HIV/AIDS in Tanzania: Gender Based Structural Interventions

Susan Mlangwa and Ann Meier, University of Minnesota

Abstract

Current research on AIDS in Africa seeks to integrate both cultural and structural explanations as an alternative to research paradigms that focus on individual behavior. Heavily influenced by developments within interactionist sociology, cultural anthropology, women's studies, and gay and lesbian studies, AIDS research now considers the broader set of social representations and cultural meanings that shape sexual experiences in different contexts. It is unclear, however, if this shift in theory has translated to interventions. With a focus on gender, our project uses program documents and interviews to explore how and the degree to which AIDS prevention programs in Tanzania adopt structural strategies, with a particular interest in gender based structural projects. Informed by a theoretical understanding of gender as a social system, we mapped interventions in Tanzania onto a gender-based intervention typology to see which types of gender-based interventions are most common and how they are implemented. Key findings indicate a significant amount of existing gender based structural programs, which address both systems of social relations and systems of meaning that maintain the gender system in Tanzania. However, our study reveals absence of projects focusing soley on cultural dimensions i.e. systems of meaning. Furthermore, our analysis shows that the many existing gender based programs focus on women. These programs may fail to accommodate the relational context of sex of which men are also involved. Hence, such programs address the shared cultural beliefs outside social relational contexts. These findings contribute to the discussion over the link between HIV/AIDS interventions and broader societal transformations.

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Current research on AIDS in Africa seeks to integrate both cultural and structural explanations as an alternative to research paradigms that focus on individual behavior (Parker 2001). Heavily influenced by developments within interactionist sociology, cultural anthropology, women's studies, and gay and lesbian studies, AIDS research now considers the broader set of social representations and cultural meanings that shape sexual experiences in different contexts. This shift of emphasis from the study of individual behaviors to that of cultural meaning and structural conditions has drawn attention to the socially constructed (and historically changing) identities and communities that shape sexual practice within the flow of collective life. With this new focus, special attention to social determined differentials in power, particularly between females and males and across generations has come to the forefront of AIDS research.

Perhaps most theoretically akin to the idea that cultural and structural forces shape vulnerability to HIV, some scholars have examined and revealed how gendered power relations influence joint fertility decisions (Takyi and Dodoo 2005; Bankole 1995; Mwageni et al 1998; Dodoo and Tempenis 2002). These studies find that women with more power, such as those from matrilineal families (Takyi and Dodoo 2005) or those with higher education (Hollos and Larsen 2004), are better able to influence reproductive decisions. While researchers have begun to incorporate structural and cultural arguments into theories on the causes of the AIDS epidemic, it is not clear if interventions have taken note of this development. Are there gender-based structural or cultural interventions in the field? "Structural interventions are defined as interventions that work by altering the context within which health is produced or reproduced in the social, economic, and political environments that shape and constrain individual, community

and societal health outcomes" (Blankenship et al. 2000:11), while a cultural intervention seeks to transform social constructions of masculinity and femininity and the power relations implicit in their definitions (WHO 2003). In general, there has been little success in lowering the HIV/AIDS rates in Africa. This may be due in part to an overwhelming focus of interventions on changing individual behavior rather than changing norms, values, and power relations that reproduce and perpetuate risky behaviors.

With a focus on gender, our project explores the degree to which AIDS prevention programs in Tanzania adopt structural and/or cultural strategies, and we investigate how such programs are implemented. The Tanzanian case is especially instructive because it has a higher than average HIV prevalence rate in Africa (UNAIDS/WHO 2005). Tanzania is home to a large number of AIDS intervention programs that are funded and/or administered by various sources. Yet, until now, there was no register of programs with information designating their focus as structural or cultural versus individual, and no systematic detail on the degree to which programs incorporate gender.

HIV/AIDS in East Africa

About two-thirds of all people infected with HIV live in sub-Saharan Africa, and 72 percent of people who die from AIDS are from this region. HIV prevalence and death rates are thus disproportionately high – adult prevalence in the region is *five times* the worldwide prevalence rate (UNAIDS 2006). Those infected with HIV in sub-Saharan Africa have contracted the virus almost exclusively through heterosexual sexual contact, not via injection drug use or men having sex with men which are proportionately large sources of HIV infection in Eastern Europe, Central Asia, and Latin America. Within sub-Saharan Africa, East Africa has HIV prevalence above average yet not as high as southern parts of the region where prevalence rates reach 20 to 30 percent of the adult population (e.g. Lesotho, Botswana, South Africa).

Within East Africa, Tanzania has higher than average HIV prevalence – about 7 percent of the adult population is infected (TACAIDS 2005). Areas in Tanzania that had particularly high infection rates have seen some declining trends, but rates remain above average for the region (Lugalla et al 2004). Despite increased intervention efforts, rates in Tanzania have remained stable in recent years.

Uganda, Tanzania's neighbor to the north, is often touted as a success story of the late 1990's for lowering HIV prevalence in part through its ABC campaign (Abstain, Be faithful, use Condoms) which focused on behavioral change. However, recent evidence hints at possible erosion of these gains (UNAIDS 2006). This raises the question of whether or not improvements garnered through interventions aimed at behavioral change can be sustained long after exposure to the intervention. A unique feature of the AIDS epidemic in Tanzania and Uganda is its class gradient. In Tanzania, infection rates are three times higher among those in the highest wealth quintile (11% for women and 9% for men) than those in the lowest wealth quintile (3% for women and 4%) for men (TACAIDS 2005). This suggests that economic structural conditions may not drive risky behavior. Perhaps cultural meanings are a more likely source.

