educational services are usually less accessible.

Health services, for example for sexually transmitted infections (STI) testing and treatment, family planning and contraception, play a determining role in HIV prevention. In resource-constrained countries or remote geographic areas, these facilities with properly trained and

equipped staff, may be lacking. Health clinics, even if they are accessible, are not usually set up to assist sexually active young people. Clinics predominantly focus on helping mothers and babies. In most countries, young people's access to health services is lower than older people's (UNICEF/UNAIDS/WHO 2002). To enable young people to make more use of health facilities, health care workers need to be trained how to work with young people. Even if these facilities are readily available, local attitudes affect the demand for such services. The health workers need to have good links with the community and be involved in health education and counselling. Young people involved in drug abuse, sex work or men who have sex with men are at increased risk from contracting HIV and are less likely to report to local health care workers. The WHO report (2006) evaluated a number of different programmes and concluded that more information is needed about the specific needs of these different groups, so that effective interventions can be designed to help reduce HIV infection.

In relation to food insecurity, Gillespie and Loevinsohn (2003) argue that although it is true that at an individual household level AIDS related mortality affects the capacity to produce food because of loss of labour and social capital, there is no clear evidence that this deficiency can be extrapolated out to the national level. The authors point out that the labour force is unlikely to grow over the next few decades, but it will not diminish either. Afflicted households lose labour and knowledge. However, frequently, capital and land are redistributed, often to more wealthy households (Gillespie 2006:148-9). Gillespie argued that most of

the focus has been on how HIV and AIDS influence food security, rather than looking at how food systems, policy and practice affects the spread of HIV. Although there is increasing understanding that the interactions between HIV and AIDS, and government policies are two way, government ministries and donors have still failed to mainstream the implications of HIV and AIDS into their policy processes (Gillespie and Loevinsohn 2003). A religious leader in Gillespie's study expressed this need for interrelationship well 'HIV and AIDS are not very threatening compared to the hunger which most households face. In fact it is hunger, which is contributing to the rise in HIV infections in the area.' (Religious leader in patrilineal village², Gillespie 2006: 114).

This quote highlights the need for multisectoral approaches to HIV prevention. Weiser et al. (2007) found in a study conducted in Botswana and Swaziland that food insecurity led to higher sexual risk taking for women than for men. If food insecurity is contributing to the spread of HIV, then addressing food security as a way of reducing HIV is a valid response. Not only is food insecurity contributing to the spread of HIV but also people migrating within and across national borders, often in search of food and work.

Migration plays an important role in the spread of HIV. In South Africa, which has high rates of population movement both within and between countries, the HIV prevalence increased dramatically from 0.76 per cent in

² Patrilineal village- inheritance is through the male line.

1990, to 30.2 per cent in 2005 (National Department of Health, South Africa 2005:9). It has been assumed that often migrant male workers may infect their female partner after returning home. However, research also shows that women with absent partners are likely to have additional sexual partners, and as a result increase their risk of becoming HIV infected. Migration increases the risk of HIV infection, both for men and women. This observation reinforces the need for interventions that target couples and deal with migrant couples as a social unit, rather than individuals (Lurie et al., 2003). Caldwell, Anarfi and Caldwell (1997:46) maintain that all travel and the whole commercial system can cause the spread of HIV.

Migrants and outsiders are often blamed for introducing HIV, are consequently stigmatized, and persecuted (Butt 2008:121). Lindenbaum (2001) maintains that historically pandemics are associated with prejudice and persecution, and that the HIV pandemic is no exception. Lindenbaum also argues that faced with pandemics, social groups reinforce the distinction between outsider and insider, migrants and non-migrants (1998). Lindenbaum goes on to assert that as social boundaries are highlighted, in the face of the threat of HIV, marginalized groups feel more empowered to speak out about perceived injustices. However Butt (2008:117-20) in her commentary on elites in Papua, counters this argument by demonstrating how marginalized groups can be silenced when elites adopt a 'neutral biomedical language to explain AIDS'. Either way it is clear that AIDS often becomes politicised as various groups attribute blame for the disease on others.

Social and political factors influencing HIV preventative behaviour

Parker (2001:165), and other anthropologists involved in HIV prevention and control maintain there needs to be more emphasis on the social, structural and cultural factors surrounding sexual behaviour, if long-term, culturally appropriate, HIV preventative behavioural changes are to take place. Parker (2001:167) argues that effective HIV prevention interventions should operate at the 'social or collective representations' and not at the 'behavioural level' and that a transformation in societal norms needs to take place. New information about the risk of HIV will likely to be interpreted and incorporated within the existing cultural context. This means that HIV education and preventative programmes will be more effective if they are community based and culturally sensitive. The aim of these programmes is to transform societal norms and cultural values surrounding sexual meaning and behaviour.

Gender inequality, domination of women by men, coercion and other forms of abuse can lead to high rates of sexually transmitted infections (STIs), including HIV, unwanted pregnancy, unsafe abortions, and maternal mortality. Ogunjuyigbe and Adeyemi (2005:31) argue that young women are often subjected to discrimination by men, reducing their ability to protect their sexual and reproductive health and making them particularly vulnerable to HIV infection. There are a number of socio-cultural reasons for this.

Although gender roles are changing in some areas of sub-Saharan Africa, traditional stereotypes predominant. Men in this region are expected to be the providers and protectors of the family, women to bear children, grow and prepare the food. (See discussion on men and masculinities, HIV and AIDS in Chapter 3.) Many women marry considerably older men, often ten or more years older (Pettifor 2005:976). This can increase women's risk of HIV infection, because their husbands are likely to have had multiple sexual partners before marriage and young wives are less likely to be able to negotiate contraceptives and condom use (Lewis 2006:69, Maman et al. 2002:1334, Torell 2007:4)

Throughout much of sub-Saharan Africa there are cultural and gender issues in respect to expectations of fidelity. Sexual experimentation before marriage and having more than one sexual partner before marriage is still widely condoned for men, while women are expected to abstain from sex until marriage and be faithful to their husbands once married (Bankole et al. 2004, de Bruyn 2000). There is strong social and peer group pressures on young men to prove their manhood by having multiple sexual relationships before marriage, a behaviour that increases the risk of contracting HIV and other sexually transmitted infections (STIs) (Awusabo-Asare 1999, Negussie et al. 2002).

In September 2006, a group of experts gathered in Geneva to discuss HIV and behavioural change (UNAIDS 2007b). They concluded that in order to bring about a reduction in HIV prevalence and incidence there needs to be

a re-scripting of social norms surrounding sexual behaviour. Currently some societies condone concurrent sexual relationships, sexual violence and coercion directed towards women. Societies that prescribe intergenerational sex, early marriage and sexual naivety for women, also increase the risk of HIV infections. This gender inequality frequently increases the risk of HIV infection for women. However, the Geneva group concluded re-writing or re-scripting societal norms surrounding sexual behaviour is no easy task. The group recommended that tackling gender inequality, both at an individual and societal level, is one of the keys to reducing HIV prevalence.

Geeta Rao Gupta (2002:5) outlines a number of ways to reduce gender inequality. The first she labels as 'do no harm'. By this she means do not reinforce gender stereotypes that legitimize high-risk sexual behaviour. For example, promoting increased condom use may encourage concurrent sexual relationships. While correct and consistent condom use reduces HIV transmission, it fails to address the issue of concurrent sexual relationships and gender inequality. Secondly, she suggests that women are given the opportunity to be 'compensated for inequalities in power and knowledge' (Gupta 2002:6). This is closely linked to her third suggestion, which she labels 'trigger transformation' (Gupta 2002:5), a transformation in gender relations that allows women equal access to information, resources, inheritance rights and decision making relating to sex. In addition, increasing men's involvement in sexual health activities will help reduce gender inequality. Gupta believes that all these initiatives will help empower women and reduce heterosexual transmission of HIV.

However, she believes that messages of gender equality and male responsibility are too weak. What is required, in Gupta's view, is complete transformation in the way society defines men's duties and rights regarding sex and social privileges, a society in which men 'take charge of their sexuality'.

Changing society's attitudes and social norms away from a strongly patriarchal view, to one of equality between men and women, take time. However, Gupta believes this transformation can be achieved, when individuals and communities are engaged with accurate information and skills building. The mass media can be influential in reducing HIV prevalence, where television, radio and the print media combine to increase young people's knowledge of HIV and AIDS, shape social norms and increase awareness of health services. The mass media can be mobilised to help bring about social change, initiating dialogue, but this alone will not be enough. What is also needed for long lasting successful change is a political will among national and community leaders that legitimizes and reinforces the messages promoted in the mass media. The overall aim of the programme, In Gupta's view, should be to reduce HIV incidence. This can be achieved by promoting the benefits of abstinence for young people, increasing the age of sexual debut, reducing the number of sexual partners, especially concurrent multiple partner sexual relationships, reducing intergenerational sex, addressing alcohol and other drug abuse. The group in Geneva (UNAIDS 2007b) identified a number of barriers to achieving changes in sexual behaviour. The barriers are gender inequities, silence and denial on sexually related issues, inadequate voluntary counselling and HIV testing, especially for married couples.

The group in Geneva also identified ways in which these barriers could be overcome. At an individual level, people could be equipped with more sexuality and life-skills education, and girls can be encouraged to continue at school longer. At a wider community and national level there could be a safer environment for HIV testing and disclosure of status. Legislation can be reformed to improve property and inheritance rights for women. Economically, women can be given greater access to credit. The mass media can be mobilised to help denormalise intergenerational sex, multiple partners and unprotected sex. Initiatives can be found to support marriage and fidelity, and enable young people to abstain from sex before marriage. In addition, it is important to reject gender based violence, sexual coercion and views of masculinity that support these activities, increase the awareness the contribution that alcohol and other drug abuse makes to sexual risk behaviour and communicate the risks of transactional sex. The aims of these initiatives are to promote more equitable social and sexual relationships and reduce the incidence of HIV. Initiatives must be regularly evaluated for success against planned objectives. These measures of success could include the following; age of sexual debut, age at marriage, age of sexual partners, age differentials among sexual partners, frequency of communication with a partner about sex, rate and consistency of condom use, prevalence of violence against women, perception of equality and percentage of women in the community who own land (UNAIDS 2007b).

To assist policy makers and programme managers achieve these goals WHO (2006) has developed a system by which evidence for effective

interventions can be rated; either 'go', 'ready', 'steady' or 'don't go'. 'Go', indicating interventions that can be supported with confidence, 'ready', indicating interventions that can be used with caution and careful evaluation, 'steady', indicating interventions that require further development, or 'don't go', indicating interventions that should not be implemented (WHO 2006:9). WHO recognises that there are different types of HIV pandemics and that no one intervention will provide the answer to reducing HIV prevalence. However, young people are at the centre of all these pandemics and to be successful a range of interventions need to be implemented concurrently. The WHO report concluded that effective HIV prevention for young people requires good collaboration between schools, community and religious leaders, mass media and health providers. Each sector needs to be clear about what their objectives are and how their effectiveness is going to be evaluated. There also needs to be more research into the specific needs of young people and what interventions lead to a reduction in HIV. The following section looks at different groups within a community and their various needs in relation to HIV and AIDS.

Support for people with HIV and AIDS.

Within any community living with HIV and AIDS, there are different groups of people. Firstly, there is the largest majority of the community who are HIV negative, but are none the less at risk. This group of people may have been personally affected by the HIV and AIDS pandemic through the death of relatives and friends, but they are not infected. Secondly, there are a

smaller, but significant group, who are HIV positive but are asymptomatic (without any obvious symptoms). Thirdly, there are those who are HIV positive and have obvious symptoms of AIDS. Due to the widespread nature of the pandemic, each group needs support. All need cognitive, emotional, social, spiritual, economic, legal, political and international support. In a country as large as Tanzania, with a population of approximately 45 million, this is a complicated task (Joinet 1994:1-4).

The first group, those who are HIV negative, need information on what HIV and AIDS is and how to avoid becoming infected. Once those who are HIV negative know how to protect themselves, they have to adopt a safe lifestyle and maintain it. Joinet (1994:2) points out to achieve a long-term safe lifestyle, this group of people needs the emotional, spiritual and social support of their parents, teachers, peers and leaders. It is difficult to maintain a safe lifestyle, without the support of others. People may also need economic, political and legal support, since HIV and AIDS is exacerbated by poverty and inequality. Within this HIV negative group, there are often those who have been more personally affected by HIV and AIDS; widows, widowers, orphans and others who have lost close relatives. This group are in special need of close support, often for long periods, as they deal with the trauma surrounding AIDS. This support might be regarded as 'primary prevention' (Joinet 1994:2).

The second group is made up of people who are HIV positive, but are asymptomatic. This group also need emotional, social, spiritual and

possibly economic support. Joinet (1994) argues that often people in this group do not know their HIV status and may infect others. It is helpful for them to have good counselling to support them come to terms with their status and close emotional support as the realisation of their status begins to sink in. This group of people need help to adopt a safe lifestyle and maintain it. Support to this group might be regarded as secondary prevention (Joinet 1994:8).

The third group of people comprises those who are suffering from AIDS symptoms. This group needs strong support on all levels. They will often also need legal support, as they come to terms with their terminal illness and what will happen to their relatives and belongings, after their death. With the increasing availability of antiretroviral drugs, this group may also need close medical support, often for a considerable length of time (Joinet 1994:8).

Providing these different levels of support; physical, emotional, spiritual, economic and legal, in a resource constrained country like Tanzania, is very difficult. It is not only costly economically, but also politically, in time and human resources. It also requires every member of the country to make personal sacrifices in an effort to combat the pandemic (TACAIDS 2003:1).

Summary

In the past twenty-eight years since HIV was first identified different theories of development and behavioural change have influenced prevention strategies. Early on strongly scientific approaches were adopted influenced by modernisation theories of development. Later a more holistic approach, influenced by alternative theories of development and rights-based approaches, has been adopted. The holistic approaches attempt to incorporate the wider social, environmental, political, economic factors and human rights surrounding HIV and AIDS.

Despite some encouraging progress in some areas, the challenge of reducing the prevalence and rate of transmission of HIV remains a major development issue worldwide. Those working in the area of HIV preventative strategies continue to work on innovative methods to bridge the gap between knowledge of HIV and AIDS, and behavioural change and attitudes. The aim is that men and women will adopt practices that lead to effective HIV prevention. Development approaches have moved to incorporate not only individual behavioural change but also a wider transformation of cultural norms and practices that influence HIV transmission. For example understanding and shaping the factors surrounding the age of sexual debut, which is seen as a major factor influencing the prevalence of HIV. Other development initiatives include the integration of HIV prevention and treatment into existing health services and incorporating human rights into sexual and reproductive health. The above literature review on behavioural change, HIV and AIDS

concludes that for HIV preventative interventions to be successful approaches must incorporate all the factors shaping an individual's behaviour and attitudes in relation to HIV and AIDS. These include family, socio-economic and political factors influencing a person's life.

The following chapter reviews some of the literature surrounding men, masculinities, HIV and AIDS. In particular, it discusses the premise that inequity towards women from men and the socialisation of boys and young men strongly influence the spread of HIV. Chapter 3 continues to explore the notion of a transformation of cultural norms surrounding such issues as masculinity, sexuality and men's attitudes towards women. These issues are all seen amongst commentators as important factors in reducing the spread of HIV.

CHAPTER 3: MEN, MASCULINITIES, HIV and AIDS

Introduction

This chapter focuses particularly on men in relation to HIV and AIDS. Focusing on men in the fight against HIV is important for a number of reasons. Men are often gatekeepers who control women's sexual and reproductive health. Men are often pressurised to prove their manhood and take risks, posing a danger to themselves and others. They are also often the decision makers, who decide on policies and sexual and reproductive health programmes (Greig 2005:3). While men are often in powerful and influential positions, they are also vulnerable. Men have higher rates of alcohol, drug and tobacco use, injury through accidents and violence compared to women. They are also less likely to use sexual and reproductive health services.

Drawing on men and masculinities literature, and gender and development (GAD) literature, this chapter will attempt to see how these ideas can relate to positive behavioural change in relation to men and HIV. Early GAD literature often portrayed men as an obstacle to women's development, rather than part of the solution, as the following quote highlights:

With a few notable exceptions, men are rarely explicitly mentioned in gender policy documents. Where men do appear, they are generally seen as obstacles to women's development: men must surrender their positions of dominance for women to

become empowered. The superiority of women as hard working, reliable, trustworthy, socially responsible, caring and co-operative is often asserted; whilst men on the other hand are frequently portrayed as lazy, violent, promiscuous and irresponsible drunkards (Cleaver 2000:1)

This type of portrayal of men is not helpful when searching for strategies that actively work with men for change.

Firstly, this chapter will explore how men and their feelings of self worth have been affected as many sub-Saharan African societies transition from traditional hunter-gatherer, to pastoralist, to agro-pastoralist, to urban societies. Men's traditional roles have come under threat and many men are struggling to find a new identity. Secondly, this chapter examines how men have gradually been reincorporated into gendered development initiatives as development policy makers and practitioners have come to realise that women's health and development requires men's involvement and cooperation. Thirdly, this chapter discusses why those involved in tackling the HIV pandemic must take into account the wider spectrum of sexual and reproductive health for men and women, male sexuality and gender equity. Patriarchy, which dominates many societies, often creates a power imbalance between men and women. This section explores the roots of patriarchy and what can be done to counteract this power imbalance. Fourthly, this chapter looks at how the socialization of boys and young men affects their subsequent behaviour as men.

