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HIV Discourse and Prevention Practices: A Case Study of Professional and Entrepreneurial Women in Dar Es Salaam, Tanzania

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AUTHOR'S DECLARATION OF ORIGINALITY

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ABSTRACT

The dominant HIV discourse has identified poverty, lack of education and lack of gender power as primary sites for women's vulnerability. This presents women as a homogenous population. This study focuses on Professional and Entrepreneurial Women (PEW) who have at least a post-secondary education and are professionally employed and/or engaged in medium skilled entrepreneurial activities. The study suggests that PEW are women who have an education, well-paying jobs by local standards, and power. Yet their rates of HIV infection are higher than women who are uneducated and poor. An intersectional postcolonial feminist approach is employed to examine: (a) the dominant discourse on women's vulnerability, and how PEW view this discourse; (b) the discourse about PEW's vulnerability to HIV that is articulated by PEW themselves; and (c) the place of PEW in the dominant HIV discourse and prevention practices as articulated by participants. Qualitative research methods were used, which comprised the analysis of 5 government documents, 5 interviews with officials from TACAIDS and TAMWA, and 37 interviews with PEW. The results of this study demonstrates that the dominant framing of individuals in relation to HIV vulnerability fails to take into account the new positions resulting from socio-economic changes, the resulting identities of both men and women, and how these intersect with cultural norms to influence new avenues and forms of HIV vulnerability. The vulnerability of PEW is associated with the intersection of their positionalities and identities and those of their partners with socio-cultural norms and socio-economic changes. Suggestions are made for transformative changes (i.e., change in the premises of our understanding of HIV vulnerability, risks, and individual identities) for effective HIV prevention interventions.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ARVs	Anti-retroviral Drugs
COSTECH	The Tanzania Commission for Science and Technology
CSOs	Civil Society Organizations
DFID	The Department for International Development
EAC	The East African Community
GCE	The Global Campaign for Education
ASAP	AIDS Strategy and Action Plan
HIV	Human Immunodeficiency Virus
ILO	The International Labour Organization
NACP	The National AIDS Control Program
NGOs	Non-governmental Organizations
NIMR	The Tanzania National Institute for Medical Research
NMSF	The National Multi-Sectoral Strategic Framework
PMTCT	Prevention Mother-to-Child Transmission
PEPFAR	President's Emergency Plan for AIDS Relief
PRB	Population Reference Bureau
PEW	Professional and Entrepreneurial Women
RHRU	The Reproductive Health and HIV Research Unit
SADC	The South African Development Community
SSA	Sub Saharan Africa

SWAA	The Society for Women and AIDS in Africa: Tanzania
STDs	Sexually Transmitted Diseases
TACAIDS	Tanzania Commission on HIV/AIDS
TAMWA	Tanzania Media Women Association
TAWLA	The Tanzania Women Lawyers Association
TGNP	The Tanzania Gender Networking Program
THMIS	The Tanzania HIV/AIDS and Malaria Indicator Survey
UN	The United Nations
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNESCO	The United Nations Educational, Scientific and Cultural Organization
UNICEF	The United Nations Children's Fund
UNDP	The United Nations Development Program
UNGASS	United Nations General Assembly Special Session
URT	United Republic Of Tanzania
WHO	World Health Organization

CHAPTER 1

INTRODUCTION

HIV/AIDS Overview in sub-Saharan Africa

For more than 20 years HIV has been a challenging epidemic in most sub Saharan African (SSA) countries. As a region, SSA carries two thirds of the global total of people living with HIV (PRB, 2011; UNAIDS, 2011/2012). However, HIV prevalence for adults (15-49 years) varies from one country to another. Countries with low prevalence include Somalia and Senegal, with less than 1% infected. Countries with high prevalence are concentrated in Southern Africa with rates between 17.8% (South Africa) and 25.9% (Swaziland) (UNAIDS, 2010a). Tanzania, the setting for this study, has a prevalence of 5.7 % (THMIS, 2007-08) similar to several countries in Eastern Africa.

The predominant mode of HIV transmission in most SSA countries is sexual, with heterosexual transmission accounting for the majority of infections (90%) (UNAIDS, 2010a; Vaughan et al., 2000). There are variations in prevalence between males and females. Globally, women account for nearly half of the people living with HIV (WHO, 2009). In SSA, women account for 60%, with young women aged 15-24 accounting for 75% of women living with HIV in the region (UNAIDS, 2012). The imbalance in infection rate between men and women has led to studies examining the factors influencing women's greater vulnerability. These factors have included: socio-economic inequality between women and men, especially women's poverty (Cohen, 2006; Karim, Sibeko & Baxter, 2010; Lopman et al., 2007); gender inequality and the patriarchal

system (Gupta, 2000; PEPFAR, 2006; URT, 2001; WHO, 2003; Wodi, 2005); lack of education among women (Kithakye et al., 2009; UN, 2001a; WHO, 2000); violence against women (Heise, Ellsberg & Gottemoeller, 1999; Koenig et al, 2004); intergenerational sex among older men and girls (Corbin, 2012; Quinn & Overbaugh, 2005; WHO, 2009); women's greater susceptibility to infection through intercourse (UNAIDS, 2012); and social-cultural factors (Kemboi, Onkware & Ntabo, 2011; Lugalla et al., 2004; Mlangwa & Meier, 2007).

These factors have been combined to identify poverty, lack of education, and lack of gender power as the primary sites of women's vulnerability. The presentation of women as the more vulnerable sex has made them the target of HIV prevention services with poverty reduction, education of the girl-child, and empowerment strategies to reduce or combat gender inequality as the main prevention strategies (Gupta, 1995; ILO/UNESCO, 2010; TGNP & Macro International Inc., 2007; UN, 2001b).

In the HIV discourse in SSA, women are uniformly portrayed as weak, passive, poor, powerless, and unable to protect themselves against infection (Higgins et al., 2010; Mkandawire-Valhmu, 2013). Few studies have focused on women as active agents in HIV prevention or transmission (exceptions include: Haram, 2004; Seidel & Vidal, 1997; Susser & Stein, 2000). Similarly, few studies have looked at how gender intersects with other identities and social positions to create particular forms of vulnerability (Collins, Unger & Armbrister, 2008; Hale & Vazquez, 2011; Higgins et al., 2010). Tanzanian data indicate, however, that it is wealthier and better educated women who bear the highest burden of infection; yet those women lack support from the current HIV prevention

programmes. This study goes beyond the existing research that focuses on poor and less educated women by focusing on Professional and Entrepreneurial Women (PEW).

This exploratory, qualitative study, set in Dar es Salaam, Tanzania, examines PEW's own discourse about HIV risk and prevention and how they locate themselves in this discourse. It uses an intersectional post-colonial approach to understand how their social positions and identities intersect to create vulnerability to HIV infection. The analysis is set within the context of the dominant, official HIV discourse and prevention practices in Tanzania.

The term *professional women* in this study refers to women who have at least a post-secondary education and are professionally employed (e.g. as lawyers, teachers, professors, nurses). The term *entrepreneurial women* is used to refer to women with a post-secondary education who have skills such as cooking and baking, catering, arts and crafts, with medium-scale investments in enterprises such as mini-super markets, small manufacturing outlets (of soaps, shampoo, tie-dye clothing, food processing etc.). The majority of the entrepreneurial women create their own businesses and become self-employed. The term *sexuality* is used consistent with the definition provided by WHO (2006) as;

> A central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological,

psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors. (p. 4)

Human Immunodeficiency Virus (HIV) refers to a virus that infects human beings and weakens their immune system by destroying blood cells that fight diseases and infection (UNAIDS Terminology Guideline, 2011). This makes them susceptible when the body is unable to fight off infections and diseases. HIV infection leads to *Acquired Immunodeficiency Syndrome (AIDS)*, a last stage of HIV infection which can lead to death (UNAIDS Terminology Guideline, 2011).

Vulnerability to HIV refers to the broad factors that make individuals more susceptible to HIV infection (UNAIDS Terminology Guideline, 2011). These factors reduce the abilities of individuals to avoid risks associated with HIV infection and may be outside their control. For example, societal norms and practices, laws, and lack of access to proper health care. *Risk* to HIV infection is the probability of individuals acquiring HIV (UNAIDS Terminology Guideline, 2011). Risks are associated with individuals' behaviours that increase the chance of getting infected. Such behaviours may include reluctance to use condoms, dependence on surrogate testing for infection, and engaging in multiple sexual partnerships etc. Thus, vulnerability factors and individuals' risk behaviours contribute to the spread of HIV.

HIV can be spread through the exposure to infected body fluids. This can be through unprotected sex with someone who is HIV positive; mother-to-child transmission during pregnancy, birth, or breast feeding; sharing needles; or through blood transfusion. Since the bulk of HIV infection is through heterosexual transmission, *safer sex practices* are advocated within HIV prevention strategies. According to the UNAIDS Terminology

Guideline (2011), safer sex practices are the choices and behaviours that individuals adopt to reduce or minimize the chances of getting infected with HIV. The safer sex practices encouraged in the dominant discourse include HIV testing and counselling for the purpose of protecting those who are not infected and supporting those who are already infected by providing them with anti-retroviral drugs (ARVs). Abstinence, postponing sexual debut and non-penetrative sex are also encouraged particularly among youth. Faithfulness to a single sexual partner or at least a reduced number of partners, as well as consistent and correct condom use for those who are sexually active are critical to safer sex practices in the dominant HIV/AIDS discourse. The ABC (Abstain, Be faithful and Condom use) model has become the dominant acronym and message for HIV prevention, especially in SSA. Other approaches to HIV prevention include the prevention of mother-to-child transmission (PMTCT) through use of ARVs during pregnancy, treatment of other sexually transmitted infections (STIs), use of one-time-only needles, pre-exposure prophylaxis and post-exposure prophylaxis (i.e., use of ARVs before and after sexual activity).

In my focus on PEW, I do not ignore the vulnerability to HIV infection associated with poverty and/or illiteracy. I suggest, however, that changes in the economy have influenced gender relations and the economic position of certain groups of women, creating a new class of professional and entrepreneurial women who face different vulnerabilities than those that are the focus of the dominant discourse. To understand HIV vulnerability among women, they cannot only be studied as poor, uneducated, weak, passive, or powerless. The vulnerability of women with education, independent income, and power must also be studied.

While the focus of this study is on women, I note that the dominant universalist framing of women's vulnerability also presents a singular portrayal of men. Complementary to that of women, this portrays men as causal agents in women's vulnerability. This is well articulated by Rivers & Aggleton (1999), "men in developing countries have almost uniformly been characterized as inconsiderate, unreliable, predisposed to coercion, rape and violence as well as being relatively unable to control or change their behaviour" (p. 3). In most studies (not only in Tanzania), men are seen as active transmitters of the virus because of their rejection of abstinence, monogamy, and condom use (Higgins et al., 2010; RHRU, 2003; UNAIDS, 2010b; URT, 2001; Wodi, 2005). When it comes to the representation of African men's sexuality in HIV prevention, masculinity is portrayed as unchanging and static (Booth, 2004). Dworkin (2005) describes the portrayal as one of "vulnerable women and invulnerable men" (p. 616), arguing that the categorical and singular portrayal of women as oppressed and vulnerable is enmeshed in a parallel portrayal of men as powerful and invulnerable (p. 616). In reality, both men and women are multiply and diversely vulnerable to HIV infection. What is overlooked in the prevention discourse is that in-so-far as the gendered construction and framing of men as violent, unconcerned about their partners' needs, and in need of multiple partners actually reflects men's lives, they are also vulnerable (Dworkin, 2005).

Objective and Research Questions

Guided by intersectional postcolonial feminist perspectives, this study seeks to explore the vulnerability of PEW and their place within the HIV discourse and prevention practices. The research questions guiding this work are:

1. What is the dominant discourse of women's vulnerability to HIV, and how do PEW view this discourse?
2. What is the discourse about PEW's vulnerability to HIV that is articulated by PEW themselves?
3. What is the place of PEW's vulnerability in the dominant HIV discourse and prevention practices as articulated by study participants?

The first research question is aimed at setting the context for understanding how people understand HIV/AIDS. Surrounded by a dominant discourse (in advertisements, media, educational programs, interactions with health providers) that is framed from a western view of HIV/AIDS causes, risks and vulnerabilities and a lingering colonial view of African people (especially their sexuality), this question asks how PEW view all of this. When asking PEW about the discourse, attention was paid to whether they repeated and/or challenged the dominant discourse, as well as how and what they challenged. The second question focuses on the discourse of vulnerability and risks associated with HIV infection among PEW themselves. Here PEW were not asked specifically of their own experiences, but their perception of women like themselves. However, as is common in qualitative discussion, at times some women placed their own experiences and situations into the context of PEW overall. The third question is aimed at positioning PEW within the dominant HIV discourse and prevention practices. This is through the mapping of

how participants described PEW's vulnerability in relation to the dominant HIV/AIDS discourse.

This study uses qualitative research methods comprised of document analysis and in-depth interviews. An analysis was conducted of five documents that were instrumental in setting the framework and articulating the discourse for understanding HIV in Tanzania and setting the direction for prevention initiatives. The purpose of this analysis was to understand the dominant, official discourse and PEW's position in it. Semi-structured interviews were conducted with officials from the Tanzania Commission on HIV/AIDS (TACAIDS) and the Tanzania Media Women Association (TAMWA) to elaborate on and clarify issues raised in the document analysis. Finally, semi-structured in-depth interviews were conducted with professional and entrepreneurial women to explore their own discourse related to HIV vulnerability and risk.

Overview of the Chapters

This dissertation includes six (6) chapters in addition to this introduction. Chapter II is a literature review. It starts by situating the study in Tanzania and the changing positionalities of women in contemporary Tanzanian society. Then the literature on women's vulnerability in relation to HIV is examined. This is followed by a presentation of the theoretical framework. Chapter III discusses the methodology and research design. Chapter IV sets the context for this study by presenting the government discourse on HIV/AIDS in Tanzania. The focus is on the dominant HIV/AIDS discourse in relation to women's vulnerability and framing. It also examines how PEW view women's vulnerability in relation to the dominant discourse. The focus is on the discussion of risks

(such as multiple partnerships) and vulnerability (such as poverty, marriage, and prostitution).

Chapter V presents the analysis of the discourse of factors influencing PEW's vulnerability. These include educational attainment, employment, income, and marital status in relation to gender norms and expectation associated with sexuality. The discussion focuses on vulnerability to engage with multiple sexual partnerships as a risk factor for HIV infection. Chapter VI expands the discourse of PEW to consider safer sex practices of HIV testing and condom use among PEW and their partners. The final chapter focuses on the position of PEW within the dominant HIV discourse and prevention practices. This is through the mapping of how participants described PEW's vulnerability in relation to the dominant HIV/AIDS discourse, followed by concluding remarks, strength and contributions, limitations, implications and the way forward.

CHAPTER 2

RESEARCH CONTEXT: WOMEN'S CHANGING POSITIONALITIES AND THEORETICAL FRAMEWORK

Situating the Study

I conducted this study in the city of Dar es Salaam, one of the 30 regions of Tanzania. The region is dominated by Zaramo, Ndengereko and Kware tribes/ethnicities. Because of urbanization, many other ethnic groups are migrating to the city in large numbers (Dar es Salaam City Profile, 2004). Consequently, the city has a diversity of people from more than 100 ethnicities. According to Kithakye et al. (2009), the population of Dar es Salaam is about 4 million people. It is considered the third fastest growing city in Africa (City Mayors Statistics, 2012). The majority of the people in the region are aged 15-64 years (65%). Elderly people aged 65 years and above are only 2% of the population and children 0-14 years are 33%. In terms of HIV, Dar es Salaam is reported to have the second highest HIV prevalence (9.3%) in the country (THMIS, 2007-08; UNGASS/TACAIDS, 2010).

As the largest city in Tanzania, Dar es Salaam has been influenced by socio-economic processes such as urbanization, socio-economic development, neoliberalism and globalization which have transformed gender positions and the economic positionality of women. These transformations are important in assessing PEW's vulnerability to HIV infection as well as their agency with respect to their sexuality. Dar es Salaam's population is ethnically, professionally, and occupationally diverse. All these characteristics contributed to access to a diversity of participants and view-points in

my study. In addition, many HIV/AIDS related services and organizations are located in Dar es Salaam, facilitating an examination of the policies and programs of The Tanzania Commission on HIV/AIDS (TACAIDS) and The Tanzania Media Women Association (TAMWA), as both of these organizations have their main offices in this city. Finally, I lived in the city for more than 10 years. This gave me advantages in accessing the research field as well as easily connecting to participants.

Dar es Salaam is known for its economic prominence both within the country and internationally. According to the Dar es Salaam City Profile (2004) it is a major commercial, administrative and industrial center of Tanzania. It has a high concentration of manufacturing, trading and service industries (64% industries are privately owned, 19% publicly owned and 14% are joint ventures). Compared to the other regions, it accounts for more than 60% of the national income (Kithakye et al., 2009; Mwase & Ndulu, 2008). It has the main transportation systems, including an international airport, the largest seaport in the country, and the central railway terminal for the nation. It is one of the regions with multiple educational facilities, such as schools, colleges, and universities. Likewise, the city hosts most public and private organizations (including local and international organizations). As well, public service offices (including the permanent central government bureaucracy) are located in Dar es Salaam despite losing its official status as a capital city to Dodoma. Its economic advantages and political status attract professionals, non-professionals and entrepreneurs to work in various sectors (Kithakye et al., 2009).

The Dar es Salaam region is well known internationally due to its prominence in investment and international trade underpinned by Tanzania's political stability. The

region gives access to regional markets such as the East African Community (EAC) and Southern African Development Community (SADC). Additionally, Dar es Salaam has attractive beaches for tourists and a diversity of cultural and archaeological sites and museums. All the above natural and created endowments make Dar es Salaam the most developed city in Tanzania (Dar es Salaam City Profile, 2004; Kithakye et al., 2009).

Globalization and neoliberalism processes have transformed Tanzania socially, economically, as well as politically. One of the political transformations brought about by neoliberal policies was the shift from a socialist run state, with a single party political system, to a free market economy with a multiparty democracy (Pallotti, 2008; Wobst, 2001). Before liberalization of the economy, Tanzania was a socialist state and all policies were based on non-market mechanisms through which the state controlled the economy and owned all major enterprises. This, however, resulted in severe economic decline, and Tanzania adopted neo-liberal policies. Tanzania liberalized its economy in the mid 1980's. This was followed by political reforms in the 1990's. With a free market economy in place, there is a proliferation of private institutions and sectors which created employment and self-employment opportunities not only for men, but also women. Most of these institutions are located in Dar es Salaam.

Additionally, globalization has enhanced transnational and trans-cultural communication and contact, contributing to the emergence of new social values and cultural trends. This has had more impact on the younger generations, and is more prevalent in urban areas like Dar es Salaam than rural and less urbanized areas. The influences of globalization, neo-liberalism, and socio-economic changes in Dar es Salaam have transformed gender roles and women's positionalities. For example, there are

increasing numbers of women in professional, entrepreneurial, and government positions in Dar es Salaam, making it a suitable location for this study.

Changing Positionalities in Tanzania

Socio-economic changes through development, globalization, liberalization, and the rise in levels of technology as well as educational attainment, have all contributed to the transformation of gender roles and social positionalities in many African societies, including Tanzania (Mzinga, 2002; Silberschmidt, 2004). The change from a state-run socialist economy to a liberal economic regime, for instance, transformed the limited hierarchical ranking of elites, bureaucrats, and peasants (Chodak, 1973) to multiple ranks including political elites, entrepreneurs, professionals, skilled/non-skilled workers, peasants/farmers, and petty commercials (Mzinga, 2002). In Tanzania particularly, new economic positionalities among women were created mainly through professionalization and educational attainment, and entrepreneurial activities (Wink, 2009). While the majority of women in Tanzania are still found among peasants and non-skilled workers, a growing number of women belong to the professional and/or skilled-worker groups (Wink, 2009). Very few studies have targeted professionals and skilled-workers in terms of their HIV vulnerability. This study aims to fill that gap.

The political, social, and economic reforms which took place in the 1990's as a result of neoliberal policies, lead to the rise of Non-Governmental Organizations (NGOs) and Civil Society Organization (CSOs) which have influenced the way women position themselves in terms of fighting for their rights, employment opportunities, and education (Lugg, Morley & Leach, 2007). Organizations such as The Tanzania Women Lawyers

Association (TAWLA), Tanzania Media Women Association (TAMWA) and Tanzania Gender Networking Program (TGNP), have influenced the participation of women in various social, political and economic activities by providing women with resources and raising awareness in challenging traditional belief systems which legitimized their subordination (Mung'ong'o, 2003). The political, social and economic reforms also influenced changes in legislation, policies, and laws in support of women's rights. For instance, The Constitution of Tanzania, article 66-1(b) states that women must not be less than 30% in the national assembly. By 2001 women were 22.5% of parliamentary members, and by 2010 the female representation was above 30% (Benjamin & Dunrong, 2010) with 15.5% of ministerial portfolios held by women in 2006 (UNDP, 2006).

Increased access to higher education is also one of the outcomes brought by liberalization of the economy in the 1990s, with the establishment of ten new private universities and colleges (URT, 2005). This led to an increase in the number of graduates in the 2000s. Female enrolment, for instance, at the University of Dar es Salaam, Mlimani Campus increased six-fold from 985 students in 1996/1997 to 5699 students in 2006/2007 (Benjamin & Dunrong, 2010). In the academic year 2005/2006, 59% of students admitted in Bachelor of Arts disciplines were female (Benjamin & Dunrong, 2010). The increased enrolment among women was accompanied by changes in policies and mechanism such as access to scholarships to allow more people to get an education. The government of Tanzania started a loan board (Higher Education Students' Loans Board in Tanzania— HESLB) in 2004 for all eligible students (Benjamin, 2010). Consequently, the number of educated women has been increasing every year.

The literature on gender and economy highlights how gender roles have shifted over the years (see Haram, 2004; Mzinga, 2002; Silberschmidt, 2001/2004). These changes are the result of social mobility, educational attainments, changes in occupations, and the rise of the private sector, which have contributed to more women becoming financially independent. Traditionally, the position of women in Tanzania has been one of subordination to men, with most women unable to influence decisions either at home or on national matters (URT, 2009). However, in the past 10 years the gender pattern in employment has changed dramatically with more women entering the informal sector[1] as entrepreneurs, as well as becoming increasingly visible in professional jobs and government positions (URT, 2009). This has transformed the position of women relative to men and has given women some autonomy in decision-making both outside and inside their household. The 2006 United Nations Development Program report noted that among legislators, senior officials, and managers, women constituted 49%, and among professionals and technical workers, 32% (p. 370). As women have moved into new economic roles they have both contributed to household income (Naleo, 2009) and gained economic independence from men.

Socio-economic changes have contributed to a new pattern of life, especially among the younger generation. This is seen in the way they dress (more fashionable, stylish and modern), think, and act, including a rejection of traditional family systems (Tietcheu, 2005). In the traditional family system, according to Kasongo (2010), women worked in the private sphere, taking care of all domestic responsibilities, while the

[1] These are unregistered and hard-to tax groups such as small manufactures, craftsmen and individual professionals (Mbilinyi, 2010).

political and economic domains were a responsibility of men. Kasongo argues that in modern life, people's actions are influenced by "selfish satisfaction of their egoistic needs" (p. 312), rather than by what is prescribed for them. This shift in orientation of the younger generation is a result of the new emerging social values and cultural trends resulting from globalization processes in which people from developing countries are exposed to different life styles through the internet, television, radio, and newspapers (Tietcheu, 2005). All of the above have contributed to shaping minds and social relations, and developing new attitudes and skills. In a study by Haram (2004), "Prostitutes' or Modern Women? Negotiating Respectability in Northern Tanzania," women reported wanting to live autonomously, making their own independent choices and decisions, something which was unheard of in traditional times. Some women have postponed marriage so that they can further their education. Others have refused to get married because they did not want to be subjected to traditional gender roles and subordination. It is from this perspective that Tietcheu (2005) questions, "what does it mean today to be women and men" (p. 122) in Tanzania?

Socio-economic changes have also contributed to changes in norms and traditions in some men's lives in terms of their social position as heads of households (Silberschmidt, 2001). Increasingly men are seeking marriage with women who can make a financial contribution to the household (Mzinga, 2002, Nyanzi et al., 2005). Some of these men do so because they are no longer able to fulfill their traditional social expectations as heads of families and household providers and are withdrawing from household responsibilities (Silberschmidt, 2001/2004). This has led to the need, in some households, for women to take on the role of financial provider.

This shift in marital roles is seen as influencing some men to become aggressive and violent towards their wives, while others start extra-marital relationships (called *nyumba ndogo* in Swahili) as a way to raise their status as 'men' (Nyanzi et al., 2005; Silberschmidt, 2004). Additionally, the economic independence of women has created fear in men that their wives might be attracted to other men as economic independence is viewed as giving them the freedom to do whatever they want (Haram, 2004, p. 215). In a study conducted by Silberschmidt (2001), divorced women suggested that they were better off on their own (p. 263). Such changes are not uniformly experienced. Based on their study, Nyanzi et al. (2005) concluded that while urban women placed limits on what they would tolerate in their marriage, rural women preferred to stay in their marriage regardless of the circumstances (p. 204).

Nyanzi's work points out that these transformations and changes in gender roles and positionalities are not homogeneous, and do not provide all men and women with the same experiences and opportunities. It is critical to note here that these changes are more visible in urban areas and more prominent among PEW. This leads me to question whether, as countries are undergoing economic liberalization, globalization, urbanization, and a rise in levels of education, the representation of women as uniformly passive and economically dependent is still accurate (see TACAIDS, 2008, October; URT, 2001). How are these changes linked to HIV vulnerability and prevention, particularly among PEW? These are among the questions addressed in this thesis.

An Overview of HIV/AIDS in Tanzania

In Tanzania, the first three cases of HIV and AIDS appeared in 1983 in the Kagera region. By 1985 a total of 106 cases were reported countrywide (TACAIDS, 2009). The number of HIV positive people steadily increased in the 1990s. In 1997, HIV prevalence peaked at 8% and then gradually fell to 6.4% in 2005/2006 (AIDS Strategy and Action Plan (ASAP), 2008). The most recent reported national HIV prevalence is at 5.7% (THMIS, 2007-08). Despite the decline in HIV prevalence, a large number of people are still infected and affected. In 2011 alone, the number of newly infected people was 150,000, and 83,528 died of AIDS in the same year (UNAIDS, 2012). According to the *Review of the Epidemiology and HIV Prevention Programs and Resources in Tanzania Mainland* (May, 2009), the predominant mode of HIV transmission in Tanzania, as in the rest of SSA, is heterosexual sexual contact with an infected partner, which accounts for 80% of cases, followed by vertical (mother-to-child) transmission accounting for 18%, and the remaining 1.8% through medical transmission (e.g. use of needles, unsterilized equipment, transfusion with infected blood) and traditional practices (p. 11).

HIV has not affected all people equally. The uneven prevalence over different population groups has been present since the early years of the epidemic. According to official reports of the United Republic of Tanzania (2001) the groups most affected in the early years of the epidemic included youth and women. This was seen as caused by intergenerational sex, early marriage, peer pressure among youth to engage in sex, biological factors, as well as women's inability to protect themselves from infection (Ackermann & De Klerk, 2002; Hamblin & Reid, 1993; WHO, 2009). The disproportionate incidence of HIV infection among the poor, especially poor women, was

credited to illiteracy and unemployment, hence their tendency to be involved in sex work (Rodrigo & Rajapakse, 2010). Mobile populations have also been at risk since the early years, including sex workers, long distance truck drivers, and immigrants (URT, 2001). More recently there have been visible changes in the trends and patterns of HIV infection which require the interrogation of what influences such trends. For example, contrary to the dominant discourse, HIV prevalence is now higher among women in the highest wealth quintile than women in the lowest quintile (Chikuwa et al, 2007; Fox, 2010; Mishra et al, 2007; Potts et al, 2008; Shelton, Cassell & Adetunji, 2005; THMIS, 2007-08/2011-2012). For both women and men, HIV prevalence increases with education (Fortson, 2008), and women who are mobile or engaged in certain economic or business activities have higher HIV prevalence than comparison groups (THMIS, 2007-08, pp. 115-117).

HIV VULNERABILITY AMONG WOMEN

In the discourse of HIV risks and vulnerabilities women are presented as more vulnerable than men (Higgins et al., 2010). The vulnerability of women is associated with different sex-based biological attributes, differences in gender-based sexual power between men and women, unequal distribution of power, poverty, and wealth (including powerlessness and marginalization occurring in social relations) (Buve et al., 2002; Cradock, 2000; Dilger, 2006; Higgins et al., 2010; Ribot, 1995; Taylor, 2006).

Biological susceptibility. When exposed to HIV through sexual activity, women are biologically more susceptible to infection than men (UNAIDS, 2012). This results

from the biological make-up of the female genital tract and the asymptomatic nature of many but not all sexually transmitted infections (STIs) among women (Chersich & Rees, 2008; Ellis, 2000). Tissues in the female genital tract are very soft and likely to tear during sexual activity, giving HIV ready access to the blood stream. Also, semen has a higher viral load than vaginal secretions, making it more infectious. Since semen remains in the female genital tract after sexual intercourse, it increases the chances of HIV transmission to women (Chersich & Rees, 2008, p. 6). The asymptomatic nature of certain sexually transmitted diseases among women means these STIs often go untreated. Characteristics of untreated STIs, such as genital ulcers, result in breaks in the genital tract lining, creating a portal for HIV entry (Chersich & Rees, 2008, p. 29). It is important to recognize, however, that biological vulnerability is not the same for each woman as it is determined by the general health of the genital tract, a woman's age, and changes in hormonal levels, all of which influence characteristics of the genital tract that affect ease of transmission of HIV (WHO, 2006).

Poverty. The discourse on women's vulnerability to HIV infection has emphasized the role of poverty in HIV transmission. Poverty is described as influencing women to engage in prostitution to meet their own and their family's needs. This exposes them to multiple partners, increasing the likelihood of HIV infection (Cohen, 2006; Smith, 2003). Poverty also keeps girls out of school, limiting their access to jobs and thereby perpetuating poverty across the generations and also excluding them from the HIV prevention education taught in schools. Together these are seen as detracting from girls' and women's ability to negotiate safer sex in their sexual relationships (Booysen &

Summerton, 2002). Poverty also contributes to women's economic dependence, making it difficult for them to leave risky relationships for fear of being left without economic support (Gupta, 2000).

While the discourse of poverty and HIV vulnerability focuses on women, poverty makes both women and men vulnerable to HIV infection. For example, Cohen (2006) and Karim et al. (2010) argue that in the absence of sustainable livelihoods both men and women are forced to migrate to search for jobs or employment. When away for a prolonged period of time, marital stability and social cohesion are disrupted. In such circumstances there is an increase in the formation of new sexual networks placing both men and women at greater risk of HIV infection. This heightened risk extends to the spouse who remains at home. As Karim et al. point out, "when they return to their partners it is difficult to influence condom use because of the gender role expectation and dominant ideologies about marriage" (2010, p. 126).

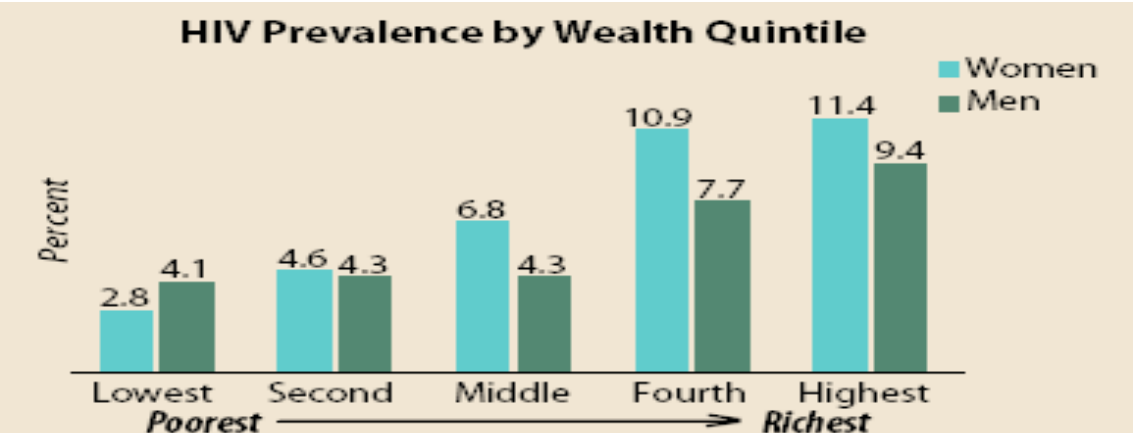
Wealth. On the opposite side of poverty is wealth. A statistical association between wealth and HIV infection has been demonstrated in several SSA countries. For example, Mishra et al. (2007), using data from 8 countries (Kenya, Ghana, Burkina Faso, Cameroon, Tanzania, Lesotho, Malawi and Uganda), identified a higher HIV prevalence among wealthier men and women than poorer ones (p. 9). They noted that wealth intersected with other factors such as gender, place of residence, education, and mobility to influence HIV vulnerability, with multiple/non-regular sexual partners and lack of condom use the major risk factors for infection. Focusing on women, Msisha et al (2008) similarly found that in Tanzania, "49 percent of the women in the richest standard of

living quintile reported having 2-4 lifetime sexual partners" (p. 1301), refuting the assumption that it is only women living in poverty who have multiple partners. Fox's (2010) comparison of the absolute poor (those whose basic needs are not met) to the relative poor (their basic needs are met, however compared to other individuals they have fewer resources) demonstrated a higher HIV prevalence among the relatively poor (p. 22), suggesting a potential positive linear relationship between income and HIV infection. Fox suggested that, "aspirations for social mobility and demand for consumer good[s]" (p. 22) may be driving risk behaviours. As in Mishra et al.'s (2007) data, wealth and education were associated with multiple and non-marital sexual partners, and the association between wealth and HIV prevalence was as strong for women as it was for men (pp. 19-20).

Studies focusing on women have begun to provide explanations of how wealth increases women's vulnerability to HIV. Wojcicki's (2005) review of the literature documents several studies that found an association between increased access to resources for women and both multiple partners and absence of condom use (p. 1). Nyanzi et al (2005) found that business women, because of their wider social network, participation in the market system, and long working hours had "numerous opportunities for making new sexual contacts" (p. 19). In a study conducted by Silberschmidt (2004) it was noted that "some successful business women were in a position to pay young men for sex" (p. 665). Hargreaves et al. (2008) credit increased opportunities for travel, as well as increased money or resources, as providing educated and professional women with access to more partners.

Clearly, it is no longer possible to focus only on how poverty creates vulnerability to HIV infection. The vulnerability of the wealthy may be greater than that of the poor. The current trends in HIV prevalence in Tanzania and several other countries support this conclusion (Chikuwa et al, 2007; Mishra et al, 2007; Shelton et al., 2005; THMIS, 2007-08). Using data from Tanzania, Chikuwa et al (2007) note that, "[the] prevalence of HIV infection among women in the highest wealth quintile is three times higher [than] in the lowest wealth quintile" (p. 18) (see Figure 1). These data clearly show higher HIV prevalence among wealthier women than even for men. Bujra (2009) suggests that instead of protecting one from HIV infection, higher socio-economic position can increase vulnerability. As research suggests, this may, in part, be explained by the higher rates of partner exchange and the ability to live long when infected that have been documented among both women and men with higher socio-economic status (Gregson, 2001; Gregson et al., 2006; Shelton et al., 2005)

FIGURE 1: HIV PREVALENCE BY WEALTH QUINTILE



Source: 2003-2004 Tanzania HIV/AIDS Indicator Survey (Shelton et al., 2007)

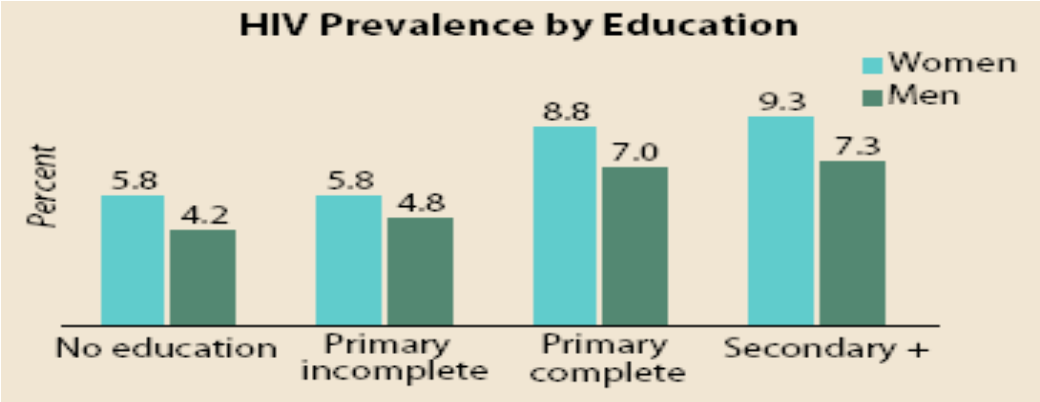
According to Wojcicki (2005), there is evidence of an "interaction between marital status, number of partners, socio-economic position and risk for HIV infection" (p. 9). As Wojcicki explains, access to resources may have different effects for married women than single women depending on the degree of control married women have over such resources and over their sexual and related activity. This is supported by studies that found that married women were less able to negotiate safer sex than unmarried women, placing them at greater risk of HIV acquisition (Browning, 2014; Silberschmidt, 2001; THMIS, 2007-08). Some studies have suggested that divorced and widowed women are at the highest risk of HIV infection (UNGASS/TACAIDS, 2010). Others have suggested that single women have lower infection rates because of the greater autonomy that they possess (TACAIDS, 2009). From these examples, it is clear that women are not a homogeneous population and that poverty is not the only economic driver of HIV vulnerability.

Education. Formal education, both independent of wealth and in combination with it, is another source of HIV vulnerability. The association of low or no education with infection is widely discussed (Bankole et al., 2007; Blanc, 2000; Guiella & Madise, 2007; GCE, 2004; Hogan, 2005; Kelly, 2006; UNICEF, 2001; World Bank, 2002). According to the United Nations Educational, Scientific and Cultural Organization (UNESCO) (1995), formal education reduces social vulnerability to HIV infection and also provides the means for individual risk reduction. This is related to formal education providing greater access to jobs and consequently to income and economic independence, thereby enhancing women's power in sexual decision-making (UNESCO, 1995; World

Bank, 2002). Formal education is also said to provide women with critical thinking skills to recognize risk, increase their knowledge about HIV/AIDS, as well as influencing health seeking behaviours. In other words, education is considered a protective factor (Ainsworth & Semali, 1998; Garbus, 2003; Gregson, 2001; Hargreaves & Glynn, 2002; Muthengi, 2007), protecting women through increased knowledge, ability to make reasoned decisions, to think critically, and increased access to jobs that will pull them out of poverty.

This explanation of the role of education is not borne out in the epidemiology of HIV in most African countries. In the early days of the epidemic, the wealthier and more educated were identified as more vulnerable than the poor and less or uneducated (Gillespie et al., 2007; Kapiga et al., 1994). This has continued in several countries as seen in Chikuwa et al's. (2007) data for Tanzania (see Figure 2).

FIGURE 2: HIV PREVALENCE BY EDUCATION



Source: 2003-2004 Tanzania HIV/AIDS Indicator Survey (Chikuwa et al., 2007)

Fortson (2008) quantifies this association for Tanzania; "adults with six (6) years of schooling are 51 percent more likely to be infected with HIV than adults with no schooling" (p. 310). The Tanzania HIV/AIDS and Malaria Indicator Survey— THMIS (2007-08) also notes that HIV prevalence for women with some secondary education is above that of men at the same educational level (5% and 3% respectively) (p. 117). Several studies have connected education with employment and income in enhancing vulnerability to HIV infection. TACAIDS (2008), for example, makes the connection to employment and travel, suggesting that women who travel are likely to expand their sexual networks increasing their likelihood of exposure to HIV. Education is an avenue to employment and thus is implicated in the higher HIV prevalence for employed (6%) men and women than those who are not employed (3%) (THMIS, 2007/08, p. 115). The interaction between gender, education, and employment is further illustrated in the findings of Msisha and colleagues (2008) who found that "women working on professional jobs [which require a higher level of education] had the highest probability of having HIV, but for men it was the unemployed who were more likely to be HIV positive" (p. 1301).

Gender power. Historically, the differential power between men and women has positioned women as subordinate to men. The subordination of women to men has been used to explain their position as victims of violence, discrimination, and domination by men. For instance, power in gender relations places men in control of when, where and how sex takes place (Gupta, 2000), stereotypes and norms associated with masculinity and femininity influence non condom use and non-consensual sex (Vetten & Bhana,

2001). Masculinity encourages men to view sex as a form of conquest (WHO, 2003) supporting aggression rather than negotiation. In contrast, women are socialized to be passive, silent, and subordinate to men with these characteristics particularly desirable in marriage (Gupta, 2000; Wodi, 2005). Gupta notes that the culture of silence surrounding sex norms such as premarital virginity and motherhood in marriage influence women not to ask about sex or to use condom. All of these place them at higher risk of HIV infection. However, with changes in the socio-economic position of women, increasing numbers are challenging the differential power that positions them below men. However, rather than contributing to greater equality between men and women, research has shown that these challenges increase gender violence, conflicts, misunderstanding among partners, and extra marital relationships (Silberschmidt, 2001/2004).

Gender-based violence. Violence against women consists of acts that result in physical, sexual, social and/or psychological harm to women including threats such as coercion or arbitrary deprivation of liberty (Vetten & Bhana, 2001). The socio-economic changes that have led to an expansion of women's position from exclusively housewives to potentially professionals and entrepreneurs have, at times, been accompanied by an increase in intimate partner violence against women. Silberschmidt (2001) found in her study in East Africa that women who were in a position to take care of household expenses were more likely to have been the victims of intimate partner violence, including rape. She connected this to men's responses to labour market changes combined with changes in gender roles. Lack of employment and/or low income among men contributed to their failure to fulfill the prescribed and expected social role as heads

of households. This forced women to take over men's roles by providing for the household expenses. Because women had taken control, men felt deprived of their social value, decreasing their self-esteem (Silberschmidt, 2001). Some men responded by engaging with extra marital partners while others became aggressive and violent towards their wives as ways to reassert their manhood.

Koenig et al. (2004) points out that domestic violence, including coerced sex and sexual abuse, causes gynaecological problems such as vaginal bleeding and pain during intercourse, increasing the risk of HIV acquisition during violent or forced sex. This risk also increases based on the degree of trauma such as vaginal lacerations and abrasions that occur during forced sex. Exacerbating women's risk of infection is the finding, in multiple studies, that women who experience violence are more likely to have multiple partners or engage in transactional sex, with condom use neither part of their experience of violent sex nor that with multiple partners (Dunckle et al., 2004; WHO, 2004).