Gender Relations in East Africa

Among sexually active adults, condom use is the most common means of protection against HIV infection or transmission. Thus, the degree to which gender shapes condom use and negotiations over sexual matters more generally become key research questions. Here we can learn from the literature on if and how differences between husbands and wives in fertility preferences influence the use of contraception. Before we look specifically at this literature, it is important to briefly sketch the African cultural context as it relates to gender for unfamiliar readers.

Two aspects of the African family system are especially important to gender relationships. First, in most areas of Africa, the family system is patrilineal, meaning that the male line of decent is favored over the female line. This has implications for specific practices like the inheritance system, but also shapes gender relations more generally such that men have more power than women (Dodoo and van Landewijk 1996; Takyi and Dodoo 2005). Second, the African family favors lineage ties over conjugal family ties (Caldwell and Caldwell 1990). This means that ties to one's parents and children are often more important than ties to one's spouse. Thus, partner preferences regarding relationship decisions do not hold as much sway as is typical where conjugal ties are paramount to lineage (Dodoo 1998). In combination with a patrilineal society, this translates into relatively little power for women in family decision making. Finally, development policies of the 1990s in some parts of sub-Saharan Africa generated more resources for men, and this is hypothesized to exacerbate women's already weak position relative to men (Haddad 1991) Thus, structural and cultural features of African society put men in a favored position relative to women. While circumstances such as education and employment opportunities are gradually changing in women's favor, especially in urban areas, the class gradient in HIV rates indicates that socio-economic gains do not translated into lower risk.

The literature on the ability to realize fertility preferences offers some keen empirical insights regarding the influence of gender in the cultural context of sub-Saharan Africa. Early studies that explored fertility preferences revealed that sub-Saharan African women had more children than they wanted. Moreover, almost one-third of women who reported a desire to stop or delay having children did not use contraception (Bongaarts 1991; Westoff 1988). The discovery of this gap, commonly known as the KAP-gap or the unmet need for contraception, motivated the implementation of family planning programs to provide women with contraception that would help them realize their fertility goals (Dodoo and van Landewijk 1996). However,

early studies were based only on women's reports of fertility preferences. Given the important cultural features that put women at a power disadvantage in relationships, it is perhaps no surprise that women were not able to realize their preferences especially since men generally reported wanting to continue having children (Dodoo and Seal 1994; Mott and Mott 1985). More recent studies examine the joint preferences of men and women. In general, these studies find that condom use is highest when both partners want to stop having children (Dodoo and van Landewijk 1996; Dodoo 1998; Bankole 1995) and when both partners are better educated (Egero and Larsson 1999; Hollos and Larsen 2003), but when there is disagreement between partners, men's desires are substantially more likely to influence couple contraceptive behavior (Dodoo and van Landewijk 1996; Dodoo 1998; Bankole 1995).

Studies that examine variation in the cultural context show that women's ability to realize fertility preferences varies by how 'traditional' the community is. For example, in rural areas of Kenya where the gender organization of families is more traditional, women have less power over contraceptive use than in less 'traditional' urban areas (Dodoo and Tempenis 2002). Some of the increased power for women in related to urbanicity can be explained by couples having relatively the same level of education and income and are of the Christian religion (Hollos and Larsen 2004). Furthermore, in less traditional matrilineal communities in Ghana, women have more power over contraceptive use than their more traditional patrilineal counterpart communities in the country (Takyi and Dodoo 2005).

In Tanzania, women's access to education, their growing participation in formal employment, and their central role for sustaining households in the wake of the Tanzanian economic crisis of 1980's, are among the factors that have contributed to gradually improve the negotiating power of women in marriages. However, in spite of this, childbearing and sexuality

decisions still rest with males. Economic liberalization in the aftermath of the economic crisis and serious land shortages constitute the main driving forces for a transition to smaller families (Mwageni et al 1998; Egero and Larson 1999)Thus, when Tanzanian men put the idea of family planning into practice, it is usually in recognition of the economic costs of children, not because they have adopted new ideas about masculinity.

The same gendered power structure that influences reproductive decisions can easily be applied to the ability to negotiate conditions of sexual relations to prevent HIV infection or transmission. Several factors may make the preferences of men and women misaligned with regard to sexual relations and the risk of HIV. First, women are more biologically susceptible to HIV infection than men (WHO 2003), thus they may be more motivated to protect against it. Second, men more often report an aversion to condom use, one of the most effective means to prevent infection, because it is believed to inhibit intimacy and pleasure during sex (Caldwell 2001; Kapiga and Lugalla 2002). Third, several scholars note a hegemonic masculinity based on a set of beliefs that males are biologically programmed to need sex, often from more than one woman, and that sexual health-seeking behavior is unmanly (Orubuloye et al 1997; Mwaluko et al 2003; Kapiga and Lugalla 2002). Such beliefs may undermine efforts that promote abstinence and faithfulness among men and thus heighten the risk of HIV infection. For all of these reasons, relative to women, men probably prefer more frequent sexual relations, are more likely to have multiple partners, and are less likely to want to use a condom. If the cultural and structural context of society favors men as it does, men are more likely to realize these preferences.