Changing masculinities in the East African context.

In the East African context Silberschmidt (2001), asserts that societal changes during and after the colonial period have affected men's identity and their sexual behaviour. Based on the author's fieldwork in Kenya and Tanzania, she asserts that structural changes have eroded the material basis of patriarchy, and men are struggling to redefine their role as 'breadwinners'. Silberschmidt's premise is that patriarchy, male dominance, is based on a material base where the male authority is constituted. Prior to colonialism, the material base of the patriarchal system was land and livestock. Men's responsibility was to clear land, tend the cattle, make political decisions and defend their territories from attacks from other tribes. Women's role was to produce the food and rear the children. For all tribes, cattle represented wealth and power. Cattle were also the main constituent of bride price, based on the women's productive capacity. The more cattle a man owned, the wealthier he was and therefore the more wives he could afford to keep, and subsequently the more children he could father (Kandiyoti 1988:274). Extending his family meant that he could then cultivate more land and become more powerful. Lack of children and infertility were a great social stigma. Men had much greater sexual freedom than women did, and adultery on the part of women was considered much more serious than for a man (Silberschmidt 1999).

With the arrival of the European colonial powers in East Africa, the old tribal socio-economic system began to change. To generate cash to pay

taxes, men started to grow cash crops. They also began to work as paid labourers in newly expanding infrastructural and manufacturing industries in the towns and cities, leaving the women behind on the farm to produce the food and care for the children. Men started to live away from home, often for long periods, and become more financially separate from the household economy. As industry developed, more skilled workers were required and unemployment, particularly amongst unskilled labourers, increased. The number of women in paid employment in the towns and cities began to increase and the traditional tribal socio-economic system in East Africa began to change rapidly (Gutmann 1996, Chant 1997).

Following the end of World War II and continuing after independence in the early 1960s, men's former identity-giving activities changed. There were fewer tribal wars to fight and cattle numbers decreased. As population was growing in Kenya and Tanzania faster than employment opportunities, many men found there were no jobs for them in the urban sector or the rural areas. Women found it increasingly difficult to grow enough food for the family and men found that wages, if they had work, were insufficient to support themselves and the family. Men still owned the land, but their inability to provide financially for the family undermined their role as head of the household and their social value (Moore 1994, Güendel and González 1998). A new type of social value system began to emerge. Fewer cattle meant less financial security and difficulty in paying bride price. Consequently, many couples opted for informal 'marriages'. This meant that women in Tanzania and Kenya had even less land security, further reducing their primary means of

production. Men began to have less control over their wives and women began to look for means of survival that were not reliant on their husbands (Morrell 2001, Obote Joshua 2001).

As well as cultivating crops, many East African women began to supplement their income with informal trade, which was often concealed from their husbands. Although technically still responsible for providing household necessities, in practice many men failed to assist with such expenses as clothes, school fees and uniforms. Women began to develop strategies for overcoming patriarchal control, even though they still acknowledged their husbands as head of the house (Morrel 2007:6).

In many East African pastoralist societies these social changes had far-reaching effects on men's identity and self-esteem. Wealthy businessmen, who could afford more than one wife, were respected, whereas poor men were despised. Men began to neglect their family responsibilities and took on girlfriends to provide pleasure and satisfaction outside of the marriage. This process of change has caused gender roles to be redefined (Kandirikirira 2003). Although men still saw themselves as the breadwinners and providers, sometimes their inability to fulfil this role reduced their self-esteem. Whereas women found their new role as main provider of the family gave them higher self-esteem and identity, men struggled with this transformation. Tensions between men and women amplified and domestic violence increased. These new values and roles have created a new discourse which overlaps with the old one. Men, such

as those shown in Figure 14 below, still retain ownership rights over land and children, but a new class of women-headed households have emerged (Barker and Ricardo 2005:14).

Silberschmidt (2001), asserted that multipartnered relationships and/or casual sex, which increase the prevalence of HIV, are not so much as result of traditional African permissiveness and polygyny, but more a consequence of changes in society as a result of colonialism and declining economic standards since the 1980s.

Figure 14: Village men attending a training seminar in rural Tanzania.



Source: Author

Accompanying these changes has been a change in men's identity.

Because their material base of patriarchy, cattle ownership and warfare has been largely removed, accompanied by a reduction in their ability to provide for their family in an increasingly urban environment, men are suffering an identity crisis (Erikson 1980). Consequently, many men are facing feelings of inadequacy, inferiority, lack of self-esteem and depression. Faced with these feelings of disempowerment, many men often resort to alcohol and extra-marital relationships, which increase the prevalence of HIV (UNAIDS 2000:17).

Women on the other hand have responded by taking over the responsibilities of provider, creating a new social role for themselves. Many men feel threatened and jealous of their wives' increasing economic independence. This threatens their ego, honour, masculinity and sexuality. 'A man's identity, self-confidence and social value are closely linked to his sexuality' (Silberschmidt 2001:667).

This change in men's role and subsequent loss of identity is not limited to East Africa. Another area of the African continent to experience change is South Africa. Since the end of the apartheid system of rule in South Africa in 1994, there have been considerable changes in the area of gender and masculinities. Morrell (2007:5) draws attention to how law reforms, which outlaw discrimination on the grounds of gender and sexual orientation, have improved women's rights. The South African government have been very active in mainstreaming gender by creating gender units within many ministries. Most of the emphasis has been placed on improving the lives of

the most marginalised group within South Africa, namely rural, black women. Morrell (2007:6) points out that 'although considerable progress has been made in the area of gender relations and particularly women's rights, South Africa is still beset with severe gender problems. The most obvious are the HIV pandemic and gender-based violence'. South Africa has the highest rate of HIV infection in the world and most of the new infections are among young women (UNAIDS 2007:16). This high rate of HIV infection is partly due to widespread poverty, but also due to 'constructions of masculinity... which provide legitimacy for violence' (Morrell 2007:7). Understanding these historical developments and what is meant by gender equality is important, if HIV prevention initiatives are to be successful.

Reintegrating men into gender and development.

Gender within development circles has often been focused on women as a discriminated and disenfranchised group. However, gender, as the following quote explains, is much broader than just women:

Gender is defined broadly as what it means in a given society to be male or female and how that defines an individual's expectations, opportunities and roles ... gender is socially defined. (Barker 2000: 3).

Gender has become a significant issue in development since 1970 when Ester Boserup wrote *Women's Role in Economic Development* (Boserup 1970). Boserup studied agricultural systems and documented the

significant, but unacknowledged contribution made by women to these systems. She argued that women had largely been ignored in relation to development and proposed that this omission needed to be redressed. This model became known as 'Women in Development' (WID). WID was later replaced by 'Gender and Development' (GAD). While WID treated women in isolation from men, GAD seeks to examine socially and historically constructed gender relations between men and women and the link between gender and development (Moser 1993). While the theoretical constructs of WID and GAD were different, actual development practice on gender changed little. The focus continued to be on women (Cornwall 1997). Masculinity, as a gendered construct, was largely absent.

More recently there is increasing interest amongst development practitioners in men's issues and the concept of masculinity in both developed and developing countries. Some of the issues arising are increasing long-term male unemployment, male violence, reduced proportion of men in higher education, fatherhood and men's reproductive health (Esplen 2006:7). These issues are inseparable from the well-being of women and should be viewed in the wider context of overall development for both men and women. Traditionally men have been seen as the head of the family, the breadwinner, the one who has power relative to women and the one who controls the allocation of resources within society. This hegemonic view of masculinity is often associated with patriarchy (Bannon and Correia 2006:5). Patriarchy has been the dominant and traditional view of masculinity. However, the

traditional position of men as the main providers for the family is changing and causing tensions between men and women.

Sexual health, sexuality and gender

The HIV and AIDS pandemic has opened up the debate on men, masculinities and sexuality. Sexuality has often been ignored or seen as a problem, by those involved in development (IDS 2006:1). For example, issues related to sexuality such as population control, disease and violence have been approached as problems that need to be solved. However, sexuality is central to all human beings. Sexual interactions are intended for pleasure, intimacy, fun, love and closeness, as well as procreation. Sexuality, when viewed in a positive way, can be a strong force to be harnessed for our overall well-being (Runeborg 2002). The way in which our sexuality is expressed is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors. The International Conference on Population and Development in 1994 stated that reproductive health should include the right 'for people to have a satisfying and safe sex life' (ICPD 1994). In addition, people have the right to accessible services for sexual and reproductive health (SRH). However, many people are denied these health services and those who diverge from sexual norms are often excluded from health services (Burns et al. 2004:30, PHR 2007:20).

Cultural attitudes towards gender relations greatly affect sexuality. Many

cultures are strongly patriarchal and women are often made to feel inferior and weak. Men may misuse their physical strength or position in society and abuse women (Caldwell et al. 1992:408, Interagency Gender Working Group/ USAID 2003:31, Sathiparsad and Taylor 2006:118). Minority groups such as homosexuals and transsexuals are often stigmatised and harassed, within many cultures. Within an international human rights context people have the right to the highest attainable health in relation to sexuality, without coercion, discrimination and violence (WHO 2007).

The Millennium Development Goals, which were adopted by the United Nations General Assembly in late 2000, helped set the development agenda through until 2015. Although sexual and reproductive health (SRH) was not explicitly prioritised in the Millennium Development Goals (MDGs), sexuality and SRH have a connection to development, HIV and AIDS. Sexual and reproductive health is clearly related to a number of the MDGs. For example to gender equality (MDG 3), as equitable relationships will tend to improve SRH and MDG 5, which aims to reduce the maternal mortality ratio by 75 per cent, will be more easily achieved when women's SRH is improved. Combating HIV (MDG 6) is clearly related to sexuality. MDG 1, halving world poverty by 2015, is related to HIV and AIDS, as discussed in Chapter 2 above (IDS Policy Briefing 2006 (29): 2). The omission of universal access to reproductive health services from the MDGs was later redressed when a World Summit in 2005 endorsed a commitment to achieving universal access to SRH services by 2015 (Langer

2006).

Masculinity and sexual wellbeing

Some gender and development initiatives in the 1990s sought to address the male side of gender and the concept of masculinity. The International Conference on Population and Development in Cairo (ICPD 1994) included “male responsibilities and participation” as important for improving sexual and reproductive health for both men and women. The Cairo conference helped initiate programs that involve men and women. Women had come to realise that to improve their health and well-being, men must be actively engaged. However, men should not be seen solely as obstacles to women’s development, or as those who are responsible for the negative conditions that affect women. Men often face development issues in their own right and generally want to be supportive partners, loving and caring fathers. They also want to help their partners avoid unplanned pregnancies and sexually transmitted infections (STIs), including HIV. Programmes with men can help in HIV preventative behaviour, by delaying sexual debut, reducing the number of sexual partners, the use of condoms and addressing misconceptions about HIV transmission (Interagency Gender Working Group/USAID 2003). There is an increasing need to have a broader view of gender, and engage men in exploring issues of masculinity, gender equality and sexual and reproductive health, including HIV.

Cleaver (2000) asserts the generalised view that men are lazy, violent and promiscuous is now changing and approaches that enable men to be an active part of women's development are being used more widely. For example, a gender, HIV and AIDS programme called Stepping Stones, was developed mainly in Uganda, tackles issues of HIV and AIDS awareness, self-confidence, gender inequity and attitudinal change amongst men and women. This is being used in forty-two countries worldwide (Wallace 2006, Welbourn 1995). The Men as Partners (MAP) programme, which originated in South Africa, moves beyond gender awareness to a gender transformative approach. It attempts to address what many believe to be the root problem of HIV and AIDS, namely young men's socialization, pressures and societal norms, attempting to change individual behaviours, community norms and government policy (MAP 2005). Another example of a gender transformative approach is the Khululeka Men's Support Group in Capetown, South Africa, which has found that HIV positive men can support each other to change their lifestyles and become involved with community-based HIV and AIDS work. The aim is to help men become knowledgeable and responsible (Robins 2006). Harris (2006) reports that in rural Ecuador role-plays, drawings and focus-group discussions were used with men's groups to address gender-based issues and masculinity. Through this initiative, men agreed to stop pressurizing each other into proving their masculinity by having sex with multiple partners (Harris 2006).

Many men may lack the life-skills necessary to take more responsibility for areas traditionally regarded as women's domains, for example, discussing

contraception needs and care for children. Including men in these areas is not only beneficial for women's health, but for the overall well-being of the family. It is also beneficial economically, as violence and disease are reduced, and people's human rights are protected. However, men often find it hard to discuss these sensitive issues.

Men often have unexpressed desires for greater access to relevant reproductive health information and health services (Thielman et al. 2006: 114). Throughout the world, men do not access health services to the same degree as women (Barker 2003a). They often delay treatment and may regard family planning clinics as women's spaces. Public health agencies are becoming more aware of this and some are seeking to redress this imbalance by employing more suitably qualified male staff, having opening hours that allow more access for working men and working with men in their places of work. Many men often want a safe environment in which they can access professional help for areas of their lives that cause them great concern. Those involved in the battle against HIV have come to realise they need to more fully understand the needs of men in the area of sexual and reproductive health, be prepared to challenge men to evaluate what it means to be a man, and possibly encourage men to redefine masculinity, along more gender equitable lines (Interagency Gender Working Group/USAID 2003:15). This requires a rewriting of cultural norms surrounding masculinity and the socialisation of boys and young men.

Young men and masculinities: rewriting the script

Socialization of young men affects their subsequent behaviour and often they are socialized to behave inequitably towards women (Archer 1984). Thus Cleaver (2000) emphasises that focusing attention on men will not only be beneficial for men, but also for their female partners.

Research with young men has often focused on specific aspects of their behaviour, such as violence. Compared to young women, young men have higher rates of alcohol and tobacco use, accidents, injuries and violence. Consequently, young men have often been classified as disruptive, aggressive and hard to work with. This violent behaviour is often related to the way young men have been socialised in their families and communities. Young men often carry forward these destructive social behaviour patterns learned in adolescence, into adulthood. Men tend to suppress their emotions and have generally been socialised to be self-reliant and independent. For many young men, sexual conquest, rather than developing a long-term intimate relationship, is an aspect of proving their manhood (Gupta and Mahy 2003, Rivers and Aggleton 1998, UNAIDS 2000). WHO reports that alcohol and other drug abuse and peer group pressure are often important factors that influence young male's sexual relationships (WHO 1997). Research has also shown there is a strong link between alcohol consumption and STIs (Clift 2003, Garbus 2004, Greeley 2000, Torell et al. 2007). Alcohol may encourage risky behaviours such as dangerous driving, unprotected sex and violence. Men are generally physically stronger than women and they may be conditioned by their

social context to use their physical strength violently, either towards each other or towards women (Castells 1997:136, Foreman 1999:14). Not only are some men perpetrators of violence but they are also victims. Sadly, many men are involved as combatants in wars and soldiers are sometimes perpetrators and victims of atrocities that leave them scarred for life (Honwana 2005:68).

These social behavioural patterns also have a direct impact on the health of women, including violence, rape, abuse, STIs and unplanned pregnancies. For this reason, it is imperative to involve men in any intervention aimed at improving the health status and gender equity of women (Interagency Gender Working Group/USAID 2003:32-46). If the HIV pandemic is to be combated then it is important to try to understand what young men need for healthy development and how these needs can be met.

Research has shown that certain traditional views of masculinity can have detrimental effects on men's health. Courtenay (1998) found that in the USA beliefs about manhood were the strongest predictor of risk-taking behaviour, amongst young men, ages 15-19, as discussed above. Observers believe that young men's lack of concern for their own and their partner's sexual health is a strong factor in the HIV pandemic (Barker 2000:263, Gifford et al. 1999:177). Childhood and adolescence are the periods when boys begin to lay the foundation for their relationships with women and often these foundational views are not always gender

equitable. Bledsoe and Cohen (1993), and Jejeebhoy (1996) state that men often view women as sexual objects and view sex from a performance orientated perspective, rather than intimacy. Some studies suggest that for adolescents reporting their sexual *conquest* to their peer group is as important as the sexual relationship (Gorgen et al. 1998:68).

Michael Kaufman (1999:1-6) attempts to explain why men behave inequitably towards women and identifies what he describes as the seven P's of men's violence. The first P, patriarchal power, not only brings privilege and power, but also perpetuates violence; not only men's violence against women, but also violence against other men and a man's violence against himself. Kaufman posits that patriarchal societies have created social structures and ideologies over a long period of time, that use violence (or the threat of violence), to maintain men's position of power and privilege.

The second P Kaufman labels as the sense of entitlement to privilege. Men may justify their inequitable behaviour towards women by claiming a prerogative to behave in a certain way. For example, a man may claim a right to sexual pleasure; even if it causes pain and suffering to a woman.

Permission, the third P, Kaufman describes as the endorsement a society gives to violence, either as a way of solving disputes or how violence is glamorised in sport, film, literature and warfare. Ironically, the very power

and privilege men have created for themselves over generations, Kaufman believes, also creates a sense of isolation, fear, anger and suffering for men. Hence, he labels the fourth P the paradox of men's power. It is these insecurities, Kaufman maintains, which cause men to act violently, in an effort to reassert their masculinity.

The fifth P, what Kaufman calls the psychic armour of manhood, describes the way in which men have conformed to reject the feminine qualities of care giving and nurturance. The result is a lack of empathy towards others and an inability to experience the pain of violence. From an early age boys are conditioned to repress certain feelings. This repression, Kaufman asserts, causes men to channel feelings of fear, rejection, insecurity or belittlement, into anger. He describes this as the psychic pressure cooker of masculinity, the sixth P. The various emotions men experience are often expressed in anger and violence.

