AT THE CROSSROADS:
EXPLORING INTERSECTIONS BETWEEN GENDER NORMS AND HIV/AIDS VULNERABILITY IN RURAL MOZAMBIQUE

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THESIS SUBMITTED FOR THE DEGREE OF DOCTOR OF PUBLIC HEALTH

TO THE

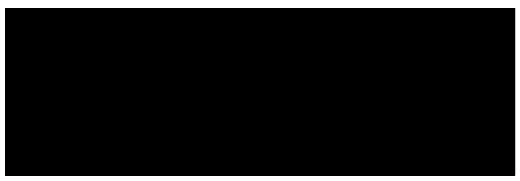
UNIVERSITY OF LONDON

LONDON SCHOOL OF HYGIENE AND TROPICAL MEDICINE

April 2011

Author's Declaration

I, Sarah Bandali, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.



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April, 2011

Abstract

This thesis contributes to an understanding of how gender norms shape HIV/AIDS risk perception, but importantly, the responsive actions taken by men and women to reduce noted risks. Data was gathered in mid-2008 in Cabo Delgado Mozambique and consisted of 16 participatory group discussions to better understand local norms and HIV/AIDS risk determinants and 29 in-depth interviews to explore how gender views interface with risk reduction efforts. The theory of triadic influence and gender and power theory were used in the conceptual framework to guide the research in terms of the factors that influence risk across a multitude of levels.

The findings are based on three key social situations where HIV/AIDS risk was deemed high by respondents and where the interplay of gender norms between men and women could be analysed in greater detail: 1) partner behaviour; 2) marriage and 3) the exchange of sex for resources. Men and women who actively take measures to decrease the threat of HIV/AIDS do so in a context of often repressive gender norms, however, the decision to engage in risk reduction behaviour is also based on other factors including an assessment of risk, various level of influence from family or peers, prior experience, relationship dynamics and a reflection of broader personal outcomes. The findings demonstrated that the move towards more gender balanced relationships and norms, while essential for reducing HIV/AIDS disparities in prevalence rates and risk, are not a precondition for the employment of HIV/AIDS risk reduction strategies. Efforts however, should continue to promote gender equality in its own right as well as to help reduce HIV/AIDS risk among men and women. Programmes should simultaneously build on local gender dynamics and norms and incorporate strategies already being used by men and women to reduce HIV/AIDS risk into interventions and policies.

Acknowledgements

There are numerous individuals who deserve gratitude for their support and guidance through the research process. I would like to thank all the research respondents for agreeing to participate and sharing their intimate experiences with the team. I would also like to recognize the two research assistants – Nancy Amimo and Vitor Jatila for the valuable support they provided. I extend my gratitude to all staff at the host institution, the Aga Khan Foundation (Mozambique) and the Coastal Rural Support Programme for accommodating the research during its implementation phase. The funding provided by the Aga Khan Foundation International Scholarship Programme and the Gordon Smith Travelling Scholarship of the Wellcome Trust was very much appreciated and made the realization of this research possible.

I would like to express gratitude to my supervisor, Joanna Busza for her guidance and support from the very start of the degree, as well as Susannah Mayhew and Martine Collumbien on my advisory committee for their advice during the write-up. Other individuals I would like to thank include John Tomaro, Faiza Janmohamed, Catharine Heironymi, Sharmin Jaffer, Shelina Jaffer, Zena O'Gallagher, Zara Merali, Sara Nam, BB and my family.

Integrating Statement

The Doctor of Public Health (DrPH) offered by LSHTM is aimed at equipping candidates with the requisite leadership, research and management skills required to effectively take on senior level positions in public health settings. The skills are acquired through three key components: a taught component, a professional attachment and a research project. The ability to evaluate, transfer and translate evidence into sound public health programmes and policies is an overall objective of the degree. My decision to pursue the DrPH was based on a need to enhance my analytic and research skills to better allocate resources and inform health priorities and policies in public health settings. I also embarked on the degree to re-enter the field of public health at a more senior level.

Taught Component

For the taught component, I took six modules, half of which were required while the other three were selected from existing MSc modules based on my own research interests and required skills. The compulsory DrPH modules consisted of two modules on Evidence Based Public Health Practice (EBHP) and one on Leadership, Development and Management (LDM).

EBHP focused on analysing various research paradigms, critically reviewing and evaluating studies, and deciphering how evidence can be used to inform the design and implementation of effective public health programmes and policies. I reinforced the knowledge gained from EBHP through two assignments: (1) a systematic review of the promotion of breastfeeding by lay health care workers, and (2) a "knowledge transfer" assessment that considered the policy arena of distributing free insecticide treated bednets in Mozambique. LDM provided useful knowledge to better manage public health programmes in terms of efficiency, effectiveness and quality through case studies and business frameworks and tools. Through the LDM assignment, I applied the management frameworks and theories learned in class to analyse a situation I previously encountered in the work setting. I used power, politics and leadership theories to understand some of the underlying staff and management tension that appeared to be impeding programme implementation. The theories were

also used to substantiate recommendations to resolving similar types of scenarios in the future. Both EBHP and LDM provided the requisite knowledge and skills required for conducting, analysing and using research findings in practice, while also ensuring adequate training and preparation for the professional attachment (PA) and research project. I also obtained the highest grade in two of the three compulsory modules furthering my confidence and ability to put my knowledge into practice.

The remaining modules were selected from MSc courses and related to gaps in my research expertise and knowledge. The Qualitative Methodology module provided the foundational and theoretical background to help facilitate my PA and research project and ensured that the research design and instruments reflected my own research aims and objectives. Given the nature of my research topic examining interactions between gender norms and HIV/AIDS risks and vulnerabilities, I decided to pursue the Social Epidemiology and Gender and Health modules to gain some additional insights into frameworks, theories and past studies that could guide my own research.

Professional Attachment

The professional attachment (PA) component (or Organisational and Policy Analysis project) was undertaken from June to September 2007 at the Canadian International Development Agency's (CIDA) Health and HIV/AIDS Policy Unit. Given my prior experience working within NGO and UN settings, I wanted to experience first-hand the donor environment and the context through which decisions are made to prioritise and allocate resources to countries and programmes. This interest fit with the requirements of the PA as well as my own academic research. I was able to examine a public health organization which I had never directly worked with through a management paradigm while also learning more about the HIV/AIDS programmes and direction undertaken by CIDA.

It was evident that collaborations with stakeholders are a fundamental mechanism through which CIDA implements its development activities. After observing how the policy unit functions and its relationship with the broader organization as well as with external partners, it was clear that further insight was required to better understand,

investigate and provide recommendations to ensure a more enabling environment with which the unit could manage policies and programmes. I conducted in-depth interviews with 19 individuals from within and outside the policy unit to assess factors that promote and inhibit effective working relationship. Based on the knowledge, theories and frameworks gleaned from the LDM module, I applied the descriptive model and stakeholder management principles to analyse the findings and develop appropriate recommendations. Through the research, I was able to critically assess management operations such as mistrust, lack of coordination and consultation, unclear goals and expectations and minimal transparency from a theoretical lens and apply relevant frameworks to resolve key issues and constraints unique to the PA setting. The skills and knowledge gained through the PA will help me better identify, understand and resolve management issues in the future.

Research Project

My academic research project emerged from my previous work in Mozambique around gender, health and HIV/AIDS as well as a gap in the literature on risk reduction strategies that are already being employed by men and women despite some gender imbalanced norms. Data collection for the research took place from July to December 2008 in the province of Cabo Delgado in Mozambique and was conducted through the Aga Khan Foundation. I used qualitative methods such as gender separate and mixed participatory group discussions and in-depth interviews to gather data and better understand HIV/AIDS and gender norms in specific community contexts as well as identify the factors motivating men and women to reduce their noted HIV/AIDS risks.

The theoretical knowledge and skills gained through various modules such as EBHP, LDM, Qualitative Methods, Gender and Health and Social Epidemiology as well as insights gleaned from the research process while undertaking the PA all combined to inform the academic research project. The research also provided me with an understanding of how individual and contextual factors interact to influence HIV/AIDS risk. Based on the learnings gained from the research project, I am better placed to engage in higher level programme and policy dialogue around issues pertaining to HIV/AIDS and gender.

Overall

The taught component, the PA and academic research provided the knowledge and skills needed to assess and analyse research studies in the public health setting. Each component served to complement the other with the modules providing valuable theoretical skills required to take on the more practical elements such as the PA and research project. The PA provided the skills necessary to design and implement sound qualitative research which were in turn applied to the research project. The rigorous nature and dedicated time required to design, collect and examine research findings has provided me with the knowledge and skills to conduct high quality research and use this to better inform programme implementation or contribute to policy dialogue. Even if I am in situations where studies are commissioned rather than directly implemented, I will have the necessary analytical skills to constructively critique public health research which comes my way. With the knowledge, skills and experience gained from the three components, I am better placed to critically consider, rather than blindly accept research findings. I have already re-entered the field of international public health at a more senior level, with research as a key component of my role. Although the work does not specifically relate to the African context or HIV/AIDS, I have used the management and research skills gained from the DrPH to track programme implementation but also make recommendations on how maternal health interventions in Cambodia can improve based on both qualitative and quantitative research findings. Overall, the DrPH at LSHTM has been an incredible leap forward in my journey along a career path in international health development.

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Indices

List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral (Therapy/Treatment)
ARRM	AIDS Risk Reduction Model
CRSP	Coastal Rural Support Programme
GBV	Gender-Based Violence
HARAR	HIV/AIDS Risk Assessment and Reduction Model
HBM	Health Belief Model
HIV	Human Immunodeficiency Virus
MoU	Memorandum of Understanding
PD	Positive Deviance
PGD	Participatory Group Discussions
SIDA	Síndrome da Imunodeficiência Adquirida (AIDS)
SSA	Sub-Saharan Africa
STI	Sexually Transmitted Infections
TTI	Theory of Triadic Influence
UNAIDS	Joint United Nations Programme on HIV/AIDS
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

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Introduction

HIV/AIDS is one of the most devastating epidemics the world has ever faced due to the harsh health consequences and often socio-economic repercussions of the disease. Although the impact of HIV/AIDS is most pronounced among marginalised and disempowered individuals, it shows no boundaries seeping into every race, religion, ethnic, cultural, economic, social, gender and geographical context. Efforts to combat HIV/AIDS have been extensive, with promising results shown in Thailand [1, 2], Uganda [3] and Brazil [4], although for different reasons, including a strict condom use policy among sex workers, strong leadership as well as a civil society force backing prevention efforts and free access to anti-retroviral treatment for all. A concerted response to the epidemic related to the coordination of efforts and resources at the global level, while essential, needs to be locally adapted taking into account distinctive social, cultural and gender dimensions in each setting in order to effectively respond to the HIV/AIDS crisis [5].

The thesis sheds new light on the interaction between gender norms and HIV/AIDS risk reduction practices through qualitative research conducted in Northern Mozambique. Although a vast array of literature has noted the consequences of gender inequality and inequity on increasing HIV/AIDS risk [6-8], very few studies have examined the manner in which men and women work within existing gender norms to mitigate their perceived risk. Factors from a multitude of levels from the individual, normative, social learning and structural level were analysed to assess those most influential in motivating men and women to take action and reduce their HIV/AIDS risk.

Thesis Structure

Chapter 1: Literature Review: An in-depth overview of the literature is presented in the area of gender and HIV/AIDS at multiple levels in order to better understand how various factors interface with gender norms to exacerbate or reduce HIV/AIDS risk among men and women.

Chapter 2: Conceptual Framework: The research aim, objectives and questions are conveyed based on noted gaps in the literature. A framework is also presented on the factors which influence gender norms and HIV/AIDS risk to guide the research.

Chapter 3: Study Setting: A detailed description of the research setting is presented including an overview of the Mozambique context and the host organization.

Chapter 4: Methodology. A rationale for the use of qualitative methodology and related methods is presented alongside strategies for data analysis and ensuring validity and reliability.

Chapter 5: Results: Sexual Behaviour and HIV/AIDS Risk. The selection of partners and an assessment of their behaviour are examined, particularly in the way it may exacerbate gender differences and influence individuals to engage in risk reduction strategies based on partner type.

Chapter 6: Results: Marriage. The risk and protective aspects of marriage are examined in relation to gender roles and HIV/AIDS. Strategies used by men and women to decrease noted HIV/AIDS risk in their marriages are then analysed.

Chapter 7: Results: Exchange of Sex for Resources: The motivations of women and men to engage in sexual exchange are analysed in relation to its influence on shifting gender norms and HIV/AIDS risk.

Chapter 8: Conclusion and Recommendations: Findings are synthesised and compared to relevant literature in Mozambique and elsewhere and linked to broader programme and policy implications.

Chapter 1: Literature Review

A search of the literature was carried out using public health databases such as EMBASE, MEDLINE, Global Health, Popline and PubMed. Key terms such as 'gender', 'gender equality', 'norms', 'gender inequality', 'women' 'men' 'self-efficacy', 'power', or 'culture', were combined with terms such as 'HIV', 'AIDS', 'prevention', 'interventions', 'prevalence', 'sexual behaviour', 'transactional sex', or 'sexually transmitted infections'. Publications from this initial search strategy were reviewed and a snowball technique was employed by examining the reference list of articles to identify additional sources of information pertinent to this research.

Gender roles and expectations, particularly in sub-Saharan Africa (SSA), have been implicated in increased HIV/AIDS risk and are partially responsible, alongside demographic population structures, for differences in infection rates between men and women. Inequalities in gender relations are a critical factor influencing HIV/AIDS rates, particularly in SSA according to a number of studies examining global HIV/AIDS trends [6, 9-11]. HIV/AIDS is spread primarily through heterosexual intercourse and diffuse sexual networks, with SSA the only region in the world where women are more infected by HIV/AIDS than men [12] highlighting the vast gender disparities of the devastating disease. Although women may be at elevated HIV/AIDS risk, one study in South Africa found that norms associated with men such as sexual prowess, dominance and control, influences protection use and contributes to men's increased risk [13]. As a country within SSA, Mozambique is in the epicentre of the worldwide epidemic. While most other countries in southern Africa have witnessed a stabilization of HIV/AIDS, the prevalence in Mozambique has generally been on the increase with no signs of decrease among youth [14]. Gender inequalities have also created barriers to the use of HIV/AIDS protection among youth and adults in studies conducted in Mozambique and South Africa [15, 16], reinforcing arguments at international levels such as the UN to address gender inequalities in HIV/AIDS prevention strategies [17, 18]. There are important differences between women and men in the underlying mechanisms of infection and in the social and economic consequences of HIV/AIDS. These originate from biological and socially constructed gender differences between women and men in

terms of roles and responsibilities, access to resources, agency and self-efficacy. Gender, as defined by social construction theory, is a categorization based on social influences leading to power, resources and status [19]. Cultural constructs of femininity and masculinity are intertwined with other social dimensions, such as the division of labour within the household, and power inequalities within relationships according to Gender and Power theory [20]. Understanding the interface between local gender norms and HIV/AIDS risk is thus essential in mounting appropriate programme and policy responses in different settings.

Based on research conducted in several SSA countries such as Zimbabwe, Tanzania and South Africa and across 17 low-income countries, women tended to refrain from having multiple sexual partners, avoided initiating sex, could not negotiate the terms and timing of sex, and required permission from their husband to seek HIV testing and counselling [16, 21-26]. Sexual relations prior to marriage were noted to inhibit young women in South Africa from accessing services or protect themselves from unsafe sex practices due to fears of social disgrace and moral transgression [27, 28]. According to research conducted across various cultural settings including SSA countries, a number of universal norms attributed to masculinity were found which included: being aggressive and tough, expressing sexual power and suppressing emotion [29-31]. Although common traits exist, there are pluralistic forms of masculinity in any society [32]. In South Africa and Namibia, manhood was defined by multiple partnerships and fatherhood [22, 33] while in Zambia, sexual relationships among men were critical to self-esteem and social status [34]. As noted through numerous studies in South Africa, these norms translated in some cases to risky behaviour, such as gender-based violence (GBV), sexual relationships with multiple women, control over women, and inconsistent or low condom use which can lead to heightened HIV/AIDS risk [33, 35, 36]. Despite the noted risks, men are often neglected from HIV/AIDS prevention initiatives [37].

Studies conducted in Mozambique suggest the existence of widespread gender disparities in the social realm, particularly lack of access to prevention, as well as on the economic front, including minimal income generating opportunities which can adversely affect HIV/AIDS risk for women [38, 39]. As demonstrated in studies conducted in Southern Africa, gender inequalities can create enormous power

imbalances within a relationship [13, 40]. Findings from a study in Mozambique indicate that the acceptance of power inequalities between men and women was linked to low HIV/AIDS knowledge [38]. Studies from South Africa suggest that power inequalities between men and women in a relationship influenced the extent to which a woman was able to effectively negotiate safe sexual practices with her partner [41, 42]. Even when women had knowledge of HIV/AIDS prevention, they identified the unsafe sexual behaviour of their partner (i.e. multiple partners and minimal condom use) as HIV/AIDS risk factors over which they had limited control and power based on studies conducted in North America and South Africa [13, 43, 44]. In studies conducted in South Africa, women with less power in a relationship, according to the sexual relationship power scale [45], were found to be at increased HIV/AIDS risk [46, 47].

A vast array of research across both high and low income countries indicates that gender inequalities, particularly power within a relationship can play a vital role in facilitating or hampering HIV/AIDS protection [41, 42, 48-56]. According to studies from South Africa, some women were less likely to discuss condom use in disempowered relationships while other women were more likely to discuss condom use despite experiencing financial and domestic abuse [41, 57]. Young men in Brazil who participated in an intervention combining gender equitable messages with HIV/AIDS prevention were more likely to use condoms with their primary partner compared to men who just received HIV/AIDS prevention information [58]. In Ghana, men who held more gender equitable views tended not to have multiple sexual partners compared to counterparts who held inequitable beliefs [59]. The differing results between genders and across sites could be related to the various definitions, constructs and measures of gender equality and equity used in each study. Nonetheless, the studies suggest the need to consider contextual gender dynamics in order to understand potential influences on sexual risk-taking and responses.

One of the most extreme manifestations of gendered power inequalities is gender-based violence (GBV). Violence is often used to control the lives of women, with the acceptance of masculine norms associated with attitudes which tolerate GBV based on studies conducted in the US and South Africa [33, 60]. There is increased recognition of the intersection between HIV/AIDS and gender-based violence (GBV)

according to a review of over 25 studies from the US and SSA, where the interaction between the two epidemics creates a vicious cycle of dual risk [61]. According to various global reviews, women experiencing GBV were at increased risk of HIV/AIDS and less likely to engage in prevention strategies [56, 61-63]. In South Africa, women were at greater HIV/AIDS risk if they were in a controlling or abusive relationship. This risk was found to be far greater than that of having multiple partners, engaging in sex for survival and abusing substances [46]. A study in Rwanda noted that women who experienced GBV were placed at increased HIV/AIDS risk through coercive sex with an infected partner [64]. In studies conducted in Kenya and Tanzania, HIV positive women reported higher rates of sexual and physical violence with their partners than HIV negative women [65, 66]. Studies from South Africa as well as a global GBV overview noted that women experiencing violence are less capable of negotiating safe sexual practices [13, 62, 67]. A global review as well as specific country studies in Kenya, Tanzania and the US noted that the fear or threat of violence served as a constraint among women in getting tested or disclosing their status to partners [68-73]. In studies conducted in Mozambique and South Africa on barriers to accessing HIV/AIDS services, findings demonstrated that violence can occur when women try and discuss HIV/AIDS or disclose their HIV status to partners [74, 75]. Studies in the same two countries by different authors noted factors such as age disparities, financial dependence, GBV and relationship dynamics as salient to whether men and women will discuss HIV/AIDS or use condoms [38, 57].

Studies from various parts of the world, including South Africa, demonstrate that men who perpetrate physical or sexual violence have an increased number of sexual partners, experience a greater frequency of sexual relations and were more likely to be HIV positive [46, 57, 61]. In a study conducted in Zimbabwe, men were more likely to engage in coercive sex if they had threatened or were physically violent towards their partners, compared to men who were not violent [76]. Another study in Tanzania showed that men who reported violence were more likely to use force in order to have sex with a partner [77]. In studies conducted in South Africa and Rwanda, men who perpetrated abuse were at higher odds of being HIV positive than their non-abusive counterparts [46, 78]. While there is ample evidence on the

existence of a relationship between GBV and HIV/AIDS, most of the studies are cross-sectional, making it difficult to ascertain the direction of the association.

Protective and Risk Factors for HIV/AIDS

Despite the wealth of literature demonstrating strong associations between gender inequalities and HIV/AIDS risk, such linkages remain overly simplified since the relationship between the two areas is not always clear cut (i.e. inequalities may not always lead to higher risk) thus requiring further investigation according to leading researchers in South Africa on gender and HIV/AIDS [57]. Examining factors related to HIV/AIDS risk and risk reduction solely at the individual level can be limiting and a noted weakness of many HIV/AIDS prevention programmes [79-83]. There are a host of other factors at the individual, social and structural levels which need to be taken into account when assessing the influence of gender norms not only on risk, but the ways in which men and women have worked within existing gender dynamics to protect themselves from HIV/AIDS.

Individual Level

Individual factors such as biology, knowledge, self-efficacy and susceptibility influence whether men and women will engage in risk reduction. Women are at higher risk of acquiring HIV/AIDS than men as a result of biological characteristics [18]. A lack of information, particularly among women, can also contribute to heightened HIV/AIDS risk [84], which is often compounded by differences in norms that encourage male dominance and promote female subordination as noted in Botswana [85]. Although HIV/AIDS knowledge can generally increase the likelihood of practicing safe sex, it is insufficient to motivate behaviour change [86, 87]. In a study of school girls in Mozambique, although there was a marginal link between higher HIV/AIDS knowledge and consistent condom use, the association was not statistically significant [38]. In a study of women in Rwanda, most had accurate HIV/AIDS knowledge but only a small percentage practiced protective behaviour in the past year [88]. Risky sexual behaviour in SSA is largely influenced by socio-cultural and gender norms and practices, which may explain the lack of association found between HIV/AIDS knowledge and safe sex practices in a study conducted in Nigeria [89].

According to prominent behaviour change theories examining HIV/AIDS, such as the Health Belief Model (HBM) and the AIDS Risk Reduction Model (ARRM), factors at the individual level which influence men and women to engage in prevention efforts include perceived risk and severity of HIV/AIDS, analysis of the costs versus benefits of behaviour change, self-efficacy and emotional factors [86, 90-92]. It is not evident however, which, if any, of the factors are more salient in motivating individuals to enact change. A US study noted that perceived severity of the disease and self-efficacy were linked to HIV/AIDS prevention [93], while another US study showed that these factors did not predict safe sex behaviour [94]. According to research conducted among US adolescents, past experience and learning from situations have been suggested as key elements required to negotiate safe sex behaviour and noted to be more indicative of sexual behaviour than corresponding attitudes [95, 96].

In studies conducted in Mozambique, Ghana and elsewhere, the following factors were all linked to condom use: knowledge of someone living with HIV/AIDS, the use of voluntary counselling and testing (VCT) services, self-efficacy and assessing one's own risk [59, 96-98]. A study conducted in Kenya, Uganda and Zambia demonstrated that knowing someone who is infected or affected by HIV/AIDS prompted individuals to use condoms [99]. However, students in Tanzania and factory workers in Ethiopia, although largely aware that condom use is a preventative measure against HIV infection, had a low perception of their risk and thus did not consistently or ever use a condom, even though they reported risky sexual behaviours [100, 101].

One study from South Africa found that women used a number of strategies to deal with HIV/AIDS risk but tended to use passive strategies, such as avoidance, rather than active strategies, such as problem solving or confrontation [102], which may be influenced by power differences in the relationship. This has implications for dealing with the consequences of HIV/AIDS since active strategies have been linked to better health outcomes and enhanced self-esteem, while passive strategies have been associated with psychological distress [103].

Social Level

Peer influence, family structure and relationship dynamics can influence responses to HIV/AIDS in both protective and risky ways. A study in Mozambique examining knowledge among prisoners and another study in Ghana among unmarried youth found that positive peer influences can have a significant effect on changing high risk sexual practices [59, 104]. However, in a separate study conducted in Ghana, adolescents, particularly women, who perceived their friends as more sexually active had a higher likelihood of also being sexually active compared to those who believed their friends had not yet engaged in sexual encounters [59]. In another study conducted in Mozambique, peers were known to have influenced fellow secondary school students to forgo condom use in order to maximise sexual pleasure [15]. Given the relative isolation of rural communities in Northern Mozambique, individuals are likely to be heavily influenced by their family members and peers on gender norms and sexual behaviours.

At the family level, parental communication had both a positive and negative influence on safe sexual behaviour among Ghanaian adolescents [59]. Young men were more likely to practice abstinence if they discussed this with their family, whereas discussions with family members about contraceptives were associated with both men and women being more sexually active. Residing with parents was found to be a protective factor against risky sexual behaviour among adolescents in Cameroon [105] but not in Zambia [106]. The contradictory evidence may be due to different cultural norms in African countries or the specific influence of community norms on youth behaviour [59, 107].

Within relationships in Mozambique and elsewhere in SSA, sexual behaviour is often influenced by socio-economic and cultural forces as well as inequalities and power imbalances [108-110]. Although women may be aware of protection measures, they fail to use them due to broader factors such as economic dependence, lack of power or conformance to gender norms of appropriate female behaviour [91]. Women researched in studies from South Africa and Mozambique found it difficult to suggest or negotiate condom use since it was seen as questioning male authority [13, 38]. A systematic review examining factors shaping adolescent sexual behaviour as well as

studies conducted in South Africa, Tanzania and Uganda, indicate that women may resort to unsafe sex to strengthen the relationship, please a partner or avoid emotional or financial loss [36, 111-113].

In studies conducted in Nigeria and South Africa, risk assessment among youth was based on partner appearance and personality [114, 115] with condoms generally used with self-identified risky partners according to a systematic review on adolescent sexual behaviour [112]. In Mozambique, risk assessment among youth may be attributed to some media campaigns which have associated condom use with casual partners and high risk groups [15]. Protection is often foregone in relationships due to trust, love, desire to conceive or economic and emotional dependence [116-121]. Various categorizations of partners exist across settings such as Cote d'Ivoire and Mozambique and include *spare tyres, saca sena, sengue and pitos* [108, 109, 122], which demonstrate how casual, commercial, romantic, and marital partners can be viewed differently. It is thus important to understand motivations behind sexual relationships with different individuals as well as relationship types and how these influence risk reduction behaviour.

Findings from a study in Malawi highlighted the forms of agency among adolescent women who are taking steps to negotiate condom use in order to avoid pregnancy and disease [123]. Safe sex behaviour, particularly condom use has been linked to relationship duration, value, exclusivity and communication with a partner based on findings from studies in Mozambique and Ghana [59, 98]. According to research in Zimbabwe, Nigeria and Ghana, the use of condoms was noted to be higher among single than married individuals and also among men than women [59, 124, 125]. Despite this, many HIV/AIDS prevention programmes have centred on unmarried individuals even through rates are increasing among married women.

Structural Level

At the structural level, culture, economic status, religion, the education system, laws and policies influence HIV/AIDS risk and have a bearing on how gender norms are learned and enacted. Laws and policies that aid in ensuring the rights of women, as

well as broader efforts aimed at reducing discrimination and inequities are important in creating the enabling environment necessary to engage in effective HIV/AIDS responses [126].

Cultural influences play a key role in shaping sexual behaviour yet can also create barriers to the employment of HIV/AIDS risk reduction strategies [112]. A review of HIV/AIDS prevention programmes in low-income countries noted that an understanding of culturally constructed gender norms are required for the response in Africa [127]. Social and cultural influences can cause gender norms to be sustained in particular settings, however the distinct roles between men and women are believed to cut across all cultures [128, 129]. Practices which are culturally or religiously based, such as circumcision in SSA, can have direct consequences on HIV/AIDS transmission. In countries where circumcision is common such as Kenya and Uganda, associations were noted between the practice and reduced HIV/AIDS risk among heterosexual men [130, 131]. As a result, the WHO is now promoting male circumcision as an HIV/AIDS prevention measure [132]. However, the way in which circumcision is implemented can influence HIV/AIDS protective effects, particularly if safe clinical procedures are not followed. Evidence in Kenya, Lesotho and Tanzania demonstrated that circumcised men and women who never had sex were more likely to be infected with HIV/AIDS compared to their uncircumcised virgin counterparts through unhygienic blood exposure [133].

Differences in access to education, income and assets, including property rights, contribute to women's HIV/AIDS risk [134-136]. According to a South African study, among some women, a lack of education and employment influences self-efficacy and self-worth [137]. In many parts of SSA, research has shown that gender norms are often learned while in school [138, 139] which can in turn influence gender equitable and egalitarian views or behaviours. Educating girls is viewed as one of the most prominent means to empower girls [139]. Yet, there is conflicting evidence on the association between being educated and HIV/AIDS risk [140]. In Mozambique, Zambia and Tanzania, research has shown a strong association between being educated and condom use [98, 141, 142]. In Ghana however, women with primary education and men with higher education were more likely to be sexually active and have multiple partners [59].

Individuals of higher economic status tend to be more knowledgeable about HIV/AIDS prevention compared to those of lower economic status [10]. In a South African study, financially autonomous women were in better positions to negotiate safe sexual behaviour compared to women who were economically dependent on men [57]. A study in Mozambique showed that adolescent women from a middle-class background had fewer numbers of sexual partners, used condoms, confronted harmful gender norms and were generally more assertive compared to adolescent girls from working class backgrounds. Moreover, women from working class backgrounds were more likely to be dependent on male partners for economic resources, which in turn decreased their ability to negotiate safe sexual relationships [38].