Intergenerational sex. Intergenerational sexual relationships also place women at greater risk of HIV infection. The term *intergenerational relationship* is used to refer "to relationships with a 10-year or more age gap between sexual partners" (UNAIDS Terminology Guideline, 2011, p. 17). Corbin (2012) reports that, in sexual relationships among older men and younger women, younger women are at higher risk of HIV infection both because the men are likely to already be infected and the younger women have no ability to influence condom use. As a result, the younger women are vulnerable to infection (Quinn & Overbaugh, 2005; Smith, 2002; WHO, 2009). Myths about younger women being free from infection and about sex with a virgin 'curing' a man of

HIV infection motivate men to seek out younger women (Walker, Reid & Cornell, 2004). The literature also suggests that intergenerational sexual relationships are characterized with non-condom use, manipulation and power imbalance (Leclerc-Madlala, 2008). As a result, young women are not only courted for sexual relationships, but are also subject to violence and coerced sex, exacerbating their risk of HIV infection (Muula, 2008; Smith, 2002).

While the bulk of the literature addresses sex between older men and younger women, for women with economic means, the tables may be turned. In her study in East Africa, Silberschmidt (2004) found that, similar to men, affluent older women at times paid younger men in exchange for sex. Like older men, they take control in these relationships, with the younger men unable to influence condom use. However, unlike the younger women in intergenerational sex who often are virgins, or at least less sexually experienced than their older male partners, the younger men often also have a network of other sexual partners closer to their own age. Thus, both partners are at increased risk of exposure to HIV in intergenerational relationships involving older women and younger men because of the sexual networking of both partners.

Customs and traditions. There are many customs and traditions that are specific to certain ethnic groups that may influence women's vulnerability to HIV infection. Widow cleansing for instance, a practice where a designated male (either a relative or someone hired for this purpose) has sex with a widow to cleanse her of the remaining influence of her husband and release his spirit, can enhance women's vulnerability because the cleanser may have multiple sexual partners in the process of cleansing (Day

and Maleche, 2011). Additionally "dry sex" (i.e. use of herbs to tighten and dry the vagina) makes the vaginal tissue more susceptible to tears and bruises which can facilitate the acquisition of HIV (Muula, 2008). Unprotected sex is practiced by the majority of couples in SSA (Muula, 2008), this can be explained in relation to the cultural significance of sex as a sign of commitment, love and trust, as well as for procreation. Thus, the majority of married couples never use condoms.

Intersecting Positionalities and Hybridized Vulnerabilities

In the HIV prevention discourse, individuals are typically framed with one identity or position, ignoring how other identities or positions intersect to hybridize their vulnerability (Cradock, 2000). Cradock suggests that the rigid boundaries on singular identities overlook the fact that individuals assume a multitude of identities at various points in time and space. Take the example of sex workers. Sex workers are framed as only sex workers, ignoring their other potential identities and positionalities as mothers, wives, daughters, perhaps also professionals. Thus, for example, a married sex worker may adhere faithfully to condom use with her commercial partners but be unable to convince her husband to use condoms. If her husband has multiple partners and does not use condoms, her vulnerability to HIV comes not from being a sex worker, but from marriage. Thus, it is the intersection of these positionalities that tell the comprehensive story of vulnerability for a particular sex worker (Hankivsky et al., 2010). There is a need to acknowledge that vulnerabilities vary across sub-groups of women and that those variations are influenced by cultural, social, economic, political, and personal issues.

The recent changes in socio-economic positionalities and gender role transformations among women require an interrogation of how these relate to HIV vulnerability and prevention. Recognizing that women with higher education and economic status have higher rates of infection raises the question of what influences their vulnerability. Focusing on PEW, I examine the following research questions:

1. What is the dominant discourse of women's vulnerability to HIV, and how do PEW view this discourse?
2. What is the discourse about PEW's vulnerability to HIV that is articulated by PEW themselves?
3. What is the place of PEW's vulnerability in the dominant HIV discourse and prevention practices as articulated by study participants?

Although research has shown that poverty, lack of education, and gender inequality are important to understanding HIV vulnerability among women, it is clear that these are not the only factors that make women vulnerable. In light of the transformation of gender roles and social positionalities among women influenced by development, globalization, neo-liberalism and educational availability, both a broader and a more focused lens is required in analysing women's vulnerability, one which accommodates intersections among different positionalities that influence women's vulnerability to HIV infection.

HIV DISCOURSE AND PREVENTION PRACTICES

Discourse in this study is used to refer to a way of representing knowledge about a topic at a particular historical moment. This representation influences the way a topic is

presented or reasoned about. It also influences how ideas are put into practice and used as regulatory frameworks (Hall, 2001, p. 72). In line with Hall's (2001) definition of discourse, in this study HIV discourse refers to the system of representation of HIV/AIDS through which meanings and practices such as risk, prevention, testing, treatment and disease are socially constructed and organized. In order to legitimize the constructed meanings and practices, there is a system created that is used to influence stakeholders (example health providers, NGOs, government, CSOs) to agree on the problem (transmission, acquisition and infectivity) and proposed solutions (intervention, prevention and treatment). The current HIV prevention discourse has conceptualized, shaped, and legitimized particular meanings and responses to the AIDS epidemic (De Cock, Mbori-Ngacha & Marum, 2002). These constitute the framing of prevention. Framing, according to Entman (1993), involves selection and salience. Entman notes that:

> To frame is to select some aspects of perceived reality and make them more salient…in such a way as to promote a particular problem definition, causal interpretation...treatment recommendation for the item described. Frames then, define problems…offer and justify treatments for the problem and predict their likely effects. (In Hallahan, 1999, p. 207)

The Tanzania Commission for AIDS has the role of creating the National Multi-sectoral Strategic Framework (NMSF) that all stakeholders who are working in the area of HIV/AIDS interventions are required to follow (National HIV/AIDS Prevention Policy, 2001). In the process of creating the framework, there is a careful selection of

populations to be targeted with very specific messages and projects in line with prioritized themes and ideas. Framing does not end, however, with identification of problems and creation of meaning, it also has the power to label. Goffman (1974, p. 21), for example, notes that "framing is a schemata of interpretation that provides a context for understanding information and enables individuals to locate, perceive, identify and label" (in Hallahan, 1999, p. 211). Thus, HIV and AIDS, and various populations (e.g., women, youth, sex workers) are framed in a particular way or ways such that certain behaviours and actions are identified and labelled as risky, others as preventive or risk reducing; certain segments of the population are identified and labelled as especially vulnerable or at high risk and others as not; and certain social, cultural, or economic conditions as creating or contributing to vulnerability and others as not.

There is no doubt that most SSA countries are faced with numerous challenges, including HIV and AIDS. The HIV epidemic has led to afro-pessimism as the latest discourse on Africa (Echenberge, 2006). Afro-pessimism is the perception that "Africa has always been and will continue to be a scary, backward and a poverty ridden place" (Schorr, 2011, p. 23). Afro-pessimism, in the current postcolonial era, encompasses characteristics that are used to define, present and portray 'Africa' and its people. Some of the characteristics identified by Schorr (2011, pp. 29-34) and Mulwo, Tomaselli & Francis (2012, p. 570) include: homogeneity of problems, issues and their causes across all of Africa; a continent that is over-burdened by diseases, illness and starvation; prevalence of violence, tribal conflicts, political instability and civil conflicts; ruthless poverty. These features are based on and further promote stereotypes and negative images of Africa carried forward from colonialism.

Mulwo et al. (2012) contextualize HIV within afro-pessimism by looking at factors that shape the dominant discourses on HIV and AIDS. In their article, "HIV/AIDS and Discourses of Denial in sub Saharan Africa: An Afro-pessimism Response?" Mulwo et al. note that African sexualities and cultural practices dominate commentary in the HIV/AIDS discourse (p. 568). In this discourse, African people are viewed as promiscuous, uncivilized, backward, and following superstition (Michira, 2002; Mulwo et al., 2012). African women, in particular, are portrayed as immoral, passive, powerless, and lacking control of their sexuality (Parker et al., 2002). This framing of Africa and its people is used to explain the escalation of HIV in the region, i.e., HIV has spread in Africa is a result of promiscuity, ignorance, dangerous customs and traditions, and a reluctance to change behaviours.

In the HIV prevention discourse, HIV is framed as a disease of poverty and powerlessness (TACAIDS, 2008, October). Thus, gender, poverty, and the patriarchal system are problematized as the factors that make women vulnerable to the epidemic. In this frame, men are seen as intransigent and their vulnerability to the epidemic less salient (Higgins et al., 2010). They are also made invisible in the exclusive focus on women whenever gender is discussed (Booth, 1998/ 2004; Kolawole, 2004). Thus, gender programming is often developed from an exclusively <u>woman</u> orientation (Booth, 1998/2004). In this framing, there is a lack of recognition that gender and patriarchal systems affect not only women, neither do they affect all women equally, nor do they present all women (or men) with the same experiences. Africa is additionally framed (consistent with Afro-pessimism) as a continent that lacks expertise and the resources necessary to deal with its own issues, and therefore, solutions to problems are imported.

This includes western HIV prevention policies and practices based on the dominant framing of HIV and AIDS. The lack of success of these approaches seen in the African context is taken as further support for Afro-pessimism rather than the inappropriateness of the policies and practices to the African context.

Framing HIV Prevention Interventions

The framing and discourse surrounding HIV in Africa is used to justify the imposition and importation of HIV prevention interventions from the west into African countries. During the rise of the epidemic in the early 1980's, understanding, interventions, and research were influenced and dominated by biomedical and behavioural approaches aimed at changing individual behaviours (Altman, 1999; Dennis & Becker, 2006; Higgins, 2009; Parker, 2001; Taylor, 2006). Priority was given to biomedical models of disease control. As Taylor (2006) points out, western medical science was presented as a trans-cultural model of reality.

In the biomedical model, diseases are understood as "biological phenomena in which health and illness are conceptualized at the level of the individual" (Higgins, 2009, p. 967). Health is determined and measured quantitatively as the presence or absence of diverse indicators of health or illness, with less emphasis on people's lived experiences and subjectivities, and with the assumption that medical processes would solve recurring health problems (Boyce et al., 2007). This however, does not recognize and take into account non-medical determinants of illness and health, which are consequently omitted from interventions. Boyce and colleagues (2007) suggest that biomedical approaches are inadequate to comprehend the cultural depths, individual richness, and inter-personal

complexities in relation to HIV risks and vulnerabilities. Dennis & Becker (2006) similarly suggest that they are too narrow to comprehend HIV risks and vulnerabilities.

In the early 1990s in SSA, the HIV epidemic was additionally framed as a development crisis. This is evident in the Tanzania National HIV/AIDS policy of 2001, which notes that HIV is a development problem which requires development interventions (particularly poverty reduction programs). Framing HIV as a development challenge influenced participation by donor institutions such as the World Bank, UK Department for International Development (DFID), Joint United Nations Programme on HIV/AIDS (UNAIDS), and The President's Emergency Plan for AIDS Relief (PEPFAR) through commitment of financial resources and technical support (Whiteside, 2002). According to Said (1978), it is the interests of western donor institutions that determine the framing of non-western people, with the western lens used to deconstruct the lived realities of non-western people. In an effort to understand 'Africa,' donor countries and institutions started with the failures of African countries rather than examining the influence of socio-economic changes on African states and people. International institutions emphasized particular HIV prevention interventions that were developed and tested in the west since it seemed to them that Africans were incapable of contributing to their own effective solutions (Jones, 2004; Mulwo et al., 2012).

When a country or region is dependent on funds from the outside to support programming, it is donor agencies that shape and legitimize meanings and responses to social issues (UNAIDS/UNGASS for example). Through identification, framing, and defining the problem of HIV and AIDS in specific ways these agencies and institutions have influenced public debate and policy-making in this arena, ultimately shaping reality,

perception, and HIV intervention practices. The focus on empowerment of women that dominates HIV prevention strategies, for instance, is assumed to reduce women's vulnerability to HIV. UNAIDS/UNGASS (2001) frames empowerment of women as essential to reversing the high infection rate among women. PEPFAR (2005) offers access to income for women as a solution to the epidemic (p. 59). These approaches are simplistic and too general given the diversity of populations of women living in various socio-cultural and political systems (Boyce et al., 2007; Dennis and Becker, 2006).

These approaches also do not account for how globalization driven socio-economic changes affect HIV vulnerability and prevention among populations. It was not until the late 1990's that HIV prevention interventions turned to multi-sectoral approaches, involving multiple stakeholders, as well as multiple approaches to HIV prevention (Merson et al., 2007). These combined biomedical, behavioural and structural interventions. The biomedical approach to HIV prevention focuses more on medical responses in terms of producing and providing vaccines and/or microbicides, male circumcision, sexually transmitted disease control, use of diaphragms, substance abuse treatment, the provision of ARVs, and prevention of mother-to-child transmission (PMTCT) (Mayer, Skeer & Mimiaga, 2010).

Behavioural approaches are centered on reproductive health, behaviour change and condom provision (Hulme, 2009). The assumption attached to these approaches is that individuals are accountable and will make rational choices given knowledge and information about HIV and AIDS. As a result, the emphasis is on the provision of HIV/AIDS education (Dennis & Becker, 2006). Do and Fu (2011) suggest that while HIV related knowledge and skills are necessary, they are not adequate for prevention,

with self-efficacy mediating individual behaviours (p. 274). Life Skills Education (LSE) is recommended with the expectation that it will improve individuals' skills and self-efficacy in terms of relationship, communication, decision-making and problem solving, as well as increasing self-awareness, self-control, stress management, critical and creative thinking, and empathy (Higgins, 2009). The underlying assumption of this approach is that people lack life skills and consequently are vulnerable to bad life choices, bad relations, and bad health choices. The LSE approach is aimed at creating "abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life" (WHO 1998 in Higgins, 2009, p. 15).

The ABC (Abstain, Be faithful, and use Condom) model, as advocated by all donors, is a behavioural intervention that is widely promoted across SSA. The approach advocates for change of individual behaviours. The main message is to urge people to "first and foremost Abstain from sex until marriage; if not Abstaining, Be faithful to one, uninfected partner, if this is not possible, use a Condom" (Gallant & Maticka-Tyndale, 2004, p. 1339). However, this approach does not take into account how abstinence, monogamy, and condom use play out in women's lives in SSA or how they fit with existing cultures of sexuality. According to Jungar (2010) the ABC approach fails to take into account the significance of pleasure and emotions when people are asked to abstain. Be faithful frames couples as safe while condoms are the last alternative to prevention and signify problems within relationships (p. 184).

Structural interventions are interventions that are not directly related to HIV but act on structural factors that create vulnerability. These are interventions that locate vulnerability in the social, political, and economic environments that shape and constrain

individuals' capacity to protect themselves against HIV infection (Blankenship & Merson, 2000). Structural interventions may include changes in the legal environment such as enforcing laws that require condom use in brothels or that make female circumcision illegal; that make syringes available, affordable and accessible; that legalize prostitution. They include policy changes that make micro-credit available to reduce women's dependence on men, that reduce economic inequality through empowerment and livelihood approaches, or that eliminate tuition fees for education increasing its availability. They also address changes in customs and traditions that influence the spread of the epidemic (e.g., wife inheritance, widow cleansing, circumcision practices).

The contemporary view is that all these approaches (behavioural, biomedical, and structural) must be used in combination for positive results. This is a step forward from the predominantly biomedical approach. However, the problem that remains is the way the HIV epidemic and people are framed and represented even in the multi-level, multi-sectoral discourse. Men and women are framed and defined with conventional identities and categories that present them as homogeneous groups. The planned services and strategies must be more diverse as well as more particular if they are to be successful. They must be designed to address the vulnerabilities created by intersecting positionalities.

THEORETICAL FRAMEWORK: AN INTERSECTIONAL POSTCOLONIAL FEMINIST APPROACH

This dissertation is guided by an intersectional postcolonial feminist approach. The intersectionality and postcolonial feminist approaches are theoretical contributions of

feminists of color whose purpose was to make feminism more diverse and inclusive (Archer Mann & Huffman, 2005). The approaches are closely aligned, with both of them embracing differences among women. They challenge the definition of women based only on their gender with a universalization of their experiences based on the singular status of 'woman.' They turn the theoretical eye to considering gender in combination with other identities and positionalities such as race, sexuality, and social class, together with the influence of colonialism on how women were, and continue to be, defined and labelled. Additionally, they critique the depiction of non-western women as victims of masculine control, customs, and traditions (Mohanty, 1986). An intersectionality approach within postcolonial theory, according to Naples (2008), critiques approaches that construct women's concerns without attention to differences that shape these experiences. It embraces the interrelationships between social positions and identities and how these influence women's experiences. Thus, an intersectional postcolonial feminist approach not only turns our attention to women's different experiences, histories, social positions and identities, but also to understanding how differences in social positions and identities intersect to shape women's lives.

Counter to the framing of women as a homogeneous group, the postcolonial feminist perspective problematizes how racism and the long-lasting effects of colonialism and imperialism affect people in post-colonial countries (Weedon, 2000). Critical to the work of post-colonial feminist researchers is an analysis of how gender-power and sexuality are framed. Research guided by a post-colonial perspective suggests that the stereotypical framing of non-western people's sexuality is rooted in colonialism (Aniekwu, 2006; Maurer, 2000) with men's and women's sexualities framed within the

context of western standards and understandings of sexuality and gender (Maurer, 2000). These framings persist today in various HIV/AIDS programs and policies as evidenced in the understanding and interpretation of non-western women's sexuality as promiscuous, powerless, and passive (Bulbeck, 1998; Mohanty, 1986) and of men as sexually insatiable, demanding, and dangerous (Booth, 2004).

In terms of gender the dominant discourse has assumed that men have more power than women, that men are more likely to involve themselves in risky sexual behaviour and bring HIV to their partners, and that women lack abilities to protect themselves (Higgins et al., 2010, Wingwood & Declemente, 2000). The assumption is that sexual division of labor, sexual division of power, and social norms disadvantage only women. This has contributed to essentialization of women and masking of their agency as Crenshaw (2000) notes:

> While it is true that all women are in some way subject to gender-discrimination, it is also true that other factors relating to women's social identities such as class, … are "differences that make a difference" in the ways in which various groups of women experience discrimination. These factors can create problems and vulnerabilities that are unique to particular groups of women or that disproportionately affect some women relative to others. (n.p)

According to a report prepared for the Commonwealth Secretariat and Maritime Centre of Excellence for Women's Health (2002), the dominant discourse on HIV and AIDS has influenced gender mainstreaming projects and programs to focus on women independent of men and boys. This has also failed to take into account the vulnerability of men and boys and their continual involvement in HIV prevention projects and

programs. The report suggests that although women face unique vulnerability challenges, men are also vulnerable and need to be targeted.

Mohanty (1986, 1991) critiques the universal use of concepts such as gender, reproduction, marriage, patriarchy, and family to explain women's oppression as lacking cultural and historical context. The universal use of concepts is also carried in the HIV discourse and prevention practices. For instance, Wodi (2005) in his article, "Gender Issues in HIV/AIDS Epidemiology in sub Saharan Africa" notes that the "patriarchal nature of African societies continue to shape women's sexual behaviour…this in turn accounts for the high prevalence of HIV among women..."(n. p). This does not take into consideration how patriarchal systems intersect with other aspects like socio-economic changes and how this affects sexual practices. It also suggests that the patriarchal system is static and universal in African communities and affects all women in the same way. This is what Mohanty (1986, 1991) critiques. She suggests that women need to be presented within their specific local, cultural, and historical contexts, and that it is critical to consider how change in positionalities influence women's and men's relationships within patriarchy, to understand women's vulnerability to HIV infection.

Just as women are complicated in postcolonial feminism, so are men. Booth (2004) criticizes the donor community for framing men as "unchangeable"— with the consequence that devising HIV interventions for men is seen as a waste of time. Despite the complementarity of the discourse about men's predisposition to coercion, rape, and violence (Rivers & Aggleton, 1991) to that of women as subservient, powerless and at risk, and the consequent identification of men as the transmitters of HIV to women (Higgins et al. 2010), the focus of HIV prevention interventions remains on women,

rather than on men. The view is that men are intransigent, unable to control or to change their behaviour (Booth, 2004; Dworkin, 2005; Rivers & Aggleton, 1999). As a result, the prevention discourse has focused almost exclusively on behavioural interventions for women. What is missed in the dominant discourse is the intersection and joint positionalities of couples/partners and how these impact on vulnerability. Boyce et al. (2007) suggest that the conceptualization of women as passive victims, as vulnerable to HIV acquisition, and as subject to male domination is limited by the understanding of HIV and AIDS. HIV/AIDS is framed as affecting specific groups, with these groups becoming the targets for prevention. These risk groups are segments of the population with the highest rates of infection. Women are one of these groups. Thus, the focus is on those who are vulnerable to HIV, not those that transmit the virus. From this understanding women have become the target for HIV interventions, but for successful interventions, men also need to be involved. This requires moving away from individualistic-centered approaches to broader approaches that take into account the multiple issues influencing both men's and women's individual and joint vulnerability to HIV.

The narrow framing of men and women in the dominant discourse fails to consider multiple issues that intersect to influence their experiences of vulnerability. Mohanty and other postcolonial feminists stress the need to take into account the micro and macro politics, together with the systemic issues that woman face and that structure their lives (Booth, 2004; Kaplan & Grewal, 1994; Mohanty, 2003; Pietrzyk, 2005). Pietrzyk (2005) identifies the post-colonial feminist lens as an antidote to the persistent, singular focus on gender inequality, violence, and poverty as the only factors that

influence women's vulnerability together with the assumption that all women share the same experience. Women's lived experiences in their local settings are critical to understanding their vulnerability and risks to HIV infection. These experiences need to be linked with the broader social structures in which such experiences are lived. A salient question from this perspective would be: What is the contribution of socio-economic change to the shift in gender roles and positions of women, and how do these affect women's HIV vulnerability?

An intersectional analysis typically focuses on the concurrent analysis of multiple, intersecting sources of subordination or oppression (Collins, 1998; Davis, 2008; Friedman, 1995). In this dissertation, intersectionality is used to examine how diverse social locations or positions shape the lived, embodied experiences of women (Cole; 2008; Hankivsky & Christoffersen, 2008; Naples, 2008) in relation to the HIV epidemic. For the women in this study, these positions and locations include being educated, employed, and having an independent income. These are positions and locations that are assumed to empower, rather than subordinate or oppress them.

Framing of Women: An Intersectional Postcolonial Feminist Approach

In the AIDS prevention discourse in SSA, women are framed as uniformly in need of empowerment in the face of dangerous, "unchangeable men" (Booth, 2004). At the core of an intersectional postcolonial feminist approach is the critique of this unitary, homogeneous framing of men and women. Booth, for example, challenges the idea that masculinity is fixed and static, necessitating the direction of efforts towards empowerment of women so that they are able to protect themselves against men. She

argues that international agencies and organizations working on HIV prevention have contributed to perpetuating male dominance by focusing on women's weakness and ignoring the dynamics of gender power. Similarly, Berger (2004) notes that:

> [. . .] the attempt to find a single theory to explain a complex phenomenon tends to overplay vulnerability in a way that risks entrenching the realities of many women's lives… In suggesting a solution that lies primarily in changing power relations so that women can protect themselves from those men that cannot be made responsible, the discourse of vulnerability risks rendering the essence of gendered relationships as immutable and unchanging. (p. 47)

This discourse is echoed in national and international reports (NMSF II, 2007, UN, 2011). Shefer (2009) notes that the discourses of HIV and AIDS and women, "have emphasized the lack of positive discourse on female sexuality, that is, women are not able to express their sexuality or their sexual desires and pleasure as positive" (p. 7). Stillwaggon (2003) takes this further to say that the realities of the lives of African women are made invisible by the uniform representation of patriarchal domination over women. As Berger (2004) and Silberschmidt (2004) point out, this framing of the HIV epidemic in relation to women in Africa reinforces a conceptualization of African women as passive victims who are vulnerable to HIV infection through subjugation to masculine domination.

In contrast, women's agency has been illustrated in several studies. In Haram's study in Northern Tanzania (2004), men reported that single women have a particular behaviour or nature which is beyond men's control, and that some women pursue rich

lovers and leave men who cannot provide for or serve them. Studies by Silberschmidt (2001; 2004) document men's perception that they are losing control over women; i.e., that the power of men under patriarchy is slipping. Nyanzi and colleagues (2005) found that women refused sex when they felt their husbands or partners had behaved irresponsibly or failed to provide for family needs. These and other studies suggest that women need to be understood based on their own complex accounts rather than on generalized, stereotypical identities or categories (Kopelman, 2002; Lockhart, 2005).

These studies provide evidence to support Mohanty's (1986; 2003) challenge to the view that all non-western women are homogeneous and share the same experiences. She urges us to understand non-western women not only through oppressions but also through historical complexities and struggles that can change these oppressions. In her 1986 article, "Under Western Eyes: Feminist Scholarship and Colonial Discourse", Mohanty suggested that women need to be understood in their specificity in relation to the broader socio-economic and political systems under which they live. In her later article "Under Western Eyes, Revisited: Feminist Solidarity through Anticapitalist Struggles", she further argues that knowing the differences among populations, particularly women, is crucial in theorizing general concerns (Mohanty, 2003).

In contrast to Mohanty's view, in the current HIV prevention discourse in SSA which is driven by international development funding models and expectations, there is no acknowledgment of women's differences or changes in women's lives brought about through the macro-level forces of globalization, capitalism, and neoliberal policies. This has influenced HIV prevention strategies, which do not accommodate the needs of diverse groups of women. In the HIV prevention discourse, African women's and men's

sexuality is represented as a common experience across the continent, without recognizing that Africa is a continent with many different countries, and even more different ethnicities and cultural groups. African men's and women's sexuality is not monolithic. As Bujra (2009) observes, given the "diversity of this huge continent, there is no such object as African sexuality" (p. 5). Thus, referring to African women's sexuality or African men's sexuality in monolithic terms is an over generalization and essentialisation of these populations (Helle-Valle, 2004; Kolawole, 2004; Wingood & DiClemente, 2000).

In the HIV prevention discourse, gendered accounts and economic disadvantages are presented as if they affect all women's exposure to HIV infection in the same way, with economic disadvantage the primary social driver of the epidemic. As Bujra (2006) and Msimang (2003) point out, however, economic disadvantage alone cannot explain the escalation of the epidemic. Bujra suggests that there is a crucial intersection of social position and gender relations that contributes to the epidemic and its complexities. There is a need, therefore, to understand the influence of women's social positions, while linking questions of subjectivity, agency and identity with those of political economy and the state when dealing with issues of HIV risks and vulnerabilities (Mohanty, 2003).

Kitzinger's (1994) notion of visible and invisible women contributes to our understanding here. The HIV prevention discourse and practices are influenced by the stereotypical binary of women as bad (prostitutes) or good (married) which translates to unsafe or at risk and safe or not at risk. When safe women become infected, they are portrayed as innocent victims of the unsafe or bad women who have transmitted HIV and other sexually transmitted diseases (STDs) to men, with men the mere conduits of

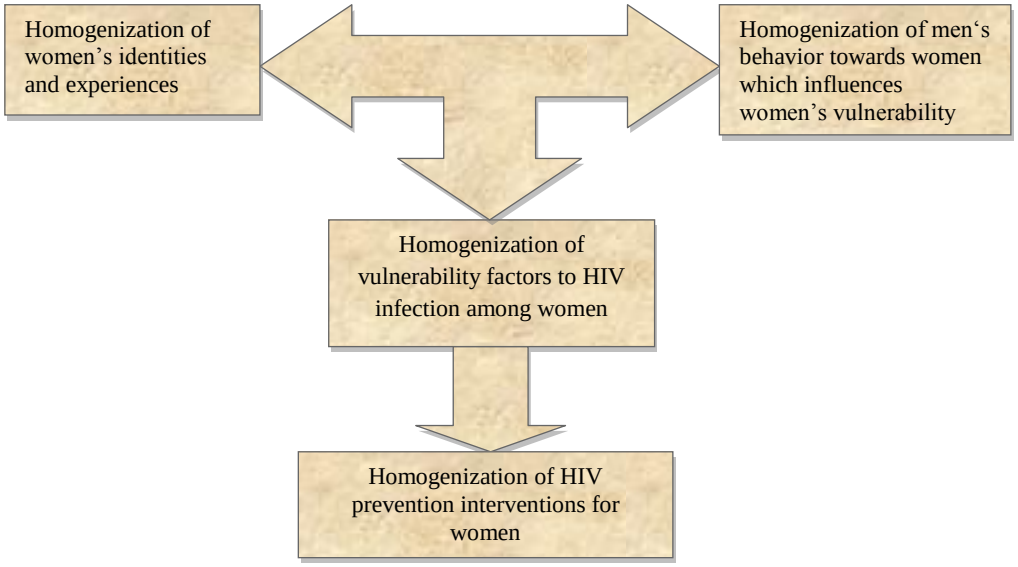
infection between the two groups of women. Men are portrayed much like 'puppets' controlled by their biological sex drive reinforced by cultural roles and expectations that necessitate 'sexual release' (Kitzinger, 1994; Shefer 2009). The feminine binary has a geographical and relationship dimension. Rural women are portrayed as good women who are faithful to their husbands. Urban women are portrayed as bad women who are often unfaithful to their husbands, or are prostitutes (Booth, 1998; Haram, 2004). Throughout this framing, sex within marriage is portrayed as safe, and a positive expression of female sexuality. The married woman is innocent and good. In contrast, sex outside marriage is portrayed as unsafe and a negative expression of heterosexual female sexuality, and women who engage in it as prostitutes and bad (Kitzinger, 1994). Hence, blame is focused on particular populations that are objectified and distanced from each other (Shefer, 2009).

This contributes to a particular scenario where prostitutes are held responsible for spreading HIV to men, who in turn infect their innocent wives (Kitzinger, 1994; McCormick, 1994; Parker et al., 2002). But there is barely any consideration (other than poverty) as to how women become engaged in prostitution, how men get involved with prostitutes, and who infected the prostitutes in the first place. There is also no consideration of women who have sex with men outside marriage for reasons other than prostitution. In this frame, non-marital sex is always associated with prostitution, prostitution is always associated with poverty, and women get involved in prostitution because it is the only way they can earn a living (see NMSF II, 2008-2012; Tanzania National HIV/AIDS policy, 2001). The solution, then, is to lift women out of poverty. Kitzinger (1994) critiques this kind of framing, suggesting that it is simplistic and does

not take into account all aspects that influence the escalation of the epidemic. Important to note, is that people get involved in prostitution for many reasons that are not necessarily economic or associated with earning a living; women involved in prostitution have multiple identities and positionalities such as married, mother, professional, educated etc. Women engage in non-marital sex other than as prostitutes. Different identities and positionalities influence the spread of HIV differently. As Epstein and colleagues point out, "… identities in themselves do not explain sufficiently the spread of HIV… it is more the context within which these identities are lived that has a significant impact on the prevalence of HIV" (2004, p. 1).

To develop and deliver effective HIV prevention services and strategies, an intersectional postcolonial feminist approach is crucial. This approach starts by identifying barriers to understanding women's HIV vulnerabilities and how these influence prevention interventions.

FIGURE 3: BARRIERS TO UNDERSTANDING WOMEN'S VULNERABILITY TO HIV INFECTION



Barriers to understanding women's vulnerability to HIV infection are also barriers to creating effective HIV prevention interventions. The primary barrier is homogenization, i.e., creating a singular, homogeneous discourse about men, women, and HIV vulnerability and risk (see Figure 3). An intersectional postcolonial feminist approach helps deconstruct this barrier. Women's experiences of vulnerability must be understood as the result of multiple, intersecting factors linked to their multiple, different social positions and identities. Additionally, masculinity must be understood not as fixed or unitary but as linked to men's multiple, intersecting social positions and identities. Vulnerability for both sexes is the result of interactions grounded in complex individual and joint positionalities. Both men and women exercise power and agency within the context of their individual and joint positions. That being said, there is a need to recognize that there is no single approach that is effective in reducing HIV infection, but rather an integration of multiple approaches that take into account the needs of each population group is crucial.

CHAPTER 3

METHODOLOGY AND RESEARCH DESIGN

The philosophical assumptions guiding this research stem from the subjective epistemology and ontology that understands reality as socially constructed, with researchers attempting to understand social phenomena by accessing the meaning that participants assign to them (Mingers, 2001; Stake, 2005). This is consistent with an intersectional postcolonial feminist approach which is described as guided by the belief that "knowledge is socially constructed and situated" (Archer Mann & Huffman, 2005, p. 65). This research then uses a qualitative, interpretive approach which strives to provide insights into "the complex world of lived experience from the point of view of those who live it" (Schwandt, 1994, p. 118). However, what must be acknowledged is that not only is the experience of an objective reality socially constructed, so too is the researcher's understanding of those constructions. Thus, "what we call our data are really our own construction of other people's construction of what they and their compatriots are up to" (Geertz, 1973, p. 9).

According to Boland (1991), Deetz (1996), and Orlikowski and Baroudi (1991) the approach is suitable in addressing 'why' and 'how' particular social phenomena are created. Given the topic and objectives of this study and the research questions that have been posed, this approach is appropriate to developing an understanding of (1) how the dominant HIV/AIDS discourse is constructed and how PEW view it; (2) how the

discourse about PEW's vulnerability to HIV infection is constructed; (3) how PEW are positioned within the prevention discourse. It is anticipated that PEW will also provide insights into their own theories of why women in Tanzania who are educated, employed and have an income of their own have the highest rates of HIV infection.

RESEARCH DESIGN

I used qualitative research methods in a case study of PEW to explore the discourse about PEW's vulnerability and its fit within the dominant HIV discourse and prevention practices in Dar es Salaam, Tanzania. The case study used three (3) sources of data: documents, interviews with officials, and interviews with PEW. Documents were read and analyzed between February and May 2012 and the interview data were obtained over three (3) months between August and November, 2012 in Dar es Salaam, Tanzania.

Sampling and Recruitment

Documents. Five documents were analyzed: *the Tanzania National HIV/AIDS Policy of 2001*; the *Second National Multi-sectoral Strategic Framework (NMSF II) for 2008-2012*; the *Review of HIV Epidemiology and HIV Prevention Programs and Resources in Tanzania of 2009*; the *National Multi-sectoral HIV Prevention Strategy for 2009-2012*; and the *UNGASS Reporting for 2010 for Tanzania Mainland*. These documents guide all the HIV prevention interventions in Tanzania and set a framework for all stakeholders engaged in HIV prevention (public and private) in terms of what should be done, where, how, and who should be the target. These documents helped explain the position of PEW in interventions.

Officials. A total of five (5) officials were recruited out of eight (8) officials who were approached: two (2) from TACAIDS and three (3) from TAMWA. The selection of the institutions from which officials were drawn was influenced by the roles that the institutions play in HIV prevention in Tanzania. TACAIDS has the authority to coordinate the national response to the HIV epidemic and is responsible for implementing the national policy on HIV/AIDS. It also has the role of overseeing and evaluating all other organizations working on HIV/AIDS in Tanzania. TAMWA is a non-profit association of professional journalists. One of the tasks of TAMWA is to advocate for women on issues related to HIV/AIDS. Thus, TACAIDS sets the official discourse and oversees its translation into programmes and services, while TAMWA interprets the discourse for the public, with a focus on women.

Officials were recruited directly from their institutions by contacting the institution's administration who referred me to the officials. When I met with potential participants, I explained verbally the purpose, risks, benefits, and rights of participants in my research. I also insured that they had enough time to ask questions. These officials were given a letter of information (see Appendix A) and consent form (see Appendix B). Then we arranged for another meeting where potential participants were asked if they had any questions regarding the letter of information and consent provided to them. Officials who consented to participate were asked to sign a consent form. All officials chose to be interviewed in their offices when they had free time and thus it was only me and the official at each interview.

Professional and entrepreneurial women (PEW). A total of thirty seven (37) professional and entrepreneurial women participated out of forty three (43) women who were approached. Eighteen (18) of these women were professionally employed, ten (10) were involved in entrepreneurial activities and nine (9) were professionally employed and were also involved in entrepreneurial activities when this research was conducted. The age range of these women was between 24 and 57 years. Nine (9) of these women were single, twenty five (25) married, and three (3) divorced/separated when this research was conducted. Some participants identified themselves by the place/region they came from and others identified themselves by their ethnicities/tribes, including Sukuma, Chaga, Pare, Pogoro, Luguru, Haya, Kerewe, Kurya, Nyamwezi, Ngoni, Bena, Nyiramba and Nyakusya. The regional distribution of participants involved in this research includes Mwanza (5), Shinyanga (2), Kilimanjaro (12), Morogoro (3), Kagera (5), Mara (1), Tabora (2), Songea (2), Iringa (1), Singida (2), Mbeya (2), (see Figure 4 for Tanzania map indicating the regions). All participants were living in Dar es Salaam when this study was conducted.

There was diversity in terms of professions and occupations as there were teachers, lawyers/advocates, university lecturers, human resource managers, doctors, journalists, sociologists, librarians, environmental management officers, entrepreneurs, geologists, public administrators, graphics and arts printing officers, entrepreneurs and management analysts in the sample. Furthermore, in terms of education, there was 1 (one) participant pursuing a doctorate degree, 12 participants with master's degrees, and 24 participants with undergraduate degrees.

FIGURE 4: TANZANIA REGIONAL MAP INDICATING REGIONAL DISTRIBUTION OF PARTICIPANTS

In recruiting PEW for interviews, purposive sampling was used to ensure diversity in terms of profession and occupation. A flyer (see Appendix C) was used to recruit professional women from various public and private offices such as: Aga Khan Foundation Dar es Salaam, National Environmental Management Council, Ministry of Natural Resources and Tourism, Tanzania National Institute for Productivity, two (2) high schools, two (2) hospitals, the High Court of Tanzania, the Tanzania Government Press office, two (2) universities, one (1) law firm, Clinton Foundation Tanzania, Benjamin Mkapa HIV/AIDS Foundation, to mention a few. These offices were selected because they were accessible and also had a diversity of professionals. Entrepreneurial

women were directly approached in their various work places including commercial and manufacturing venues. In both types of venue, I started by introducing myself, explaining my research, and inviting them to call me if they were interested in participating in the study.

When women who were considering participation in the study called me, I arranged a meeting with them. In the first meeting I explained verbally the purpose, risks, benefits and rights of the participants in my research. In the process, I gave participants enough time to ask questions. Then I gave participants a letter of information (see Appendix D) and consent form (see Appendix E) and we arranged for another meeting at their convenience. This was to make sure that potential participants had enough time to read through the letter of information and consent form and make a reasoned decision whether or not to participate. In the second meeting, potential participants were given time to ask questions and they were also asked whether or not they were interested in participating. After participants provided their written consent, I asked them if they were comfortable to be interviewed at their work place or somewhere else. The majority of the participants were comfortable to be interviewed in their offices and/or work place conference or meeting rooms. Some participants had their own offices and the interviews were conducted during lunch time when the offices were locked and other people had no access to them. The same for participants who chose to use conference or meeting rooms at their work places, they ensured that the rooms were not used at the time we conducted the interview.

Some of the interviews were conducted in my house. In these, confidentiality was ensured by making sure that no one else was in the house. This location was based on

participants' choice as some were not comfortable at their work place or their own home. A few participants chose to be interviewed in their homes. To ensure confidentiality I asked them if there were other people in the house. They assured me that there was no one in the house as we conducted the interview. Twenty nine (29) interviews were conducted in the workplace of participants, five (5) in my house, and three (3) in the participants' houses.

Data Collection Methods

Secondary data (documents). Data collected from the analyzed five (5) documents focused on themes related to HIV vulnerability and prevention practices. Mason (2002) suggests that documents are "constructed in particular contexts, by particular people, with particular purposes, and with consequences—intended and unintended" (p. 110). They may have multiple implications for social relations and have the capacity to construct human identities that can be social facts produced and used in social ways (Atkinson & Coffey, 1997; Prior, 2003). The reviewed documents were analyzed to understand the official discourse of the socially constructed drivers of the epidemic among various populations, the risk groups, target groups for interventions, the advocated interventions, and how PEW are positioned in the discourse.

Primary data (interviews). The semi-structured interviews with officials from TACAIDS and TAMWA were for the purpose of gaining information about how these organizations understood and incorporated the needs of PEW into their policies and strategies. One interview guide was used for both TAMWA and TACAIDS officials (see

Appendix F). Questions were directed towards their description of prevention strategies and factors contributing to HIV infection as articulated by their organizations, how the prevention strategies advocated by their organizations are determined, who are targeted to benefit from the proposed strategies, and the place of PEW in these strategies.

For PEW, the semi-structured interviews facilitated an in-depth exploration of (1) their understanding of the dominant discourse in relation to women's vulnerability and prevention practices; (2) their discourse about PEW's vulnerability to HIV and their theory of why PEW are vulnerable to HIV. The specific topics that were explored included their understanding and interpretation of each component of the dominant prevention mantra: Abstain from sex before marriage, Be faithful to a single partner, use Condoms correctly and consistently, as well as the barriers and facilitators to practicing A, B and C. None of the interviews were conducted in a public place. The same interview guide (see Appendix G) was used for both professional and entrepreneurial women.

All interviews with officials and PEW were audio recorded with the consent of participants (see Appendix H). And a combination of English and Swahili was used based on the comfort and preference of the interviewees. Five (5) interviews were conducted in English and thirty seven (37) in Swahili. The interview duration was between 40 and 80 minutes. All Interviewees were offered an honorarium of 13,000 Tanzanian Shillings (approximately $10 Cdn) to recognize their time and contribution to this research study.

Data analysis Methods

The data analyzed in this thesis consisted of documents and interviews. In regard to the documents, thematic analysis (identification and analysis of messages and themes) was employed. Focused coding was conducted for the documents by reading them multiple times with the themes relating to my research questions highlighted. The documents were printed, read and annotations were made on documents to understand the purpose and the resonating themes. Coding for each document was done in relation to themes that were identified in terms of vulnerability factors, target groups, vulnerable and at risk groups, as well as HIV prevention interventions. A table was created that included all the information that related to the identified themes. In addition, when reading the documents annotations were made on how women are presented and discussed within these documents. Again, all the annotations that related to women's presentation and discussion were written down and reviewed particularly looking at how women were framed and portrayed. The information obtained was synthesized and reported in relation to research questions.

The analysis of the interviews began with transcripts obtained from each interview. I transcribed all the audio interviews, translated those in Swahili to English. Then the information was transcribed onto my computer. Using Scolari N6 software, the data from interviews were coded using themes or topics in relation to the interview questions and other emerging themes as they appeared during the interviews. N6 software was used for coding all the interviews. The coding started with broader themes (free nodes) in relation to the research questions. Each individual interview was coded using the broader themes such as, “poverty, women and HIV/AIDS”, “HIV, women and

multiple partnerships", "PEW vulnerability". Then, sub-themes (tree nodes) were created under each free node and all the relevant information was put together by cutting and pasting. For instance under, "poverty, women and HIV/AIDS," I had sub-themes such as 'behaviour', 'not poverty' etc. Then the coded data were printed and read through along with the notes that were taken during the interviews, to identify the patterns. I synthesized and interpreted the information for writing the findings. The purpose was to highlight the important themes in relation to my research questions and to examine how different women discussed each theme. These themes were then examined for similarities and differences in discussions for women positioned differently in terms of education, occupation, marital status, ethnicity, age and other life statuses and positions. An intersectional approach was used to identify intersecting factors that influence PEW's vulnerability to HIV. Both differences and commonalities among women were examined. Then the data from interviews and reports were triangulated for the purpose of showing convergences, inconsistencies, and contradictions (Mathison, 1988) about the HIV discourse and prevention practices in relation to PEW.