The seventh P, past experiences, greatly affect men's propensity to violence. Men who grow up in a violent environment are more likely to be violent themselves. Violence has become a norm of behaviour. To end this violence Kaufman suggests that masculinity needs to be redefined. The cultural structures that support patriarchy, power and privilege need to be transformed into cultures that encourage men to nurture children in a violence free environment. He proposes that men are challenged, in a spirit of love and compassion, to examine their traditional views of masculinity and patriarchal privileges. In this way, men can be taught to

deal with their emotions, without resorting to violence (Kaufman 1999:6).

While many men act in inequitable ways towards women, Barker (2000), working with adolescent boys in Brazil, noted that some did not conform to traditional expectations of masculinity. Barker (2000:268) and his colleagues spent a year investigating a group of twenty-five young men in a *favela*, a low-income urban suburb, of Rio de Janeiro. *Favelas* often have rival gangs of young men that are involved in drugs and violence. Barker identified gender equitable men as those who are respectful to women, do not use violence against women, assume some responsibility for reproductive health issues and for those with children are involved fathers. All these characteristics are opposite to the predominant view of masculinity in the *favelas*.

Barker's research focused on trying to identify factors at individual, family and community level that enabled these young men to behave in an equitable way towards women. He was able to identify a number of factors associated with gender equitable attitudes among young adolescent males. These factors include, an acknowledgement of the costs of traditional masculinities, access to adults who do not conform to traditional gender roles, family intervention or rejection of domestic violence, and a gender equitable male peer group. They also underscore the importance of male role models, within the peer group and the family, who behave in gender-equitable ways. These men might be referred to as 'positive deviants', after a school of thought known as positive deviation.

Positive deviants are described as people who act in a positive way, counter to the surrounding culture and norms. They have overcome a serious problem that everyone in their community is facing, with the same resources and constraints available to everyone (Barker 2003).

Another example of positive deviation would be those in a very poor community who are not involved in sex work as a response to poverty. Sternin and Choo (2000:14-15) suggest that those working with the community ask, "Does everyone who is poor in this community do this?" Then the community helps identify those people who have overcome poverty without becoming involved in sex work. They then identify what individual, family or community factors have enabled those individuals to reject sex work as a way out of poverty.

Traditional views of behavioural change rely on knowledge, attitude and practice (KAP). The theory of KAP (Fishbein et al. 1994) proposes that if people are provided with new knowledge, their attitudes and subsequently their behaviour (practices) will change. However, observations show that equipping people with new knowledge does not necessarily change their attitudes and behaviour (Bazargan et al. 2000, Braithwaite and Thomas 2001).

The theory of *Positive Deviance*, as introduced above, (Sternin and Choo 2000:14-15) reverses the KAP paradigm, proposing that people are more

likely to act their way into a new way of thinking, than think their way into a new way of acting. Positive deviance starts with identifying positive habits and by equipping people to acquire new habits. These new habits, or new ways of behaving, in turn alters their attitude and finally assists them in internalising new knowledge. The theory of Positive deviation posits that the solution to an issue often already exists within the community. The Positive Deviation model focuses on the practices and strategies that succeed in producing positive outcomes and stresses that the role of the outsider is to help the community 'discover' the solution, not the outsider 'discover' the solution. Positive Deviation works best where a solution requires behaviour or social change. It does not work for technical changes. It is therefore suitable for dealing with a worldwide complex problem such as the HIV and AIDS pandemic, where the solution involves a change in behaviour (Babalola et al. 2002, Friedman et al. 2008).

Using the example of the gender equitable young men in a *favela*, Barker (2000:268) reasoned that the best people to help solve the problem of gender inequity were those who had already overcome the prevailing attitude of violence and domination towards women. Barker et al. identified young men who could be positive role models for other young men and had demonstrated positive aspects of manhood (Barker et al. 2003b:15). They identified individual, family and community level factors that influence gender equity. At an individual level, Barker (2000:273) found that those young men in his study who had the ability to reflect on life struggles and construct a more positive version of masculinity, were

more gender equitable. They were better able to express their past experiences, connect past to present, and identify the consequences of the predominant view of masculinity, including the cost of violence against women. At a family level, access to positive role models proved to be an important factor in achieving a more gender-equitable identity. Community level factors that promote gender equity include belonging to an alternative peer group or institution that reinforces gender equity. However, Barker and his colleagues concluded that more research is needed to see what socialization factors led these young men to act in a more equitable way towards women (Barker 2000:281).

Barker (2003a:3) raises two questions in relation to how we can help young men find positive, caring, socially aware models of masculinity.

- What are the implications of sex-specific health needs for young men, and what can be done to improve their health?
- How can we work with young men to improve the health and well-being of young women, and to promote greater equality between the sexes? (Barker 2003a:3)

Barker (2003a:3) stresses that it is not a question of increasing the emphasis on men, over women, or vice versa. The challenge is to improve the sexual and reproductive health of both men and women together by working with both genders. In Tanzania, men and women's roles are often clearly defined and distinct. This might mean there is a need for strategies which talk with women and men separately, but both discuss the SRH of men and women. Figure 15 below shows women sitting and talking

together separate from men.

Figure 15: Women talking at a funeral in rural Tanzania.



Source: Author

Summary

The above discussion shows that addressing masculinity, gender, identity, socio-economic changes and sexuality issues are very important in the context of HIV and AIDS. The reintegration of men into development policy and practice following on from WID and GAD is to be welcomed (Cornwall 1997). In Silberschmidt's view (2001) because the culture in sub-Saharan Africa is changing, men's ability to provide for their families has reduced. She also believes these changes have caused men's self-esteem to diminish. She continues that some men may resort to extra-marital affairs in an effort to restore their self-esteem and sense of identity.

Barker (2003) asserts that socialisation of boys and a young man is a crucially important factor in the fight against HIV. He believes that where young men are socialised to be more gender equitable, taking into account the sexual and reproductive health of their partners, then more progress will be made in reducing HIV. Kaufman (1999) goes on to attempt to discern why men behave inequitably towards women. He describes the seven P's of violence against women: patriarchal power, privilege, permission, paradox of power, psychic armour of manhood, psychic pressure cooker of masculinity and finally past experiences. Kaufman believes these seven P's combine together to create an atmosphere of violence. He agrees with Barker in that masculinity needs to be redefined.

With HIV and AIDS pandemic in sub-Saharan Africa and more women than men affected, there is a need for further research into the interaction of men's overall life situations, male identity and self-esteem, and how these affect sexual behaviour. There is also a need to make men and women aware of how socioeconomic changes have affected their gender roles. Re-empowering men economically, along with gender education, may improve the sexual and reproductive health of both men and women. Addressing these gender issues and inequalities will hopefully reduce the spread of HIV. This research project aims to shed further light on the interactions between the changes in culture in Tanzania, socialisation of young men and the spread of HIV. The following chapter looks at the research process utilised in this thesis.

CHAPTER 4: RESEARCH PROCESS

Introduction

Previous chapters in this thesis have examined the development of HIV and AIDS in the United Republic of Tanzania and how various theories of behavioural change affect development practices in relation to reducing the spread of HIV. Chapter 3 focused on a review of the current literature surrounding men and masculinities in relation to HIV and concluded that women and men cannot be treated in isolation from each other, but both must be helped to have more gender equitable relationships. Chapter 4 first traces the historical development of HIV and AIDS research, the ethical considerations and some research biases and power issues encountered in cross-cultural research. It then goes on to discuss the research methodology employed and how participants were selected in this study project. Chapter 4 also discusses some of the sound principles in cross-cultural research and how participants for this study were selected.

This study seeks to answer the question 'What factors influence the attitudes and subsequent behaviour of Tanzanian men regarding HIV and AIDS?' In an effort to provide answers to this question, a qualitative research approach was chosen. Qualitative research has its roots in social science and seeks to understand why things are the way they are, and why people behave as they do, their knowledge, attitudes, beliefs and fears

(Bryman and Burgess 1999). For this study a series of twelve semi-structured interviews and two focus group discussions were conducted with men in the Iringa region of Tanzania from different socio-economic backgrounds, over a period of a month in mid-2008. This chapter briefly discusses how this thesis project developed and why qualitative research methods were chosen.

All researchers have their own particular worldview and biases, which create power gradients between researchers and the participants. Therefore, it is important to be aware of these biases and power gradients and to mitigate their effects with sound ethical research, which incorporates the principles of informed consent and reciprocity.

Progression of social science research on HIV and AIDS

Because HIV in sub-Saharan Africa is predominantly spread by heterosexual activity (UNAIDS 2006), this study explored factors that have shaped men's attitudes and behaviours towards sex, HIV and AIDS, what influences men and their peers, and how the culture surrounding men affects sexual behaviour. The early years of research on HIV and AIDS mainly focused on collecting quantifiable data, for example, the number of sexual partners, the frequency of different sexual practices and other quantifiable issues that contribute to the spread of HIV (Varga 2001). The aim of these research projects was to collect data that could be used to shape policy and develop intervention programmes that would cause

individuals to change their behaviour, and thereby reduce the spread of HIV (Carballo et al 1989, Chouinard and Albert 1989, Cleland and Ferry 1995). The methodology was largely shaped by theories of individual behaviour change, such as the Health Belief Model, the Theory of Reasoned Action, or the Stages of Change Model (Parker 2001), as discussed in Chapter 2. The premise was that intervention programmes could be developed to influence individual behaviour change.

However, as the HIV pandemic has spread it has become clearer that educational programmes focusing on individual behavioural change are insufficient to bring about the desired change in reducing risk taking behaviour, as discussed in Chapter 2 (Dilger 2003, Varga 2001). The theories of individual behaviour change, as they relate to HIV risk-reduction strategies, began to be questioned (Herdt et al. 1991, Parker et al. 1994). A greater understanding of the different cultural and social contexts of HIV and AIDS was needed. Anthropologists such as Parker (1994) and Herdt (1991) sought to understand the spread of HIV in different social settings and to develop more culturally appropriate prevention programmes. For example, Coast (2007:391) argues that for Maasai pastoralists, like those in Figure 16, the ABC programme of HIV prevention, which focuses on sexual abstinence, fidelity and using condoms, is not readily accepted. The Maasai culture prizes fertility and believes the flow of semen is essential for a girl's body to mature (Coast 2007:391). Consequently, Maasai are unlikely to use condoms. This example shows that understanding the culture of social scripting of sexual encounters is important for developing successful risk-reduction

programmes. It has become increasingly important to gain the ‘insider’ perspective about how members of specific cultures interpret their everyday lives. The limitations of quantitative data in gaining the ‘insider’ perspective began to be exposed.

Figure 16: Maasai women and girls in central Tanzania.



Source: Author

Consequently, there has been a rising interest in qualitative research to address this gap. Qualitative research, which applies a more in-depth approach, can be used to determine how different cultures and communities establish sexual practice. O’Leary (2004) in her book *The Essential Guide to Doing Research*, attempts to bring together the dichotomy between quantitative and qualitative research, by describing a

more holistic type of research, which combines both strands. She sees research as combining the analytic, logical left-brain attributes, with the creative and intuitive right-brain attributes. O'Leary advocates moving beyond the scientific, positivist approach to research, to a post-positivist approach that acknowledges that research can be intuitive, researchers can be subjective and collaborative, and research methods can be inductive and exploratory. Due to the sensitive nature of the research question in this research and the multiple factors affecting the spread of HIV, this study uses a more inductive and exploratory approach.

During the 1990s there was an increasing interest in the wider structural factors that affect people's vulnerability to HIV and AIDS, such as poverty, education, access to health services, migration, gender inequality and the socio-political environment. Parker (2001:168) uses the term 'structural violence' to try to determine the social vulnerability of communities and individuals to HIV and AIDS. Parker argues that the issues of poverty, economic exploitation, gender inequality and sexual oppression must be addressed to have any hope of reducing the spread of HIV (Farmer et al. 1996, Parker et al. 1994, Singer 1998).

In response to this growing understanding of structural factors that influence the spread of HIV, more research has been done on how societies structure the possibilities of sexual interaction, choice and restriction of choice for sexual partners, and the ways and circumstances of sexual interaction (Parker et al. 1991). Such issues are determined by

the rules and regulations imposed by different societies and the political and economic power relations operating in these societies. This interest in structural factors that affect the spread of HIV has also led to a greater interest in gender inequality (Harris 2006, Silberschmidt 2001). The way that different societies structure sexual inequality determines the possibilities for sexual negotiation, sexual violence, contraceptive use and risk-reduction strategies (Gupta and Weiss 1993).

Due to the complex nature of HIV and AIDS education and prevention, programmes have become much more community-based and culturally sensitive. These programmes aim to understand social norms and cultural values that shape sexual behaviour of different societies, cultures and even different subcultures within a society (Ackeroyd 1997, de Zalduondo and Bernard 1995, Gupta and Weiss 1993, Parker et al. 1991, Schoepf 1992). The move towards more community-based HIV prevention programmes has come about largely because of the use of more qualitative research methods, which attempt to gain a deep understanding of the factors driving the HIV pandemic. Even those researchers who attempt to understand the social norms that shape sexual behaviour in a particular society will bring their individual biases into their research. The following section discusses some of these biases and how they influence the research process.

Issues of biases and power in research

All researchers represent their own bias and it is impossible for research, whether it is qualitative or quantitative, to be completely objective (Chambers 1997). All of us see, hear and interpret things through our own experiences and worldview. The fact that I am white, male, married and Christian, with life experiences from Great Britain, New Zealand and East Africa, will inevitably influence the interpretation of my research results. Being aware of and acknowledging bias is the first step in acknowledging subjectivity (Scheyvens and Storey 2003:68). I have been fortunate to have worked with the Anglican Church in rural development in Tanzania since 1995, assisting smallholder farmers improve their crop and livestock production. While working with farmers I saw firsthand the devastating effects of HIV and AIDS. Families were often losing their primary income earner, leaving dependants further marginalised. This became the motivating force in choosing this thesis topic, to try to understand better the root causes of the pandemic and help families be better equipped to deal with HIV and AIDS. My experience with rural Tanzanian families, knowledge of Kiswahili and culture has hopefully enabled me to approach this study in a more culturally sensitive manner. While interviewing men I was careful not to allow my Christian beliefs influence participants' responses by making a conscious effort to avoid judgemental comments or any response that that would influence participants' answers. Questions were carefully checked and reviewed by two local Tanzanian people to be as open-ended as possible.

Mays and Pope (1995) outline a number of steps that can be taken to protect against potential biases and enhance the reliability of the findings.

Firstly, the research question must be identified and clearly stated. For this study, the research question is ‘What factors influence the attitudes and subsequent behaviour of Tanzanian men regarding HIV and AIDS?’ Secondly, it must be clearly described where the research took place. In this study, there were two sites, one at a local university in Iringa town and second in a rural village, 12 km from Iringa town. These sites were chosen to give a cross-section of men from different socio-economic backgrounds. Thirdly, methods of data collection have to be explained. This study relied mainly on semi-structured interviews backed up by two focus group discussions. Fourthly, it has to be considered if it would be useful to employ the services of a local research assistant because this may have increased the reliability of the information. I decided not to employ a research assistant. Due to my experience in Tanzania, I felt confident interviewing men in Kiswahili and did not want to introduce another person, and consequently increase the set of biases.

There has been much debate about the power imbalance between a Western researcher and those being researched in resource-constrained countries (Becker 2007, Clifford 1997, Cook et al. 2005, England 1994, Escobar 1995, Madge 1993). In many cases, researchers from Western backgrounds will be wealthier than participants from developing countries. However, much can be done to minimise these power imbalances. While we cannot control our size, sex and colour, we can control the way we dress and the way we approach communities and participants. Dress should be clean, tidy and culturally sensitive (Scheyvens and Storey 2003:151). I attempted to mitigate the power

imbalances present by dressing in the same manner as the participants, using Kiswahili and sitting in such way that I was at their level and part of the group in the focus discussions. Researchers need to be genuinely interested in the lives and welfare of the participants and value their contribution (Scheyvens and Storey 2003:156). Chambers (1997) considers that putting the participants at ease, by meeting them in an environment that they are comfortable and familiar with, assists considerably the interview process. The participating university students were interviewed on campus in a private area in which they felt at ease to discuss sensitive matters confidentially. The rural participants were interviewed in a village home, where the environment was familiar and private. No other family members were present and men were free to answer questions openly and honestly.

Questions of representation must be considered when engaging in cross-cultural fieldwork. This has led some researchers to withdraw completely because they have felt unable to fairly represent participants from another culture (Kobayashi 1994). However, this response ignores the value of cross-cultural fieldwork. A number of writers point out that the complex development issues cannot be solved by the Global South alone (Potter 1993, Shaw 1995, Sidaway 1992). We live in an interdependent world, where issues of poverty, gender imbalance and injustice can benefit from outside research. The other benefit of cross-cultural research is that it exposes the researcher to a new culture, a different reality (Heggenhougen 2000). Gupta and Ferguson (1997:36-7) go further and argue that cross-cultural fieldwork 'counters Western ethnocentrism and

values detailed and intimate knowledge of economically and politically marginalised places, peoples, histories, and social locations’.

To counter the power relations, inequalities and injustices inherent in a relatively privileged Western researcher working with people living in poverty, some have suggested using research methodologies such as Participatory Rural Appraisal (PRA) and Participatory Learning and Action (PLA), which allow participants to be heard and empowered (Chambers 1997, Smith et al. 1997).