A Framework for Gender-based Interventions

Gender theorists have re-conceptualized gender from an identity or role to an institutionalized system that categorizes people as men or women and organizes social relations

unequally on the basis of this categorization (Ridgeway and Smith-Lovin 1999; Risman 2004). This re-conceptualization suggests that widely shared *hegemonic cultural beliefs* about gender and their impact on s*ocial relational contexts* are among the core components that maintain or change the gender system (Ridgeway and Correll 2004). The idea that cultural beliefs impact social interactions by shaping the context of these interactions suggests that the gender system operates on multiple levels from the individual level (e.g. individuals define themselves in relation to others) to the interactional level (e.g. social interactions are shaped by beliefs about gender) to the institutional level (e.g. cultural beliefs and the distribution of resources according to these beliefs are assumed by organizations and structures) (Ridgeway and Correll 2004).

Across most societies, women and men differ in the resources and opportunities granted to them, and in normative ideas of masculinity and femininity to which they are expected to adhere. However, within and across societies, there are many different resource arrangements and definitions of masculinity and femininity that vary by time, social class, race/ethnicity, sexuality, and age. This variability indicates that modifications in gender based structural systems and cultural definitions are possible (WHO 2003).

A WHO report (2003) on integrating gender into HIV/AIDS programs suggests a typology of gender-based HIV/AIDS interventions that range in the degree to which they attempt to alter the roots of the gender imbalance in society. The four types of gender-based interventions suggested by the report are: gender segregate programs; gender sensitive programs; gender transformative programs; and empowering programs. *Gender segregate programs* are interventions that provide separate programming for men and women, but do not consider the relational interaction between them. As one example, programs that focus on mother to infant transmission of HIV usually do not include men or discussions about the male role in influencing their partner's thoughts, attitudes, or behaviors. Other gender segregate programs offer separate

programs for men and women on condom use, but do not address the relational aspects of the sexual exchange.

Gender sensitive programs are interventions which recognize that "the prevention, care, treatment, and support needs of men and women are often different, not only because of physiological differences, but more importantly, because the context of gender roles and relations substantially influences how men and women will respond to initiatives designed to reduce risk or vulnerability or to alleviate the impact of AIDS" (WHO 2003). Educational messages about prevention that recognize the gender power imbalance are one example of this type of programming. Programs that promote the development of female-controlled prevention technologies are also examples of gender sensitive approaches. While gender sensitive programs address gender by acknowledging differences in power, they usually do not attempt to change the conditions that create gender-related differences in the first place (WHO 2003).

Gender transformative programs "seek to transform gender roles and create more gender-equitable relationships. These programs extend gender sensitive approaches because they seek to change the underlying conditions that cause gender inequities" (WHO 2003). They consider both men and women important in combating HIV/AIDS, and as such, they attempt to reach both genders. An example of a gender transformative program is one that uses drama to stimulate discussions among participants about challenging dominate norms of masculinity and femininity (WHO 2003). These types of programs directly address relational contexts that evoke hegemonic gender beliefs which influence people's sexual relationships and their evaluations of themselves and others in gender-typical ways (Ridgeway and Correll 2004).

Finally, *empowering programs* are those that seek to equalize the gender balance of power in areas outside the domain of sexuality in order to ultimately reduce vulnerability to HIV (WHO 2003). For example, micro finance projects for women seek to enhance their status in

society by helping to generate income. It is believed that this general increase in power will diffuse to their relationships with men, and eventually increase women's power in matters of sexual decision making.

Of these types, gender segregate programs are the least structural or cultural in nature because they treat gender as a role or identity rather than an institution or social system. Gender sensitive programs are slightly more structural or cultural because they recognize a gender power imbalance. Gender transformative programs are the most cultural in nature, and empowering programs are somewhat more structural. Are there gender-based programs in Tanzania? If so, how are they distributed in this typology? While the WHO (2003) typology implicitly suggests that most programs will fit into one these four categories, we believe that many programs will contain elements of multiple categories. Do most programs that incorporate gender fit neatly and exclusively into one of these categories? Do programs reflect the theoretical notions of gender as a structural system? If so, how do they attempt to change the gender system?

Present Study

In this study we assess the degree to which interventions aimed at dealing with HIV/AIDS have adopted gender-based strategies in Tanzania. First, we describe the prevalence of interventions which are based exclusively or in part on structural or cultural strategies. We examine the characteristics of these programs such as their geographic reach, target population and funding source. Then, among structural or cultural strategies, we report the prevalence of programs with gender-based elements. Finally, in keeping with our theoretical understanding of gender as a social system, we map interventions in Tanzania onto the gender-based intervention typology offered by the WHO report (2003) to see which types of gender-based interventions are most common. We examine in some detail the content of those gender-based interventions that

aim to change the cultural or structural features of Tanzanian society—transformative or empowering interventions.