A study conducted in Zimbabwe noted that women in economically dependent situations may be more likely to suffer from power imbalances [76]. Poverty can drive women into transactional sex, a term coined by Webb, involving the exchange of resources or goods for sex [38, 41, 111, 122, 143-145]. Transactional sex is widespread in SSA and a driver of HIV/AIDS transmission [110], with the practice more prevalent among women and adolescents [143, 146, 147]. It is also noted to be a tolerated practice in Northern Mozambique, particularly in age disparate encounters [148]. Gender inequalities and poverty are underlying determinants of transactional sex causing some women to engage in sex for survival as noted in studies conducted in Tanzania, Mozambique, South Africa, Kenya and Malawi [23, 38, 149-155]. Transactional sex has also been viewed a product of dependency relationships prevalent through some SSA countries including Malawi and Uganda [154, 156].

Transactional sex, as in Mozambique and other SSA countries such as Ghana, South Africa, Tanzania, and Uganda enables some women to use their sexuality as an asset to obtain resources from men, finish their education, gain freedom and economic independence or achieve greater social status [83, 108, 110, 146, 147, 151, 153, 157-161]. Regardless of the rationale for engaging in the practice, transactional sex is viewed as a means through which economic dependency and control over women are sustained according to various studies from South Africa [153, 161, 162]. The provision of resources to women has been used by some men to symbolise their

power and wealth and perceived as a necessary component in attracting sexual partners according to findings from a South African study [161].

Studies from South Africa and Malawi have noted a possible connection between transactional sex and GBV as well as HIV/AIDS risk [153, 154, 163]. There is a strong association between transactional sex and increased HIVAIDS risk based on findings from two studies in South Africa even after controlling for lifetime number of partners and length of time since initiation of sexual activity [163, 164]. There are numerous ways in which transactional sex has elevated HIV/AIDS risk, particularly in studies from SSA, including through concurrent sexual partnerships [165-167], increasing the number of sexual partners to enhance economic gains [38, 146, 159] and the lack of condom use during transactional sexual encounters, in which more money can be earned for unprotected sex [145, 146, 151, 163, 168]. While a vast array of evidence is available on HIV/AIDS risk and transactional sex, information on the specific strategies between such encounters in relation to risk reduction practices are required [109, 110].

Prevention Programmes and Future Direction

Given the prominence of Africa's collectivist culture, it can be difficult for individuals to employ certain coping strategies to deal with HIV/AIDS if it falls out of the realm of predefined social and gender norms [13, 107, 138]. As demonstrated in Namibia, despite high awareness of gender equality and sexual rights, the need to conform to cultural expectations prevented men from realizing these rights [169]. It thus becomes increasingly important to understand local notions of both masculinity and femininity in relation to the HIV/AIDS epidemic to ensure prevention strategies are successful [22, 170]. Findings from a global review of HIV/AIDS programmes also suggest that effectiveness is maximised when gender inequalities are acknowledged and reduced [8]. A number of initiatives such as Stepping Stones [171], Men as Partners [35] and Promundo's [172] work have sought to address the link between gender and HIV/AIDS through the use of participatory approaches in various settings. With the exception of Promundo, which focuses on men, the other initiatives have not built on existing gender equitable practices to inform their interventions. Although results such as increased HIV/AIDS knowledge and more positive attitudes towards gender relations have been noted across these initiatives

[171-174], it can be difficult to sustain these changes once individuals return to their families and communities [35].

While much insight has been gained in the area of gender inequalities and HIV/AIDS transmission, there are many unanswered questions, particularly the ways in which a reduction in gender inequalities affects HIV/AIDS risk [175]. There are gaps in knowledge on the social interactions influencing relationships and gender relations, particularly in the context of HIV/AIDS, which need to be examined from a multitude of angles in order for more localised responses to be developed as noted through research in South Africa [176, 177]. Additional research is also required on theoretical constructs related to HIV/AIDS protection, including self-efficacy, risk perception, social norms and role expectations between men and women [178, 179]. Moreover, women's agency in light of gender inequalities needs to be understood in different contexts in order to design more responsive HIV/AIDS programmes according to research conducted in Mozambique [109]. Understanding and incorporating gender into HIV/AIDS programmes has been suggested as a critical mechanism to help mitigate the spread of HIV/AIDS [180].

Chapter 2: Research Rationale and Conceptual Framework

There is much evidence on the mechanisms through which gender inequalities enhance HIV/AIDS acquisition, yet minimal investigation has been conducted on how men and women within situations of gender inequalities and inequities negotiate risk reduction strategies. Understanding HIV/AIDS risk and risk reduction within a specific context, including its interface with gender norms should provide insight for more responsive programming and policy. The aim of this study was thus to examine the interaction between prevailing gender norms in Northern Mozambique on HIV/AIDS risk and the risk reduction strategies employed by men and women.

Specific objectives included:

- To determine how gender norms are defined, enacted and maintained by men and women in the context of HIV/AIDS risk

- To examine the strategies men and women use to reduce their risk of HIV/AIDS within prevailing gender norms

Key Research Questions:

- What are the factors influencing HIV/AIDS risk among men and women at the individual, family and community levels?

- How do men and women attempt to overcome harmful gender norms or use existing gender norms to protect themselves from HIV/AIDS?

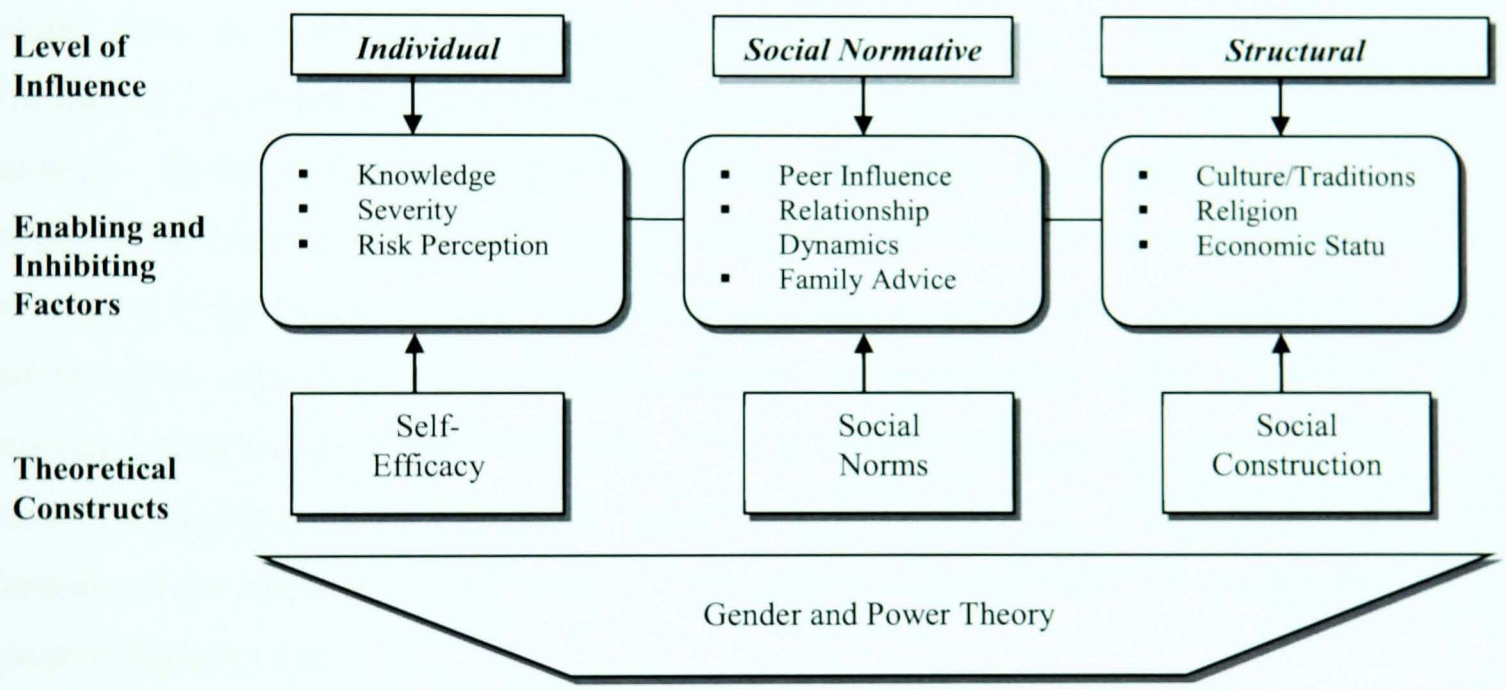
The terms gender equity and equality can vary across geographical contexts and settings, as such, standard international definitions by the World Health Organization [181] were used to guide this research: **Gender equality:** "*equal treatment of women and men in laws and policies, and equal access to resources and services within families, communities and society at large.*" **Gender equity:** "*fairness and justice in the distribution of benefits and responsibilities between women and men. Women and men have different needs and power and these differences should be identified and*

addressed in a manner that rectifies the imbalance between the sexes." Although these definitions guided the research, during the field work, descriptive accounts from respondents were used to explore local notions of gender norms.

Conceptual Framework

The conceptual framework (Figure 1) used to guide the research was developed from the Theory of Triadic Influence (TTI), to account for the multiple levels of influence on norms, attitudes and behaviour, with gender and power theory used to collate findings across levels.

Figure 1: Conceptual Framework



Theory of Triadic Influence

Based on the literature indicating that factors at a multitude of levels affects HIV/AIDS risk and to escape focusing on factors solely at the individual level, an ecological approach was used to guide this study. Many ecological frameworks exist but do not always clearly mark the dynamic and integral nature of different levels (i.e. individual, family, community) as they are visually displayed as concentric circles, which TTI overcomes. TTI examines the interplay of risk factors for health outcomes at multiple levels [182]. The framework has proved useful in understanding risk taking behaviour among youth in the US, where interventions based on the model were found to decrease violent behaviour [183]. TTI has also been used to gain

insight into vulnerabilities to sexual violence among adolescents in South Africa [184]. An adapted version of TTI served as the conceptual framework for this study by preserving individual, family and community levels with corresponding theoretical constructs. However, specific factors from the literature which inhibit or enable risk reduction practices were inserted at each level (individual, social normative and structural) alongside corresponding constructs such as self-efficacy, social norms and social construction. TTI helped account for the close relationship between the various factors under each of the levels that can combine to influence beliefs, attitudes or behaviours on gender roles or HIV/AIDS risk. Factors incorporated within each of the levels can be both enabling and inhibiting in terms of influencing an increase or decrease in HIV/AIDS risk. Thus, TTI facilitated in guiding the development of research methods to ensure factors at multiple levels were captured as well as identify which were most influential in motivating men and women to enact change. Theoretical constructs at each level helped better understand and substantiate research findings. Based on their use in previous studies, self-efficacy was used to examine factors at the individual level, while social norm and social construction were applied to factors at the social normative and structural levels respectively. Self-efficacy, defined as an individual's belief of their capability in implementing certain actions to produce a desired effect [185] was a key construct used in this study because despite factors at multiple levels which can influence risk reduction, it is ultimately the decision of the individual to act upon it. The construct was also used to help identify positive deviant cases.

a) Individual Influences

Individual influences which were considered for this research include knowledge, severity of HIV/AIDS and perceptions of risk. Self-belief and determination can lead to self-efficacious behaviour in terms of an individual taking action to mitigate HIV/AIDS threat or reconcile gender imbalances. Through TTI, the research considered the social, economic and cultural contexts that individuals are nested within to fully understand the complex nature of individual decisions [186].

The concept of self-efficacy has been used extensively to examine individual influences through TTI. Self-efficacy was first introduced by Bandura as a core concept of social cognitive theory and has shown to be a very strong predictor of

behaviour change across a diverse range of research disciplines including health [187]. Key tenants of self-efficacy include experience, modelling the behaviour of others, social persuasions and physiological factors. Bandura stipulated that self-efficacy operates within personal and collective systems and stressed the importance of socio-cognitive influences in regulating an individual's behaviour [188]. Self-efficacy is as much determined at the individual level as it is through social interactions, particularly when trying to understand gender disparities which are dictated through social norms [189].

Self-efficacy provides insight into why individuals with the same knowledge and skills may behave in different ways [185]. The premise of self-efficacy is that an individual's behaviour is best predicted by their beliefs about their capabilities which in turn determines how they will use their knowledge and skills. However, despite high self-efficacy, individuals may not behave in ways that are consistent with certain beliefs, if outcomes of that behaviour will result in undesired effects [190]. In the case of gender norms, this may cause some men to refuse relinquishing their decision-making power in relationships for fear of not conforming to ideals of masculinity.

Given its strength in predicting individual actions, as well as its recognition of wider socio-cultural influences, the research utilised the construct of self-efficacy to examine knowledge, practices and beliefs among men and women which influence HIV/AIDS risk and risk reduction. Factors related to the creation and maintenance of positive self-efficacious beliefs leading to more gender balanced norms were also explored using this construct. In the research, self-efficacy emerged among men and women when they acted on their perceived risk despite situations where gender roles and expectations made this challenging. Factors examined at this level included knowledge, perceived risk and severity of HIV/AIDS prevalence rates among men and women.

b) Social Normative Influences

Social normative influences refer to situations, contexts, and interpersonal relationships that lead to a common set of beliefs or practices. Though the types of relationships examined are the same, "social normative" was selected for this research over "social" level influences because the former allowed for a deeper analysis of

how various social interactions shape norms and attitudes rather than just how different interactions influence individual action.

Social norms have been used to gain insight into the levels of influence others have over an individual's actions or behaviour. The construct was first developed by Perkins and Berkowitz and is premised on an individual's preconceived notion of appropriate behaviour according to how other people act rather than on actual norms, or an individual's real beliefs and actions [191]. Norms are usually situated in the middle of the continuum between how people should act based on morals and ideals versus their actual behaviour. Appropriate or 'normal' behaviour is where norms are defined in that they are neither the perfect ideal nor reflect unacceptable or taboo activity. According to Perkins and Berkowitz, the gap between social expectations and actual behaviour is where the greatest effect on behaviour can take place.

Social normative beliefs are in part formed from perceived norms based on how individuals feel others would like them to behave [186]. Such beliefs are also a means through which individuals gain social acceptance. An individual's sense of themselves, or their level of perceived empowerment, also influences social normative beliefs [182]. These beliefs are particularly important in understanding the types of influences that promote behaviour or practices among men and women which can increase or decrease HIV/AIDS risk.

Social normative influences emerged in this research through the way in which men and women defined, maintained and enacted their gender roles in specific social interactions including among peer groups, family as well as within sexual encounters and intimate relationships. Such interactions also proved insightful to assess related influences on HIV/AIDS knowledge and risk as well as risk reduction efforts across different social encounters. Social interactions offered useful insight into how gender norms are instilled in individuals and how such norms influenced HIV/AIDS risk. Factors examined at this level included peer influence, negotiation of sexual behaviour between men and women, decision-making processes within relationships and family advice and monitoring.

c) Structural Influences

Structural factors such as culture, tradition, religion and economic status influence knowledge and values which in turn inform attitudes and behaviour. The distinction between community and societal factors that influence behaviour is ambiguous and widely debated in the literature [192]. For the purpose of this research therefore, community and social factors were grouped into one category.

Gender interacts with culture, race, ethnicity, class and other factors to influence the manner in which individuals conform to or resist notions of masculinity and femininity [193]. Gender norms become learned and reinforced at various levels including through the education system and differ widely across settings. Yet these same factors, including access to opportunities such as education and income generating initiatives can also influence individual responses to HIV/AIDS risk.

Gender norms are in large part formed through social influences, thus, how men and women define and construct their gender identities were explored through social construction theory. The social construction of gender norms provided insight into the realities in which people make sense of their world against a backdrop of cultural, historical, political, religious and social contexts unique to Northern Mozambique, such as the matrilineal setting, access to and control over income, access to health services and inheritance laws. Unique to the study areas are that they follow a matrilineal system, which traces ancestry through female decent, and that the majority of villagers are Muslim. Polygyny is common and largely based on cultural and religious underpinnings with matrilineal groups tending to marry at an early age [194]. Socially constructed gender roles and responsibilities for men and women offered an understanding into the ways in which individuals and society create and institutionalise notions of femininity and masculinity [195]. Gender identities are often differentiated on the basis of labour, power, roles and responsibilities which can result in imbalances and disparities [193]. From a social constructionist perspective, the research analysed the specific context in rural Mozambique through which culture, traditions, religion and economic status (through access and control over income) influence gender norms which in turn shape HIV/AIDS risk.

Gender and Power Theory

Since many of the theoretical constructs in the conceptual framework have not previously been applied to understanding notions of masculinity and femininity, the research also used gender and power theory [20], as an overarching approach, to collate and examine findings across levels through a gender lens. The theory has been used in the past to analyse HIV/AIDS risk from a gender perspective with findings applied to the development of interventions in Africa [51]. A number of other gender theories, including script and role theory were reviewed and considered for this study but were not used because they are very specific to how men and women should act in response to stimuli and how behaviour becomes dependent on socially permitted and appropriate gender roles. Gender and power theory on the other hand delves further into how men and women negotiate their roles within social structures widely recognized to influence disparities such as through labour, power and emotional ties, many of which are also relevant to HIV/AIDS risk behaviour.

Developed by Robert Connell, gender and power theory focuses on three complementary social structures that guide relations between men and women: 1) the sexual division of labour (paid and unpaid); 2) the sexual division of power (decision-making and authority) and 3) the structure of cathexis (emotional attachment). The three structures were used to analyse factors from a gender lens at the individual, social normative and structural level. The sexual division of labour refers to specific work designated for men and women, with men's work typically valued more financially and socially. This has implications for the types of skills, training and opportunities available to each gender, which can in turn lead to economic and power differentials between men and women, and adverse health consequences for the latter (14). The sexual division of power states that as power imbalances between men and women become greater, less favourable health outcomes are experienced by women. The division of power has been used to explain associations between GBV and HIV/AIDS risk (14). The structure of cathexis describes the emotional and sexual attachments between men and women. It provides a basis to understand social expectations of gender relations and the appropriate roles of men and women with regards to sexual behaviour. These three structures helped examine how differences in opportunities through divisions of labour and roles and responsibilities affect

HIV/AIDS risk. Power differentials between men and women, often related to gaps in education and income access, also facilitated in understanding the constraints posed on risk reduction efforts. Finally, emotional intimacy with a partner was a prominent factor used to determine why men and women decided to or refused to engage in HIV/AIDS protection.

Chapter 3: Study Setting

Background

The research was conducted in the province of Cabo Delgado in Northern Mozambique. The country has a population of 22.4 million people [196] and shares its borders with South Africa, Swaziland, Zimbabwe, Zambia, Malawi and Tanzania (Figure 2).

***Figure 2**: Map of Mozambique*

Mozambique has long been embroiled in warfare, which began ten years prior to the country gaining independence from the Portuguese in 1975, followed by a civil war that erupted thereafter for another sixteen years until a peace accord was signed in

1992. Despite the war wreaking havoc on the country's social and economic infrastructure, Mozambique has made a remarkable recovery with stable economic growth [197]. Agriculture, fishing, tourism and mining comprise the country's main economic industries. Actions taken to reduce poverty under national strategic plans have to an extent been successful, most notably, the percentage of Mozambicans living on under $1/day decreased from 69% in 1996/97 to 54% in 2002/03 [198]. Despite noted gains, Mozambique still remains one of the poorest countries in the world, ranking 172 out of 182 countries on the Human Development Index [199].

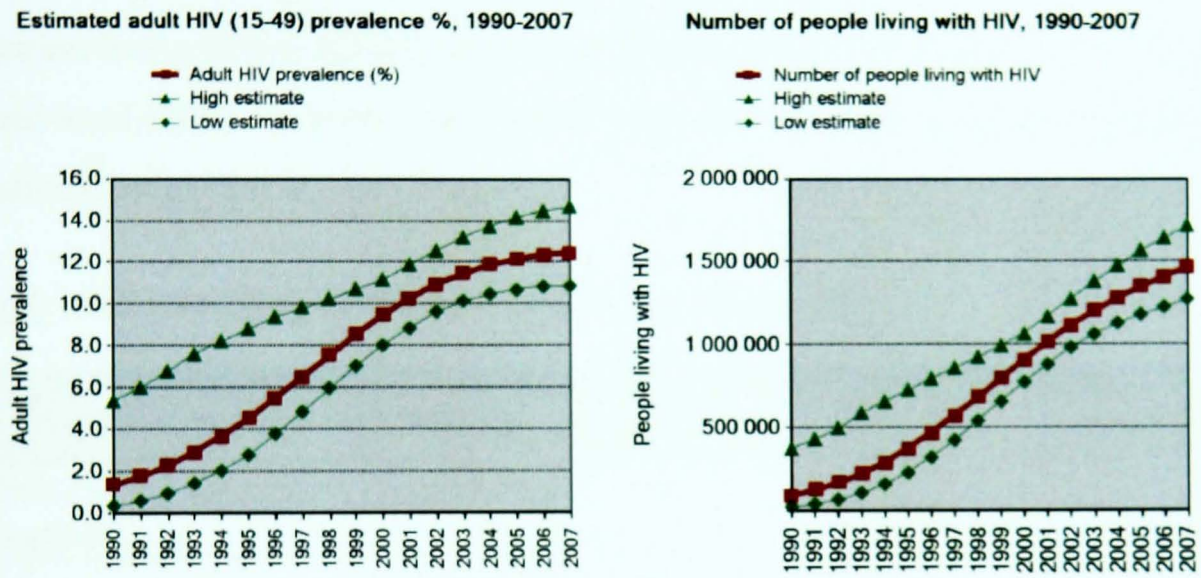
On the Gender-related Development Index, Mozambique ranked 145 out of 155 countries, indicating substantial disparities between men and women measured through a healthy life, literacy and standard of living [200]. Mozambique has ratified the Convention on the Elimination of All Forms of Discrimination against Women [201] and made strides to incorporate gender frameworks into various sector plans and policies. However, the lack of requisite skills and capacity to implement gender related programmes has prevented the issue from moving forward [202, 203]. Although concerted efforts are now being directed at understanding gender inequalities and inequities, including a gender profiling study conducted in Cabo Delgado [204], focus is on describing women's limited access to information and services, rather than reflecting on measures which can be implemented to reduce differences between genders.

Although Portuguese is the official language of the country, a variety of local languages are spoken including Emakhuwa and Xichangana [205]. Approximately 70% of the population, primarily poor, live in rural areas and earn their livelihoods through subsistence farming [198]. Based on recent estimates, life expectancy for men is 49 years while for women it is 51 years of age [206]. The adult illiteracy rate is 60% with widespread disparities between men (39.4%) and women (71.3%) [207].

Malaria is the primary cause of mortality in Mozambique, closely followed by HIV/AIDS [208]. Ever since the first case of HIV/AIDS was diagnosed in 1986, Mozambique has made swift strides to contain the epidemic through various programmes and policies [209]. According to recent estimates from 2008, the HIV/AIDS prevalence rate of adults aged 15-49 years of age was 12.5%.

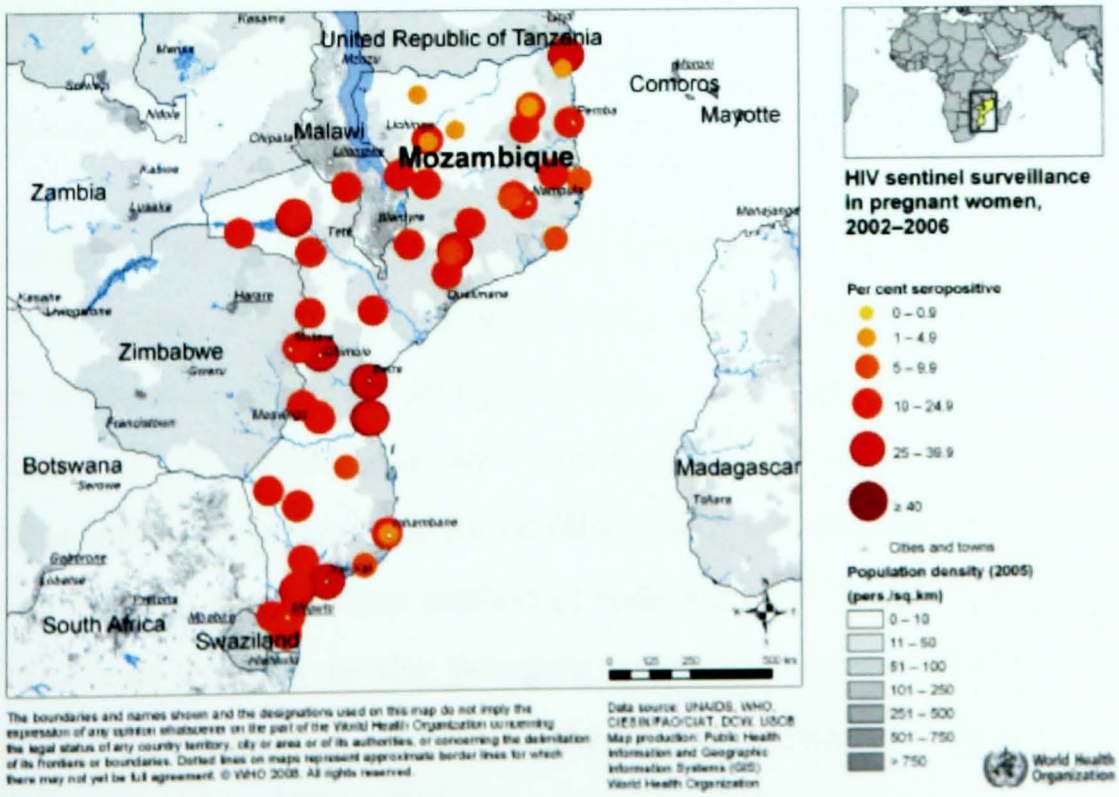
Approximately 1.4 million adults were living with HIV/AIDS and over half (58%) of these infections were among women. HIV/AIDS incidence and prevalence rates among adults (Figure 3) have been increasing steadily from 1990 [210]. Factors contributing to the rise include gaps in condom prevention and provision, inadequate referral linkages, low levels of community involvement and limited access to health services [211].

Figure 3: ***HIV/AIDS Prevalence and Incidence Rates in Mozambique***



Source: UNAIDS/WHO, 2008

Figure 4: ***Geographical Distribution of HIV/AIDS Prevalence in Mozambique***



As noted in Figure 4, although the impact of HIV/AIDS is higher in central and southern Mozambique, the percentage of seropositive cases in some pockets of northern Mozambique is quite high.

Study Site

The research was conducted through the Coastal Rural Support Programme (CRSP), based in the province of Cabo Delgado (1.6 million inhabitants). Cabo Delgado is one of the poorest provinces in Mozambique with approximately 63% of the population living below the poverty line (under $1 dollar/day) compared to 54% at the national level [208]. In most cases, health indicators for Cabo Delgado are worse than the national level (Table 1).

Table 1: Selected Health Indicators in Mozambique [208]

Health Indicators (2003)	Cabo Delgado Province	National
Children (12-23 months) with complete vaccination	57.9% n=169	63.3% n=1933
Prevalence of diarrhoea among children under 5	18.3% n=806	14.1% n=9400
Chronic Malnutrition (>-3SD) among children under 5	30.4% n=693	18.1% n=8697
Infant mortality rate (per 1,000 live births)	178	124
Child mortality rate (per 1,000 live births) – highest	241	178
Total Fertility Rate (Women 15-49 years)	5.9	5.5
Current use of contraception method (condom use)	0.7% n=851	1.1% n=8736

In examining HIV/AIDS knowledge and practices in Mozambique (Table 2), data from Cabo Delgado generally fares far worse relative to the rest of the country, with gender disparities noted for most indicators. Although the majority of individuals have heard of HIV/AIDS, men and women in Cabo Delgado had the lowest rates in believing that there are ways to avoid HIV/AIDS, and the highest rates in the country of not being able to name any method of reducing HIV/AIDS. HIV/AIDS knowledge rates for both genders in the province were some of the lowest in the country, particularly on abstinence, decreasing the number of sexual partners and condom use as methods to reduce HIV/AIDS.

***Table 2:** HIV/AIDS Indicators in Mozambique [208]*

HIV/AIDS Indicators (2003)	Cabo Delgado Province		National	
	Women	Men	Women	Men
Heard of HIV/AIDS	96.9% n=1071	100% n=237	95.7% n=12,418	97.8% n=2490
Believe there are ways to avoid HIV/AIDS	30.8% n=1071	36.2% n=237	63.8% n=12,418	77.1% n=2490
Does not know a programmatic method to reduce HIV/AIDS	69.1% n=1071	63.7% n=237	36.3% n=12,418	21.8% n=2490
Knowledge of at least two ways of avoiding HIV/AIDS	23.6% n=1071	25.6% n=237	53.7% n=12,418	71% n=2490
Knowledge of condom use to reduce HIV/AIDS	24.1% n=1071	23% n=237	53.3% n=12,418	70.3% n=2490
Knowledge of limiting the number of sexual partners to reduce HIV/AIDS	23.6% n=1071	15.7% n=237	52.7% n=12,418	66.5% n=2490
Knowledge of using a condom and limiting the number of sexual partners to reduce HIV/AIDS	18.7% n=1071	12.4% n=237	45.2% n=12,418	61% n=2490
Knowledge of abstinence to reduce HIV/AIDS	16.2% n=1071	16.3% n=237	46.2% n=12,418	63.3% n=2490
Rejecting two misconceptions of HIV/AIDS acquisition and indicating that a person who looks healthy can have HIV/AIDS	8.8% n=1071	14.4% n=237	23.2% n=12,418	39% n=2490
Median age at first sexual relation (yrs)	15.1	16.3	16.1	17.7
Unmarried with two or more sexual partners in last 12 months	14.4% n=791	48.6% n=2301	6.4% n=9824	30% n=2117
Individuals who used a condom in their most recent high risk sexual relation	9.2% n=241	6.1% n=148	23.5% n=2309	33.1% n=1105
Married with just one sexual partner	90.3% n=851	53.2% n=166	96.2% n=8736	73.8% n=1466
Used condom in their last sexual relation with their husband/wife	1.1% n=851	0.6% n=166	1.6% n=8736	2.4% n=1466
Married individuals who used condoms in their last sexual relation with a habitual partner	9.2% n=214	6.1% n=148	23.5% n=2309	33.1% n=1103
Women justified in asking a husband/partner infected with an STI to use a condom	46.1% n=1071	70.% n=12418	46.4% n=237	80.1% N=2490
Married couples who have discussed HIV/AIDS with their spouse	50.8% n=851	49.4% n=166	49.5% n=8736	58% n=1466
Individual who have gone to get an HIV test and received results	0.1% n=1071	3.7% n=12418	1.4% n=237	3.6% n=2490

Men and women in Cabo Delgado tend to have their first sexual encounter at a young age compared to the rest of the country. Unmarried women and men in the province had some of the highest rates of having two or more sexual partners, while condom use during the most recent high risk sexual encounter was the lowest in the country. Although many individuals have never had an HIV test, the rate for men in Cabo Delgado who got tested is much higher than that of women.