ETHICAL CONSIDERATIONS

The University of Windsor's Research Ethics Board, The Tanzania Commission for Science and Technology (COSTECH) Research Ethics Board, and The Tanzania National Institute for Medical Research (NIMR) Ethics Board each reviewed the research plans and informed consent procedures. The study was granted three ethical clearances including from the University of Windsor (REB number 29826), COSTECH (REB number 2012-380-NA-2012-86), and NIMR clearance certificate. These ethical

clearances are required for ensuring the research benefits and confidentiality of participants, also for minimizing risk of harm for both the participants and the researcher. All participants were assured of confidentiality and were provided with consent forms. There were two different consent forms: One was for PEW which stated the details of the study, use of data and the rights of participants. This included information about how the participants' true identities would be protected and not used in the presentation of data. Participants in this research are identified by the names they chose. The second consent form was for officials from TACAIDS and TAMWA. It was difficult to hide the identities of officials from the selected organizations. The consent form, therefore, allowed officials to choose among their name, position or title occupied, and organization name as the way they were identified.

Procedural ethics is necessary, but not sufficient. Ethics of participation is also crucial, as Greenwood and Levin (2000, p. 95) suggest. Ethics of participation are important in a meaningful knowledge creation process. Therefore, participants were involved in the whole process of exploring issues they face in their everyday lives, especially in relation to HIV/AIDS. Furthermore, relational ethics such as creating interpersonal bonds, initiating and maintaining conversations (Ellis, 2007) were followed. On some occasions I was in a position to help participants with their regular activities at home. At times these influenced a changing relationship with my participants as some participants became my friends. Borrowing from Ellis (2007), "the people you study are active participants at every step of the process. You research with them rather than look into their lives from outside…" (p. 13). In the context of my research, at times it was difficult to detach myself from my participants. My participants were aware that I was a

Tanzanian, thus I was expected to act and behave like one, meaning I was culturally responsible to take action in some circumstances. For instance, at one point I was expected to attend to a crying baby while the mother was getting ready for the interview. Because I was able to help in various occasions and circumstances, it contributed to opening doors for participants to share their stories. Bergum (1998) suggests that, "relational ethics requires researchers to act from our hearts and minds, to acknowledge our interpersonal bonds to others, and initiate and maintain conversations" (In Ellis, 2007, p. 4). This exemplifies treating participants not as objects of research, but as partners in the research process. However, as a researcher I still had the ethical duty to maintain the confidentiality of the participants.

I employed a member check strategy to ensure trustworthiness of the data collected in terms of credibility, confirmability, transferability, and dependability as noted by Guba (1981) in Shenton (2004, p. 64). Member checking is one of the strategies for establishing data trustworthiness in qualitative research (Guba & Lincoln, 1985). During the interview, I sought clarification of the information provided and also at the end of each interview I paraphrased and summarized the information participants provided while inquiring about its accuracy from participants. I also gave participants an opportunity to add some information that was missing or left out in the paraphrased information. Note taking also aided the whole process of the interview while the interview was also recorded. Therefore, I was able to compare the notes I took and the audio recorded information.

SITUATING MYSELF

Max (2005) argues that "social location, skin color, class, gender and sexuality...all conspire to form a lens through which I make sense of the world" (p. 81). I recognize that my positionality influenced the research process as well as the research outcomes. Therefore, reflexivity and openness to critique from other people and the critical reflection of the self are imperative in my own research process (Max, 2005). Apart from being reflexive, I acknowledge the fact that research is not value-free; hence I am conscious of my own biases. I approached this study as a Tanzanian female, single, and a graduate student in Canada. My interest in conducting this research was instigated by the experiences and knowledge that I acquired in various academic institutions and life experiences through which I observed that women in developing countries were often presented in homogeneous terms and as if they had homogeneous experiences. Further, when it came to studying women and HIV/AIDS, the focus was mostly on poor or lower class women. In this study I am moving away from studying poor or lower class women, to focus on PEW. Also, relevant to my positionality, this study was conducted as a partial fulfillment of the requirements for the degree of doctor of philosophy in sociology.

I left Tanzania in 2006 when I joined St. Cloud State University (SCSU)-Minnesota for a master's degree in social responsibility. Soon after I graduated from SCSU, I was admitted to the University of Windsor for PhD studies in sociology with a focus on social justice. Although I was able to go back to Tanzania during my holidays, going back for fieldwork posed a lot of ethical and fieldwork challenges and dilemmas. Tanzania is the place I call 'home;' the place where I was born and raised. During my fieldwork, it did not seem like my 'home' as I found myself in a position of justifying my

nationality as a Tanzanian who is studying abroad. This happened as I was applying for the ethical clearance in Tanzania. The fact that I was not affiliated with any Tanzanian institution in the course of doing this research, and the fact that I was never employed in Tanzania posed a dilemma for the ethical clearance institutions. I was asked: "what is the difference between you and white people who come and collect data and go back to their countries?"

In negotiating my social location, I responded to the raised question by saying, given the fact that I hold a single citizenship as a Tanzanian and I live abroad on a student visa makes a great difference. It was finally recognized that I am one of the rare cases that the institutions had encountered. However, thinking of the question asked, I remembered Linda Tuhiwai Smith's (1999) and Denzin & Lincoln's (2000) arguments about the objective way of representing the 'other' in foreign countries. Both, Smith and Denzin and Lincoln challenge the production of expert knowledge of the 'other' that promotes the imperialistic way of understanding the life experiences of the 'other', especially non-western people. It was also a reminder for me to work with participants as equal partners in the production of knowledge rather than as objects of research (Hagnar, 2002). This is also consistent with the theoretical and methodological approaches that I have adopted as they both challenge the objective reality as claimed by some social science researchers.

Throughout the fieldwork I occupied multiple positions which were fluid and constantly shifted depending on various circumstances. At times I felt participants accepted me as an insider, at times as an outsider, and/or as an outsider within (Gilbert, 1994; Mullings, 1999; Pierce, 1995). I had to negotiate the multiple subjective

positionalities I occupied as they became important in my reflexivity with respect to the research process in general. Ganga & Scott (2006) argue that the insider status facilitates acceptance and enhances rapport between researchers and participants; however, the insider status also impacts the way other people perceive researchers within the social world. One of the aspects that influenced participants to consider me as an insider was my fluency in Swahili, a language that the majority of Tanzanians speak as an official language, and a language that unites people from different ethnicities in Tanzania. Apart from speaking Swahili, other shared identities such as my gender, ethnicity, class, and marital status contributed to my fluid social location as an insider, outsider and/or outsider within. For example, the fact that I was not married and was a student living abroad, positioned me as an outsider and in the 'other' category compared to the majority of married women that I interviewed.

While I shared some identities with my participants, this did not make me a complete insider, just as it did not make me a complete outsider. At times I was an outsider within. Some participants thought I had dual citizenship, others thought I was no longer a Tanzanian citizen; some even called me 'Mkanada' [a Canadian]. Many of my participants asked me 'Which organization are you working with?' 'Are you married?' and 'Do you have kids?' Unfortunately, I was not working with any organization, not married and had no kids. However, most of my participants admired my position as a PhD student studying in Canada and suggested that I was fortunate to have this opportunity. Despite stating my status as a student, some participants positioned me as an expert and it was assumed that I had authority to change policies and HIV/AIDS related practices. To some participants, especially officials, I did not seem like a total

stranger. They affirmed this by suggesting that "we get many people like you asking questions." Hopkins (2007) stresses the importance of understanding and taking into account the differences and similarities between researchers and their participants. Hopkins (2007) quotes Harvey (1996, p. 30) as saying:

> Differences can never be characterized, therefore, as 'absolute otherness, a complete absence of relationship or shared attributes.' The similarity deployed to measure difference and otherness requires, then, just as close an examination… as does the production of otherness and difference itself. Neither can be established without the other. To discover the basis of similarity (rather than to presume sameness) is to uncover the basis for alliance formation between seemingly disparate groups. (p. 388)

I believe that my positionalities have had an impact on my research, including the way participants responded to the interview questions. It would be un-wise for me to assume that I had fully and exclusively occupied one or another positionality. I recognize that these positionalities were fluid and changed over time (Pierce, 1995). The differences and similarities that I shared with my participants and the way I carried myself through the field work helped me bridge the gaps, create alliances, collaborate, and build rapport with my participants to the extent that some called me their sister [dada Neema], young sister [mdogo wangu], daughter [mwanangu] and others simply called me '*shosti*,' a Swahili slang referring to a female best friend. It is my belief that who I am and the way I interacted with my participants helped build rapport, relationship and trust which are critical in any field work. My familiarity with the research settings was also helpful in bridging the gaps. This is because I had lived in Dar es Salaam, the research

site, for many years. As a researcher and as a Tanzanian, I was also aware of the ethical considerations, hence I had to preserve the confidentiality of my participants in terms of their identities and the information they provided.

CHAPTER 4

SETTING THE CONTEXT: HIV DISCOURSE AND PREVENTION PRACTICES IN TANZANIA

The official public discourse about HIV in Tanzania has been guided by a series of documents produced by various government branches. This discourse sets the policy framework for delivery of prevention, care, and treatment services, both by government and non-government agencies (i.e., the practices associated with HIV), and also influence how HIV and affected populations are presented in the public arena (i.e., the public discourse about them). As such, they set and define the context for public (and different segments of the public such as PEW) understanding of HIV, personal risk, vulnerability, and protection. This chapter examines this context using five key government documents and interviews with PEW.

The reports analyzed include: the *Tanzania National HIV/AIDS Policy of 2001*; the *Second National Multi-sectoral Strategic Framework (NMSF II) for 2008-2012*; the *Review of HIV Epidemiology and HIV Prevention Programs and Resources in Tanzania of 2009*; the *National Multi-sectoral HIV Prevention Strategy for 2009-2012*; and the *UNGASS Reporting for 2010 for Tanzania Mainland.* These documents were chosen because they provide programmatic direction for HIV prevention intervention in Tanzania. Thus, these reports set a framework for the work of public and private stakeholders engaged in HIV prevention intervention in terms of what should be done, where, how, and who should be the target. The risk reduction targets set in these reports are also used for monitoring and evaluation, indicating the progress that has been made toward reducing or eradicating HIV/AIDS in the country. The segments of the interviews

with PEW used here focused on their general views of HIV in relation to who is most vulnerable and why. In this chapter, the reports and interviews are used to understand the dominant HIV prevention discourse and to identify and understand PEW's interpretation of that discourse.

An Overview of the Reports

The government of Tanzania, through the Prime Minister's Office, created the *National Policy on HIV/AIDS of 2001*, with the purpose of establishing a framework and general principles for national HIV/AIDS interventions. The main goal of the policy was to develop an operational framework for leadership and coordination of multi-sectoral responses to the HIV epidemic. This policy created the Tanzanian Commission on AIDS (TACAIDS), which has the mandate to guide and monitor HIV/AIDS interventions throughout the country. In addition, TACAIDS has the role of creating strategic documents, policies, and reports regarding HIV/AIDS. Thus, four of the reports that are used in this thesis were produced by TACAIDS. The *NMSF* was the first document to set goals and indicators to be achieved by prevention stakeholders. The *NMSF I* covered the years 2003 through 2007 and the *NMSF II* covered the years 2008 through 2012. Following this, the *Review of HIV Epidemiology and HIV Prevention Programs and Resources in Tanzania* of 2009 was created with the purpose of reviewing the trends and drivers of the epidemic. This is important in establishing a prevention strategy that aligns with these trends and drivers. These two documents (i.e., *NMSF II* and the *Review of HIV Epidemiology and HIV Prevention Programs and Resources in Tanzania* of 2009) informed the creation of the *National Multi-sectoral HIV Prevention Strategy* for 2009-

2012. Finally, *UNGASS Reporting for 2010 for Tanzania Mainland* is part of the progress report to the United Nations General Assembly Special Session (UNGASS) on Tanzania's actions in curbing the epidemic.

THE GOVERNMENT POLICY DISCOURSE ON HIV/AIDS

Since Tanzania reported its first cases of HIV in the early 1980s, different preventive approaches have been taken to control the spread and impact of the epidemic, with the government response(s) evolving as the epidemic progressed. It started with the creation of the National HIV/AIDS Control Program (NACP) in 1985 under the Ministry of Health (URT, 2005). During this period, HIV/AIDS was perceived solely as a health problem. Thus, NACP efforts to deal with the epidemic were situated exclusively within the health sector. This approach was not successful in reducing the infection rate. In 1992, HIV control efforts were initiated in non-health sectors with NACP remaining the central coordinating unit until the year 2000 (URT, 2007, July). In 1999, President B. W. Mkapa declared HIV/AIDS a national disaster. This led to the creation of the *Tanzania National Policy on HIV/AIDS of 2001* and the Tanzania Commission on AIDS (TACAIDS) (URT 2007, July). TACAIDS was mandated to deal with all HIV/AIDS issues in Tanzania.

Most recently, HIV/AIDS in Tanzania has come to be considered a priority development problem which has devastating social and economic impacts (URT, July, 2007). To deal with the HIV epidemic, the government has formulated policies and strategies/projects to control the epidemic and reduce its impact. Table 3 summarizes the key components of the five reports that articulate these strategies. These reports

represent the government discourse on HIV and HIV prevention interventions. The table includes what are identified in each report as the drivers of the epidemic among various populations, the risk groups, target groups for interventions, and the advocated interventions. Important to note here is that the specific framing of groups has an influence on the HIV prevention practices.

HIV prevention interventions in Tanzania are largely influenced by donor agencies (Seckinelgin, 2004). Thus it is the policies and intervention practices of donor agencies that are implemented and sustained in recipient countries through government institutions, Non-governmental Organizations (NGOs), and Civil Society Organizations (CSOs). Donor agencies shape and legitimize meanings and responses in relation to the epidemic by identifying and defining people, their actions, and the epidemic in particular ways (Peters, Van Driel & Jansen, 2013). This has influenced politicians and government bureaucrats to align national policies with donor policies in order to maintain the flow of donor funding (Seckinelgin, 2004). The framing of HIV starts from the pathways through which HIV is transmitted, who is most vulnerable or at risk, who should be the target and what prevention strategies should be implemented. This framing is based on western notions about people, HIV transmission, agency, and sexuality which were imported to Tanzania through colonialism and imperialism (Peters et al., 2013). These frames are embedded within a combination of the colonial framing of Africa and African sexuality and the historical development of the framing of HIV with its continual privileging of biomedical and behavioural drivers and solutions. It is this framing that is deconstructed here using a postcolonial feminist lens (Booth, 2004; Kitzinger, 1994; and Mohanty, 1986).

TABLE 1: SUMMARY OF REPORTS

Name of document	Author/publisher	Purpose	Drivers of the epidemic	Most vulnerable or at risk groups	Who and what to target	Prevention strategies
Tanzania National Policy on HIV/AIDS published November, 2001.	United Republic of Tanzania (URT), Prime Minister's Office	Provide a framework, "for leadership and coordination of the national multi-sectoral response to the HIV/AIDS epidemic" (p. 11), including direction and general principles in the National HIV/AIDS interventions (p.5)	Stigmatization Poverty Women's powerlessness Lifestyle of individuals Multiple partnership & unprotected sex	School children, adolescents and young adults, particularly girls Women People with multiple partners	(a). School children, adolescents and young adults (primary and secondary school) (b). Out of school youth (c). Adults (d). People with multiple partnerships and commercial sex workers (e). Drug substance abusers (f). People Living with HIV/AIDS (PLHAs)	(a). HIV/AIDS information & Sexual & Reproductive Health (SRH) education in the school curricula (b). Information on correct and consistent use of condom, abstinence & fidelity; voluntary counselling and testing; & encourage girls to avoid unwanted pregnancies (c). Develop Information Education Communication (IEC) with the purpose of promoting safer sex practices; fidelity, abstinence, correct and consistent use of condom (d). IEC and counselling services to influence safer sex practices (e). IEC and counselling services (f). Influence them to adopt healthy behaviours <u>Other interventions</u> • Prevent & manage STI's; make blood, blood products and donated organs, tissues and body fluids safer; make invasive & non-invasive skin penetration surgical, dental and cosmetic procedures safer

						• Prevention from Mother to Child Transmission (PMTCT), address gender equity & promote equal participation of men & women in negotiating safer sexual practices
The National Multi-sectoral Strategic Framework on HIV and AIDS for 2008-2012: Published October 2007	Tanzania Commission on HIV/AIDS (TACAIDS)	"Provides a broad orientation and principles that guides the national response to HIV & AIDS [for 5 years: 2008-2012] by setting indicators and targets to be achieved" (p. xxviii)	Promiscuous sexual behaviour Low and inconsistent condom use Intergenerational sex Concurrent sexual partners Lack of knowledge of HIV transmission Presence of other STI's Poverty& transactional sex with increasing number of commercial sex workers Male irresponsible sexual behaviour Social, economic & political gender	Women aged 30-39, & men aged 35-44 years in urban areas have high infection Widows & divorcees [women] The wealth have high HIV prevalence than the poor Women engaging in commercial and transactional sex Sexually abused children Men who Sex with Men (MSM), prisoners, refugees, displaced persons. People with disabilities and intravenous drug users.	(a). Children and young people [children of school age & out of school youth] (b). Most vulnerable populations: These include: Women (without control to practice safe sex, in commercial & transactional sex); sexually abused children; MSM; prisoners; widows & divorcees; persons with disability; refugees and displaced populations; IDUs. (c). Workers: special attention on mobile and migrant workers (road workers, mining, tourism, plantation, transportation, military, traders, fishermen, small scale miners and farm workers).	(a). Promote abstinence, delayed sexual debut, partner reduction and consistent condom use through school based life skills and HIV education programs and life skills education and HIV activities linked with livelihood programs for out of school youth (b). Open discussion and awareness about gender inequality, gender based violence and sexual abuse by empower girls to negotiate safer sex: enhancing knowledge about sexuality, reproductive health and HIV Promotion life skills and male responsibility, IEC, condom access, peer education, counselling and testing, and STIs services Provide PEP, emergency contraception presumptive treatment of STIs legal support for rape victims, sexually abused children and for women in abusive and forced marriages Education, condom provision, harm reduction measures and rehabilitation measures for IDUs (c). Support for PLHIVs; Reduce risk taking and promote safe sex; created guideline and work place intervention; integrate HIV

			inequality including violence against women Substance abuse Local cultural practices Mobility Lack of male circumcision			education in new staff orientation and seminars; ensure legal environment (protection of worker's rights , adherence to ILO code of conduct on HIV/AIDS). Strengthen labour and employment policies and regulation to incorporate HIV and to discourage and address misconduct -sexual harassment and sexual exploitation in work place Make information and condoms available to all mobile and migrant workers in public and private sectors <u>Other interventions</u> • Prevention, treatment and control of other STIs • Promotion and expansion of HIV testing and counselling services • PMTCT • Promotion and distribution of condoms • Prevention of HIV transmission through blood transfusion , exposure to contaminated body fluids and contaminated instruments • Introduction of new prevention intervention i.e. Male circumcision & Self-testing
Review of HIV Epidemiology and HIV Prevention Programs and Resources	TACAIDS	Provides "a systematic review of the trends and drivers of HIV in Tanzania, coverage and scope of HIV	Low and inconsistent condom use Multiple sex partners	Older adults aged over 30 years are more likely to be infected than younger adults. Individuals in marital union or those formerly married.	(a). General population and high risk groups, and youth in and out of school (b). Young people and adults including commercial sex	(a). Behavioural prevention initiatives: interpersonal communication, educational and life skills programs; educational programs in the work place aimed at promotion of safer sexual behaviours, delaying sexual debut,

in Mainland Tanzania, published May, 2009.		prevention programs, and assessment of the alignment of HIV prevention programs to the dynamics of the epidemic with the purpose of informing the formulation of the HIV prevention strategy" (p. 5)	Mobility Untreated STIs Transactional sex & cross generational sex (among young women and older men). Poor quality of transfused blood, unsafe injection and contact with body fluids Lack of male circumcision Gender inequities, gender and sex based violence, socio-cultural norms Poverty and wealth Alcohol, drugs and injecting drug use Lack of knowledge on own partner's HIV status Conflict situations	Individuals living in more wealthy households, including employed and educated individuals Individuals living in urban areas. MSM Women	workers (c). Pregnant women, reproductive age women and their partners, HIV infected women and their partners, antenatal mothers <u>Others</u> Vulnerable and high risk populations groups (sex workers, MSM, prisoners, refugees, displace populations and IDUs) Women and children, mobile populations and single mothers	decreasing number of partners , condom use and health seeking behaviour (b). Condom promotion: increase knowledge about condoms and address misconception; make them accessible; address gender and socio-cultural barriers to condom use (c). PMTCT <u>Other Interventions</u> • HIV counselling and testing • Control of STIs • Blood transfusion safety • Medical infection control (Including injection and post - exposure prophylaxis (PEP)) • HIV prevention among positives • Medical male circumcision • Programs addressing gender, socio-cultural and other underlying factors of HIV transmission: Universal primary education for boys and girls; growth of CSOs and women organizations with active role in identifying gender inequalities and lobbying to advocate for change; awareness rising by women organization, PLHAs Networks and other CSOs on links between gender, poverty and HIV

The National Multi-sectoral HIV Prevention Strategy for 2009-2012, published November, 2009.	URT/ TACAIDS	"Aims to guide comprehensive multi-sectoral HIV prevention efforts of all stakeholders…by providing them with a guided reference for the prevention of new HIV infections" [p. 1). For 4 years from 2009 to 2012.	Multiple sexual partners Vertical transmission High prevalence areas Gender norms that promote values of masculinity and femininity; gender based violence; wide spread acceptance of multiple sexual partnership Inaccurate risk perception: low self-efficacy & low locus control Alcohol and other substance abuse	Adults aged over 30 years are likely to be infected than younger age groups, particularly women and girls. Individuals in marital union or those formerly married Individuals in wealthy households Most at risk population i.e. transactional sex workers and their clients, men and women who work away from home, MSM, and IDUs and other substance abusers	General population and at risk adults and youth who have more than on partner Youth/partners in cross generational sexual relationships Men and women engaged in commercial sex Men and women who work away from home (transportation workers, migrant workers, the uniformed services) Parents who plan to have children or who are pregnant Regions with high HIV prevalence; epidemic hotspots (transport corridors, border crossing points; and urban areas) Structural drivers-societal norms Individual factors Injecting drug abusers	Communication programs (aimed at reducing risky behaviours such as multiple partnering, low condom use, and mixed-aged relationship). PMTCT, HIV counselling and testing , management of STIs, blood transfusion and injection safety, post-exposure prophylaxis for post rape and occupational exposure , prevention with positives (PwP), adult male circumcision, IDU services. Address gender norms, harmful socio-cultural practices, and gender based violence. <u>Other interventions:</u> Integration of HIV prevention into SRH services, life skills education, primary health care, HIV/AIDS care and support. <u>Priorities:</u> Reduce multiple and concurrent sexual partnership to reduce unsafe sex (multiple partnerships, early debut especially for young girls, cross generational sex and transactional sex) Make unsafe sex safer: condom promotion and distribution, increase male circumcision Address gender/socio-cultural/structural constructs Scale up PMTCT services, medical

						infection control, blood transfusion safety and STIs control. Focus on MSM and IDUs
UNGASS 2010 Progress Reporting for Tanzania Mainland, published in 2010.	URT/ TACAIDS	"Provides updates about the status of the epidemic, the national response, major challenges, best practice and information about monitoring and evaluation of the response to the epidemic in Tanzania" (HIV ALERT[2], 201I)	Poverty Pervasive socio-cultural norms and practices (early marriage, gender inequities, gender based violence and cross generational Multiple partnerships Infants (during pregnancy, labour and delivery, or through breast feeding)	Adults in the age group of 35-39 are more likely to be infected that other age groups. Women are more likely to be positive than men. The prevalence is higher among the richest and is lower among the poorest. Prevalence is higher among widowed, divorced and separated women than for men Prevalence is higher in urban centers	Who and What to target on this report is aligned with the government goal which is to: (a) Reduce HIV prevalence among 15-24 year pregnant women (b) Reduce HIV prevalence between the ages 15-24 years olds (c) Reduce HIV & AIDS prevalence among women & men with disabilities (d) Increase knowledge of HIV & AIDS transmission in the general population (e) Reduce HIV & AIDS stigmatization	Blood Testing PMTCT Prevention among the youth (HIV life skills and education for in and out of school youth) Knowledge and Behaviour change

[2] HIV ALERT (2011) UNGASS 2010 Progress Report-Tanzania [http://www.hivalert.net/web/guest/resource?id=25324eaa-eafc-4b97-8d8d-010c78f39180]

The table above seems to include a diversity of issues in terms of the drivers of the epidemic vulnerable/at risk groups, target populations, and prevention interventions. However, looking at the presentation and discussion of women in these documents it is clear that there are three main salient issues that are emphasized: poverty, lack of gender power, and lack of education among women. These are presented as the main frames for women's vulnerability and risk practices. This is also evidenced by the programming interventions which have focused on women as poor and powerless.

Depending on the drivers of the epidemic identified in each report, various population groups are targeted for HIV prevention. Although two of the reports, the *Review of HIV Epidemiology and HIV Prevention Programs and Resources in Mainland Tanzania* (2009, May) and the *National Multi-sectoral HIV Prevention Strategy* (2009, November) recommend efforts be directed to the general population, there are still specific categories/groups in each document that are suggested as primary targets. Critical to note here are the government goals for HIV prevention as described in the *Tanzania-UNGASS Progress Report* (2010):

> Reduce HIV prevalence among 15-24 year old pregnant women from 11% in 2004 to 5% in 2010. Reduce HIV prevalence from 11% in 2004 to 5% in 2010 between the ages 15-24 years. Reduce HIV prevalence among women and men with disabilities, and increase the knowledge of HIV and AIDS transmission in the general population, as well as reduce HIV and AIDS stigmatization. (p. 3)

The target groups in these goals were not set in Tanzania, but by arms of the World Health Organization (WHO) and United Nations (UN). These institutions define

and identify health in relation to populations, thus advancing national and international agendas for health. Within the HIV/AIDS epidemic, these agendas are based on western framing and understanding of the epidemic influenced by biomedical and behavioural understandings. Thus, young pregnant women, youth between 15 and 24 years, and people with disabilities are targets for reduced prevalence, with the general population targeted for increased knowledge and reduction of stigmatization. These then became the target groups for HIV interventions in Tanzania.

Gender and Sexuality in the HIV Discourse

Peters et al. (2013) note that labelling and classification of people with specific characteristics as target groups (earlier in the epidemic these were referred to as "risk groups") is a common practice in the HIV/AIDS discourse. Such labelling is driven by a particular understanding of gender and sexuality. For example, research shows that the higher prevalence among married, divorced, and widowed women results primarily from their husbands or male sexual partners infecting them, rather than from non-marital sexual activity on the part of the women themselves (*NMSF II, 2008-2012*). Yet, it is married, divorced, and widowed <u>women</u> who are identified as target groups, not their husbands. In two of the reports, women are described as lacking power and abilities to negotiate condom use (*National Multi-Sectoral HIV Prevention Strategy*, November, 2009; *NMSF II, 2008-2012*) with no consideration of whether they want to negotiate condom use or <u>how</u> they exercise power in sexual relationships. Such framing and labelling has influenced the discussion of drivers of women's vulnerability and has made women the target for HIV prevention.

Multiple drivers of the epidemic that influence women's vulnerability are identified in the reports. However, the government discourse on women's vulnerability to HIV infection presents homogenized, acontextual experiences of poverty, powerlessness, and victimization by male domination as the main drivers. It portrays women as either innocent victims of men and the epidemic, or complicit in the spread of HIV through prostitution. The presentation of women in these terms is rooted in imperialist interpretations of diverse, flexible, egalitarian gender systems and their transformation in compliance with the predominant gender systems of colonial powers (Chilisa, 2006). Under colonial rule, women became associated exclusively with the private sphere and traits that suggested passivity, and men became associated with the public sphere, giving them power over women (Silberschmidt, 2004, p. 243). When women were in the public sphere, especially with respect to sexuality, it was as prostitutes, with the framing of sexuality as transactional in pre-colonial cultures of sexuality translated into the western framing of prostitution.

From a postcolonial perspective, this framing of men's and women's sexualities and genders ignores contextual socio-cultural and economic differences. Concepts such as gender and poverty are universalized to explain vulnerability. There is no account in the dominant discourse of how social positions and identities intersect to influence differences in vulnerability. As well, men and women are presented within a western framing of gender and sexuality, with no consideration that a local framing and experiences may be quite different.

The discussion of women's vulnerability and risks to HIV infection presented in these documents is uncritical of the construction of women's and men's experiences.

Some of the drivers of HIV presented in Table 3 are presented in such a way that women are seldom sexually active themselves. They are merely receptive of men's sexual initiation and activity (Kolawole, 2004). This reflects gender norms that support ideals of masculinity and femininity that pre-dominated western understandings during the colonial era (Booth, 2004). What is not explored is how gender and sexuality are locally constructed, how women may have resisted the western ideals, and how understandings of gender and sexuality have become hybridized as a result of experiences living under colonial rule.

Women's powerlessness, gender inequality and violence. All five (5) documents noted women's powerlessness, gender inequality, and violence as drivers of women's vulnerability. In some documents this was framed within the context of socio-cultural norms and practices (noted by 4 of the 5 documents). The *National Multi-Sectoral HIV Prevention Strategy* (November, 2009) framed the sexual behaviours and gender roles of men and women as different and in contrast to each other, with women disadvantaged in this portrayal. For example, women are portrayed as having limited decision-making power and accepting of male infidelity as a prescribed norm. The *National HIV/AIDS Policy* (2001) also frames HIV transmission as influenced by gender norms, in this case stressing gender violence and women's lack of control over their sexuality (p. 8). These framings of HIV in the context of sexuality present women as lacking agency in the prevention and transmission of HIV. It brings a western lens, rooted in a discourse of women as subservient and powerless, especially in the realm of sexuality and gender, against demands of masculinity that frame men as sexually

insatiable, self-centered, and violent. Even indigenous norms and scripts are interpreted through this lens.

Concurrent multiple partnerships. Concurrent multiple partnerships, i.e., engaging in sexual activity with several different, overlapping partners, is another driver that was common to all reports. It is identified as a leading driver of the epidemic in Tanzania and appears in multiple forms such as extramarital sex, casual sexual relationships, cross-generational and transactional/ commercial sex (*National Multi-Sectoral HIV Prevention Strategy, November, 2009*). Cross-generational or intergenerational sex is the focus of 4 of the 5 reports. However, the framing of this driver is exclusively within the context of women's poverty (*National Multi-Sectoral HIV Prevention Strategy, November, 2009; Review of HIV Epidemiology and HIV Prevention Programs and Resources in Tanzania Mainland, May, 2009*). Young women are portrayed as driven by poverty to engage in cross-generational/ intergenerational sex with older men. They are framed as victims of poverty and of older, wealthier men, and as lacking agency over their decisions and in these relationships. Such framing ignores intergenerational relationships between older women and young men, agency of the younger partner, and any motivations on the part of the younger partner other than economic need. Agency and initiative are placed entirely in the hands of older men, and risk of infection is discussed exclusively from the perspective of younger women.

Transactional/commercial sex was a focus of two reports. This practice is also framed, interpreted, and given meaning within the context of poverty and the economic survival of women. The *National Multi-Sectoral HIV Prevention Strategy* (November,

2009) notes, for instance, that, "the motivation for engaging in sex work is money, although some individuals are trafficked and coerced into selling sex" (p. 15). Transactional or commercial sex is not regarded as a choice that may be motivated by something other than material needs. It is assumed that sex workers are girls or women (no mention is made of men) and that they would not engage in sex work if it was not an absolute necessity for their survival. Customers are always men and the power in the sex work relationship rests entirely with them.

The framing of multiple sexual partnerships is uniformly through a western lens that again replicates the colonial framing of African sexuality. Women, especially young women, are powerless victims driven primarily by economic need. They are victimized through heightened risk of HIV infection by men who have the power over sexual relationships and are driven by norms of masculinity that define them as having an insatiable, uncontrollable sex drive with coercion and violence an acceptable means of satisfying that drive.

Absent, low, and inconsistent condom use. Low, inconsistent, or absent condom use were presented as drivers in 3 of the 5 reports. In all, lack of appropriate condom use was framed within the context of gender identity and power in sexual relationships *(Review of HIV Epidemiology and HIV Prevention Programs and Resources in Tanzania Mainland*, May, 2009; *NMSF II, 2008-2012*). The *NMSF II* (2008-2012) notes that the use of condoms is hindered by women's limited decision-making power on sexual issues. Low, inconsistent, and absent condom use was also framed as resulting from norms that prohibited acceptance of condoms as an interference in the masculine

experience of sex, i.e., in a way that enhanced maleness. Again, this framing is one of male power and control and female powerlessness. In addition, it ignores how condoms are framed within the context of women's gender roles and sexuality. As with the other drivers, it is embedded within and driven by a western, colonial framing of African sexuality.

Poverty. Poverty was identified as a major driver of the epidemic in 4 of the 5 reports. In the HIV prevention discourse, poverty is a master frame used to contextualize and explain all other factors associated with women's vulnerability. Poverty among women is explained and presented as the context for increased risky sexual behaviours such as engaging in intergenerational and commercial sex for purposes of survival (National HIV/AIDS Policy, 2001, p. 8). Poverty is also seen as limiting women's bargaining power in sexual relationships (e.g., for condom use), placing them under the control of men's preferences and desires which are portrayed as egotistical with no concern for their partner *(Review of HIV Epidemiology and HIV Prevention Programs and Resources in Tanzania Mainland* May, 2009).

The framing of poverty in relation to HIV vulnerability has solely focused on women, ignoring men. Identifying poverty as a major driver of women's vulnerability has led organizations to prioritize programming for poor women, especially programs designed to 'lift them out of poverty.' There was no identification of programming for women who are not poor in any of the reports. Poverty is also used by donor institutions as the rationale for empowerment strategies that focus on economic gain for women (such as microcredit funding) claiming the main purpose of these strategies is to reduce

women's vulnerability. This is also rooted in the colonial and imperial framing of Africa and African people as poor. It is this framing and labelling of Africa and its people that influenced the framing of HIV as a development challenge that requires poverty reduction strategies as noted by the *Tanzania National HIV/AIDS policy of 2001*. However, within this framing there is no account of how socio-economic changes (such as development or empowerment) influence vulnerability, particularly among women.

PEW's DISCOURSE OF RISKS AND VULNERABILITY AMONG 'WOMEN'

People encounter the dominant HIV/AIDS discourse through the media, advertisements, educational programs, and interactions with health providers. Using intersectionality within the context of postcolonial feminist theory, I interrogated how PEW speak about and understand HIV and AIDS. I was interested in whether they replicated the dominant discourse or had developed an alternative or hybridized one. This was of particular interest since PEW do not fit within the framing of women as poor, uneducated, and dependent on sex work for survival. Among these economically empowered, highly educated women was there evidence of interrogation of or resistance to a dominant discourse based on a non-indigenous framing of African men's and women's sexuality? Was there evidence of a hybridized discourse that combined the dominant with an alternative, more locally informed, understanding and experience of sexuality? To answer these questions, I followed the outline of topics generally presented in reports by asking women about who was most at risk, what contributed to their risk, and whether and why those at risk were unable to protect themselves, with the latter two questions for the purpose of uncovering any local theories or discourse of vulnerability. The focus

here is on general responses that PEW provided in relation to HIV vulnerability and women rather than the specific situation, circumstances, or experiences of PEW.

When identifying populations that have the highest prevalence of HIV– referred to by PEW as "most at risk" or "most affected" -- the majority of participants named women. Participants identified the same themes that appear in the reports as the reasons for women's vulnerability. These themes are: poverty, multiple partnerships, dependence on men, customs and traditions, as well as biological factors. Most participants distanced PEW from vulnerability by focusing on poverty and dependence on men. They spoke of "other women," referring to women who were uneducated and poor which made them dependent on men. In terms of a theory of vulnerability, some of the vulnerability factors that were in the dominant discourse were challenged and resisted. Participants provided alternative framing of vulnerability within specific contexts, although in some circumstances they spoke more generally and acontextually. A few participants even challenged the claims about higher prevalence among women.

The Discourse of Poverty

There was no doubt expressed about poverty influencing HIV vulnerability, however, participants' opinions on the role of poverty in women's vulnerability varied. Although some participants echoed the discourse of poverty contributing to vulnerability, most participants suggested that behaviour cannot always be explained by poverty. Participants spoke of individual behaviours as the driving force behind women's vulnerability. They felt that, at times, poverty was used to justify or excuse individual

behaviours. PEW spoke of two ways in which poverty is used. First, women use poverty as an excuse for their behaviours, as A. Jumanne said:

> I can say yes, because if a person, especially a woman, has no income she can use her poverty to get money for the purpose of satisfying her needs. But all these to me are just a person's behaviour, all other reasons are just used to do what they wish to do… this is one of the things that people do but they need to justify why they do that. (Personal communication, November 5, 2012)

Second, poverty is used by others to justify how they view and/or act toward poor women. Here women who are perceived as poor are seen as accessible for sex because they are desperate for work or income, as N. Guma explains:

> Depending on the level of poverty, you can find that income is the main source of vulnerability but in the largest percentage it may not be the only way [case], because a person can get income in many other ways/means not necessarily prostitution. For example, in industries most women are raped and others are forced to engage in sex just to get a day of work. House girls also…What I want you to understand is that people use women's poor condition to satisfy their needs while most women are not willing to do that, they are just forced. (Personal communication, October 29, 2012)

Both A. Jumanne and N. Guma resist the dominant framing of poverty in relation to women's vulnerability. They provide alternative views, suggesting that poverty is used to excuse or justify behaviours. Thus, both the actions of the women and the actions of others towards them place them at risk of acquiring HIV. However, within the dominant HIV/AIDS discourse, poverty in relation to women's vulnerability lacks context/explanation. The PEW's view suggests that the social position of the woman concerned (employed but poor or unemployed), her personal desires or preferences, and poverty intersect to create different forms of HIV vulnerability. An important point to note here is that other populations (apart from the poor) may also become vulnerable, for

example people who use their positions to sexually coerce or harass the poor or those who are clients of prostitutes. This is also determined by the HIV status of the people involved and whether they use condoms. Therefore, it is critical to understand the multiple contexts and intersecting pathways through which poverty contributes to HIV vulnerability.

The Discourse of Prostitution

Poverty driven prostitution figures prominently in the government discourse, and the majority of participants similarly linked prostitution and/or sex work with poverty. As in the government discourse, participants felt that poor women were most likely to engage in prostitution to meet their needs. Some women, however, suggested that prostitution is not only done because of poverty, but also for reasons such as sexual satisfaction and desires, pleasure, and other personal reasons. Participants warned against making poverty the only, or predominant, cause of prostitution. T. Jumanne said:

> … What I see is that income is not the reason, but people use that to hide their behaviour. For example, my younger sister is a prostitute despite having a different business, which brings in a lot of money. So if this person is not poor when she gets infected, will we say that poverty contributed? (Personal communication, October 18, 2012)

Poverty, as framed in the dominant HIV/AIDS discourse, leads to poor women engaging in prostitution. However, PEW's discourse suggests that this cannot be generalized to all women engaged in prostitution. In addition to challenging the discourse on prostitution as inevitably the result of poverty, most PEW also challenged the claim that prostitution is the primary explanation for multiple partners among women and that it is inevitably a contributing factor to women's vulnerability. They suggested that women other than

prostitutes have many partners and that prostitutes are more likely to protect themselves against HIV infection. J. George's contribution represents the discourse of many participants on the issue of prostitution.

> In the past when the diseases started it was so. Not all women go into the streets to sell their bodies, there are those who don't stand on streets but are still prostitutes. A prostitute is a woman who has more than one man [partner], if this woman has many sexual partners what difference does it make from a woman who stays at home or is working but has many partners? When you compare in terms of percentages you may think that prostitutes in the streets are leading but they are in the same percentage level...what I know prostitutes in the streets are very [more] careful than other women. (Personal communication, September 17, 2012)

Again, participants provided an alternative view of prostitution in relation to HIV. When discussing the role of prostitution in HIV transmission, participants identified what they referred to as 'hidden ways' through which women 'prostitute' themselves, which also contribute to HIV infection. There was a notion that prostitutes in the streets were safer than other women (with multiple partners). In another interview, M. Sungusia spoke about the difference in the actions of sexual partners who trust each other as compared to the actions of a client with a prostitute:

> I think they [prostitutes] are very safe because they don't trust anyone...If I had to be asked whether my husband should take a prostitute or be in a relationship with a woman who is not a prostitute, I will prefer him to be with a prostitute, because, I will be very sure that with a prostitute, he will be very careful than a non-prostitute. (Personal communication, October 11, 2012)

This view was approached from the other side by M. John who spoke of vulnerability in the context of love and trust, "…we entertain men from when we start relationships, we only think of love and forget everything else" (Personal communication, October 11, 2012). Entertaining men was spoken of as growing into love and trust. With love and trust, the need to protect one-self faded into the background.

Participants included two specific groups in their framing of prostitution, those who stand in the streets and sell themselves and women with multiple partners (without an economic exchange) who do not stand in the streets. PEW's discourse views street prostitutes as safer than those who do not stand in the streets.

The Discourse of Marriage

PEW's discourse views marriage as a source of vulnerability for the majority of married women. This is consistent with some of the reports that have shown increased rates of HIV infection among married couples (*Tanzania National Multi-sectoral HIV Prevention Strategy, 2009; NMSF I1 of 2008-2012).* Almost all women said marriage was one of the places where they saw the most infection and that married women were more vulnerable than single women. M. Daudi who is married expressed the views of most participants that, "single women have [more] autonomy over their bodies than married women." As many said, married women have no autonomy over their sex life, because the focus is on sustaining marriage and protecting their children rather than their own well-being or desire.

Additionally, a number of participants replicated the dominant discourse that married women were infected by their husbands. Others deconstructed this discourse with an alternative view, saying infection could come from either partner. M. Simon, who herself is single, felt that marriage made women vulnerable to HIV infection but that women could also contribute to HIV in their marriage.