Data & Methods

We use printed and internet materials from 83 HIV/AIDS intervention programs and a few interviews with key persons in Tanzanian HIV/AIDS prevention. We identify most intervention programs from a fairly comprehensive database of HIV interventions maintained by the Tanzanian Commission for AIDS (TACAIDS). The interviews with key persons were conducted by the lead author in the summer of 2006 to learn of additional programs and to augment the information gleaned from the printed and internet material for other programs. With these data, we have created an inventory of AIDS prevention programs in Tanzania, and coded data for key program features such as: geographic reach, target populations, funding source, and other elements. Importantly, we code for the individual, structural, or cultural nature of the program, and the ways in which gender is incorporated into programming. Below we describe the state of programmatic affairs and examine in some depth several programs that have unique and promising gender-based interventions.

Results

Table 1 describes the prevalence of programs that focus on changing individual behavior, features of the culture, or features of the structure of Tanzanian society. Many programs have multiple foci, or operate to change both behavior and structural features of society, for example. The top panel of Table 1 shows that most programs have some element that focuses on changing individual behavior (about 70 percent). Thus, as expected, it is quite common for programs to attempt to change individuals' behavior to lower the risk of HIV infection or transmission. Just over half of the intervention programs have a structural element whose objective is not to change cultural norms. That is, they attempt to change some structural feature of society that puts

individuals at risk for HIV. For example, these programs may focus on improving educational opportunities for young people or providing micro-financing to entrepreneurs for small businesses establishment. These examples are ones where positive opportunities can indirectly minimize the risk of HIV infection by enhancing knowledge and/or providing alternative futures. Only about one-third of programs (36 percent) contain a cultural element. That is, fewer programs attempt to change the cultural context that creates vulnerabilities to HIV/AIDS.

Table 1: Prevalence of Individual Behavioral, Structural, and Cultural Elements in Intervention Programs

Program has a:	Percent
Individual behavioral element	69.0
Structural element	55.8
Cultural element	35.6

Program has component elements:	Percent
behavioral only	31.3
structural only	21.7
cultural only	0.0
behavioral and structural	10.8
behavioral and cultural	13.3
structural and cultural	9.6
behavioral, structural, cultural	13.3
Total	100

The second panel of Table 1 shows how programs combine these three elements – behavioral, structural, and cultural. Here we see that almost one-third of programs (31 percent) focus exclusively on changing individual behavior. About 20 percent of programs focus exclusively on changing the structural environment. Surprisingly, none of the 83 programs assessed deal exclusively with cultural features that support a high risk environment for HIV/AIDS. However, cultural elements are combined with behavioral and structural elements in some programs. For example, 13 percent of programs couple behavioral and cultural elements;

10 percent couple structural and cultural elements; and 13 percent combine all three elements. The remaining 11 percent of programs combine behavioral and structural features.

When taken as a whole, we can see that just over half of programs have a single focus, and usually this focus is on changing individual behavior. When programs are multi-faceted, behavioral change continues to figure prominently. Cultural elements appear in programs, but always in combination with other foci – behavior and structural. They are never the sole focus of the intervention program.

Unfortunately, from the printed and web-based material it is difficult for us to know the relative weight of each element when they are combined in programs. For a few of the programs where we feel we have enough information to know which of the foci is primary for the program, it appears that when combined, the behavioral element is often show-cased more in the printed material. While we cannot be sure if this reflects actual programming, it suggests that even when combined with other program elements, changing behavior is a prominent motive.

We find it interesting that there are no culture-only focused programs, especially since the scholarly literature has suggested that cultural and structural features are at the root of the HIV/AIDS epidemic. There are several possible explanations for the lack of cultural-only focused programs. First, culture is a system of meanings. Changing meanings is perhaps a murky endeavor. That is, the methods by which meanings change are not clear. In contrast, there are many models for seeking behavioral change for health benefits (e.g. smoking cessation, exercise promotion, etc). These seem more straightforward. Second, and related to the first issue, it may be difficult to measure the effectiveness of programs that have the goal of changing meanings of masculinity and femininity. Because funding is often tied to measurable results, funding for programs that exclusively address cultural change may be difficult to obtain. Finally, changing

meanings and beliefs is a long-term project. Because there is much urgency in efforts to make gains in lowering HIV/AIDS rates, it may be difficult to wait for cultural change to take hold.

Next, because we are interested in the prevalence of behavioral versus structural and/or cultural programs, we divide the programs into two groups: programs with a behavioral focus only and programs with some structural or cultural element. Table 2 shows similarities and differences in these two sorts of programs with regard to program geographic reach, funding, management, curriculum development, and target populations and age groups. First, regarding geographic reach, we see that programs that focus exclusively on individual behavior are slightly more likely to reach across Tanzania, while those that contain structural or cultural elements are slightly more likely to focus more narrowly on a region within the country. Perhaps this is because structural or cultural features are more place-specific. For example, building educational infrastructure (a structural type of focus) may be more of an issue in rural areas than urban areas. Thus, programs with goals of altering structural features may work best if they focus on the structural context in a specific region of the country.