Married women who stated they had only one sexual partner was much higher compared to men in Cabo Delgado. Although similar levels of men and women in Cabo Delgado felt that a woman who knows her husband or partner has an STI is justified in proposing condoms, the rates were the lowest in the country suggesting that it may not be an accepted rationale for women to negotiate condom use despite knowledge of risk. Among men in Cabo Delgado who indicated having sex with a prostitute (40.4%), very few reported using a condom (10.8%) compared to the national rate (21.2%). In Cabo Delgado, most men have been circumcised pointing to some direct means through which HIV/AIDS risk can be reduced [208].

Coastal Rural Support Programme (CRSP)

CRSP, an initiative of the Aga Khan Foundation (Mozambique), is a non-governmental organization that has been implementing development activities in Cabo Delgado since 2001. It works across various sectors, including health, education, rural development and civil society. CRSP considers both gender and HIV/AIDS as cross-cutting themes and works to integrate each across its sectors, which made it an ideal organization for the research. Gender activities within CRSP have centred on mainstreaming the issue into sector activities. However, the lack of a gender focal point and minimal expertise to address gender issues has resulted in limited impact of gender interventions. In the area of HIV/AIDS, CRSP has worked on: a) building AIDS competence for internal staff and partners to address the epidemic in the province; b) incorporating prevention messages into existing sector activities; c) encouraging voluntary counselling and testing behaviour in communities and d) linking with existing groups to create an enabling care and supportive environment for people living with AIDS. As with gender, the extent and reach of these HIV/AIDS initiatives over the last few years has been limited primarily due to a

severe lack of VCT and anti-retroviral (ARV) treatment services in programme areas. Although one VCT facility exists in Quissanga, it is often closed. The nearest facility which offers comprehensive VCT services and ARVs is in the capital of Pemba, about a 2-3 hour drive from the villages, making it extremely difficult to access by the population. I worked as a programme officer with CRSP from 2004-2006 overseeing its health and gender programmes including developing strategies to address constraints and leading on interventions. This position helped me better understand the contextual factors related to the research and interpret the findings. Prior experience working with communities and understanding their priorities, social organization and ways of living helped developed certain levels of rapport with members and greatly aided in the research as participants appeared open in their responses despite sensitive questions on sexual behaviour.

The research took place in Pemba-Metuge, a peri-urban district and Quissanga, a rural district. The villages of Mahate (~2706 inhabitants) and Bilibiza (~4,056 inhabitants) in Quissanga district, and the villages of Mieze (~4,109 inhabitants) and 25 de Junho (~4,034 inhabitants) in Pemba-Metuge district comprised the study sites [212]. These villages were selected due to close geographical proximity and because interventions have been implemented across health, education, rural development and civil society. The selection of study sites also responded to the vast array of literature pointing towards structural factors that need to be in place in order for gender equality and reductions in HIV/AIDS transmission to be realised [50, 213, 214].

A breakdown of religious and ethnic affiliations in each of the four villages is highlighted in Table 3. Most of the study population is of Muslim origin and Makua ethnic background, with Kimuani and Makonde the other predominant ethnicities. Based on a pluralism study conducted by CRSP [215], individuals identified themselves initially by their ethnic background and then by their religion. Generally, Makua and Kimuani are Muslims and Makonde are Christians; however, belonging to one ethnicity does not necessarily mean affiliation to a specific religion. The study areas are also matrilineal, which traces ancestry through female decent.

***Table 3:** Religious and Ethnic Breakdown [215]*

Village	Religious Breakdown	Ethnic Background (Estimates)
Mahate	80% Muslim	80% Kumuani; 20% Makua
Bilibiza	70% Muslim	50% Makua; 25% Kimuani; 25% Makonde
25 de Junho	60% Muslim	60% Kimuani, and greater proportions of Makua than Makonde (specific percentages not available)
Mieze	50% Muslim	75% Makua; 25% Makonde

Chapter 4: Methodology

As the aim of the research was to assess the ways in which gender norms influence risk and responses to HIV/AIDS, a qualitative approach seemed most appropriate to gain such insight through respondents' own accounts. Both interviews and group discussions were used to examine factors from the conceptual framework motivating men and women to respond to HIV/AIDS risk while also providing a more holistic perspective on their beliefs, attitudes and practices. Given the prominence of grounded theory in influencing rigorous qualitative analysis, the research adapted techniques from the theory [216, 217] including "constant comparative analysis" to compare and contrast themes across gender and age groups.

To understand the gender norms that enable or inhibit individuals from engaging in risk reduction behaviour, it was first necessary to explore how such norms are collectively learned and enacted. The literature has recommended that participatory research, which includes the active involvement of men and women, be used to facilitate a more empowered research process [218]. However, the independent nature of this research limited the participation of respondents in the design and collection of data. Although a truly participatory approach could not be used, group exercises were used to encourage more interactive discussions. The use of participatory methods in developing more engaged interaction with respondents, upon whom programmes are centred, was a key reason the method was selected [219-221]. Participatory group discussions (PGD) helped illicit information on the construction of norms that might be difficult to capture individually [222, 223], as well as explore the definition of gender norms, and assess HIV/AIDS knowledge levels and its behavioural determinants. Rather than directing the process of inquiry, I encouraged respondents to partly facilitate discussions themselves by exploring topics which resonated with their experiences and situations; this provided insight into how they shaped their own realities [224, 225] and helped explore social normative beliefs based on discussions emerging among respondents on gender, social and sexual practices. Once a greater understanding of gender norms was established, in-depth individual interviews were employed to explore how these norms influence assessment and responses to potential HIV/AIDS risk among men and women. Interview methods were selected in order to gain deeper insight into the specific

experiences of an individual compared to group discussions which generally delve into normative behaviour [217, 226].

The positive deviance approach was used to identify individuals from group discussions for in-depth interviews. Positive deviance has primarily been used to inform programme interventions, but the approach in identifying 'good practices and behaviours' is of particular use for research studies seeking to better understand the factors which influence individuals to engage in healthy behaviours. It is based on the premise that there are some individuals who engage in certain behaviour and find solutions to problems [227] such as taking measures to reduce HIV/AIDS risk, compared to others in their community, despite living in the same conditions and having the same access to resources. Since behaviours are already undertaken by individuals in similar situations and contexts, they are more likely to be accepted and sustained [228]. The approach was initially used to identify the practices of mothers who have healthy infants even though they live in conditions of poverty. PD has since been extended and applied to child growth [229], breastfeeding [230] and birth outcomes [231]. Although there is a lack of research demonstrating the impact of using the PD approach on health outcomes, it has shown to be a useful catalyst for enticing positive behavioural change [232]. For this research, PD was used to help identify individuals and assess the extent of the relationship between the following: 1) individuals already taking action to reduce their HIV/AIDS risk, given that DHS data indicate a general lack of risk reduction knowledge and practices among men and women, and 2) those who hold gender balanced attitudes, given that widespread gender disparities exist in the country.

Data were collected over a six-month period from July to December 2008 inclusive. A three-pronged approach was used to enhance the rigour of data by comparing and contrasting findings across multiple methods [233]: 1) Interviews with village chiefs and traditional leaders; 2) Participatory exercises with gender specific groups and 3) In-depth interviews with positive deviant cases. After seeking permission from respondents, all group discussions and interviews were digitally recorded. A total of 4 leader interviews, 16 group discussions and 29 in-depth interviews were conducted over the time period.

Two research assistants, a man and woman, were hired to facilitate the group discussions, translate in-depth interviews and transcribe and translate data sets. To ensure high quality data was obtained and the assistants felt comfortable with the methods and tools, I conducted an intensive training over a one week period on research topics, participatory methodologies, facilitating group sessions, conducting interviews and transcribing and translating data (Annex 1 - Training Schedule). In addition, an overview of the research protocol was thoroughly discussed to ensure assistants were familiar with the approach, terminology and methods used in the research process [234].

During the data collection phase, the two research assistant led the group discussions based on training they received and referred to the questions in Annex 3 to help facilitate discussion among respondents. I was present for each group discussion to assess how things were progressing and also to support the research assistants in case they had any questions. Although the group discussions took place in local language, I had the opportunity to communicate with the research assistants after each exercise to assess if respondents were engaged and comfortable. I played a more active role in the in-depth interviews where I asked the respondent questions in Portuguese which were then translated by the assistant into local language. The assistant in turn translated a summary of the respondent's answer back to me and I proceeded to ask follow-up questions. The cyclical translation process continued until the interview was complete.

Pilot Study

A pilot study was held with married women and men in the village of 25 de Junho to ensure that assistants were well prepared to handle the research topic, the tools made sense to respondents and appropriate and relevant data were gathered. Based on the pilot test, slight revisions to the group method were made and tested on unmarried men and women in the same village. During this time, my DrPH supervisor was also present to observe and provide guidance on the participatory group discussions. As a result, additional modifications were made to the group method, most notably, reducing the number of questions in each exercise, incorporating one exercise into another, and combining the group of men and women at the end to better explore gender norms and dynamics.

Approach and Scope

Interviews with Village/Traditional Leaders

Interviews with leaders in each village were conducted due to their critical role in shaping and maintaining social norms [235], but more importantly, to seek permission in carrying out the research in their respective villages. CRSP community mobilisers, based in the districts, linked the research team with leaders in each village. One to two leaders were interviewed in each village to obtain an impression of religious and ethnic backgrounds and gain a better sense of community wide notions related to gender roles as well as perceptions of HIV/AIDS risks (Annex 2 – Questionnaire for Leaders). The leaders were provided with an overview of the research aim and objectives and in conjunction with CRSP staff, were also asked to help mobilise individuals for the participatory group discussions. Since the primary aim was to seek permission from leaders and because information detailed in the leader interviews replicated those from group discussions, these discussions were not incorporated into the analysis. In addition, some of the information relayed during the interviews, such as government and administrative issues (i.e. lack of office space and government resources) were not necessarily relevant to the particular aims of the research and thus excluded from the analysis.

Participatory Group Discussions (PGD)

Participatory group discussions (i.e. interactive group exercises) were employed to understand gender norms and perceptions of HIV/AIDS risk, despite recognition that it may not completely capture the range of beliefs held among the study population [22]. While numerous PGD tools and approaches exist, they reflect principles of general qualitative research [236, 237] including the: a) existence of multiple perspectives and interpretations for any given experience; and b) group dynamics which help make sense of how people construct their reality. The group context has been effective in stimulating dialogue between respondents and understanding what people think, how they rationalise their thoughts, and how they develop, for example, collective notions of gender norms [238]. Interaction between respondents can also facilitate in aiding and elaborating experiences among individuals [239], particularly those practices viewed as gender balanced [240]. While the observed norms and behaviour arising from group discussions may not be representative of the entire

village, they do provide an important understanding into social interactions that may influence attitudes, beliefs and behaviour among participating individuals [241].

Programmes such as stepping stones have used participatory methods to elicit information on sensitive topics such as HIV/AIDS, with findings incorporated into the design of interventions [173, 242, 243]. CRSP has also used participatory approaches to understand community issues and develop programme interventions. Participatory methods however, have been criticised for their lack of academic rigour. The use of complementary methods such as in-depth individual interviews should have addressed this concern and helped triangulate the data [244].

Respondents for the group discussion were selected based on purposive and non-random sampling. In each village, leaders selected individuals from naturally existing groups or groups formed through CRSP interventions (i.e. village development associations, nutrition groups, farmers associations, youth groups). Across all study villages, each individual, if not all, in the group sessions had greater access to information, such as HIV/AIDS knowledge as a result of AKF interventions, than their fellow villagers and this may have introduced a selection bias in the study design. However, to facilitate access into communities, only villages where AKF had interventions were selected for this research.

Although using naturally existing groups has the advantage of tapping into ideas and practices between individuals already familiar with one another, these views may be inherent to the specific group and not necessarily reflect broader community norms [245, 246]. This challenge was tackled by limiting the number of individuals who participated in the research to a maximum of two or three for each naturally existing or pre-formed group. The approach allowed individuals from various community groups to participate so that a more representative view could be obtained.

In each village, discussions were held with four gender specific groups consisting of approximately 10 individuals per group (40 individuals per village). Unmarried adolescent men and women were separated into their own group as this is a time when gender identities become engrained [247]. However, when groups were mobilised, it was apparent that some of the men and women were in fact married in the past, but of

a 'single' status at present, despite this they were included in the group discussion. The four groups comprised of: 1) married men; 2) married women, 3) unmarried women and 4) unmarried men. In total, discussions were held with 16 groups (4 groups/village) with approximately 160 respondents (~10 individuals/group). Respondents were provided with snacks as a symbolic appreciation of their time and involvement with the research.

Participatory exercises on gender and HIV/AIDS compiled by the International HIV/AIDS Alliance [248] were reviewed and a total of three exercises were selected and adapted: 1) Octopus; 2) Gender Boxes and 3) The Gender table (Annex 3 – Participatory Exercises). The exercises were informed by the three levels of the conceptual framework (i.e. individual, social, structural) to capture factors contributing to HIV/AIDS risk and risk reduction strategies, while also helping to understand how gender roles and responsibilities are contextualized. As a result of the pilot study, activities from the gender box exercise were incorporated into the gender table to reduce the length of time to a maximum of three hours for each group session. The exercises were sequenced to ensure a smooth transition through the topic areas which began with HIV/AIDS knowledge and risk, then moved onto roles and responsibilities between men and women at different levels (i.e. individual, family, community) and ended with exploring the relationship between HIV/AIDS and gender roles. Although the initial two exercises took place with gender separate groups, after pilot tests, it was determined that the last exercise could combine the groups of men and women, as this proved to be a lively and interactive discussion on current and evolving gender norms and HIV/AIDS risk reduction strategies.

Research assistants were matched to their gender group in response to widespread criticisms that qualitative methods often dismiss gender aspects, as well as to accommodate for the sensitive nature of the initial participatory exercises and maximise comfort levels of respondents [249, 250]. Group sessions were conducted in the language which could be understood by all respondents. Guides were developed to remind the research assistants of each exercise and ensure they met objectives of group discussions, yet were flexible enough to allow the assistants to hone in on pertinent points brought up by respondents.

The purpose of the first exercise, the octopus, was to determine HIV/AIDS knowledge levels and explore perceptions of risk among respondents. The exercise inadvertently turned out to be a learning process for respondents who were misinformed or did not have knowledge on modes of transmission. When inaccurate knowledge (i.e. HIV transmitted through foreigners and condoms) was communicated by respondents during this exercise, there was always a group member who had more knowledge than others on HIV/AIDS and corrected any misinterpretations that emerged. The correction of inaccuracies among respondents was a natural progression in the discussion and as such, a decision was made not to interrupt this dialogue as objectives of the exercise were not compromised. This discussion revealed the various knowledge levels among respondents and how this may have directed certain prior actions based on their perceptions of how HIV/AIDS is transmitted. Since the correction of knowledge occurred naturally in the group discussions, at the end of the exercise, accurate HIV/AIDS messages were summarized by the facilitator for ethical considerations. It also helped to establish a more focused discussion for the subsequent two exercises around the potential effects of gender norms on risk based on accurate rather than inaccurate HIV/AIDS knowledge. The correction of inaccurate information at this stage may have introduced its own biases, such as influencing the communication of respondents' experiences in subsequent exercises (i.e. individuals who believed HIV/AIDS is transmitted through condoms may not have engaged in any type of prevention strategies and thus not contributed to discussions).

The second exercise, the gender table, explored the roles and social normative attitudes of men and women in different types of social interactions. Objectives of the exercise were explained to respondents who were then left on their own to fill out a table on expected roles for men and women at the individual, family, friends, sexual encounters and community levels. Respondents were then asked to make a brief presentation to the research assistant based on information contained in the table. Once the exercise was completed, the assistant brought out the octopus exercise and placed it next to the gender table to allow respondents to explore relationships between gender roles and HIV/AIDS risk and risk reduction.

The final exercise brought together the groups of men and women to present their gender table to the broader group and achieve some level of consensus on gender roles within the village. The discussion also probed issues related to power at multiple levels, whether gender roles should be changed and how reductions in HIV/AIDS risk could be achieved among men and women.

In-Depth Interviews

The collective norms emerging from group discussions helped identify 'positive deviant' cases, such as those men and women who held gender balanced beliefs and attitudes or engaged in HIV/AIDS risk reduction strategies. The interaction and level of participation in each group session usually resulted in individuals detailing either their own accounts or strategies they would use to address specific situations related to HIV/AIDS risk reduction. Such discussions helped the research assistants identify individuals for in-depth interviews who could provide greater insight on actions taken to reduce perceived HIV/AIDS risk. The assistants also used Table 4, developed from the literature, as a guide to identify men and women in the group sessions who discussed attitudes, beliefs and practices pertinent to the research.

Individuals for in-depth interviews were selected from participatory group discussions (usually 1-2 per group) based on two key criteria: 1) demonstration of gender balanced attitudes, beliefs or practices **or** 2) stated measures, actions or strategies to reduce HIV/AIDS risk, with preference given to those individuals where the two criteria intersected. Since it was difficult to keep track of respondents who fulfilled both criteria simultaneously during the group session, a change in the definition of a positive deviant was undertaken at this stage. Thus, only one of the two criteria, with preference given for individuals mentioning their strategies to reduce risk (i.e. demonstrating self-efficacious actions), was deemed sufficient to select an individual, with linkages to the other criterion explored in more detail during the interviews. This resulted in a strengthened methodological approach since identifying individuals who fit both criteria was a short-coming of the research design and would have introduced a fundamental bias in data collection (i.e. individuals who held gender imbalanced views and took action to reduce risk may not have been captured) making it extremely difficult for the research questions to be answered. Instead for practical feasibility, the revision of a 'positive deviant', which centred more on whether men

and women engaged in risk reduction practices, had the unintended consequence of revealing that irrespective of gender egalitarian attitudes, individuals still engaged in risk reduction strategies. Such a revelation would not have emerged without the change in definition of a 'positive deviant' which led to a conceptually improved definition and thus analysis for this study.

Table 4: Guide to Identify Positive Deviant Cases

	Intrapersonal	**Social Normative**	**Culture/ Environmental**
Female	-Communication and negotiation skills (i.e. suggesting condom use,) -Knowledgeable about HIV/AIDS prevention and takes action to reduce risk	-Late sexual debut -Discussion of safe sexual behaviour with husband/partners/parents -Access to or control over financial resources in the household	-Seeking out HIV/AIDS services and information on prevention -Non-acceptance of multiple partnerships from male partner - Delayed marriage
Male	-Accurate perception of HIV/AIDS risk and related actions to reduce it -Use of condoms -Use of VCT services	-Late sexual debut -Practicing abstinence in adolescence -Joint decision-making over financial resources with partner -Non-controlling attitudes or behaviour	-Faithful to one partner -Progressive views on gender norms (i.e. ability for women to discuss condom use, fidelity, get educated etc)

Before potential interviewees were selected, the assistants explained to me why they thought a particular individual was of interest to invite for an interview. The in-depth interviews were conducted on the same day as the group session due to logistical and time issues as well as to avoid loss to follow up. A total of 29 in-depth interviews took place with 6 married women, 6 married men, 7 unmarried men and 10 unmarried women. Interviews were conducted with positive deviant individuals to better understand how gender views interfaced with HIV/AIDS risk reduction, the factors influencing the decision to engage in such strategies, and whether there were

differences in measures taken by men and women to mitigate HIV/AIDS threat. To help build some level of rapport and address sensitive topics with individuals, questions in the interview transitioned from general life experiences (i.e. key milestones in your life) to more specific questions on roles, sexual encounters, risk and risk reduction strategies [251].

An interview guide was developed to ensure consistency in the information sought across interviews, yet flexible enough to probe points of interest (Annex 4 – In-Depth Interview Guide). Interviewees were informed they could skip questions they were uncomfortable with or did not want to answer, though this situation never occurred. Interviews were conducted in a safe and confidential place in each village, which in some cases, involved shaded private areas behind a hut or in abandoned school classrooms out of view from the general public.

Interviews provided the opportunity for respondents to expand on or explain issues they felt uncomfortable discussing in a group setting [252, 253]. Although there were a few interesting points to follow up on in some of the interviews, due to time and resource constraints, each individual was only interviewed once. After each PGD and in-depth interview, debrief sessions were held with the research assistants to review issues that emerged (i.e. relevant information gathered, how to deal with dominant versus quiet members) and determine if changes were required to the approach.

Data Analysis

Data generated from the group discussions and individual interviews were transcribed from local language (Makua or Makonde) into Portuguese by the two research assistants. During transcription, all information that could identify an individual was removed and replaced with alphabetical codes to preserve confidentiality. Since Makua and Makonde are oral rather than written local languages, a direct translation into Portuguese was conducted. It is acknowledged however, that the transcription process is never perfect since it is unable to capture the intricacies of the interaction between the interviewer and respondent [254]. To overcome this and account for greater reliability and validity, transcription and translation of the data from local language to Portuguese was made verbatim to the extent possible [255-257]. In addition, a random sample of translated documents from local language to Portuguese

were passed onto the assistant who was not involved in this process to make sure it accurately captured what was written. As an added layer of translation reliability and because of my working knowledge of Portuguese, I looked over the translated documents from Portuguese into English using two language tools: Globallink Power Translator Pro and Google Language. Any discrepancies or questions were then reviewed with the research assistant before finalizing each translated document. Although the translation of data from local language into Portuguese and then into English can result in various layers of interpretations, this was minimised since the assistants and myself, who have first-hand knowledge of the discussions, were directly involved in this process.

The analysis was conducted using modifications to the grounded theory approach. Developed by Strauss and Glaser [258], grounded theory follows a cycle of induction, deduction and verification with a focus on theory building through the research process and careful coding of data. It responds to criticisms noted of qualitative research by incorporating a set of strategies to analyse data, thereby improving the validity and reliability of the methodology [259]. Adaptations to the grounded theory approach were made for this research by incorporating conceptual and theoretical orientations into the analysis rather than assuming no prior knowledge of the data [216]. Derived from grounded theory, a constant comparative analysis [260] was used to ensure rigorous methods where used to analyse the data. This involved comparing and contrasting codes and themes within and across individual and group narratives. The analysis began with data familiarization, which involved multiple reviews of translated documents to become sensitised to the information and better understand how respondents made sense of their worlds [217]. Once the translated documents were reviewed, the following coding strategy was developed based on modifications of grounded theory and constant comparative analysis: a) initial coding; b) focused coding c) thematic development through clustering and d) constant comparison between and across codes, themes and cases.

Nvivo software was used to code and categorise the translated data. Initial coding entailed a broad sweep of all the narratives using categories derived from the conceptual framework with nvivo and additional codes also emerging from within the data. Over 100 initial codes were developed, which was followed by more focused

coding to subsume each of the initial codes into the more salient and frequent codes and engage in a deeper level of analysis. Once codes were reconstituted using focused coding, they were then clustered into themes. Codes that most represented what was reflected in the data were selected as 'core codes' or themes around which clustering was conducted. Clustering provided a way to distil the data and helped explore patterns, ideas and relationships across various themes [253, 261].

Group and individual narratives were then charted in an excel worksheet with key themes used to compare and contrast cases, analyse patterns and trends within and across gender and age groups as well as delineate experiences which were specific to an individual case [261-263]. Differences and similarities within and across narratives were explored to uncover more depth and meaning within the data [264]. The exploration of negative cases helped identify other avenues through which the phenomenon under study could be analysed and explained [217]. Visual models were also developed for each of the key themes to better assess underlying codes and associated relationships.

Throughout this process, from data collection to the analysis, I kept memos on the research process and emerging codes and themes from the data [217]. This allowed me to become more proximal to the data and aided in transforming codes into higher conceptual categories. Through the memos, a documented trail of emerging impressions of the data and the relationships between them were captured [265]. Careful consideration was paid to elaborating the properties of each code, rationalizing why some codes were subsumed into others, comparing codes, and incorporating theoretical backing and respondent accounts as evidence to develop assumptions about the phenomena.

Although theoretical saturation or gathering data until no new information emerges is a key foundation within grounded theory, this was not possible due to the limited size and scope of this study. Moreover, it can be argued that experiences are unique to each individual and that the same experience can be portrayed differently depending on the person. Each experience thus provides different vantage points to better gauge the phenomenon of interest. For this research, Charmaz's definition of theoretical

saturation was employed, whereby themes were fully developed until no new properties related to a category emerged [217].

Language

Research in languages not spoken by the researcher is challenging due to the various layers of interpretations that may be lost when data is translated [234, 266]. Although there is a lack of rigour associated with the translation of qualitative data in a foreign language, many qualitative studies have been conducted this way [267]. This study used a layered approach by first translating data into Portuguese, and then English, to minimise any loss of data. While it would have been useful to engage a third party to check all the transcriptions and translations from local language to Portuguese and then to English, this was not possible due to resource constraints.

Interpreter bias could have emerged since the study was not conducted in the researcher's own language. This bias was somewhat mitigated through intensive debrief sessions with the research assistants after each group discussion and interview. In cases where word to word translations did not accurately portray the meaning of the account, a contextual translation was included. For example, a Portuguese phrase commonly brought up in the research was '*andar em qualquer maneira*', which if translated directly into English means 'to walk in whichever manner'. However, this phrase was consistently brought up in the context of multiple sexual partners and infidelity. After discussions with the research assistants, it became clear that the local idiom was used to imply that 'men and women have sexual relations with whomever and whenever according to their desires'. The research assistants were directed to be mindful of the context used to translate accounts in order to minimise potential interpretation biases [267, 268].

Terminology can play an important role in the research as topics under discussion may be greatly misunderstood if different meanings are attached to concepts or words by respondents and the research team. Although the term 'gender equality' was a key area of analysis in this research, it was rarely if ever used in the study due to its loaded nature and differential meaning across settings and individuals. Instead, questions aimed at equality were framed in less suggestive terms, such as through power, control, responsibility and decision-making authority, which were then

assessed in terms of how they are applied in various situations. Intensive training helped ensure the research team were clear on research related vocabulary and that they were able to explain the meaning of terms which respondents did not understand. One notable example was during the octopus exercise, where the term 'vulnerabilidade do HIV/SIDA' or HIV/AIDS vulnerability, was at times confused with HIV/AIDS risk ("***Risk*** *is defined as the probability or likelihood that a person may become infected with HIV. Certain behaviours create, increase, and perpetuate risk - i.e. unprotected sex with a partner whose HIV status is unknown.* ***Vulnerability*** *results from a range of factors outside the control of the individual that reduces the ability of individuals and communities to avoid HIV risk - i.e. lack of knowledge and skills required to protect oneself and others).*" [269]. The confusion among respondents could have stemmed from minimal information or unimportance attached to interchanging the two terms. However, to ensure that factors beyond just direct means of HIV/AIDS transmission were considered, the assistants explained the difference between the two terms and then asked respondents' to name what they thought was an HIV/AIDS risk versus a vulnerability.

Reliability and Validity

Similar to other studies examining sexual behaviour, measures to enhance validity and reliability were critical since such behaviours cannot be confirmed through observation [270]. For this research, validity was maximised through the use of different, yet complementary research methods and theories to triangulate data and allow for greater confidence in the findings [270-272]. Theoretical triangulation, through the use of constructs such as self-efficacy, social norms, social construction as well as gender and power theory to analyse and interpret a single phenomenon helped enhance validity [270] because they have been used to examine similar research topics in very diverse settings. Different methods such as the use of participatory group discussions and individual interviews to gather data aided in improving validity [184, 273] and limited potential criticisms that findings may be inherent to a specific method [274]. The use of both theoretical and methodological triangulation also contributed to decreasing any potential systematic biases in data analysis [263]. Although respondent validation of the findings has been suggested to increase validity [270], this was not possible due to financial and time constraints. Validity was achieved through constant review of the data, continuous debriefs with

the research assistants, and through detailed notes [217]. To further enhance validity, codes which contained more than two respondent references were kept while others were submerged into broader codes.