Power however, not only resides with the researcher. Respondents can exercise power by withholding information and use language as a way of controlling their responses (Cotterill 1992). It seems the question of power gradients and research ethics can best be answered by how well informed and how sensitive the researcher is to the topic and the local context, rather than such characteristics as nationality and sex (Scheyvens and Storey 2003:151).

Ethical considerations

Before commencing fieldwork, Massey University’s Human Ethics Committee (MUHEC) required approval for this research. An extensive in-house ethical proposal had been prepared for supervisors at the Institute for Development Studies, Massey University, followed up by an in-depth

peer-review discussion conducted via Skype communication. Ethical issues were also discussed with one of my supervisors when she visited Tanzania. Considering this thorough preparation, the small scope of this study and the familiarity with the environment, MUHEC approved the proposed methods for this study as low-risk.

However, a high standard of ethics in research is more than satisfying a university's ethics committee. The aims of a stringent ethical review before commencing fieldwork are to minimise harm to the participants and researcher and foster good relationships (De Laine 2000). The primary concern is the privacy and safety of the participants and the cornerstone of sound ethical research, is the principle of informed consent. Informed consent means that a participant has had the opportunity to be fully informed about the objectives of the study and given the opportunity to withdraw at any time. These issues of informed consent, the right to withdraw and participants' privacy were fully addressed in an information sheet provided to participants before each interview (Appendices 3 and 4). Participation was voluntary and every effort was made to minimise the risk for all those concerned in this study project. Interviews were conducted in a private area and all records were kept confidential. The need for confidentiality was also emphasised with those who participated in interviews and focus group discussions.

Research methods

Qualitative research allows respondents to identify the important issues surrounding the research question (Bryman and Burgess 1999). There are three main methods for gathering data in qualitative research. They are

unstructured or semi-structured interviews, focus group discussions or workshops, and participant observation.

Semi-structured interviews (sometimes referred to as focused interviews) involve a series of open-ended questions. The question defines the topic, but the open-ended nature allows the interviewer and interviewee to discuss the question in more detail. In a semi-structured interview, the interviewer has the freedom to follow a line of enquiry introduced by the interviewee and to explore more deeply, in order to clarify or elaborate on a response. This encourages the interviewees to discuss their views at length. In this study project twelve semi-structured interviews, six with urban men and six with rural men, (Table 2), were found to be a successful approach to gathering the data, because the informal, conversational nature of the interview allowed for detailed discussion.

Powell and Simple (1996) suggest focus group discussions involve approximately six to twelve people, which allow group members to debate and exchange views on a particular topic. Its purpose is to obtain in-depth information on concepts, perceptions and ideas of the group. The facilitator's role is to guide the discussion. Focus group discussions can be used to focus research, formulate appropriate questions for a survey, help understand and solve unexpected problems in interventions, develop appropriate messages for health education programmes and explore controversial topics (Powell and Simple 1996). HIV and AIDS are sensitive topics and it is often best to have focus group discussions with only single

sex groups. Later a mixed focus group discussion could have been used to discuss the different opinions of women and men. It is important to ensure confidentiality of opinions and ask group members to keep what has been discussed confidential. It should be stressed that a group member may bring up experiences of friends as well as their own, and it is not necessary to bring painful personal experiences out in the open. If group members present very personal problems and need advice or help, this can be followed up after the focus group discussion. Another way to ensure confidentiality in a focus group discussion is to give participants the option of introducing themselves under a pseudonym.

Focus group discussions proved to be a powerful research tool, which provided valuable information. However, it is risky to use focus group discussions as a single research tool. In group discussions, people tend to centre their opinions on the most common opinion. In reality, opinions and behaviours are usually more diverse. Therefore, it is advisable to combine focus group discussions with some semi-structured or in-depth interviews (Morgan 1993, Powell and Simple 1996). In this study twelve semi-structured interviews were combined with two focus group discussions, held with eight university students and seven rural farmers. All those men who had been interviewed also participated in the focus group discussions, plus an additional three men. The result was a great wealth of detailed information which be discussed in more detail in the following chapter.

Selection of participants

Before interviews could proceed the question guidelines were extensively checked by a number of different Tanzanian people, both male and female, for grammar, spelling and contextual errors in translation (See Appendices). It was then necessary to contact a number of key gatekeepers. Gatekeepers are 'those individuals in an organisation that have the power to withhold access to people or situations for the purposes of research' (Miniechello et al. 1997 in Scheyvens and Storey 2003:153). For the purposes of interviewing university students, it was necessary to have the permission of the Deputy Provost. The Deputy Provost kindly gave me permission to interview students and use the university's facilities. He introduced me to the Dean of Students, who in turn introduced me to the Warden and the Student President. The Warden arranged for me to meet an initial group of students. These permissions and introductions proved extremely valuable in assisting the research process to proceed smoothly.

The interview participants were all men and came from diverse backgrounds, in terms of age, marital status, geography, religion and educational levels. The age of the participants ranged from twenty-two to forty-seven (Table 2 on page 120). There were five married participants and seven unmarried. All the married participants had children of their own, ranging in age from twenty-six down to six months old. The number of children ranged from two to six, the average being three. Six of the participants identified themselves as from urban areas and six from rural

areas. One participant identified himself as a committed Muslim, all others identified themselves as Christians. Educational attainment ranged from those who had completed primary education, to those who were currently studying towards a bachelor’s degree.

Rural participants were contacted through one of my former agricultural students, who now works as a farmer in the village. He approached a number of men and asked them if they were prepared to take part in the study project. He made his home available so that interviews could take place in a relatively private and neutral area. He was not present during the interviews.

Table 2: Interview participants

Interview Participants	Single	Married	Urban	Rural
Age (20-29)	7		6	1
Age (30-39)		3		3
Age (40-49)		2		2

Interviewing process

At the beginning of the interviews, participants were handed an information sheet outlining the purpose of the study and their rights (Appendix 3: Information sheet in English and Appendix 4: Information sheet in Kiswahili). Enough time was given to let the men read this

information and for questions. The men were reminded that they had the option of not answering any question they felt uncomfortable with. Participating men were also asked to read and sign a participant consent form (Appendix 5: Participant consent form in English. and Appendix 6: Participant consent form in Kiswahili). They were then asked for permission for the interview to be recorded, explaining again that the recording would be confidential and not be made public. All men agreed to have their interview recorded.

The interview questions were narrowed down to focus on the main themes of knowledge, attitudes, behavioural change, stigma and culture. The questions were translated into Kiswahili and piloted with two men, before the official interviews. As a result of these pilot interviews, further refinements and translation corrections were made. These pilot interviews were included in the final set of data and were carried out under the same ethical guidelines as the main interviews. The final set of questions were used a basis for the interviews (Appendix 1: Question guidelines in English. and Appendix 2: Question guidelines in Kiswahili).

Throughout the course of the interview, as well as recording the interview, short notes were taken against each question. I made an effort to keep a significant amount of eye contact, to reinforce an atmosphere of informality and maintain close communication. The interview notes provided sufficient information to clarify the interview transcripts. The participants were relaxed and forthcoming with their responses. Beginning

with general questions on HIV and AIDS helped the participants relax. Interviews lasted approximately one and half-hours. At the conclusion of the interview, the men were asked if there was anything further that they would like to contribute, discuss, or ask.

Men were then asked if they knew of other men who might be interested in participating in this study. This snowballing technique proved effective in a student campus setting, where most students had their own mobile phones and were reasonably easy to contact. At the conclusion of the interview, I thanked each participant for his time and contribution. Following a series of interviews, two focus group discussions were arranged, one with university students and one with rural participants. Most, but not all, of the focus group participants had previously been interviewed for this study project. Three additional focus group participants had heard about the study and asked if they could attend.

Focus Group Discussions

Focus group discussions were conducted to deepen the understanding on issues gained during interviews. These took part in a similar setting as the interviews; at the university in a quiet, private conference room and in the village in a private dwelling. The size of the groups was deliberately kept small, seven or eight people, so that members did not feel intimidated and to allow for a more intimate discussion. As many, but not all, of the participants of the focus group discussions had previously conducted an

interview, they were familiar with the topic and the information sheet and participant consent form; consequently, these were only distributed to those who had not previously taken part in an interview.

For the first focus group discussion with university students, a student studying community development was asked to be the facilitator, to allow me to take notes. This worked well initially, but as it became clear that two hours would not be sufficient for completing all the questions, I directed the last few questions to make the most use of the remaining time. For the subsequent focus group discussion with rural farmers, I decided to facilitate and take notes at the same time, so that the line of questioning could be more easily directed to make the most of the available time. Focus group discussions proved particularly useful in clarifying information that had been gathered in the semi-structured interviews.

As most of those taking part in the focus groups had already participated in an interview, I was able to raise various issues for clarification or discussion by the group. This generated valuable insights into various cultural practices that affect the spread of HIV. For example, participants discussed the strengths, weaknesses and risks surrounding wife inheritance. Many of the participants were anxious to hear my own answers to the questions or had further questions of their own. However, I made a conscious effort to remind participants that the purpose of the study was to record their views, not my own. At times, I gave short

answers to questions to stimulate further discussion on particular topics. When faced with a direct question, I found a useful technique was to refer the question back to the questioner, for him to answer his own question. This worked well and provided valuable insights into the participant's world-view. Another useful technique was to use participant's names and direct questions to those who had not contributed their views. Semi-structured interviews and focus group discussions proved to be very valuable tools in gathering data for the overall study project. Many of the participants reflected on how valuable it had been for them to take time out to address the issue of HIV and AIDS for themselves, their families and their communities. Some said how they had greater confidence to talk more openly about HIV and AIDS with their family and friends. Married men with children commented on how they planned to talk with their children about human reproduction.

Limitations and strategies to overcome these limitations

Although the qualitative techniques used in this study were well suited to the research question, there were still some limitations. The time consuming nature of semi-structured interviews necessitated a small sample size. The consequence of this small sample size is that the results may not be representative of the wider population. This is a common criticism levelled at qualitative research (Hancock 1998, Mays and Pope 1995). Another criticism is that the participants were not selected randomly, which may indicate a certain bias. Due to the participants' wide

range in age, educational attainment and background, a reasonable cross-section of views is represented in the results. It is suggested for focus groups to work well that the participants have something in common (Powell and Simple 1996). However, this commonality may also lead to the group having a particular perspective or bias. Having separate, focus group discussions for university students and rural farmers worked well. Each group had very distinct characteristics. The university students were mainly younger, single men. The rural farmers were all married men with children. The distinctiveness and common backgrounds of each group, allowed the participants to discuss issues more freely with each other, than they would have done had the focus groups consisted of wider cross-section of men from different backgrounds.

Using semi-structured interviews and focus group discussions allowed me to explore participants' views on the extent of the HIV and AIDS pandemic in Tanzania and understand what they felt were activities that led to the spread of HIV. This method also gave the opportunity to examine certain cultural traditions and issues that influence the transmission of HIV. Finally, we discussed the role of families and what shapes people's sexual behaviour. Although the participant group is small, 15 men, their range of ages, marital status and backgrounds, meant that results from this fieldwork will enable some insight into men's behaviour and attitudes, in relation to HIV and AIDS.

Summary

Research methodology related to HIV and AIDS has developed over the last thirty years, from focusing primarily on quantitative data to incorporating more qualitative data, in an effort to understand why people behave in certain ways, in the different cultural and social contexts in which HIV and AIDS are found (Parker 2001:167). The qualitative research methods employed for this study were semi-structured interviews and focus group discussions. The limitations of a small sample size were mitigated by having a wide cross section of men from different backgrounds.

The following chapters will show how these interview methods resulted in a wealth of data, addressing the attitudes and behaviour changes of Tanzanian men in relation to HIV and AIDS. Field results showed that influential role models, such as parents, teachers and other leaders are significant in shaping young men's attitudes towards women and relationships. Cultural norms were also shown to have a strong determining factor in men's attitudes and behaviour in relation to HIV and AIDS. Chapter 5 looks at these and other field results in more detail.

CHAPTER 5: FIELD RESULTS

Introduction

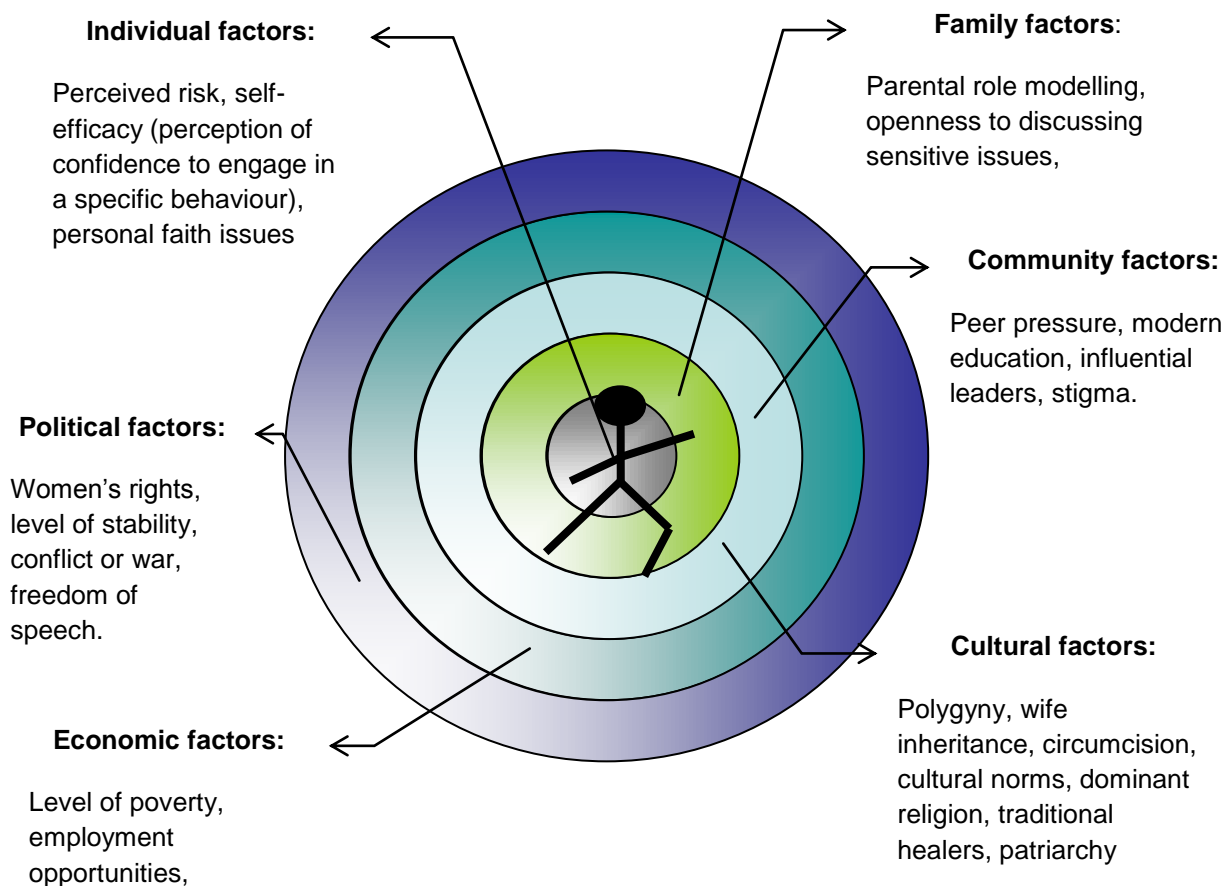
This chapter presents the results of interviews and focus group discussions. Some of the more significant themes to emerge from these interviews and discussions were the influence of peer pressure, high-risk activities and family, cultural and traditional beliefs on the spread of HIV and AIDS.

Figure 17 illustrates how these themes of peer pressure, high-risk activities and family, cultural and traditional beliefs fit into the different spheres of influence a person encounters in relation to HIV preventative behaviour. As well as personal convictions and beliefs, the community and culture surrounding people influence them strongly. Results from fieldwork showed that Tanzanian men's behaviour and attitudes in relation to HIV and AIDS is strongly influenced by those around them, such as influential leaders and peers. Religious convictions and beliefs also strongly influenced the men's behaviour.

As discussed in Chapter 4 fieldwork for this thesis was conducted in Iringa region of the United Republic of Tanzania during June 2008. Men of different ages and different socio-economic backgrounds were contacted

and interviewed at two different locations.

Figure 17 : Diagram of factors influencing HIV preventative behaviour among Tanzanian men in this study.



Source: Adapted from HIV/AIDS: The Society for the Scientific Study of Sexuality p.1.
Retrieved on 25/10/07 at <http://www.sexscience.org>

Firstly men at a university in Iringa town were interviewed and secondly men in a rural village 12 km outside Iringa town. Following the individual interviews, two focus group discussions were conducted, one at each of the two different locations. Presentation of results is structured around the diagram in Figure 17. This diagram has been discussed in Chapter 2 and attempts to depict pictorially the different spheres of influence and

the factors influencing HIV preventative behaviour for an individual. Here, I have made the diagram specific to my research findings for men in Tanzania. These can be helpful in categorising and describing the different field results. Where possible field results are discussed in this chapter using the individual, family, community, cultural and economic categories.