Table 2: Description of Programs by Individual Only v. Those with Structural or Cultural Elements

	Program Focus	
	Individual Behavior Focus Only	Structural or Cultural Element
	n=26	n=57
Program Geographic Reach		
Country-wide	36.0	32.1
Regional	56.0	67.9
Other	8.0	0.0
Total %	100.0	100.0
Program Funding		
foreign funding	73.1	72.7
local funding	7.7	5.5
both foreign and local	19.2	21.8
Total %	100.0	100.0

Table 2 continued on next page

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	Individual Behavior Focus Only	Structural or Cultural Element
	n=26	n=57
Program Management		
foreign	50.0	64.3
local	7.7	7.1
both foreign and local	42.3	25.0
Total %	100.0	100.0
Program Curriculum		
foreign	30.8	21.1
local	19.2	24.6
both foreign and local	50.0	54.4
Total %	100.0	100.0
Target Population(s)		
general public	19.2	49.1
students	80.8	59.6
young adults	76.9	56.1
persons living with AIDS	16.0	61.4
Target Age Group(s)		
adolescents	80.8	76.8
young adults	65.4	89.3
adults	26.9	75.0
all sexually active ages	53.8	76.4

Next, the general funding source (foreign or local) is almost identical across these two sorts of programs. Foreign funding is the dominant source of funding for both behavioral focused programs and those that seek to address structural or cultural issues. Regarding program management, a small percentage of programs are managed only by local people regardless of program focus (about 7 percent). Structural or cultural programs are more likely than behavioral programs to have foreign-only program management. While half of all behavioral programs have foreign-only management, a relatively large proportion (42 percent) combines foreign and local management. So, in total, 50 percent of behavioral focused programs have some local management (8 + 42), whereas only 32 percent of programs with structural or cultural elements

have some local management (7 + 25). We are somewhat surprised by this, as we suspected that programs that address structural, and especially cultural elements would likely benefit more from local involvement because structural or cultural features require a deep and nuanced understanding of the history and norms of the society. Local people are more likely to have this sort of understanding.

The next program feature we examined was program curriculum. Again, we coded who was responsible for designing the curriculum as foreign, local, or both. Here, our findings are slightly more aligned with our expectations. Behavioral focused programs are slightly more likely to be foreign designed (31 v. 21 percent), whereas programs with structural or cultural elements are slightly more likely to be locally designed (25 v. 19 percent). About half of all programs have curriculum that is jointly designed by foreign and local persons. This fits better with our expectation that structural and cultural focused programs should be more effective if local persons help develop the programs. While program *management* may be foreign, the actual *curriculum* that is delivered to program participants in structural and cultural programs is more likely to be informed at least in part by local voices than it is in behavioral focused programs.

The next two sections address the target populations of programs. Here we expected that programs that have structural or cultural elements will attempt to reach a broader audience because they aim to change general features of society like the educational system or gender norms. Indeed, we find that programs with a structural or cultural element are more than twice as likely to target the general public than programs that focus exclusively on changing individual behavior (49 v. 19 percent). In contrast, programs that focus exclusively on changing individual behavior are more likely to target specific groups like students or young adults, although programs with structural or cultural elements also target these groups to a reasonably large degree. We assessed the degree to which programs targeted people living with AIDS. We found

that this was a much more common target population for programs with structural or cultural elements than for programs that focused exclusively on individual behavior. Upon closer inspection (not shown), persons living with AIDS was a primary target group for structural programs much more often than cultural programs, and the type of structural programs targeted to this group were largely infrastructure building projects (hospitals, schools, orphanages, etc) that would directly help sick people or their families.

Finally, we assess the target age groups for the two types of interventions. Here we see that structural and/or cultural interventions are equally as likely to target adolescents, and more likely to target all other age groups than behavioral interventions. Again, this may have something to do with the broad appeal necessary for structural or cultural changes to take hold in a society.

Next, in Table 3 we turn to the primary interest of our study, the degree to which interventions that have some element of structural or cultural programming engage gender issues. All programs that engage issues of gender are coded as structural or cultural. Of the 57 programs that have some element of structural or cultural programming, 26 of them engage issues of gender. Thus, almost half of all programs that address the structure or culture of society deal in some way with gender. Next, we coded programs that incorporate gender into the four-type schema offered by WHO (2003) – gender segregate, gender sensitive, gender transformative, and empowering programs. Interventions that engage gender issues could have various programs that fit into different types in this schema. For example, an intervention could have one program that is gender sensitive and another that is gender transformative or a single program could employ both gender sensitive and gender transformative strategies. An intervention like this was coded to have both a gender sensitive and a gender transformative program. About one-quarter of the programs that engaged gender issues in some way offered

gender segregate programs. Recall that gender segregate programs are those that simply offer different programming for males and females. By doing so, they are implicitly recognizing gender differences, but not addressing them directly to program participants.

One-third of the interventions offered gender sensitive programming. Recall that this sort of programming explicitly recognizes that the "context of gender roles and relations substantially influences how men and women will respond to initiatives designed to reduce risk or vulnerability or to alleviate the impact of AIDS" (WHO 2003). For example, among the interventions in Tanzania, one gender sensitive intervention is the female condom project by Population Studies international (PSI) which has been running since 1998. This project is sensitive to the gender differential power relations existing in the sexual domain, with men having the upper arm. The female condom aims to give women a chance to decide for themselves to have safe sex, without men. PSI targeted to a greater extent female sex workers, and generally all women.