In order to maximise reliability, I reflected on the potential effect I had over data collection and analysis [239, 253]. My identity may have influenced individual responses owing to power differentials of the data gathering process [272, 275]. In addition, the interaction in an interview, which is co-constructed, can influence the manner in which individuals portray realities and experiences [217, 276]. To address these limitations, during the analytic phase, I reviewed translated documents a number of times and pursued line by line coding to preserve respondent accounts as much as possible [277]. The fact that I am an outsider, a female and previously as well as currently affiliated with the implementing organization may have influenced the extent to which respondents remained open in their responses. This was addressed by ensuring local research assistants were matched with their gender group as well as having them conduct group discussions and in-depth interviews in local languages. It was also explained to respondents that while the research was linked with the host organization, no other individuals beyond the research team would have access to identifiable information. Reliability would have increased if themes extracted from the analysis were compared with another researcher [239]. However, this was not feasible because of the independent nature of the research.

Strengths and Limitations

The lack of knowledge of respondents' HIV status was a noted weakness of the research and could not be ascertained due to ethical and resource constraints. Instead, the research examined behaviours that have been deemed protective as evidenced by previous research and analysed these within the context of specific gender norms.

The research utilised a qualitative design which allowed for a richer exploration of the experiences that have helped men and women engage in HIV/AIDS risk reduction efforts within their existing gender roles. While qualitative research can provide insight into lived experiences, this can alter through time and portray only one representation of that truth [277, 278]. The research thus provided a snapshot, rather

than complete insight into particular norms, beliefs, attitudes and practices in the study communities [279]. However, as in previous studies exploring sexual relationships, the mixed method approach, through group discussions and individual interviews helped provide a more comprehensive understanding of relationships and norms among men and women [257, 280].

Conducting the research with a host institution helped gain access to remote rural villages as well as key information and expertise. The organization's long standing presence in the research setting also facilitated in mobilising individuals to participate in the group discussions since trust and relationships with the villagers had already been established. Gaining trust is an inherent part of the data collection process as it encourages respondents to divulge more open and honest responses [217]. Since it was the aim of the study to incorporate findings into on-going programmes, conducting the research with a host organization paved the way to help ensure that findings are put into practice.

The group setting provided awareness of how interactions occur between individuals and the ways in which experiences are shared and constructed among respondents [281]. Group discussions however, can suffer from a 'group think' effect where respondents converge on a certain viewpoint, even though it may not necessarily reflect their own perspective [282]. Given the dynamic nature of the discussions and the varying views that emerged, this effect may have been minimised. There may however, have been other dimensions such as power, race and ethnicity specific to the cultural context that I did not detect [283].

Interviews allowed for a deeper assessment of accounts and proved to be an effective method to tap into individual experiences despite acknowledgment that such accounts do not always portray an exact picture of reality [217, 284]. Self-reported data is always under scrutiny since it can never be validated or confirmed. While it may have been useful to interview a partner or spouse to confirm an interview account, this was not possible due to time and financial constraints. Instead, the research adopted one version of events, highlighting the subjective nature of data collection [285]. Despite this, important factors were gleaned that could be used in prevention

campaigns and influence other individuals to engage in HIV/AIDS risk reduction strategies.

Within individual interviews, recall bias may have been introduced which can compromise accounts provided by individuals, and lead to less reliable data [239, 271]. Since interviews delved into sensitive areas such as sexuality and HIV/AIDS, respondents may not have been truthful in their account, in order to show adherence to certain cultural values [286]. To overcome this, interview guides and oral questions were worded so that similar information could be obtained from various angles. A careful examination of each transcript confirmed that consistent accounts of experiences were provided by each respondent. Respondents were also assured that their information would only be used at an aggregate level [75]. To address recall and memory biases attributed to the collection of retrospective data [287], respondents were asked about particular identifiers to facilitate memory of the experience. For example, individuals who indicated they had multiple sexual partnerships were asked to provide characteristics of each partner such as financial provision, decision-making power and/or emotional intimacy. Individuals may have also provided socially desirable responses not necessarily reflecting their own attitudes or behaviour (i.e. condom use), however this was somewhat addressed by ensuring questions were worded and asked in a non-judgmental manner [270].

Although findings from qualitative research cannot normally be generalised to broader populations because of the small sample size, non-random selection of respondents and data collection taking place in a specific time, place and geographical context, it can result in information of high validity because it accounts for the reality of an individual's lived experience through their own words and perspectives [284]. Generalizability of participatory group discussions are also limited as views and norms are only representative of the individuals participating in the discussion [288]. Nonetheless, findings portray insights into strategies used by men and women to internalise and respond to risk in rural areas of Northern Mozambique.

Ethics

Ethics approval was obtained from both LSHTM (Annex 5 – Ethics Approval) and the host organization (AKF). AKF currently has a formal Memorandum of

Understanding (MoU) with the government of Mozambique whereby joint plans and programmes are developed prior to implementation. This study falls under stipulations of AKF's existing MoU with the government of Mozambique.

Before group discussions were undertaken, a detailed information form was read to all respondents which entailed: a) information on the research; b) advantages and disadvantages to their participation; c) ability to leave the sessions without providing a reason and d) potential participation in a follow up individual interview where separate consent would be sought. Due to high illiteracy rates in the area, the assistant read the form, answered any questions, and then signed it to confirm the above information had been conveyed to the respondents. All individuals initially mobilised for the research agreed to participate and only on a couple of occasions did an individual need to leave the group session in order to attend another pre-planned meeting or event. Although the research tackled some sensitive issues which may have led to gossip or caused tension between group members (i.e. a cheating husband), there was no evidence that this was an issue as most group members continued to actively participate in the group sessions even when mixed with the opposite sex. If an issue was deemed too sensitive to discuss or if an individual was fearful of repercussions, it is likely that they may not have contributed to discussing the topic during the group session. Referral information was made available for any individual wanting to discuss or access services related to gender based violence or HIV/AIDS.

Presentation of Findings in Results Chapter

The presentation of quotes in each of the results chapters are based on participatory group exercises and in-depth interviews. The octopus, gender table and comparison of these two exercises were conducted using specific tools and questions to guide the session and meet certain objectives including: ascertaining HIV/AIDS knowledge and experiences, understanding gender roles between men and women and exploring local perceptions of the intersection between HIV/AIDS and gender. The discussions were recorded with the quotes collated across each exercise as part of broader 'group discussions' and differentiated by unmarried or married men or women in the analysis. This was done because themes emerging from one group exercise tended to

cross over to others. For example, in the octopus exercise, although the intention was to discuss HIV/AIDS risk patterns in the community, discussions between members also delved further into why 'sex for business' was more of a risk for women than men thus shifting dialogue more towards expected behaviour among genders in the community. Similarly, for the last exercise which combined HIV/AIDS risk and gender norms, numerous themes emerged which were relevant to the entire analysis. The group quotes were thus derived from individuals speaking during the group discussions and may not always reflect group consensus as sometimes there were wide ranging opinions on some issues, such as which roles men and women should or should not enact. In all cases however, efforts were made to highlight accounts where consensus was achieved by more than one person in the group. The presentation of the group discussions therefore represents an individual's viewpoint within a much larger dialogue which reinforces the rich yet divergent nature of participatory group discussions. Only in cases where the mixed group (i.e. men and women) were present are the quotes from the individual detailed as either male or female. Similarly, the in-depth interviews have been categorized by their gender, age and marital status in the analysis to differentiate the type of methodology used. At times, in order to better express meanings, Portuguese words and phrases have been placed in italics with corresponding translations and context provided in English.

Chapter 5: Sexual Partners and HIV/AIDS Risk Assessment

Assessing and Responding to HIV/AIDS Risk based on Partner Type

This chapter examines expectations of different partner types and how these shape HIV/AIDS risk assessment and responses. The first section presents an overview of practices that increase HIV/AIDS risk and transmission in communities. It also forms the basis for the remaining chapters that examine local HIV/AIDS transmission patterns and the measures taken by men and women to reduce perceived risk. The next section presents an overview of characteristics sought after in a partner including those that indicate behaviours suggesting HIV/AIDS risk. The remaining sections describe case scenarios among men and women in relation to the use of risk reduction strategies with partners, which range from minimal to consistent use. The factors influencing men and women to remain complacent or engage in risk reduction with different partner types are examined in light of prevailing norms.

Conceptualizing HIV/AIDS Risk

In accordance with DHS [208] and HIV/AIDS surveillance data [289] on the key causes promulgating transmission in Mozambique, respondents indicate that low condom use in conjunction with men and women having multiple sexual partners contributes to the heightened spread of HIV/AIDS in their areas:

> *The factor which increases HIV/AIDS is having sexual relations in whichever manner. Men and women should have in mind only one partner, when you have sexual relations without condoms then you soon infect a person and spread it around the village or in the districts. – Participant in Married Male Group, Village A*

Phrases such as '*andar em qualquer maneira /practicar sexo em qualquer maneira*' (wandering around in whichever manner and having sex in whichever manner) or variations of these are often used to describe some of the HIV/AIDS risks among men and women who have multiple sexual partners. Such phrases are usually employed in the context of assessing a partner's behaviour and potential risk of contracting HIV/AIDS. Inherent in their meaning are a lack of control and carelessness in not only increasing potential HIV/AIDS risk, but also failing to engage in prevention measures to decrease its spread:

HIV/AIDS increases because people have many partners and they change women or men in whichever manner, these people have no control. We know the information that we must use condoms but we don't want to use it. - Participant in Married Male Group, Village B

Blame is cast on both men and women for having multiple sexual partners. Some respondents feel women harbour the virus, and as a result, cannot be trusted while others blame men for their risky behaviours and poor use of protection. Irrespective of how blame is assigned, respondents agree that the practice of having multiple sexual partners is a key driving force behind HIV/AIDS transmission:

Men increase HIV/AIDS because no matter where we go, and whichever woman we meet, we have to speak with her, it is because of this that we men can infect an entire community. – Male Participant in Mixed Married Group, Village D

The good thing is to have only one woman, but trust doesn't exist with women because on the day that you don't appear, she finds some man to satisfy her at night, so this is the way HIV/AIDS always increases. – Participant in Unmarried Male Group, Village D

The woman is infected and wants to have men of this village, and because of this, she begins to distribute the disease throughout the community. - Male, 67, Married, Village B

Many respondents also attribute risk and transmission to community wide beliefs that HIV/AIDS does not exist. This disbelief in turn serves as a barrier to condom use and getting tested for HIV:

People know about HIV/AIDS but they don't want to believe it, there is a lot of HIV/AIDS here, but men and women refuse to do the testing. - Female, 45, Married, Village A

Many do not believe HIV/AIDS exists and so many are reluctant to use condoms. – Participant in Unmarried Male Group, Village D

Disbelief in the existence of HIV/AIDS is noted by some as '*poverty of thought*' in that individuals' either misinterpret or refuse to acknowledge prevention information which results in low risk perception:

Many people don't believe that HIV/AIDS exists and I feel a lot for them...that's why they are contaminated because they don't believe in the existence of HIV/AIDS, they misinterpret the information related to HIV/AIDS. – Participant in Unmarried Male Group, Village B

Poverty of thought is when people say they don't believe HIV/AIDS exists and they don't want to use condoms, they refuse to accept the information. – Female, 29, Divorced, Village C

There is widespread and pervasive fear of getting an HIV test among both men and women. This is due to confidentiality concerns as well as anxiety related to the health consequences of an HIV positive status, with some viewing it as an immediate death sentence. Some women also avoid getting a test due to a fear of being abandoned by their partners:

Others refuse to go and do a test, they are afraid that if the partner discovers this they are going to leave them. – Participant in Married Female Group, Village B

We fear going to the GATV (voluntary counselling and testing site) and being told that we have HIV/AIDS. I am afraid to get tested, when you are told that you are HIV positive that is where you want to hang yourself. – Participant in Unmarried Male Group, Village D

A lot of people are afraid to do the testing because it might be known within the community. – Participant in Unmarried Male Group, Village C

In addition to obstacles in seeking an HIV test, there are many noted barriers to condom use among respondents including perceptions that condoms are responsible for the spread of HIV/AIDS and a belief that condoms reduce pleasure during sex. Phrases such as '*meat to meat*' or '*taste of sex*' highlight the perceived interference of condoms in promoting pleasurable sexual activity:

Women don't want to use condoms, they think it has the virus and they want to have sex without condoms to feel the taste of sex, we men also refuse. – Male Participant in Mixed Married Group, Village D

Nobody likes condoms they say it does not bring good sensations; you cannot have 'meat to meat' with a condom. – Participant in Unmarried Male Group, Village A

Condom use in risky sexual encounters is often forgone due to a common misperception among many that condoms are themselves responsible for spreading HIV/AIDS:

We don't use a condom because if you take it and place it in the sun, you will see bacteria coming out, so it is condoms that bring diseases. – Participant in Married Female Group, Village A

We heard that condoms bring HIV/AIDS, they say there are 'microbios' or very small bacteria in it, that's why many people don't like to use condoms. - Participant in Unmarried Male Group, Village C

Despite general lack of condom use, there are certain norms governing when they should be used and by whom. Many young men identify low levels of trust in a partner as a determinant of condom use. In such cases, condoms are used with women who are sought primarily for sexual enjoyment and who are generally not trusted by men vis-a-vis pregnancy prevention and disease acquisition. Many men also place the onus and responsibility of using protection on women even though they acknowledge that risky behaviours are practiced by both sexes:

Sometimes I use condoms with girlfriends who I don't trust and those that I have fun with, this is when I use a condom to prevent pregnancy and disease, but there are very few times I use a condom. – Participant in Unmarried Male Group, Village C

Women are responsible for forcing men to use a condom. They cannot select whether to use a condom, women must always use it because they don't know if a man has [HIV/AIDS] or not. – Male Participant in Mixed Married Group, Village D

Women are often held responsible for suggesting condom use with their partner, which can be difficult to do when they feel powerless. Many women feel uncomfortable suggesting condom use due to its association with prostitution. Even in cases where women did try, men made convincing counter-arguments to relinquish its use. Some individuals also feel that negotiating protection is not worth it since men might actually destroy the condoms:

Here nobody prevents HIV/AIDS because we don't like using condoms, when someone uses it we think that they are a prostitute. – Male Participant in Mixed Unmarried Group, Village D

Using a condom is doing zero work because the men usually tear the bottom of the condom, so it is not worth using a condom, it has no value. – Participant in Married Male Group, Village A

Sometimes us women, when we meet a boyfriend or anybody, he soon asks us to have sexual relations, he does not accept having sex with a condom, he speaks to us until we are convinced and soon accept it.- Female, 23, Divorced, Village B

Women, however, may also refuse men's attempts to use protection due to condoms' association with a person's infection:

> *I still have not made love with a condom, if someone brings me a condom to sleep with me, I don't want and don't need it, because he certainly has something and wants to give it to me. – Participant in Married Female Group, Village A*

Characteristics of an Ideal Partner

Unmarried men and women's descriptions of an ideal partner provide insight into the ways gender differences can be exacerbated in a relationship. Many unmarried women indicate that it is the role of men to conquer them; they thus feel restricted in their ability to venture out and do the same:

> *We have limits, we are not able to conquer men, it is always men who do this, when you speak of things that you want they get angry, they always want you to follow what they want. – Participant in Unmarried Female Group, Village D*

Most women focus on characteristics of men whom they would like to marry rather than discussing expectations of casual partners. The ability of a man to adequately provide resources and support are key criteria used by women to identify a future husband:

> *I am with him to help me and marry me. He helps me, gives me money or food, I would like my boyfriend to think of having a large farm or doing business. - Female, 50, Widowed, Village C*

> *I don't want a boyfriend, I just want a man to marry, he must have a job like doing business and buying and selling goods. - Female, 15, Unmarried, Village A*

The importance placed on the role of a man to provide finances is founded on a belief by many women that they lack the capacity to obtain their own resources. Some women rely on the ideas of their partner in determining how to improve livelihoods and are hesitant to challenge his advice. Despite such imbalances, some of these women aspire to help their partner in earning an income or ensure there is joint decision-making power over income expenditure in the household:

> *We women like many things but we don't know how to get it. We would like to do something to gain more but we don't have anything... When a man receives his money, he should bring it home and say here is the money, both of us should decide that some money will be for a small business and the other part for the children at school. - Female, 45, Widowed, Village A*

> *I want to bring what I can and give it to him, what I want is to combine with him and see what we can do, so he as a man can say what is missing. I can see what we need but I cannot disapprove his ideas. - Female, 29, Divorced, Village C*

Alongside the expectation that men should provide financially, women also place great value on emotional intimacy, which is described as giving advice and listening to and understanding one another, with many viewing it as a key component of a '*normal*' relationship:

> *I want a boyfriend who advises, who leads me on a good path, who can feel my feelings in difficult moments, even in sadness and in happiness, like a normal couple. - Female, 23, Divorced, Village B*

> *The type of man I like is one who shows love and understanding inside the house, to be your friend... you can say something and he listens to you and he speaks and you also listen to him, but that of not accepting what the other person says cannot be. - Female, 40, Divorced, Village B*

Most men desire a girlfriend who can work and earn an income, which may seem suggestive of attitudes encouraging greater opportunities for women. However, closer scrutiny reveals the motivation is primarily to increase wealth within the household through a dual income, and that women are expected to hand any money earned to the man who decides how it is spent, perpetuating income differentials between genders:

> *If I had a job I would like for her to also have a job, it's good in a house to be two workers. For example, in my work when I get money, it must be for planning and the woman's should be for spending. Despite receiving a salary, the money should not stay with her, she must show respect and present it to me. - Male, 20, Unmarried, Village D*

When women describe an ideal partner, there is no mention made of monogamous or faithful behaviour expected from men. This is in contrast to the majority of men who emphasise appropriate behaviour to be displayed by a potential girlfriend, which encompasses her 'not having sex in whichever manner'. The absence of such criteria by women may be telling of predominant norms tolerating sexual infidelity among men and their acceptance of this behaviour. Similar to women, emotional intimacy

figures strongly across men's accounts, with many desiring love and happiness with a potential partner, but basing these values on a trustful girlfriend who will not exhibit promiscuous behaviour:

> *She must show happiness with me during our courtship and to love me, I should also love her for us to live happily...I should have a girlfriend who has trust, that doesn't walk the streets in whichever manner. - Male, 27, Unmarried, Village B*

> *A good girlfriend is one who does not wander around in whichever manner, to take care of herself and not sleep with other men because it can create diseases. - Male, 20, Unmarried, Village A*

Among men, respect is a salient characteristic and is intimately associated with a woman's appearance, behaviour and family life. A respected woman is defined as one who dresses conservatively and either resides or comes from a good reputed family. These factors help alleviate concerns among men that a girlfriend may '*mess around*' with others. Women who adhere to notions of a respected and reputable status are considered '*good*', educated, and worthy of marriage:

> *I like her because she has respect and everyone at her home has respect, she comes from a good family, you won't see her wearing short clothes or showing her stomach. - Male, 22, Unmarried, Village C*

> *I like a woman to have respect, this type of woman deserves to marry, I have to see her behaviour, if she lives with or near her family this is good. - Male, 20, Unmarried, Village A*

> *On the part of women, I admire those that have a good way of living, they don't mess around, they remain at home, behave well and are educated. - Male, 28, Unmarried, Village C*

Although not mentioned by women, some men note the importance of physical attractiveness and beauty that their partners should possess. Interestingly, others are beginning to reflect on the potential for beauty, to be a marker of potential HIV/AIDS risk. Perceived risk is not only based on a partner's physical appearance, but also on their likely sexual networks. Such reflection is prompting some men to use condoms or abandon the sexual encounter:

> *When I see beautiful women, I begin to think about HIV/AIDS, I question how many men she already had sex with, so I do not accept to meet or be with her. - Male, 27, Unmarried, Village B*

You must have sexual relations with a condom, don't be convinced that because the woman is beautiful that she is healthy, HIV/AIDS is not identified on the outside. – Participant in Unmarried Male Group, Village C

Risk Assessment and Limited Response

HIV/AIDS risk is often evaluated on the basis of a partner's behaviour, however dependence on a partner often conflicts with the ability of women to take measures and reduce the noted risk. Many women report that while they practice monogamy, it is their partners' seeking other women and their inability to confront this that heightens their HIV/AIDS risk. Although the fear of a partner being sexually active with other women is acknowledged, the loss of the requisite financial support from a partner proves to be much greater. Women are aware of their potential HIV/AIDS risk but remain fearful of negotiating safe sex with their partners:

Even before HIV/AIDS came, I prevented wandering around with just anyone because I wanted to know if I got any diseases who infected me...I only follow with one, if he gives me support or not, I stay with him. I don't know if I am at risk, when a man discovers a new woman they ignore the old one. We women do not like it when the man likes another one, but we are always afraid to inform them. - Female, 29, Divorced, Village C

In other cases, despite acknowledged HIV/AIDS risk, a woman's overall satisfaction with her partner, combined with the desire to maximise sexual pleasure, results in lack of condom use:

I am happy with my boyfriend because he helps me a lot...The fear of him having other women is there but what to do, if I get HIV/AIDS then I get it....we don't use a condom, it's that proverb we say 'you cannot eat a banana with the peel, it doesn't have any taste'. - Female, 40, Divorced, Village B

Low Perceived HIV/AIDS Risk

Some individuals feel they are at low HIV/AIDS risk as a result of their own behaviour and thus do not feel the need to use protection. Some men, for example, remain abstinent. For these young men, adherence to religious norms, the desire to pursue their education and respect the wishes of their girlfriend accounts for their noted abstinence. Although the respondent below could conform to peer behaviour by engaging in sex with multiple women and act on his beliefs that "I make decisions

as a man", he has chosen to remain abstinent with his girlfriend who does not want to engage in sex, and this is in large part justified by wishing to concentrate on his education:

> *I have friends who have many girlfriends, today they are here tomorrow there. I just have one girlfriend, I like her a lot but have not had sex with her because she is still a virgin, when we reach an older age then we will get married...I never had another girlfriend before her, she is my first girlfriend, I do not have time to face women, I am just worried about my studies. - Male, 21, Unmarried, Village A*

Some men select to remain abstinent based on religious grounds and past negative experience with a girlfriend. The '*evil*' behaviour associated with engaging in sex with multiple women and the acquisition of '*women's diseases*' is linked with the belief that it will forbid entry into heaven. Past experience with an unfaithful partner can also lead men to abandon the relationship and take control by not having sex in '*whichever manner*' and remaining abstinent. The desire to behave appropriately is also rooted in the need to maintain a positive social standing in society:

> *A Muslim who dies from women's diseases does not enter paradise. I had a girlfriend but I did not like her attitude, she began wandering around with men and did not respect herself, I preferred to stay without a girlfriend...I do not feel at risk, I do not wander around in whichever manner, if I do this and others hear about it, I will be ashamed of myself. I take care of my body, I never practiced evil behaviour and feel embarrassed to embrace a woman. - Male, 28, Unmarried, Village A*

Even when women are able to survive on their own, many still adhere to norms where men are responsible for providing resources. Men who are unable to adequately provide for a woman may be subject to abandonment. On the other hand, women who are able to survive independently may be subject to forced abstinence by the lack of men requesting a relationship. Such men may feel threatened by their inability to fulfil a gender norm that generally assumes them as providers and thus they may avoid approaching women who earn their own living:

> *In the past I didn't like or accept it when my husband had other women so I left the marriage. I met someone after the separation but there was no understanding. For example I prepared food and other things but he did not do the same to help me. I had to do everything myself so I felt it was not necessary to have him...I don't feel at risk of HIV/AIDS because I don't have any man after me. - Female, 58, Divorced, Village D*

Selective use of Protection

There are some men and women who base their use of HIV/AIDS protection on partner type and the kind of relationship sought. Partners deemed 'suitable and safe' are eliminated from the use of protection while 'others' who are suspected of having a disease or engaging in unsafe practices are conferred with protection. Some men and women neglect to use protection with their primary partner, but feel the need to use condoms with casual or 'outside' partners. How individuals classify their partners or categorise their relationships plays a pivotal role in determining whether they will use prevention methods during early encounters and over time. Contrary to norms which discourage condom use in order to maximise sexual pleasure or because of perceptions that they contain a virus, some men overcame these barriers with certain partners. Condoms may be used with a new or casual partner when a persons' health status cannot be easily ascertained. In relationships where the '*outside*' woman in a marriage is considered a casual encounter rather than a girlfriend, condoms are used since trust levels have not been fully established. Over time and once a relationship has strengthened, condom use is abandoned. It is often men who decide when to utilise or abandon condom use based on partner type, with many women conceding to a man's wishes:

> *In the beginning of the relationship we used a condom and after that he said I am the only one outside of his wife, and that he will not look for other women...he convinced me that he was only with me so we began to make love without condoms. - Female, 29, Divorced, Village C*

Women are cast as '*outsiders*' because levels of emotional intimacy, such as love, trust and care normally associated with a primary partner are absent. However, as noted above, not all '*outside*' women are considered harmful, and this difference determines whether a man will use a condom in the sexual encounter. Women who are strangers or whose behaviour remains a mystery are '*suspects*' since men believe they are unable to accurately assess their HIV/AIDS risk thus motivating the use of condoms. Careful risk perception allows some men to conform to the behaviours of peers by having sex with multiple women while also protecting a primary relationship through responsibility in using condoms:

> *Most have many partners, here today if you have one girlfriend, tomorrow it is another... I also have many partners and can get a disease, I am at risk .... I*

have trust in one unique girlfriend so I don't use a condom with her. I have not yet noticed any HIV/AIDS risk with her. When I am away and with other women, I use condoms in order to avoid diseases, whether it hurts or not I must use condoms so I do not infect my girlfriend, it is a form of prevention because I have responsibility...I usually go to the health centre and ask for condoms when I suspect a woman. - Male, 20, Unmarried, Village D

Men often seek girlfriends who are well-behaved and can be trusted in order to minimise HIV/AIDS risk. The respondent below feels at minimal HIV/AIDS risk based on his own protective action but also because of established trust levels with his girlfriend through her own stated fidelity. Although the respondent appears to hold gender balanced views, indicating that "the decisions are made by the two of us, there is no separation because the man considers the woman and the woman considers the man", sexual double standards are evident. Despite open communication on risky sexual practices with his girlfriend and expectations that she will remain faithful, he pursues other sexual partners, but is cautious to use condoms with these unknown women:

I don't feel at risk because I already know about HIV/AIDS and ways to prevent, I don't know about my girlfriend but I trust she will not betray me with other people and get infected, that's what my girlfriend says...we spoke of the disease, that we cannot sleep around in any manner if we don't want to get it...I will have other girlfriends, it is not possible to only have this current one. I use condoms but not with my girlfriend, only when I am with other women. - Male, 27, Unmarried, Village B

The distinction made between a primary partner and others also proves pivotal for women. Consistent with men's accounts, some women who feel at heightened HIV/AIDS risk will use condoms when faced with a casual partner's unknown status. Through such actions, some women are confronting power differentials faced by other women who feel unable to negotiate safe sex. In these cases, a woman abandons a partner should he refuse to use a condom, possibly because she is able to survive on her own and not depend on men for any kind of financial support: "I have a business, with my money, I am able to get my necessities". Despite the respondent's own perceptions that men have the most advantage "because all the decisions here are entrusted in men", she nonetheless makes her own decisions by engaging in protection measures with casual partners and using contraception with a long-term partner:

I always use a condom, if someone doesn't accept it I don't agree to have sex. I do not have to use a condom if I am with and trust only one man, that is the way I prevent....I cannot use condoms if I am married and want to be pregnant but if I do not want to be pregnant, I will use a condom with my husband so we can also avoid pregnancy. - Female, 23, Divorced, Village B

Consistent Employment of HIV/AIDS Risk Reduction Strategies

There are some men and women who consistently engage in HIV/AIDS risk reduction across all partner types regardless of relationship status. As a result of their unique practices to reduce HIV/AIDS risk compared to others in the community, this specific sub-group of individuals are classified as positive deviants with their experiences detailed in this section. There are signs that norms are changing regarding appropriate times to engage in risk reduction based on factors that reach beyond a risk assessment of each potential partner. Individuals may accept certain gender norms which place them at increased HIV/AIDS risk such as sex with multiple partners, but nevertheless protect themselves against its acquisition. These men and women usually engage in multiple risk reduction strategies including abstinence, abandonment, HIV testing and/or condom use across a variety of partner types to minimize HIV/AIDS acquisition.