> In some way it is true, some men are dishonest to their wives and have a lot of women. It is also known that husband and wife never use condom, hence difficult for the wife to protect herself from HIV infection and other

> sexually transmitted diseases. It is nature and known in our societies that men are meant to be polygamous and ladies are for one man. You can even see the Law Act Cap 29 RE 2002, it allows for example a Muslim man to marry up to 4 wives with consent of the first wife as long as it is a customary marriage. If he sees the 4 wives are not enough is another point…Today some women go out of their marriage as well…some women are not sexually satisfied in their marriage given the nature of the husband's responsibilities. Also, ladies are always subdued to their husbands you cannot say anything…you keep quiet and have another man outside, in the same way she can bring HIV to her husband. However, this depends on the behaviour of the couple. (Personal communication, August 23, 2012)

Participants' discourse suggests that marriage does not protect either partner. Men are reported to be unfaithful and women may be unfaithful as well. The vulnerability of married women (or couples), is also presented within the context of avoiding bad luck. M. Simon explained it well:

> …Now days marriage is not the matter for protection, but people marry to get away with 'gundu' [bad luck], they say 'ndoa suna' [marriage is a blessing] if you are not married and you are old enough people see you different and that you have bad luck. I have been asked several times; why don't you get married… people see you and the society sees you as you have some issues/problems. Being the case, as a lady you get tired and decide to get married with whoever comes. As a result some of these are not compatible in marriage…women get married to the men they don't love to get the bad luck away, they fear people and the society looking at them in a different way. (Personal communication, August 23, 2012)

A relatively uniform perspective on adulthood across all ethnic groups in Tanzania is that marriage is expected, with the unmarried are viewed negatively. In this discourse, women get married to avoid bad luck or a negative reputation. There is no expectation of monogamy, particularly for men, but rather men are said to need multiple partners. When marriage proves unsatisfactory for women, perhaps because they married just to avoid bad luck and not with due consideration of what they want in a partner, they also seek partners outside marriage. So men always, and women often, because of multiple

sexual partnerships, have the potential of bringing HIV infection into the marriage. This discourse more fully explains how marriage makes women (and men) vulnerable to HIV infection than what is available in the dominant discourse or government reports.

The Discourse of Higher Infection among Women

Some participants challenged the discourse of a higher infection rate among women. H. Nzaga, questioned whether the data on HIV prevalence properly takes account of the demographic imbalance in women and men in the population:

> …in terms of population and statistics women are many compared to men, when you test the impact according to the number of women and men, we [women] will still be the most affected, I don't think it should be generalized that much. (Personal communication, October 10, 2012)

An alternative explanation for the higher prevalence among women was provided by M. Sungusia who suggested that prevalence appears to be higher among women because they are tested more often than men.

> … the chance of getting infected between men and women could be the same but we are more affected because when we get married for example we reproduce. In the process it is easy to notice [infection] than for men, some women do abortion and such things…because of many things that women have to go through, they will easily be diagnosed with HIV than the man who infected them. Not only that but we attend hospitals more often than men and we are best when it comes to HIV testing... (Personal communication, October 11, 2012)

For H. Nzaga and M. Sungusia, given the differential in the number of women and men in the population, the biological make up of women (i.e., it is women who get pregnant), their more frequent attendance at hospital, and mandatory HIV testing with pregnancy, it is likely that infection will be more readily identified in women, conveying

the appearance that they have higher infection rates and therefore are more vulnerable than men.

The Discourse of Women's Passivity and Weakness

In the dominant HIV/AIDS discourse, women are portrayed as weak and passive, with these attributed to lack of education and income, prevalent norms and practices of gender inequality, a patriarchal system, and customs and traditions. As a result, prevention programs focus on empowerment strategies. Participants went beyond education and income and provided an alternative and/or hybridized discourse about weakness and passivity. Some participants framed women's weakness and passivity within the context of socio-cultural norms and practices, historical context, and socio-economic changes. Others held women accountable for their inability to protect themselves. Critical to intersectional postcolonial feminist approaches is the analysis of root causes of what influences the experiences of women within specific contexts. The majority of participants, when discussing women's weakness and passivity identified such root causes in the exclusion of girls from schooling, in cultural traditions, and in recent socio-economic changes that are affecting the positioning of women and men alike and consequently their gender relations and power. One participant, B. Mwampepe, went so far as to say the portrayal of women as weak and passive lacked substance. As she put it, "I think this is just a notion" (Personal communication, September 17, 2012).

Historical approach. Some participants explained women's weakness and passivity within an historical context. Lack of education and income were rooted in a

history where women were excluded from western forms of schooling and income earning opportunities. With the structural changes brought with colonization, women became part of the private sphere of the home, making them dependent on men. S. Alphayo said:

> The history of our lives since our grandparents, women were never empowered, like taking them to school so that they become independent. You find that she is married and depends on the husband, even the husband does not empower her. (Personal communication, September 21, 2012)

Because of their dependence on men, even for household provisions, they may be forced to be submissive and accept everything for the purpose of continuing or sustaining their lives. This discourse was also articulated by M. Mangowi who spoke of how education was not prioritized for women in the past. In her view, education is important in the prevention of HIV because it opens opportunities that can keep a woman away from risks. She adds to education a discourse of empowerment through entrepreneurship as an avenue to reducing vulnerability and spoke of recent changes:

> Most women in the past were not given a chance to go to school, as a result they cannot even think of other ways to live [manage] their lives. ...But if they were empowered, for example in entrepreneurship it could be a different thing… The 10 years ago women are not the women of today. So if women are empowered into entrepreneurship it will make a difference. Now we see women as head of families feeding their families, taking their children to school and are not oppressed as it used to be, because they are in a position to say you cannot do this to me or get out of my house. And many women now can stand on their own different from what happened in the past. (Personal communication, October 10, 2012)

S. Alphayo and M. Mangowi are talking about 'other women' who are vulnerable because they are not empowered to stand up for themselves. However, there is recognition that women's weakness and passivity is not a fixed, inalterable condition.

Contemporary women are becoming active in fighting for their rights. As M. Mangowi explained, women are now having a voice that is different from the past.

Alongside this alternative discourse of socio-economic and structural change that results in more women going to school, taking up income-earning activities and fighting for their rights, was the replication of the dominant discourse of poor and uneducated women, dependent on and submissive to men.

> Most of the women are weak and this weakness is the result of lack of education and also because of poverty. And if you find a woman with a foolish husband [a husband who does not care about the wellbeing of his wife], the wife will be humiliated and denied the right to make decisions that even borders around her life. (S. Joel, personal communication, October 29, 2012)

While this replicates the dominant discourse of education, poverty, and vulnerability, S. Joel expands the frame to include the attitudes of husbands. Vulnerability thus rests in the relationship between husband and wife, not merely in a wife's lack of education and consequent weakness. S. Alphayo, who earlier spoke of the history of women's exclusion from school contributing to dependence, here expands on this theme. For her, women who remain exclusively within the home have no say in the family.

> Women are always viewed to be down… the main thing for women being seen as weak is when 'baba' [father] is working while 'mama' [mother] is a house wife. Very few of these women can have a say in the family, but most of them tolerate... (Personal communication, September 21, 2012)

The discourse of lack of education and income contributing to weakness, passivity, and dependence which, in turn, make women vulnerable to HIV infection because they cannot negotiate for their own well-being within the context of marriage, takes us back to the colonial framing of men and women. With women placed in the private/domestic sphere and only men having access to the public sphere and consequently to education

and employment, and with the shift in the economic system from subsistence and wealth accumulation within the context of extended family, clan, and village life to a market driven economy, women are made dependent on men.

Socio-cultural approach. Several participants discussed traditions and customs that link marriage to social status and the relation of this link to women's vulnerability. P. Banturaki identified marriage as central to women's role as *goal keepers*. *Goal keepers* focus on marriage and children. This is their primary goal in life. The performance required to achieve this goal, is one of dependence and subservience to a husband. They purposefully and consciously engage in this performance. This goal and the gender norms associated with it are rooted in a patriarchal system as well as the customs and traditions of most tribes in Tanzania.

> You know a woman as a 'goal keeper' has affected us much and it is the outcome of patriarchal system which we grew up in. It was used to discriminate and oppress women that you cannot go to school, instead you have to get married. It also originated in customs and traditions which are the source of most women's problems in the society. (Personal communication, October 10, 2012)

The customs and traditions dictate that women comply with their partners' wishes and not question anything. In the patriarchal societies of Tanzania, women are not encouraged to talk in front of their partners. Men are heads of families who need to be respected, and women have to be obedient to their husbands. In these circumstances, being silent means respect and obedience. This contributes to women's vulnerability in several ways. For instance, women may choose to stay in a marriage, regardless of the circumstances, because they need to maintain their social status as 'married' or because

they are not in a position to support themselves or raise their children outside of the marriage. In childhood, women are socialized to pay respect to men as heads of households. It does not matter whether you are educated or not, whether you have an income or not, you will still be a wife who owes obedience to your husband. The expectation is that the husband makes decisions and you only have to agree.

> Most women, especially we Africans, the environment in which we are raised, we are told to respect the husband. The husband has the say in the house, he is the head of family; you will even find the wife calling their husbands "baba" [father]. It is the fear and our values that contribute to the large extent in our weakness. (M. Kundael, personal communication, September 10, 2012)

Men know they are heads of families and have a right to make decisions. As E. Mayela said, "Even if women speak, for a Tanzanian man, he is always the head of the family. And men know that they have a say in family matters over women…" (Personal communication, August 23, 2012).

Two participants spoke of the role of Christian teachings in reinforcing these traditional norms. They explained that in the Bible women were meant to be below men.

> …religious beliefs contribute to this, do you know that we have been oppressed from the biblical point of view, men were counted and we were not counted, then a woman came from a man's rib, at the end of the day even when we argue, men end up saying that you know I am the head of the family… (M. Sungusia, personal communication October 11, 2012)

> From the biblical point of view ladies are subdued to men and we are told 'tulizaliwa kutoka kwenye ubavu wa mwanaume' [we came from a man's rib], wanaume ni utukufu wa Mungu [a man is the glory of God]. Given this, a lady cannot even comprehend the fact…to tell her husband...ohh you know I wish we use rubber [condom] today, because she does not even have the right to tell her husband. The power and the talk flows from the husband to the wife… (M. Simon, personal communication, August 28, 2012)

Several women, like H. Nzaga, pointed out that, 'weakness' and 'passivity' are not inherent characteristics of women, but cultural expectations of a woman in marriage. As such, she, and other participants, questioned whether it was appropriate to speak of women as weak, dependent, or passive.

> Being weak or not weak is relative. We are not dependents, but there are customs and traditions which lead us into being dependents. There are many women who live alone and they live a very good and enjoyable life. (Personal communication, October 10, 2012)

From this perspective, women are led into dependence in marriage. But women who live alone, independently, cannot be considered weak or dependent. Customs, traditions, and religion contribute to making married women dependent on their husbands. The normative ways in which women maintain themselves in this relationship of dependency are interpreted as a sign of weakness or passivity. But, perhaps these are instead signs of strength – the strength of women to do what needs to be done to sustain their marriage and thereby maintain the valued social status as married women and insure economic support for themselves and their children.

The reinterpretation of women's apparent weakness, passivity, and lack of power as a performance that actually demonstrates ways in which women exercise power was contained in the following descriptions of how women "carry themselves" around men. N. Guma, and M. Walter spoke of how women play the part of being inferior to men, bestowing on men power and control over them.

> ...most women are not weak because they are almost on the same level with men [in terms of education and income], but the difference comes in the way we portray ourselves as inferior to men, as a result we are controlled … (N. Guma, personal communication, October 29, 2012)

> We are not that weak, it may be the way we carry ourselves. Men are stubborn beings but these do not mean that we can tell them anything, we can tell them, but forcing them to adhere is what is difficult… (M. Walter, personal communication, September 13, 2012)

Both of these women portrayed the tension between playing a part (as inferior) that was not reflective of reality ("almost on the same level"; "we can tell them") and the consequences of such performance ("as a result we are controlled"). The danger is that the performance becomes a reality which women have colluded in making.

> Sometimes we contribute in putting ourselves down, we have been very passive, we are just following customs and traditions instead of waking up, and we give men power over us, because we are unable to react, it doesn't matter whether you have income or not, you have to speak for your life. (T. Selemani, personal communication, October 18, 2012)

T. Jumanne also rejected the interpretation of such performance as weakness and identified it instead as foolishness.

> That is not weakness it is foolishness. I told you, why should you see something that affects you and keep quiet? ...Even those who say lack of income contributes to their weakness is not true, how is it possible you give away your life like that? Even if you don't have money... it is a must that you will fight my friend, I see it is foolishness to sit and watch that go on. (Personal communication, October 18, 2012)

Rather than weak, women are foolish, for through their performance they have given men control over them. Participants were clear that women are not inherently, or by virtue of some innate characteristic, dependent, weak, or passive. They pointed to single women who maintain themselves independent of a husband and show strength and assertiveness in doing so. Married women were described as performing dependence, weakness, and passivity for purposes of survival within the context of deeply rooted customs and traditions reinforced by Christian teachings related to gender roles and gender power.

Thus, as Mwampepe said, women as weak and passive "is just a notion." However, it is a notion that becomes a reality in women's lives.

Socio-economic approach. Some participants moved beyond long-standing customs and traditions and spoke of how socio-economic changes have contributed to changes in gender roles. In this regard, participants began moving from speaking of poor and uneducated women, or women in general, to women more like themselves. They felt that as women are educated and earn their own income they gain power to make their own decisions and choices. H. Frank, expressed a view shared by other participants that educated, employed women can no longer be perceived or weak. "I now see we have same education as men. Now we all get employed, in life today women are not weak…" (Personal communication, September 21, 2012). While it is clear that PEW are educated, employed women, what is important about H. Frank's view is that she has expanded the effect to all women.

Discussion

The government discourse of HIV/AIDS in Tanzania, particularly in relation to women, is limited and narrow and based not on the social, cultural, and economic experiences of Tanzanian women and how these influence vulnerability, but on a discourse of gender, sexuality, and power and a theory of vulnerability imported from the west. This has resulted in a focus on the experiences of women who live in poverty, portrayed as made vulnerable by virtue of poverty combined with norms of gender inequality. PEW portrayed women's vulnerability as far more complex, with the complexity resulting from

intersections of marital status, personal choices, and ways of expressing power within the boundaries of economic, social and cultural contexts. They did not exclude women from responsibility for their own choices by blaming those choices on poverty, inherent weakness, passivity, or men. Even when they took up the dominant themes of poverty, prostitution, weakness, and passivity, they presented alternative explanations. They explained women's vulnerability within specific contexts. For instance, participants problematized the discourse of poverty, interrogating and deconstructing the multiple ways that it contributes to vulnerability. Others challenged the discourse of poverty and vulnerability, disagreeing with claims of prostitution inevitably and exclusively resulting from poverty.

Most participants, when they spoke about women's weakness, made reference to "other" (i.e., not PEW) women, suggesting that lack of education and income, customs, traditions, and religion contributed to women's weakness. They almost never ascribed these characteristics to themselves. Speaking of weakness, participants provided alternative views by looking at the fundamental causes of women's passivity and weakness. Within a postcolonial feminist approach, examining the underlying drivers of social phenomena is critical to understanding how such phenomena came into being and how they impact people. Thus, in the discourse of participants, women's weakness and passivity are rooted within historical, socio-cultural norms and socio-economic changes. Although the dominant discourse has ascribed women's weakness and passivity to lack of education and income, participants in this study suggest that factors such as customs and traditions, patriarchal structures, religion and faith intersect with education and/or income to influence the way women relate to men.

Within an historical approach for instance, participants explained how historical lack of education contributed to women's weakness and/or passivity. It is important to note that formal school-based education was imposed in developing countries by western colonizers. The imposition and importation of such education has contributed to the widening gap between public spheres where schooling influences one's position (for men) and private spheres where schooling is of little or no influence (for women). This widens the gap between men and women because the preference for who needed education was for boys and not girls. This was continued even after colonialism and thus made men more visible in the public spheres and provided them with income earning opportunities. With the shift to a market economy, it affected gender and power relations as women became dependent on men for household provision. Thus, women were forced to be passive or submissive. But within the dominant discourse, western formal education carries only positive impacts on the wellbeing of people. As PEW pointed out, formal education carries negative impacts as well, not only in terms of increasing inequality between men and women but also in other spheres of life, such as HIV vulnerability, as will be discussed in the next chapter. Apart from western formal education, Christianity (also a western practice imposed on Africa countries) is used by participants as an explanation for women's weakness and passivity. Participants explained the role of Christian teachings in relation to imposed fidelity and subservience. Thus, both religion and formal education occupy complex intersecting positions in relation to HIV vulnerability and protection.

A few participants blamed women for their own perceived weakness and passivity, suggesting that women are not weak, rather it is a position or performance that

women choose. In the process, men are given power to dominate over women. However, within the socio-economic approach, participants suggested that some women are now empowered, just like men, through earning their own income. But empowerment strategies for women are rooted within a western conception of agency, (i.e., through education or income). The focus on income related empowerment strategies for women, has contributed to the failure to understand other issues that intersect with income or education in women's lives. This is because it has failed to take into account the historical, cultural and socio-economic changes and how these affect women's vulnerability in their specific social positionality.

It is also important to note that there is tension between customs, traditions, and norms (and the needs to abide by these for women) and socio-economic changes. Contemporary interpretation of traditional norms, customs, and traditions are influenced by experiences rooted in colonialism. At the same time, current socio-economic changes are based in western forms of capitalism and a market economy that compete and co-exist with pre-existing norms, customs, and traditions to influence new life experiences. A narrow focus on one of these aspects will not take into account the true experiences of women's vulnerability to HIV infection. What PEW have challenged in the dominant discourse on HIV/AIDS is its acontextual nature, ignoring historical, cultural, and social contexts of HIV transmission; its focus for prevention on women ignoring relational contexts of HIV transmission; and its offering of poverty alleviation as a primary method of combating the epidemic, ignoring vulnerabilities of those who are not poor.

CHAPTER 5

THE DISCOURSE OF FACTORS INFLUENCING PEW's VULNERABILITY TO HIV

According to the *National Multi-sectoral HIV Prevention Strategy* (November, 2009), multiple sexual partnerships is the leading driver of the HIV epidemic in Tanzania (p. 11). In their various forms (extra-marital partnerships, casual sexual relationships, cross-generational or intergenerational sexual relationships and transactional or commercial sexual relationships), these sexual interactions are influenced and /or driven by a complex interplay of issues such as socio-economic influences, gender relations, and socio-cultural norms. Within the dominant HIV/AIDS discourse, multiple sexual partnerships are described as pervasive among men (Bengenheimer, 2010), and invariably framed within the context of men's sexual needs/ desires. Conversely, when multiple sexual partnerships are associated with women, they are framed within the context of socio-economic needs of women (poverty and economic survival). *The Second National Multi-sectoral Strategic Framework* (NMSF II) report (October, 2007) notes, "women are driven by economic needs to engage in transactional sex" (p. 38). These socio-economic needs are generalized to all women (i.e. all women are motivated by economic needs to engage in multiple sexual partnerships) and it is claimed that, "whenever sex is part of an economic exchange, women's ability to protect themselves from STIs and HIV is limited" (*National Multi-sectoral HIV Prevention Strategy*, November 2009, p. 15). The assumption here is that men's income gives them power to decide and act on what they want, and women's dependence denies them the opportunity to make decisions or act on the decisions they make. In this discourse, women are portrayed as an "already

constituted group, one which has been labelled powerless, exploited and sexually harassed" (Mohanty, 2000, p. 346 in Archer Mann & Huffman, 2005, p. 67). Thus the dominant discourse portrays a woman as "a socially disadvantaged, monogamous, and unsuspecting woman [who] is infected not through her own behaviours but as a consequence of her partner's wrongdoing" (Higgins et al., 2010, p. 436). This kind of framing elides how women themselves come to engage in multiple sexual partnerships and how diverse economic, social, and cultural influences make them variously vulnerable to multiple partnerships.

This chapter focuses on the intersection of social positions and identities that produce and reproduce conditions for multiple sexual partnerships among PEW, thereby making them vulnerable to HIV infection. I use an intersectionality approach within postcolonial feminist theory to examine how PEW's different social positions and identities produce multiple and different experiences of vulnerability to engage in sex with multiple partners. For instance, a woman, a lawyer, a spouse and a mother are all identities that one can hold. Each of these identities has its own challenges and may make one vulnerable to HIV in different ways. When combined, they manifest in complex and diverse interplays of challenges. An intersectionality approach shifts from the universalized categories of analysis within the dominant discourse (e.g. woman, poor) to differentiated social identities (Hankivsky & Cormier, 2009). This chapter focuses on the relation of five social factors to HIV vulnerability through multiple sexual partnerships: educational attainment, employment, income/wealth, marital status, and socio-cultural norms. These factors intersect to increase or decrease PEW's vulnerability to HIV.

The presentation of this chapter begins with PEW's discourse about the social factors (education, income, employment and marital status) that influence vulnerability to HIV among women of their stature. In the next section, these factors are linked with the expectations associated with sexuality which place PEW at high risk of acquiring HIV. This is followed by a discussion of the intersection of factors influencing PEW's vulnerability to HIV infection.

Before examining the discourse of social factors influencing PEW's vulnerability, it is important to note that HIV/AIDS remains a sensitive topic of discussion in most sub-Saharan African (SSA) countries. This is because of the images that are associated with the disease (dangerous, incurable, death), how it is transmitted (promiscuity and prostitution) and the perception of people who are HIV positive (including stigmatization and social isolation). All these are influenced by myths and stereotypes about the disease and people who become infected. Thus, the majority of people, when talking about HIV/AIDS avoid associating the disease with themselves and their specific experiences. In the same way, the majority of participants distanced themselves from their responses suggesting that they were speaking of other women, albeit women who were PEW as they themselves were. Only a few women claimed the experiences they spoke of.

EDUCATIONAL ATTAINMENT

> …we believe that these people [PEW] are educated and have resources to protect themselves, but what translates to their infection or vulnerability is unknown to us...and people believe that this is a safe population. (TAMWA Information Officer, personal communication, October 4, 2012).

Despite the presentation of education as a protective factor in the dominant HIV/AIDS discourse and the belief that PEW are a safe population, the complex and nuanced role of education was recognized by the TAMWA information officer. The assumptions made within the dominant discourse suggest that educating women will contribute to balancing power relations between men and women, by providing women with employment opportunities and thus income. With education and income, women are expected to be independent and able to make and act on decisions that serve their own best interests. Education is also suggested to influence women to have control over their sexuality and avoid risks, and to provide critical thinking skills so women recognize risks, and engage in health seeking behaviours. One of the participants affirmed this discourse suggesting that "It [education] reduces my risk in some way in terms of me being aware and to protect myself. I protect myself. As of now I am HIV free, I know the use of rubbers [condoms], I have one partner" (M. Simon, personal communication, August 23, 2012). Education was also credited by PEW for endowing them with cognitive resources and power to make good decisions, as well as to exercise good judgement. As presented in the dominant discourse, being uneducated, in tandem with having inadequate or no income, was associated with lack of decision-making power, disrespect, and humiliation. E. Mayela for instance, compared her husband's respect for her before and after she obtained higher education and could earn a good income.

> …me being educated, also to some extent made him respect me more. Because when I was getting a little income, he did not respect me at all, he thought I could never be successful because by then I had no education to do all that I am doing now. It is this oppression that pushed me to go back to school and learn different skills and later joined the University... You know a man will have discipline when you earn a good income. And when you have income it is not going to be easy for him to divorce you or leave

> you. And because of this now, I feel his love towards me has increased [husband listens, cares and values her contribution] and I can say something and he will listen, sometimes he seeks advice from me. (Personal communication, August 23, 2012)

E. Mayela's narrative outlines how education's role in providing an avenue to jobs and income influenced her relationship with her husband. Her explanation is a replication of the dominant discourse. Despite such benefits, however, participants also identified multiple ways in which education increased PEW's vulnerability to HIV.

'Underwear Degrees[3]'

Participants described how educational institutions, including universities and colleges, exposed female students to HIV infection. Participants spoke of female students pursuing male professors for good grades, and higher GPAs in exchange for sex. Students are aware that their future careers are determined by their academic credentials. The increase in the number of graduates from colleges has created competition in the job market, therefore one not only needs a degree, but also grades to translate education into a job.

> ... Most of lecturers [male] sleep with their students...there are people with higher GPAs which are not real [never worked to earn them]. When you get used to be favoured at school you would want to be favoured at work place as well, because now if you need a PhD, you can just be connected and be called a doctor but these doctorates are "underwear doctorates", when you get there you just sleep around... (M. John, personal communication, October 11, 2012)

The exchange of sex for grades is a common phenomenon in post-secondary schools (Eyre, 2000; Omale, 2002) and educational institutions are claimed to be hubs for sexual

[3] 'Underwear degree' was a phrase used by participants indicating how female students exchange sex for grades and/or help with assignments from male professors or young male students.

promiscuity. Participants spoke of male professors pursuing female students for sex as well as female students pursuing male professors for grades. Grades are not the only goal for female students. Participants also spoke of students dating professors as a way to elevate their social status, at the same time positioning themselves to secure favours, including financial support. S. Shosye, who is married to a lecturer, expressed this view by saying, "He [her husband] is a lecturer, female students will follow him because they want free marks [or good grades], some want elevated status, and some need favours..." (Personal communication, October 9, 2012). In all of these relationships, both the professor and the student may become vulnerable, particularly if they engage in unprotected sex. This is exacerbated as both may have multiple partners. When a student or professor is married, this extra-marital affair also puts the spouse at risk.

Participants also spoke of how the increasing age diversity among students (particularly female students) has contributed to vulnerability. It was claimed that some older female students pursue younger male students for academic as well as personal reasons:

> ...for those [women] who are educated for example, I see them at the University, they will be around young men all the time and they claim that those young men are helping them in their studies, but if you go deeper, they don't only help them in their studies, they also sleep with them. (R. Fanta, personal communication, September 14, 2012)

> What I can say is that the diversity of people in the sector of education and universities was not there in the past. In the past people of the same age were schooling together and they respected one another so much. Now older people and youth are all in same schools and respect has gone down and ethics in general, its consequences are getting “underwear degrees” or “underwear positions.” (T. Seleman, personal communication, October 18, 2012)

T. Seleman saw the increase in sexual liaisons at universities as a result of a decline in what she referred to as "respect and ethics" governing students' relationships. She linked this to the return of older women to universities as students. Some women are portrayed as dependent on men for purposes of earning their degrees (or help in assignments and free marks). This help is exchanged for sex in what T. Seleman refers to "as underwear degrees" or "underwear positions."

Sex to Meet Financial Needs

Respondents also spoke of financial needs such as paying school fees, living expenses, and maintaining a certain lifestyle. These were seen as influencing some female students to engage in prostitution or to otherwise have multiple sexual partners. C. Serena, provided an example:

> I have two examples from ladies that we lived together at a hostel. One of them had three men, two of them were older men and the other one was just a young boy to take her out. Despite having three men she sold herself at night clubs in town... she told us that she has all these other men because she needed good life, while at the same time financially supporting her siblings, plus her mum depends on her… 'I am looking for a life of a certain standard and I pay for my own school fees'. That is what she told us and she is not willing to be employed because if she is employed, she will be at work full time, and there will be no school... The other lady was pursuing her studies at one of the colleges in Dar es Salaam, she was also paying for her school fees and her parents don't live together, her mother took care of her and she [the mother] has no ability to pay the university... (Personal communication, September 17, 2012)

In another interview, E. Nyambuli explained how female students engage in prostitution for the purpose of earning an income, focusing on University students in Dodoma region. Dodoma is the national capital of Tanzania. It is where the Tanzania National Assembly

[Bunge] holds its meetings. Female students are said to prostitute themselves to members of parliament during the national assembly meetings.

> [....] those students during 'Bunge' [national assembly], whenever it reaches 7pm you will find them on the sides of the road well-dressed looking for customers. Whoever passes with a car they will follow the person around selling themselves for cash. (Personal communication, September 8, 2012)

Prostitution or transactional sex is spoken of within the dominant discourse as applying only to poor/uneducated women (*National HIV/AIDS Policy, 2001, September; NMSF II*, 2007, October). Participants challenged this view, suggesting that it is not only the poor or uneducated who engage in transactional sex. Participants' narratives portrayed educated women as likely to get involved in transactional sex. They also reproduced the discourse that relates multiple partnerships or transactional sex to economic needs, in this case need to pay tuition, for a particular lifestyle or potentially for family support. One could also say the need for grades is economic since grades lead to jobs and income. Of note however, is that these are not the needs associated with poverty, but with attaining a wealthier lifestyle.

Change of Attitudes as a Result of Being Educated

Participants also spoke of attitudes developed as part of advanced schooling that contribute to PEW's vulnerability. These included individualism, thinking in probabilities, and demands for gender equality. Participants claimed that the knowledge attained in particular subjects such as mathematics, philosophy, or social sciences may contribute to making educated PEW vulnerable to HIV infection. This is because the

acquired knowledge influences behaviour and opens people's minds to see things in different ways. A director of policy and planning at TACAIDS, expressed this by saying:

> The theory they [educated people] have in their brain, the biology and everything, the chemistry they have is poorly used by learned individuals, they translate the knowledge of probabilities that infection is also a probability. This is what we have seen in African countries. So they say, if the husband can have HIV in discordant couples, so the probability of not having HIV is also there for me [as in mathematics], if you do modeling and whatever… so they assume that it is a probability. (Personal communication, October 12, 2012)

This position was also articulated by J. George when discussing factors contributing to high infection rates among educated women.

> ... What I can say probably the way you get education, you may see things in a different light than what you knew before. Let us say you are taught 'philosophy [of] individualism' you are told at the end of the day a human being need to give herself/himself enjoyment. If you take this position… you will see that you need to enjoy yourself, I can make my own decisions and do what I want as long as I am enjoying. (Personal communication, September 17, 2012)

Educational attainment within the dominant HIV/AIDS discourse is portrayed as carrying only a positive impact on well-being, particularly in advancing health. However, in PEW's discourse, education does not always have positive impacts. Thus, participants felt that, depending on the field of study, some people may apply what they have learned in school to endorse new behaviours which place them at risk. Alternatively, new attitudes and expectations may influence conflicts and misunderstandings within families. For instance, participants claimed that most educated women insist on gender equality in their families. Men, however, are not ready to accept this, leading to conflict and misunderstanding between partners. Each partner then is said to search for comfort (i.e., sex) somewhere else.

> The largest percentages of the educated women need equality at home. But in the African traditions, it is men who are heads of families, but when a woman is educated and gets a higher income, she wants to show that they [she and her husband] are the same which leads to misunderstanding in the family and also causes marriage break up and people going out of their marriage. (S. Alphayo, personal communication September 21, 2012)

> …Something we learn as women, especially those educated, is equality in the family. If you see your husband doing something wrong, instead of discussing you want to pay back [revenge]. As a result there will be competition and tensions in the marriage, everyone would go out [having other sexual partners outside marriage] and the end result is getting infection. (S. Shosye, personal communication, October 9, 2012)

A woman's desire for equality at home clashes with the pervasive patriarchal traditions of most people in Tanzanian communities. From the perspective of Tanzania's cultural traditions, women are expected to be married, have children and take care of household responsibilities. M. John, for instance, spoke of her experience in marriage and her decision to leave her partner:

> […] you know men [referring to her husbands tribe] don't like women being in the same position with men or above men, they want to see a woman at home...also I needed a social life even though I was married...why can't I go out with my husband?...he was always busy, not knowing he had other things [referring to other sexual partners]… Now I live alone …I have been able to flourish because I decide what I want to do. But, if you are married and you want something, he will want you to do a different thing. You can't do anything outside what he wants... (Personal communication, October 11, 2012)

M. John described her lack of decision-making power within marriage, which is consistent with the dominant discourse that portrays women as lacking power within marriage. But her experience challenges the dominant discourse that has framed women as tied to marriage and unable to leave abusive relationships. The current social and economic changes have shifted these age-old gender roles. Some women now are educated and employed. Their perceptions of life have changed; however, participants

spoke of educated women as arrogant, proud, disrespectful, and pompous. They averred that educated women tended to instigate conflicts at the family level because they talked much and they did not respect their husbands. As a result, there was no peace in marriages and the potential for partners going outside marriage was increased.

> …educated and wealthy women may be they never had been there before, it is just an opportunity [a chance to become educated or wealthy] that came so they are curious to explore everything. Also educated and wealthy women are arrogant, they know everything just as their husband or even more. As a result in coping with life and their status they get into many things... (J. Jonas, personal communication, September 9, 2012)

The expectation is that women need to be subservient to their partners regardless of their social positions. J. Jonas, one of the few participants who spoke of her own experience rather than merely of PEW in general portrayed struggles in her marriage and her mother's advice to remain in her marriage.

> …We have no decision-making power and we can't even make choices on what we want and what we don't want regarding our sexualities... You know in my tribe [referring to her tribe] a woman is supposed to respect the husband. My husband [referring to his tribe], they believe the same… I have no say unless I pretend that I am sick, but if he notices that I am lying, he can even rape me. It happened one time, we fought about the same issue and you know men have more energy, he did whatever he could do… when I left my husband and went to my parents, my mother told me it is a normal thing for a husband and wife to fight, and that should not make me leave my house, because if I leave my house, I am giving him a chance to bring another woman... She told me to think of my children, what is going to happen to them? Of course, I saw the truth in that and I went back and I never even said a word about the fight. It was as if nothing happened. (Personal communication, September 9, 2012)

Although J. Jonas is educated and has her own income, she succumbed to the dominant cultural reasoning of her mother and went back to her husband to protect her marriage and raise her children within the marital home. This view is also emphasized by

one of the officials from TACAIDS who understands the risks of HIV infection and its impact, but still sees the need for women to be obedient to their partners.

> We don't have decision making power as women, we are created to be receptive as women and that is when you become a good wife. So even if you know your husband is a big cheater, when he comes home he is still your husband…even those with money and education, when you come home you still need to be an obedient wife. Those who can defend themselves are very few… If there is a problem, take a weaker position to deliver your message. To say the truth, the differences still exist, he is a man and you are a woman. (TACAIDS Public Relations Officer, personal communication, October 8, 2012)

Participants here speak of the gender ideals of masculinity and femininity which originated within the colonial framing of women and men, rather than the more flexible and equitable traditional gender systems (Chilisa, 2006). Women who challenge these roles based on what they learned through education become vulnerable. PEW interpreted gender equality meaning women could have extra marital relations just as men did, they could pursue their own pleasures, justifying these with philosophies of individualism and hedonism and downplaying the risk of HIV by applying probabilistic thinking. Thus, in the discourse of PEW, what women learned in higher education made them vulnerable to HIV infection rather than protecting them.

This is not to suggest that changes and life views as a result of being educated were only associated with negative consequences. A few participants suggested education helps partners relate to each other as it nurtures and fosters communication, understanding, and compatibility. They suggested that when both partners were educated, they were able to discuss critical issues that were facing them. For instance, R. Mohamed, said, "The environment and our education contribute to the understanding between us. Moreover, we have a high ability of scrutinizing things and we are jointly

responsible in many things" (Personal communication, September 9, 2012). R. Joe spoke of her personal experience:

> I think it [education] helps me relate well with my husband, this is because I am aware of what is happening in the world... actually when we were planning for kids we had to talk about what we should do and how we do it. He accepted, and I think he agreed with me because he is educated, we discussed all possibilities from condoms to family planning; we visited all places that we thought could help. (R. Joe, personal communication, September 25, 2012)

The accounts of R. Mohamed and R. Joe remind us that both partners' identities and positionalities are important to explore, particularly when considering HIV vulnerability among partners. What is missing in the dominant discourse is the interaction of these positionalities and identities and how these affect each of the partners.

Educated Women are wanted

> Men fear educated women and the large percentage of educated women are arrogant, they boast 'what can a man tell me', as a result even when they are married they will start competing within the family. (M. Kundael, personal communication, September 10, 2012)

Although M. Kundael (above) had the view that men fear educated women in their marriages, the value of educated women was spoken of by PEW. Men were considered to prefer to marry educated women rather than those who are illiterate. M. Mangowi speaking of her own experience, associated her education with benefits to her husband as she could manage their business, even in his absence.

> Getting married to me...you know, most men don't like women who are educated, but I think that he benefited a lot because I have the power and ability to make decisions even in his absence in the businesses we have. I also help him 100% to manage our businesses. (Personal communication, October 10, 2012)

For these women, the benefit of education cited in the dominant discourse in terms of acquisition of skills and abilities to think critically and make reasoned decisions is clearly evident. However, as already seen, the process of acquiring education created vulnerabilities, as did the attitudes and ways of thinking acquired with education. The desirability of an educated wife poses other challenges. According to M. Simon, men now are more interested in women who are educated because of high cost of living which requires both partners to be working and earning income.

> Even now men are looking forward to marrying a woman who has education; they are not looking for physical beauty, because they know that this woman will be helpful in helping family responsibilities in terms of expenses. As a result women who are educated and have money are wanted so bad. Different from the past when men with money were the most wanted. Because of these changes people go into marriage not because of love, because of material things, as the result men will still go outside because no love to the wife and the wife will go out as well because there is no love in marriage. (Personal communication, August 23, 2012)

Thus, socio-economic needs influence men to search for educated women who can take care of their own financial needs and also contribute to the household expenses. Vulnerability to HIV enters in when partners come into marriage with different expectations and are not joined by love. This may increase the chances of both partners having extra partners. M. Simon also expanded on her comment to describe the multitude of possibilities for sexual liaisons she faces as an educated woman. "… Most men approach me because of the level of education… I meet people who are most educated given the nature of my job…lawyers, advocates and judges, business men as well...this makes me vulnerable" (personal communication, August 23, 2012). HIV vulnerability here is explained within the context of extended social and potential sexual

networks. Here there is an intersection of educational attainment and employment. The nature/type of education that one receives influences their employment and also the possibilities of meeting or developing large sexual networks. PEW have a potential of having an extended sexual network because of their mobility, social position, and where they work. The sexual networks created are broader compared to sexual networks created by non-working women in rural areas, who are less likely to be mobile (Omorodion, 1993). Thus, the extended network of PEW increases their vulnerability to HIV. However, it is critical to note here that the tendency of individuals to engage in wider sexual networks depend on issues such as cultural norms, socio-economic factors, gender, marital status and personal issues or circumstances.

Delayed Marriage and Trust of Educated People

Participants spoke of the likelihood of educated women delaying marriage to complete their education. In the process, participants felt that they may have multiple partners, making them more vulnerable to infection.

> … Most people who have high education don't get married early, so you may find they had many partners in their past life. Also, people who are educated tend to trust each other that they are educated and they know the effects of diseases like HIV/AIDS, so they think that they are safe, just by having knowledge of HIV/AIDS different from a person who is not educated and has no income. For example, a person with a master's degree takes a master's degree partner, it is not easy for these people to use condoms because there is a sense of trust between them, it is easy to think that she is safe and he is safe, by no means this woman/man will make himself/herself vulnerable. This is where the infection occurs if one of them is infected. (N. Guma, personal communication, October 29, 2013)

There is a sense of elitism and trust of people like oneself. An assumption made in the dominant discourse is that educated people are safe, and education is a protective

factor (Garbus, 2003; Muthengi, 2007). This translates to popular thinking that well educated partners are not a risk. Thus they trust that an educated partner is not infected; as a result, they don't use condoms. H. Frank, shared her experience before marriage, referring to lack of condom use as 'normal': "...when I was schooling [in Morogoro] my boyfriend was schooling [in Dar es Salaam] and still we were not using condom and I saw it was a normal life" (Personal communication, September 21, 2012). Officials also suggested that PEW's attitudes and ignorance influenced lack of condom use among educated women: "...the amazing thing is that educated people know about the disease but still they will convince each other not to use condom and they don't use them (TAMWA Member and Journalist, personal communication, October 3, 2012). Another official said: "... educated women are the most infected and the reason is because they just don't care and they decide to do business as usual... [practice sex without a condom]" (Public Relations Officer, TACAIDS, personal communication, October 8, 2012).

Summary. What is evident from these interviews is that there is a complex discourse of educational attainment and HIV vulnerability among PEW. At least two risk factors were identified by participants in relation to educational attainment. First is the greater likelihood of educated women to engage in extra-marital or multiple sexual partnerships. Participants suggested that vulnerability starts in colleges where students strive to get good grades and to pay for expenses and lifestyle in exchange for sex. Educational attainment intersects with marital status both negatively and positively. Education/knowledge brings a quest for gender equality at home, a recognition that husband and wife are on an equal footing. This puts PEW into vulnerable circumstances

because it increases the chances of creating conflict or misunderstanding between partners that leads to partners equally seeking sexual partners outside the marriage. However, education may also endow women with cognitive skills and contribute to understanding and compatibility between partners. Other participants claimed that educated women are highly desirable for marriage because of the economic contribution they can make; thus many men pursue them. This, however, is also associated with vulnerability since partners go into marriage for economic reasons and end up dissatisfied, each seeking other sexual partners. Finally, participants spoke of how educated women delay marriage, increasing the chances of engaging in multiple premarital sexual partnerships.

Second, participants claimed that educated people are more likely to engage in sex without a condom. This is because of the sense of trust that they have in educated cohorts and also relying on probabilities i.e. the probability of infection is low. The combination of circumstances leading to multiple partners and lack of condom use enhances vulnerability for educated women. However, educational attainment does not play out independent of other social positions and identities. Neither does it have a uniform effect, but rather at various points and depending on various circumstances and experiences, education can either increase or decrease one's vulnerability to HIV infection.

EMPLOYMENT

Participants reported multiple dimensions of employment that influence women's vulnerability, from the employment search to what occurs at work places. Although

employment for women is viewed as decreasing vulnerability in the dominant HIV prevention discourse, little is known of how employment influences PEW vulnerability. While there is a recognition in the dominant discourse of certain types of workers being vulnerable, the focus has been on mobile and migrant workers (such as road workers, mining, tourism, plantations, transport, military, traders, fishermen, etc) as noted by the *Second National Multi-sectoral Strategic Framework of 2008-2012,* (p. 58). PEW focused on how women like them become vulnerable. Some participants shared their own experiences, while the majority spoke of their perceptions of PEW and did not disclose their own experiences.

Sexual Harassment

A few participants spoke of sexual harassment when applying for jobs and the majority described harassment in maintaining their jobs. As H. Nzaga, said, "…. employed women in work places experience sexual abuse, you cannot get promoted without bribe of sex; you cannot get work trips without offering sex…" (Personal communication, October 10, 2012). E. Nyambuli provided details of how she was pressured to have sex in at least two different work places.

> …I met a man who was working in one of the ministries, he needed a person to help him because he was blind, but very intelligent and brilliant, sometimes he was writing papers to international organizations…the first and second day worked fine, the third day I went early in the office than usual, I found him with his wife in the office, a very beautiful woman, and you can't believe that she is married to a blind person…[later] He said 'can you believe that a beautiful woman like that can accept me?' I said, 'it is very difficult to believe.' He said, 'because she accepted me, I gave her a gift of a car; a small drug dispensing outlet and a ladies salon.' I asked him, 'why did you do that?' He said, 'I did that so that she does not desire anything'. Since that day, this man showed signs of wanting to be with me… He said if I accept him, he will buy me a car, open a shop for

> me to sell anything I want, and I will follow him on every trip he goes outside the country, and he added, you will be rich, and money won't be a problem to you...His driver always takes him for lunch, but that day, he said no, I have to take him and bring him back, which I did. I was very angry, but did not want to be rude, when we came back, you won't believe he gave me a check of Tanzania shillings 200,000 and he said this is just the beginning. To be honest, I took the money, I didn't refuse, but I never went back to work since that day until today…Also, when I was working at the ministry, the human resource officer was a whore...he wanted to sleep with all ladies who came there for field work; he was promising them that when they are done with school, they should just bring their CVs and he will give them employment, and indeed he got many of them. One day, he called me at his desk; he wanted to give me instructions of what to do while he was away. I went there, but he kept on insisting "come close"! I did, he said "why are you afraid"?... after so many attempts to get me, this time he took my hand and directed it to his penis saying, "every day I tell you, I love you, you don't understand why are you tormenting me like this...if you accept, there are many trips here, I will give them to you," when I said no he said "you will regret," and it is true I regretted Neema, he was getting 3-4 trips he never gave me any, and he will tell me you pretended to be clever. But, I never fell in his trap. (E. Nyambuli, personal communication, September 8, 2012)

Many women described similar experiences. Whether they succumbed to engaging in sexual acts depended on how desperate they were to maintain their jobs, fulfill their desires for a career, or keep a good relationship with their bosses. Some participants spoke of how they were invited with sexual proposals before they were even interviewed, or given a job. M. Charles, who had searched for a job for some time, and decided to go outside the city of Dar es Salaam, had this to say:

> …without shame one of the bosses I approached told me, with that one degree it is just a waste of time to search for a job because the salary is too small and you cannot sustain life. He suggested that I accept him so that he can be adding some money towards my salary each month. I thought of this, and I told myself, I will be his woman forever, I decided not to take the offer I left although they called me for the interview I never went…and decided to open the business I am running now. (Personal communication, November 5, 2012)

The pressures were exacerbated when they had not been continually in the labour force and were desperate to return. This was the case for H. Frank.