Conducting interviews and focus group discussions with men of various ages, marital status, educational background and professions revealed some of their understanding and attitudes towards HIV and AIDS. All men openly discussed sensitive issues relating to sexuality and had a genuine desire to increase their understanding of the virus and the effects it brings. Men were also able to offer insights into the local customs and culture that influence the spread of HIV. Most men reiterated that the influences of alcohol and a rapidly changing environment, especially increased access to secondary school and the effects globalization, are shaping the HIV pandemic in Tanzania.

Scope of HIV and AIDS in Tanzania

Men were first asked to consider the extent to which HIV and AIDS are problems within Tanzania. All the men interviewed regarded HIV and AIDS to be major problems, both at an individual level and on a wider national level. The following two quotes, one from a married man and one from a single man, represent the general view:

Yes, it [HIV and AIDS] is a large problem for Tanzania, and for the whole world, because it robs people of their strength and their

ability to work. It also takes away faith and hope from families; both the sick person and those around them are affected psychologically. Therefore, it is a problem for everyone (Married, urban student, age 38).

HIV and AIDS are big problems for Tanzania, because I remember when it first started in Kagera in 1983, many people died. They didn't know what they were dying from. They thought it was witchcraft. By the time they discovered what it was, many people had died. From 1983 to 1994 many people died, leaving old people and children behind. Therefore, the number of orphans has increased and it has affected the economy (Single, urban student, age 27).

These quotes highlight the huge impact the HIV pandemic is having for Tanzania, both at individual, family and national level. Families are losing loved ones, who are often parents and the main caregivers and providers. This has not only a detrimental economic impact on the family's ability to produce food, but as the first quote highlights, a severe psychological effect. Communities are also seriously affected as their human and financial resources are stretched, as they care for those with HIV and AIDS. Loss of community members means that overall productive capacity is reduced. As discussed in Chapter 1, nationally Tanzania has lost many people to the AIDS pandemic. In 2009 UNAIDS attributed 140,000 deaths in Tanzania to HIV and AIDS, however UNAIDS estimated that only one in five cases are actually reported, grossly understating the extent of the

pandemic (UNAIDS 2009). Economically HIV and AIDS cause a high cost in health and medical care and an increasing numbers of orphans. While nationally Tanzania continues to suffer from the ongoing effects of the HIV pandemic, efforts are being made to reduce the spread of the disease by focusing on the factors influencing HIV preventative behaviour, which will be the focus of the following section.

Individual factors influencing HIV preventative behaviour

Individual factors that influence HIV preventative behaviour can be linked to a person's gender, how much they perceive themselves to be at risk from HIV, their confidence to engage in a specific behaviour and their ability to negotiate healthy relationships. Nevertheless, how much a person perceives themselves to be at risk greatly affects their attitudes and behaviour in relation to HIV. The less likely they perceive themselves to be at risk, the more likely they are to engage in high-risk activities, for example unprotected casual sex and/or injecting drugs using contaminated equipment, as discussed in Chapter 2 above.

Where and when sexual interactions take place are shaped by a multiplicity of factors. Understanding these complex personal and social factors and seeking to influence individual sexual behaviour is not easy. The knowledge, attitudes, practice (KAP) model discussed in Chapter 2, which forms the backbone of most HIV prevention programmes, tends to ignore the power inequities involved in many relationships. Cornwall and Welbourn (2002) caution that changing what people know may have no

impact on what they do. Simply providing information on HIV and AIDS is often insufficient to change behaviour. Men were asked if they had noticed a change in behaviour among people they knew, since they had heard of HIV and AIDS, and if their own behaviour had changed. Most men indicated that any change in sexual behaviour amongst their acquaintances that they were aware of, was short lived. A university student reiterated the views of many interviewed when he talked about the short-lived nature of sexual behavioural change:

When people are shocked by something, their behaviour might be changed for a short time, but it won't continue. I remember when we were at secondary school a nurse came and showed us a video, which showed graphically, sexually transmitted diseases. Afterwards students said they were definitely not going to get involved in sex. However, by the time they had reached Form 2, 3 and 4 they had already forgotten. The same thing happened here at university. *Students Against AIDS* showed a film, but after a short time the students had forgotten about it. There is a short-lived change (Single, urban student, age 24).

Faith can play an important part in sexual behaviour. The following response is from a married man who talked about behavioural change and the role his Christian faith plays in relation to his sexual behaviour and to remaining faithful to his wife:

A few have changed their sexual behaviour, but only a few. Most have continued as before. I have tried to sit and talk with my Uncle and encourage him to change his habit of sleeping around,

especially as he knows his HIV status. I thank God I was born into a Christian family, into a safe lifestyle. I have not got into casual sex. I have remained faithful to my wife. So this question of change in behaviour doesn't apply to me (Married, urban student, age 38).

When the same man was asked if he had noticed any change in sexual behaviour at the university during the four years he had studied there, his response talks about the influence of television and pornography on students behaviour:

It [sexual promiscuity] has got worse. There are students who have come from villages and those who have come from towns. They learn from each other. Those from the villages learn a new way of living, from those in town. In addition, we have globalisation this affects how people live. Students watch television, look at pornography and copy what they see (Married, urban student, age 38).

These quotes illustrate how changing preventative behaviour in relation to HIV is not easy. Providing information about HIV and AIDS through different media forms can be helpful, but may only lead to short-term changes in behaviour. The effect of globalisation, especially in urban areas, where the influence of television, film and the internet can sway people's behaviour in relation to high-risk HIV activities; for example, increased exposure to pornography may encourage more casual sexual relationships. The quotes also exemplify the different dynamics of relationships on university campus and the peer pressure students face to have sexual relationships.

Prevention practices regarding HIV

Men were asked to note the ways HIV could be avoided. All men were aware of the ABC (Abstinence, Be faithful, Condom) programme, as discussed in Chapter 2, promoted by the government and non-government organisations, for avoiding HIV. There was a consensus among the university students, that abstinence and virginity were the most effective ways for people to avoid HIV transmission, but also an awareness of the reality that it is difficult for young people to abstain from sex because of their natural sexual drive, as the following quote from a single male student explains:

I think virginity can help reduce HIV, but it is difficult for someone of my age not to have sex, because people have sexual drive. Virginity is not really talked about. People know that sex is the main way HIV is spread, but I haven't heard people talk about virginity (Single, urban student, age 28).

Older married men also emphasised, in relation to a question about the ABC programme, that they saw virginity and abstinence as important ways of avoiding HIV: "Teach our children to say *no* to sex, both boys and girls, this requires confidence and self-control" (Student focus group discussion). Older men also cited examples of fear tactics that were used in the past to deter young people from sex, as the following quote illustrates:

In the past the grandfathers and grandmothers taught that if you

got pregnant before marriage, then your father would die and you would be thrown out of the home. Therefore many young people were afraid, both boys and girls. Nowadays the grandparents don't teach the young people, because the young people look down on the old people as old fashioned. The problem was that the old people taught that your father would die, but when they went to school, they learnt this was a lie. They then stopped believing the old people. They wouldn't accept teaching, which used lies (Married, urban student, age 38).

This quote not only raises the issue of sex before marriage, but also highlights the important issue of changing cultural traditions, which will be discussed in more detail below.

Men also discussed faithfulness (the B aspect of the ABC campaign). They regarded faithfulness to mean remaining with one sexual partner in a committed relationship, such as marriage. Men identified unfaithfulness as a risk activity and major contributing factor to the spread of HIV: "For example I might be unfaithful in my marriage, but my wife is faithful. I contract HIV and then transmit it to my wife. I have broken the law (the law of marriage)" (Married, urban student, age 38).

There was a consensus amongst men that unfaithfulness and sex before marriage was something that has increased in recent years. Reinforcing faithfulness within a committed relationship, is seen as one of the main

HIV prevention strategies. Men discussed the use of condoms (the third prong of the ABC HIV prevention programme). The use of condoms as a way to avoid HIV is widely publicised by many government and non-government agencies. However, many of the men interviewed had misgivings about promoting the use of condoms as the main strategy for HIV prevention. As the following quote highlights:

I am worried that promoting condoms is not really helping. For example if you give someone a sweet they will automatically unwrap it and eat it. Likewise, if you give someone a condom, they will want to use it. I think people have forgotten the purpose of condoms. Originally, they were for family planning and can still be used for that purpose. The problem is nowadays they are associated with casual sex and are given out freely. It's an easy thing for organisations to do (Married, rural farmer, age 47).

There is no doubt that when used properly condoms can significantly reduce the spread of HIV. However, there is often a negative view of condoms and a low level of consistent and correct use of condoms. Men interviewed reinforced the view that condoms reduced sexual pleasure and were associated with lack of trust in a relationship. Consistent use of condoms is often related to perception of risk of contracting HIV. If the perceived level of risk is low, then men are less likely to use condoms regularly.

Personal perception of risk to HIV

Perception of risk to HIV is a very important factor in the fight against the

disease. People may know about HIV and how it is transmitted. They may also be aware of the high-risk activities that increase the spread of HIV. However when men were asked to rate their own personal perception of contracting HIV, they had a range of different responses. These responses can be divided into passive and active perception of risk to HIV. The following are examples of passive reasons of risk to transmission of HIV: “Yes I am at risk because I am a member of a society where there is a lot of HIV” (Single, urban student, age 25). “Yes [I am at risk from contracting HIV] if I have to go to hospital and the equipment is not clean or I am in a road accident” (Single, urban student, age 28). “I don’t think I am at risk because I am prepared to wait [to have sex] until I am married and I know the effects of HIV and AIDS” (Single, urban student, age 22). These passive reasons for perception of risk are not associated with a specific activity. Active reasons for perception of risk to HIV are linked to specific activities, examples of which are given below.

Oh yes, oh yes, I am a young man surrounded by many temptations. As a human being, not an angel, I am at a very big risk. I have many challenges. Everywhere I go I am chosen to be a leader and a public person. Standing in front of the whole university, students look for your [phone] number, you get these messages, and you don’t know where they come from (Single, urban student, age 25).

In the beginning, people didn’t believe that sex was the major route of transmission. Because they believed HIV and AIDS came from witchcraft. As time went on people came to realise that sex with infected people was the problem. Now they realise that

unsafe sex is dangerous, but they have the habit of sleeping around, which is difficult to change (Single, urban student, age 27).

These quotes highlight that people's perception of risk varies. Those who gave a passive response generally believe that being in an environment with HIV positive people present, places them at a degree of risk. Those men who gave an active response to HIV risk were able to identify more specific activities, such as unprotected sex, that increase the risk to HIV. They may ascribe an explanation of HIV and AIDS to witchcraft or blame their partner. Others take little responsibility for their actions. Men interviewed commonly held the view that: 'It will not happen to me' or: 'It happens to others, but somehow I am immune'. While men's perception of risk naturally varies along a spectrum from passive to active, so does their own personal beliefs and convictions in relation to HIV and AIDS. It is very common in the Tanzanian context for people to ascribe a spiritual explanation to HIV and AIDS, as can be seen in the following section.

Personal convictions and beliefs in relation to HIV and AIDS

Men were asked what personal convictions and beliefs they have that could influence the way they live in relation to HIV and AIDS. For many of the research participants their own personal Christian faith strongly influenced their sexual behaviour. These two quotes, one from a married man and one from a single man indicate the importance they place on their faith, and how it relates to their sexual behaviour:

My Christian faith has taught me how to behave [sexually]. My

marriage vows have helped me remain faithful to my wife. We also received two to three hours teaching from elders on our wedding day. Although this wasn't enough, it was better than nowadays. Also, the fear of HIV/AIDS has helped me keep faithful. Even my course of study [Theology] has helped me. I want to keep faithful to the things I have learnt. I don't want to be hypocritical by teaching one thing, but doing another (Married, urban student, age 38).

A younger student expressed the way in which his faith influences his sexual behaviour in the following way:

Personally, since I have heard about HIV and AIDS there have been some things that have stopped me entering into sex. Before form five I was under my parents, they protected me. After form six, I was in a hostel and we were freer to do some things. However, in my heart there was a conscience that stopped me doing some things. I was tempted, but God helped me overcome these temptations. There is a big difference in those who are truly born again and those who are just pretending. Those who are born again, take vows to keep sex for marriage. My faith is a big thing for me. For example, I have made a stand not to enter into sex until I am married. It is good to tell your girlfriend where you stand and that you want to protect her. Later she will remind you of the promises you made. When you feel like having sex, she can help you do something else. In our culture, we don't have the tradition of hugging. Some say this can awake a desire for sex. It is good to put things in place to stop having sex, for example not

sharing a house or a room with somebody of the opposite sex. It is good to recognise your weaknesses. If you pray regularly, God will help you (Single, urban student, age 24).

Men interviewed described how religious teachings help them abstain from sex until they are married and be faithful to a single partner. The above quotes describe clearly how men associate their faith in God and the way it shapes sexual behaviour. They understand that ultimately they are accountable to both God and their partners. This accountability helps them honour the teaching that sex is intended for staying within marriage and that God would help maintain a celibate lifestyle until married.

Some men described how witchcraft and witchdoctors form a central aspect of many people's worldview, not only in relation to HIV and AIDS, but also in all aspects of life. This will be discussed later in the section on traditional beliefs. The following section explains how the environment in which the men interviewed had grown up had strongly influenced their views, although for most of them HIV and AIDS was unheard of or relatively new in their younger years.

Family factors influencing HIV preventative behaviour

Parental role-modelling and openness to discussing sensitive issues

The influence of their parents and other close family members was probably one of the strongest factors influencing subsequent HIV preventative behaviour. However, in most cases the lack of clear teaching

from their parents on human reproduction, left the research participants with many unanswered questions.

None of the participating men could recall their parents teaching them anything about human reproduction and sex. Parents seem too shy to discuss this sensitive topic with their children. The general perception is that children will lose respect for their parents, if they discuss human reproduction with their children. The shyness that some parents feel about discussing sex with their children is exemplified in this quote from a married man.

This is not something that families talk openly about. When people are getting married, they are taught about sex, but not before that. It is not permitted in African society. Even in my own family, I can't talk about sex with my children, because I don't want them to know that my wife and I have sex. Our children are not allowed in our bedroom. We have two separate beds, so that they will not know we sleep together (Married, urban student, age 38).

Although none of the men interviewed had received any sex education from their parents, most believed that it was important for parents to take a more active role in helping educate their children in this area. The following comment is from a married man during a focus group discussion who suggested that parents recognise that they need to take a more active role in sex education of their children, even if it is something they feel shy about:

The tradition of respected elders teaching our young people has

just about stopped for various reasons. It is really the job of parents to teach our children about sex, HIV and AIDS. We need to overcome our shyness. The current environment forces us to teach our children openly. The teaching they receive elsewhere is not enough. If we fail to teach our children, we are failing them. HIV doesn't discriminate; it could affect any of our own children. I have learnt that it is important to start teaching our children when they are still young and not leave it until they are too old. They will then respect us and their elders (Rural focus group discussion).

When discussing the influence of peer pressure on sexual behaviour men also commented on the influence of parents and other family members. Many young people are told by their parents that they cannot marry until they complete their studies, have a job and can afford to marry. One student expressed it this way:

People are surprised if you get married in your early twenties. Families think you should wait and they will often try to stop you getting married until you are thirty, even though they themselves got married in their early twenties (Single, urban student, age 27).

Parents and close family members play a significant role in shaping a young person's attitudes and behaviour towards HIV and AIDS. Some participating men realised the importance of helping young people discuss human reproduction and issues surrounding HIV and AIDS in a safe environment. Parents' reluctance to bring up these subjects often means children under their care gather information at school or from their peers.

This information is not always accurate and may lack teaching on moral values surrounding opposite sex relationships. Parents and close family members are not the only significant adults in a young person's life. The following section links into these discussions by showing how teachers, religious leaders and other community leaders can also play a significant role in shaping a young person's value system.

Community factors affecting HIV preventative behaviour

Peer pressure

Peer pressure is known to play an important role in how people shape their behaviour, not just sexual behaviour (Harris 2006). This peer pressure applies to both males and females. New students feel a great deal of peer pressure to have a boyfriend or girlfriend. These relationships often lead to sexual intercourse. The following comment from a single male student aged twenty-five reflects the view of the majority of men interviewed, that male identity is closely related to sexual performance: "If you are a man, they [fellow students] will think shame upon you, how come you have not yet practised sex?" (Single, urban student, age 25). Women too can assert peer pressure in the realm of sexual activity, as the following quote from a single male student, when asked to about what it is like on campus at the beginning of the academic year, demonstrates:

A female student came here from the village. She was modestly dressed with a long skirt and blouse, typical of village clothing. However, after a few months she had changed to tight clothing,

typical of other female students. She started to look for a boyfriend and they started having sex. Soon the boyfriend left her. This happened a number of times. They didn't use condoms. This hurt her very badly. (Single, urban student, age 27).

Peer pressure, either positive or negative, can be one of the most significant factors influencing a person's sexual behaviour, especially among younger people. Positive peer pressure can also encourage healthy lifestyles. Conversely, negative pressure may encourage unhealthy lifestyles, including multiple sexual relationships. The following quote from a university student reveals the negative peer pressure students experience and the commonly held belief that if you do not have sex regularly you will get unwell. It also confirms research, which shows the low level of consistent, and correct use of condoms, which has been discussed in more detail elsewhere in this chapter:

Even here at university, I have a friend who believes that if you don't have sex at least once a week, you will get sick. I once encouraged him to go and be tested for HIV, but he was too afraid to go. I said, "Do you want to die?" I asked him if he used condoms. He said that for the first couple of times he used a condom, but after that, not usually. This is very dangerous. Like many men, he doesn't believe it will affect him (Single, urban student, age 27).