Table 3: Prevalence of a Gender in Programs with a Structural or Cultural Element

	yes	no
Program deals with gender	45.6	54.4
N	(26)	(31)
If Yes, type of gender programming:	n=26	
Gender Segregate	25.9	74.1
Gender Sensitive	33.3	66.7
Gender Transformative	38.5	61.5
Empowering	80.0	20.0

About 40 percent of interventions that engage issues of gender were coded as gender transformative. Recall that this type of gender program is the most cultural in nature in that it

attempts to change underlying gender norms. An example from our data of this type of intervention is the 'Twende na Wakati' project.[1]

> **Twende na Wakati**
> Twende na Wakati' has been applied to HIV prevention and control in form of popular radio and television soap opera. By role modeling people discussing HIV and family planning, the project intended to stimulate interpersonal communication about AIDS in audience individuals, in order to challenge some of the actions pertaining to how best to live in the AIDS era. The characters in 'Twende na Wakati' were designed to provide negative, transitional and positive role models for HIV prevention behaviors from a local perspective. These include how men only decide whether a couple should use a condom or not, men's continuing extra marital relations, women's silences and beliefs about sex is better without condoms etc. By dramatizing these scenes in context of everyday life this project offers a space to critically discuss prevailing unequal conditions perpetuating gender inequality. Hence this is a gender transformative project as it prompts people *to discuss* how to change conditions creating inequality such as silence is part of femininity and man are expected to have much sex, and forge equitable roles. The aim was for people see themselves in the characters and reflect.

This is a project in the form of a popular radio and television soap opera. It exposes in drama conditions of gender that may lead to sexual risk. This is a gender transformative project becaues it prompts people *to discuss* how to change conditions creating inequality such as the ideas that silence and submissiveness are valued feminine characteristics and having frequent sex is thought to be masculine.

Another project is Kivulini Women's Rights Organization.[2] The Kivulini intervention program aimed to get participants talking about women's rights, the impact of domestic violence, human rights, and HIV/AIDS in the Mwanza community of Tanzania. It is transformative because it challenges conditions of women subordination.

> **Kivulini**

[1] The words 'Tewnde na wakati' means 'Lets go with the times' in Swahili.
[2] Kivulini means in the shade/shelter in Swahili .It implies a safe place where women, men and children fee supported

> Through education sessions, theatre productions, and song and dance, the program attempted to create an awareness of the link between HIV/AIDS and gender based violence and to challenge current attitudes surrounding sexual practices to ensure reduction in the transmission of HIV. The Kivulini women believe that creating violence-free communities involves empowerment of entire communities to promote women's rights. To create an equitable environment for men and women the project attempts to change the conditions allowing violence by supporting women's rights, particularly women's right to live free of violence,by mobilizing the whole community to challenge. Its efforts include the Local Government, Street Leaders and Sungu Sungu (informal community policing). Groups whose close ties to the community, are often the first level of response to women experiencing violence and, as leaders, they deeply influence the environment and culture within communities.

Finally, of all of the interventions that engage gender, a surprising 80 percent are empowering interventions. Empowering interventions are those that address gender inequities in structural features of society (schools, the labor force, health care, etc). These sorts of interventions attempt to alter structural features with the hope of ultimately reducing vulnerability to HIV by increasing women's power and access to interventions, we found that many addressed gender inequities in the areas of emancipative resources (i.e. economic material, knowledge of rights such as legal rights, skills and self esteem building), education, and training. For example, 'Family Care International' helps young people learn about their bodies, develop assertiveness and decision-making skills, and plan for healthy futures. This project is gender empowering because it attempts to equalize power between men and women by affecting the domain of body self knowledge and ability to make own decisions in women who have traditionally depended on men to make decisions for them. This skill is expected to trickle down to gaining the ability to make sound sexual decision-making.

Another project, 'The Girls Talk Project', empowers women by providing micro finance services so that they can generate income for their needs (i.e .to support family) and depend less on men. The project aims to empower women who find themselves unable to stand for circumstances such as gender violence, rape, transactional sex due to poverty. These all amount

to increased vulnerability to AIDS infection. This project is gender empowering because it works at equalizing gender differential power at the economic resources domain.

'Tuseme'[3] project, on the other hand, is a school-based theatre for development initiative. It is a project that it aims to empower girls to understand and overcome problems that can hinder their academic and social development, such as sexual health, teenage pregnancies by providing forums to dialogue day to day issues. It is empowering through self expression skills building.

> **Tuseme**
> Using a performance-based approach, a play, dance, song, puppetry or game drives the process and post performance discussions are held. The project is gender empowering in that it cultivates a habit of dialogue and interpersonal communication amongst women and between men and women from a young age, of different life issues including favorable and unfavorable social norms. The project's objective is that this skill for self expression will trickle down to all areas of life including sexual relations. And a girl and boy will grow up without the social inhibitations of fearing to express themselves as has been with traditionally socialization. (i.e. women speaking about sexual matters, and men speaking about health needs).

Our data revealed an interesting pattern that we did not think to code in our initial workings with the data. Many of the programs that engage gender in Tanzania have used women, not men, as the point of entry into addressing gender issues. In doing so, they assign sexual health issues to be women's issues. Perhaps this is because the marginalized position of women in Tanzania is very vivid. Some of these programs remain locked in the women question, attempting to affect gender change with women alone, while a few proceed to address women and men, from a relational perspective. Among those that do address men, it is often after women or women's issues have first been established as the primary population of interest. Because we did not code our data with this pattern in mind, we do not yet have empirical evidence of this. Our observations are merely suggestive in this regard.