> It depends how long you have stayed home... 3-4 years, when you are promised to be employed you can find yourself accepting to the conditions... Soon after I completed my university education…I was promised to be employed but the condition was that we meet in a hotel. I decided not to go...but I needed the job because I was tired of staying at home, but under such conditions and I was already married... (Personal communication, September 21, 2012)

Despite what E. Nyambuli, M. Charles and H. Frank experienced none of them slept with their bosses. Other participants spoke of professionals or employed women who went through similar experiences and were unable to resist. For those who cannot resist, such offers may expose them to HIV infection, because asking for condom use with a boss could be seen as a threat or an insult. Some women, like M. John, turned to their religious faith to provide confidence that a job without sexual harassment could be found.

> I have faith in God, if that place I applied and I am asked for sex, this does not mean that I will not get a job anywhere else, because if I agree, they will still ask me for sex. Such a place is not good if you have qualifications you can still get a job somewhere else. (Personal communication, October 11, 2012)

Participants described women who succumbed to the sexual overtures or harassment of employers as driven by personal desires for a high status job, to have more and bigger material things than they could afford, and to keep up with class status. Rather than seeing these as goals a woman should strive for, they saw them as women contributing to their own vulnerability.

> …you can find a lady looking for a certain job that she thinks has status, she is also a lady of high status, as a result even if you are told what it requires you to get that job, you will go for it regardless of the conditions. Because you also need to maintain your high status and you see that job can keep you where you want. Because you are already prepared, you may

> carry yourself in the way that makes the boss get attracted to you. For example, the cloth that you wear might put you in certain risks and may draw men's attention towards you and they will want you... sometimes we make men desire us in work places by not dressing decent clothing. (S. Shosye, personal communication, October 9, 2012)

Participants felt that such things in work places could be avoided, but because some women were desperate to get a job at the place they wanted or to advance in their career or benefit from certain advantages of their work, they were willing to do anything. Women were also chastised for sometimes not dressing properly in work places, as a result influencing men who were assumed to be driven to desire them because of their dress. Thus, in the discourse of PEW, it is a woman's own fault if she has multiple partnerships.

Type of Job/Employment

The place and type of employment were also identified as aspects that could influence PEW's vulnerability. For instance, hardly any of the teachers who participated in the interviews saw any risks of sexual harassment associated with their employment or occupation. They made reference to direct job postings from the government and fixed income levels. Thus higher salaries for sexual favours were not an option. S. Shosye explained the situation of teachers:

> Given the nature of my job as a teacher, risks are very rare, because you get the appointment direct from the ministry of education so there are no interviews or bosses to worry about. Also at the work place, everyone earns about the same, one cannot take a risk of getting a lady in the same school. (Personal communication, October 9, 2012)

Women working in government institutions also presented fewer risks, especially when applying for employment, because the government has a centralised secretariat that

regulates all the interviews for all job seekers. Participants claimed that in private institutions women were likely to be sexually abused right from the time of applying for jobs. As a result they felt more vulnerable than other women.

Women who worked night shifts were also seen as more vulnerable than those working during the day. M. Walter, spoke of how night work contributed to vulnerability:

> … In industries you find that workers stay until late night and some get at work for the late shifts. For some, they may use this opportunity to lie to their partners that they are at work while they may not be going to work. Also those in leadership position can use that opportunity to get sex from people below them, which put them in a risk of HIV... (Personal communication, September 13, 2012)

M. Walter put forward the view that women could use night shifts as an opportunity to have extra partners. Also, women working during the night were seen as more likely to face sexual harassment from their bosses. Thus, employment position intersected with the timing of the employment to create vulnerability, the positionalities of both employees and employers also intersecting to contribute to this vulnerability.

Other participants focused on the challenges that they face given their profession, competence/intelligence, marital status and working location. M. Simon described her personal experiences with her employment intersecting with marital status (as single) and age to influence vulnerability.

> I find myself very vulnerable also with my students, especially male students, given the fact that I am young and also I teach mature and older students some are 45 years or 50 years. For example, at one point I was approached by a professor who is doing law, a second year student in my class [the professor in a different field is a student in her class]. He wanted to buy me a car, so that I have sex with him. The purpose of him buying me the car was not only to have sex with me but also he wanted free marks in my class... (Personal communication, August 23, 2012)

As a young female lecturer, M. Simon faced sexual invitations from her students, particularly those who were older than she was. Her narrative challenges the view that only women depend on men (as discussed under educational attainment— "underwear degrees") for advancement or grades in schools. Men are also more likely to pursue female professors not only for sexual relationships but also for grades. Again, this illustrates the possibility of intergenerational/cross generational sexual relationships between older, affluent men, and young, affluent women (rather than poor young women) as money/gifts are used to advance the needs of the men. M. Simon extends the discussion to her other job and the challenges she faces:

> Given the nature of my work as an advocate most of the men fear me especially those who are not educated... At the place I work in the city center, this area is surrounded with a lot of 'nyumba za starehe' [luxury houses] ... In these areas there are a lot of business men, people with money, traders and foreigners. Therefore, I meet many people. Even in my office I have created a wide network of people, and this puts me at risk....In my office [as an advocate], I was once loved by my boss. He is 64 years old, when I rejected him, he has to 'cross' me to his young son and he wanted me to marry his son. He insisted and he was eager to see me have sex with his son… Because he sees me as very intelligent, he sees me as a woman who is independent, I can work on my own, I can do my own stuff and I can handle a family even if I don't have a husband, because I have income and I have good thinking capacity. I guess he wanted to have sex with me so that I don't leave his office, he even sees me as a very potential employee. He tells me I am potential, I have positive impact to his advocacy and his chamber ... It has been difficult to work in such circumstances. But the fact that I have my own stand … and given the fact that I am potential in that office it is even difficult to fire me. Therefore, the father wishes I become friendlier so that I do not leave the office… (Personal communication, August 23, 2012)

M. Simon suggests that her employment creates the possibility of a large social network. This combines with her economic position to influence her vulnerability. Men pursue her because of what she can offer or contribute in the household and also at work.

Her narrative supports the discourse that women who are educated are more desired for marriage, as discussed in the education section. As a result, men are willing to do what it takes to pursue such women.

Summary. Within the dominant HIV/AIDS discourse it is suggested that vulnerability to HIV is rooted in lack of economic resources because of absence or marginal employment. The assumption is that employment opportunities will provide women with an income that will lift them out of poverty and also out of dependence on men. However, what is missed in this discourse is how employment may influence vulnerability. Critical to note here is that the kind of education that one gets determines where one works and the type/nature of employment, which were seen as key to the vulnerability of women. Participants in this research pointed to many employment aspects that make PEW vulnerable to HIV infection.

First, the stage of employment (such as job search, advancement and promotion) determined women's vulnerability. However, this intersected with where one works (public, private). Participants suggested that sexual harassment was at the core of employment-related vulnerability. The majority of the women were said to experience sexual harassment from the time they were applying for jobs, particularly in private institutions. When it came to job promotion or advancement, participants suggested that both women in public and private institutions are more likely to experience sexual harassment. Although women are now getting educated in the same way as men, still the majority of the men hold top positions in both private and government institutions. Very few women hold such positions. This differential is also related to the courses that men

and women take at universities. The majority of women are in social science streams compared to men in business. This affects their positioning when it comes to employment opportunities, and occupational position.

Second, the type or nature of employment was also identified as a factor in PEW's vulnerability. Participants suggested that government jobs or women who are working in government institutions are less vulnerable than those working in private institutions. The type of occupation, for instance teachers, administrative personnel and human resource officers were identified as less vulnerable, this however, was only during the search and job application process as one central secretariat coordinated the interviews and selection of potential employees. Teachers particularly were less vulnerable, as they received direct posting from the government and were all on the same salary scale. The nature and type of employment also intersected with one's education to influence the size of social networks as in the case of M. Simon. Her education intersected with her employment, her marital status, and her age to influence vulnerability.

Third, various circumstances also were identified by participants. For instance, PEW working during the night were seen as more vulnerable than those working during the day. Mobility also influenced vulnerability.

However, despite all the issues that participants suggested, some held PEW responsible for creating their own vulnerability. The assumption was that they had agency to walk away from risks, but chose to stay because of their personal needs and desires. Participants did not see these as necessities. Thus, the discourse that participants

advanced is that women should stay in their place, should not pursue too much, and should seek safe jobs. Choosing risky jobs contributed to one's own vulnerability.

INCOME AND/OR WEALTH

Out of the five documents used in this thesis, only the *Review of HIV Epidemiology and HIV Prevention Programs and Resources in Mainland Tanzania* (May, 2009) identified wealth as a driver of the epidemic. Other reports, like the *National HIV Prevention Strategy* (November, 2009, p. 4) and *Tanzania-UNGASS 2010 Progress Report* (p.10) do, however, recognize the higher infection rate in individuals living in more wealthy households but wealth is not identified as a driver of the epidemic. The focus of the dominant discourse is on the need for economic empowerment with the assumption that this will translate to agency and power in decision-making, thus mitigating HIV vulnerability. Economic empowerment within the dominant discourse is suggested to influence abilities to control/avoid risks (International Center for Research on Women (ICRW), 2010).

Income for instance, is said to reduce the chances of women engaging in transactional and commercial sex, and also the chance of being economically dependent on men. This view was supported by some participants like M. Salehe who claimed that a woman is accorded respect when she makes a financial contribution to the household: "if you participate in the family in terms of covering the expenses, he respects you, I am not dependent, I am respected by my partner. But when you are loose [irresponsible], you can't even purchase a match box, he despises you" (Personal communication, September 2, 2012). Her views affirmed the dominant discourse that women require

income earning opportunities to gain respect in marriage. In the dominant discourse, women with an income of their own are expected to be able to negotiate condom use and to avoid having multiple partners for economic survival. This was supported by officials when talking about PEW's vulnerability suggesting that:

> ...for PEW at least they have stable income, because sometimes the poor tend to go into prostitution to earn income. So, I think PEW are better in terms of protecting themselves from HIV because for them they are even educated and they know how to protect themselves compared to lower class women. (TAMWA Journalist, personal communication, October 4, 2012)

As it is for education, in the dominant discourse income/wealth for women is associated mostly with positive outcomes. Nevertheless, according to the PEW interviewed in this study, when income intersects with marriage it does not necessarily mitigate HIV vulnerability. PEW described affluent women as pompous, proud, arrogant and disrespectful towards their husbands. It is these attributes that were said to lead them to engage in extra partnerships and eschew condom use. Thus, it was personal characteristics fostered by wealth and income that made them vulnerable. On this issue, none of the participants shared their personal experiences. They distanced themselves and spoke about PEW in general terms, perhaps because they placed the blame for HIV vulnerability solely onto the PEW.

Choices and Pleasures

Participants felt that women with independent income have opportunities and power to do whatever they want. It was suggested that income or wealth are used to satisfy the egoistic needs of women with little concern for their heath as I. Ivan explains:

> […] if someone has money, has her own income that she controls, what she needs is enjoyment. At the end what is put forward is enjoying 'I need to enjoy'. Some even say how can I eat unpeeled banana [Having sex with a condom]? I also think that it is lack of clear reasoning capacity. (Personal communication, October 11, 2012)

Although, affluent women have the resources to purchase condoms, and they are expected to be in a position to negotiate condom use, in this case they choose not to, as they seek pleasure. Thus, personal choices (pleasure) intersect with income to influence how women behave towards multiple partnerships and condom use.

M. Daudi felt that women with income misuse their income/resources: "… it could be the misuse of income. Income makes people arrogant particularly when they opt to have multiple partners. Because when she has money, money is everything, as long as you have money you can get anything" (Personal communication, September 17, 2012). Income in the dominant discourse is supposed to provide women with abilities to control and avoid risks. What participants suggest is that income/wealth makes women arrogant, violating gender norms that focus on women being passive. Rather passivity producing vulnerability through an inability to protect oneself, here arrogance and the resources to do as one chooses, make one vulnerable because those choices focus on pleasure rather than safety or health. Thus, blame is put on affluent women who use their income/wealth to pursue self-pleasure in sex as do wealth men.

In the participants' discourse, PEW are framed as seeking independence and freedom, with the majority not wanting to marry. Exposure to the internet and social media are presented as introducing PEW to new ways of making love, including practices that may subject PEW to greater HIV risks. M. Simon a single woman herself spoke of these issues:

> …Some don't want to get married, therefore wish not to have one man because they don't want to be controlled. They have everything and they can buy young men "wenye damu ya moto na damu changa" [with warm blood and fresh blood]... they can move to several night clubs, can move from party to party which makes them more vulnerable…when you have money, you have a wide social network ..., you are mobile…you can Google and search a lot of things, network in different social media like Facebook, Badoo, Twitter where you can see awkward things than a poor lady who cannot even get an advantage of seeing all these things. You can also move from one club to another during the night, you can have many men as you want because you have money. [Later] The rate of infection is higher among these populations because they change the nature of making love given the fact that they view a lot of stuff on the web from Western cultures and from different networks. For example, it is suggested that in 10 women in Dar es Salaam married and not married, more than six do anal sex…as a result most of them get infected because you know the place is usually dry than the vagina. (Personal communication, August 23, 2012)

M. Simon speaks of commitment to a partner as associated with control, placing women in subordinate positions. Income gives women the resources to resist prescribed gender roles, to seek power and freedom to live their life in their own way, freely expressing their sexuality. This challenges the normative conceptualization and framing of women in relation to men. Here they appear as independent actors with agency rooted in their own resources. The discourse also locates vulnerability in the choices they make to live a life of pleasure. Income/wealth within the participants' discourse facilitates mobility for PEW and helps them get connected to the global world. This influences PEW's attitudes and behaviours because they wish to try what they see, with such actions contributing to their vulnerability.

Power and Control

Some of the participants claimed that the search for other partners was a search for power and control. For this reason affluent women looked for young men, for whom they provided "everything" in exchange for being in control, reversing the normative gender roles. P. Banturaki and N. Guma, spoke of this situation.

> ... I think they are looking for power to live their own lives as they want especially those with money. Because, in the past they had no opportunities as they have them now, they want to show that they can also do something… you know there are those who have experienced life...that they have never had love...meaning that they have been oppressed all the time and that men see sex as not something that women need to enjoy. So in the struggle of life, she realizes that she cannot get this from someone above her, so she looks for a young man who she knows she can control, provide him with everything and just dictate what she wants from him. (P. Banturaki, personal communication, October 10, 2012)

> …Most of the women these days, don't want to get married and be commanded, they also want to be like men, independent and take care of themselves, and they can command these young men. She will tell him to do anything she wants and the woman will be satisfied in her life. (N. Guma, personal communication, October 29, 2012)

P. Banturaki and N. Guma saw the actions of PEW as rebellion against the customary and traditional roles. In most African cultures, women and girls are constrained in expressing their sexuality and are expected to be subservient to the sexual needs of their partners, especially within marriage. Even during sexual intercourse women are supposed to remain silent, passive, and submissive. As a result, most women do not question or ask, even when they are not sexually satisfied. Women with income/wealth can find alternatives outside marriage by engaging with young men to whom they can dictate what they need. Participants identified this freedom as influencing PEW's vulnerability to HIV infection.

> …People say that for most women who have money, young men suit them well to their maximum so that they continue earning money from these women. Young men are aware of the wealth of these women and therefore they use all their artistic [skills] to make ladies get maximum satisfaction. While a woman will be going there for sexual satisfaction, the young man will be going for money or other materials. As it is for a man who loves you, he gives you money and offers you all the necessities; it is the same to ladies who have money to pay these young men for the sexual services. (M. Simon, personal communication, August 28, 2012)

Intergenerational/cross generational sex between older PEW and young men is rarely discussed in the dominant discourse. Only the *National Multi-sectoral HIV Prevention Strategy* (November, 2009) mentions cross generational sexual relationships (and mixed age relationships, p. 6), referring to sexual relationships between youth and older people without reference to gender (p. 10, 11). However, the discussion in this report is centered on young women and older men. It did note that the young women (rather than the older men) might be the 'exploiters,' (p. 13). In this research participants expanded this frame to affluent older women and young men. Here, young men rely on older women for money, gifts, and other material things in exchange for sex. Thus, affluent women act just like men, rejecting the prescribed gender roles of women being pursued by men. Participants suggested that affluent women pursue young men with the purpose of getting what they do not get within their marriage. Thus, income provides them with autonomy to obtain what they need.

Summary. The vulnerability of affluent women as presented by participants is associated with their mobility, networking, and exposure to the global world. These intersect with the power that women have by virtue of their income and values, such as hedonism and equality, that they learn about and adopt through education. In the

discourse of participants, affluent women can afford more partners, they have power to decide on what they want, and are also in a position to determine the use of condoms with their extra partners. Nevertheless, income or wealth does not affect all PEW the same way, other circumstances, in addition to wealth, determine vulnerability.

MARITAL STATUS

Women, particularly married women, are identified in the dominant discourse as powerless and lacking agency in sexual decision-making. This lack of decision-making agency is associated with lack of education and income, and prevalent gender inequality, the patriarchal system, and customs and traditions which deny women the opportunity to make decisions that affect their lives (Ackermann & De Klerk, 2002; Garcia-Moreno & Watt, 2000). The dominant discourse frames women as victims who are universally oppressed by a patriarchal system. However, what is not explored is the qualitative differences among women's and men's experiences, identities and positionalities and how these are related. For instance, *The National Multi-sectoral Strategic Framework of 2008-2012*, suggests that widowed, divorced and married women have a high HIV prevalence because they may have been married to infected men or because their impoverished circumstances lead them to engage in sex for survival (NMSF II, October 2007, p. 55). The vulnerability of these women is related to their partners and poverty. This presents the picture that women have no agency in the transmission of the virus, but rather HIV is brought to them by their partners. Rather than blaming women's vulnerability on men and poverty it is imperative to consider women’s and men’s positionalities in their relationships and how these are influenced by norms related to

gender and sexuality, and how women accept or challenge them, or position themselves within their sexual relationships. A. Jumanne, for instance, contrasted her position inside and outside her home.

> You know a woman is just a woman, even if she is empowered she will still be a woman. Most of us see that we can't do anything; we leave men to direct our lives. [*I asked her: Are you one of those women?]* Yes, I am. I will make all the noise outside. When I go back home he makes all the decision and I accept the decision and I don't even see if it is a problem… (Personal communication, November 5, 2012)

This narrative suggests that decision-making within marriage continues to be constrained by cultural and gendered norms related to marriage, despite social and economic changes in women's positioning outside marriage. Thus a broader lens is required in exploring the vulnerability related to marital status as The Director of Policy, Planning and Research, from TACAIDS suggests,

> …the partners, the customers for commercial sex workers are married men. These populations as customers, married couples, are also customers to the working society...So this interaction predisposes them. Also any employed and married people have financial capacities; they have leadership and political decisions so they use both to prescribe for any involuntary sex. (Personal communication, October 12, 2012)

The intersection of professional positions, income, and marital status affect behaviours. In the discussion with participants, the majority spoke of married women as vulnerable to HIV infection. Consistent with the dominant discourse, participants suggested that married women are more vulnerable than single women. Some associated this with their partners' attitudes and behaviours as well as their own responsibilities as bread winners; however these were also influenced by norms surrounding gender and sexuality and the desire to either adhere to or abandon them. Some participants also challenged the assumption that only men infect women, rather women's attitudes and choices with

respect to multiple sexual partnerships influenced both partners' vulnerability to HIV infection.

Partner as a Risk Factor

In presenting the risks posed by partners, participants focused on condom use, lack of sexual satisfaction and intimacy between partners, and the demands on men as bread winners. Three participants narrated their own experiences, reporting that their partners were a risk factor to them. E. Mayela, is self-employed and most of her business and activities take place at home. As a self-employed woman she was not exposed to the sexual harassment of employment. For her however, risk came from her husband.

> ...the risk to me is where my husband works, even if I am safe at home, how about him at work? Because I am not sure how he takes HIV/AIDS… I am sure there are risks where he works, because every Friday evening women sell their bodies around that area... (Personal communication, August 23, 2012).

Similarly, H. Frank, a government employee working in Dar es Salaam, sees the only risk to be her partner, who works and lives away from the home. During the interview, H. Frank noted that they are unable to live together because she cannot quit her job as it provides her security and her husband cannot find work in Dar es Salaam. H. Frank also reported her inability to influence condom use within her marriage.

> ... the risk comes from my husband... my husband lives in Arusha and I live in Dar es Salaam, I don't know what my husband is doing in Arusha, and when he comes home and we make love I cannot tell him to use condom because he is already my husband. And when you tell him he will think that it is you who is going out. I can now say that I am in risk than someone who is not married and has a boyfriend in Arusha, because she can tell her boyfriend to use condom. (Personal communication, September 21, 2012)

Both E. Mayela and H. Frank are unsure of their husbands' fidelity. H. Frank brings into the discourse condoms in marriage. As discussed in the dominant discourse, the majority of married women are unable to negotiate condom use. The assumption is that when partners get married they are expected to trust each other, condom use suggests unfaithfulness and lack of trust (to be discussed in greater detail in the next chapter). These concerns were also shared by J. Jonas who not only saw her husband to be a risk to her but also saw risk in her own actions. She adds to the discourse how a husband's infidelity excuses her from a need to be faithful since he is already bringing risk into the marriage.

> […] I told you my experience, I am not a prostitute but I sleep with more than one partner. I meet various people and some whom I make love with them sometimes I don't even use any protection… My husband is also a risk factor to me because I know he is not settled [faithful], but you know what, even if I settle I don't think he will settle, he will just end up killing me… But you have opened my eyes to think through my life, it pains me but I had no choice (Personal communication, September 9, 2012).

Thus, participants portray married PEW as vulnerable because their partners bring HIV from outside. Women's actions may also contribute to both partners' vulnerability. This was explained as women creating their own vulnerability by wanting more than what they have in their marriage. J. George sharing from her own experience, explains her vulnerability as related exclusively to her choices.

> […] I think I was raised in a high class life, and when I got married, my husband was not from that class, so what I experienced with him, was not easy and I was kind of tired. I knew that I married him because of love but why was I going through hardship...and you meet a person who tells you that he likes you and he would love to be around you and when you think you see this was supposed to be my husband. I married my husband because of love, but I forgot one thing that there is life in general, now I am going through all these difficulties, psychologically I was affected and

> me being with that person was a relief... (Personal communication, September 17, 2012)

Lack of Sexual Satisfaction

Vulnerability in relation to marriage was also associated with lack of sexual satisfaction for some PEW. Norms associated with gender roles and sexuality socialize women to be ignorant about sexual matters and not to express their sexual desires to men. Women's pleasure is not a consideration in marital sex. To challenge this discourse suggests that a woman is promiscuous. Because of fear of being labelled promiscuous, rather than raising the issues of their own sexual needs in their marriage, women choose to sexually satisfy themselves somewhere else. P. Banturaki said, "…most of us are not satisfied with our husbands and we cannot tell them because we are scared of making them angry, as a result we go outside marriage" (personal communication, October 10, 2012). This was also supported by M. Mangowi who suggested that "…you can also find that both partners have income, but there is no sexual satisfaction, both of them can be going out to meet their sexual satisfaction outside..." (Personal communication, October 10, 2012). Clearly, sexual satisfaction, matters for women.

As participants expressed, lack of satisfaction in marriage is one of the driving forces for both husband and wife to search for extra partners. Lack of satisfaction was linked by some PEW with men devoting undue time to a search for material things and lacking time for intimacy with their partners. Thus, wives searched for other sexual partners outside their marriage.

> …men are so busy with work and the search for money than even women, so when the husband comes home, he is always tired and has no interest to his wife, so it is easy for a woman to search for another man who is

> always available for her. (H. Gervas, personal communication, October 6, 2012)

> …fathers [husbands] always return home busy, a father travels every day, in a year, he is home for 40 days… I see that jobs have destroyed marriage and contribute to women having multiple partners... (M. Daudi, personal communication, September 17, 2012)

Men's actions in fulfilling their prescribed gender roles as bread winners, take them away for extended periods of time and exhaust them, contributing to lack of time for intimacy and a failure to sexually satisfy their wives. Because of the expectations associated with women's sexuality, they are unable to express their concerns. As a result women search for extra-marital partnerships.

One of the participants also focused on men's irresponsibility toward their wives. Men getting drunk and returning home late were blamed for less sexual satisfaction for women, sending them outside the marriage.

> ...imagine a man who comes home at night let's say at 10pm, but he left work at 5pm and went to a bar, when he arrives home he is drunk and sometimes cannot even touch or satisfy his wife… And because of the African culture, a woman cannot tell the husband she needs sex ...so when she gets another man outside it is obvious she will have sex with him. (M. Simon, personal communication, August 23, 2012)

But, as with employment and education, PEW also described these as excuses used by women who break gender norms. They suggested that complaints about sexual satisfaction were just excuses justifying extra-marital sex.

> …she can just say my husband is this and that, he does not satisfy me but these are just justifications. It is her behaviour. Even if their husband does not satisfy them, they don't have a single partner outside, they have several partners. (J. George, personal communication, September, 17, 2012)

The majority of participants felt that PEW were driven by sexual desires, contrasting this with a sense of duty or following religious teachings. B. Mwampepe explained:

> It is sexual desire which have gone to the extreme; it is sexual desires because they have left God... People don't have the fear of God anymore, and if they feared Him, then all these sexual desires would not have been there. A woman can leave her house (marriage) when she is 38 years, and she can stay like that without knowing men things until she dies. Since I separated from my husband, I don't want to be with men, and I never loved anybody, and I think people fear me because of my activities in church. (Personal communication, September 17, 2012)

Summary. Marital status, as discussed by participants, influenced HIV vulnerability in various ways. Traditionally, marriage was an economic and procreative unit. Adult men were expected to marry women who would provide and raise children and care for the family. A husband's major responsibility was providing for the family economically. His needs for care and sex were foremost. He was in control and owed respect. However, among PEW, some women did not want to get married for fear of being controlled. Their income provided them with the ability to have children and raise them independently. Their discussion of sexual satisfaction challenged the notion that women do not need to enjoy sex. But marital norms related to sexuality prohibited them from raising their needs within marriage. Consequently, whether married or single, PEW saw their income as providing them with resources to seek sexual pleasure outside marriage.

Multiple and extra partnerships was a common theme for both men and women. For men this was consistent with the traditional scripting of male sexuality. For women, it was not necessarily contrary to sexual scripting, although their new economic independence and the values and philosophies they were exposed to through education such as gender equality, self-fulfillment and self-actualization raised the profile of extra

partners in their lives. In contrast to the dominant discourse which associates multiple partners for women with poverty and economic needs, when participants discussed multiple partnerships and marriage it was within the context of women's sexual pleasure.

EXPECTATIONS ASSOCIATED WITH SEXUALITY

In the dominant HIV/AIDS discourse HIV prevention is of primary importance. As a result, the focus is on changing sexual behaviours and activities to accommodate the maintenance of an HIV negative status. Other things related to sexuality do not matter. It is expected that if women are in control of their sexuality they will act to prevent HIV acquisition. The discourse portrays women as only involved in multiple sexual partnerships for economic survival. However, participants presented a different discourse about women's sexuality. As already seen, PEW engage in sex with diverse partners to meet a variety of needs including material needs (e.g. grades, jobs, status, support), sexual enjoyment, or as a guarantee against being without. Typically, participants distanced themselves from what they were talking about in line with the norms that prohibited speaking of sexuality, but some women occasionally pointed to their own experiences. PEW felt extra partners were about sexual desires, frustration in marriage, poor treatment from spouses, search for work trips and promotions, or culture and traditions. Critical to note is that PEW's positionalities, identities and responsibilities intersected with each other as well as with those of their partners to influence their actions in relation to their sexuality.

Search for Comfort

A few participants focused on the concept of 'kidumu[4]' and what it implies. C. Serena, explained ‘kidumu’ using an allegory:

> When you are carrying a bucket of water, while walking you can slip and the water in the bucket may pour out [this is your husband], while kidumu [an extra partner] can comfort you. When this kidumu slips the water will pour out slowly. When you tell your husband about your issues he does not respond well, when you tell your partner outside, it touches him and you find that you have a good relationship with him...he advises you in your problem and is your guide in life. (Personal communication, September 17, 2012)

C. Serena is suggesting that women get more comfort outside marriage than within marriage. This is the husband’s fault, as he is unable to take good care of his wife. As a result, a woman will look for an alternative partner who will give her comfort. The allegory also applies to women looking for security outside marriage, meaning that in case something happens within their marriage they have another sexual partner. This position is supported by I. Ivan, who felt that a partner outside makes a woman feel better and more important, especially when things are not working in marriage.

> You know, you may find that an open minded woman has a partner outside marriage… me being one of the women who are affected by such things...you can have someone either you are married to him or you are in a serious relationship and you are committed 100% but at the end you find out that man is not treating you the way you should be treated; he treats you like a stranger or nothing ok...you know, everyone needs a shoulder to cry, so at the end of the day you find that you need someone to comfort you or tell you sorry, everything will be okay… so you find that person struggling to search for another man … sometimes you may find your partner is giving you stress while the partner outside marriage is treating you well. Trust me, an outside relationship treats you very well... (Personal communication, October 11, 2012)

[4] Kidumu [singular] or vidumu [plural] literally means a woman needs a gallon, 'an extra partner'. Kidumu/vidumu can be younger or older

What C. Serena and I. Ivana see is that partners outside marriage are better in taking care of women than partners (husbands) at home. The emphasis in the two quotes is the search for comfort rather than material things or even sexual satisfaction.

Search for Material Benefits

Other participants felt that the search for material things influenced PEW to have extra partnerships. Even though PEW earn their own independent income, participants suggested that there are those who are not satisfied with their earnings, or they need more income to maintain a certain social status or a high standard of living. On the same concept, 'kidumu,' M. Simon, and M. Charles explain:

> In this case, you have a husband who helps you in most of the things but cannot shoulder for small or just some of the things. So a woman will have another man to assist in getting what is missing or what is not provided by your husband [material things]. Picture it this way, a person is carrying a bucket of water on top of her head …and she is also carrying a gallon [kidumu] of water in one of her hands. This means a husband does a lot of responsibilities and having another man to have the little responsibilities. Some do not even use '*mwanamke kidumu'* [a woman needs a gallon— an extra partner] they use '*mwanamke mafiga matatu'* [a woman needs three stones-used to support a pot when cooking. Literally, the stone refers to sexual partners]. (M. Simon, personal communication, August 23, 2012)

> … Some women say they want to be up to date…I see most ladies with 'vidumu' [extra partners] some younger than me, they feel that they have not yet reached their dream life, and kidumu [extra partner] is a person to fulfil their dreams. Most ladies at my age wish to have cars, beautiful houses etc. and this is when kidumu come in. (M. Charles, personal communication, November 5, 2012)

Work trips and being up-to-date (modern) are also aspects that were identified as influencing extra partnerships. M. Sungusia speaking about employed women said, "…liking free things, you find a woman as we in offices, she is married, has a profession

and is employed but she has kidumu to give her work trips…" Thus, an extra partner, 'kidumu,' becomes important and necessary in different ways depending on the needs of the woman concerned.

Pursuing Younger Men

PEW spoke of women pursuing younger men for three reasons: because they could not access men of their own age, because younger men provided more sexual satisfaction, or because they posed less HIV risk and were cheap. If PEW are divorced or widowed, they are of lower 'market value.' Thus men are unlikely to pursue them and they do not approach older men or men of their own age for fear of being rejected. As H. Nzaga said, "most of the women go with young boys because their husbands are dead, with this case, their market goes down…" (Personal communication, October 10, 2012). Some were said to pursue young men because their husbands/partners could no longer function sexually.

> …a very close friend of mine…said there was a certain woman confessed to my friend that she does that because her husband is impotent. He used to function well but he got sick and he couldn't function anymore, so the woman opted to be with this young man [her friend] although she still lives with her husband… (E. Joseph, personal communication, August 28, 2012)

Some preferred young men because they were "cheap" and thought to present less HIV risks.

> …women are tired of being humiliated so they think it is better that they live alone but we are human beings, so one may need a partner…for women they see that a young boy is safe just like how men take girls, they see them cheap and safe … (M. John, personal communication, October 11, 2012)

Of note is that M. John draws a parallel between women and men in terms of searching for their own sexual partners outside of marriage/relationship using their own income.

Cultural Traditions and Expectations

Cultural traditions and expectations were also associated with multiple sexual partnerships by participants. Extra marital partnerships are dominant in certain ethnicities (such as Zaramo) in Tanzania. In such ethnicities women are socialized to seek extra partners, outside their marital union (i.e. *Mafiga Matatu*[5]*)* and this is known to their marital partner. It is from this perspective that M. Walter explains extra partners as motivated by cultural traditions and customs. This conflicts with Christianity, given its monogamous marriage doctrine. The question is how women negotiate their customs and traditions while at the same time adhering to their Christian faith.

> Women seek services from vidumu [extra partners], this is in line with customs and traditions as well as religion. For most Zaramo people, when you go to their celebrations like kitchen party they are taught to have 'mafiga matatu' [three stone supporting a cooking pot]…in Christianity we are told one husband in sorrows and in happiness whether you have money or not. But all in all most people have no fear of God…our driver at the office told us that he always think that his wife has other men, so if he travels, before he comes home he has to call so that she knows that he is coming not to bring the other men at home, he does this because he does not want to be hurt finding his wife in another man's arms. (M. Walter, personal communication, September 13, 2011)

Some participants acknowledged these customs but called them outdated, especially now with HIV/AIDS and STDs.

[5] This is a practice with reference to three stones needed to support the cooking pot (in this sense a woman needs extra partners for support). But, this practice is mostly associated with economic needs, suggesting that one's marital partner cannot provide for all the economic needs.

> Those who have extra partners, I see it much behavioural and some blame on customs and traditions something which is not true. If I know there is HIV/AIDS and STDs, why do I need an extra partner and what do I benefit? Is it the money...but I end up losing my life? Most of us have very narrow mind, we only think about where we are and not in the future and that is why we see all these. For example, people believe that Pare people like sex, so if you want to justify this you can sleep with anyone because you are Pare and you like sex. We need to sit and evaluate our life skills, we don't need to just follow customs and traditions, and some are out dated. (N. Guma, personal communication, October 29, 2012)

Significantly, there are many things that influence women to have multiple partners. H. Nzaga felt that each woman is motivated by different things:

> … Can be categorized in two or three reasons; first vidumu exist because of income; second, nature/behaviour; and third, lack of satisfaction. Customs and tradition could be part, but kidumu is negotiable, having an outside partner is very personal and we cannot blame that to customs and traditions for example, we come from the regions that we don't have such traditions or customs, but there were the traditions of being inherited [referring to a widow being inherited by her dead husband's brother]. (Personal communication, October 10, 2012)

Having more than one partner creates a network of many other partners in which a long chain of HIV transmission is facilitated. If these people are involved in sex without a condom it is very possible that they are at a high risk for HIV infection, R. Mtafutaji explains it well:

> Both those with young men and vidumu [extra partners], contribute to the transmission of HIV, because if you are married and you have kidumu [extra partner], kidumu also has a girlfriend, so if one of them is infected the possibility of them being infected is high, the girlfriend can also have kidumu on the side. (Personal communication, September 14, 2012)

Summary. Women use their income or education to get what they need in their lives. Income intersects with their employment, marital status, customs, and traditions to create diverse avenues and experiences of vulnerability. Sexual scripts and desires are an

influential component of HIV vulnerability. Sex is described as used for diverse purposes in the context of different relationships and power dynamics. In the dominant discourse it is discussed merely as a route for HIV transmission over which women lack control. The dominant discourse ignores women's sexual agency and pursuit of diverse needs in terms of sexuality. In this research, participants contended that PEW use their positionalities to achieve diverse sexual goals (including sexual satisfaction, pleasure, comfort, and security). Their social positions in terms of income, employment, marital status, and education intersect with social duties, responsibilities and customs to influence sexual choices and resulting vulnerability. Multiple partnerships were spoken of as common. This leaves condoms, HIV testing and treatment as the main strategies for preventing HIV transmission and acquisition.

Discussion

Multiple sexual partnerships is acknowledged in the dominant discourse as the major source of vulnerability to HIV infection among women in Tanzania. However, multiple partnerships are discussed only within the context of poverty and women's survival needs. This fails to take into account other factors that contribute to multiple sexual partnerships among women of diverse socio-economic statuses. Prior research (Epstein et al., 2004; Higgins et al., 2010; Helleringer & Kohler, 2007; Walque, 2006) and the women interviewed in this study identify multiple intersecting circumstances and conditions that contribute to multiple sexual partnerships among women.

The assumption of the dominant discourse is that education, income and employment reduce women's vulnerability to HIV by contributing to their ability to

avoid or protect themselves in situations of risk. The PEW interviewed for this study described how these intersected with each other and with marital status, cultural and gender norms to create diverse circumstances and conditions of vulnerability. The very process of attaining an education or attaining and maintaining a job was identified as replete with risks associated with sexual harassment and the normative construction of sex as transactional and useful to fulfill diverse wants and needs. This is contrary to the dominant HIV/AIDS discourse that presents both education and employment as singularly protective against HIV (Gregson, 2001; Hargreaves & Glynn, 2002; Muthengi, 2007). Obtaining an education is emphasized in the HIV/AIDS discourse as protecting women by increasing their knowledge, ability to make decisions, think critically, and opening opportunities for employment. What is ignored in the discourse is how educational institutions themselves create conditions of HIV vulnerability through condoning or ignoring sexual harassment and sexual transactions associated with obtaining an education. This parallels the disconnect between the dominant discourse on employment and income and the realities portrayed by participants. Various forms of employment, especially in the private sector, also created conditions of vulnerability through sexual harassment and the normativity of sexual transactions where sex was exchanged for career advancement, job benefits, and other associated gains. As women gained income, they 'turned the tables' so to speak using their income to obtain sex from younger males in much the same way that men with more power and wealth than women obtain sex from females. Thus, both the process of obtaining and maintaining employment and income, and having income create conditions of vulnerability for women. This is counter to the dominant discourse which only presents employment and

income as beneficial to women with respect to HIV vulnerability. The dominant discourse also ignores women's agency and collusion in contributing to their own vulnerability and creating conditions of vulnerability for others.

Education is not only an avenue to employment and income, but also exposes students to new ways of thinking and seeing the world. Consistent with the dominant discourse, PEW reported that education contributed to communication, negotiation and decision-making with partners, including marital partners. However, this did not extend into the domain of sexual decision-making, especially in marriage, where men maintained control and even communication about sexuality was absent. The ways of thinking learned through education also contributed to women's vulnerability by making them more likely to demand equality in marriage, leading to conflict and equality in both partners seeking sexual relationships outside marriage. Valuing self-fulfillment and approaching sex from a consumerist and egotistical position justified extra-marital relationships, especially with peers who, like PEW, were considered less vulnerable or with younger men who were seen as 'safer' because of their age. Income enhanced PEW's ability to pursue additional partners. They had the resources to buy sex and also to support themselves should their extra relationships threaten their marriage.

While women are portrayed in the dominant discourse primarily as victims of male control, sexual proclivities, and HIV infectivity, participants suggested that some PEW are to blame when considering vulnerability. Their educational, career, and status goals combined with their income made them arrogant, greedy, and desirous of too much, turning them into initiators of 'risky' sexual relationships and activities. What is not explored in the discourse is the actions of women themselves and the circumstances that

influence them to have multiple partnerships. As presented by the PEW in this study, education interacted with employment, income, and cultural traditions related to marriage to influence multiple partnerships. Lack of sexual satisfaction, partners' responsibilities, and changes in life circumstances combined with income and gender norms to influence the search for extra partners for sexual satisfaction, pleasure, security, and comfort.

FIGURE 5: PEW'S HIV VULNERABILITY FRAMEWORK

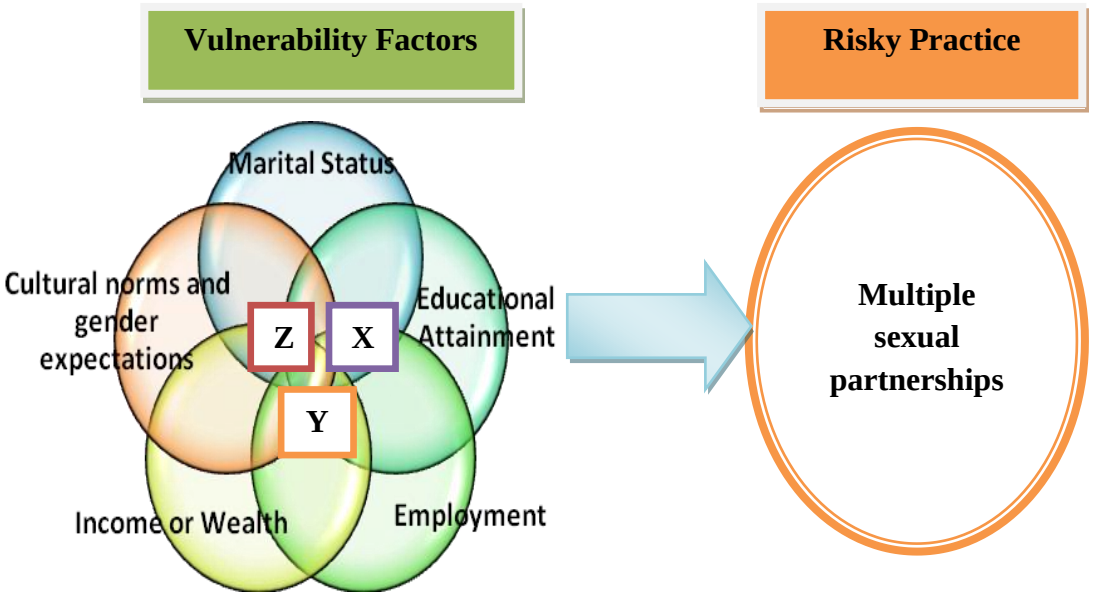


Figure 5, above, provides a graphic depiction of the overlapping/intersecting social situations and experiences that influence PEW's vulnerability to engage in multiple sexual relationships. Although the dominant discourse suggests the mechanisms that make women vulnerable to HIV, such as biological susceptibility, multiple sexual partners, lack of condom use, and adherence to traditional gender roles in marriage are common to all women, women do not experience these homogeneously.