Risk reduction strategies are used to avoid HIV/AIDS but also to address underlying trust issues with a partner. Without a sufficient length of time to observe and assess a partner's behaviour, some women rely on HIV/AIDS risk reduction measures as a means to decrease potential risk in any given sexual encounter. Women will undergo an HIV test with new partners as a way of ascertaining HIV status but also as a means to assess partner values. When a new or casual partner agrees to get an HIV test, it suggests they are willing to listen to a woman's wishes, an indication of future partner behaviour in the relationship. Even when in a committed relationship, an HIV test may be sought when the potential for distrust arises. The respondent below openly admits the possibility of having sexual relationships while travelling away from her village and equates her behaviour to something men do. Despite fears of HIV testing in the study population, the respondent's immediate instinct is to get tested with all partners, whether casual or long-term. While a test is used with casual partners to mitigate distrust, it serves a different role with a boyfriend, namely as an attempt to determine the extent of emotional intimacy and commitment he has for her. Though

now widowed, this respondent admits strong influence from her husband and acknowledges "I always obeyed everything that he told me...he started getting the HIV test and then always took me", a practice she has carried on with all her subsequent partners. The respondent states that "since my husband's death, I feel I am suffering, I just stay at home and wait for my family to help me", a scenario which could lead to financial dependency on men and make it difficult to enact risk reduction strategies. Yet, it is the result of her husband's actions which influences the respondent to insist on getting tested across all partner types:

> *When someone comes to ask me for relations and I accept, I first go for an HIV test. I already went to the hospital to get tested and I am in maximum condition with no infection. If a man comes and I do not know his behaviour, I ask him to go to the hospital so we can do a test and know our health status. One day if I travel and leave my boyfriend, during the trip I can be with another man like he has done. When I return, we must go and get a test before we continue with our love. If he really loves me he will agree to get a test done, if not than he does not want me. - Female, 45, Widowed, Village A*

Similar to the association of an HIV test with a partner's love, some women will leave a relationship if their partner refuses to use a condom because this is viewed as a sign that the partner does not care her. For these women, an agreement to use condoms is closely tied with emotional intimacy, which contrasts the widely practiced use of condoms with partners who cannot be trusted or where there is a lack of intimacy. In the following case, a respondent feels women in the community do not have much power to negotiate anything. She nonetheless took measures to abandon a previous marriage because of a husband's infidelity and is also adamant on using condoms in all new relationships to prevent unwanted pregnancy and HIV/AIDS. If men do not agree to these terms, she refuses to have sex. The respondent acknowledges that "to stay without a man is tough in this village" yet favours protection from HIV/AIDS over the highly valued companionship and critical financial support offered by a partner. Although the respondent recognises that men cannot stay very long without having sex, this is unacceptable behaviour and she would rather leave than put herself in harm's way:

> *I think that a woman knows how to take care but the man increases the disease, he cannot hold onto and support only one woman. When you have women with no power to talk, they practice sexual relations in any manner, these days we do not have value because we don't have money, we depend on men. To stay without a man is tough in this village...I go to the farm, produce*

> *something to sell and do my business. With my first husband, he did not consider me well, he had other woman and I didn't like that so I left... I feel embarrassed when I ask for condoms, sometimes the nurses wonder why an older women like me uses it. I keep them and wait for my partner to arrive and inform him that I was able to get condoms to use so we can avoid disease and unwanted pregnancies, then I tell him that without condoms you are not able to be with me, if he understands we will use it, if he refuses he can leave. I do not need to see or speak with someone who doesn't use condoms because I know that it brings conflicts on the part of health and he doesn't want to hear the decision of the woman, this type of person is never good. - Female, 38, Divorced, Village C*

The respondent's overriding views that men are bearers of the disease and that women lack power to negotiate sexual encounters do not pose as barriers to the enactment of protection from her end. The desire to remain healthy and her self-sufficiency may have played a role in overcoming views on gender imbalances and taking measures to reduce any perceived HIV/AIDS risk. The wish to maintain a healthy status and avoid STI or HIV/AIDS acquisition is a driving force encouraging the use of condoms, with the acceptance of protection providing insight into a partner's character and whether he will capitulate to the '*decision of the woman*'.

Some women value the companionship of a partner, expressed by a respondent who "never stayed alone without a man", yet are determined to ward off any HIV/AIDS threat through multiple risk reduction efforts including condom use, getting an HIV test, and maintaining a relationship with only one man at a time. Consistent with other women, the refusal of a partner to use condoms indicates his lack of interest in her and the relationship. Contrary to widespread beliefs that women who suggest condom use may cause a man to leave the encounter, the respondent below feels that she does not need a man who refuses to oblige to condom use. Despite a partner exhibiting '*good behaviour*' the decision to use a condom in the relationship holds strong:

> *With this one friend, we have not stayed together much time to learn about each other's behaviour, but he has still not shown me bad behaviour, I see that he has good behaviour even when something comes up he helps me...If he stops me from using a condom then he doesn't like me, and I do not need him. When I tell him to use a condom he has to use because I don't know where he has been. - Female, 50, Widowed, Village C*

This respondent also gets an HIV test with all new partners in an effort to regulate her body and ensure a negative status. Self-respect figures strongly in the respondent's account to protect herself and maintain a good status in society by not '*wandering around in whichever manner*'. The term 'respect' also corresponds to notions of an ideal partner noted by many men, based on a woman's ability to maintain a good social standing and avoid promiscuous behaviour. Although the respondent has assets from her husband and is able to generate an income: "I have two houses in Quirimba that my husband left for me and I get money from the rental of house ", she still places value on a man's role to provide resources. This stance however, does not interfere with her desire to respect herself and control her body:

> *In the first few days we started to sleep together, I went with this man to be examined in the hospital, we did an HIV test and it was negative. Always when I am with a man I go to the hospital to control my body...To have many men to help me, never, I do not need it, being with only one man is enough to get things that I cannot get, when you respect your body in your home you do not wander around in whichever manner. When I have a partner we stay together, people will never say that I change men, it has never been, I am a person of respect, I still have not had a disease. - Female, 50, Widowed, Village C*

Younger unmarried women tend to fear HIV/AIDS as a result of the uncertainty associated with the disease rather than feeling at any direct risk. Contrary to their peers who may not always attend school because they want "to have fun with boys", parental guidance and self-determination has been pivotal to ensure these young women not only finish their education but avoid sex until marriage. Education contributes to opening up opportunities for young women and provides some leverage in the negotiation of future safe sexual behaviour, either through an initial HIV test prior to marriage or confronting a husband's potential infidelity during marriage. A future husband's refusal to get an HIV test provides some insight into the type of behaviour, such as lack of support or understanding, a woman can expect in the marriage. Similar to unmarried adult women, these young women associate the acceptance of protection by a future partner as a sign of love, trust and commitment in a relationship. Education and the desire to have a job and make their own living may be motivating factors encouraging these young women to take an adamant stance to HIV/AIDS risk reduction while also resolving some gender imbalances by completing school:

I fear HIV/AIDS but do not feel at risk because I have not yet started having sex with a man. If someday I meet a man who wants to have sex with me I will not accept it even if I love him, first we have to get married...With my husband, before marriage we must first go get tested to know our state of health, if he refuses to get an HIV test he will have to leave me. If he tells me something and I accept it and then if I say something to him and he refuses then how can we live?...My mother always gives me moral strength to go to school and she says education is the future of tomorrow. - Female, 15, Unmarried, Village A

I have fear because I don't know this disease, if one day I find a boyfriend and he doesn't want to use a condom, I will leave him even if I like him because he is going to bring me diseases. If he is my husband I will talk to him to have one partner, if he refuses that is when I will leave him... I would like my husband to be my age and with a job, if the man accepts to marry me and lets me go to school I will marry him, if he doesn't want me to study I will not marry that man. - Female, 16, Unmarried, Village A

Similarly, unmarried men also assess the suitability of a woman for a long-term relationship based on her acceptance to use HIV/AIDS protection. As with young women, education as well as family guidance may influence these men to engage in protection. Young men are overcoming norms that encourage condom use with outside women and instead believe that partner agreement to condom use is a sign of trust and love, consistent with the accounts of women. With strong influences from an uncle, the young man below uses a condom in all sexual encounters to avoid pregnancy and prevent disease. A woman who agrees to use protection, which is generally linked to notions of distrust, is embraced by this man who instead believes it represents a woman who exhibits '*good behaviour*':

I was always told by my uncle that we have a disease with no cure and that without prevention I will die early, he told me if I can't stay with only one girlfriend I must use a condom...When I get a girl I use a condom, if she refuses I leave and look for another one who will follow my example. I look for someone who is normal and has good behaviour. If a girlfriend, she will always have to use it (condom) to avoid many things like pregnancy and disease. - Male, 20, Unmarried, Village D

Negative past experience with a partner can inform and help shape more careful assessment of future partners. Prior experience with a girlfriend's unfaithful behaviour can motivate men to abandon the relationship and dissociate themselves from the '*contaminated*' behaviour of others. Even though the respondent below believes that all "decisions should be made by a man because he is the head of the

house", he acts on these thoughts and takes action to minimise any potential HIV/AIDS risk, and in doing so overcomes peer barriers discouraging condom use in sexual encounters with a primary partner:

> *She was my only girlfriend, but she behaved badly with my friend and for that I left her, I did not need to be contaminated, she can sleep with other people....Yes I always use a condom, there are other youth with girlfriends who say that I cannot use a condom with my principal girlfriend, that I should use condoms with other ladies or women, but I use it with all women. - Male, 20, Unmarried, Village A*

Similar to some women, dual protection against both HIV/AIDS and pregnancy is a common rationale for young men to use condoms. In some cases, this is to ensure a sound and healthy future, including the completion of school, rather than plans being destroyed by pregnancy or disease. As noted below, dual protection is used by the respondent to successfully negotiate condom use with his long-time girlfriend, but as an added measure of protection, he also convinces her to get an HIV test. The girlfriend's acceptance to use protection and get an HIV test is met with respect and indicative of the type of person the respondent would like to marry in the future. The respondent appears to hold gender balanced views by indicating transparency on money matters with a future wife, "when I get money I will show my wife and tell her the money is here to go buy what we want, and if she is able to get money, to do the same", but associates emotional intimacy with partner agreement to risk reduction strategies just as men with gender imbalanced views do:

> *I did the test to know my status, protect my body and live well. I spoke to my girlfriend and she went and did it and it was negative...Even in sexual relations we use a condom because we are students, and we use it to prevent pregnancies. If we didn't use it, she will get pregnant, and we will destroy our future plans. We also use it to prevent diseases. She likes to use it, that's why I don't leave her because many girls don't like using condoms. She was not angry to use it, first we had a conversation and then we decided to use a condom. I cannot imagine if there was no condom, in this phase we would already have children or would have abandoned school, my life would be having children or working in the farm to support the family, and for this we feel better using the condom. - Male 22, Unmarried, Village C*

Unlike many of his friends who seek multiple sexual partners, this respondent is influenced by parental monitoring and strong guidance from his father to remain monogamous and secure a sound future through education. Observation of his

father's behaviour in remaining faithful in his marriage also contributed to the respondent's monogamy:

> *I have only one girlfriend but many of my friends have many girlfriends. Everyone deserves to have a girlfriend that you trust, I have only one girlfriend, she knows my secrets and I know hers. She is the one who I want to marry...My father did not have other women outside of my mother, and I now practice the advice that he gave me. He prohibited me from going out at night, it was either to work, study or sleep, I didn't even go see films. - Male, 22, Unmarried, Village C*

Conclusion

Within the study population, multiple sexual partners, apprehension in using condoms, and fear of getting an HIV test are factors contributing to the spread of HIV/AIDS. Unlike women, when men initially assess partners, HIV/AIDS risk is one of the criteria used to determine suitability for a relationship. Both men and women value a partner who exhibits emotional intimacy through love, trust, respect, care and support. Characteristics sought out in a partner, however, often serve to widen gender differences and reinforce gender norms, such as when women look for a man who can provide adequate financial support or when men want their partner to work yet want control over the finances. Once in a relationship, careful assessment of a partner's behaviour is a critical means through which some men and women ascertain their own risk and decide whether to respond.

Some men and women remain complacent to their own or partner's risk whereas others refuse to accept it and take measures to prevent HIV/AIDS acquisition. Women often feel powerless to negotiate safe sex with an unfaithful partner to avoid loss of financial support. Other men and women do not feel at particular risk of HIV/AIDS due to practising abstinence. Some men and women selectively use condoms based on partner type which is often linked to trust levels. Condom use is often forgone with a primary partner due to established trust levels but utilised in more casual encounters when a person's health status remains unknown or their sexual behaviour cannot be determined. Some men who selectively use condoms with 'outside' partners also do so in an attempt to protect their primary partner and the relationship.

Although the link between a distrustful partner and HIV/AIDS prevention is common, this is being challenged by some men and women who instead associate the acceptance of HIV/AIDS risk reduction strategies by a partner as evidence of love, trust and care. A partner's acceptance of condom use or an HIV test can indicate attitudes and behaviours one can expect in a relationship.

Unlike many of their peers who did not engage in HIV/AIDS prevention, a sub-group of individuals overcame barriers to risk reduction efforts and consistently employed these across various partner types regardless of gender views, attitudes or practices. Such individuals were thus 'positive deviant' cases as their practices were quite unique and stood out against widespread and often constraining social and gender norms posing barriers to HIV/AIDS risk reduction efforts. In an effort to minimise any HIV/AIDS threat, these men and women are using various risk reduction strategies, such as walking away from a risky encounter, getting an HIV test or using condoms with all partners, primary or causal. Although gender norms can cause some men and women to be placed in situations of heightened risk, this did not pose a barrier to the employment of risk reduction strategies for positive deviant individuals. The decision to engage in such strategies is intimately linked with observed partner behaviour, past experience, the wish to protect one's health and relationship status, strong family support and guidance, the desire to maintain a good social standing and to avoid pregnancy. Having an education and being self-sufficient, particularly in the case of women, are also influential factors.

Careful partner selection, based on desired characteristics, and an assessment of behaviour to gauge HIV/AIDS risk, are strategies used by men and women to identify future spouses. Marriage is an important and highly valued social institution, making it imperative men and women seek out a desirable spouse. The next chapter examines norms within marriage more closely, particularly the way it influences HIV/AIDS risk and gender roles and responsibilities, and the strategies men and women use to overcome risk and gender disparities.

Chapter 6: Socially Constructed Views on Marriage

Norms and Practices within Marriage which Influence Gender Roles and HIV/AIDS Risk

This chapter presents rationales for the overriding expectation that individuals will marry and considers how marriage norms can simultaneously preserve gender roles and aggravate HIV/AIDS risk. The social importance placed on the institution of marriage is examined, particularly in the way it maintains and reinforces gender norms. The elements which constitute an ideal marriage are discussed to highlight the similarities and differences in expectations between men and women, including anticipated roles and behaviours. The chapter then details the perceived protective effects of marriage in mitigating HIV/AIDS risk and the socially wayward behaviour commonly associated with unmarried adult men and women. Views from respondents who challenge the protective effects of marriage are also presented, with discussions centred on the norms and pressures which may heighten HIV/AIDS risk, most notably, those which tolerate married men seeking multiple sexual partners and the social limitations placed on condom use within marriage. The chapter concludes with factors that influence men and women to reduce perceived HIV/AIDS risk, despite constraining gender norms and marriage pressures.

Being Single

Marriage fulfils social obligations and earns respect for men and women. The weight placed on universal marriage is such that that those who refuse to get married are seen to be sidestepping important social responsibilities. Remaining single up to a certain age is acceptable and depicted as a stage of innocence. However, once men and women reach marriageable ages, between 15-25 years old according to respondents (which fits with DHS data [208] indicating that the mean age at first marriage for women is 17.5 years and 21.8 years for men), a single status is no longer valued and indeed viewed negatively. Individuals who are single and at an age where they should be married are seen as problematic and considered a bad influence in society by being 'bandits' or engaging in sex with multiple partners:

> *Girls don't want to be married even the men don't want to marry, today you will see a man in Sofia's house, the same one goes to Zaina's house, so from*

there he starts to cause social problems, the people don't know what to do. – Participant in Married Male Group, Village A

Every single man, whether rich or poor, is a 'bandido' if he doesn't marry. These men have little ideas because if they don't marry they are fleeing from their responsibilities and it is them who try to conquer every woman in front of him. – Participant in Married Male Group, Village C

Marriage also serves as a social boundary with implications for how HIV/AIDS risk is perceived. Men and women who remain unmarried are perceived to be at heightened risk and blamed for spreading HIV/AIDS in the community through concurrent sexual partners. Marriage thus serves as a means to control risky and negative behaviours, with many associating the delay or refusal to marry with '*bad behaviour*'. Although negative connotations are associated with unmarried individuals, these views are much more pronounced for women who bear the brunt of blame for HIV/AIDS transmission:

There is an increase in HIV/AIDS among women because many of them are single, these women spend the night with men, they like this a lot and feel it is better to have sex than to marry. - Male, 37, Married, Village B

We don't want to marry, we don't want to sit in the market to do business, or arrange a man to marry us, that's why the diseases are many. - Female, 34, Married, Village C

All the diseases are from unmarried women, they don't like to marry because of their bad behaviour so they depend on sex. To reduce this disease we have to force the single men and women to marry so that we can reduce bandits and prostitution. – Participant in Married Male Group, Village B

Social disapproval of unmarried men and women is rooted in fears that they will seduce the spouses of married individuals and disrupt the marriage. In addition to controlling HIV/AIDS risk among unmarried individuals, the push for marriage is also a means through which married men and women feel secure that their spouses will be protected from unmarried individuals:

In this community a woman is respected only if she is married because we know she won't disturb anyone else's husband. – Participant in Married Male Group, Village C

Normally for men who don't marry, his life is only to seduce our wife, nobody likes his attitude, he's like a lion. There is no trust with a bachelor, he steals married women and ruins marriages. – Participant in Married Male Group, Village D

Some women decide not to marry regardless of enormous social pressure because they prefer to make their own living and not be placed in situations where they are required to be at the whim of a husband's needs. Some men also choose to remain single for their own reasons, such as wanting to study. These individuals appear to have greater agency in deciding to get married despite what their peers may be doing or what society deems as an obligation:

> *Many women choose not to marry because they will need to do all the work to support their husband, the husband will not do anything. – Participant in Married Female Group, Village C*

> *I am not going to marry because my friend has married. I am studying and have not reached the phase to marry, if the time never comes for me to marry then it was my destiny. - Male, 20, Unmarried, Village A*

Norms of Marriage

Marriage marks a life transition from the uncontrollable behaviour of single men and women to the acceptance of responsibilities that includes procreation, stability and security. According to respondents, it is usually the man who selects a woman and if she agrees, parental permission is obtained from both sides before the marriage takes place. Men and women tend to select their own partners, although some elders will encourage women who have reached a certain age to marry:

> *I went to the ceremonies with the elders, they advised me that when with people you should treat them in a certain form, and if you are older, to pick a man to marry and follow his ways...The elders said to me 'my child you are already grown up you should marry' and so I listened to their words. - Female, 37, Married, Village D*

There are certain customs followed prior to marriage, such as initiation ceremonies, and after a marriage, such as the payment of a dowry, where the expected roles and responsibilities for men and women are conveyed. According to respondents and corroborated by CRSP participatory research [215], the family of a woman getting married receives what is known as a *Mahari* or a symbolic amount of money which represents the purchase of the woman by the man's family (approximately USD $4-5). Initiation ceremonies occur between the ages of 8-13 years for boys and girls. During this time, boys are circumcised while women are informed about sex, pleasing

a husband and keeping a marriage strong. Information about sex is conveyed through metaphors related to food and girls are warned against starving a man if they refuse to have sex with him. Even though initiation rites are a form of traditional passage into adulthood, for girls there is social pressure exerted by elders to maintain their virginity for marriage:

> *One thing we have in this area are customs and traditions in a marriage, in the first meeting, when a woman loses her virginity the elders are present at the marriage to confirm she was a virgin. - Male, 21, Unmarried, Village A*

An important function of marriage is to produce offspring to ensure the sustainability of both the family and society. The social requirement to procreate is instilled to an extent that one man suggests taking on a second wife in order to have children if his first wife is infected with HIV/AIDS:

> *I cannot reject marrying a girlfriend if she has HIV/AIDS. When I want to have children I can have another wife, do the HIV test and see if it is negative, then I can marry her and also be with the other one [with HIV]. - Male, 22, Unmarried, Village C*

According to CRSP [215], women are not expected to prove their fertility per se, but are considered prepared to procreate after their first menstruation. For the Makua and Kimauni tribes, a girl's first menstruation signals she is ready to be informed about marriage and reproduction through initiation ceremonies, while for the Makonde tribe, girls are expected to undergo initiation rites prior to their first menstruation to understand the purpose of the reproductive cycle. Men who impregnate unmarried women are expected to take responsibility for their action and get married. Those who do not follow through on this responsibility or refuse to support a woman after the birth of the baby are thought to incite suffering:

> *In women we noticed a situation where she suffers because the men make women pregnant and don't assume responsibility of the pregnancy. – Female Participant in Mixed Married Group, Village D*

> *After he got me pregnant he was obliged to accept me, therefore we stayed together until I gave birth. After the baby started walking he did not give me anything. - Female, 29, Divorced, Village C*

To avoid a situation of pregnancy out of wedlock, parents often encourage or force early marriage of their daughters. Parents also feel that early marriage will prevent

their daughter from going hungry and help her escape poverty, even if it means forsaking her education. Other parents view early marriage as a protective factor against disease. The alleviation of suffering is a key factor parents consider in the decision to marry their daughters at a young age. As a result, many girls feel they have little choice but to obey the wishes of their parents:

> *We are being forced to marry older people and early, even if we refuse we are forced. It's because of not getting pregnant before marriage that we are forced to be married early. – Participant in Unmarried Female Group, Village A*

> *They are very worried about how they are going to eliminate this disease so sometimes parents force their young daughters to marry. – Participant in Married Female Group, Village C*

> *The family is full of poverty and there is hunger in the family. When a man arrives for marriage and there is not enough food at home, a father speaks to his daughter to leave school and insists on getting her married to take advantage of things. – Male Participant in Mixed Unmarried Group, Village A*

Influential elders in the community often force girls to marry young at the expense of completing their education. Men are also resistant to their wife pursing an education because they feel she may neglect her marital role, such as preparing meals. Women are also prohibited from going to school by their husband for fear she may find another man:

> *In this village, women study until they are an adult but when someone arrives to marry they do not study any longer. They say when a married woman goes to school she finds another man. Men don't like their wife going to school and staying with other men, that's why they make her stay at home... Our elders just think of daughters growing up and sending them to marry, only to marry never to study. - Female, 37, Married, Village D*

> *Some women continue learning but others do not, they are prohibited. The husband thinks their wife will be seduced and also feels she will not have enough time to prepare food, so it's better the woman stays at home. – Participant in Unmarried Male Group, Village A*

Marriage is heavily engrained as a social norm, particularly for girls. The inability to find a husband is linked to notions of suffering and illness. For many women, marriage is a mechanism to ensure financial and social security and a means through which suffering can be alleviated. The value placed on marriage is based on the requisite support for daily life, but also as insurance against turbulent times:

If you are married and you get ill, your husband will do everything to take good care of you until you feel better. I think that if I am alone, no one will take care of me...If I live without getting married, I will suffer and stay sick. - Female, 34, Married, Village C

When I am not married I am very afraid, I no longer have protection and security, when the men arrive they stay for a time and then disappear. I need to marry, to stay without a man is hard. - Female, 38, Divorced, Village C

For men, the term 'respect' figures strongly in describing expectations of a wife. Married women are required to maintain a certain level of respect and adhere to the norms of married life, which includes listening to the commands of a husband, not '*wandering around*', and living within the means of what the husband can afford. Women who contradict expected marriage norms are viewed as escaping their responsibility in society:

A married woman doesn't respect her husband when she is wandering around and doing things without the permission of the husband, this is not good, she should respect the norms of marriage. – Female Participant in Mixed Married Group, Village D

My wife cannot contradict my ideas, she cannot come home and exchange words with me because she saw a woman with clothes that she does not have. It is a lack of consideration and she does not have respect for the husband or the marriage. Like this, a lot of women do not want to follow their marriage and escape this responsibility. - Male, 28, Married, Village C

Married men and women describe factors that create and sustain a marriage, many of which reflect socially prescribed and accepted gender norms. There is a clear delineation of roles and responsibilities between genders, which serve to reinforce discourses of dominance among men and acquiescence among women. Women are expected to abide by the wishes of their husband, while men are responsible for earning an income, providing for the family and making decisions for their wife. These assigned duties often serve to widen power imbalances between men and women:

A responsible man takes care of his house by buying plates, a bed, pots and other household goods...A responsible woman doesn't do anything without the consent of her husband, she lives according to his orders. – Female Participant in Mixed Married Group, Village D

In the house it is the man who brings home the food, the woman only knows how to receive and prepare it for her husband, it's the key responsibility of a man in the marriage. – Male Participant in Mixed Married Group, Village B

For a woman, she has to follow the words of her husband. If he stops her from doing something, she must obey and respect him. For example, they both cultivate the farm and remove the crops, but when they go home, the man has the power to keep or sell the products. – Participant in Married Female Group, Village C

Changing Views on Marriage Norms

Many respondents accept marriage as a social norm, however, some young men want to delay getting married in order to finish school or wait for a future wife to complete her education:

I just have one girlfriend. When we reach an older age, then we will get married. She is 14 years old, studying and in the 6th class. I am 21 years old and studying. We must continue to study to see if we can have something better for us in the future. - Male, 21, Unmarried, Village A

Even though younger generations may want to delay marriage, this is not always possible, especially for girls. Some men and women express concern over the missed opportunities for girls to pursue and finish an education. The potential loss of opportunities and income earning potential by leaving school can perpetuate dependency on men, as noted by references to the suffering a woman may experience if she wants to leave an unhappy marriage in the future. Missed opportunities that prevent a woman from getting an education and being able to survive on her own are factors which some respondents have linked to increased HIV/AIDS risk:

It doesn't take long for a woman to abandon school, but when this woman wants to abandon a marriage in the future where will she go? She will suffer a lot. – Participant in Unmarried Male Group, Village A

Women who marry early have an HIV/AIDS risk. Their parents don't understand that girls have not yet reached the age to marry, but they force her. You hear that someone is getting married instead of studying, which I see as a risk. For example, she is 10 or 12 years old, she is still in school and must be educated until she has reached a proper age to get married. If she marries early, she will not have knowledge of how to behave as a married person. If her husband goes to Pemba and starts wandering around with other women how will she take care of herself? - Male, 35, Married, Village A

Younger men and women tend to view and define an ideal marriage as one in which there is shared decision-making and understanding, indicating a slight shift in expected roles and responsibilities compared to their older and married counterparts. Rather than placing responsibility for supporting the family solely on men, young respondents are moving towards marriages where there is joint responsibility in sustaining the family. Future generations are keen to create cooperative relationships by sharing power with a future spouse:

> *A woman is also a person, we don't get married to have women as slaves. Who said that it is only a man who can speak? I think we have to change, it's not that I say one thing and she has to obey. If she speaks and I respond badly, it will never be love and the marriage will never exist. A woman should speak, a man should also speak, we need to have understanding between the two of us. - Male, 22, Unmarried, Village C*

> *For me a good marriage is about understanding, if I have a decision, he also has a decision. In the case that he has negative information, we both have to analyse it, we have to do this until we come to the same conclusion, we must accept the mistakes of each one. - Female, 23, Divorced, Village B*

Some respondents are keen on women being able to secure an income in a future marriage, albeit for different reasons. Young men appear more receptive for their future wife to work to improve living standards. Young women express the desire to get educated or work despite being in a marriage in order to survive should the husband leave:

> *I would like my girlfriend to work because when she works it's a step for the family, later when the money arrives we can do our plans. - Male, 27, Unmarried, Village B*

> *No I will not accept a husband if he stops me from being a nurse because if one day he leaves me then I will be the one who will suffer. - Female, 15, Unmarried, Village A*

Forms of and Practices within Marriage

Polygyny

Although there are shifting attitudes on marriage norms, there are some practices within a marriage that are prevalent. It is common in the study communities for men to have more than one wife. The rationale behind the prominence of polygynous relationships, according to respondents, is in part related to the apparent greater

proportion of women compared to men in villages (supported by the 2007 census [212] and largely due to out-migration). Local norms enable men to marry more than one woman but not the other way around:

> *Money is a thing in the world of men who like many women to bear close to their hearts. The number of women is higher in relation to men, and for this the religion says that a man can marry more than one woman, there is no woman that will say they must be married to four men. - Male, 28, Unmarried, Village A*

According to local interpretations, Muslims are permitted to have more than one wife due to religious grounds, while Christians do so for more traditional or cultural reasons [215]. The ability to take on two wives is also based on certain beliefs where men feel they can marry as many wives as they wish as long as they are able to provide and support each of them. The fair treatment of each wife is an essential component of polygyny:

> *The [Islamic] religion explains that to have two or three wives is not a problem, the only thing is that the two or three women cannot say they are suffering and that the husband is not considering them...If you buy rice for one wife you have to do the same for the other wife in terms of equal rights in a polygamous marriage. - Male, 28, Married, Village C*

Polygynous marriages are where equal rights between wives come into a play and where favouritism and inequality are frowned upon. Ultimately, it is the decision of a man to take on another wife, either because he is unhappy with the current wife or because he is accepting responsibility for actions such as getting a woman pregnant. Women who feel they are treated unfairly can take measures to leave the unbeneficial marriage:

> *He has to give the same rights to the two wives...I was the first wife and then he married the other one because her parents forced him to as he had impregnated her. She had more work, support and responsibility than me so I decided to leave them in peace. - Female, 29, Divorced, Village C*

Although polygyny is an accepted form of marriage, its principles have been extended by some individuals to include more casual relationships with multiple women. Among respondents however, there is a clear distinction between men who take on the responsibility of supporting wives through a committed polygynous marriage and men who develop sexual relationships with many women outside their wife. Some

men do not accept polygynous relationships as they feel it is used to rationalise promiscuous behaviour. Others suggest that polygynous marriages are a useful strategy to prevent men from seeking partners outside marriage since wives can be selected based on various desired traits and characteristics:

> *If you want to marry more than one woman and love each one it is possible, for example you can have four women: fat, thin, tall and short. You can marry each one, this is to avoid finding others because you already have several different features in these women to your liking. - Male, 28, Unmarried, Village A*

> *I do not have another woman, I do not like to follow this process of polygamy. My wife will be taken by another man because she thinks that I am not close to her. But it is not out of our custom. For example, I am a man, so I can have many wives and can be a polygamist, but when I leave she can call her boyfriend and on the other side he does the same thing with other women, so I do not feel good about this life of polygamy. - Male, 32, Married, Village C*

Infidelity

Male power and dominance are spread across all facets of life, but feature most prominently in sexual discourse. Infidelity among men is common in marriage with society often turning a blind eye to married men seeking '*outside*' women for sex. Men can freely express and act on their sexual needs because of a perception that they are unable to control their sexual urges compared to women:

> *Men are not able to stay without a woman outside, even if they promise to marry. A woman is able to stay many years without the need for a man outside her husband, but not the man. - Female, 38, Divorced, Village C*

> *A man gets sick when he spends a few days without having a woman. Therefore a woman knows how to take care but the man cannot hold onto and support only one woman. - Female, 34, Married, Village C*