[3] In Swahili, 'Tuseme' means 'Let's speak' and 'Twende na Wakati' means 'Let's go with the times.'

Conclusion and Discussion

Against a backdrop of increased research attention to cultural and structural explanations for the AIDS epidemic, we set out to examine the degree to which intervention programs in Tanzania had followed suit and adopted cultural and structural programming. Furthermore, because of the central role that sexual contact between men and women plays in HIV transmission in sub-Saharan Africa, we wanted to know the prevalence of interventions that acknowledged gender as an important structural or cultural feature.

Our results indicate that interventions that focus on changing individual behavior are more prevalent than those that focus on changing structure or culture. However, a non-trivial proportion of programs contain elements that address changing the structure or culture of the society. Most often, programs that have a structural or cultural focus also have an individual focus. That is, there are relatively few programs that focus exclusively on changing structural elements of society, and none that focus exclusively on changing culture. Where programs have multiple foci, our data do not allow us to say definitively which focus is the primary one or if the program emphasis is shared equally them. However, where it is clear that one foci features more prominently than the others in the printed material we reviewed, it is usually the individual behavioral focus that seems to be given more emphasis. Structural and cultural programs tend to be more regional in their reach (v. national), and they are more often managed solely by foreign persons. Importantly, however, curriculum for these programs is more likely to have at least some local involvement than programs that focus exclusively on changing behavior. Finally, structural and cultural programs are more likely than behavioral programs to target the general public across all age ranges, probably because they are seeking to change things that require large-scale adoption (e.g. definitions of masculinity) in order to sustain real change in a society.

Are gender issues incorporated into structural or cultural interventions? We find that they are – about half of the programs that focus on structure or culture address gender issues (37 percent of all programs studied). *How* gender is incorporated, however, differs across programs. Our analysis indicates that programming that seeks to empower women is the most common sort of gender incorporation. This type of program is inherently structural in nature because it seeks to improve women's participation in many societal institutions that are associated with well-being like education and the labor force. Yet, according to the WHO (2003) typology we have used, empowering programs seek to improve women's situation in society, but do not deal directly with power imbalance in the sphere of sexuality. This is the purview of gender transformative programs. A substantial minority (39 percent) of the programs that engage gender strategies are gender transformative programs. Thus, the most common gender programming strategies are transformative and empowering, and these two types are the most cultural and structural, respectively. From this we can conclude that when gender is incorporated, it is often done so in a way that has the potential to alter structural or cultural features of society. Of particular interest, we noticed that most interventions that take-up the topic of gender use women as their entry point to gender issues.

Tanzanian intervention programs that incorporate gender in some way do not fit neatly in the WHO (2003) typology of gender programs. Instead, we find that most programs contain elements of more than one gender strategy. We are not sure if this is a beneficial or detrimental characteristic of these programs. On the one hand, programs that offer gender sensitive *and* gender transformative elements have the potential to reach people who are in differentially open to various sorts of programming. For example, some program targets may not be willing to accept or work on the idea that men may become less masculine as it is traditionally defined. However, these targets may be interested in adopting female-controlled contraception, a gender-

sensitive program element, in order to reduce their risk of infection. That is, they may recognize the power differential between men and women, but may not be willing to or interested in working to change that differential beyond gaining power through contraceptive control for a particular sexual interaction. Other program participants may be willing and interested in working to change the deeper cultural norms associated with gender. A program that contains both elements can reach both types of targets.

On the other hand, programs that contain multiple gender elements may struggle with competing messages. Advocating for female condom use recognizes power differentials, but in part it enables the continuation of these differentials by simply providing a device that allows women to secretly reduce their vulnerability to risk without having to address broader cultural gender norms. If this program also seeks to change broader cultural issues, these elements may seem in contradiction to one another.

If the current scholarly work that encourages structural and cultural approaches as a means to lower the risk of HIV is right, we can be somewhat encouraged by the fact that some programs are adopting such approaches. Gender relations are key to HIV transmission as most infections happen through sexual contact between men and women. Thus, it is important that any structural and cultural approaches address gender relations. Again, here we find hope in the fact that almost half of the structural and cultural programs incorporate gender, and when they do, they often incorporate it in ways that attempt to change male dominance in interpersonal relations that are likely to apply in sexual negotiation, and/or in ways that increase women's power in other societal institutions like work and school with the hope of eventually increasing their overall power in society. An over-focus on women as the lead to unlearning gender norms that perpetuate unequal sexual negotiations is still predominant.

With regard to our theoretical framework, recall that *shared hegemonic cultural beliefs* about gender and their impact in *social relational contexts* are among the core components that maintain and change the gender system. The programs we have discussed address some of the social relational contexts that maintain sexual gender inequality (i.e. family planning, gender violence, sexual practices and many more). Those that do not, fail to accommodate that sexual risk is a social relational behavioral, hence they address the shared cultural beliefs outside social relational contexts, or do not address cultural beliefs at all.

References

Bankole, Akinrinola 1995. "Desired fertility and fertility behavior among the Yoruba of Nigeria: A study of couple preferences and subsequent fertility." *Population Studies* 49: 317-328.

Blankenship K, Bray S, & Merson M. (2000). Structural interventions in public health. *AIDS*, 14(suppl 1), 11-21.