There are many factors that influence the different ways these vulnerabilities are experienced among women. The circumstances of PEW are different from those of other women because they have education, independent income, and a higher status. Thus, they do not have to depend on men for economic survival. This leads to the expectation that they should be in a position to negotiate safer sex practices. But it is precisely their pursuit and attainment of education, and employment combined with their marital status, gender roles and expectations associated with sexuality, and income/wealth which intersect to influence them to have multiple sexual partnerships. However, this is not common to all PEW, rather predicated upon unique constellation of social position and social identities such as where one works, type of education one received and how it is practiced, responsibilities and needs, marital status and its challenges, and financial endowment.

With reference to **Figure 5**: I present here three (**X, Y** and **Z)** scenarios to illustrate the types of circumstances that participants used to explain vulnerability of PEW. As I noted in the beginning on this chapter, the majority of participants did not associate themselves with the scenarios they presented and some only occasionally spoke about their own experiences. Thus the scenarios included here do not directly reflect the experiences of participants. Within their discourse and theories of vulnerability, participants identified several ways that social positions and identities intersected to create conditions for extra/multiple partnerships. **X, Y** and **Z** are presented as illustrative of how positionalities may intersect to create vulnerability in the discourse of PEW.

X: is married but her husband does not satisfy her or pay attention, meaning her personal desires are not fulfilled. In university she took courses that introduced her to hedonism i.e. self-satisfaction as a priority. She has a job that puts her in contact with many men who pursue her.

Y: Is single and has no stable partner. She has income which she uses to get any man she wants to satisfy her sexual desires. She is also employed, but she wants work trips and promotion. To earn these she sleeps with her boss.

Z: Is 45 years old and divorced. Before divorce she had no freedom and she was controlled in marriage. Z has income from her business; the course she took at school influenced her to see HIV vulnerability as merely a probability; therefore, she does not use protection in her sexual relationships.

The circumstances that **X, Y** and **Z** face influence them to have extra/multiple sexual partners, thus, their risk of HIV infection is increased.

CHAPTER 6

PEW'S DISCOURSE ON SAFER SEX PRACTICES

Economic disempowerment within the dominant HIV/AIDS discourse is presented as a factor pushing women to practice unsafe sex in the form of multiple partners without the protection of condoms. Furthermore, lack of formal education is operationalised as denying women access to skills and information, and as a determinant of poverty (ILO/UNAIDS/UNESCO, February, 2011). Gender inequality and poverty are said to influence a woman's inability to negotiate condom use and HIV testing (*NMSF II*, 2008-2012). Because of these shortcomings, women are said to lack power as they cannot refuse unprotected sex that is dangerous to their health, leave a relationship, or influence their partner's decision to have multiple partners or use a condom (Michau, Naker, & Swalehe, 2002; Philemon & Kessy, 2008). This is to suggest that women become infected by their partners, have little or no role in the transmission of HIV, and no agency to protect themselves. In Chapter 5, I examined the interplay of social positionalities and identities (resulting from the intersection of educational attainment, employment, marital status, income/wealth, gender roles, and expectations associated with sexuality) and how, within the participants' discourses, they influenced the potential for PEW to engage in multiple sexual partnerships. This chapter seeks to expand participants' discourse with the focus on two safer sex practices, HIV testing and condom use, in relation to HIV vulnerability.

HIV TESTING AMONG PEW AND THEIR PARTNERS

In the dominant discourse HIV testing and counselling are important steps in HIV prevention. They are important not only because they can identify those who are infected so treatment with anti-retroviral therapies (ARVs) may be initiated, but also because it is assumed that when people get tested and counselled about HIV they are better able to maintain their own health and protect their partners. HIV testing, counselling, and treatment emphasize the biomedical approach to health, where health is a priority and understood exclusively at the level of the individual. Under this approach there is little concern with the lived experiences of individuals and competing life priorities.

In Tanzania, HIV testing goes hand in hand with counselling. These programs are well funded, made available across the country, and delivered free of charge at centres accessible to the majority of Tanzanians. Despite this, the majority of Tanzanians are still reluctant to get counselling and testing (URT, 2009). According to the *Tanzania HIV/AIDS and Malaria Indicator Survey* (THMIS) of 2007-2008 more than 80% of men and women were aware of HIV testing and counselling centers; however, only 37% of women and 27% of men had gotten tested for HIV and received their results. According to this survey, HIV testing was most common in urban areas, among adults with secondary education and above, as well as among those in wealthy households. I asked participants to speak about HIV testing among PEW and their partners. The majority of them made reference to their own experiences, speaking of the times they go for testing or why they did not get tested.

The only times that participants or their partners got tested were before marriage and when they were pregnant. The majority claimed that they could not convince their

partners to go for HIV testing at any other time. They averred that men are always reluctant to get tested, instead, they use their partners/wives to "test themselves", taking their partner's test result as a sign of their own status. Before marriage was the only time that the majority of partners submitted to testing, some without prompting from women. M. Daudi and M. Sungusia spoke of their husbands using them as "surrogates" in testing and premarital testing.

> Before he married me, we got tested and before I was pregnant. But as soon as he married me and after he was a whore, you cannot get him tested, he never agrees. But before we got married it was his idea that we get tested. Now he says when you get tested and if you don't have HIV, I also don't have HIV. This is what most men say, they use us as their test, he doesn't know that I can be safe while he has it. (M. Daudi, personal communication, September 17, 2012)

> …Before we got married, I forced him to get tested, when we came from that place, he said 'this is your first and last time to bring me here'. I told him 'I will be going alone, and when I come back I will give you the results', so I will test you automatically through me. (M. Sungusia, Personal communication, October 11, 2012)

M. Sungusia spoke earlier of considerable communication and negotiation with her husband. This included influencing her husband to open a joint bank account and allowing her to further her education. Although M. Sungusia praised her husband for generally being supportive, when it came to HIV testing, she was unable to influence his decision. What M. Daudi and M. Sungusia reported is the experience that the majority of the women shared. Surrogate testing, as this is called, is a poor way to judge one's HIV status since one partner may not be infected while the other is. Nevertheless, women who demanded that their husbands go for testing with them were accused of being involved sexually with other men. J. George related that, "each time I tell my husband, he will ask me why he needs to go there. He tells me I have my own issue [involved

sexually with other men] that is why I go" (Personal communication, September 17, 2012).

Married women were no more enthusiastic about testing than their husbands were. As H. Gervas alleged, "…sometimes if you are married you don't see the need of getting tested" (personal communication, October 6, 2012). Even though participants spoke of the challenges women face within their marriage and how the majority of married couples are no longer faithful, still the majority did not see the need to get tested precisely because they were married. The implication is that the pattern of testing for PEW was often the same as that of married men, with married women only getting tested before marriage and when they were pregnant. R. Mohamed reflected on both the absence of testing in marriage and testing of both partners in pregnancy.

> When you get into marriage the habit of getting tested frequently disappears because you build trust to your partner. It is only when you are pregnant that you can get tested but your husband still does not go with you, and he uses you to test himself. I have made a good effort to take my husband with me twice now, but the last time I went, he did not have time, but if he had time he would have come with me. (Personal communication, September 9, 2012)

Testing early in pregnancy (as found in the dominant discourse) has become a standard practice and is mandatory for all pregnant women who attend clinic. The purpose is to ensure that the child is born free of HIV. This is where Prevention-of–Mother-to-Child-Transmission (PMTCT) comes in. Testing during pregnancy is combined with treatment for infected women to prevent transmission to the unborn child. Husbands are expected to accompany their wives and also be tested. However, while testing is part of prenatal care for women, as seen in R. Mohamed's comment above, men do not always come. While reflecting on the responsibility of childbearing in marriage

and HIV, M. Obedy suggested that, "they should get tested before they get married even before they conceive." Her views were shared by E. Joseph, who suggested both partners get tested before conceiving.

> People need to have one partner and then they should go and get tested, if you are safe one can conceive, but this requires that you stay faithful to each other. For example, I have only one child, If I wish to add another child, I will be required to get tested again, and my husband as well will need to get tested. (E. Joseph, personal communication, August 28, 2012)

Women's acknowledgement of the importance of testing at pregnancy cannot, however, be taken as an indication of willingness to be tested. As seen in R. Joe's comment, even when a husband gets tested on his own, the wife may not go. "He has gone testing twice without me…He ended up getting tested because they were given a HIV/AIDS seminar at his work place, which motivated him to get tested …when I am pregnant I can do the test" (personal communication, September 25, 2012). Reluctance to be tested for HIV was often motivated by fear associated with the stigma linked with HIV/AIDS, stereotypes, and social and religious beliefs regarding the transmission of HIV. As S. James reported:

> I am afraid because the society has a perception that whoever is infected with HIV is promiscuous and has bad behaviours... Personally, I don't have the courage to go and get tested, I will wait until I get pregnant then I can get tested...I know that this is not good… (Personal communication, September 16, 2012)

Single women did not appear to share this fear and reluctance. They openly reported that they often got tested. N. John spoke not only about getting tested herself, but also about her boyfriend getting tested.

> I get tested often because I want to be confident that I am safe and I know the environment that I am in. But I don't know the environment that my

> boyfriend is working in and what he does. He probably thinks that I am a risk to him. That is why we get tested now and then. We also need to know the status of our health. (Personal communication, October 1, 2012)

M. Simon also said, "I know my status, as of now I am HIV free, and I use condom." Both single women, N. John and M. Simon reported getting tested often. This was different from the majority of married participants among whom testing was expected only before marriage and when they were pregnant. In the HIV prevention discourse, testing before marriage is advocated with the hope that partners will remain faithful during marriage. This is consistent with some participants whose discourse focused on fidelity. Participants like T. Seleman said, "Faithfulness is the most important thing, I don't see anything else. Even when you get tested often and you are not faithful it does not help, because at some point you may be infected (Personal communication, October 18, 2012). M. Mangowi advocated faithfulness over testing as the main way to protect against HIV infection: "We all need to be faithful and get tested often. However, the best way, I think could be being faithful to one another" (personal communication, October 10, 2012). This view was shared by R. Mohamed who related testing to child bearing. "Getting both [partners] tested and being faithful is the only way that I see [to fulfill child bearing responsibilities]." When considering how to protect herself, E. Mayela suggested that, "people need to get tested often." Although both R. Mohamed and E. Mayela suggested getting tested often, they, themselves, only got tested during pregnancy. Their views about protection and child bearing were reiterated by N. Guma who expanded on them to address condom use, "With condom, there is no reproduction, so faithfulness of married couples is required plus checking their health regularly."

In general, only a few married participants, in addition to those who were single, spoke positively about getting tested. The majority spoke of their reluctance to get tested. Getting tested was only seen as necessary before partners got married or during pregnancy. The majority did not want to get tested and were only tested when they became pregnant. This was most likely because testing in pregnancy was required, not because it was their choice. Curiously, although the majority were themselves not willing to get tested, their prevention discourse included both HIV testing and being faithful as the primary means for women to be protected.

ATTITUDES TOWARD CONDOM USE

Within the dominant HIV/AIDS discourse, fidelity is conceived of as the most reliable way to prevent HIV infection in a couple when neither partner is infected (i.e., couples are constructed as safe). Condom use becomes necessary in the absence of faithfulness. This suggests that "condoms are needed only in bad, unhappy, violent or hopeless relationships" (Jungar, 2010, p. 184). In the dominant HIV prevention discourse it is suggested that women are willing and wish to protect themselves from HIV infection, but they lack the power and ability to negotiate condom use (Higgins et al., 2010; National Multi-sectoral HIV Prevention Strategy, November 2009). Condom use within the dominant discourse is framed within the context of gender and power in sexual relationships *(Review of HIV Epidemiology and HIV Prevention Programs and Resources in Tanzania Mainland,* May, 2009; *NMSF II, 2008-2012*). What is not explored in the discourse is women's own attitudes toward condom use and how this affects condom use negotiation (Higgins et al., 2010). In this study, PEW described not only men's

reluctance to use condoms, but also their own negative attitudes toward condoms and condom use in general.

Few participants demonstrated positive attitudes toward condoms. J. Jonas was the exception, speaking of condoms in general and female condoms in particular: "Condoms should be used by all people, female condoms should be made available maybe we can use them if men don't want to use condoms" (Personal communication, September 9, 2012). The other PEW spoke almost exclusively about male condoms. They expressed negative attitudes, conveyed misinformation about condoms, spoke of how Christian teaching prohibited their use, and saw promotion of condoms as contributing to early sex among youth and unfaithfulness in marriage. The mere mention of condoms within marriage raised questions about fidelity and interfered with procreation, seen as a necessity in marriage.

The Purpose of Condoms

The main purpose of condoms, as articulated in the HIV discourse, is to reduce the risk of infection with HIV as well as other STDs. In this discourse condom use is constructed within a western understanding that focuses on individualism and personal responsibility. When such notions are used in a non-western context, they contradict gender roles and personal identities, and clash with the cultural significance of sexual culture and scripting where unprotected sex is a sign of commitment, love, and trust. Asking women to negotiate condom use is asking them to be assertive, contradicting their traditional feminine identity and gender role and to suggest there is no love, trust or commitment in the sexual relationship. Participants in this research articulated these

concerns and contradictions in relation to condom use. The viewpoints of the participants in relation to the purpose of condoms were contrary to what is presented in the HIV discourse. To them, condoms promote "irresponsible sex," are not for marriage, and when used, they are for pregnancy prevention.

Condoms promote irresponsible sex. Participants spoke of how condoms influence or promote early sex among youth, promiscuity, and unfaithfulness among older people and couples. Condom promotion and distribution were blamed for influencing youth to have early sex. The majority believed that young people should not be involved in sexual intercourse. R. Joe, spoke of these concerns.

> ... I think they make people practice sex more frequently than if there were not to be there. Most youth for example, think that using condoms will help them stay away from diseases, but what I know because I have been there before I got married, you can use condom once or twice with the same partner and you will end up putting it aside...youth are now practicing sex because of the availability of condom...out of 10 students now in A-level [high school], only 2 or 3 will not be practicing sex. (Personal communication, September 25, 2012)

Some participants believed that condoms did not contribute to reducing HIV infection, but instead increased the infection rate by increasing sexual activity and giving people the opportunity to have many partners, both before and during marriage.

> Condoms foster the problem of HIV/AIDS. They do not reduce [infection] as many people think. If you will tell a person to use condom so that he does not get infected, you are increasing the chance of that person going outside marriage or you are increasing the chance of her/him having many partners. Unless you tell the person to abstain or be faithful there is a higher possibility of that person staying with one partner. (H. Nzaga, Personal communication, October 10, 2012)

The distribution and promotion of condoms, according to M. John, "influence people to do sex because they know they are using protection, and I think it has given people the opportunity to do sex with any person" (personal communication, October 11, 2012). Thus, participants suggest that the promotion of condoms influences early sex among youth, promiscuity, and unfaithfulness among married couples, which are all seen as contributing to HIV spread.

Condoms are not meant for married couples. Participants spoke of the difficulties of using condoms in marriage. E. Mayela and J. Jonas demonstrated the difficulties they encountered in asking for condom use.

> When I asked him to use condom, he asked me 'why we need to do so'. He refused, insisting that I am his wife and we married in church. When the issues of marriage come in, you have no choices rather agree with him, because if you disagree that means you want to be divorced. (E. Mayela, Personal communication, August 23, 2012)

> I know for sure that my husband has many women outside our marriage ... but when it comes to making love he doesn't want us to use condom, and I am unable to force him to use condom.... (J. Jonas, personal communication, September 9, 2012)

The church and fear of divorce are powerful threats that keep women from pushing for condom use. In Tanzania, most women who are divorced and those who choose to leave (even when partners are abusive) are stigmatized. The assumption is that they were not obedient and had extra sexual relationships (Rugalabam, 2010). Thus, to protect their marriage some women would rather accept the risk of HIV infection than raise the topic of condom use with their partners.

Participants suggested that using or asking for condoms raises suspicion of infidelity in marriage, which might lead to divorce. Not asking for condoms suggests that partners are faithful to each other and hence chances of sustaining the marriage are higher. This position is supported by a study by Higgins et al (2010) who noted that "condoms seem antithetical to trust, love, closeness and fidelity, so women may choose not to use them or negotiate their use" (p. 436). Even though participants claimed lack of faithfulness on their partners' part (and some spoke of their own infidelity), condoms still were not used in order to preserve the marriage. For instance, M. Daudi knows her husband is 'malaya' [a whore] and still she is unable to convince him to use protection. When I asked her why she herself is not using protection she said:

> Just leave it... it is like that we already sacrificed ourselves [by getting married] that the day he brings it okay... we won't even know when he brings it…because if you deny him sex he will ask you 'why are you denying me? I am your husband...' (Personal communication, September 17, 2012)

While men were claimed to resist condom use in marriage, participants were also unwilling to promote condom use outside marriage even when they knew that their husbands were unfaithful. The view was that asking husbands to use condoms with other partners was an explicit endorsement or license allowing sex outside marriage. Thus, the solution for them was to insist on a husband's faithfulness, even though they knew this would not happen. M. Walter spoke about this, saying, "some suggest that they [men] should be given condoms when they travel, to me I feel like I am sending them to go and do it, I will only stick in telling my husband to be faithful" (personal communication, September 13, 2012).

Participants also focused on fidelity because they felt that, at best, condoms would only be used occasionally. This is reflected in the interview with M. Sungusia who reported that she did not like talk of safe sex, which she defined as sex with a condom.

> I think I am very different, if you talk of safe sex, I still don't like it…I prefer being faithful and that is a preference even though there are risks. Being faithful is perfect but it is also a risk. All other protection are not, because if you use let us say, condom today you can just use it for some time and then you can stop, because people tend to trust each other, not only that but sometimes we are told condoms are not safe or they only protect you to some percentage…I think the perfect way...is to be faithful. (Personal communication, October 11, 2012)

What appears to be ignored is that faithfulness also appears to be, at best, only occasional.

Condoms are only used for pregnancy prevention. M. Simon articulated an additional problem of condom use for married couples, its interference with conception.

> For a married woman you cannot use condom with your husband because your husband did not only marry you for the purpose of creating happiness [pleasure] between you two, but also to have children. It is with the consent of the husband, a lady cannot decide, hence she cannot use condom… (Personal communication August 23, 2012)

While people get married for various reasons, the expectation of traditional marriage is to procreate. Participants thus suggested that when a condom is used, it is for family planning and the husband needs to consent. With condoms used as a protection against unwanted pregnancies, M. Charles pointed out that other means of contraception have decreased condom use, "... If they [condom] are used they are used to protect pregnancy not HIV. But the availability of birth control pills and the morning after pill have also contributed to the down fall in the use of condoms…" (Personal

communication, November 5, 2012). M. Simon expanded on her earlier comments to explain why condoms are not necessary for either pregnancy or HIV prevention.

> Condoms now in Tanzania are not used as a means of HIV protection. Most people use them to prevent unnecessary pregnancy. But for a man who can do sex and ejaculate outside, he does not necessarily need to use condom and women are also willing to accept that if they are assured that he will ejaculate outside. Some have a belief that ejaculating outside, a woman will not get infected with HIV and she will not be pregnant. (Personal communication, August 23, 2012)

M. Simon's narrative indicates the agreement of both partners not to use condoms. Although strategy setting documents such as the *Gender Operational Plan for HIV Response in Mainland Tanzania for 2010-2012* point to the inability of women to negotiate condom use (URT/TACAIDS, 2010, p. 20), these interviews suggest that women themselves do not support condom use. It was also clear from the interviews that some participants did not even attempt to negotiate or influence condom use.

Supports for PEW's Discourse on Condom Use

In the HIV/AIDS discourse it is suggested that women's lack of power is what influences them not to use condoms. In this study, participants explained other issues that contributed to little or no condom use among women. Religion, myths, a dislike of condoms, the perception of condoms as of questionable effectiveness, concerns about correct use and the availability of condoms, as well as challenges associated with female condoms, all supported PEW's general rejection of condoms as a way to prevent HIV infection.

Religious discourse. PEW's discourse about condoms was often grounded in a religious perspective that prioritises procreation and faithfulness. In support of their views, women cited religious teachings that prohibited condom use. N. Ngoko, for instance, felt that, "…if they knew God, they would not promote condom use. What I advise is for people to know God, and if God is with them, there will not be such things" (personal communication, October 9, 2012). What is claimed here is that if people followed religious teachings about being faithful and/or abstaining, chances of HIV infection and transmission would be close to zero. But this requires both partners to follow these teachings.

Throughout the interview, N. Ngoko spoke of her faith in God and how believing in God had helped her overcome many risks. She trusted what she heard in church to be true. Other participants saw condom use as a contradiction to Christian faith. In the HIV prevention discourse, people are asked to abstain, be faithful, or use condoms. But when it comes to religious teaching, people are told to abstain until marriage and then be faithful to their partner. Condom use is not an option. M. Sungusia expressed sympathy for the challenge faced by religious leaders.

> I even feel sorry for religious leaders, because people are told to abstain and if they cannot abstain they should use condom [in the HIV discourse]. Of course, this is what is needed you give a person a freedom of choosing. But in religion it is not allowed and the strictness in religion is what the problem becomes. (Personal communication, October 11, 2012)

E. Nyambuli summarized the problem of condom use for religious people, "People are 'stammering' in the use of condoms because of religious values…in religion, they believe that people came in the world to procreate and there were beliefs that condoms make people impotent"(Personal communication, September 8, 2012). Thus, PEW's discourse

of condom use aligns with, and is supported by the religious discourse. However, if people follow religious teachings, particularly Christian teaching, the infection rate would be reduced. Especially, if both husband and wife are faithful and HIV negative.

Myths. Myths related to condoms and racism were endorsed by PEW. E. Nyambuli who has worked with one of the HIV/AIDS international organizations in Tanzania encountered this belief in delivering interventions in rural areas.

> … In Mtwara [a region in Tanzania], they still believe that when you use condom, the condom is made with white people purposely to come and finish people in other countries. They believe that the virus is not visible and is put in the condoms, and they were telling us live while we were creating awareness about the use of condoms, some people said 'no, they have virus'. (Personal communication, September 8, 2012)

Some people have a belief that HIV is a western creation that is aimed at eliminating the 'inferior' races. This perception is influenced by competing discourses in terms of where HIV originated. Some believe that HIV was created in western countries and sent to third world countries. HIV/AIDS, as a disease, was defined and named in western terms and western approaches to treatment and prevention are emphasized. Thus, people question the authenticity of the intentions behind the interventions, particularly when it comes to condoms. These views are not only held by uneducated people, but also educated people.

> One of my friends heard that 'salama kondoms' [salama condom brand produced in Tanzania] have small holes that allow the virus to pass and that the condoms have the virus. He believes that salama kondoms have HIV and white people created them and put them into the condom. (R. Mtafutaji, personal communication, September 14, 2012)

Distrust of Salama condoms is because it is believed that they are produced outside Tanzania and are imported by white people. However, Salama condoms are produced in

Tanzania. Such myths gained added credibility when spoken by people seen as knowledgeable and truthful. This was the case with religious leaders who reinforced their messages about faithfulness by portraying condoms as dangerous.

> ... I heard that even when people use condoms during sex, the condom expand and the holes are open for the virus to pass through…So, what is the benefit of using condoms...I heard this at a seminar where one expert, a man of God came to teach young people...(B. Mwampepe, personal communication, September 17, 2012)

The combination of myths and religious teaching has influenced the lack of condom use among both uneducated and educated people.

Dislike of condoms. Lack of enjoyment of sex when using a condom, was another issue that influenced people not to use them.

> Most men don't like using condoms unless you force them. I think they don't like it just because of what they have in their minds that if they use condom, they don't enjoy sex. There are also women who refuse the use of condoms. I have a friend who doesn't like using condoms because she does not enjoy. (I. Ivan, Personal communication, October 11, 2012)

As I Ivan suggested, lack of enjoyment of sex with a condom is not only the concern of men, but also of women.

Are condoms effective for HIV prevention? There are those who doubt the effectiveness of condoms overall. H. Gervas, who used to work in a medical dispensing outlet, saw inexpensive condoms as problematic and actually contributing to the spread of HIV.

> I don't have faith in condoms and I don't trust them because of the differences in prices. I heard some of the condoms are very expensive and some are cheaper. I also know that there are people who are using

> condoms, but why is the infection rate still high? I think that condoms are not safe. I think the cheaper condoms are weak and can allow the virus to pass through or they only protect to less percentage compared to the other expensive condoms… (Personal communication, October 6, 2012)

Although speaking about the difference in prices, H. Gervas also spoke of the myth that some condoms have holes that allow the virus to pass through. Some participants claimed that they were aware that condoms do not protect a person fully from HIV infection. They assume that if condoms could protect 100%, then the rate of infection would be reduced. R. Fanta said: for instance,

> …the problem is only that condoms does not protect 100%, if it had to be that it protects 100% the infection rate would have been low. For those who claim that there are fake condoms [condoms with defects], I don't understand if it is just a conspiracy for people not to use condoms, because I don't think there is any truth in such claims. (Personal communication, September 14, 2012)

There are no data that support the claim that many people are using condoms. R. Fanta was reflecting on media reports of condoms with defects. The *NMSF II for 2008-2012* (October, 2007) discusses the confusion that these reports have created "messages on condoms and their effectiveness in the prevention of HIV have been highly unbalanced leaving majority of prospective users in total confusion" (p. 65). E. Mayela's comments illustrate the confusion; "At the same time we know that there were some condoms with defection and it was advised that people should not use them, but do you know how many people used them? And those who knew do you think they used any other condoms?" (Personal communication, August 23, 2012).

Concerns about accessibility, affordability and correct use of condoms.

Participants spoke of how people who want to use condoms do not use them correctly

and consistently. Some felt that, particularly in rural areas, people had inadequate knowledge about condom use and most often misused them. E. Nyambuli, who has worked with HIV/AIDS organizations in Tanzania said, "…for people in rural areas, this issue is a problem because they still don't know the safe way of using condoms. They know [believe] you can use a condom and wash it and still use it" (personal communication, September 8, 2012). This phenomenon was also confirmed by M. Simon who claimed that:

> … At a particular point in several villages… it was noted that people could use condom and wash it for another person to use. Not only that people use 'rambo bags' [nylon bags] as condoms, because condoms are not available to them. These people have no knowledge about the use of condoms... It was aired through the Femina talk show. They even showed condoms 'zimeanikwa' [hanging] to dry and these people were questioned and they had a view that they can be used twice as long as they are washed properly. (Personal communication, August 23, 2012)

Participants suggested that such incorrect condom use could be associated with the lack of education about condoms, as well as problems in accessibility and affordability of condoms in these areas. However, participants never spoke about their own lack of knowledge about proper use of male condoms. The question is why people in urban areas, with adequate income, where condoms are easily accessible still do not use them.

Only a few participants suggested the need for condoms, such as S. Shosye, who said, "Condom use is still needed to a large extent. Because people still have multiple concurrent partners, if you visit any guest houses you will find them full and there are no condoms there" (personal communication, October 9, 2012). However, M. Simon felt that even if people used condoms, or if people were encouraged to use them as a means

of protection, there was a need to make sure that they are fully protected, including in all the activities preceding sexual intercourse.

> ... If one wish to protect herself/himself from HIV, must protect herself/himself fully. Imagine a person could use a condom during sex only, while all the prior actions are not catered for with protection as a result she/he becomes more vulnerable. For example, if a person sucks [practice oral sex] for a long time one can get bruises or wounds and the mouth is one place that gets bruises easily, some use their fingers which can easily cause bruises on women private parts. It is significant that during the pre-action one uses a dental-dam, should you wish to do deep kissing you need it. The same if a man/ lady wishes to suck [practice oral sex] the other they also need a dental-dam, but people are not even aware of such things. (Personal Communication, August 23, 2012)

Challenges associated with female condoms. While most of the conversation focused on male condoms, some participants also described the challenges associated with female condoms. They spoke of low knowledge of how to use female condoms. Most had never seen a female condom. M. Salehe and S. Alphayo, spoke of the challenges saying:

> …there are very few female condoms, they don't have users because there is no education about female condoms, I am not sure if women know how to put them on, they say "nivae bakuli" [I should wear a bowl]? And they believe that when they put them on they will go in the stomach. (M. Salehe, personal communication, September 2, 2012)

> The problem that is on female condoms is the process of wearing it. If there are people who use it, maybe only 5%, personally I have never tried to use it. (S. Alphayo, personal communication, September 21, 2012)

Overall, attitudes toward condom use were negative. In the HIV prevention discourse, use of condoms is presented as an issue of women's inability to influence partners. Among PEW we have women who are on the same socio-economic level with men but are unable to influence condom use. What is evidenced is not only a lack of

power to influence condom use, but also their own attitudes and unwillingness to use them.

Discussion

In terms of HIV testing, the majority of women spoke of both their own unwillingness to get tested and their inability to convince their partners to get tested. Testing was only seen to be important during pregnancy and before marriage. These, however, are mandatory tests that are required by the health institutions and some religious institutions. It was clear in the PEW's discourse that in most cases neither men nor women get tested of their own will. It is also critical to note here that educational attainment, income and employment did not influence HIV counselling and testing or condom use. However, marital status did play a part in HIV testing and condom use with single PEW expressing willingness to get tested and use condoms in comparison with married PEW who did not.

The issue of condom use among married couples is widely contested in most African countries (Maticka-Tyndale, 2012). In this research, the majority of participants, particularly those who were married, had negative attitudes toward condom use. They claimed that condoms influenced people to have multiple partnerships, which increased their risk of HIV infection. Some believed that condoms had holes or that those sent to Africa had the virus inside them. Thus, the majority never used condoms. The negative attitudes toward condoms and reasons for them paralleled those in religious teachings, customs, and traditions, and what has been reported in other regions of SSA (Leclerc-Madlala, Simbayi & Cloete, 2009). Grieser et al. (2001) noted that condom use conflicts with the focus on fertility and procreation in most African communities, a point raised by

participants. Additionally, in Chapter 5, I presented participants'views on the impact of educational attainment on condom use. Participants claimed that even though educational attainment can contribute to exposing individuals to knowledge about safer sex practices, it can also lead to ignoring the need for these in one's own life. For instance, participants claimed that educated people tend to trust that others like them are not infected, thus they are less likely to ask for or negotiate condom use with people at the same educational level. Also, depending on what courses one took in school, HIV infection can be seen as an unlikely probability, and thus may affect condom use.

All in all, participants' narratives indicate little or no condom use and HIV testing. Both HIV testing and condom use are western framings of HIV prevention that privilege individual responsibility in HIV prevention and rely on western technologies. Participants expressed suspicion, particularly of condoms, as effective in HIV prevention precisely because they came from the west. While PEW's discourse about testing and condom use displayed little evidence of intersectionality of different positions affecting their attitudes, it did reflect a distrust of western, imperialist technologies of prevention. Rather than protecting against HIV, condoms were seen to promote precisely the kind of sexual activity that contributes to the spread of HIV. Beyond that, condoms were suspected as actually directly contributing to infection as part of an imperialist conspiracy to decimate the African population. Less was said by PEW about testing except that it was not widely used. The discourse of PEW with respect to these technologies of prevention has contributed to Afro-pessimism. Suspicions that these technologies are part of western conspiracies are viewed as evidence of general ignorance among African people rather than suspicion and distrust rooted in abuses perpetrated under colonialism.

CHAPTER 7

MAPPING OF PEW's VULNERABILITIES WITHIN THE HIV DISCOURSE AND PREVENTION PRACTICES

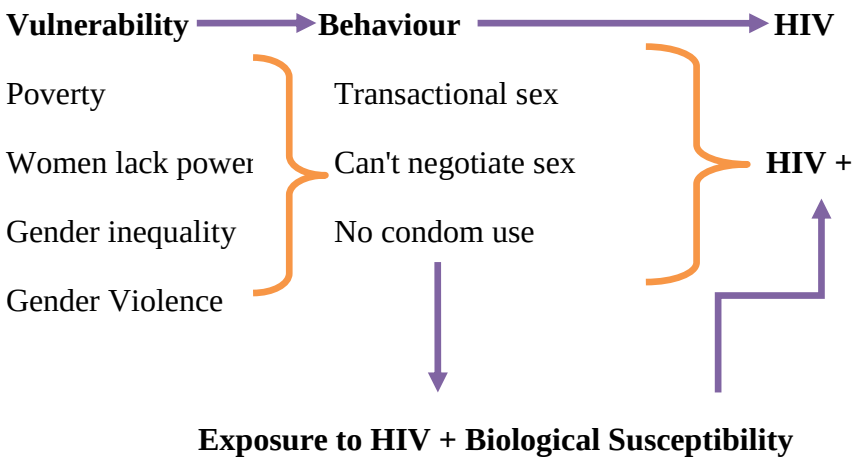
O'Manique (2010) notes that, "our knowledge of HIV and AIDS is limited by the way in which we see and understand the multiple dimensions of the epidemic" (p. 10). The government discourse as discussed in Chapter 4 is profoundly influenced by colonialism. The framing and characterization of individuals, vulnerabilities and risks associated with HIV and AIDS are associated with the western framing of diseases and individual behaviours (Jones, 2004; Mulwo et al., 2012). The narrow understanding of HIV and AIDS influences and shapes prevention interventions. For instance, the understanding of women's vulnerability to HIV infection is linked to weakness of women and economic inequality. The dominant discourse has suggested that poverty, lack of education and lack of gender power create women's vulnerability to the epidemic. This discourse is applied homogenously to women in the third world (Aniekwu, 2006; Mkandawire-Valhmu et al., 2013). As a result, poverty reduction strategies, education of the girl-child, and other empowerment strategies are prioritized as prevention strategies for women. Reflecting on the discourse of factors influencing PEW vulnerability, it is clear that the dominant discourse has not considered the specific needs of PEW. Although there is a recognition that PEW are vulnerable (TACAIDS, 2009, May), there is no adequate explanation of how they become vulnerable.

In this final chapter, I will map PEW vulnerability to HIV infection as described by participants onto the dominant discourse and present implications and some potential ways forward.

The Dominant HIV Discourse on Women's Vulnerability

The dominant discourse on HIV in Tanzania portrays women's vulnerability to HIV infection as resulting from poverty, gender inequality, lack of access to income and gender violence. These make it impossible for women to control sexuality to protect their own health and well-being, as a result women are said to engage in multiple sexual partnerships or "sex for survival." In these circumstances women are unable to influence condom use, and thus they are exposed to the risk of HIV infection (see Figure 6)

FIGURE 6: WOMEN'S VULNERABILITY TO HIV INFECTION AS PORTRAYED IN THE DOMINANT DISCOURSE



Women are portrayed as either innocent victims of men or the epidemic, or complicit in the spread of HIV through prostitution (Booth, 1998; Kitzinger, 1994). As postcolonial feminists point out, this HIV discourse was developed in the west and grounded in colonial framing of African sexuality-now translated into afro-pessimism. Imperialist frames are perpetuated by international organizations such as UNAIDS, UNDP, and WHO, and donor institutions such as PEPFAR, the Global Fund, and Gates Foundation. Targets, benchmarks and goals are set that bind on developing countries, if they are to

benefit from funds that are essential to build and maintain infrastructures required in such areas as health, education, and development. The worst scenario is where sub-Saharan African governments are coerced to tailor their national goals and priorities in line with the goals and priorities of donor institutions and international bodies (for example, the Millennium Development Goals) (Ilcan & Phillips, 2010; Stiglitz, 2006; Vandemoortele, 2009). Thus, the priorities of these countries and their specific needs are not catered to, as the focus is on generalized populations and problems that are tackled with similar (nonspecific) projects and policies.

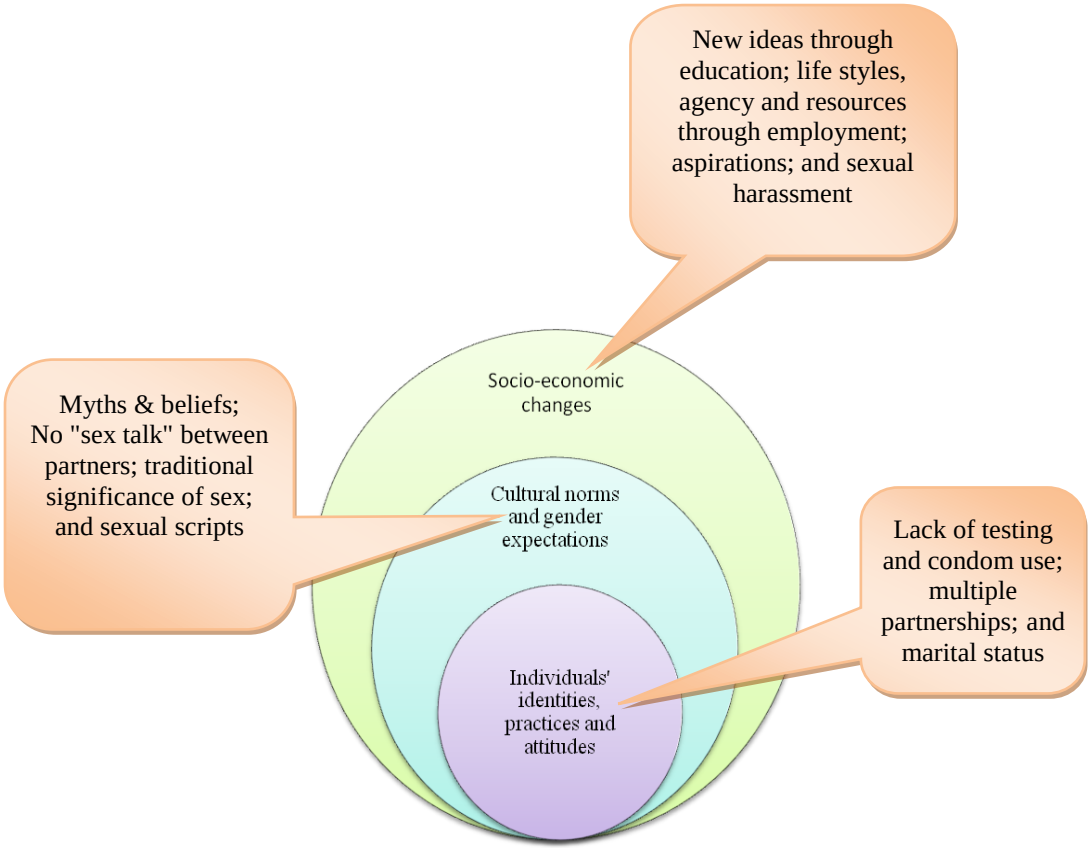
In this study, participants critiqued the framing of women's vulnerability as rooted in poverty and lack of gender power which are purported to make them dependent and force them to use their sexuality for survival. Critical to the participants' discourse was a focus on agency and structural factors placed within the historical, socio-cultural, and socio-economic contexts of women's lives. They focused on locating women within particular contexts through which vulnerability was created. In addition, participants suggested that the social positions of women like themselves have changed and could not be understood within an out-dated discourse of women as inevitably and uniformly poor, dependent, and subservient.

MAPPING OF PEW'S VULNERABILITY TO HIV INFECTION

Changes in the economy of Tanzania have created a new class of professional and entrepreneurial women. Applying an intersectional postcolonial feminist theory (Hankivsky & Cormier, 2010), how this new class of women described and explained their vulnerability to HIV infection was examined from within the context of historical,

socio-economic, and political structures that frame their lives and their subjective positions, experiences and identities. This is illustrated in Figure 7.

FIGURE 7: HOW PEW MAP THEIR VULNERABILITIES TO HIV INFECTION



Socio-economic Changes and HIV Vulnerability

Socio-economic changes have led to women's empowerment through educational attainment, income, and employment. Women's positionalities resulting from these changes intersect with and challenge traditional gender and marital norms producing diverse pathways to vulnerability in the form of multiple sexual partnerships. Income provides some women with the opportunity to access multiple sexual partners because

they are in a position to afford them. Likewise, employment and occupational opportunities facilitate upward mobility among PEW, contributing to wider sexual networking. The *National Multi-sectoral HIV Prevention Strategy* (November, 2009) noted that "empowerment of women can actually lead to more multiple partnerships" (p. 5). However, prevention programming focuses on mitigating women's vulnerability by empowering them through educational and income earning opportunities. Little consideration is given to how education, income and empowerment might increase vulnerability.

The dominant discourse is based on the assumption that avoiding HIV infection is of the highest value and actions to avoid infection (presented as Abstain, Be Faithful and use Condoms—ABC) will be followed if at all possible. When women are empowered through education and independent income to act in their own best interests, it is assumed that interest will place avoidance of HIV at the forefront. Afro-pessimism leads those who develop and fund HIV-related policies and interventions to place their faith in the western framing of the epidemic and its solutions. When these solutions fail, the so-called ignorance, promiscuity, and primitive nature of Africans is blamed. Research that uncovers anomalies in the logic underpinning this dominant discourse tends to be ignored or is, at best, acknowledged but neither pursued nor incorporated into the thinking of major donor agencies and international organizations with respect to prevention. Prior research has shown that while educated, income earning, and employed individuals are more knowledgeable about HIV prevention, they have a higher propensity for risk taking and consequent HIV infection (Bujra, 2009; Fortson, 2008, Fox, 2010, Glynn et al., 2004; Mishra et al, 2007; Nyanzi, 2005; Wojcicki, 2005). The PEW in this study elaborated on

how education, employment and independent income intersected with marital status and cultural norms to create vulnerability to HIV infection among women.

Socio-economic changes have contributed to transformation in social positionalities and gender roles, giving women access to greater independence and power to pursue and realize their own interests. Globalization and neo-liberalism have introduced egoistic values in place of traditional norms (Kasongo, 2010; Tietcheu, 2005; Uchudi et al., 2010). The new values and ways of living resulting from these changes have opened doors to multiple sexual partnerships in the context of work trips, conflicts or misunderstandings in marriage, obtaining good grades, or promotion at work places, and lack of sexual satisfaction in marriage. Not all PEW go through these open doors. Going through the door was described as a choice influenced by social position and identity, such as where one works, personal needs or responsibilities, type of education and marital status. PEW's agency (as a result of income or education) intersected with the societal/institutional processes (such as getting employment and education) to create situations or conditions of potential vulnerability. Participants suggested that the vulnerability of PEW is a result of choice or sexual harassment.

Sexual harassment as a risk factor. The pervasiveness and acceptance of sexual harassment as a form of male privilege in educational and economic/occupational institutions was part of the context of PEW's vulnerability. This is also explained in other studies (Godfrey, 2005; Morley, 2011). Consistent with results reported by Morley (2011) for Ghana and Tanzania, PEW described numerous situations of sexual harassment. Morley argues that the increasing number of female students in institutions

of higher learning is seen as a threat to patriarchal systems. As a result, men use harassment to disrupt the advancement of women and maintain male dominance. Sexual harassment of female students in exchange for grades, as well as women paying male students for sex and tutoring, suggests that women need men, undermining their agency and independence. In this study, a young female professor described being sexually harassed by older male students for the purpose of gaining good grades. While gender roles were reversed compared to those in Morley's study, the harassment still undermined this PEW's authority and accomplishments. Sex could buy grades rather than grades being based on the objective appraisal of the female professor. Sexual harassment in the workplace was similarly used to reinforce patriarchy. Women described sexual harassment at every career stage, beginning with applying for a job to getting promotions.