Men were asked at what age people usually became sexually active. The average ages given for sexual debut were 14 years for females and 15-16

years for males. Men were then asked where young people learn about sex. As mentioned above all men interviewed said that their parents had been too embarrassed to teach them about sex. They said that young people learnt about sex from their peers and at school. Married men with children expressed a desire to overcome their shyness and have more involvement in teaching their children about human reproduction, HIV and AIDS. Several participants expressed a desire for the church to have a greater involvement in teaching young people the truth about sex, HIV and AIDS.

Modern education

In Tanzania over the last half century, there has been a move away from traditional customary education in the villages, where respected village elders were responsible for teaching younger people, to more formal 'modern' education in schools. Interview participants discussed the role this change in education had on young people and more specifically the connection of education, HIV and AIDS. The consensus among the men in focus group discussions was that schools were the right place for young people to learn about human reproduction, HIV and AIDS. However, they also had concerns about sex education in schools.

In Tanzania, most children start primary school when they are aged seven or eight and complete seven years of primary schooling. This means that nearly all primary school students will enter into puberty while at primary

school. Participants judged the mean age of sexual debut for males to be 15.5 years and for females 13.8 years. This is slightly higher than results of Jordan-Harder et al. (2004:292) in South West Tanzania, which put males at 13.1 years and females 12.4 years. They will normally graduate from primary school at about fourteen or fifteen years old. In recent years, the Tanzanian government has increased the topic of human reproduction HIV, and AIDS awareness education in the primary school curriculum. However, while parents believed it was the role of schoolteachers to teach human reproduction, teachers often find it often difficult to discuss sexuality, human reproduction, HIV and AIDS openly.

The following quotes represent some views of participating men on modern education and sex education. These quotes show how aspects of culture change significantly when traditional tribal societies adopt more contemporary modern educational practices. The introduction of modern education and the increasing impact of globalization have meant that older, especially selected elders who were given the task of sex education for younger people has virtually ceased, and meanwhile they felt the open teaching of sex education was encouraging young people to have sex:

Before modern education, young people were taught by special grandfathers and grandmothers. It was mainly teaching people not to get involved in sex. According to our customs and traditions, this type of teaching was kept for those who are newly married or close to getting married. They were taught what the purpose of sex is for a man and a woman. Modern

education has meant that even young people know about sex. They are taught what sex is, how babies are made, which time of the month a woman can conceive, but are not taught the purpose of sex within marriage and the moral values surrounding sex. They are stimulated to experiment with sex. When modern education came, it taught schoolchildren that sex was ok, even for young people. They are taught how to use condoms and all about sexual reproduction. The teaching wasn't bad in itself, the problem was that it was very open, compared to our culture and traditions. It encouraged us to enter into sex before marriage. There were those young people who went out and practised what they had been taught (Married, urban student, age 38).

Many men viewed secondary schools as high risk for HIV transmission. "During secondary school, they think it is a time to enter into sex" (Single, urban student, age 28). "Everyone says form 2 is a very bad class [for sex]" (Single, urban student, age 25). "My experience from secondary school is that many students avoid their parents and enter into sexual relationships" (Single, rural student, age 26).

However, while the percentage of primary school students moving onto secondary school has increased recently, it is still only 19.5 per cent of those who complete primary school (MoEVT 2010). As secondary school is a time and environment when many students become involved in sexual relationships, this increases their risk to contracting HIV.

Tertiary students experience greater freedom than secondary school students. For many it is the first time away from their parents' control. The following quote from a university student, illustrates some of the ways this freedom finds expression:

Imagine you are in your first year, you have not known these girls very well. So you just go and pick one, you don't know where she came from or how does she behave. Within two weeks, you are going to bed, so you can be infected. That is the type of interaction at this college. This is because most African parents are taking good care of their children, because when you are home you are not allowed to stay outside late at night. Therefore, when that young person comes here, it is a free land. Nobody is asking you if you go to class or not, it's up to you. Imagine I came here when I was 22, so now I am free. For all those days and at age 22 I am free. ... I tell you, if you go there [dormitories] at mid-night, you will see men and women in each other's dormitories, until the morning. You will see women in the men's bathrooms. You are there, brushing your teeth, and you see a woman (Single, urban student, age 25).

The above quote describes the sense of liberation and freedom many younger students feel when they attend university. The lack of strict parental control that many have been used to is no longer present and many students become involved in sexual relationships, increasing their risk of contracting HIV.

The following quote reflects the view of a mature married student, who was in his fourth and final year at university, when asked to comment on the changes he has observed:

Here at university it [sexual promiscuity] has got worse over the last four years I have been here. Students are free to do what they want; there is no one to question them about what they do, even in the dormitories. There is much sex here; especially towards the end of term when students start to leave and there are spare rooms. I don't think they should be so free. The local bylaws are not enforced (Married, rural student, age 45).

The above quote, expressed the concerns of an older student in regard to lack of control and supervision in the dormitories and the behaviour of younger students. This lack of supervision may be encouraging some students to increase their risk to HIV.

There is still a large amount of stigma associated with HIV and AIDS. This is because it is largely a sexually transmitted disease and people overall are reluctant to discuss freely sexually related issues. The following section will look more closely at stigma, HIV and AIDS.

Stigma, HIV and AIDS

The stigma surrounding HIV and AIDS continues to hinder progress in reducing the incidence of HIV. Men talked openly about the stigma they

had observed. The following response from a single man is typical of many of the men:

Yes, I know some [people with HIV and AIDS], I've seen some dying. I was not able to talk with them about the disease. Talking about HIV and AIDS is not easy because of the shyness. Most people believe that HIV and AIDS is because of sex. Therefore, if you have HIV, people will think you are a womaniser. So that's the problem. If it were another disease, such as malaria, it does not have anything to do with sex (Single male, age 25).

Participants agreed that it is only when the stigma of HIV and AIDS is reduced and individuals, families, communities and even nations can openly discuss the disease, that real progress can be achieved. They also agreed that they could each play a significant role in overcoming taboos associated with HIV and AIDS, and discuss the topic more openly with their wives and children. In focus discussion groups, men shared ideas freely with each other and discussed what they could do to help bring about a change in attitudes.

The following sections discuss how cultural traditions, tribal beliefs relate to HIV preventative behaviour. These factors were found to be very important for Tanzanian men and HIV preventative behaviour. This required adding a new and separate section to Figure 17.

Cultural factors influencing HIV preventative behaviour

Cultural traditions affect the context of sexual relationships and the transmission of HIV. In Tanzania, there are many different tribes and traditions. The majority of tribes are patriarchal, but there are also some matriarchal tribes. Patriarchy guarantees the dominant position of men and the subordination of women (Connell 1995). Strebel (1997) and McFadden (1992) identify the entrenchment of patriarchy and poverty as two major factors that affect the spread of HIV. In addition, girls may find it difficult to refuse to have sex with an older man out of cultural respect. Men in this research project highlighted the cultural traditions of polygyny, wife inheritance, circumcision and tribal markings as contributing to the spread of HIV. Men commented on how society has changed in relation to marriage and sex. The following from a married man, summarises the views of many men interviewed:

You know in the past people normally got married about twenty or twenty-one and it was possible to find people who hadn't had sex before they were married. However, nowadays even young children know about sex. This is a big change. I remember that around 1974 it was unusual for young people to sleep together. Even at weddings, young people didn't sleep together. Now there is a big change. Even at a youth camp, some people will run off into the bush and have sex (Married male, age 47).

The reality for most people living in the non-Western world is that they believe that their daily existence is controlled by the ancestors, spirits,

demons, witchcraft, witchdoctors, superstitious beliefs, charms and the like. An earlier quote above on people's perception that HIV and AIDS came from witchcraft shows this. The quotes below also illustrate a non-Western worldview about health and wellbeing encouraging practices which can lead to contracting HIV:

In the past when people got sick they would go to the local witchdoctor for help. He would cut the skin with a razor and place a cow's horn in the cut. In the top of the horn would be a small hole. He would then suck blood out through the horn. If he had a sore in his mouth it would be easy to contract HIV. Nowadays most have stopped this practice (Married, rural farmer, age 47).

In Ilula there is a tradition of incest that is encouraged by witchdoctors, who say that if you have sex with your relations you will become rich and if you don't do this you won't have money (Rural focus group).

Polygyny and wife inheritance

Tanzania has a history of polygyny and sister-in-law inheritance and this has influenced the spread of HIV. The following quotes illustrate how most polygamous relationships nowadays are unofficial and sister-in-law inheritance is decreasing:

We have different traditions of polygyny. Usually it is one man having multiple wives; sometimes it is one woman having multiple husbands. Often these relationships are not authorised. People don't marry many wives, but they still sleep with many women. I

saw on television a government leader who had a number of wives and he called himself a Christian (Single, urban student, age 24).

We had this tradition of sister-in-law inheritance which wasn't helpful. Due to HIV and AIDS, this is decreasing. Nowadays people are stopping. For example, I know one case nearby where the husband died and the brother-in-law took the sister-in-law. Later the wife died and the brother also. From this, the local people learnt that this tradition was not good. Now if the husband dies they leave the wife free to return home or marry as she chooses (Married, rural farmer, age 47).

A number of men commented that the practice of wife inheritance is decreasing because of HIV and AIDS. However, circumcision, both male and female, is still widely practiced in Tanzania, as is tribal marking and ceremonial shaving. Concern expressed amongst the men interviewed was that equipment used for these practices might be contaminated with blood from HIV positive people.

Policy makers and those designing intervention programmes often tend to overlook the way in which people perceive HIV and AIDS. If people believe that HIV and AIDS is caused by a curse or that having sex with a relative is going to make them successful in their business enterprises, then encouraging them to use condoms is not likely to be very successful. Participating men also mentioned cultural practices, which may involve contaminated instruments such as circumcision, female genital mutilation (FGM) and traditional tribal markings. Interventions need to address

people's daily reality. The reality is adherence to cultural and tribal practices intermingled with a transition from traditional rural societies to modern urban societies.

Economic factors influencing HIV preventative behaviour

Whether people live in remote rural areas or rapidly growing urban centres the need to survive is paramount. Often men are forced to travel away from home to help achieve economic survival. These often prolonged trips away from their wives and family may increase the risk of contracting HIV.

Men identified a number of activities that place people at a high risk of contracting HIV. All participants were aware that unprotected sexual intercourse accounts for the major route of transmission of HIV. Men also identified a wide-range of activities that increased people's likelihood of unprotected sex and thereby increasing their risk to HIV infection. Those activities that were mentioned included business, long distance lorry driving, logging, studying and travel, because men are often away from home for long periods. One of the most frequently cited was the influence of bars and guesthouses. The following two quotes illustrate the role those using guesthouses and consuming alcohol have in the spread of HIV:

Those who work at bars and guesthouses are at risk. I saw this one time when I had to stay at a guesthouse. I arrived about six in the evening. I was afraid. Two women came to the room I was sleeping in. Fortunately, I had locked the door! Later I heard many

men come into the guesthouse and the goings on [sexual intercourse] that leads to HIV being spread around. Guesthouses are dangerous places for people (Married, rural farmer, age 47).

Another activity that causes the spread of HIV is the local beer trade. Many men after they have been drinking [beer] force themselves on their wives, without any discussion. In addition, this beer causes men to sleep with women who are not their wives, some of whom are prostitutes (Single, urban student, age 27).

Not only were clients of bars and guesthouses identified as high risk of HIV infection, but also the employees of bars and guesthouses. Young women in these bars or guesthouses often come from rural areas to towns and cities looking for work. The following quotes highlight the risks these young women face. These quotes not only highlight the risk that employees of bars and guesthouses face, but also the links between poverty, gender iniquity and HIV transmission:

People are trying to combat poverty; they come in from the villages looking for work as house cleaners or barmaids. Daily workers are in dangerous situations (Single, rural student, age 26).

Another place is the bar; those barmaids and the way they dress bring about harm. The way they dress attracts men. It is difficult for them to have just a drink; they are attracted to have sex with the barmaids. This is a big problem; I have seen it in many places (Married, rural farmer, age 47).

Gender inequity

Most cases of coerced or forced sex are committed by men known to the victim, such as husband, family member, friends or men in positions of authority such as schoolteacher (Garcia-Moreno 2000, WHO 2002). Coerced sex is often more physically traumatic than consensual sex, and this increases women's vulnerability to HIV. Men identified different contexts of gender inequity, which contribute to the spread of HIV. For example, 'Sexual favours from students to teachers misusing their power' (University focus group). Girls often find it difficult to refuse older men or men in authority over them, as this following quote illustrates:

A big factor is poverty that causes women in particular to engage in sex. When they don't have money, they may be tempted to provide sexual favours. Some students are tempted in this area to get something in return. Sometimes the parents are involved; maybe they have five children and cannot afford the school fees. Sex becomes connected with money. The daughter may bring some money home, but the parents don't ask where she got the money. It often involves an older, richer man. Older men often look for younger women because they are virgins or haven't had children. Girls find it difficult to refuse an older man, because of the culture. This is a big danger for girls (Single, urban student, age 24).

Economic deprivation forces people to take risks, which affect their health and well-being. The basic human need to survive may force some men and women to engage in activities as a way of survival even if they know those

activities to be unsafe. Many of these activities are clandestine and hidden from public view, making it harder for welfare agencies to help.

Summary

Field results provide the heart of any research project and results from this study were extremely revealing. HIV and AIDS is a major problem in Tanzania and men of different ages and background shared willingly in interviews and focus group discussions on sensitive subjects. This cooperation and openness enabled me to record and collate the results easily. All men are subject to strong internal and external factors that shape their attitudes and behaviour in relation to HIV and AIDS.

The main individual factors that research participants discussed were the influence of personal faith and perceived risk in relation to HIV. Those who had a strong Christian faith were clear about the importance of abstaining from sex before marriage and being faithful to one marriage partner, as two of the main ways to reduce the risk of contracting HIV. They said that it was their faith that helped them resist the temptation to engage in pre-marital sex or extra-marital affairs. Personal perception of risk to HIV can be very subjective and a number of participants indicated that it was something that happens to others, but they were immune. They also noted that changes in behaviour were usually short lived.

Research participants highlighted peer pressure, alcohol and other drug

abuse, poverty, societal norms, spiritual and cultural beliefs as being the key factors in relation to HIV preventative behaviour. University students talked about the strong peer pressure they felt from other students to have girlfriends and sexual relationships. They said they were made to feel unusual and strange if they did not have a girlfriend. However, peer pressure is not always negative; it can be used to reinforce positive healthy lifestyles. Men commented that parents and other influential leaders can help support healthy choices for young people.

Interviewees talked about the strong influence of cultural practices, such as polygyny, on the spread of HIV, although nowadays most polygamous relationships are unofficial. Men also observed the way in which cultural traditions are changing, due to contemporary education, globalisation and young people's attitudes towards their parents and elders. Men perceptively recognised that seeking to bring about behavioural change based on knowledge, shock or fear, are often unsuccessful. Men said what is needed to bring about long lasting changes in sexual behaviour, as well as correct education on HIV and AIDS, are programmes incorporating such issues as power relationships, sexual patterns and the context within which sexual decisions are made. They commented that men and women should be given the opportunity to discuss issues such as intimacy, self-confidence, respect, faithfulness, alcohol and other drug abuse. The consensus among research participants was that a greater degree of preparedness to discuss HIV and AIDS related issues is required to combat the disease.

The following chapter goes on to explore in more depth how the fieldwork results relate to the main themes of the socialization of young men, such as those shown in Figure 18 below, and gender inequity in relation to HIV preventative behaviour, as discussed in earlier chapters.

Figure 18: Teenage boys on their way back from school in rural Tanzania.



Source: Author

CHAPTER 6: DISCUSSION and CONCLUSION

Introduction

While there have been some encouraging signs in the battle against HIV and AIDS, and some countries have managed to stabilise or reverse climbing HIV prevalence, the battle continues to rage in sub-Saharan Africa, Eastern and Central Europe and Asia. There can be no doubt that anti-retroviral therapies (ARTs) are a major weapon in the armoury against HIV and AIDS, however ARTs are not a vaccine or a cure. Currently only approximately half of the six million people who need ARTs are receiving them (HIVAIDS Care 2012). This means that the current rate of distribution of ARTs is not keeping pace with new infections. There is still relatively little research on the rate of transmission of HIV from those who are using ARTs, although early evidence suggests consistent use of ARTs significantly reduces the rate of transmission of HIV (Blower and Farmer, 2003). While ARTs may be important in helping those with HIV and AIDS, and everything should be done to increase access to those who need them, they require expensive resources, efficient channels of distribution, trained medical personnel and health facilities, all of which are often lacking in developing countries, particularly in remote rural areas. If the battle against HIV and AIDS is to be won, more needs to be done in the area of HIV prevention. For this to happen people's attitudes and behaviours must change.

This discussion and conclusion chapter will relate the fieldwork results presented in Chapter 5, with the review of literature on HIV, AIDS, behavioural change, and men and masculinities discussed in Chapters 1, 2 and 3. It will look at in what areas the results of this study confirm or deny what has been found elsewhere and in particular address the main research question:

What factors influence the attitudes and subsequent behaviour of Tanzanian men regarding HIV and AIDS?

This chapter will also focus on how results from this study can be used to support recommendations for individuals and institutions involved in the prevention and treatment of HIV and AIDS, and in what areas further research may be needed.