Caldwell, John C. 2000. "Rethinking the African AIDS Epidemic" *Population and Development Review* 26(1): 117-135.

Caldwell, John C. and Pat Caldwell. 1990. "High Fertility in Sub-Saharan Africa." *Scientific American* 262: 118-125.

Dodoo, F. Nii-Amoo. 1998. "Men Matter: Additive and Interactive Gendered Preferences and Reproductive Behavior in Kenya." *Demography* 35(2): 229-242.

Dodoo, F. Nii-Amoo and Poem van Landewijk. 1996. "Men, Women, and the Fertility Question in Sub-Saharan Africa: An Example from Ghana." *African Studies Review* 39(3): 29-41.

Dodoo, F. Nii-Amoo and A. Seal. 1994. "Explaining Spousal Differences in Reproductive Preferences: A Gender Inequality Approach." *Population and Environment* 15: 379-394.

Dodoo, F. Nii-Amoo and Maria Tempenis. 2002. "Gender, power, and reproduction: Rural urban differences in the relationship between fertility goals and contraceptive use in Kenya."

Rural Sociology 67: 46-70.

Egero, Bertil and Larsson, Rolf. 1999."Is fertility transition possible in traditional patriachal societies? A discussion based on data from Meru, Tanzania." The African Population in the 21st Century, Third African Population Conference, Durban, South Africa.Vol 2: 69-90.

Farmer P, Connors M, Simmons J, eds. 1996. *Women, Poverty, and AIDS: Sex, Drugs and Structural Violence.* Monroe, Maine: Common Courage

Haddad, Lawrence. 1991. "Gender and Poverty in Ghana: A Descriptive Analysis of Selected outcomes and Processes," *IDS Bulletin* 22: 5-16.

Hollos, M and U, Larsen. 2003. Women's empowerment and fertility decline among the Pare of Kilimanjaro region, Northern Tanzania. *Soc Sci Med,* 57(6):1099-115

Hollos, M and U, Larsen. 2004. "Which African men promote smaller families and why? Marital relations and fertility in a Pare community in Northern Tanzania." *Soc Sci Med,* 58(9):1733-49

Kapiga, S. H., and Lugalla, J. L. P. 2002. Sexual behavior patterns and condom use in Tanzania: results from the 1996 Demographic and Health Survey. *AIDS Care*, 14 (4): 455-469

Lugalla, J.L, M. Emmelin, et al. 2004. Social, cultural and sexual behavioural determinants of observed decline in HIV infection trends: lessons from the Kagera Region, Tanzania. Soc Sci & Med, 59(1):185-198.

Mott, F. and S. Mott. 1985. "Household Fertility Decisions in West Africa: A comparison of Male and Female Survey Results." *Studies in Family Planning* 16: 88-99.

Mwageni, Eleuther, Augustine Ankomah, and Richard Powell. 1998. "Attitudes of men towards

family planning in Mbeya region, Tanzania: A rural-urban comparison of qualitative data."*J biosoc.Sci,* 30: 381-392.

Mwaluko, G. Urassa M, Isingo R, Zaba, and B. Boerma J.T. 2003.Trends in HIV and sexual behavior in a longitudinal study in a rural population inTanzania, 1994-2000.*AIDS*, 17 (18:2645-51

Orubuloye, I.O., John C. Caldwell, and Pat Caldwell. 1997. "Perceived male sexual needs and male sexual behavior in southwest Nigeria," *Social Science and Medicine* 37(7): 859-872.

Parker, Richard 2001 Sexuality, Culture and Power in HIV/AIDS Research. *Annual Review of Anthropology 30: 163-179.*

Ridgeway, Cecilia. & Smith-Lovin L. 1999. The Gender System and Interaction. *Annual Review of Sociology*, 25:191-216

Ridgeway, Cecilia L. and Shelley J. (2004). Unpacking the Gender System: A Theoretical Perspective on Gender Beliefs and Social Relations. *Gender & Society*, 18(4):510-531

Risman, Barbara J. (2004) Gender As a Social Structure: Theory Wrestling with Activism. *Gender & Society*, 8(4): 429-450

Singer M, ed. 1998. *The Political Economy of AIDS.* Amityville, NY: Baywood.

Tanzania Commission for AIDS (TACAIDS), USAID., National Bureau of Statistics., Development Cooperation Ireland (2005). Tanzania HIV/AIDS Indicator Survey 2003-04. Calverton, Maryland, USA: TACAIDS, NBS, and ORC Macro.

Takyi, Baffour K. and Francis Nii-Amoo Dodoo. 2005. "Gender, Lineage, and Fertility-Related Outcomes in Ghana. *Journal of Marriage and the Family* 67: 251-57.

UNAIDS 2006. "AIDS epidemic update: special report on HIV/AIDS: December 2006." Geneva: Switzerland. http://www.unaids.org/en/HIV_data/epi2006/default.asp, accessed

Feb. 12, 2007.

UNAIDS/WHO 2005. *AIDS epidemic update*. Geneva. Joint United Nations Programme on HIV/AIDS (UNAIDS) & World Health Organization (WHO).

WHO 2003. *Integrating Gender into HIV/AIDS Programme*s. Geneva: Switzerland. http://www.who.int/gender/hiv_aids/en/Integrating%5b258KB%5d.pdf accessed on Feb. 12, 2007.