Choice as a risk factor. Uchudi et al. (2010) posit that involvement in high risk sexual behaviours is the result of choices that individuals make, especially when individual autonomy is increased (p. 4). PEW's sexual harassment of professors to get good grades, employers to get a higher status job, extra income or to obtain a certain standard of living, further undermined their independence, demonstrating they needed men. Their use of what they learned (e.g. probabilities in mathematics, right to self-fulfillment and hedonistic pursuits) to discredit risk and justify extra sexual partners, illustrates how egoistic needs were met. Thus, PEW's discourse explained how educational attainment and income increased risky behaviours (Chikuwa et al., 2007; Fortson, 2008; Fox, 2010).

Research that advocates for education as a protective factor only associates education with enhanced cognitive skills to understand and control risk. What is underexplored is how higher education makes women vulnerable through values and cognitive skills that allow them to justify behaviours and how education intersects with changes brought by globalization. These include changes in the economy and in access to new ideas and ways of living, or how persistent patriarchal structures frame women's participation. Educational attainment intersects with income, employment, socio-cultural norms, and marital status to affect PEW vulnerability. These intersectional linkages feature in other studies like Glynn et al. (2004) and Mishra et al. (2007) whose results are consistent with those here.

The aspiration in SSA for multiple sexual partnerships cuts across levels of education and income (Fox, 2010; Leclerc-Madlala, 2008; Nyanzi, 2005; Uchudi et al. 2010). As illustrated in this study, an increase in individual autonomy, dissatisfaction with the marital partner, increased freedom and aspirations for upward mobility and pursuit of modernity, all influenced women to engage in multiple sexual partnerships and intergenerational sexual relationships. Although the dominant discourse has related multiple partnerships primarily to poverty, it is evident that multiple partnerships are common across economic groups. Fox (2010) and Uchudi et al. (2010) associated this with a rising culture of consumerism that has come with globalization. In consumerism sex becomes both a commodity and a medium of exchange for desired commodities. Thus, Uchudi et al. (2010) suggest that sexuality in the era of socio-economic changes is “a resource that can be used to gain emotional and socio-economic benefits" (p. 23).

Cultural Norms, Gender Expectations and HIV Vulnerability

The socio-economic and socio-cultural changes brought by globalization exist in combination (interaction) with traditional cultural norms and gender expectations. These include norms forbidding sex talk between partners, an exclusive focus on men's sexual needs, procreation as the focus of marriage, and acceptance of multiple partnerships. As discussed by participants, cultural norms interact with socio-economic changes to increase PEW's vulnerability to HIV infection. Baxen and Breidlid (2004) suggest that cultural norms and socio-economic changes create contradictory realities, particularly when it comes to sexuality. PEW spoke of navigating these contradictions. Socio-economic changes gave women autonomy and led them to question cultural and gender norms. They gave them access to resources to pursue their own desires. However, autonomy, resources, and personal desires of women contradicted cultural norms and instigated conflicts with marital partners.

Some PEW followed the traditional norms, regardless of their education and socio-economic position. This allowed them to raise their children, maintain family respect, maintain their marriage, and their status as married women. In some cases, fear of violence or social disapproval contributed to their decision to defer to their husband's authority and tolerate his behaviours. Some PEW sought extra marital partners for comfort to satisfy personal sexual desires or to show they were equal to their husbands. Some PEW openly challenged cultural norms, demanding equality in their homes. This was said to produce conflicts that led both partners to seek extra partners. Persistent across all of the scenarios of extra marital sex was the ability of PEW to afford other partners and education empowering them to question their traditional norms or in the case

of some PEW, to follow cultural norms that condoned multiple partners for both men and women.

Thus, even though PEW positionalities are transformed by globalization and socio-economic changes, cultural norms and traditions continue to influence behaviours and to intersect with women's postionalities. These create conditions and contexts of vulnerability which PEW must navigate. Clearly, education, employment and income do not mitigate vulnerability, but rather create new vulnerabilities.

Individual Identities, Practices and Attitudes

Individual identities, practices and attitudes in terms of multiple partners, condom use and HIV testing, combined and interacted with those of their partners to influence vulnerability. The dominant discourse has suggested that women are willing and wish to practice safe sex, i.e. pursue HIV counselling and testing and use of condoms, but are inhibited by lack of agency, power and resources (Higgins et al., 2010; Scott, 2009). However, PEW proved unwilling to get tested or to use condoms. Besides vulnerability to engaging with multiple partners, the educated, employed, and income earning married women in this study did not articulate a discourse of prevention through condom use or HIV testing. Only single women included testing and condom use in their prevention discourse.

Lack of HIV testing and or surrogate testing. The dominant HIV prevention discourse suggests that educated and wealthy people are more open to testing and using condoms (URT, 2009). There are contrasting results in the literature. Bashemera,

Nhembo and Benedict (2013) for instance, looked at the role of women's empowerment and HIV testing in Tanzania. They found that women who were culturally, politically, and/or professionally empowered had confidence to decide on testing as they did not depend on their partners' decision of whether to test or not (p. 7). Fox (2010) who looked at HIV testing among the wealthy, educated, and urban residents found, however, that the majority of these populations were not willing to get tested. Fox's results are consistent with this study. PEW, despite their alleged empowerment professionally, educationally and income-wise, were generally reluctant to get tested. Married men and women both resisted testing.

Lack of HIV testing among PEW was only associated with their marital status. Some PEW feared stigmatization if they were found to be positive. Thus the majority suggested getting tested only prior to marriage and when pregnant. However, these were mandatory tests. There was no evidence that education, occupation, or income influenced this. However, single PEW did speak of testing for themselves as well as their partners.

Lack of and inconsistent condom use. Consistent with other studies, when participants spoke about condom use it was not only gender power (as articulated in the dominant HIV prevention discourse) that constrained the use of condoms (Black, 2001; Higgins & Hirsch, 2007). Although marriage was described as a risk factor in this study, PEW suggested that condom use within marriage was unacceptable. This was because of the cultural and religious significance of sex for procreation and trust within marriage. As participants suggested, marriage today has a Christian framing that includes monogamy

and trust. Pre-Christianity, trust was not part of marriage. Men were recognized to have many partners and women did not 'trust' them not to have multiple partners. Christianity brought in a new framing of marriage, but not new behaviours. Now there is 'trust,' meaning people cannot talk about multiple partners or introduce condoms, although they know there are multiple partners. The assumption is that when people get married they need to trust one another. Suggesting condom use means that one of the partners is exposed to risk, not committed, and therefore cannot be trusted. Participants suggested that not asking for condom use implies that they are faithful. Thus, both partners in marital union are bound not to use condoms and to behave as if they trust one another within marriage. However, as it was reported, in some cases both partners were not faithful to each other, but still performed trust to maintain their marital union.

Unlike married participants, single PEW spoke of consistent condom use. Here education was a constraint on condom use since there was trust that educated people were not infected and therefore (applying probabilistic thinking) there was a low risk of infection and condoms were unnecessary.

Trust also came up in relation to the effectiveness of condoms in preventing HIV transmission. Participants spoke of condoms as contributing to the epidemic through encouraging promiscuity and because condoms themselves were purposefully flawed by western manufacturers. From an Afro-pessimist perspective this merely reflects the ignorance and backwardness of African people. From a postcolonial feminist perspective it reflects understandable suspicion of western technologies and intentions that are rooted in abuses by colonial rulers.

It is critical to note here that issues of globalization and westernization in developing countries are complex topics. Nicolaides (2012) suggests that it is difficult to pinpoint to the benefits and or problems that are associated with globalization and westernization. I do however, acknowledge that globalization has contributed to creating platforms to explore alternative view points and open new ideas, values and experiences. But some values and ideas clash with traditional cultural norms, values and traditions. This research does not denounce the moral duty and responsibility of donor institutions and western countries to help and intervene in developing countries. However, the use of western models and afro-pessimistic views toward developing countries do not reflect the realities of the people and also the root causes of problems.

Within the frame of globalization, individuals have freedom and choice on issues that seem salient to their lives. For instance, participants in this study suggested that globalization opened opportunities to experience new things through televisions or the internet. However, individuals are not obliged or forced to follow what is aired or advertised. It is important to acknowledge that globalization and cultural traditions intersect to influence how individuals live their lives. As a result, complex social problems are arising that require broader and multidimensional approaches.

SUMMARY AND CONCLUSIONS

The dominant discourse about HIV and women presents women's vulnerability within a reductionist colonial framing of African people and their problems. This representation of women's vulnerability lacks context and historical bases. It does not take account of the experiences of women and ignores recent transformations in their economic positions.

The gendered discourse is one of men as transmitters of the virus to women who are powerless to protect themselves. Prevention strategies focus on women, particularly poor women (assumed to be the most powerless and vulnerable), despite epidemiological data showing higher prevalence of infection among better educated and wealthier women. PEW provided an alternative explanation of women's vulnerability. They place the vulnerability in historical, socio-cultural and socio-economic contexts. Central to this discourse was the agency of women and structural factors that influence their vulnerability.

PEW are women who have achieved positions which HIV interventions are targeting as goals for women. Based on the prevention initiatives in the dominant discourse, they should be among the least vulnerable. But they are not. As PEW explained, the intersection of educational attainment, income, employment, marital status, cultural norms, and gender expectations created conditions supportive of multiple partnerships and lack of condom use. The individual and joint positionalities of PEW and their partners created diverse conditions of vulnerability. Consistent with the dominant discourse, they increased PEW's agency and independence and often contributed to enhanced communication and gender equity between partners. However, for married women these did not translate to safer sex practices. Cultural norms and scripting of sexuality did match with the ABCs of safer sex.

Feminist post-colonial theory casts attention on the western assumptions about gender, sexuality, a hierarchy of values (with health and safety at the top), agency, and power that were foundationational to the dominant discourse of the social and interpersonal dynamics of HIV transmission, vulnerable groups, and prevention. It

counters Afro-pessimism, which is rooted in colonial interpretations of African sexuality and intervention failures. Within the context of feminist post-colonial theory, attention to how intersections between education, occupation, income, and cultural norms set within a history of colonization and the changes brought with globalization and neo-liberalism provided an analytic framework to understand the vulnerability of women who, according to the dominant discourse, should not be vulnerable.

Education, an occupation and income did not uniformly mitigate women's vulnerability. They might for single women who, based on the discourse of those in this study, appear to use condoms fairly consistently and to check their status with HIV testing. They do not, however, mitigate the vulnerability of married women who are governed by marital and gender norms that are counter to condom use and even monogamy. PEW's education, occupation, and income may increase their vulnerability through exposure to sexual harassment on the one hand and resources to access multiple partners on the other.

In general, for PEW, vulnerability, their positionalities and identities intersected with those of their partners. Socio-cultural norms and socio-economic changes gave them power to do what they wanted. This included multiple sexual partners, condom free sex, and HIV testing only when required, all increasing their risk of HIV infection.

STRENGTHS AND CONTRIBUTIONS OF THE STUDY

This is one of the few studies that has focused on professional and entrepreneurial women in relation to HIV vulnerability. The majority of studies has paid attention to poor and/or uneducated women. This study provides an understanding and description of how

professional and entrepreneurial women explain experiences of women like themselves in relation to HIV vulnerability, agency and sexual health with respect to HIV. The data for this study were obtained in a natural setting and included multiple viewpoints from various stakeholders, including women from various professions and occupations as well as officials from HIV/AIDS related organizations. The multiple viewpoints were also accompanied by document analysis. All these gave me confidence in drawing conclusions and answering my research questions.

An intersectional postcolonial feminist approach was beneficial in several ways. This approach contributed to identification of the existing gaps and the deconstruction of colonial framing of HIV risks, vulnerabilities, and prevention strategies. It was also useful in deconstructing the narrow framing of people by focusing on their experiences within their specific social contexts. It sets the context for understanding how pre-colonial, colonial, and postcolonial attributes impact vulnerability. Racine (2003) suggests that postcolonial approaches to health are beneficial in examining, exposing, and deconstructing dominant discourses and structural issues. Thus, a postcolonial feminist approach to the study of women's health is critical to providing a lens to examine how colonial and postcolonial practices impact on women's health in Tanzania.

An intersectionality approach was also beneficial in operationalizing women's vulnerabilities and risks. This was not only by focusing on their agency, but also the process through which they become vulnerable. Hankivsky and Cormier (2010) suggest that an intersectionality approach "...brings to the forefront the complexity of social locations and experiences for understanding differences in health needs and outcomes..." (p. 1). In this study, this approach brought a comprehensive understanding of the

complex relationship between micro, meso and macro level factors that influence vulnerability among PEW.

In terms of contribution, this study contributes to knowledge about the positioning and social inclusion of PEW in terms of HIV risks and vulnerabilities, and may be useful in developing and delivering initiatives targeted to the needs of women who currently have the highest rates of infection in Tanzania. However, the analyses in this study show that HIV transmission occurs within the context of the fluid and changing identities and positionalities and the dynamics of sexual partnerships. This suggests interventions must be diverse and responsive to change.

This study contributed to extending and enriching the intersectional postcolonial feminist approach. Despite embracing differences among women, the approach is mostly used in relation to oppression and discrimination against lower class women. Within my study, this approach was used to examine how the intersection of privilege and oppression of women who are assumed to be empowered, influence vulnerability to HIV infection. The current prevention strategies are aimed at creating PEW, i.e., women who are educated and have jobs and an income; however, from this research it is clear that this does not decrease vulnerability, but rather creates new vulnerabilities. Additionally, this approach moves from the common categories embraced within the dominant HIV discourse to other dimensions that create unique vulnerabilities. Therefore, it contributed to identifying some of the mediating vulnerabilities and risk factors that influence HIV infection among PEW

Methodologically, this study contributes to the positioning of researchers in field research. The assumptions that as researchers we are able to fit in the field because we

share identities with participants or we belong/originated from the research area was challenged in this research. Instead, the multiple positioning as insider, outsider and outsider-within contributes to creating interpersonal bonds with participants, and enhances data collection and production of knowledge. Additionally, this study calls for taking into account ethics of participation (Greenwood, 2000) and relational ethics (Ellis, 2007), instead of exclusively focusing on procedural ethics which present participants as objects of research i.e. their role is only to provide information. Participants are not only providers of information, but partners in creation of knowledge, we research with them than look in their lives from outside (Ellis, 2007).

LIMITATIONS OF THE STUDY

There are several limitations to this research. First, this study focused only on PEW in relation to the HIV discourse and prevention practices. The selection of the PEW was limited due to the fact that the sample did not include a large number of participants in all professions and entrepreneurial activities. Second, this study was limited to one city/region, Dar es Salaam, hence, this poses difficulties knowing how broadly these results are relevant. Third, originally this study intended to use three HIV/AIDS organizations, however only two organizations (TAMWA and TACAIDS) were involved in the study. This was because the Society for Women and AIDS in Africa (SWAA—Tanzania), whose main task was to advocate for women, children and families in the fight against HIV in African countries, was no longer operating at the time of this research. SWAA was a non-profit organization and depended on membership contributions. During my field work in Tanzania they did not have any offices because they were not in

a position to afford rental payments and most of their members had gone back to school or had traveled.

A fourth limitation that I encountered in the field was that there was not any specific organization available that was working on PEW and HIV/AIDS. This is both a limitation in that there is no representation of what work specific to PEW might look like and is also a reflection of the field of HIV prevention work, i.e., there is little or no attention paid to PEW vulnerability. Fifth, in conducting the literature review there was little literature on women's agency, especially in Tanzania. As well, the data available for this population were very limited. In terms of the theoretical approach adopted, the intersectional postcolonial feminist approach recognizes the multiple intersections of oppressions among poor women, but less literature has focused on non-poor women. Despite these limitations the data collected portray PEW's view of their place in the current HIV discourse and prevention practices in Tanzania, how they describe the vulnerability of PEW to HIV and their theories of why PEW are vulnerable.

IMPLICATIONS AND THE WAY FORWARD

In general the dominant discourse has constituted women as helpless, through which attention is given to gender norms that reflect dominant masculinity and femininity ideals that make women subordinate and influence their lack of control of their sexuality (Booth, 2004). What is not taken into account is the transformation of gender roles and women's positionalities. Clearly, different and changing positionalities, especially in terms of the economy, create multiple identities and statuses among women. These differences need to be interrogated in relation to women's vulnerability to HIV infection.

Dworkin (2005) suggests that it is crucial "to uncover the ways in which women and men gain or lose ground in given economies and what impact this has on power, negotiations, and [HIV] risk in relationships" (p. 618). Therefore, women's vulnerability in the face of HIV and AIDS needs to be understood in the context of their relational positions and in terms of how these interact with their cultural environment and social positions and identities rather than merely in terms of their singular status as women.

Thus, I suggest transformative changes of the dominant HIV discourse and prevention practices. Eguren (2011) suggests that transformative changes require "un-learning and liberating oneself from those mindset, relations, identities, formal and non-formal institutions which hinder and delay the probability of enacting new realities that are more just and fair in economic, social and political terms" (p. 5). This means that a change in the premises on which we base our understanding of HIV vulnerability, risks, and individual identities is required. This necessitates a new frame from which the reality of HIV is understood and socially constructed in meaningful ways as opposed to essentializing the experiences of individuals. The following therefore are my recommendations:

Donor communities need to rethink their approaches to HIV interventions in developing countries. Rather than exclusively focusing on the most vulnerable at risk groups on the global level, country-centered approaches should also be put in place. These need to focus on key areas of vulnerability, taking into account the dynamic needs of each population within a particular country. Tanzania mainland for instance, is experiencing a generalized epidemic i.e., each population is infected with HIV. This suggests a focus on diverse sub-populations by attuning interventions to people's

conditions in their various social positions. This also requires multisectoral approaches (Kippax, 2012; O'Manique, 2010) and involvement of stakeholders from various fields.

Public health policy makers, scholars and researchers need to conceptualize and analyze health issues in complex and multidimensional ways that reflect the experiences of the people concerned (Law et al., 2013). Such research and policies need to be set within the context of everyday life of Tanzanians and an examination of how people understand and navigate HIV in that context. An intersectional postcolonial feminist approach can be used as a unifying language and a theoretical framework for public health (Hankivsky & Cormier, 2010). Additionally, other stakeholders such as government officials, religious leaders, and politicians need to ne involved. For instance, in terms of HIV testing, religious institutions can be involved to encourage their members to get tested not only before marriage, but also in creating a habit of testing often.

For other government and private institutions, professional and non-professional institutions, seminars, and workshops should be delivered, each encouraging people to get tested as part of safer sex practices. This requires making HIV testing and counselling services available in various places where people would be free to go without fear. Moreover, community members need to be provided with information about the importance of getting tested. This will also reduce the stigma surrounding testing. Educational and employment institutions could be used as starting points for mobilization of information, programing of workshops, seminars related to HIV, as well as encouraging individuals to practice safer sex.

Structural changes are required at the national level. HIV prevention practices should not only focus on individual risks and vulnerabilities, but also those embedded in

social structures. Empowerment of women in the form of educational attainment and income earning opportunities are encouraged in the dominant discourse. These empowerment strategies have focused on increasing women's autonomy in decision-making and failed to take into account resistance to social change and the structural factors that contribute to HIV transmission. Sexual harassment for example, is used to disempower and contribute to HIV spread by creating an environment that limits choices of women within these institutions. Thus, structural changes are required to ensure that educational institutions and work environments are safe, by holding accountable those who sexually harass women (or men). PEW need to be able to pursue their education and occupations based on their own skills and accomplishment rather than their sexuality. Sexual harassment policies need to be reinforced in these institutions targeting both men and women.

Additionally, there is a need to involve men and boys in gender mainstreaming projects. Singling out women fails to take into account that in SSA, HIV is spread primarily through sex between women and men. The focus on men and women is supported by other studies. Kippax (2012) suggests that the focus should not be on individuals alone, rather on groups/networks as connected members who talk, negotiate and have sex with each other. A major challenge however, is that marital, gender, and sexual norms appear to be especially resistant to change according to the PEW in this study. Since gender mainstreaming projects has focused on women, there is a need to research and understand the perspective, attitudes and behaviours of men for an effective prevention strategy.

We need to learn more about sexuality. As evidenced in the analysis in this study, sexuality in postcolonial Tanzania is influenced by various intersecting factors, while being experienced at the personal level. The current conceptualization of sexuality by donor institutions is centered on illness and violence (Arnfred, 2004). This suggests that sexuality is dangerous. Additionally, in relation to women, the dominant discourse has framed women using their sexuality only for material gain, or to provide for the sexual needs of their husbands. This study demonstrated other expectations associated with sexuality. The implication of this is that we need to engage in positive talk about sexuality on issues such as pleasure, enjoyment and desires (Boyce et al., 2007; Arnfred, 2004). This will open doors for people to talk about sex and sexuality. This requires taking into account specific social contexts and engaging individuals in meaningful dialogue about their sex lives and sexuality. I also recommend the establishment of sexuality and reproductive health centers. These centers need to be made accessible for all people (men and women) to engage in reflexive and positive talk about sex and sexuality. Positive approaches to HIV prevention contribute to influencing and changing sexual norms and scripts (Boyce et al., 2007). Thus, various dimensions of sexualities such as pleasure, desires, selling sex, sex as a marital duty etc, need to be discussed positively taking into account the meaning and symbolic value of sexualities.

Support groups for PEW that acknowledge their specific vulnerabilities are also important. So far there are no organizations that specifically service PEW in relation to HIV and AIDS. This, however, could be because PEW may be unaware of their risks and vulnerability. Consistent with the dominant discourse, and as evidenced in the interviews for this research, they may assume they are in control of their risks. This is noted in the

National Multi-sectoral HIV Prevention Strategy (November, 2009), "It is unclear whether these socio-economic groups [wealthy Tanzanians] understand their risk and behaviours that expose them to HIV infection" (p. 24). As it is for the dominant discourse on women's vulnerability, the current woman-centered professional organizations have focused on empowering/helping lower class women. However, their needs are not catered to by any institution, including needs in the area of HIV and AIDS. Thus, we need to raise awareness for this population for them to see their risks and vulnerabilities and ways to reduce their vulnerability.

I admit that it is difficult to make all these changes. This will take a long time. Nevertheless, change can start by creating a space for engagement, negotiation, and dialogue, and interdisciplinary collaboration of various stakeholders in exploring ways to dealing with the HIV epidemic.

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APPENDICES

APPENDIX A: OFFICIALS LETTER OF INFORMATION

LETTER OF INFORMATION FOR CONSENT TO PARTICIPATE IN RESEARCH

Title of Study: HIV/AIDS Prevention for Professional and Entrepreneurial Women in Dar es Salaam.

You are asked to participate in a research study conducted by **Neema William Jangu**, from the University of Windsor, Canada. Your participation in this study will help me **fulfil the research requirements for completing my doctoral dissertation.**

If you have any questions or concerns about the research, please feel to contact Neema William Jangu. This study is done under the supervision of Dr. Eleanor Maticka-Tyndale. If you have further questions about this study, feel free to contact her.

PURPOSE OF THE STUDY

The purpose of this study is: (a) To explore factors that make professional and entrepreneurial women more or less vulnerable to HIV infection and how they exercise agency in decisions related to sexuality and sexual and reproductive health. (b) To examine the position of professional and entrepreneurial women in current HIV/AIDS prevention in terms of supporting or not supporting their needs

PROCEDURES

If you agree to participate in this study, you will be asked to read and sign a consent form. You will then be asked to take part in one interview of approximately one hour long. If you agree, the interview will be audio recorded.

POTENTIAL RISKS AND DISCOMFORTS

No risks are anticipated. Nevertheless, since we will be talking about HIV/AIDS, you may find some of the questions raise uncomfortable memories or feelings. If this happens, you can choose not to respond to those questions or you can decide to stop the interview.

POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

Current HIV/AIDS prevention rarely pays attention to professional and entrepreneurial women. It focuses mostly on risks to poor women. It is hoped that the results of the study will contribute to improving services for professional and entrepreneurial women. You may personally find that our conversation provides you with new knowledge and awareness about HIV/AIDS.

PAYMENT FOR PARTICIPATION

In appreciation of the time and information you provide, you will receive Tsh. 13,000/=.

CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential. To ensure this, the written data produced, as well as my notes, you will be asked to decide on how you want to be presented or referred in the report—name, organization or title. The digital information produced in my study (audio and written files) will be kept in a password protected computer. The hard copies of these files will be kept locked in a secure location. After the study is completed and I have defended my dissertation, all hard copies of data will be erased (audio tapes) and the documents will be shredded. Electronic copies of data will be kept in a stand-alone computer with password protected access. All data will be destroyed 3 years after I have defended my doctoral dissertation

PARTICIPATION AND WITHDRAWAL

You can choose to be part of this study or not. If you volunteer to participate in this study, you may withdraw within 24 hours from the time the interview was conducted. Should you withdraw from the research; all information collected from you will be destroyed and completely removed from the results of the study. You may also refuse to answer any questions you do not want to answer and still remain in the study.

FEEDBACK OF THE RESULTS OF THIS STUDY TO THE SUBJECTS

Participants and organisations will be furnished with a summary of the report. On June 1st, 2014 the results of this study will be posted on the University of Windsor Research Ethics Board website at: http://www.uwindsor.ca/reb. If you do not have internet access I can mail a copy to you.

SUBSEQUENT USE OF DATA

This data may be used in future studies, as well as in this one.

RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. If you have questions regarding your rights as a research subject, contact: Research Ethics Coordinator, University of Windsor, Windsor, Ontario N9B 3P4; Telephone: +1519-253-3000, ext. 3948; e-mail: ethics@uwindsor.ca.

SIGNATURE OF INVESTIGATOR

These are the terms under which I will conduct research.

_____ _____

Signature of Investigator Date

BARUA YA TAARIFA YA IDHINI YA KUSHIRIKI KATIKA UTAFITI

Utafiti Juu ya: Sera na Vitendo Katika Kujikinga na Maambukizi ya Virusi Vya UKIMWI: Wanawake Wenye Kipato na Wasomi Dar es Salaam.

Unaombwa kushiriki katika utafiti utakaofanywa na Neema William Jangu kutoka Chuo Kikuu cha Windsor, Canada (University of Windsor). Ushiriki wako katika utafiti huu utanisaidia katika kukamilisha vigezo vya kuweza kutimiza utafiti utakochangia katika kutunukiwa shahada ya juu.

Kama unamaswali yoyote kuhusu utafiti huu, tafadhari wasialiana na Neema William Jangu. Utafiti huu unafanyika chini ya mwongozo wa Dr. Eleanor Maticka-Tyndale. Na kama kuna maswali zaidi tafadhali wasiliana nae.

LENGO LA UTAFITI

Lengo la utafiti huu ni kuangalia: (a). Sababu mbalimbali ambazo zinachangia katika kuwaweka wanawake wenye kipato na wasomi katika hatari ya maambukizi ya virus vya UKIMWI. Vile vile kuangalia njia ambazo hawa wanawake wanazitumia katika kulinda ujinsia na uzazi salama. (b). Pia kuangalia nafasi ya wanawake wenye kipato na wasomi katika kujizuia na maambuzki na namna ambazo wanahusishwa na mashikirika mbalimbali katika sera na vitendo vya kujikinga na maambukizi ya UKIMWI.

TARATIBU ZA UTAFITI

Kama utakubali kushiriki katika utafiti huu, utaombwa kusoma na kuweka sahihi kwenye form ya kukubari kushiriki. Pia utaombwa kushiriki katika mahojiano ambayo hayatachukua zaidi ya saa moja. Na vile vile kama utakubali mahojiano hayo yatarekodiwa.

HATARI NA USUMBUFU

Hakuna hatari yoyote ambayo inatarajiwa kwa washiriki. Lakini kwasababu tunaongelea juu ya UKIMWI, baadhi ya maswali yanaweza kusababisha usumbufu kwa kukumbusha mambo yaliyopita. Kama usumbufu huu utajitokeza unaruhusiwa kutojibu swali/maswali kama hayo na vilevile unaweza kusitisha mahojiano mara moja.

FAIDA KWA WASHIRIKI NA JAMII

Njia za kuzuia au kujikinga na maabukizi ya UKIMWI hazitilii mkazo mahitaji ya wanawake wenye kipato na wasomi, badala yake zinatilia mkazo kwa wanawake wenye kipato cha chini. Hivyo basi utafiti huu unakusudiwa katika kuchangia huduma mbalimbali hususani kwa wanawake wenye kipato na wasomi. Pia utafiti huu au mahojiano yetu yanaweza kuchangia katika kuleta elimu mpya au ufahamu zaidi juu ya UKIMWI.

MALIPO KWA WASHIRIKI

Katika kukushukuru kwa muda utakoa tumia utapewa Tsh 13, 000/= kama shukurani.

USIRI

Taarifa zozote ambazo zitakusanywa kwenye utafiti huu, ambazo zitakutambulisha wewe kwa namna moja au nyingine zitabaki siri. Ili kuhakikisha taarifa hizi zinabaki siri, taarifa zote zilizokatika maandishi zitatambulishwa Kulingana na jinsi ambavyo wewe mshiriki utapenda kutambulishwa, mfano kwa kutimia jina la taasisi yako, cheo chako au jina lako. Taarifa zote zilizorekodiwa pamoja na za maadindishi vitahifadhiwa katika komputa iliyofungwa kwa neno la siri. Machapisho ya taarifa hizi yatahifadhiwa kwenye kisanduku ambacho kitafungwa. Baada ya utafiti kukamilika na nimetetea utfaiti huu, taarifa zote zilizokusanywa na kutumika zitahifadhiwa kwa muda wa miaka 3, tangu nitakapotetea utafiti wangu.

USHIRIKI NA KUJITOA KATIKA UTAFITI

Unaruhusiwa kuchagua kuwa mshiriki au kutokuwa mshiriki katika utafiti huu. Kama utachagua kushiriki, unaweza kujitoa ndani ya masaa 24 tangu mahojiano yalipofanyika. Kama utajitoa katika utafiti huu, taarifa zako zote zilizokusanywa zitaondolewa na hazitatumika katika uandishi wa utafiti huu. Na vile vile unaweza kuchangua kutojibu swali/maswali yoyote ambayo unadhani hayastahili na ukabaki kuwa mshiriki katika utafiti huu.

MATOKEO YA UTAFITI KWA WASHIRIKI

Washiriki wote watapewa nakala ya utafiti huu baada ya kukamilika. Tarehe 01/06/2014 utafiti huu utapatika katika tovuti ya chuo kikuu cha Windsor –University of Windsor Research Ethics Board http://www.uwindsor.ca/reb. kwa mshiriki asiye na mtandao wa intaneti, nakala itatumwa kwa njia ya posta.

MATUMIZI YA TAARIFA ZA UTAFITI HUU KATIKA TAFITI NYINGINE

Taarifa hizi zinaweza kutumika katika tafiti nyingine zitakazofanyika mbeleni.

HAKI KWA WASHIRIKI

Unaweza kujitoa katika utafiti huu wakati wowote bila adhabu yoyote. Kama unamaswali yoyote kuhusu utafiti huu kuhusu haki zako kama mshiriki, tafadahri wasiliana na Research Ethics Coordinator, University of Windsor, Windsor, Ontario N9B 3P4; simu: +1519-253-3000, ext. 3948; barua pepe: ethics@uwindsor.ca.

SAHIHI YA MTAFITI

Haya ni mashariti ambayo yatazingatiwa katika utafiti huu

_____ _____

Sahihi ya Mtafiti Tarehe

APPENDIX B: OFFICIALS CONSENT FORM

CONSENT TO PARTICIPATE IN RESEARCH

Title of Study: HIV/AIDS Prevention for Professional and Entrepreneurial Women in Dar es Salaam.

You are asked to participate in a research study conducted by **Neema William Jangu**, from the University of Windsor, Canada. Your participation in this study will help me **fulfil the research requirements for completing my doctoral dissertation.**

If you have any questions or concerns about the research, please feel to contact Neema William Jangu. This study is done under the supervision of Dr. Eleanor Maticka-Tyndale. If you have further questions about this study, feel free to contact her.

PURPOSE OF THE STUDY

The purpose of this study is: (a) To explore factors that make professional and entreprenurial women more or less vulnerable to HIV infection and how they exercise agency in decisions related to sexuality and sexual and reproductive health. (b) To examine the position of professional and entreprenurial women in current HIV/AIDS prevention in terms of supporting or not supporting their needs

PROCEDURES

If you agree to participate in this study, you will be asked to read and sign a consent form. You will then be asked to take part in one interview of approximately one hour long. If you agree, the interview will be audio recorded.

POTENTIAL RISKS AND DISCOMFORTS

No risks are anticipated. Nevertheless, since we will be talking about HIV/AIDS, you may find some of the questions raise uncomfortable memories or feelings. If this happens, you can choose not to respond to those questions or you can decide to stop the interview.

POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

Current HIV/AIDS prevention rarely pays attention to professional and entreprenurial women. It focuses mostly on risks to poor women. It is hoped that the results of the study will contribute to improving services for professional and entreprenurial women. You may personally find that our conversation provides you with new knowledge and awareness about HIV/AIDS.

PAYMENT FOR PARTICIPATION

In appreciation of the time and information you provide, you will receive Tsh. 13,000/=.

CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential. To ensure this, the written data produced, as well as my notes, you will be asked to

decide on how you want to be presented or referred in the report—name, organization or title. The digital information produced in my study (audio and written files) will be kept in a password protected computer. The hard copies of these files will be kept locked in a secure location. After the study is completed and I have defended my dissertation, all hard copies of data will be erased (audio tapes) and the documents will be shredded. Electronic copies of data will be kept in a stand-alone computer with password protected access. All data will be destroyed 3 years after I have defended my doctoral dissertation

(a). Organization name (b). Position/Title (c). Name (d). Other _____

PARTICIPATION AND WITHDRAWAL

You can choose to be part of this study or not. If you volunteer to participate in this study, you may withdraw within 24 hours from the time the interview was conducted. Should you withdraw from the research; all information collected from you will be destroyed and completely removed from the results of the study. You may also refuse to answer any questions you do not want to answer and still remain in the study.

FEEDBACK OF THE RESULTS OF THIS STUDY TO THE SUBJECTS

Participants and organisations will be furnished with a summary of the report. On June 1st, 2014 the results of this study will be posted on the University of Windsor Research Ethics Board website at: http://www.uwindsor.ca/reb. If you do not have internet access I can mail a copy to you.

SUBSEQUENT USE OF DATA: This data may be used in future studies as well as in this one.

RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. If you have questions regarding your rights as a research subject, contact: Research Ethics Coordinator, University of Windsor, Windsor, Ontario N9B 3P4; Telephone: +1519-253-3000, ext. 3948; e-mail: ethics@uwindsor.ca.

SIGNATURE OF RESEARCH SUBJECT/LEGAL REPRESENTATIVE

I understand the information provided for the study**:** HIV/AIDS Prevention for Middle Class Women in Dar es Salaam as described herein. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

_____

Name of Subject

_____ _____

Signature of Subject Date

SIGNATURE OF INVESTIGATOR

These are the terms under which I will conduct research.

_____ _____

Signature of Investigator Date

Utafiti Juu ya: Sera na Vitendo Katika Kujikinga na Maambukizi ya Virusi Vya UKIMWI: Wanawake Wenye Kipato na Wasomi Dar es Salaam.

Unaombwa kushiriki katika utafiti utakaofanywa na Neema William Jangu kutoka Chuo Kikuu cha Windsor, Canada (University of Windsor). Ushiriki wako katika utafiti huu utanisaidia katika kukamilisha vigezo vya kuweza kutimiza utafiti utakochangia katika kutunukiwa shahada ya juu.

Kama unamaswali yoyote kuhusu utafiti huu, tafadhari wasialiana na Neema William Jangu. Utafiti huu unafanyika chini ya mwongozo wa Dr. Eleanor Maticka-Tyndale. Na kama kuna maswali zaidi tafadhali wasiliana nae.

LENGO LA UTAFITI

Lengo la utafiti huu ni kuangalia: (a). Sababu mbalimbali ambazo zinachangia katika kuwaweka wanawake wenye kipato na wasomi katika hatari ya maambukizi ya virus vya UKIMWI. Vile vile kuangalia njia ambazo hawa wanawake wanazitumia katika kulinda ujinsia na uzazi salama. (b). Pia kuangalia nafasi ya wanawake wenye kipato na wasomi katika kujizuia na maambuzki na namna ambazo wanahusishwa na mashikirika mbalimbali katika sera na vitendo vya kujikinga na maambukizi ya UKIMWI.

TARATIBU ZA UTAFITI

Kama utakubali kushiriki katika utafiti huu, utaombwa kusoma na kuweka sahihi kwenye form ya kukubari kushiriki. Pia utaombwa kushiriki katika mahojiano ambayo hayatachukua zaidi ya saa moja. Na vile vile kama utakubali mahojiano hayo yatarekodiwa.

HATARI NA USUMBUFU

Hakuna hatari yoyote ambayo inatarajiwa kwa washiriki. Lakini kwasababu tunaongelea juu ya UKIMWI, baadhi ya maswali yanaweza kusababisha usumbufu kwa kukumbusha mambo yaliyopita. Kama usumbufu huu utajitokeza unaruhusiwa kutojibu swali/maswali kama hayo na vilevile unaweza kusitisha mahojiano mara moja.

FAIDA KWA WASHIRIKI NA JAMII

Njia za kuzuia au kujikinga na maabukizi ya UKIMWI hazitilii mkazo mahitaji ya wanawake wenye kipato na wasomi, badala yake zinatilia mkazo kwa wanawake wenye kipato cha chini. Hivyo basi utafiti huu unakusudiwa katika kuchangia huduma mbalimbali hususani kwa wanawake wenye kipato na wasomi. Pia utafiti huu au mahojiano yetu yanaweza kuchangia katika kuleta elimu mpya au ufahamu zaidi juu ya UKIMWI.

MALIPO KWA WASHIRIKI

Katika kukushukuru kwa muda utakoa tumia utapewa Tsh 13, 000/= kama shukurani.

USIRI

Taarifa zozote ambazo zitakusanywa kwenye utafiti huu, ambazo zitakutambulisha wewe kwa namna moja au nyingine zitabaki siri. Ili kuhakikisha taarifa hizi zinabaki siri, taarifa zote zilizokatika maandishi zitatambulishwa Kulingana na jinsi ambavyo wewe mshiriki utapenda kutambulishwa, mfano kwa kutimia jina la taasisi yako, cheo chako au jina lako. Taarifa zote zilizorekodiwa pamoja na za maadindishi vitahifadhiwa katika komputa iliyofungwa kwa neno la siri. Machapisho ya taarifa hizi yatahifadhiwa

kwenye kisanduku ambacho kitafungwa. Baada ya utafiti kukamilika na nimetetea utfaiti huu, taarifa zote zilizokusanywa na kutumika zitahifadhiwa kwa muda wa miaka 3, tangu nitakapotetea utafiti wangu.

(a). Jina la taasisi (b). cheo chako (c). Jina lako (d). vinginevyo _____

USHIRIKI NA KUJITOA KATIKA UTAFITI

Unaruhusiwa kuchagua kuwa mshiriki au kutokuwa mshiriki katika utafiti huu. Kama utachagua kushiriki, unaweza kujitoa ndani ya masaa 24 tangu mahojiano yalipofanyika. Kama utajitoa katika utafiti huu, taarifa zako zote zilizokusanywa zitaondolewa na hazitatumika katika uandishi wa utafiti huu. Na vile vile unaweza kuchangua kutojibu swali/maswali yoyote ambayo unadhani hayastahili na ukabaki kuwa mshiriki katika utafiti huu.

MATOKEO YA UTAFITI KWA WASHIRIKI

Washiriki wote watapewa nakala ya utafiti huu baada ya kukamilika. Tarehe 01/06/2014 utafiti huu utapatika katika tovuti ya chuo kikuu cha Windsor –University of Windsor Research Ethics Board http://www.uwindsor.ca/reb. kwa mshiriki asiye na mtandao wa intaneti, nakala itatumwa kwa njia ya posta.

MATUMIZI YA TAARIFA ZA UTAFITI HUU KATIKA TAFITI NYINGINE

Taarifa hizi zinaweza kutumika katika tafiti nyingine zitakazofanyika mbeleni.

HAKI KWA WASHIRIKI

Unaweza kujitoa katika utafiti huu wakati wowote bila adhabu yoyote. Kama unamaswali yoyote kuhusu utafiti huu kuhusu haki zako kama mshiriki, tafadahri wasiliana na Research Ethics Coordinator, University of Windsor, Windsor, Ontario N9B 3P4; simu: +1519-253-3000, ext. 3948; barua pepe: ethics@uwindsor.ca.

SAHIHI YA MSHIRIKI/MSHIRIKI

Naelewa kuwa taarifa nilizopewa kwenye utafiti**:** Sera na Vitendo Katika Kujikinga na Maambukizi ya Virusi Vya UKIMWI: Wanawake Wenye Kipato cha Juu na cha Kati Dar es Salaam. Nimeridhishwa na majibu yaliyotolewa kwa maswali yangu na ninakubari kushiriki katika utafiti huu. Nimepewa nakala ya fomu hii

_____

Jina la Mshiriki

_____ _____

Sahihi ya Mshiriki Tarehe

SAHIHI YA MTAFITI

Haya ni mashariti ambayo yatazingatiwa katika utafiti huu

._____ _____

Sahihi ya Mtafiti Tarehe

APPENDIX C: RECRUITMENT FLYER FOR PROFESSIONAL AND ENTREPRENEURIAL WOMEN

Department of Sociology, Anthropology and Criminology

Invitation to Participate In a Study; "HIV/AIDS Prevention for Professional and Entrepreneurial Women," Between August and November, 2012

Principle Investigator: Neema William Jangu, PhD student

What is the purpose of the study? To examine the HIV/AIDS prevention needs of Professional and Entrepreneurial Women in Dar es Salaam. Prevention has paid much attention to lower class women's vulnerability. This study will focus on understanding the needs of Professional and Entrepreneurial Women.

Who can participate in the study? Any professional or entrepreneur woman, who has at least a post secondary education, is invited to participate.

What are you asked to do? Participate in one interview of approximately one hour long.

Who Do I contact if I have questions about the participation in the study? If you or your friend wishes further information about the study, you can contact Neema William Jangu.

Your participation is valuable to this study

Unakaribishwa kwenye utafiti wa; "Vita Zidi ya Maambukizi ya Ukimwi Miongoni mwa Wanawake wenye Kipato na Wasomi" Utakaofanyika kati ya Mwezi 8 na 11, 2012

Mtafiti Mkuu: Neema William Jangu, PhD student

Nini Kusudio la Utafiti huu? Kuangalia jinsi gani wanawake wenye kipato cha kati na cha juu na wasomi wanahusishwa kwa namna moja ama nyingine katika njia mbalimbali za kujikinga na maambukizi ya UKIMWI. Hii ni kwa sababu, mikakati iliypo inajali sana wanawake masikini na wenye vipato vya chini. Utafiti huu unalenga katika mahitaji ya wanawake wenye kipato cha juu na jinsi ya kujinga na maambukizi

Nani anakaribishwa? Mwanamke yeyote ambaye ameajiriwa au mjasiriamali na ambaye anaelimu ya chuo kikuu anakaribishwa.