Helping people adopt long-lasting healthy behaviours requires interventions at all levels. Ideally, individual, family, community and national interventions need to work together with a clear consistent message in order to be successful in reducing the prevalence of HIV. For example in Uganda, many different institutions joined in a concerted effort to reduce the prevalence of HIV (Asimwe-Okiror et al. 1997, Pettifor et al. 2005: 978).

Men's sense of being invulnerable

If people do not perceive themselves to be at risk from HIV then they are

unlikely to adopt preventative strategies. Those working in the area of HIV prevention find this sense of invulnerability a major obstacle in their work (Duncan et al. 2002). Amongst the men interviewed, there was a range of different responses to the question on perception of personal risk of contracting HIV. Although most men had an awareness of HIV risk, some of them appear to have externalised the risk of contracting HIV and saw no reason to modify their sexual behaviour. Other studies confirm the view that young people tend to perceive themselves not at risk from HIV, and therefore have little incentive to practice safe sex or take responsibility for their sexual behaviour (Harrison et al. 2001, Koenig et al. 2004, Nzioka 2001, Selikow et al. 2002). Mann and Tarantola (1996) cited in Awasubo-Asare (1999:128) suggest that young people have as sense of invulnerability as a function of their stage of development. This may also affect how they rate their risk to HIV. This study reinforces other studies, that if HIV preventative strategies are to be effective then people need to be able to correctly assess their own level of risk to HIV as an integral part of long-lasting healthy lifestyle.

Results from this study suggest that some men categorised those they perceived to be at risk from contracting HIV and often placed themselves outside those categories. For example, they saw clients and employees of guesthouses and bars and truck drivers at risk, but not themselves. Many participants commented that amongst their peers, preventative behavioural change was often short-lived. Even though some of the participants had had a succession of different sexual relationships and inconsistent condom usage, they still rated their personal risk to HIV as

low. Most of the participants had personally lost family members or friends to AIDS. However, this personal loss did not always lead to long-term change in behaviour. Achieving long-lasting behavioural change that leads to a healthy lifestyle is difficult and requires a concerted campaign across a number of fronts. Further research could seek to identify why some people externalise their risk to HIV.

Resistance to use of condoms

In relation to the fight against HIV self-efficacy is often linked to condom usage. Of the men interviewed for this study there were differing opinions on the promotion and use of condoms. Most felt that condoms were associated with promiscuous sexual behaviour, a lack of trust and reduced sexual pleasure. This study reinforces earlier findings that condom use is often inconsistent (Schnell et al. 1996). Although it is clear that when used correctly and consistently condoms can significantly reduce the spread of HIV, as Bond and Dover (1997) point out, relying entirely on condoms to reduce the HIV transmission is not sufficient. Government and non-government institutions that have in the past focused on condom promotion and distribution should include strategies that address the wider issues of personal and cultural reasons why condom use is often inconsistent. For example Maasai people prize fertility and believe semen is necessary for young women to develop properly, they are therefore unlikely to use condoms (Coast 2007:391).

Encouraging youths to abstain from sex

The men interviewed believed sexual abstinence before marriage was an effective HIV preventative behaviour. However, they also noted that abstaining from sexual relations before marriage was difficult to achieve. In a study with Rwandan youth, Babalola (2002) found that the factors that helped young people abstain from sexual relations before marriage included non-urban residence, Christian religion, not using alcohol, perceptions about peers' sexual behaviours, self-esteem and perceived self-efficacy to refuse sex with someone known for more than three months. Helping young people identify these and other factors that improve their ability to abstain from sex before marriage can be seen as effective HIV preventative strategy. Life skills can influence an individual's ability to adopt HIV preventative strategies.

Wieggers and Scott (2004:21) found that relevant life-skills that help strengthen HIV preventative behaviour include dealing with emotions and communication skills, decision making about relationships and sex, dealing with peer pressure to have sex, negotiating safer sex, unhealthy use of alcohol or other drugs, conflict resolution, problem solving and risk avoidance. This study confirms these findings and in particular found that peer pressure to engage in sexual relations strongly influenced university students. This will be discussed in detail below.

Early sexual debut, peer pressure and influence of role models

Men who were interviewed for this study project talked about the strong peer pressure on young people to engage in early sexual relationships. This peer pressure is especially evident at secondary and tertiary institutions. Participants judged the mean age of sexual debut for males to be 15.5 years and for females 13.8 years. This is slightly higher than results of Jordan-Harder et al. (2004:292) in South West Tanzania, which put sexual debut for males at 13.1 years and females 12.4 years. This compares with data presented in Table 1, that just over 10 percent of men and women aged 15-24 had sex before 15. This young age of sexual debut increases the vulnerability of adolescents to STIs, including HIV, and should be a matter of concern for those working with young people in HIV preventative strategies. The perception amongst the men interviewed was that as young people experience puberty and mature physically, they are ready to engage in sexual relationships. Very little research has been done in Tanzania relating to the circumstances that surround young people's first sexual encounter. Because heterosexual transmission accounts for over 90 per cent of the transmission of HIV in sub-Saharan Africa, understanding the circumstances and context of first, and subsequent, sexual experiences is important for developing effective HIV prevention strategies. Not only is it important to better understand the circumstances surrounding sexual debut, but also the role influential role models have on the socialisation of boys and young men.

All young men are strongly influenced and socialised in the way they behave towards women from a very early age by influential older male role models around them (Greig 2005:1). Fathers, uncles, teachers, religious leaders, media and sports stars and others, all shape the way a young boy relates to girls and women around him. Young men may observe their father or other close relative abusing women. This may cause them to behave violently towards women or view women as sex objects. At a wider level the pressure of patriarchy, male domination of women, strongly influences the way in which men relate to women (Kaufman 1999:1-6).

Working for greater gender equity via appropriate socialisation of boys

Rolling back thousands of years of patriarchy, or male dominance, is no easy task. The WID movement in the 1970s clearly sought to address male domination in the area of development. Later policy makers and practitioners realised the limitations of WID and sought to reintegrate men through GAD. Now there is a very clear recognition that if women's rights, health and overall development are to be improved, men must be included. Hence, the integration of right-based approaches to development issues, including health (WHO 2010).

To fight ingrained patriarchal beliefs about masculinity every man must start to examine in what areas he is exploiting or disrespecting women and girls, and promoting male domination of women. Men still largely

control many of the decisions relating to women's rights, health and development. The ideal is that women and men discuss together in an equal and fair environment what needs to be changed to achieve a healthier lifestyle for both women and men together. If women are consistently abused by men who believe that they have the right to abuse women, then men need to be encouraged to re-evaluate the beliefs behind their actions. Those working with men in the area of sexual behaviour and HIV prevention aim for a long lasting change, a transformation, into equitable and responsible men (Barker 2003, Robins 2006). They encourage men to examine the ways in which their relationships with women may be inequitable, posing a risk to themselves and their partner. Greig (2005:1) and other commentators believe this issue of socialization of boys and young men to be the most important factor in developing healthy HIV preventative strategies.

Barker (2003) and others seek to reverse the domination and abuse of women by searching out individual men in a community, men who face similar constraints, but who act in a responsible and equitable way towards women. These men become role models for other men in their community. Parker (2001) and Gupta (2002) take a slightly different approach to gender inequity by seeking to identify socio-economic factors that exacerbate gender inequity. Both approaches are important and not mutually exclusive. Communities and nations are made up of individuals, individuals who need to be challenged to examine areas in their own lives where gender inequity exists and examine areas at community or national level where gender inequity exists. There is much that can than can be

achieved at individual and community level to improve the health and welfare of women. Positive peer pressure can be a powerful force in bringing about change; when societal norms and the pervading culture dictate that women be treated fairly in all areas, the battle against HIV and AIDS will have taken a giant step forward. This rescripting and socialisation of boys and young men into responsible gender equitable men could be the most important weapon against HIV and AIDS. Gender equitable men are defined as those who are respectful to women, do not use violence against women, assume some responsibility for reproductive health issues and are involved fathers, for those with children (Barker 2000). Creating more gender equitable young men is a slow process when the forces of patriarchy have been amassing for generations. Parents and guardians are some of the most influential role models in this socialisation and rescripting process.

Change in society regarding age of marriage and sex education

Although all the men interviewed said none of their parents talked to them about human reproduction, the influential male role models and culture in which they grew up will have strongly shaped their attitude towards women and sex. It is significant that single male university students interviewed talked about the pressure they received from family to delay marriage until they had completed their studies and could afford to get married. The mean age of single students interviewed was 25.3 years (n=7). This means that many men in Tanzania will not get married until their late twenties or early thirties, whereas their parents generally

married in their early twenties. Delay in marriage is seen as one of the factors that increases the prevalence of HIV, as there is more likelihood of multiple and concurrent sexual relationships (Barker 2003b:4, Ntozi and Nakayama 1999:178).

The men participating in this study believed it was predominantly the role of schools to inform children about sex, HIV and AIDS. In the past specially assigned '*babus*' and '*bibis*' (grandfathers and grandmothers) in the community were given the task of teaching young adolescents about sex and marriage. They took single sex groups away from the normal everyday home environment to give them some concentrated teaching to help them prepare for adulthood. Certain tribes and in the more remote areas of Tanzania this practice continues. However, men said that in many areas this traditional practice of preparing young people for marriage has largely disappeared, only the older men interviewed had had a time of preparation as described above. The introduction of formal 'modern' schooling into Tanzania in 1960s and 1970s and greater mobility among the population has precipitated the decline in traditional teaching. Parents have largely abdicated the responsibility of ensuring their children receive good sexuality teaching to the schools. However, many of the married men with children expressed a desire to be better equipped to teach their own children on sex, HIV and AIDS.

Many teachers, who are often parents themselves, feel embarrassed to teach openly about sensitive sexuality issues. The Tanzanian education curriculum requires all schools to teach on human reproduction, HIV and

AIDS, but many teachers have received no specific training in these areas and feel inadequately prepared to teach these topics in the classroom. Men reported that some teachers resort to distributing simple one-page handouts in an effort to meet the needs of the curriculum. Tanzania has a widely distributed population, many of whom are in remote rural areas, which suffer from poor education and health facilities, this makes improving health education for young people difficult. Many teachers are deterred from working in these remote rural schools because of very large class sizes, understaffing and poor facilities. Unfortunately, many teachers have also succumbed to AIDS and there is a national shortage of trained primary and secondary teachers.

With parents and teachers frequently feeling too shy and inadequately prepared to teach on sexuality issues, young people are often left to discover about sex from their peers. The information they receive may be inaccurate and lead to sexual experimentation. When students move from secondary into tertiary education they are usually in their twenties and are frequently pressurized from their fellow students to have boyfriends and girlfriends. These relationships often lead to sexual liaisons, some of which may be short term and involve concurrent partners. All the male tertiary students interviewed talked about this 'culture' of promiscuity on the campus and that although there were rules for the dormitories, that these rules were not enforced. They also talked about the widespread use of pornographic material, both in the computer laboratories and dormitories. This material, they believed, encouraged students to experiment with different sexual relationships, increasing their risk to STIs including HIV. In

the orientation programme for new students the university spends considerable time and resources in helping to educate students about HIV and the risks of pre-marital sex.

Cultural traditions have a strong influence on people's attitudes and behaviour

One of the major findings of this research is that certain tribal and cultural traditions strongly influence HIV preventative behaviour. Tanzania has a rich and diverse cultural heritage. Traditional African belief systems intermix with the influence of Christianity, Islam and globalization. Known as the cradle of humankind, Tanzania has experienced the influence of human settlement and migration for millennia. Sparsely spread traditional hunter-gatherer civilizations have given way to more settled agro-pastoralists where clusters of villages centred around tribal chiefs have grown up. Each tribe is characterised by their own language or dialect and distinct traditions. However, there is a considerable degree of overlap between neighbouring tribes due to trade and intermarriage. There was also considerable hostility between tribes as they disputed scarce resources such as productive land and water. Many of the tribes are strongly patriarchal, believing that men are superior to women. This patriarchal worldview persists in many areas today and affects men's view of women. Men who perceive women as inferior may treat them inequitably, causing them to be more vulnerable to abuse and at greater risk from STIs including HIV. Traditions of polygyny where men have more than one wife also influence the spread of HIV. Nowadays these relationships are more likely to be informal. Following a HIV seminar a

group of men expressed the view that to remain in a monogamous relationship for the whole of their adult life was alien for them (Personal communication 2004).³ They expressed the view that it was quite normal and expected that men would have multiple relationships.

Tanzania, along with most other sub-Saharan countries, is in a time of transition as it moves from traditional customs and culture into a postcolonial culture, strongly influenced by the West and globalization. These new structures have different rules and norms surrounding sexual behaviour. Awasabo-Asare and Anarfi (1999:10) assert that young people in sub-Sahara Africa are confronted by four contrasting moral regimes relating to sexual behaviour; traditional, Christian-Muslim, administrative-legal and 'romantic love'. The traditional and Christian-Muslim regimes support sex only within marriage. However, the traditional and the Christian-Muslim regimes are giving way to the other two regimes, which lack formal enforceable codes. 'Romantic love' allows for sex before marriage, so long as the people involved are 'in love'. Men interviewed confirmed that the expectation amongst secondary school students was that Form 1 (the first year of secondary education) was the generally expected time to begin sexual relationships and that pre-marital sex was the norm, rather than the exception. As traditional tribal societies adopt modern educational systems, they are forced to adapt. However, it may be possible to retain some of the older traditional practices, for example specially selected elders whose role it is to teach younger people about human reproduction.

³ Personal communication with the author in July 2004.

Within the last hundred years urban settlement in Tanzania has expanded rapidly and now accounts for approximately 35 per cent of the population. Although a considerable proportion of Tanzanians now live in towns and cities many of their cultural and tribal traditions persist. For example, circumcision is still widely practised amongst certain tribes, even though they may live far from their tribal homeland. Men in urban environments especially those who have recently moved from a rural environment, are often struggling with issues of change in identity and where they fit in. Silberschmidt (2001:667) argued that 'a man's identity, self-confidence and social value are closely linked to his sexuality'. Harris (2006) in his work with men in rural Ecuador encouraged men to stop pressurising each other to have multiple partners in order to prove their manhood. This suggests that men believe that masculinity is closely linked to sexual activity. Some men may be more interested in reporting their sexual conquests than developing long lasting close relationships. HIV prevention programmes that allow men and women space to discuss issues such as identity, urbanisation, intimacy and equitable relationships, are more likely to be successful.

Empowerment of women and also vulnerable men is needed

As discussed in Chapter 2, in sub-Saharan Africa young women (15-24 years) account for 75 per cent of HIV infections and are approximately three times more likely to be infected than young men of the same age (UNAIDS 2004:31). Women and girls are also particularly vulnerable to

domestic violence. Domestic violence is often hidden from the public eye and frequently involves men misusing their physical strength to abuse women both physically, psychological and sexually. Reducing the levels of domestic violence by holding men accountable for their actions and empowering women to seek help from the relevant authorities can be one important way in achieving a more gender equitable society. Studies from Rwanda, Tanzania and South Africa show up to a three-fold increase in risk of HIV among women who have experienced violence, compared to those who have not (Dunkle 2004, Maman et al. 2002, van der Straten et al. 1998). Although the participants of this study project were not asked specifically about gender equity or domestic violence, a number of responses indicated that it was an issue. As in the case of the man who talked about the detrimental influence of alcohol on marital relationships.

Alcohol consumption has been linked directly to increased risk from STIs including HIV (Clift 2003, Garbus 2004, Greeley 2000, Torell et al. 2007). Alcohol often increases the risk of the casual sexual relationships and violence between men and women. HIV prevention initiatives that address alcohol and other substance abuse and seek to discover the root causes of the abuse, are more likely to achieve positive results. Men partaking in this study talked about the way in which the misuse of alcohol is often linked to casual or coerced sexual liaisons, both in urban and rural settings. It is not easy to define why certain people become entrapped in substance abuse (which includes alcohol and other drug abuse). Alcohol and other drugs are addictive and breaking any addiction is difficult. Feelings of insecurity and low self-esteem may cause some people to be

involved in substance abuse and poor economic conditions may also encourage substance abuse. In the same way that HIV and AIDS are clearly linked to poverty, substance abuse can also be linked to poverty. However, it is insufficient and inaccurate to say that HIV and AIDS, and substance abuse are caused by poverty. HIV and AIDS, and substance abuse can be found in both high and low income areas. Untangling this web of cause and effect when discussing HIV, AIDS, substance abuse and poverty is no simple affair. One thing is clear; HIV, AIDS, substance abuse and poverty all interact with each other to exacerbate each other. The challenge is to enable people to be released from this web of misery, addiction, poor health and to be empowered.

Interventions should focus on societal change not just individual change

Many of the models and theories of behaviour change, as discussed in Chapter 2, emphasise individual behavioural change. Factors such as, gender, perception of risk, self-efficacy (perception of confidence to engage in a specific behaviour) and life skills (especially self-esteem), are all significant factors in a person's ability to adopt HIV preventative behaviour. However, this thesis concludes that wider family, faith, community, economic and political factors play as much, if not more, of an influence in the spread of HIV.

Personal convictions and faith in relation to HIV and AIDS

There is increasing awareness amongst secular organisations involved in HIV prevention and treatment, that faith plays an important part in shaping people's behaviour. This research aimed to explore further the link between faith, HIV and AIDS.