Men who have a wife and a girlfriend allocate different financial resources to each based on relationship status. Mistresses or girlfriends are at a disadvantage because they do not get as much income from a man as a married woman would receive, causing many to acknowledge how a single life can be '*expensive*'. Men usually provide a greater share of their earnings to their wife and any reserve they have for their girlfriend. The provision of finances based on partner type may be linked to the symbolic value of a wife who is responsible for domestic activities, supporting the

family and taking care of the children, compared to a girlfriend who is sought for purposes of pleasure:

> *My wife works in the farm, even my girlfriend has a farm. When I have money, I give 20 meticais to my wife and 10 meticais I give to my girlfriend. - Male, 37, Married, Village B*

> *A single life is very expensive, but a married life is very good because when a man gets money or anything else he always takes it to his wife, from there he takes a little and gives it to his mistress. - Female, 40, Divorced, Village B*

Many men are able to act on their sexual needs as they see fit, however sexual urges are often fulfilled at the expense of HIV/AIDS risk. The common perception that marriage prevents loose behaviour are contradicted by a few respondents who acknowledge the potential HIV/AIDS risk brought on by a man's actions, thus questioning the extent to which marriage provides a source of protection for women. Infidelity can sharply contrast the provider and protector role usually associated with married men who, through their indiscretions, may put themselves and their families at heightened HIV/AIDS risk:

> *There are certain marriages that increase HIV/AIDS, you have married men, going out looking for other women and then bringing diseases to the wife. – Participant in Married Male Group, Village D*

> *Who spreads the disease is always a man, he can marry today but leave and go to another woman then come back and infect his wife. – Participant in Married Female Group, Village A*

Respondents feel it is a general lack of control causing men to continue with risky behaviour. Even when women discuss potential HIV/AIDS risk with their husband, power imbalances serve as barriers to such efforts:

> *I always explained to him that there are diseases. I can die, he can die and so can these women he is with. When I talked to my husband about it he told me to shut up, that I know nothing and that he is a man and knows everything. - Female, 58, Divorced, Village D*

Infidelity is widespread among men, however it is also practiced by some married women. Sexual pleasure motivates many men to have extramarital affairs, and while the same may be true for women, many overtly state that it is a husband's inability to adequately provide support that causes them to seek other men. A man who is incapable of supporting his wife financially can motivate her to engage in unfaithful

behaviour so that she can meet basic survival needs. Despite a critical survival strategy for some women, many acknowledge the HIV/AIDS risk associated with this behaviour:

> *When I ask my husband to give me 5 meticais and he refuses, I go and look for another man who will provide this because I am hungry. But surely this man will not give me his money just like that, so if he has HIV/AIDS then so do I. – Participant in Unmarried Female Group, Village C*

> *If I go to the districts and stay there for weeks or months, my wife will have no soap or food, she will go to Antonio to be given the money and if he is infected, she will also be infected and then so will I when I return. – Participant in Married Male Group, Village A*

Sexual double standards are apparent based on how society tolerates infidelity among men and generally forbids it among women. Many married respondents acknowledge norms allowing men to seek out additional partners, while for women, it is considered inappropriate behaviour that can result in divorce. Even though women may have knowledge of their husband's infidelity, there are few women who take action given the strong prevalence of this practice among men, and reluctance to become single. Many men on the other hand will leave a wife or a mistress if infidelity is discovered:

> *I told both my wife and girlfriend about this disease, if they change men and I discover that they have a man outside of me I will never be with them, I will leave and have another woman. - Male, 37, Married, Village B*

> *Married men are the bearers of this disease and the married women can do what they can to prevent...I am waiting for my husband and hope his behaviour of seeing other women will decrease. I do not like how he treated me but I stay with him because I cannot be single - Female, 37, Married, Village D*

Condom Use in Marriages

The majority of men and women suggest that condoms are used with '*outside*' women and almost never used with a wife except to avoid pregnancy. Condoms may also be inappropriate in a marriage when pregnancy is sought. For many married women, although a husband's infidelity is recognised and at times discussed, HIV/AIDS risk may still linger because of a reluctance to confront norms of condom non-use in the marriage and limited power to successfully negotiate safe sex. Some married men however, do use condoms with outside partners to protect themselves. Married

individuals often forgo condom use in a marriage because the behaviour of a wife is both controlled and trusted whereas the same cannot be assured for a woman outside the marriage:

> *I can use a condom with women outside of my wife. I don't use it at home because I have control with my wife, I use a condom only when I don't know a woman's behaviour. – Male Participant in Mixed Married Group, Village B*

> *Condoms are used outside the house, at home with your husband it is not used. My husband always has other women. I try to speak with him but there is no understanding. I tell him that we have an HIV/AIDS risk, but we still have sex without condoms because he is my husband. - Female, 35, Married, Village B*

Married women are held responsible for ensuring protection against their husband's infidelity, yet the decision on whether to use a condom ultimately rests with the husband. A wife who knows of her husband's infidelity is expected to convince him to use a condom with 'outside' partners or try to abolish his risky behaviour altogether. Such responsibility is placed on women despite many feeling powerless to act on it. A constant struggle over negotiation attempts by women, versus the control and use of protection by men, reinforces power imbalances in the marriage:

> *For married women to reduce [risk], they should ensure the husband stays inside the marriage, and inform him that they are in a difficult situation because of HIV/AIDS. – Participant in Married Male Group, Village A*

> *The woman has to buy the condom and give it to her husband, control whether he has used the condom or not when he returns. – Participant in Married Female Group, Village C*

> *A woman has no way to prevent [HIV/AIDS] because she can tell her husband to use a condom but he refuses. – Participant in Married Female Group, Village A*

Low HIV/AIDS Risk in Marriage

There are certain marriages where spouses have been together for so long, and where levels of trust have been built, that neither partner feels susceptible to HIV/AIDS. Part of this trust is established because each partner is able to detect whether slight changes in the behaviour of a spouse is a cause for concern in relation to infidelity. The respondent below alludes to balanced decision-making in the marriage because her husband "brings home the money and then we make plans", a behaviour that may

also influence levels of trust. The ordeals and upheavals experienced through years of marriage can help strengthen a relationship and build confidence in a spouse's fidelity:

> *I don't feel at HIV/AIDS risk because we understand each other, I do not betray my husband and he does not betray me...Many things happen in the marriage that we must endure, other days everything is well, others not so well. It is 30 years since we have been together. – Female, 45, Married, Village A*

Open communication on HIV/AIDS with a partner is a mechanism through which trust can be strengthened in a relationship. The case below highlights the potential infidelity that may be brought on by a husband should his wife let him travel alone. The candidness of a husband's potential infidelity is rooted in the mutual support and understanding shared over many years of marriage. In some sense, the husband is reaching out to his wife to accompany him on travels to prevent his '*heart*' from going out to other women. The honesty of her husband's intentions helps provide added reassurance of his fidelity, particularly due to the absence of any underlying differences or problems in the marriage. The respondent is able to generate her own resources based on guidance received from her father "he told me that I must always have my own farm. In this way I can have food and everything I need rather than being commanded by others". This independence may have influenced the respondent's husband to discuss potential HIV/AIDS risk with her to avoid losing a resourceful partner. Regardless of the motivation for opening up the lines of communication, the respondent feels at little risk of HIV/AIDS and deems it unnecessary to engage in any type of protection:

> *Since marrying my husband we never separated. I never noticed any differences or problems with him since we have been together, we support each other. Until today, I am with him because he is considerate, everything that I want he gives me. I want him to go on journeys alone to do business, but he said 'no, as men we have many hearts' so I should go with him...My husband and I never use condoms when we sleep together. - Female, 45, Married, Village D*

Decreasing HIV/AIDS Risk within Prevailing Norms and Practices

Despite marriage norms that pose as barriers to the employment of protection strategies, some respondents overcome potential risks in their marriages, doing so

against social and gender pressures, thus making them stand out as 'positive deviants'. The specific experiences and influencing factors motivating risk reduction strategies among positive deviant cases, not common in the study population, are highlighted in this section. For some men who take control over their family's well-being, a key factor behind their avowed fidelity in marriage is the desire to preserve an '*admired*' status in society by not '*wandering around*' with other women. Trust established with a wife over the duration of a marriage helps reinforce confidence that she is faithful and is not displaying '*bad behaviour*'. Despite a jobless husband, a wife who stays by his side rather than leave with someone else, helps ensure happiness and builds trust that she would not have sex with other men as noted by the phrase '*that is a woman*'.

> *My wife does not work, she is at home. I find and bring food home to eat from the farm... I am happy in my marriage, even though I do not have a job, my wife has never left me to marry another man. She has always been with me, it has been 10 years and I have not seen any bad behaviour in her. That is a woman. I do not feel at risk, a lot of people admire that I do not have bad behaviour, I am always with my wife and do not wander around in whichever form. I have not seen misbehaviour on her part and she has also not seen bad behaviours on my part. - Male, 35, Married, Village A*

The absence of bad behaviour in a marriage promotes its duration but also attracts social admiration. The desire to be a good married man and the value placed on marriage are incentives for men to remain faithful in their marriages. However, other influential factors include a father's advice to be with one woman, and a strong sense of responsibility to protect the family. Past negative experiences of having sex with many women and STI acquisition convinces some men to take a new direction in life by remaining faithful. Although some men conform to dominant discourses of superiority through financial control and decision-making power over women, the desire to avoid disease acquisition based on past negative experience, the need to maintain an admirable social standing, the value placed on marriage, and parental guidance are factors leading to their stated fidelity:

> *I am the one that gives orders, I make decisions personally because if I don't act there is nothing. I do not have that desire or time to look for women other than my wife. I know that if I get infected it will be from her because I have only one partner. If my family comes by and is told that I have gone to visit my mistress, this is not good, they should find me at home like a good married man. My father advised me to just have one woman, because with more women, I will not be able to see who is happy with me, he said I must help my*

family. In the past I had sex with women and during this time I had no ideas of marriage and became infected with women's diseases. From then on I took a new direction in life and stopped looking for other women. - Male, 28, Married, Village C

There are common factors motivating fidelity among men regardless of whether they share decision-making authority and/or financial control with their wife. The desire to avoid STI acquisition or '*women's diseases*' appears to be a critical factor encouraging married men to be faithful. As noted in the cases above and below, parental guidance to live a positive life, combined with concern on how behaviours are viewed socially, are common features that also encourage men to be faithful, regardless of gender views or practices. In an effort to avoid spending valuable time and money on other women, some men remain faithful as one way to alleviate poverty. Other norms, such as having sex with other women if a wife is unwell, have also been challenged by men out of care, concern and support for their spouse. The absence of '*strange movements*' may also help strengthen a marriage and establish trust levels with a wife. In the cases below, positive reinforcement from parents, the fear of being contaminated by STIs, the desire to maintain a good social status, the alleviation of poverty and strong emotional intimacy with a spouse are factors attesting to male fidelity and practiced in the face of competing peer and social norms:

I do not hide anything from my wife, she believes in me. Since I was born I have not had women's diseases [STIs], I learned about this from my parents, they told me that a complete man has to create positive ideas...If we separate I can have another one, but when I am married I will continue to always be with one woman. It's good when people see that I am with my wife and happy with my marriage...When we bring our money home, we combine it and make plans together. - Male, 32, Married, Village C

I have friends that have two women, but I wonder why a white man does not have two women, he just works, so like this he can remove poverty by supporting one woman...I also have only one woman, when I leave the house for another village I do not have sexual relations with other women, and this is how I prevent STI's...My wife is the one who takes care of things, when it is not a good thing I say so but she makes the decisions. - Male, 46, Married, Village D

I have not seen strange movements with my wife. She was sick with something for three months but I never found another woman. People said that because my wife is sick I can have another woman for my necessities but I didn't do anything, I stayed and supported her. I have not sought another woman, even STIs I don't know how they are obtained...When we have money, I discuss with

my wife if it is a good idea. That's why I married this woman, it is because of her understanding with me. - Male, 67, Married, Village B

Some women who state their own fidelity yet feel threatened by their husband's promiscuous behaviour, take measures to reduce their perceived HIV/AIDS risk, and in doing so, challenge predominant norms discouraging condom use in a marriage. Such women insist on taking action to decrease HIV/AIDS risk regardless of whether there is equal decision-making power, shared responsibility over income or other mutually supported roles in a marriage. In some cases, it is a husband's influence to open the lines of communication, get an HIV test and suggest the use of condoms in situations where distrust may arise with a wife. In the case below, despite mutual fidelity, a woman routinely gets an HIV test with her husband, and each has agreed to use condoms if they ever suspect one another of infidelity. The HIV test and condom use was her husband's idea as a means to strengthen the bonds of trust in the relationship. Although by her own account, "a lot of women have a fear of getting a test", her husband's support and encouragement persuaded the respondent to seek these services. In alignment with the respondent's own beliefs that the ideas of "men are much more advanced than a woman's", it is the result of her husband's positive influence and compliance to his ideas that she feels at decreased HIV/AIDS risk:

We talked about this disease, he said that since we trust each other, we don't have to use condoms, but if one day we suspect one another or there is distrust, he said he is going to use a condom...He was the one who initiated getting a test, he heard from lectures and saw films that showed people with HIV/AIDS, he told me about it and we both believed that this disease exists and is dangerous. He said that for us to live well and trust each other, we have to do the test, and I accepted. We went and did the test twice and both times it was negative...I don't have any boyfriends and he also doesn't have any girlfriends, I trust him because I see the way he behaves, I never caught him in adultery that is why I don't feel any HIV/AIDS risk. - Female, 22, Married, Village B

Generally, women who make their own living are more inclined to discuss condom use in the marriage if they feel at risk, and if this fails they would leave the marriage. This is in contrast to strategies employed by women who are solely dependent on their husband. Women in economically dependent marriages are more likely to forgo discussions on condom use and either take no action or leave the marriage. Some women who earn their own income initiate discussions on safe sex behaviour with their husband despite the stigma associated with condom use in marriage as noted in

the case below. High satisfaction in terms of support, decision-making power and open communication with a now deceased husband prompted the respondent to engage in discussions with him about extramarital affairs. Similar to the woman above, open communication on sexual risks and protection alleviates potential distrust. However unlike the case above where it is a husband's influence to engage in protection, the respondent below began discussions with her husband on safe sex, which may have been possible because of her stated financial independence: "I am able to sustain myself" and shared decision-making power in the marriage:

> *With my late husband I didn't see any HIV/AIDS risk, he died from malaria... My husband said he hasn't been with any other women and that he doesn't want to infect me with diseases...I liked him because he bought everything possible for me and when we slept together, each one was able to satisfy the other. There was understanding between us and in making decisions no one was unhappy. We bought condoms when absent from the house and anytime we suspected something we used a condom...Others don't like to use condoms but I used it with my husband. - Female, 50, Widowed, Village C*

For some women who are able to survive independently, the fear of acquiring an infection is a motivating factor to use condoms if there is evidence of a husband's infidelity. Slight modification in a man's behaviour can be determined by differences in the way a woman is treated. The respondent below overcomes norms of silence around men's sexual indiscretions and communicates with her husband about HIV/AIDS largely based on her ability "to take decisions because I help out with the household finances". Negative experience with a previous husband's infidelity compared to a current husband who does not display '*strange movements*' may influence a perception of decreased HIV/AIDS risk. The respondent may have been encouraged to discuss HIV/AIDS with her current husband to avoid being placed in a similar risky situation. The absence of '*bad behaviour*' combined with open communication provides security that a partner is not pursuing other women. In the event that the respondent discovers infidelity, she will insist on condom use in order to protect her own and her unborn child's health status. If a husband refuses to engage in condom use despite confrontation of his infidelity, the respondent claims she will leave the marriage. The desire to protect her family and kin from HIV/AIDS is a key factor to take action:

> *I believed that he [former husband] had other women. When someone is bitten by a snake, everytime they pass that route, they get frightened and think*

the same thing will happen...With this one [current husband], we live well, my heart is happy, I have not seen strange movements or bad behaviour with him because for a man to treat you badly, he needs to discover another woman. I spoke to my husband about HIV/AIDS and he says he can't afford to have many women...When I am married, I like to stay with my husband only. I want to have children, but if I discover that he has many partners, I will make him use a condom. I prefer not to have children and take care of my health because he does not want children if this is how he behaves. If he doesn't want to use a condom I will leave because I don't know if the other women have partners besides my husband and then we end up getting a disease. - Female, 34, Married, Village C

Among women who are financially dependent on men, many will take measures to reduce their HIV/AIDS risk, but usually do so by leaving their husband rather than negotiating condom use. The concern arising from a husband's infidelity and the potential HIV/AIDS risk that could be brought into the marriage or affect an unborn child are prevailing concerns for women, regardless of their ability to earn an income or make decisions. Although both respondents below lack financial decision-making power in the marriage, they engage in discussions with their spouse to try and reduce HIV/AIDS risk, albeit with limited results. In both cases, the husband reacted negatively or did not listen to the concerns of his wife. After communication endeavours had failed, rather than negotiate other safe sex behaviour, these women choose to leave their marriages:

We divorced a long time ago. In the past when I was with my husband I didn't do any kind of business, I just waited for him to tell me what to do with the money...During the marriage he had lots of women, at the time we didn't use a condom we just had sex without it, that's why I explained to my husband we must prevent diseases, because who knows if the women he was with were infected. I tried to explain that 'we women have diseases' both of us can die because of it, but he reacted negatively and said I know nothing and he knows everything so I left. - Female, 58, Divorced, Village D

With my former husband, he supported me because I did not have anything, but he had very bad behaviour. He goes out at night and then always comes home to have sexual relations with me, I explained to him that what if he infects our unborn child. He did not want to listen so I asked for a divorce. - Female, 37, Married, Village D

Women who have the support of their family tend to use this as leverage to make decisions on whether to stay within a marriage or leave it, especially when they feel at HIV/AIDS risk due to a husband's infidelity and they are '*suffering*'. Some married women avoid discussing condom use because of a belief that they may devalue the

significance of their marriage by treating their husband as if he is any ordinary man. Strong family support during such difficult circumstances provides the impetus for the respondent below to leave her marriage, especially given her '*limited*' ability to confront her husband. Such actions are in contrast to other financially dependent women who engage in initial communication with their husband prior to leaving the marriage:

> *My husband sold fish and was a carpenter, the little that he got he brought back for me, but then that turned into suffering, I began to see strange movements with him and realised that this is not a marriage.. I felt HIV/AIDS risk with him because he was a womaniser, I was afraid to say anything because they say we can use condoms with women outside not inside the marriage. I also did not talk about condoms because he will say that I forced him to use a condom as if he is any ordinary man, not my husband. That's why I don't know what to say, I am limited and just follow his guidelines... When my father heard of this situation, he said it is better to leave so I went to my father's house to live. - Female, 35, Married, Village B*

Conclusion

This chapter highlights the norms and practices within marriage that serve to maintain gender roles as well as influence HIV/AIDS risk. Marriage is a highly valued institution through which the often risky behaviours of single men and women are controlled and where social responsibility and respect are conferred. For women, marriage is seen as providing protection against financial insecurity and HIV/AIDS, while for men, it helps realise their expected role as a family provider. Compared to older married counterparts, younger unmarried respondents are much more amenable to marriages where men and women share responsibilities and decision-making.

Although marriage is generally thought to be protective against HIV/AIDS, some respondents acknowledge that certain practices such as early marriage, infidelity and social limitations placed on condom use within marriage serve to not only enhance HIV/AIDS risk, but in some cases, widen the gender gap. Within marriages, women often feel at HIV/AIDS risk due to a husband's infidelity. Despite this, women are the ones society deems responsible for enacting HIV/AIDS prevention measures. Married men on the other hand, engage in condom use at their own discretions based on perceived risk from 'outside' women. As a result of relationship duration and trust levels established with a spouse, some married women feel at minimal HIV/AIDS

risk. In some cases, a husband's influence to engage in protection helps women feel at minimal risk.

Some men and women take measures to reduce their perceived HIV/AIDS risk regardless of whether they are in a marriage where there is financial autonomy, control or decision-making power. These individuals are considered positive deviant cases because of their ability to confront prevailing social and gender norms by responding to HIV/AIDS threat. For both men and women, there are common factors motivating each to minimise their HIV/AIDS risk despite gender views or practices. Past experience with an unfaithful partner, fear of STI acquisition and parental guidance and support are influential in leading men to remain faithful and women to discuss risky practices in the marriage. Among men, regardless of their stance on financial control and decision-making power in the marriage, factors related to their stated fidelity include the desire to maintain a good social standing, the value placed on their spouse and the marriage and the need to protect and provide for their family by not diverting time and resources to other women. The specific strategies married women use to reduce their HIV/AIDS risk are more closely linked to their ability to earn an income. Concerns such as fear of disease and wanting to protect an unborn child motivate women to engage in initial communication with a husband about his infidelity. Married women who help with household income are more likely to discuss the use of condoms with their husband, and if this fails, they will leave the marriage. Women who lack such financial stability resort to leaving the marriage altogether rather than discussing condom use with their husband.

Marriage is based on economic dependence of women on men, which is why the male role of provider is so important. Women who are not married or who find their spouse inadequately provides for them may resort to other means of living such as relying on sex in exchange for resources. Some women who do not see marriage as an ideal, secure or safe option, may also engage in sexual transactions to secure their independence and autonomy. The next chapter examines the exchange of resources in greater detail in terms of how the practice perpetuates patterns of resource distribution across genders, the way it enhances HIV/AIDS risk and how it is becoming a strategy among rural women to attain greater agency and control over their lives.

Chapter 7: The Exchange of Sex for Resources

Examining a Practice that both Maintains and Confronts Gender Norms

The ways in which local gender norms are enacted within societies can be understood in the context of specific social interactions. Partner selection and behaviour as well as marriage are socially significant interactions where the roles of a man as provider and a woman as dependent become crystallised. The exchange of sex for resources is another interaction that preserves yet also challenges sexual and gender norms. This chapter addresses how the exchange of sex for resources (primarily money but also food, transportation, housing and gifts) is enacted and perceived, with a focus on how prevalent gender norms are reflected in this practice. The first section examines how gender norms shape access to resources differently for men and women. The next section describes how differences in access to opportunities and income earning potential contribute to the emergence of sexual exchange for purposes of survival, but also as a strategy for upward social mobility among women. The way men and women rationalise their behaviour in the practice and how it creates social anxiety is then presented. The chapter concludes by addressing how the exchange of sex for resources challenges existing gender norms among some men and women against a backdrop of HIV/AIDS risk.

Gender Norms and Resource Allocation

Gender norms are defined by society based on certain characteristics, expectations and behaviour applied differently to men and women, particularly in relation to work and educational opportunities. According to respondents, prevailing gender norms posit men as superior, dominant and decision-makers while women are considered subservient, passive and obedient. Such differences appear to be largely based on varying income generating opportunities between genders with notions of dependence centred highly in the construction of femininity:

> *The difference is that a man is always superior and a woman is always weak, she never has confidence. Naturally a man was considered politically, historically, physically, economically and psychologically as powerful. A man is the one who can transform things. A woman always accompanies him.*
> *– Participant in Married Male Group, Village C*

A man is the owner of the house, he is the one who commands. A man is at the top because when you all go to the farm, come back together, and are tired, why does he just sit there and not help to cook and fetch water...If he wants to help his wife, he can, he must decide that or think of it by himself. A man has power in everything even if he is a bush man. If he doesn't give you 10 meticais you are nothing. – Participant in Unmarried Female Group, Village C

The nature of these gender roles lends itself to often distinct and structured ways of life, enabling men to have certain advantages over women. Based on respondent accounts, such roles are rooted in the protector and provider role men often assume and the subservient and passive role among many women. Most respondents feel it is futile to alter gender norms given their integration into the community's social fabric:

You can say, "I want to be a man" and God has not created you as one, what will you do? So just leave it. - Female, 40, Widowed, Village D

Change will not go over well here in Africa. When married, a woman does not have a word, only the man...For example, a man that works, he wakes up early in the morning, eats his breakfast and goes to work and returns to eat lunch. But a woman, when she wakes up at 5am, she does not rest until the hour of sleeping. - Female, 45, Married, Village A

Sexual exchange and Wealth Distribution

The social structure of communities is based on a system where wealthy men often distribute their resources to the poor. It is a system rooted in dichotomous gender norms that clearly divide the lines between provider and dependent. Men are conscious of differences in access to income between genders with some feeling it is within their role to provide resources to women in dire circumstances. Resource distribution between genders is thus one of many outcomes resulting from the sexual exchange:

Here in our village poverty affects us a lot and many women need to eat, so the man gets money and gives it to the woman for sex. – Participant in Married Male Group, Village D

For a poor woman who is at home with nothing, the only way of getting money to support the family is having sex with a man. For the men, it is a little easy in relation to the women, for example I can stay two or three days without doing anything while for a woman she cannot because she does not have a home. - Male, 27, Unmarried, Village B

Similar to men, many women accept that poverty can push women into having sex for money. With minimal opportunities, some women are faced with little else but to use sex to gain resource. According to some women, the exchange of sex for resources is one route through which dependency on men is perpetuated:

> *It is because of poverty that women have many partners...If women stay from the morning to night or even two days without them or their children eating, of course they would go with a man who shows them money – Participant in Unmarried Female Group, Village A*

> *For example, Joao conquests me, today we sleep together then he doesn't come back and I have my child who is hungry. Someone comes with 20 meticais for me and we sleep together, then tomorrow he doesn't come. I don't wait for men, I will go find another, it is because of poverty. – Participant in Unmarried Female Group, Village D*

A few women however, challenge rationales linking poverty to having multiple sexual partners. They point towards alternative forms of earning an income, and thus reject suggestions that poverty is an acceptable excuse for engaging in the practice. Such views prevail despite potentially limited options in research areas to pursue alternative forms of income generation for both genders:

> *It has nothing to do with poverty, when you want to get rid of poverty you need to look for an occupation or do some business. There are others who do not want to have sex with men, it is not a case of poverty, they just don't want to do anything else. - Female, 50, Widowed, Village C*

Respondents suggest that some men feel it is their duty to help women overcome suffering, consistent with their provider role, although they may not always be selective in exchanging resources based on grounds of economic need alone. There is recognition that women can use sex to overcome dire poverty while others may use it as a means to obtain resources rapidly. Despite this distinction, respondents note that many men will engage in sex for resources with women who are poor and with women who crave material goods:

> *The single women are a lot and beautiful, and they need help to get food, but a lot of them don't want to go to the farm (to cultivate food), they only wait for the night to fall and come well dressed and look to men for money. – Participant in Married Male Group, Village B*

The men don't save the money, they receive today and spend tomorrow on those girls that nobody supports, but it is also the girls who find me to have money to buy new clothes or sandals to be equal with women from the city. – Participant in Married Male Group, Village A

Through financial access and control, respondents feel that some men are able to manifest their power by providing resources to multiple women while those men who do not have sufficient resources are considered 'worthless'. Although sex is viewed as an inherent biological need for both men and women, the reasons for pursuing multiple sexual partners differs for each gender. Some respondents feel that men who have multiple sexual partners do so in order to demonstrate their economic and sexual power. According to respondents, some women who engage in the practice do so out of poverty or in other cases, as an explicit strategy to retrieve desired financial resources from men:

They say that every man who has a high number of girlfriends is enjoying life and that we are the bosses because we have money, that's why all the women like us, those who don't have money are nothing. – Participant in Married Male Group, Village A

Sex is a basic necessity for humans, today it's different because when you beg women for sex, they command you to give them money. – Participant in Married Male Group, Village A

A lot of women have many partners, they don't have the conditions and are poor so they exchange sex to get money. – Participant in Married Female Group, Village C

Respondents are concerned about the risks that the exchange of sex for resources poses to individuals and its implications for enhancing the spread of HIV/AIDS. Blame is often attributed to women for remaining ignorant or lacking concern that a man could be infected with HIV. As a result, respondents feel that women who exchange sex for resources distance themselves from HIV/AIDS or fail to acknowledge it as a threat in order to acquire much needed resources:

A woman leaves the children at home in the morning and looks for men to have sex with in order to get money to buy food, so in this way, women bring diseases to the community. – Female Participant in Mixed Gender Married Group, Village B

It is women who increase this disease, they follow men with money because of need and they don't know the health status of people, they just receive the

money, all this is because of poverty. – Participant in Unmarried Male Group, Village B

Women get money in exchange for sex, without knowing that the man can be infected with HIV/AIDS. - Participant in Married Female Group, Village C

Given that financial expectations form a vital part of sexual exchange, some respondents are aware of the constraints placed on the ability of women, particularly those who use it for survival, to effectively negotiate safe sexual encounters. Through resources, respondents feel that men often control the terms of the sexual encounter, which tends to involve unprotected sex. Thus for women in such situations, the failure to comply with a man's request to forgo condoms may result in a missed economic opportunity according to respondents, as men will seek out other women who will agree to their preferences:

Sometimes we want to use a condom, but if you meet someone who has money and you need money and he doesn't want to use condom, there is no other way, you have to follow what he wants. - Participant in Married Female Group, Village D

It depends on the person who thinks about living a healthy life, these men use a condom and those who do not use it do not want to know about the disease or its danger, and they have unprotected sex because they have money. A woman does not tell a man when to use a condom, he says he wants to feel sex and she also needs the money so the children do not die of hunger, so they have sex without a condom. - Male, 32, Married, Village C

Some respondents consider the limited ability of women to negotiate condom use in these situations as reinforcement of women's lack of control and agency. Through circumstances of poverty, there is recognition that some women are forced into behaviours they would not normally accept:

A girl who has not eaten in five days can meet a man who will give her money for sex, and she agrees, but wants him to use a condom only that he doesn't want to. The girl still accepts because she wants money and this is an HIV/AIDS risk. The disease then begins to spread in all sorts of ways, poverty forces us to do things that we are not ready to do. - Participant in Married Female Group, Village A

Female respondents are critical of men involved in sex for resources who do not uphold their side of the exchange, and for unnecessarily placing women in a vulnerable position. Many view this as further evidence of men's power over women by controlling when and if to provide resources during the sexual exchange:

If the hunger continues, they go out and start begging for money from men so that they can buy bread...This is when a lot of men take advantage because he cannot give 1,000 meticais just like that without any kind of exchange, so he convince her to have sex with him, then he will give money to her to buy the bread. So she does not know if he has an illness or is a thief. - Female, 34, Married, Village C

Many here in the village are those who are not married and depend on men for money, each day these women do the same thing and ask for money and do sex and then one day they are not given the money. - Female, 50, Widowed, Village C

Anxiety over Social change

Respondents describe how sexual exchange can be mutually beneficial, allowing men to attain sexual pleasure and women to acquire desired resources. This is viewed with suspicion, disapproval, and social anxiety as such women are thought to be approaching sexual exchange as an 'easy option' rather than a last resort to ensure survival:

You can see a girl who is pregnant but she doesn't think of wearing decent clothes, only short clothes with her stomach showing. Most of the girls want to have things quickly, they do not have patience to wait and want everything at once through men. - Participant in Married Female Group, Village A

When parents tell girls to go to the farm, they refuse, they just wait for the evening and go to the discos, then on the day they feel hungry, they get money from men and don't think about doing business, they don't see value in it. - Female, 34, Married, Village C

There also appears to be discomfort among respondents around the increased ability of women to forge economic independence for themselves, whether through sexual exchange or other means of income generation. Respondents indicate that when women seek out other forms of earning an income that are traditionally male dominated, such as through small enterprises which require them to leave the village, community members place them into the same category as women who use their bodies to gain resources and label them as 'prostitutes'. It appears that '*prostitution*' has become a local metaphor for women's income earning potential, and in some cases, used to slander, discredit, or shame women who transgress expected gender roles. Faced with a tarnished reputation of being classified as a prostitute, some women find it difficult to succeed venturing into fields of work that are usually male

dominated. As noted below, a women's ability to sell goods, such as food or clothes, may hinge on access to land and shops which require travel outside the village sparking the use of the term 'prostitution'. Some women who cross the invisible gender divide to take on responsibilities generally associated with men are viewed by some community members as promiscuous, either because of assumptions they will betray a spouse or that they are a prostitute:

> *Sometimes I take money and I go to the city to buy things and bring them here to do business. Many people use to ask my husband why he lets me leave the village alone because they thought I might be a prostitute. Here in this village, women were not allowed to do business in the market but I used to. - Female, 45, Married, Village D*

> *Others think that if my husband works I also have to do something in order to help out. But other men prohibit their wife from running a business or doing work because they think their wife will betray them with other men. - Participant in Married Female Group, Village C*

Some male respondents express concerns over competition within the system of sexual exchange, suggesting that they sometimes feel their role as a provider is in peril rather than reinforced in modern enactments of the practice. According to male respondents, many women in these circumstances are thought to have the authority, power and agency to leave an encounter that does not prove worthwhile. The 'masculine' traits taken on by these women leave some men feeling threatened by the shift in gender relations:

> *There are other young ladies who like to have many partners. For example, I was a lover of one lady, but she always asked me for money. The day that I don't give it to her, she goes and looks for other men to give her money. - Participant in Unmarried Male Group, Village C*

> *The attitude of women here is that they only consider a man as rich and when sleeping with these men they have no respect, they want money without respect. They just want to snatch the money and after they finish it they leave you. - Male, 28, Unmarried, Village A*

Men and women tend to blame foreign influences for perpetuating the exchange of sex for resources. Some women feel it is the fault of the media for encouraging young women into prostitution, while men hold migrant workers such as teachers or newcomers to the village, responsible for the surge in transactional sexual encounters:

Here there is a lot of prostitution, you can find a young girl who sleeps with men. The discos and videos show many things, there are children who see this and think that in their parent's house they do not have these items, so at times it causes prostitution because the girls want to have the things they see. - Female, 40, Divorced, Village B

People who are more vulnerable here are workers, for example the teachers who come from other villages. I think that they already convinced so many students to have sex, the teachers don't save the money, they receive it today and spend tomorrow. - Participant in Married Male Group, Village A

When we search and get to know where HIV/AIDS came from, it is from the newcomers of other zones, for example from Nampula [province] and Zambezia [province]. The women start running after this type of man who comes from another zone without knowing about their health status. - Participant in Married Male Group, Village B

The blame on external influences enforces widespread beliefs that the exchange of resources and HIV/AIDS has been imported. When foreigners or newcomers arrive in a village, respondents note a surge in the number of women who gravitate towards these men due to their potential wealth. Some local men feel threatened by their inability to produce enough resources to purchase sex from women and also at risk for potential HIV/AIDS acquisition when women from their village, in an effort to gain resources, are thought to neglect prevention strategies. Views of HIV/AIDS risk are changing among respondents as a result of adaptations towards sexual exchange, rather than a consequence of having multiple sexual partners per se:

This disease increases because of people who come from outside - the businessmen, tourists, the workers and other persons. When they come here, women try to be close to these men and much more so when they hear they have money. So us local men when we call our women they say they don't want us. We heard that different men have already arrived here full of money, but nobody knows if these newcomers are seropositive or not. Women will receive money from these men, then they return to us for sexual relations and in a short period we are infected. - Participant in Unmarried Male Group, Village B

Emerging agency

Based on respondent accounts, the practice of exchanging sex for resources can indirectly be viewed as a form of liberation and a manifestation of agency and power among some women. Perceptions from respondents suggest that sexuality is a critical asset women use in order to achieve upward social mobility by changing partners

until a desired financial sum is reached. Respondents note that women who use sex to gain resources rapidly are selective of partners based on one key criterion – wealth. Such women are thus able to confront gender norms that place them in a relatively passive and subordinate position through two routes, first by deciding to use sex for resources, even though respondents indicate the existence of other potential forms of earning an income, and second by being selective in relation to sexual partners:

> *There are women who accept to take the money from a man and be with him, then there appears a man with more money, they soon begin to follow this new man, then another one appears that has even more money than the first and second one, the women accepts to have sex with this new man and so on. - Female, 23, Village B*

> *Today a man meets a woman, sleeps with her and tomorrow he leaves and she finds another. Now when an elder woman tells her that 'my daughter you cannot be like this', they start to insult her, it is because of money, they want to have a lot of money. - Participant in Married Female Group, Village D*

In some cases, women are thought to pursue resources through sex in order to maintain their autonomy and not be tied down to expected marriage roles. Female respondents acknowledge that differences in gender norms within a marriage place limits on women's agency and power because they are generally required to follow a husband's demands. It is perhaps for these reasons that women who use sex as a commodity, while still dependent on men to acquire resources, can in turn keep it for themselves and make decisions on how it is spent:

> *What has influenced these women is that they want things to be easy in life and take shortcuts in order to get what they wish. Many women don't want to get married or delay getting married because they do not want to be told what to do or follow the demands of their husband. - Female, 34, Married, Village C*

> *These women always wants to get everything in a fast way, sometimes she doesn't want to marry, she only wants to have one or more men to give her 50 meticais, in one day she can be with three men. - Participant in Unmarried Female Group, Village A*

> *The girls do not want to listen because they are being told that they should look for a man to marry, but they just do things they know like having sex for money. - Female, 50, Widowed, Village C*

The pursuit of personal and financial autonomy through sexual relations carries with it an underlying risk. Similar to women who engage in the practice due to poverty,

respondents are concerned about the increased spread of HIV/AIDS among women who use it as an easy route to obtain resources. Wealth appears to take greater precedence over health status when identifying partners for sexual exchange, which differs slightly from women who engage in the practice due to poverty since the latter, are likely to have sex with men regardless of the amount offered. Respondents feel that women who select wealthy partners and choose to earn an income through sexual exchange generally refuse to act on this acquired agency to protect themselves from HIV/AIDS. These women may thus remain at similar HIV/AIDS risk levels as those who engage in the practice out of poverty. Respondents feel that the overwhelming desire to obtain resources with little regard for HIV/AIDS risk among some women is selfish and irresponsible. Whether a conscious motive or not, women who have sex to rapidly acquire resources may be prioritising short-term empowerment goals over the potential long-term consequences of HIV/AIDS acquisition. Local men engaged in the practice however, do not appear implicated in HIV/AIDS transmission in the same way as women based on respondent accounts:

> *Women pick up a man but they don't know where he is from or even if he is infected, they are quickly conquered and then have sex. When finished, this woman does not go home, it is worse, she is looking for another man. These men also never ask the women where they were from or what they do, they just think of having sexual relations, that is why us women, we are the first to get disease because when we see money we don't leave it. - Female, 37, Married, Village D*

> *We don't know who is infected but I suspect many women because a lot of times here in our country, women don't care. When they see someone they just behave in any manner without using a condom, they don't know where the man comes from but when he calls them they are given money to sleep with them. If he has HIV/AIDS he spreads it to women because they do not want to know if he has a disease or not - Male, 20, Unmarried, Village A*

Alternative strategies for improved autonomy and power in relationships are also expressed. Despite the power and resources that sexual exchange can provide, many women resort to more traditional forms of living and laud their ability to secure their own survival. Beyond the need to maintain self-respect by avoiding the exchange of sex for resources is the desire to remain self-sufficient. These women want to accumulate their resources in a secure and consistent manner, in contrast to the apparent fluctuating nature of sex for money. Some women are able to contain

resources and avoid relying on the '*men of other women*' to survive because they note their ability to earn an income through more 'respected' forms of work:

> *People will never say that I exchange men, it has never been, I am a person of respect. There are women who do business, they take vegetables and sell it, and others who do not do business and instead sell their body. These women should not pass their time selling sex because it is not all the time they will get money, sometimes they go home hungry. Among those who do business, there are few; among those who do the sex business, there are many...Those who do business are elder women who already have experience in life, we have respect and think of keeping something inside our house. A woman who thinks well goes to the farm, takes the vegetables and sells them, all this is for them not to steal money or play around with the men of other women. - Female, 50, Widowed, Village C*

Many women view the exchange of sex for resources as valueless, both financially and personally. According to these respondents, women who engage in the practice '*don't think*' of other alternatives to earn an income beyond sex. Some women feel that by not depending on others, they avoid potential suffering; this in turn serves as a strong motivation to refuse participation in the sexual exchange for resources, even though it might lead to easier forms of earning an income. The association of this practice with HIV/AIDS risk is evident among women, which they raise as an important rationale for choosing alternative forms of work:

> *I think that if I don't bother to go to the fields or work hard to get food, I'm going to suffer... I will not become a prostitute because I don't deserve that, it is not a good thing, even if it is easy to get money, it doesn't serve any purpose...If I wanted to I could have changed my behaviour a long time ago, but I don't want to get the diseases they get. Everyone is born with intelligence and ways of thinking, some do evil things and others think of ways to improve their lives, so each one has their own conscience. - Female, 34, Married, Village C*

> *Here it is easy to get money without doing prostitution, but a lot of people don't think of it. It is easy for a woman, she can go and fetch firewood, bring it here and sell it to get money. I do this to create a means of living, I have never asked for help from anyone, sometimes I didn't have anything but I didn't suffer. For me to do farming was because of my father. Since I didn't have the opportunity to study, he said I should have my own farm to be like those who studied and feed myself, so I followed his advice. - Female, 45, Married, Village D*

Some men refuse to distribute their wealth to women through sexual exchanges, and thus deviate from dominant local norms of masculinity. According to these men,

wealth itself is not necessarily measured by the number of sexual partners that can be obtained; rather, it is defined by the creation of a safe and secure future for their children. Parental advice to avoid diseases is critical in convincing some men to avoid sexual exchange. Similar to women who earn their own living and view the exchange of sex for resources as valueless, some men shun having a '*relationship with money*' to obtain sex, and feel the practice serves little purpose other than bringing about health destruction:

> *To say that I have a relationship with this money to get women, I cannot do this. I don't need these women and I prefer to stay with my wife. I don't want to look for another woman who will bring diseases from outside and through me it gets transmitted to my wife. If our child is born and he has this disease, I would feel very much about this, so I cannot do it. - Male, 32, Married, Village C*

> *I will not arrange money to go have other women, otherwise I will struggle to raise my children, that will not happen. Having a woman outside doesn't give you confidence, because you give money to her and each one goes their own way...My father was always telling me about the diseases, he said I must not have sex in any manner to avoid getting sexually transmitted diseases. I followed what he said and he was not lying because I was seeing it. - Male, 27, Unmarried, Village B*

Among men who state a preference to save their resources rather than spend it on other women, a combination of parental advice, observation and past experience contributes to this decision. In some narratives, men indicate that they want to avoid spending money on 'more than two or three women', suggesting that they tolerate sexual partners outside of marriage. However, these statements may also refer to the prevalence of polygyny common in the study population. Past experience of being in economically vulnerable situations motivates men to reserve resources for themselves and their family rather than to create '*misery*' by "wasting" it on other women. As older relatives warn, the status associated with having multiple women to showcase one's masculinity or wealth is nothing more than '*an illusion*', which in the end may cause more harm than benefit:

> *My children and wife depend on me, the little that I have is to give to my family. For many years, I did not have enough money, now I do not see the reason to abandon my children and my wife and look for misery. I do not want this life. I remember when my grandfather was alive, he said that in the world you will never hear that a man has luck for having more than three women, it is nothing more than an illusion, you do not gain anything, on the contrary*

you will waste it and have more expenses. He said it is good to just have and support one wife, which I do. - Male, 28, Married, Village C

Men who take the decision to contain their resources rather than spend it on women are perceived to be self-regulating their own behaviour for the greater good of their family. Notions of support, care and a healthy family are driving forces which prevent men from diverting their resources to other women. These men still maintain dominant masculine norms of protecting and providing, but finances are used towards improving their family's lives. In such a resource poor setting, some men come to view money as a valuable resource and as a result, escape the common '*habit*' of spending money on other women:

With many girlfriends it happens that each women wants money, each one asks for 50 meticais, so I will have no money, it will never stay in my pocket...My heart doesn't think of these things, when I get a lot of money, I like buying nice things and putting them in my house. First it is my habit and second I was told by my father about this, and I now practice the advice that he gave me. - Male, 22, Unmarried, Village C

I do not have that habit of seeking women outside. My brother gave me money to start a business, if I was others I could use this money to look for women outside...For me, to not have more than two women is as follows, I get money and from this I give some of it to a woman, but at home I have children that depend on me, the children are crying of hunger and that is very painful, and I feel for my children. I prefer not to give that money away, let the women go away instead of spending my money on them. - Male, 32, Married, Village C

Another avenue through which men contain resources and ensure that money is preserved for family needs is to hand it over to women, who are deemed by some men as better at taking care of household expenditures. When the norm is for resources to rest in the hands of men, it can be an obstacle to see past this custom. Observation and learning from others in different contexts and witnessing positive outcomes provides the impetus for some men to follow suit. Similarly, some married women do not trust their husbands' with money and feel they will use it frivolously on outside women rather than cater to the survival needs of the family:

People say that a woman should not be given your money but I think that a woman is the one who has good economic sense...I lived with people from Nampula and Zambezia for a long time, the majority of these people accept giving economic power to women in their houses. When I asked them why they give a woman such power, they said when you trust a woman and leave the money with her, she can use it wisely...I will tell my children that when

they are married, in order to live well, they should give the money to their wife because she is the one who knows the things of the house that you do not know, you will give the money to your girlfriends. - Male, 46, Married, Village D

Other men, when they get money they take it and give it to other women even though they know that at home there is no food. When you ask for money to buy food they reply they have nothing, but they have given it to other women, men do this. - Participant in Married Female Group, Village B

Conclusion

Transactional sexual encounters have created tension between genders given the multiple forms of masculinity and femininity emerging among men and women to justify participation in the practice according to respondent perceptions. There are numerous ways in which men and women either conform to or confront gender norms when exchanging sex for resources, despite acknowledgement of the HIV/AIDS risk posed. Respondents note that many men who exchange resources for sexual favours rationalise their behaviour as one of a good 'provider'. Some women are thought to engage in sexual transactions for purposes of survival, while others use it as a means to acquire resources rapidly, rather than resorting to alternative forms of work or getting married. Since these women remain reliant on men for resources, female respondents feel the practice serves to further entrench dependency relationships between genders. "Prostitution" is a term employed by some respondents to describe women who step beyond the boundaries of their gender role by venturing into male dominated fields, particularly travelling outside their village, even though they may follow respected forms of work. According to many women, sexual exchange is considered a contentious issue and frowned upon when their peers, regardless of rationale, engage in the practice.

The exchange of sex for resources is a practice that highlights emerging agency among women and poses a challenge to gender norms. Some men reflect on their gender role and take a different stance to wealth distribution by containing resources for their family instead of diverting it elsewhere. In addition to financial security, these men also have a desire to protect their family from HIV/AIDS. Self-regulation, parental guidance, observation, prior experience and an overriding fear of the disease influences men to reject normative male behaviour. Some women refuse using their

bodies to obtain resources despite the practice being considered an easy route for financial or material gain. Factors encouraging these women to pursue other forms of work and avoid sexual exchange include the need to maintain self-respect, prevent HIV/AIDS, and alleviate suffering by not being dependent on others. Parental influence and past experience are other factors encouraging women to remain on a certain positive path and avoiding participation in the sexual exchange for resources.

The findings highlight tensions in gender norms and a shift in HIV/AIDS related risk patterns. Some men challenge norms of having sex with multiple women to secure their family's well-being, which may help reduce HIV/AIDS risk, while according to respondents, some women who confront roles of dependence and powerlessness through sexual and economic agency may in fact heighten their HIV/AIDS risk. The practice is also viewed as a means for women to escape from gender norms of passivity and dependence often manifested in marriage. However, this autonomous behaviour is also met with social criticism due to its interference with predominant gender norms. Greater agency among women through sexual exchange can be viewed as one means through which women are gaining emancipation and breaking free from repressive gender norms according to the opinions of some male respondents. The move towards more balanced gender norms, in the case of some women who are believed to demonstrate their agency through the practice, may not always result in a reduction in HIV/AIDS risk, while conformance to gender norms, as in the case of some men who reconstruct norms of protector and provider, may at times cause them to engage in risk reduction efforts.

Chapter 8: Conclusion and Implications

This thesis explores the ways in which local constructions of gender norms influence and motivate responses to HIV/AIDS in rural Mozambique. The findings help fill a gap in the literature by demonstrating how gender norms can serve to simultaneously facilitate and reduce HIV/AIDS risk. Based on the literature, it was initially hypothesised that individuals who hold attitudes or state behaviours that could be broadly characterised as "gender balanced", such as supporting equal access to educational and employment opportunities or considering decision-making and agency as optimally shared within relationships, would be more likely to engage in HIV/AIDS risk reduction if they felt at risk compared to individuals who express more imbalanced views. However, the findings demonstrate that although there appears to be a prevailing shift towards more gender balanced relationships and norms, which may be essential for reducing HIV/AIDS risk, it does not currently seem to be an indicator of individuals' engagement in HIV/AIDS risk reduction strategies.

Although the findings support widespread literature highlighting that gender disparities can exacerbate HIV/AIDS risk [5, 23, 42, 57, 78, 79, 174, 290-292], they also suggest that these disparities do not inhibit men and women from responding to perceived risk. Individuals often work within and use existing gender norms to help reduce their perceived HIV/AIDS risk, and when this fails, some men and women will confront gender norms. Contrary to other literature suggesting that more gender equitable and egalitarian practices are necessary to control HIV/AIDS transmission [293], this research found that in some cases, more empowering gender norms may put individuals at greater risk of HIV/AIDS, while reconstructing predominant gender norms helped others negotiate risk reduction.

This chapter begins by summarizing the findings to articulate the link between gender norms and HIV/AIDS risk and risk reduction efforts. It examines how socially prescribed gender roles and responsibilities between men and women influence perceptions of HIV/AIDS risk. The factors that drive risk and facilitate risk-reduction efforts among individuals are also discussed against widely held gender norms and

those in flux. The next section situates study findings within the wider literature on themes related to partner behaviour, marriage and transactional sexual encounters. The factors that motivate men and women to engage in risk reduction are placed into a model alongside a discussion on related theories. The above findings are then examined in relation to wider programmatic and policy implications.

Summary of Findings

Definition and Maintenance of Gender Norms

The construction of gender norms and how they are enacted can be understood through partner selection, marriage and the exchange of sex for resources. Unmarried men and women seek out characteristics in long-term partners that reflect prevailing gender norms. Men tend to seek women who exhibit respectful, trusting and good behaviour. Although young unmarried men seem open to the idea that women should work, many still want control over their income. Unmarried women desire a partner who will be supportive both financially and emotionally but did not mention monogamy, which may be due to the widespread practice and tolerance of sexual infidelity among men.

Marriage is considered a social obligation and helps control the potentially carefree and hazardous behaviour of single men and women. Younger unmarried individuals are usually blamed for spreading HIV/AIDS in the community by having multiple sexual partners and stealing spouses. For women, marriage provides respect, legitimacy, status and protection from both financial instability and HIV/AIDS infection by hypothetically removing the need to rely on sex with multiple men to survive. For men, marriage allows them to take up their expected role of provider and decision-maker in a family. In return for financial stability, women are required to abide by a man's decisions and cater to his needs, otherwise they are seen as avoiding marital responsibilities. Early marriage is another route through which gender differences are maintained, as girls are often pulled out of school thus limiting their education and income-earning potential. The stated justification for early marriage is to alleviate a girl's suffering, avoid disease acquisition and prevent pregnancy out of wedlock. Limited access to opportunities can influence a woman's ability to discuss or engage in safe sex behaviour and may serve to widen power differences in the marriage.

The exchange of sex for resources is a practice that can also reinforce men's provider role and women's dependence on men for resources. Some women engage in transactional sex out of poverty, however, many individuals do not consider this as a sound excuse. Although the exchange of sex for resources reflects general patterns of economic control and distribution across genders, it is a tolerated practice for men but considered immoral for women regardless of their rationale for engaging in the practice.

HIV/AIDS Knowledge and Risk Perception

Consistent with DHS data [208], key factors linked to HIV/AIDS risk in the study setting include multiple sexual partners with minimal use of protection, and the inability of women to negotiate safe sexual encounters. There appears to be a strong disbelief in the existence of HIV/AIDS, which interferes with risk assessment and in turn, curtails prevention efforts. There are widespread notions that condoms contain HIV/AIDS with many refusing to use them during sex, however, condoms are also forgone in order to maximise sexual pleasure, enhance remuneration (in the case of women who exchange sex for resources), avoid being labelled a prostitute and conform to norms which discourage its use in marriage and with primary partners. There is also extensive apprehension in getting an HIV test, largely due to concerns about confidentiality, partner abandonment, and a fear of facing adverse health consequences if found to be HIV positive.

Communities often dissociate themselves from HIV/AIDS by blaming outsiders such as teachers and men from other villages for the spread of the disease. Blame is also cast on particular risk groups such as women who engage in sex for resources, which can lead to perceived immunity among individuals who do not see themselves as falling into these categories. Appearance helps some men assess a potential partner's HIV/AIDS risk, although it did not seem to do so for women. The way a partnership is defined, whether based on emotional commitment, relationship length, or exchange of resources has important implications for assessing and responding to HIV/AIDS risk.

Gender Norms and HIV/AIDS Risk

Gender norms influence the ability of individuals, particularly women, to act on perceived risk. Lack of control or agency, based on unequal economic opportunities can severely limit women's ability to engage in risk reduction behaviours. Although women state their own monogamy, the potential loss of economic support from a man and avoidance of a single status prompts many to remain with their partner despite his risky behaviour. Marriage is one route through which women gain economic security; despite this, there is recognition that rather than a source of protection, the relationship may pose a high HIV/AIDS risk, with married women being held responsible for preventing against a husband's infidelity. For men, norms encouraging sexual conquest can increase HIV/AIDS risk, which is in part rationalised by the acceptance of polygynous marriages in the study population. Due to differences in wealth distribution and access to opportunities, some women use sex to gain much needed resources to survive and often forgo condom use. Men in such encounters generally decide how resources will be used and tend to negate condoms in order to maximise sexual pleasure.

Gender Norms and Risk Reduction Strategies

Men's roles are often associated with providing and protecting, with many using their wealth to access sex from multiple women according to respondents. Some men, however, interpret this masculine role differently and refuse to spend scarce resources on other women by 'protecting' their family from both financial insecurity and HIV/AIDS acquisition. Men who use resources to improve the lives of their family are influenced by a discourse of self-regulation, prior experience of being economically vulnerable, the wish to provide for children, observation of their peers and family influence. Some men who have sexual relationships outside of their primary relationship take steps to reduce perceived HIV/AIDS risk through the use of condoms with new or casual partners. Other men maintain norms of sexual conquest but consistently use protection with all partners to reduce their HIV/AIDS risk. Many of these men also relate a primary partner's acceptance of risk reduction methods as confirmation of emotional intimacy in contrast to widespread norms associating condoms with distrust and lack of closeness. Although some of these men hold gender imbalanced views in relation to income control and decision-making authority.

they consistently engage in risk reduction efforts. In some cases, a husband or partner's insistence on HIV/AIDS risk reduction, despite self-noted superiority and authority over women, results in the woman feeling at reduced risk. Men are still taking decisions to control the sexual encounter but some do so in ways that protect the primary relationship. Some women who are in gender imbalanced relationships do take measures to reduce perceived HIV/AIDS risk due to a previous partner's influence, family support and the desire to remain healthy and protect their unborn child. Given challenges faced by women to confront male norms of sexual infidelity, some took responsive action to perceived HIV/AIDS threat, regardless of being financially dependent on their partner or husband. Although women will abandon relationships if men fail to provide financial support, they are also doing so when they feel threatened by a partner's HIV/AIDS risk.

Fluid Gender Norms and HIV/AIDS Risk

The exchange of sex for resources seems to allow some women to gain emancipation from gender disparities and avoid the often repressive gender roles and responsibilities expected in a marriage. Based on respondent accounts, the agency and autonomy gained by women who choose to earn an income in this way contributes to fluctuating gender norms by placing decisions in their own hands. Greater sexual agency, however, does not mean women act on it to protect themselves from HIV/AIDS. Selecting partners based on wealth and leaving an encounter if it does not yield the expected level of resources are routes through which women are believed to exert agency. Yet, respondents acknowledge that men retain some level of control over the exchange of sex for resources by determining what, if any, HIV/AIDS protection measures are taken. Among some women who engage in sexual transactions to obtain resources rapidly, the resulting agency and decision-making power gained may be a trade-off to potential HIV/AIDS risk. Some unmarried men are open to their current girlfriend completing their education and as a result keen on having a future wife who can earn an income and help provide for the family. However, in some cases, greater receptiveness to employment does not necessarily translate into a wife being able to decide on how resources are used. Thus, more gender balanced attitudes in terms of income generation may not result in equal decision-making power or control in the economic realm leaving such women

in potentially similar positions to those who are economically dependent on men and likely with comparable HIV/AIDS risk patterns.

Fluid Gender Norms and Risk Reduction Strategies

Some men who share financial and decision-making power with their wife remain faithful in their marriages based on similar reasons to men who do not hold more gender balanced attitudes. Men in both scenarios appear to be reconstructing male norms and feel it is their responsibility to ensure the family's health and well-being through fidelity. The fear of infection combined with parental influence, the need to maintain a good social status, strong intimacy with a spouse and past experience are common rationales for remaining faithful. Agency is realised among women through the employment of risk reduction strategies such as negotiating condom use, abandoning a relationship or getting an HIV test based on perceived partner risk. Some young women are keen to finish their education rather than marry early in order to secure their autonomy and avoid dependence on men. These women suggest using their educational attainment and future income earning potential as a leverage to insist on obtaining an HIV test with a potential husband prior to marriage, and also to negotiate safe sex in a future marriage if necessary. Married women with financial decision-making power who feel at HIV/AIDS risk take measures such as condom use negotiation and partner abandonment to reduce this risk largely because they are self-sufficient. These women influence their husband to practice safe sex by highlighting the need to protect their own health status or that of their unborn child from HIV/AIDS acquisition. In response to perceived HIV/AIDS risk, married and unmarried women are overcoming barriers such as fear of a partner's reaction and getting an HIV test to ensure a partner is of sound health or negotiating condoms despite norms limiting their use in order to protect themselves. Some women use an HIV test, the negotiation of condom use or abandonment as strategies to reduce potential HIV/AIDS risk, and similar to some men, assess values and levels of emotional intimacy in a relationship based on a partner's acceptance of risk reduction efforts. As with some men, these women are influenced to engage in risk reduction based on parental guidance and the desire to maintain self-respect and a good social status.

Contribution to Literature

The gender divide that posits men as superior and women as inferior based on respondent accounts is consistent with other literature in Mozambique [12]. Gender roles and expectations are enacted through, among other social encounters, partner selection, marriage and transactional sexual encounters. In each of these social situations, men are portrayed as providers, protectors and risk takers, particularly in sexual encounters which conforms to findings from global reviews as well as studies in South Africa, Namibia, Brazil, Tanzania, India and Peru [13, 22, 63, 68, 145, 290, 294, 295]. Similarly, this study relates to other literature from South Africa, Uganda and Thailand among other places highlighting that male identity, power and reputation often hinge on the ability to attract multiple sexual partners [36, 111, 115, 296-298], a well-recognized HIV risk [299, 300]. These masculine traits are likely linked to men's greater access to wealth and resources which conforms to findings from a study in Tanzania [23]. As indicated by global reviews including one from SSA, this study affirms widespread respondent views that women are submissive and subservient, with minimal decision-making ability in sexual matters and in relationships [55, 102, 242, 270, 301, 302]. Consistent with other studies, there are similar characteristics sought out in men and women that reflect prevailing gender norms. Men tend to seek women who exhibit traits linked to monogamy which coincides with a study in Malawi [123], while women feel that men who provide them with finances conform to an expected role, a finding also noted in a Kenyan study [303]. Expectations among married men and women reflect norms in society with men as providers and women as caregivers which relates to findings from a study from Zimbabwe [76]. Sexual double standards are also consistent with other studies in Zimbabwe and South Africa where men are given free rein to have extramarital partners [24, 26] while women are shunned for the same behaviour.