Nini unachoombwa kufanya? Kushiriki mahojiano na mtafiti ambayo hayatazidi muda wa saa moja.

Nani anahusika kwa maelezo zaidi juu ya utafiti? Kama wewe au rafiki yako atapenda kupata maelezo zaidi au kuwa mmoja wa washiriki, tafadhali wasiliana na Neema William Jangu.

Ushiriki wako ni wa muhimu katika utafiti huu.

APPENDIX D: PEW LETTER OF INFORMATION

LETTER OF INFORMATION FOR CONSENT TO PARTICIPATE IN RESEARCH

Title of Study: HIV/AIDS Prevention for Professional and Entrepreneurial Women in Dar es Salaam.

You are asked to participate in a research study conducted by **Neema William Jangu**, from the University of Windsor, Canada. Your participation in this study will help me **fulfil the research requirements for completing my doctoral dissertation.**

If you have any questions or concerns about the research, please feel to contact Neema William Jangu. This study is done under the supervision of Dr. Eleanor Maticka-Tyndale. If you have further questions about this study, feel free to contact her.

PURPOSE OF THE STUDY

The purpose of this study is: (a) To explore factors that make professional and entrepreneurial women more or less vulnerable to HIV infection and how they exercise agency in decisions related to sexuality and sexual and reproductive health. (b) To examine the position of Professional and Entrepreneurial Women in current HIV/AIDS prevention in terms of supporting or not supporting their needs

PROCEDURES

If you agree to participate in this study, you will be asked to read and sign a consent form. You will then be asked to take part in one interview of approximately one hour long. If you agree, the interview will be audio recorded.

POTENTIAL RISKS AND DISCOMFORTS

No risks are anticipated. Nevertheless, since we will be talking about HIV/AIDS, you may find some of the questions raise uncomfortable memories or feelings. If this happens, you can choose not to respond to those questions or you can decide to stop the interview.

POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

Current HIV/AIDS prevention rarely pays attention to professional and entrepreneurial women. It focuses mostly on risks to poor women. It is hoped that the results of the study will contribute to improving services for professional and entrepreneurial women. You may personally find that our conversation provides you with new knowledge and awareness about HIV/AIDS.

PAYMENT FOR PARTICIPATION

In appreciation of the time and information you provide, you will receive Tsh. 13,000/=.

CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential. To ensure this, the written data produced, as well as my notes, will be identified by a name that you choose (not your true/real name). True names or identifying data will not be used in my research drafts or in the main published products of the research. The digital information produced in my study (audio and written files) will be kept in a password protected computer. The hard copies of these files will be kept locked in a secure location. After the study is completed and I have defended my dissertation, all hard copies of data will be erased (audio tapes) and the documents will be shredded. Electronic copies of data will be kept in a stand-alone computer with password protected access. All data will be destroyed 3 years after I have defended my doctoral dissertation

PARTICIPATION AND WITHDRAWAL

You can choose to be part of this study or not. If you volunteer to participate in this study, you may withdraw within 24 hours from the time the interview was conducted. Should you withdraw from the research; all information collected from you will be destroyed completely removed from the results of the study. You may also refuse to answer any questions you do not want to answer and still remain in the study.

FEEDBACK OF THE RESULTS OF THIS STUDY TO THE SUBJECTS

Participants and organisations will be furnished with a summary of the report. On June 1st, 2014 the results of this study will be posted on the University of Windsor Research Ethics Board website at: http://www.uwindsor.ca/reb. If you do not have internet access I can mail a copy to you.

SUBSEQUENT USE OF DATA

This data may be used in future studies, as well as in this one.

RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. If you have questions regarding your rights as a research subject, contact: Research Ethics Coordinator, University of Windsor, Windsor, Ontario N9B 3P4; Telephone: +1519-253-3000, ext. 3948; e-mail: ethics@uwindsor.ca.

SIGNATURE OF INVESTIGATOR

These are the terms under which I will conduct research.

_____ _____

Signature of Investigator Date

BARUA YA TAARIFA YA IDHINI YA KUSHIRIKI KATIKA UTAFITI

Utafiti Juu ya: Sera na Vitendo Katika Kujikinga na Maambukizi ya Virusi Vya UKIMWI: Wanawake Wenye Kipato na Wasomi Dar es Salaam.

Unaombwa kushiriki katika utafiti utakaofanywa na Neema William Jangu kutoka Chuo Kikuu cha Windsor, Canada (University of Windsor). Ushiriki wako katika utafiti huu utanisaidia katika kukamilisha vigezo vya kuweza kutimiza utafiti utakochangia katika kutunukiwa shahada ya juu.

Kama unamaswali yoyote kuhusu utafiti huu, tafadhari wasialiana na Neema William Jangu. Utafiti huu unafanyika chini ya mwongozo wa Dr. Eleanor Maticka-Tyndale. Na kama kuna maswali zaidi tafadhali wasiliana nae.

LENGO LA UTAFITI

Lengo la utafiti huu ni kuangalia: (a). Sababu mbalimbali ambazo zinachangia katika kuwaweka wanawake wenye kipato na wasomi katika hatari ya maambukizi ya virus vya UKIMWI. Vile vile kuangalia njia ambazo hawa wanawake wanazitumia katika kulinda ujinsia na uzazi salama. (b). Pia kuangalia nafasi ya wanawake wenye kipato na elimu katika kujizuia na maambuzki na namna ambazo wanahusishwa na mashikirika mbalimbali katika sera na vitendo vya kujikinga na maambukizi ya UKIMWI.

TARATIBU ZA UTAFITI

Kama utakubali kushiriki katika utafiti huu, utaombwa kusoma na kuweka sahihi kwenye form ya kukubari kushiriki. Pia utaombwa kushiriki katika mahojiano ambayo hayatachukua zaidi ya saa moja. Na vile vile kama utakubali mahojiano hayo yatarekodiwa.

HATARI NA USUMBUFU

Hakuna hatari yoyote ambayo inatarajiwa kwa washiriki. Lakini kwasababu tunaongelea juu ya UKIMWI, baadhi ya maswali yanaweza kusababisha usumbufu kwa kukumbusha mambo yaliyopita. Kama usumbufu huu utajitokeza unaruhusiwa kutojibu swali/maswali kama hayo na vilevile unaweza kusitisha mahojiano mara moja.

FAIDA KWA WASHIRIKI NA JAMII

Njia za kuzuia au kujikinga na maabukizi ya UKIMWI hazitilii mkazo mahitaji ya wanawake wenye kipato na wasomi, badala yake zinatilia mkazo kwa wanawake wenye kipato cha chini. Hivyo basi utafiti huu unakusudiwa katika kuchangia huduma mbalimbali hususani kwa wanawake wenye kipato cha kati/juu na wasomi. Pia utafiti huu au mahojiano yetu yanaweza kuchangia katika kuleta elimu mpya au ufahamu zaidi juu ya UKIMWI.

MALIPO KWA WASHIRIKI

Katika kukushukuru kwa muda utakoa tumia utapewa Tsh 13, 000/= kama shukurani.

USIRI

Taarifa zozote ambazo zitakusanywa kwenye utafiti huu, ambazo zitakutambulisha wewe kwa namna moja au nyingine zitabaki siri. Ili kuhakikisha taarifa hizi zinabaki siri, taarifa zote zilizokatika maandishi zitatambulishwa na jina ambalo wewe mshikiriki utachagua (tofauti na jina lako halisi). Jina halisi au taarifa ambazo zitakutambulisha mara moja havitatumika katika uandishi wa ripoti yangu. Taarifa zote zilizorekodiwa pamoja na za maadindishi vitahifadhiwa katika komputa iliyofungwa kwa neno la siri. Machapisho ya taarifa hizi yatahifadhiwa kwenye kisanduku ambacho kitafungwa. Baada ya utafiti kukamilika na nimetetea utfaiti huu, taarifa zote zilizokusanywa na kutumika zitahifadhiwa kwa muda wa miaka 3, tangu nitakapotetea utafiti wangu.

USHIRIKI NA KUJITOA KATIKA UTAFITI

Unaruhusiwa kuchagua kuwa mshiriki au kutokuwa mshiriki katika utafiti huu. Kama utachagua kushiriki, unaweza kujitoa ndani ya masaa 24 tangu mahojiano yalipofanyika. Kama utajitoa katika utafiti huu, taarifa zako zote zilizokusanywa zitaondolewa na hazitatumika katika uandishi wa utafiti huu. Na vile vile unaweza kuchangua kutojibu swali/maswali yoyote ambayo unadhani hayastahili na ukabaki kuwa mshiriki katika utafiti huu.

MATOKEO YA UTAFITI KWA WASHIRIKI

Washiriki wote watapewa nakala ya utafiti huu baada ya kukamilika. Tarehe 01/06/2014 utafiti huu utapatika katika tovuti ya chuo kikuu cha Windsor –University of Windsor Research Ethics Board http://www.uwindsor.ca/reb. kwa mshiriki asiye na mtandao wa intaneti, nakala itatumwa kwa njia ya posta.

MATUMIZI YA TAARIFA ZA UTAFITI HUU KATIKA TAFITI NYINGINE

Taarifa hizi zinaweza kutumika katika tafiti nyingine zitakazofanyika mbeleni.

HAKI KWA WASHIRIKI

Unaweza kujitoa katika utafiti huu wakati wowote bila adhabu yoyote. Kama unamaswali yoyote kuhusu utafiti huu kuhusu haki zako kama mshiriki, tafadahri wasiliana na Research Ethics Coordinator, University of Windsor, Windsor, Ontario N9B 3P4; simu: +1519-253-3000, ext. 3948; barua pepe: ethics@uwindsor.ca.

SAHIHI YA MTAFITI

Haya ni mashariti ambayo yatazingatiwa katika utafiti huu

_____ _____

Sahihi ya Mtafiti Tarehe

APPENDIX E: PEW CONSENT FORM

CONSENT TO PARTICIPATE IN RESEARCH

Title of Study: HIV/AIDS Prevention for Professional and Entrepreneurial Women in Dar es Salaam

You are asked to participate in a research study conducted by **Neema William Jangu**, from the University of Windsor, Canada. Your participation in this study will help me **fulfil the research requirements for completing my doctoral dissertation.**

If you have any questions or concerns about the research, please feel to contact Neema William Jangu. This study is done under the supervision of Dr. Eleanor Maticka-Tyndale. If you have further questions about this study, feel free to contact her .

PURPOSE OF THE STUDY

The purpose of this study is: (a) To explore factors that make professional and entrepreneurial women more or less vulnerable to HIV infection and how they exercise agency in decisions related to sexuality and sexual and reproductive health. (b) To examine the position of professional and entrepreneurial women in current HIV/AIDS prevention in terms of supporting or not supporting their needs

PROCEDURES

If you agree to participate in this study, you will be asked to read and sign a consent form. You will then be asked to take part in one interview of approximately one hour long. If you agree, the interview will be audio recorded.

POTENTIAL RISKS AND DISCOMFORTS

No risks are anticipated. Nevertheless, since we will be talking about HIV/AIDS, you may find some of the questions raise uncomfortable memories or feelings. If this happens, you can choose not to respond to those questions or you can decide to stop the interview.

POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

Current HIV/AIDS prevention rarely pays attention to professional and entrepreneurial women. It focuses mostly on risks to poor women. It is hoped that the results of the study will contribute to improving services for professional and entrepreneurial women. You may personally find that our conversation provides you with new knowledge and awareness about HIV/AIDS.

PAYMENT FOR PARTICIPATION

In appreciation of the time and information you provide, you will receive Tsh. 13,000/=.

CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential. To ensure this, the written data produced, as well as my notes, will be identified by a name that you choose (not your true name). True names or identifying data will not be used in my research drafts or in the main published products of the research. The digital information produced in my study

(audio and written files) will be kept in a password protected computer. The hard copies of these files will be kept locked in a secure location. After the study is completed and I have defended my dissertation, all hard copies of data will be erased (audio tapes) and the documents will be shredded. Electronic copies of data will be kept in a stand-alone computer with password protected access. All data will be destroyed 3 years after I have defended my doctoral dissertation

Preferred Name to be used in the report _____

PARTICIPATION AND WITHDRAWAL

You can choose to be part of this study or not. If you volunteer to participate in this study, you may withdraw within 24 hours from the time the interview was conducted. Should you withdraw from the research; all information collected from you will be destroyed and completely removed from the results of the study. You may also refuse to answer any questions you do not want to answer and still remain in the study.

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SUBSEQUENT USE OF DATA

This data may be used in future studies as well as in this one.

RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. If you have questions regarding your rights as a research subject, contact: Research Ethics Coordinator, University of Windsor, Windsor, Ontario N9B 3P4; Telephone: +1519-253-3000, ext. 3948; e-mail: ethics@uwindsor.ca.

SIGNATURE OF RESEARCH SUBJECT/LEGAL REPRESENTATIVE

I understand the information provided for the study**:** HIV/AIDS Prevention for Middle Class Women in Dar es Salaam as described herein. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

Name of Subject _____ _____

Signature of Subject Date

SIGNATURE OF INVESTIGATOR

These are the terms under which I will conduct research.

_____ _____

Signature of Investigator Date

IDHINI YA KUSHIRIKI KATIKA UTAFITI

Utafiti Juu ya: Sera na Vitendo Katika Kujikinga na Maambukizi ya Virusi Vya UKIMWI: Wanawake Wenye Kipato na Wasomi Dar es Salaam.

Unaombwa kushiriki katika utafiti utakaofanywa na Neema William Jangu kutoka Chuo Kikuu cha Windsor, Canada (University of Windsor). Ushiriki wako katika utafiti huu utanisaidia katika kukamilisha vigezo vya kuweza kutimiza utafiti utakochangia katika kutunukiwa shahada ya juu.

Kama unamaswali yoyote kuhusu utafiti huu, tafadhari wasialiana na Neema William Jangu. Utafiti huu unafanyika chini ya mwongozo wa Dr. Eleanor Maticka-Tyndale. Na kama kuna maswali zaidi tafadhali wasiliana nae.

LENGO LA UTAFITI

Lengo la utafiti huu ni kuangalia: (a). Sababu mbalimbali ambazo zinachangia katika kuwaweka wanawake wenye kipato na wasomi katika hatari ya maambukizi ya virus vya UKIMWI. Vile vile kuangalia njia ambazo hawa wanawake wanazitumia katika kulinda ujinsia na uzazi salama. (b). Pia kuangalia nafasi ya wanawake wenye kipato na wasomi katika kujizuia na maambuzki na namna ambazo wanahusishwa na mashikirika mbalimbali katika sera na vitendo vya kujikinga na maambukizi ya UKIMWI.

TARATIBU ZA UTAFITI

Kama utakubali kushiriki katika utafiti huu, utaombwa kusoma na kuweka sahihi kwenye form ya kukubari kushiriki. Pia utaombwa kushiriki katika mahojiano ambayo hayatachukua zaidi ya saa moja. Na vile vile kama utakubali mahojiano hayo yatarekodiwa.

HATARI NA USUMBUFU

Hakuna hatari yoyote ambayo inatarajiwa kwa washiriki. Lakini kwasababu tunaongelea juu ya UKIMWI, baadhi ya maswali yanaweza kusababisha usumbufu kwa kukumbusha mambo yaliyopita. Kama usumbufu huu utajitokeza unaruhusiwa kutojibu swali/maswali kama hayo na vilevile unaweza kusitisha mahojiano mara moja.

FAIDA KWA WASHIRIKI NA JAMII

Njia za kuzuia au kujikinga na maabukizi ya UKIMWI hazitilii mkazo mahitaji ya wanawake wenye kipato na wasomi, badala yake zinatilia mkazo kwa wanawake wenye kipato cha chini. Hivyo basi utafiti huu unakusudiwa katika kuchangia huduma mbalimbali hususani kwa wanawake wenye kipato na wasomi. Pia utafiti huu au mahojiano yetu yanaweza kuchangia katika kuleta elimu mpya au ufahamu zaidi juu ya UKIMWI.

MALIPO KWA WASHIRIKI

Katika kukushukuru kwa muda utakoa tumia utapewa Tsh 13, 000/= kama shukurani.

USIRI

Taarifa zozote ambazo zitakusanywa kwenye utafiti huu, ambazo zitakutambulisha wewe kwa namna moja au nyingine zitabaki siri. Ili kuhakikisha taarifa hizi zinabaki siri, taarifa zote zilizokatika maandishi zitatambulishwa na jina ambalo wewe mshikiriki utachagua (tofauti na jina lako halisi). Jina halisi au

taarifa ambazo zitakutambulisha mara moja havitatumika katika uandishi wa ripoti yangu. Taarifa zote zilizorekodiwa pamoja na za maadindishi vitahifadhiwa katika komputa iliyofungwa kwa neno la siri. Machapisho ya taarifa hizi yatahifadhiwa kwenye kisanduku ambacho kitafungwa. Baada ya utafiti kukamilika na nimetetea utfaiti huu, taarifa zote zilizokusanywa na kutumika zitahifadhiwa kwa muda wa miaka 3, tangu nitakapotetea utafiti wangu.

Jina utakalo pendelea litumike katika utafiti huu _____

USHIRIKI NA KUJITOA KATIKA UTAFITI

Unaruhusiwa kuchagua kuwa mshiriki au kutokuwa mshiriki katika utafiti huu. Kama utachagua kushiriki, unaweza kujitoa ndani ya masaa 24 tangu mahojiano yalipofanyika. Kama utajitoa katika utafiti huu, taarifa zako zote zilizokusanywa zitaondolewa na hazitatumika katika uandishi wa utafiti huu. Na vile vile unaweza kuchangua kutojibu swali/maswali yoyote ambayo unadhani hayastahili na ukabaki kuwa mshiriki katika utafiti huu.

MATOKEO YA UTAFITI KWA WASHIRIKI

Washiriki wote watapewa nakala ya utafiti huu baada ya kukamilika. Tarehe 01/06/2014 utafiti huu utapatika katika tovuti ya chuo kikuu cha Windsor –University of Windsor Research Ethics Board http://www.uwindsor.ca/reb. kwa mshiriki asiye na mtandao wa intaneti, nakala itatumwa kwa njia ya posta.

MATUMIZI YA TAARIFA ZA UTAFITI HUU KATIKA TAFITI NYINGINE

Taarifa hizi zinaweza kutumika katika tafiti nyingine zitakazofanyika mbeleni.

HAKI KWA WASHIRIKI

Unaweza kujitoa katika utafiti huu wakati wowote bila adhabu yoyote. Kama unamaswali yoyote kuhusu utafiti huu kuhusu haki zako kama mshiriki, tafadahri wasiliana na Research Ethics Coordinator, University of Windsor, Windsor, Ontario N9B 3P4; simu: +1519-253-3000, ext. 3948; barua pepe: ethics@uwindsor.ca.

SAHIHI YA MSHIRIKI/MSHIRIKI

Naelewa kuwa taarifa nilizopewa kwenye utafiti**:** Sera na Vitendo Katika Kujikinga na Maambukizi ya Virusi Vya UKIMWI: Wanawake Wenye Kipato cha Juu na cha Kati Dar es Salaam. Nimeridhishwa na majibu yaliyotolewa kwa maswali yangu na ninakubari kushiriki katika utafiti huu. Nimepewa nakala ya fomu hii

Jina la Mshiriki_____ _____

Sahihi ya Mshiriki Tarehe

SAHIHI YA MTAFITI

Haya ni mashariti ambayo yatazingatiwa katika utafiti huu

_____ _____

Sahihi ya Mtafiti **Tarehe**

APPENDIX F: OFFICIALS INTERVIEW GUIDE

1. Introduction

- Please tell me a little bit about yourself (Name that you would like me to use in this interview, how long have you been working with the organization, and what is your position/roles/responsibilities in the organization?)
- Can you please tell me about your organization? How long has it been operating? What is the scope of your operations? What regions are you covering?
- Is there any specific population that your organization is targeting? Why this particular population?

2. Factors contributing to HIV/AIDS among middle class women

- *Tanzania without HIV/AIDS is Possible* "Tanzania Bila UKIMWI Inawezekana" what measures have been taken to realize/achieve this national policy objective?
- What specific roles does your organization play in the HIV/AIDS prevention? What services do you offer? Who benefits from these services?
- How vulnerable are professional and entrepreneurial women if compared with lower class women? What is the same/similar? What is different?
- The ministry of health has published these graphs to show rates of infection among men and women of different wealth and levels of education. What does this reveal/explain in terms of HIV/AIDS prevention measures (see graphs at the end of the interview questions)?
- What caused the higher infection rate among wealth women than men?
- What might have triggered the higher prevalence rate among wealthy women? What about better educated women?
- What does this mean in terms of services and programs related to HIV/AIDS interventions? How would services be the same/different for women of higher wealth and education?
- Do you know of any other organizations that provide HIV/AIDS prevention services for professional and entrepreneurial women? Which are they? Or does your organization collaborate with other organization?

3. Now I want to talk to you more about specific, HIV/AIDS Prevention Services

- What does your organization offer to women who are not infected with HIV? How do you reach these women? And in what ways does the organization make these services available to women?
- What prevention methods does your organization promote for married women? How do you reconcile child bearing roles with HIV/AIDS prevention strategies?
- What are some of the challenges women face in preventing infection?

- Where do you place professional and entrepreneurial women in your HIV/AIDS prevention strategies?
- How about men who are not infected? What services do you offer? And how does your organization reach men?
- How easy /difficult is it for men to participate in HIV/AIDS prevention programs? What about women?
- What are some of the challenges men face in prevention?
- What is required in controlling the spread of HIV/AIDS among professional and entreprenurial women in Tanzania?
- What changes do you suggest that can improve the available HIV/AIDS prevention services in Tanzania?

4. Sexual and Reproductive Health

- Tell me about the sexual and reproductive health services you offer to women?
- How do these relate to HIV/AIDS prevention?
- Has your organization ever thought of involving men in HIV/AIDS prevention in relation to sexual and reproductive health?

5. Who are the influential decision makers on what services to offer on what population groups? Do you have any idea about how these decisions are determined or made?
6. The Tanzania national AIDS policy suggests that this policy will be subject to review from time to time in addressing other emerging issues. When was the policy last reviewed and or revised? What are the changes that are included in the policy?
7. The Tanzania national AIDS policy note that "the objective in the national response will be effectively realized through community based comprehensive approach" How is the community involved in your programs?
8. Most of the health policies such as the National HIV/AIDS policy and the NMSF suggests HIV prevention be focused on the most at risk groups? Who are the most at risk groups and how do you reach them? What available prevention strategies does your organization promote for them?
9. In the current HIV prevention strategies there is an overwhelming focus on the youth, how does this equip them to their adulthood?
10. As an organization, do you have any access to health policies such as the National AIDS policy? How does this guide your HIV prevention interventions? Who distributes this policy to you?
11. The NMSF 2009-2012 suggests that there is "inconsistent alignment of HIV prevention programs to the drivers of the epidemic, including intervention content as well as geographic and audience targeting" (p.7). What does your organization do to deal with these issues?
12. What are the success stories of your organization? And what are the challenges? What are your priorities in the coming years?

Officials Interview guide (Swahili)

1. **Utangulizi**
    - Tafadhali ningependa kukufahamu (jina gani utapenda kutumia, muda gani umekuwa ukifanya kazi hapa na ni ngazi gani unashikilia). Tafadhali nieleze kuhusu shirika hili, lini limeanza kazi na ni huduma gani mnatoa kwa makundi gani ya watu, na mpo ktk mikoa mingapi?
2. **Sababu zinazochangia katika maambukizi ya UKIMWI**
    - "Tanzania Bila Ukimwi, inawezekana" ni sera ambayo inaungwa mkono na serikali, je ni hatua gani mmechukua kuhakikisha hii sera ya taifa inafanikiwa?
    - Je nini kazi ya shirika hili katika kuzuia maambukizi ya UKIMWI? Huduma gani mnatoa? Na watu gani wanafaidika na huduma zenu?
    - Je unadhani wanawake wenye kipato cha juu wako kwenye hatari kubwa ya maambukizi kuliko wanawake wenye kipato cha chini? Vitu gani vinafanana na vipi vinatofautiana kati ya haya makundi mawili kuhusiana na maambuki ya Ukimwi?
    - Wizara ya afya, imechapisha hizi chati, kuonyesha maambukizi ya UKIMWI miongoni mwa wanawake na wanaume wenye kipato na elimu ya juu. Nini maoni yako? Watu gani wanaongoza kwa maambukizi na kwanini?
    - Kwanini unadhani maambukizi yako juu kwa wanawake wenye kipato cha juu kuliko wanaume wenye kipato cha juu? Nini unadhani kimepelekea maambukizi kuwa juu kati ya wanawake wenye kipato cha juu? Na vipi kuhusu wanawake wenye elimu ya juu?
    - Je hii inamaanisha nini katika utoaji wa huduma na mipango ya kuzuia UKIMWI? Namna gani huduma zinaweza kuwa sawa kwa wanawake wenye kipato cha juu na elimu ya juu? Au namna gani huduma zinakuwa tofauti tukilinganisha na wanawake wasio na kipato au wenye kipato cha chini?
    - Je unafahamu kama kuna mashirika mengine ambayo yanatoa huduma kwa wanawake wenye kipato cha juu na wasomi? Ni mashirika gani amaboyo au vikundi gani ambavyo yamejihusisha na kundi hili?
3. **Huduma mbalimbali za UKIMWI**
    - Ni huduma gani ambazo shirika lako linatoa kwa wanawake ambao hawajaathirika? Je kuna mchakato gani wa kuwafikia hawa watu? Ni njia gani mnazitumia kuhakisha hawa wanawake wanapata hizi huduma?
    - Je ni huduma gani mnatangaza kwa wanawake walioolewa? Mnawashauri nini wanawake wanaohitaji kuzaa, na wakati huo huo wanatakiwa kujikinga na maambukizi ya UKIMWI?
    - Je ni mambo gani wanawake wanakumbana nayo katika kujilinda na maambuzi ya UKIMWI?
    - Je nafasi gani wanawake wenye kipato na wasomi utawaweka katika mipango na sera zenu za kujikinga na UKIMWI?

- Je wanaume ambao hawajaathirika? Ni huduma gani mnatoa? Na mnawafikia vipi? Je kuna urahisi au ugumu katika kuhakikisha wanaume wanashiriki katika kujinga na maambukizi? Vipi kuhusu wanawake? Je ni vikwazo gani wanaume wanakumbana navyo katika kujikinga na UKIMWI?
- Je unadhani nini kinahitajika katika kuhakikisha maambukizi ya UKIMWI yanakomeshwa miongoni mwa wanawake wenye kipato na wasomi?
- Je ni mabadiliko gani utapenda kuyaona ili kuboresha mapambano zidi ya UKIMWI nchini?

4. **Ujinisa, Afya na Uzazi Salama**
    - Je ni huduma zipi za uzazi salama ambazo shirika lako linatoa kwa wanawake? Je huduma hizi zinahusiana nini na mapambano zidi ya UKIMWI?
    - Je shirika lako limewahi kufikiria kuwahusisha wanaume katika vita zidi ya UKIMWI, ujinsia na Uzazi salama?
5. Je ni watu gani au mashirika gani yanafanya maamuzi juu ya huduma zinazotolewa na kwa watu wapi? Je unamawazo yoyote juu ya namna maamuzi haya yanavyofikiwa?
6. Sera ya Taifa ya Ukimwi imetayarishwa kwa kuzingatia kuendelea kufanyiwa mabadiliko kutokana na matukio yanayojitokeza. Ni lini au mwaka gani kwa mara ya mwisho sera hii ilithiminiwa na kufanyiwa mabadiliko. Na ni mabadiliko yapi yaliyofanyika kwenye sera hii?
7. Sera ya taifa ya Ukimwi inaelekeza kuwa “ni uwajibikaji wa serikali utakuwa na ufanisi pale ambapo jamii imeshirikishwa kikamilifu? Ni kwa jinsi gani jamii zinahusishwa kufanikisha lengo hili?
8. Sera zilozo nyingi za afya kama vile Sera ya Taifa ya Ukimwi na mkakati wa kupunguza maambukizi na madhara ya UKIMWI (NMSF), zinazingatia umuhimu wa kuzuia maumbiki kwa makundi yaliyo kwenye hatari zaidi? Ni makundi gani ambayo yapo kwenye hatari zaidi? Na ni njia zipii zinatumika kuyashirikisha haya makundi? Na ni njia gani zinatumiwa na taasisi yako kwa ajili ya kuyashirikisha makundi ya watu yaliyo kwenye hatari zaidi ya maambukizi?
9. Mipango iliyopo kwa sasa kuzuia maambukizi imeelekezwa zaidi kwa vijana. Ni kwa jinsi gani mpango huu unawaandaa vijana katika maisha yao ya utu uzima?
10. Una maoni gani kuhusiana na upatikanaji wa sera za afya kama vile Sera ya Taifa ya Ukimwi kwa taasisi yako? Na je sera hii inatoa muongozo gani kwa taasisi yako katika mipango ya kuzuia maambukizi ya Ukimwi? Na ni nani ambaye husambaza sera hizi kwa taasisi kama yako.
11. Mpango shirikishi wa Taifa kwa Taasisi mbalimbali kudhibiti ukimmwi kwa kipindi cha 2009 -2012 unafafanua kuwepo kwa, “tofauti ya mipango ya kuzuia kuenea kwa ugonjwa wa UKIMWI na sababu zinazopelekea kuenea kwa UKIMWI, hususani mwongozo wa kukabiliana na tatizo ikiwa ni pamoja na kuzingatia maeneo na makundi yanayotakiwa kupewa kipaumbele". Je taasisi yako inazingatia vipi hili suala?
12. Je ni mafanikio gani ambayo mmeyapata? Je ni vikwazo gani ambavyo mnakumbana navyo? Je nini malengo yenu kwa miaka ijayo?

APPENDIX G: PEW INTERVIEW GUIDE

1. Introduction

- Can you please tell me a little bit about yourself? (What name would you like me to use in this interview? work –where, education back ground, marital status, number of children if any, living location?)
- For how long have you been living with your partner? Is your partner also working? Where does he work?
- Do you have any idea of how much you partner earns per month (Earns less than Tsh. 500,000/month or more)? What about you?
- Do you or your partner have any other source of income apart from the work you have, such as a business?
- Who takes care of the family/household responsibilities such as buying food, paying rent?

2. Factors contributing to HIV/AIDS

- When and how did you first know about the AIDS epidemic, if you can remember?
- What images come in your mind when you think of HIV/AIDS?
- It is argued that women are most affected by HIV/AIDS, what do you think are the factors that make us vulnerable?
- There is a presupposition that prostitutes are the main transmitters of HIV/AIDS. What can you say about this?
- What images do we have for poor women in relation to HIV/AIDS? Can we say that poverty is making them vulnerable to the epidemic?
- What image do we have for women who pay young boys to have sex with them, and other women talking about having *an extra partner* "Mwanamke kidumu"? What can you say about these women?
- The ministry of health has published these graphs to show rates of HIV infection among different men and women of different wealth and education
- What group do you think have the higher infection rate? The educated/uneducated, the wealth/poor?
- What do you think might have triggered the higher prevalence rate among wealthy women? What about better educated women?
- Some people suggest that married women get infected by their husbands. What are your views on this issue? Please explain.
- Also for most women to get a job, especially a high paying job, women need to have sex with their bosses. What are your views on this? Do you see this as a contributing factor to the infections?

- We have images of poor women and prostitutes in HIV campaigns, what image would represent wealthy and educated women in the HIV/AIDS epidemic? What are your thoughts on this population in relation to the epidemic?
- Do you see any HIV risks associated with where you currently live (area/place) or where you currently work? What are the risks that you see? How do you overcome such risks?

3. HIV/AIDS prevention

- People believe that women are weak, dependants and are dominated by men, and that sometime makes it difficult for them to negotiate condom use and other safe sex practices with their partners. What are your thoughts on this issue?
- The government is advertising the use of safe *sex practices* "ngono salama" and also there are some advertisements in radios and television such as *If you love your partner you will protect her/him* "Kama kweli unampenda utamlinda", *use condom all the time* "tumia kondom kila wakati". Do you think, women put these saying in practice? Can you please explain.
- How is it easy or difficult to apply these advisements/sayings in our (women) real life experiences? For a person like me and you how can we make this work? Are there any woman/women that you know who practices any of the above?
- ITV has this advertisement *breaking silence between partners* "vunja ukimya, zungumza". This advertisement is meant to encourage partners to talk about sexual and reproductive health. Can you please tell me your experience about talking to your partner about sexual health and reproductive health? How do you influence decisions related to your sexuality, sexual and reproduction?
- There are organizations that have been targeting women and some offer services related to HIV/AIDS, sexual reproduction and health. Which organization do you know that offer such services? Have you ever received/seen any information from any of these organizations? How did you receive the information or where did you see such information?
- Marriage is important aspect in the lives of many Tanzanian women, for example, in my tribe, if you get married you become more respected and your status is raised. Many say marriage protect you from HIV infection. What are your views on this issue? When does marriage protect? When does it not protect?
- Condoms are offered as protection against HIV. But they also prevent conception. How can women protect themselves from HIV/AIDS while fulfilling child bearing responsibilities? What do we need to protect ourselves?

PEW interview Guide (Swahili)

1. **Utangulizi**
   - Tafadhari nifahamishe kuhusu historia ya maisha yako ? (kwa mfano jina, kazi, kiwango chako cha elemu, je umeolewa, una watoto wangapi, na unaishi wapi?)
   - Iwapo umeolewa, ni kwa muda gani umekuwa ukiishi na mumeo? Na je mumeo anafanya kazi gani na wapi?
   - Je unafahamu kipato chake? Kwa makadirio anaweza kuwa anapata kiasi gani cha pato kwa mwezi? (je ni zaidi ya Tsh. 500,000/Kwa mwezi au zaidi)? Wewe je?
   - Je wewe na/au mumeo, mna shughuli nyingine ya kuwapatia kipato?
   - Ni nani kati yenu mwenye jukumu la kulipia gharama za matumizi ya nyumbani, Kwa mfano kodi na manunuzi ya chakula?

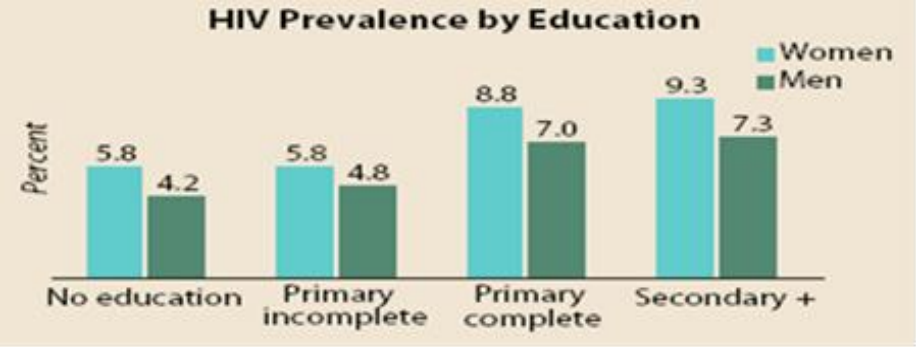
2. **Mambo yanayochangia katika maambukizi ya UKIMWI kwa watu**
   - Je waweza kunifahamisha ni lini ulifahamu kuwepo kwa UKIMWI kwa mara ya kwanza kama unakumbuka?
   - Je ni tafsiri au taswira gani unapata ukifikiri kuhusu UKIMWI?
   - Inasemekana kwamba wanawake wengi wameathrika na UKIMWI kushinda wanaume, je una mawazo gani kuhusiana na nini kinachangia maambukizi kwa wanawake?
   - Mawazo yanayotawala ni kuwa machangudoa ndio chanzo kikubwa cha maambukizi, nini mawazo yako kuhusu suala hili?
   - Ni mawazo gani tuliyonayo kuhusiana na wanawake wenye kipato cha chini au wasio na kipato kuhusiana na UKIMWI? Je ni umasikini ndio unaopelekea maambuzi kwao?
   - Je unamaoni gani kuhusiana wa kuwepo kundi la wanawake wenye kuwalipa vijana wadogo ili wafanye nao mapenzi? Na wengine wanasema wanahitaji mabwana nje ya ndo mfano umewahi sikia wanawake wakisema: “Mwanamke kidumu”? je unamifano yoyote au hadithi kuhusu hawa wanawake?
   - Wizara ya afya, imechapisha chati hizi hapa chini, ambazo zinaonyesha maambukizi ya UKIMWI miongoni mwa wanawake na wanaume wenye kipato na elimu ya juu. Nini maoni yako? Watu gani wanaongoza kwa maambukizi?
   - Kwanini unadhani wanawake wengi wenye kipato cha juu na elimu ya juu wameathirika kuliko wanawake masikini na hata kuliko wanaume wenye kipato na elimu ya juu?
   - Nini unadhani kinaweza kuwa kimechangia katika maambukizi haya kwa wanawake wenye kipato cha juu? Na je vipi kuhusiana na wanawake waliosoma katika hatua mbali mbali?
   - Tunamejijengea picha za wanawake masikini na machangudoa, je ni picha gani zitasimamia wanawake wenye pesa na wasomi katika gonjwa hili la UKIMWI?

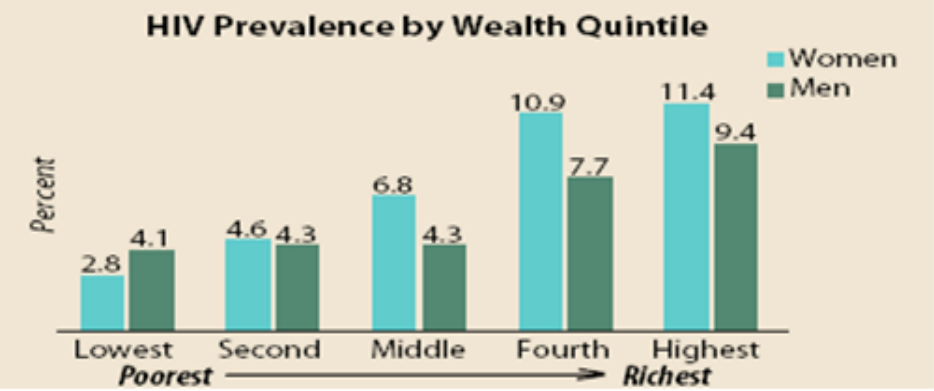
- Je kwa mtizamo wako ni wapi ukilinganisha maeneo ya makazi au maeneo ya kazi ambapo kuna mazingira yaliyo hatarishi kwa maambukizi ya Ukimwi? Na ni mazingira gani yaliyo hatarishi? Na jinsi gani mnakabiliana nayo?

3. Kuzuia maambukizi

- Watu wanaamini kwamba wanawake wengi ni wanyonge, tegemezi na wametawaliwa na wanaume, na wakati mwingine wanashindwa kuwaambiwa waume zao juu ya matumizi ya kinga kama vile kutumia kondom au kufanya ngona salama, nini maoni yako juu ya hili?
- Serikali inasisitiza kuhusu "ngono salama" kuna matangazo pia redioni na kwenye luninga kama vile "Kama kweli unampenda utamlinda", "tumia kondom kila wakati". Je unadhani nini mapokeo ya wanawake kuhusiana na suala hili na matumizi njia hizi?
- Je unaona kuna ugumu au urahisi gani kuyaweka haya matangazo katika vitendo hasa hasa kwa wanawake? Je mimi na wewe tunaweza kuyafanyia kazi katika maisha yetu? Kuna mwanamke yoyote unayemfahamu ambaye alishakufahamisha iwapo anatumia njia hizi?
- ITV kunatangazo linasema "vunja ukimya, zungumza", Je unausemi gani kuhusu hili katika maisha yako? Je matangazo haya yanachangia katika kubadili tabia na mienendo yetu? Au maisha yetu kwa ujumla?
- Kumekuwa na mashirika mbalimbali ya kiserikali na yasiyo ya kiserikali ambayo yamewapa wanawake wengi kipaumbele katika huduma zao hasa na kujinga na maambukizi ya UKIMWI, ujinsia na uzazi salama. Je kunashirika ambalo wewe unalifahamu ambalo lianatoa huduma kama hizi? Nini maoni yako juu ya huduma zao? Wapi sasa unapata huduma kama hizi?
- Ndoa inaonekana kuwa ya muhimu kwa maisha ya watanzania wengi, Mfano kwenye kabila lagu unapoolewa unaheshimika. Wengine wanasema ndoa inasaidia katika kujikinga na maambukizi ya UKIMWI. Nini maoni yako juu ya hili? Wakati gani ndoa itatukinga na wakati igani haitukingi?
- Kondom zinatolewa ilikuzuia maambukizi ya UKIMWI, na vile vile zinasaidia kuzuia mimba zisizo tarajiwa, je wanawake wanohitaji kuzaa watajikinga vipi na UKIMWI? Nini kinahitajika kwa wanawake kujikinga na maambukizi?

Graphs





Source: 2003-2004 Tanzania HIV/AIDS Indicator Survey

APPENDIX H: AUDIO CONSENT FORM

CONSENT FOR AUDIO RECORDING

Research Participant Name: _____

Title of the Project: HIV/AIDS Prevention for Professional and Entreprenurial Women in Dar es Salaam.

I consent to the audio-taping of interviews. I understand this is a voluntary procedure and that I am free to withdraw at any time by requesting that the taping be stopped. I also understand that my name will not be revealed to anyone and that taping will be kept confidential. All the audio taped files will be kept in a stand-alone computer with password protected access and all audio data will be destroyed 3 years after the researcher has defended her doctoral dissertation. I understand that confidentiality will be respected and that the audio tape will be for professional use only.

_____ _____

(Research Participant Signature) (Date)

IDHINI YA KUREKODIWA

Jina la Mshiriki: _____

Jina la utafiti: Sera na Vitendo katika Kujikinga na Maambukizi ya Virusi Vya UKIMWI: Wanawake Wenye Kipato na Wasomi, Dar es Salaam.

Ninatoa idhini ya kurekodiwa wakati wa nohijano. Naelewa kwamba huu ni utaribu wa hiari na kwamba ninaruhusiwa kujitoa katika utafiti huu kwa kuomba kukatisha kurekodi mahojiano yetu. Naelewa pia kwamba jina langu halisi halitaonyeshwa na kutumika ovyo, bali rekodi ya mazungumzo yetu itakuwa siri. Mahojiano yaliyorekodiwa yatahifadhiwa katika komputa ambayo itafungwa kwa neno la siri. Na taarifa zote zitatunzwa kwa muda wa miaka mitatu tangu mtafiti atakapotetea utafiti wake. Naelewa kwamba usiri utaheshimiwa na mahojiano yetu yatatumika kama yalivyo elezwa kwenye barua ya idhini ya kushiriki katika utafiti huu

_____ _____

(Sahihi ya mshiriki katika utafiti) **(Tarehe)**

VITA AUCTORIS

Neema William Jangu was born in 1980 in Mwanza region, Tanzania. In 2002, she graduated from Machame Girls High School in Kilimanjaro, Tanzania. She completed her Bachelor of Arts in Political Science and Public Administration from the University of Dar es Salaam, Tanzania in 2006 and her Masters degree in Social Responsibility from St. Cloud State University, United States of America in 2009. She is currently obtaining her PhD in Sociology at the University of Windsor, Canada.