'Faith is a crucial link among people's efforts to make sense, to change practices and circumstances in the face of AIDS in many societies of sub-Saharan Africa' (Geissler 2006:10). Western researchers often disregard the spiritual component of development issues; however for most people in the developing world the spiritual aspect of life forms a fundamental part of their overall worldview. For example for many people in sub-Saharan Africa, the traditional healer wields a powerful role in their day-to-day lives. Focus group discussions conducted during this study revealed some traditional healers promote incestuous or casual sexual relationships as a way of achieving successful businesses. Policy makers and practitioners involved in the battle against HIV need to consider these daily realities when designing HIV prevention programmes.

Most of the men who took part in this study identified themselves as Christians and regarded faith as an important issue in HIV preventative behaviour. Those men interviewed who had a strong personal faith in God spoke about how important their faith was in shaping their sexual behaviour. They believed that sex was only for marriage and that God gave them the strength to overcome the temptation to engage in pre-marital

sex. They also believed that God would help them remain faithful to their wife. These two points are consistent with Christian teaching and match the A (abstinence before marriage) and B (be faithful to your partner) of the ABC prevention programme widely promoted by many organisations. Although men talked openly in the interviews and focus group discussions about abstinence and virginity, the men admitted that it was not something that men readily talked about in their families or in the community. Men agreed that abstinence was the best way to avoid HIV. However, they pragmatically agreed that it was very hard for unmarried people to maintain an abstinent lifestyle.

Those who grew up in a strong Christian home and have continued in the Christian faith talked about how important the faith of their parents and their own faith is in guiding their relationship with women and their sexual behaviour. That is not to say that all Christian men behave in an equitable way towards women, in fact some churches distort the Christian message of equity between men and women and encourage patriarchy. Most of the men involved in the study project wanted the church to be more actively involved in teaching more openly and thoroughly on HIV and AIDS. They commented that many religious leaders are shy about addressing sensitive issues and that some church people are involved in pre-marital sex and unfaithfulness. Men wanted the church to be at the forefront of empowering people to delay sexual relationships until marriage and equipping married couples to remain faithful. Some church leaders may feel ill equipped to help others when they have unanswered questions, misconceptions and prejudices relating to HIV and AIDS. Unfortunately,

not only are many people within the church poorly equipped to help lower the risk of HIV transmission, but also they still condemn those that are HIV positive because it is predominantly a sexually transmitted infection. They associate HIV and AIDS with promiscuity and unfaithfulness. This condemnation leads to an atmosphere of alienation, rather than a willingness to help someone, whatever his or her situation.

The need for a culture of openness

Due to the fact that in sub-Saharan Africa HIV is largely spread by sexual activity, there is high degree of stigma and shame associated with the disease. It is often associated with premarital sex, adultery, transactional sex and rape. While all of these activities significantly contribute to spread of HIV, the stigma and shame that prevents people taking adequate preventative action must be removed. Stigma, shame and embarrassment can prevent parents talking with their children about sex, HIV and AIDS. Later parents may regret they had not overcome that embarrassment when they discover their child is HIV positive. The same reluctance to talk openly can be seen at all levels of society, from teachers, to government and religious leaders and even among young people themselves as they absorb the culture of silence and denial around them. Community, religious and national leaders can all help create a culture of openness when discussing HIV and AIDS.

The church should be a place where everyone feels welcome and

accepted, not a hostile environment where those who are struggling with issues surrounding HIV and AIDS feel ostracized. One of the men who participated in a focus group discussion talked about how the congregation he was part of had different age groups to cater for teaching all the members about HIV and AIDS. This could be an appropriate model for other churches to consider.

Concluding statements

The thesis set out to investigate what shapes the attitudes and behavioural change of Tanzanian men in relation to HIV and AIDS. It has found that men are strongly influenced by the prevailing culture surrounding them. This can be both positive and negative when considering HIV preventative strategies. Boys and young men who have been influenced, or socialised, to treat women in an equitable manner are more likely to respect women's sexual and reproductive health needs. These men are also more likely to adopt healthy HIV preventative strategies such as delaying sexual debut until marriage and remaining faithful to their partner.

Conversely, men who have grown up in a strongly patriarchal culture, which may have also included domestic violence, substance abuse, polygyny, and a culture of promiscuity are much more likely to have earlier sexual debut and multiple sexual partners, all factors that increase the spread of HIV (Barker 2003). Young people identify with influential

role models in their lives. Parents, significant family members, teachers, religious and community leaders, music or sports heroes and even presidents and prime ministers, all play a strong part in a young person's life and their subsequent decision-making. When these role models come together with a strong unified voice and lifestyle that long-term monogamous sexual relationships greatly reduce the risk to sexually transmitted diseases, including HIV, young people are much more likely to adopt healthy monogamous relationships themselves. When young people are bombarded with mixed and conflicting messages and surrounded by a polygamous culture they are left floundering, confused and isolated, with no clear direction in their lives.

The good news is that there is a great deal that can be done to limit the spread of the HIV by adopting responsible and healthy lifestyles. This study found that peer pressure played a big part in both young men and young women's behaviour. Many of the university students interviewed commented on how they had experienced strong peer pressure to have a girlfriend and were made to feel unusual if they were not involved in a sexual relationship. This study reinforces other studies that conclude faith is an important aspect in developing effective HIV preventative strategies.

This thesis also finds that it is necessary for national and international agencies to join forces with religious organisations, the local community, schools, colleges, universities and sporting clubs in the fight against HIV and AIDS. The HIV pandemic must be seen in the wider context of poverty,

addressing issues such as gender inequalities, creating employment opportunities, self-esteem, alcohol and other drug abuse, discrimination, food insecurity, stigma and human rights.

APPENDICES

Appendix 1: Question guidelines in English.

Project Title: Male attitudes and behavioural change in Tanzania in relation to HIV and AIDS

Question guidelines

1. Do you think HIV and AIDS are a major problem in Tanzania? Why or why not?
2. What kind of activities put people at risk of HIV infection? Are there other ways in which people believe they can become infected by HIV? What are these? What is being done by schools, churches, mosques and local government to encourage awareness of HIV and AIDS, and to persuade men, women and children, whose behaviour puts them at high risk of HIV infection, to change their ways?
3. How can HIV be avoided? Which of these ways to avoid HIV infection would be the most difficult to put into practice? Why is this? Do you perceive yourself to be at risk from HIV and if so in which way?
4. Do you know people who are affected by HIV and AIDS? Do you discuss with them what they can do? Are you afraid to discuss with them about HIV and AIDS? How difficult is it to overcome any negative attitudes you may have?
5. Have you noticed a change in behaviour among people you know (e.g. friends and family) since they heard of HIV and AIDS? What change? How long did it last or does it still last? Has your own behaviour changed in any ways? Please explain.
6. Do you have any useful ways of describing HIV infection in your culture? Are these helpful? Are there traditions in your culture that could increase the spread of HIV? Do you believe in traditional healers? Do you believe that they can cure HIV and AIDS? In

what way? Who would you go to if you believe in it?

7. At what age do people usually become sexually active? Where do young people learn about sex? Is it something that families are able to talk about openly? Why or why not? Do your friends consider virginity and abstinence as options for avoiding HIV? What do you say

8. If you are in a sexual relationship, do you have concerns for the health and wellbeing of the woman/women you are sleeping with? What measures do you take to protect them, or to protect yourself?

9. Can you find in yourself some personal convictions and beliefs that affect the way you live, in particular, your attitudes and behaviours regarding HIV and AIDS? How did you acquire them?

Appendix 2: Question guidelines in Kiswahili

Jina la Utafiti: Mtazamo ya wanaume na mabadiliko ya tabia katika Tanzania kuhusiana na

UKIMWI

Maswali

1. Je, unafikiri UKIMWI ni shida kubwa kwa Tanzania? Kwa nini au siyo?
2. Shughuli gani zinazowafanya watu kuwa katika hatari za maambukizi ya UKIMWI? Kuna shughuli nyingine watu wanafikiri wanaweza kuambukizana na UKIMWI? Ni shughuli zipi hizo? Ninikinafanyika mashuleni, makanisani, msikitini na utawala wa eneo ili kutia moyo ufahamu wa VVU na UKIMWI na kuwashawishi wanaume, wanawake na vijana, ambao tabia zao zina hatari za maambukizi ya VVU, kubadilika tabia zao?
3. Je, inaweza kuepuka VVU kwa njia gani? Njia gani ni vigumu zaidi kufanikiwa? Kwa nini? Je, wewe unajiona mwenyewe kuwa katika hatari ya VVU, kama ndivyo, kwa vipi?
4. Unawajua watu walioathirika na VVU na UKIMWI? Unajadiliana nao kuwa lipi wanaweza kufanya? Unaogopa kujadiliana nao kuhusu VVU? Kuna ugumu gani katika kubadili mitazamo hasi uliyonayo?
5. Je, umeona mabadiliko ya tabia katika watu unaowajua (kwa mfano wajamaa, na marafiki) tangu waliposikia habari za VVU na UKIMWI? Mabadiliko gani? Kwa muda gani? Una endelea? Tabia yako imebadilika? Kwa njia gani?
6. Je, unayo njia inayofaa ya kuelezea maambukizi ya VVU katika utamaduni wako? Hizi zinasaidia? Je, unazo desturi na mila katika utamaduni wenu ambazo zinaweza kuongoza kusambaa kwa VVU? Unaamini waganga wa kienyeji? Unaamini wanaweza kuponya VVU na UKIMWI? Kwa njia gani? Unaenda kumwona nani kama unaamini?
7. Ni umri gani vijana wanaanza kufanya ngono? Vijana wanajifunza kutoka wapi kuhusu kujamiiana? Je, ni kitu ambacho familia zinaweza kuzungumzia kwa uwazi? Kama sivyo, kwa nini? Rafiki zako wanafikiri ubikira na kutojihusiana ngono inaweza kuepuka VVU? Wewe unafikiriaje?
8. Kama una mahusiano ya kujamiiana, unajali kuhusu afya ya mwenzi wako? Unafanya kazi yeyote kulinda afya ya mwenzi wako au kujilinda afya yako?
9. Unaweza kuona kwako misimamo na imani binafsi inayo athiri jinsi unavyoishi? Ulivipataje?

Appendix 3: Information sheet in English

Project Title: Male attitudes and behavioural change in Tanzania in relation to HIV and AIDS

INFORMATION SHEET

Introduction

My name is Tim Lloyd-Jones and I am a student at Massey University in New Zealand. This research project will be conducted with both rural and urban participants in the Iringa region of the United Republic of Tanzania, as partial fulfilment of the requirements of the degree of Master of Philosophy (Development Studies). The purpose of this study is 1) to attain a Masters degree and 2) to gain a better understanding of what HIV infection and AIDS means for individuals and communities in Tanzania and what can be done to reduce the spread of HIV.

All participation will be voluntary, without pressure or coercion. If you are a student aged over 16 years, your participation (or otherwise), will in no way influence your studies or grades. No financial reward will be offered to participants or institutions. Most participants will be men, ranging in age, professions and educational attainment.

Participant's Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- Decline to answer any particular question;
- Withdraw from the study at any time up to the completion of the data collection;
- Ask any questions about the study at any time during participation;
- Provide information on the understanding that your name will not be used, unless you give permission to the researcher;
- Be given access to a summary of the project findings when it is concluded;

- Ask for the audio tape to be turned off at any time during the interview;
- Completion and return of the questionnaire implies consent.

All questionnaire sheets, tapes and records will be anonymous and be treated strictly confidential. This data will be used solely for completing the research project and will be stored by the researcher securely for five years following the completion of the project. A summary of the project will be made available to participants upon completion of the project and after approval of the supervisors.

Compulsory Statement

“This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University’s Human Ethics Committees. The researcher named above is responsible for the ethical conduct of this research.

If you have concerns about the conduct of this research that you wish to raise with someone other than the researcher, please contact Professor Sylvia Rumball, Assistant to Vice-Chancellor (Ethics and Equity), telephone +64 6 350 5249

If you have questions or need further support following your participation in this study please contact me using the details below.

Researcher: Timothy J. Lloyd-Jones, PO Box 844, IRINGA, Tanzania. Ph: +255783262317

Supervisors: Dr Maria Borovnik & A/Prof Regina Scheyvens, Massey University, School of People, Environment and Planning, Development Studies, Private Bag 11 222, Palmerston North, New Zealand.

Appendix 4: Information sheet in Kiswahili

Jina la Utafiti: Mtazamo ya wanaume na mabadiliko ya tabia katika Tanzania kuhuisana na VVU na UKIMWI

KARATASI YA TAARIFA

Utangulizi

Jina langu ni Timotheo Lloyd-Jones na mimi ni mwanafunzi ya Chuo Kikuu, (Massey University), New Zealand. Mradi huu wa utafiti utafanyika kwa washiriki wa vijijini na mjini, katika Mkoa wa Iringa wa Jamhuri ya Muungano wa Tanzania, kama sehumu ya kukidhi mahitaji ya shahada ya Uzamili wa Falsafa (Masomo ya Maendeleo). Kusudi la utafiti ni 1) kupata Masters degree na 2) kuelwa vizuri zaidi maana ya maambukizi ya VVU kwa wana inchi na wanajamii katika Tanzania na mambo gani wanaweza kufanya kupunguza maambukizi ya VVU.

Washiriki wote watakuwa wa hiari, bila kushinikizwa au kulazimishwa. Kama wewe ni mwanafunzi mwenye umri zaidi ya miaka 16, ushiriki wako (au kutoshiriki), hakuta athiri masomo yako au maksi zako. Hakuna zawadi yoyote ya fedha itakayotolewa kwa washiriki au taasisi. Washiriki walio wengi watakuwa wanaume, wenye umri taaluma na elimu tofauti.

Haki za washiriki

Hulazimishwi kukubali mwaliko huu. Ukikubali kushiriki una haki ya:

- Kukataa kujibu swali lolote;
- Kujitoa kwenye utafiti wakati wowote kabla ya kukamilika kwa ukusanyaji wa takwimu;
- Kuuliza swali lolote kuhusiana na utafiti wakati wowote wa ushiriki wako;
- Kutoa taarifa kwa maelewano kwamba jina lako halitatumika kujitambulisha na taarifa hizo, isipokua pale utakapotoa ruksa kwa mtafiti kufanya hivyo;
- Utapata fursa ya kusoma muhtasari wa matokeo ya utafiti pale utafiti utakapokua umehitimishwa;

- Kutaka kanda ya sauti izimwe wakati wowote wa mahojiano;
- Kujibu na kurudisha fomu ya maswali kunamaanisha umekubali.

Karatasi zote za maswali, kanda na taarifa hazitakuwa na utambulisho nazo zitashughulikiwa kwa tahadhali kubwa. Taarifa zote zitatumika kukamilisha mradi wa utafiti pekee na zitahifadhiwa kwa umathubuti na mtafiti kwa miaka mitano (5) baada ya kukamilika kwa mradi. Muhtasari wa mradi utatolewa kwa washiriki mara utafiti utakapokamilika baada ya wasimamizi kuupitisha.

Mradi huu umethaminiwa na kuamuliwa kuwa una athari za chini kabisa. Kutokana na hayo, haukufanywa marejeo na kamati mojawapo ya maadili ya binadamu ya Chuo Kikuu. Mtafiti aliyetajwa hapo juu ndiye atawajibika kwa kuendesha utafiti kwa maadili.

Kama una wasiwasi kuhusu uendeshaji wa utafiti huu na ungependa kuutoa kwa mtu yeyote tofauti na mtafiti, tafadhali wasiliana na Professor Sylvia Rumball, Assistant to Vice-Chancellor (Ethics and Equity), simu +64 6 350 5249

Kama una swali au una haja ya kusaidiwa zaidi baada ya kushiriki kwenye utafiti huu, tafadhali umpigie mtafiti.

Mtafiti: Timothy J. Lloyd-Jones, PO Box 844, IRINGA, Tanzania. Simu: +255783262317

Supervisors: Dr Maria Borovnik & A/Prof Regina Scheyvens, Massey University, School of People, Environment and Planning, Development Studies, Private Bag 11 222, Palmerston North, New Zealand.

Appendix 5: Participant consent form in English.

Project Title: Male Attitudes and Behavioural Change in Tanzania in relation to HIV and AIDS

PARTICIPANT CONSENT FORM

This consent form will be held for a period of five (5) years

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being audio taped.

I agree to not disclose anything discussed in the Focus Group.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature:

Date:

.....

Full Name - printed

Age:

.....

Last Education

.....

.....

.....

Area where you grew up

.....

Are you married?

.....

How many children?

.....

Appendix 6: Participant consent form in Kiswahili

Jina la Utafiti: Mtazamo wa wanaume na mabadiliko ya tabia katika Tanzania kuhusiana na VVU na UKIMWI

FOMU YA RIDHAA YA MSHIRIKI

Fomu hii ya ridhaa ya mshiriki itashikiliwa kwa kipindi cha miaka mitano (5).

Nimesoma karatasi ya taarifa na kufafanuliwa maelezo ya kinaganaga ya utafiti. Maswali yangu yamejibiwa kwa maridhio yangu, na ninaelewa kwamba naweza kuuliza maswali mengineyo wakati wowote..

Ninakubali/sikubaliani mahojiano ya rekodiwe kwenye kanda.

Ninakubali kutotoa chochote kilichojadiliwa na kikundi.

Ninakubali kushiriki kwenye utafiti huu kwa mashariti yaliyoelezwa kwenye karatasi ya taarifa.

Sahihi:

Tarehe:

Jina Kamili

Umri

Elimu ya mwisho

Mahali ulipokuwa

Umeoa ?

Watoto

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