Partner Behaviour

Findings add to the literature by examining strategies used by men and women in a rural context to select partners and monitor partner behaviour to assess and respond to HIV/AIDS risk. The categorization of a partner and the quality placed on the relationship influences whether measures will be undertaken by men and women to reduce any perceived HIV/AIDS threat. Assessing a partner's behaviour during a

relationship is an important means through which men and women determine their HIV/AIDS risk. Consistent with previous research in Sierra Leone and Malawi as well as a general study in SSA, this study found that individuals engage in casual and long-term relationships to search for marital partners and fulfil sexual pleasure [123, 146, 304]. Contrary to findings from a general report on the HIV/AIDS epidemic which noted that some respondents associate a healthy person with lack of infection [136], young unmarried men in this study consider wide sexual networks as a potential threat, and conclude that healthy and beautiful women are more likely to be part of such networks, and thus not necessarily risk-free. The difference in findings may be due to increased HIV/AIDS knowledge or changing views of a 'healthy person' among younger generations.

Consistent with other research from Mozambique and a variety of settings in SSA and beyond, this study found that power imbalances in relationships determine whether women will discuss safe sex [38, 42, 53, 54, 56, 91, 149, 305, 306]. In accordance with findings from studies in South Africa and Thailand, many women in this study are uncomfortable suggesting condoms with men to avoid raising issues of distrust or potential infidelity [307, 308]. Even though many women attest to monogamy in their long-term relationship, they feel at risk because of their partner's actions. Potential loss of economic support and emotional intimacy makes it difficult for women to request protection despite awareness of being in a risky relationship which corresponds to other studies in Africa (including Mozambique), Asia and Latin America [15, 169, 309-311]. Other women choose to remain abstinent or negotiate condom use in a relationship to prevent both unwanted pregnancy and disease, a finding similar to a Malawian study [123]. Gender norms which permit men to take control and decision-making authority over the sexual encounter, usually results in a lack of condom use as noted in this study and confirmed by the literature [312, 313]. However, some men use protection and their authority to influence their partners to do the same in order to protect themselves and the relationship.

As noted in another study in Mozambique, the belief that condoms contain HIV/AIDS poses enormous barriers to its use [15]. Despite this, some men and women use protection but do so based on partner type with condoms generally used with causal and non-marital rather than primary or marital partners, a finding which conforms to

literature from urban Mozambique, Namibia, Malawi and elsewhere [15, 314-321]. Trust is an important feature in relationships and often determines whether respondents will engage in risk reduction strategies, with condoms and an HIV test used most often when a partner's trust is not easily ascertained as confirmed by previous research [91, 322]. Some men and women who have sexual relationships outside of their primary relationship take steps to reduce perceived HIV/AIDS risk through condom use with no mention made of decreasing the number of sexual partners, a finding inconsistent with studies from Malawi [319, 323]. The difference in findings may be due to the widespread acceptance of infidelity and multiple sexual partners among men in this study setting. Unlike previous studies, findings shed light on emerging local behaviour where some men and women engage in risk reduction practices across all partner types regardless of attitudes or views on gender disparities. Contrary to many of their peers, some individuals associate a partner's acceptance of risk reduction strategies as enforcement of emotional intimacy, highlighting shifting norms on safe sexual behaviour.

Marriage

Marriage provides economic security for women, but can also pose an HIV/AIDS risk due to a husband's infidelity, a finding consistent with other studies in SSA [176, 324, 325]. Yet, similar to findings in South Africa, it is women who are expected to guard against infidelity and encourage a husband to use condoms with extramarital partners [161] despite limited negotiation power. Consistent with literature in Mozambique and elsewhere, long-term relationships, particularly marriage, which tend to be founded on trust and love create an environment in which men and women are likely to downplay any HIV/AIDS risk and minimise the use of protection [15, 91, 287, 326-328].

Polygny is a practice widespread in the study setting as well as in other areas of SSA [329]. This contrasts another study in Mozambique suggesting that Macua tribes, to which many of the respondents belong, have a low prevalence of polygyny [194]. The difference in findings may be due to the influence of cultures and traditions from nearby Tanzania. Some view polygyny as a contributing factor to the tolerance of infidelity and the ability to retain multiple sex partners. Women in polygynous marriages tend to demand fair and equal treatment with each of the other wives.

Unequal treatment of one wife over another, rather than specific HIV/AIDS risk can be grounds for abandonment. This finding is in contrast to a study in Malawi which found that women abandon polygynous marriages when they felt at HIV/AIDS risk from the other wives [319]. The difference in findings may be because women in this study feel it is easier to rationalise or are more concerned about unequal treatment over the potential HIV/AIDS risk posed.

Marriage is based on a man's ability to financially support a partner, a finding consistent with a study from Malawi [123]. If such a crucial gender role remains unfulfilled, some women may choose to leave their partner which conforms to findings from another study in Malawi [154]. While an inadequate provision of resources by a partner may be a contributing factor, some women in this study abandon their marriages to avoid HIV/AIDS acquisition, a finding that relates to a study in the Ivory Coast [122]. There are differences in strategies used by married women to respond to HIV/AIDS risk based on their income-earning potential. Financially independent women tend to negotiate condom use and discuss HIV/AIDS risk with their husband. Women who are financially dependent on their husband's however, resort to leaving the marriage, which contradicts other studies from South Africa and Malawi where such women negotiate condom use or confront a partner's infidelity directly [57, 319]. The courage for a woman who relies on economic support from a husband to leave the marriage due to his risky behaviour is based on a women's strong social support system. Many women in the study setting belong to the Macua ethnic group and live in matrilineal societies with high marital dissolution, particularly in Northern Mozambique, compared to tribes in patrilineal settings [194]. As a result, women may find it easier to leave a spouse if they feel at risk or unsupported compared to other contexts.

Although the literature on HIV/AIDS risk in marriage and women's responses to male infidelity is vast, minimal research exists on married men's responses to HIV/AIDS risk. Some men tend to avoid the widespread practice of infidelity in order to protect their family from the consequences of HIV/AIDS acquisition. This finding relates to another study conducted in North America with HIV positive men highlighting the importance of male responsibility in protecting the family from harm [330], but differs in that responsibility is directed at using protection in high risk sexual

encounters rather than adequately providing for the family by remaining faithful. Diverse geographical settings and respondent characteristics may explain the variation in results.

Findings contribute to the literature by examining how marriage enforces differences in roles and responsibilities between men and women, in some cases, deepening the gender divide and importantly, how men and women overcome HIV/AIDS risk despite imbalances in income and power in a marriage.

Exchange of Sex for Resources

Gifts and money exchange are an aspect of many casual and long-term relationships, yet there are differences in meanings attached to the provision of these resources based on relationship type which conforms to findings in Ghana and South Africa [157, 331]. Among long-term partners, the provision of resources is often an expected requirement from a man to help support and provide for a woman. In other situations, sex is an explicit commodity used to acquire resources with little intimacy or commitment involved. Although resources exchanged in long-term relationships can be used to obtain sex from a partner, the duration and level of emotional intimacy distinguishes the exchange of sex for resources from other types of relationships, a finding consistent with studies from Uganda and South Africa [111, 157, 163].

It is important to distinguish the matrilineal system in which the study took place, where focus is on the line of descent and not always related to power or the acquisition of assets. As noted from the findings, power in this matrilineal system is not always balanced out across genders, in contrast to matriarchal structures where authority and power play a more prominent role (Ndege 2007). Many women still lack access to income and remain financially dependent on men. Women engage in sex for resources for financial motivations, but also to express sexual agency and power and to maintain autonomy. As a result, there do not appear to be marked differences in discourses on transactional sexual behaviour as findings from this study, based in a rural and matrilineal context, closely resonate with literature examining women involved in transactional sex in urban and patrilineal settings in Mozambique (Karlyn 2005; Hawkins, Price, and Mussa 2009).

Sexual transactions involving resource exchange are a common occurrence in the study population and as noted in previous studies, have been linked to HIV/AIDS risk [154, 166, 332]. Limited access to opportunities among women and reduced livelihood options may cause some women to sell sex to survive as noted in other low-income contexts [27, 324, 333]. However as noted in other settings, women also engage in the practice for social and economic benefits rather than solely out of poverty [147, 151, 334]. Although conducted in remote rural areas, findings also coincide with those from urban Mozambique and SSA and beyond indicating that some women use sex to ensure freedom, social mobility, independence and power in order to reap financial rewards [108-111, 147, 153, 157, 159, 335] as opposed to being pushed into it due to gender inequality and lack of economic stability as also noted by findings from a Tanzanian study [23]. However, greater sexual agency does not mean women will use it for HIV/AIDS protection. Tension arises since it is men who normally control the initiation and circumstances of sexual encounters, a finding consistent with prior research in a range of settings [16, 32, 35, 37, 290, 336, 337]. This tension is also manifested in the use of the term 'prostitute', which is applied to women who engage in sex for resources but also for women who forge their own economic independence through 'respected' forms of work. In both circumstances, women are challenging their power in the economic realm which is viewed as threatening to some men.

Women who engage in sex for resources purposefully increase the number of partners they have sex with in order to gain more resources as noted elsewhere in SSA including Sierra Leone, South Africa and Uganda [111, 146, 304, 338]. As a result, women are often blamed in this study setting for the spread of HIV/AIDS, which contrasts a study in Tanzania where women are reproached for not using their sexuality as a financial asset [23]. The difference in findings could be related to how sexual agency and power between men and women is viewed among the various population groups. Men who distribute resources to women in return for sexual favours are perceived to be exploiting economic disparities, which is dissimilar to another study in Papua New Guinea suggesting that men who provide resources to poor women for sex are generous [339]. The variation in findings may be the result of engrained double standards regarding sexual conquest and expected behaviours between men and women. Findings fill noted gaps in the literature by highlighting

the multiple forms of femininity and masculinity drawn upon by both genders to either protect themselves from or enhance their potential HIV/AIDS risk.

Theoretical Contribution

The above discussion highlights how gender norms can influence HIV/AIDS risk levels and also demonstrates that regardless of whether men and women hold gender balanced or imbalanced attitudes, these individuals – identified as positive deviants for analysis – take measures to reduce their risk of infection. The positive deviants decrease risks against a backdrop of widespread disbelief in HIV/AIDS, lack of condom use, fears surrounding HIV testing, and the common practise of having multiple concurrent sexual partners. This section examines the specific factors that influence men and women to reduce perceived HIV/AIDS risk and incorporates these into a model, built on previous theories, for potential use in other settings.

The conceptual framework used for this research guided the development of the study's tools, methodology and analysis. Constructs and theories drawn from the wider literature contributed to developing a picture of how individual, social and structural factors shape HIV/AIDS risks. Gender and power theory highlighted how gender roles and differences in male-female relationships become reinforced through divisions of labour, sexual relationships, and expressions of power, and the ways these in turn influence HIV/AIDS risk. Although the theory provided insights into the fluidity of gender norms, it did not offer sufficient theoretical basis to determine how gender disparities can be ameliorated or how more gender balanced situations might affect social and sexual encounters. The theory also failed to account for the manner through which cultural norms and intrapersonal relationships with peers and others influence gender norms.

Models and theories analysing HIV/AIDS behaviour change, including the AIDS Risk Reduction Model (ARRM), the health belief model and social cognitive theories are important for understanding how risk is assessed and behaviour altered to reduce risk. Despite their utility, a key limitation of such approaches is their focus on the individual, with minimal attention directed at the social and relationship norms that influence sexual risk taking. In addition, emphasis is placed on risk recognition and identification, which does not necessarily translate into an individual taking action.

There may also be other factors at play which prevent individuals from reducing their risk including lack of desire or a partner who may not be amenable to change. Moreover, the models and theories are homogenous in that they do not account for gender or the different challenges faced by men and women in responding to perceived HIV/AIDS risk. This research found that factors at a multitude of levels including at the individual, normative, social learning and structural levels were important in shaping HIV/AIDS risk and responsive action, adding to the increasing body of literature indicating the importance of an ecological approach to STI prevention and treatment [340-343].

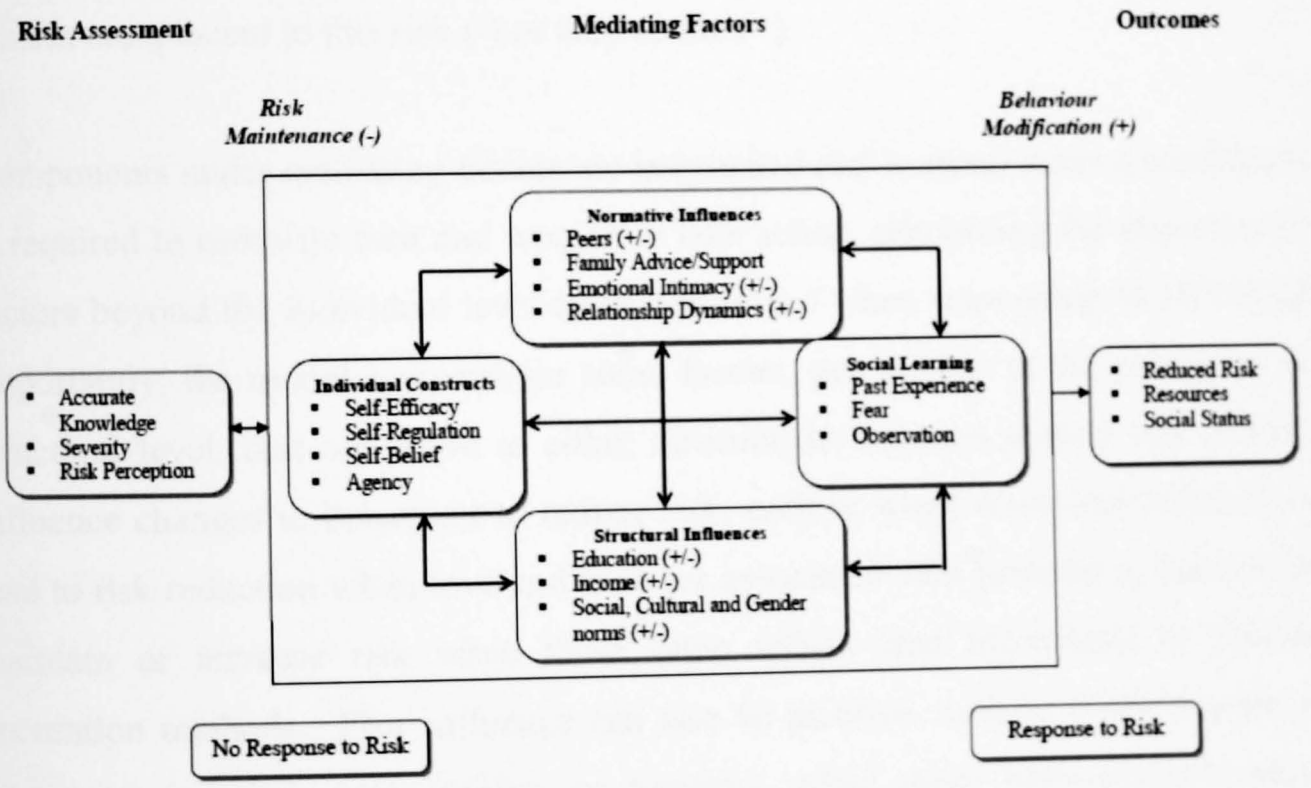
HIV/AIDS Risk Assessment and Reduction Model

The initial conceptual framework and related theories were useful in understanding risk patterns among individuals, particularly factors at multiple levels that can influence risk. However, findings from the research demonstrated a more complex interplay between the various levels, which tend to operate in an interlinked and more cyclical manner than the TTI framework allowed. These are incorporated into an HIV/AIDS Risk Assessment and Reduction (HARAR) Model (Figure 5). The model supports and adapts elements from the health belief model [90, 344] and ARRM [86] on risk perception, severity of the epidemic and knowledge, as well as from social cognitive theories [185] which focus on learning and normative influences. It also encompasses the theory of triadic influence and principles of ecological models by considering the multiple factors that influence risk and risk reduction. In addition, the research also demonstrated that the performative roles of men and women are prominent in both risk and risk-reduction practices. Unlike most ecological models, however, HARAR distinguishes the various levels to highlight factors which may operate in isolation, but also recognises that factors combine and interact at many levels to influence not only risk assessment, which the majority of models focus on, but risk reduction efforts. Importantly, the findings suggest that men and women go through three key phases (i.e. Risk Assessment, Mediating Factors and Outcomes) when at HIV/AIDS risk which in turn influences whether action will be taken. Therefore, the initial conceptual framework has been modified and placed into the HARAR model taking into account the research findings.

Factors at the individual level in the conceptual framework, specifically knowledge, severity and risk perception were shifted in HARAR under the "Risk Assessment" phase as these factors have been noted both in previous literature and in this research as crucial preconditions for individuals to engage in responsive measures. Factors in the conceptual model under social normative and structural influences have been preserved in the HARAR model under the "Mediating Factors" phase along with some modifications. In addition to the factors under structural influences in the conceptual framework, social and gender norms were included due to the inhibiting and enabling role they play on risk and risk reduction efforts. The specific roles of men and women which are culturally defined and socially enacted, as postulated through gender and power [20] as well as role and script theories [345, 346] shape identity and interaction with others as noted in this research. Since sexual encounters are the primary mode of HIV/AIDS transmission in the study setting, the manner in which men and women identify with their gender and how they learn about and act out their expected roles in society are critical to understand if the dynamics of and responses to HIV/AIDS risk are to be effectively tackled. As noted by the work of many leading gender and human sexuality theorists such as Henrietta Moore [347, 348], Simone de Beauvoir [349], Jeffrey Weeks [350] and Michel Foucault [351] among others, is the notion of fluid gender roles within discourses of shifting cultural and social norms and where multiple forms of masculinity and femininity co-exist which can transcend sexes based on experiences. Such notions were reaffirmed in this study in the context of HIV/AIDS risk reduction where at times, men reconstructed widely accepted norms of masculinity, such as the display of power through multiple sexual encounters, and instead prioritized the provider role in order to protect their family from harm. Similarly, women redefined norms of femininity (i.e. passivity and dependence) by removing themselves from risky situations through self-efficacious and autonomous actions. Under normative influences in the HARAR model, one factor, 'emotional intimacy' was added based on findings from this research which demonstrated how it can be both protective or contribute to risk. Individual Constructs and Social Learning were other components added under "Mediating Factors" as each were critical in shaping both perception of risk and subsequent action. With the exception of self-efficacy, none of the other factors noted under Individual Constructs or Social Learning in the HARAR model were in the original conceptual framework. Finally, although the conceptual framework was

developed with one outcome in mind – HIV/AIDS risk reduction – it was evident from this research that in many cases, other outcomes were just as or more important to motivate action, such as the need to maintain a good social standing and/or contain resources. These findings reinforce the need for HIV/AIDS related interventions to take on a holistic approach by considering the multiple factors of influence on risk perception and responses, particularly, that risk reduction efforts may not always be the intended or immediate outcome motivating changes in practices. It also highlights the vital role of the often evolving role of gender dynamics in both HIV/AIDS risk and risk reduction practices.

Figure 5: HIV/AIDS Risk Assessment and Reduction Model (HARAR Model)



Individuals assess their risk based on accurate knowledge, personal susceptibility and severity in terms of the prevalence of HIV/AIDS. Inaccurate knowledge such as notions that HIV/AIDS is spread through condoms or that it only affects certain groups of people influences risk perception and subsequent mitigating responses. Thus, although many ecological models, including the theory of triadic influence, state the importance of factors at a multitude of levels in influencing risk, individuals must have accurate knowledge, feel HIV/AIDS is a severe threat in their lives and perceive that they may be at risk before they decide to act on it. Once risk is assessed,

there are factors at the individual, normative, social learning and structural levels that operate in a cyclical and interactive manner that can mediate this risk and either cause individuals to maintain risk levels (i.e. no response to risk) or move towards behaviour modification (i.e. responses to risk). Men and women who take measures in response to perceived risk also do so to achieve other outcomes, such as "containing financial resources" and "maintaining a good social standing". All mediating factors in the model motivated men and women in this study to reduce their risk regardless of their stance on gender disparities; however, there are some factors which can move in both directions (+/-) as noted in previous studies. While men and women may be aware of their potential risk, other factors such as peers, emotional intimacy with a partner, relationship dynamics, past experience, education, income opportunities and social, cultural and gender norms influence whether individuals will remain complacent to this risk (-) or take action (+).

Components under mediating factors are interlinked and in many cases a combination is required to motivate men and women to take action, reinforcing the importance of factors beyond the individual level to be considered when responding to HIV/AIDS. Importantly, the model accounts for some factors, particularly at the normative and structural level, that can move in either direction to maintain current risk levels or influence changes in behaviour to reduce risk, such as when emotional intimacy can lead to risk reduction when love and trust are associated with protection, but can also maintain or increase risk when these same values lead individuals to abandon prevention methods. Peer influence can also be positive, such as when women see others earning their own income, or negative, when peers have multiple sexual partners and encourage others to abandon condoms with primary partners. Within relationship dynamics, the model accounts for how risk responses can influence men and women differently and in both positive and negative ways through decision-making authority, ability to earn and control an income, and negotiating power. Under structural influences, access to education is a positive mediating factor in this study used to escape poverty and dependence on men for money. Access to income can also move in both directions since some men spend finances on sex, usually unprotected, with multiple women while others prefer to save their income to improve the lives of their family. Social and cultural norms which shape gender roles can also move in either direction and can change over time. Social norms which tolerate

wealth distribution from men to women through sexual encounters or cultural practices such as circumcision highlight different pathways through which risk can increase or decrease. Therefore, how men and women interpret and respond to each of the factors needs to be understood and applied to local contexts.

Risk Assessment

Risk is contextualised based on influences at a multitude of levels which determine how individuals assess the severity of HIV/AIDS and their own susceptibility. Findings confirm positions by AARM and the health belief model that individuals will not engage in risk reduction without accurate HIV/AIDS knowledge. Men and women in this study believe that HIV/AIDS exists and made an assessment of their potential risk levels based on their own or partner's behaviour. Some factors at the structural and normative levels, as noted earlier, can move in either direction to maintain risk or motivate risk reduction. Gender, cultural and social norms, which interact with other mediating factors in the model including relationship dynamics, peer influence and access to education and income generating opportunities, can profoundly influence the ability of men and women to change their behaviour as a result of vested interests to comply with certain norms. For example, some women take minimal if any action in recognised risky relationships to avoid the socially hazardous 'single' status. In other cases, women and men may be aware of potential HIV/AIDS risk but deflect or deny this risk in order to secure greater resources or sexual pleasure. Roles and expectations casting women and men into certain positions in society have a bearing on perceived risk. Consistent with gender and power theory, the ability of women to take action is often but not always constrained by differences in access to labour and opportunities. Economic dependence on men at times, limits women's ability to act on perceived HIV/AIDS risk for fear of financial loss. Similarly, masculine norms are often linked to resource generation and provision, which in this study, is often used as a leverage to engage in sex with multiple women.

Differences in economic opportunities between men and women influence responses to HIV/AIDS risk. The resulting power imbalances such as lack of decision-making authority affects the ability of women to communicate safe sex with their partners even though they feel at risk, while among men who use their wealth to access sex.

pleasure is often prioritised over potential HIV/AIDS risk. Social norms may also play a role in the tendency for women to take greater heed of their health while for men, priority is placed on immediate gratification. However, in other cases, women who use sex for resources favour wealth over the health status of a man. According to gender and power theory, men who use their wealth to obtain sex from women are doing so to manifest their power. Yet, some women also use their bodies as a source of power to extract wealth from men. Peer influence and social norms promoting sexual conquest among men or dictating the use of condoms in certain sexual encounters, such as with 'outside women', have a bearing on HIV/AIDS risk or protection use. For women, norms which encourage abstinence prior to marriage or those which discourage condom use during a marriage, affect their ability to negotiate safe sex encounters for fear of being viewed as promiscuous or unfaithful.

There is a close relationship between how gender roles become maintained through certain social situations and HIV/AIDS risk levels between men and women. Cultural, religious and traditional norms that encourage polygyny and early marriage are viewed as particularly risky for women. This is not only in relation to HIV/AIDS risk but linked to the limited ability of women to pursue education and income generating opportunities to increase their agency and autonomy. Although poverty has a bearing on HIV/AIDS risk, which is affected by income access and control between genders as noted by a systematic review in East, Central and Southern Africa [325], the poor economic status of individuals across communities in the study setting resulted in minimal noted differences on risk or responses.

Mediating Factors

Individual Characteristics

Men and women who decide to act on perceived HIV/AIDS risk (self-efficacy and self-belief) feel it is within their control to take action (agency and self-regulation) in order to achieve desired outcomes (decreased risk). These individual constructs correspond to elements contained in the ARRM and HBM models. The factors that motivate individuals to enact change are based on a combination of normative influences, social learning and structural components. For example, economic differences, leading to power imbalances can make it challenging for women to mitigate HIV/AIDS risk; yet, some have made efforts to overcome this and leave a

risky relationship as a result of self-efficacy but often also due to strong family support or the need to secure a healthy life for the family. Similarly, men who choose not to allocate resources to extramarital partners, those who remain faithful, and others who use protection across all sexual encounters, are influenced by individual characteristics such as self-efficacy and self-regulation but also by observation of others, family influence, avoidance of diseases, concern for the family and emotional intimacy with a partner.

Normative Influences

Derived from social cognitive theories, normative influences include those factors which help shape social or relationship norms. Peers, family advice and monitoring, emotional intimacy and relationship dynamics are such normative influences and can affect the ability of individuals to reduce perceived HIV/AIDS risk. As noted in previous studies, peer influence is usually grounded in prevailing gender and social norms, and can be either have a positive [59, 85, 352-354] or negative effect on health practices [145, 324, 355] depending on an individual's social networks. Some unmarried men in this study are questioning peer advice and behaviour to engage in sex with multiple women, or to use condoms with only 'suspected' women. Instead, these men consider the consequences of taking on these behaviours in terms of their own HIV/AIDS risk or the need to protect a primary partner and thus always use protection. Positive peer influence was noted when men observed from other settings, the value of handing financial control over to a women, who are deemed better at spending it wisely rather than it being left with men who may spend it on other women.

Parental and family influence has a very positive bearing on men and women to pursue less risky sexual situations as also noted in other studies from South Africa and the US [102, 184, 356, 357]. For men, the need to secure a sound future for their families by containing rather than spending resources and the desire to maintain a good status in society are largely influenced by family advice or observation of others. Unmarried men are also influenced by observing parents who have remained monogamous, and abide by family advice to engage in condom use. On the other hand, men can also be negatively influenced by infidelity in their parents' marriage, but may be affected by factors such as positive peer behaviour or emotional intimacy

with a spouse to engage in risk reduction. Parental advice also plays a key role in influencing unmarried women to remain abstinent in order to prevent disease acquisition or complete school. Family support is also vital for women who want to abandon risky relationships similar to findings from Malawi [323].

Emotional intimacy and relationship dynamics between partners can either exacerbate or decrease HIV/AIDS risk, a finding which also corresponds to data from European surveys [91]. Within relationship dynamics, an individual's decision-making power over various household and sexual situations is influenced by the ability to earn an income and control resources in the household. Yet, there are instances where decision-making proved negligible and men and women still took measures to engage in HIV/AIDS risk reduction efforts because of family support, past experience and certain outcomes such as a respected social status. In relation to emotional intimacy, some men and women feel at minimal risk due to trust, love and care built with a partner over time. These individuals are confident that their partner would not betray them or do anything to harm their health. Other men and women use risk reduction strategies to protect loved ones from the harmful consequences of HIV/AIDS despite adhering to gender norms. Some unmarried men and women associate the acceptance of HIV/AIDS risk reduction methods by a partner as confirmation of love, trust and care in the relationship with such actions providing vital insight into expectant behaviour of a partner in the future.

Structural Influences

Structural influences include broad factors such as education, income and social, cultural and gender norms, which create enabling or constraining environments for individuals to enact change. Access to education and income-generating opportunities among women influences strategies to engage in HIV/AIDS prevention and also affects measures to decrease perceived HIV/AIDS risk. Some young unmarried women are determined to complete their education and will use this as a leverage to delay marriage, maintain financial autonomy and demand an HIV test with a partner prior to marriage. Married women who are financially independent tend to discuss HIV/AIDS risks and condom use in the relationship, while financially dependent women tend to abandon the relationship. Some women also take steps to survive through accepted forms of work, despite the easy money obtained through

transactional sexual encounters, and do so to maintain self-respect and financial independence. Men generally have greater access to income and educational opportunities with some relying on their wealth to purchase sex from multiple women and others using their resources to improve their living standards and protect their family from HIV/AIDS.

Social Learning

Based on cognitive theories, men and women take measures to reduce their risk often due to learning from social encounters and experiences. Alongside individual characteristics and structural and normative influences, men and women tend to engage in risk reduction strategies due to a combination of their own past negative or high risk experiences, fear of disease acquisition based on prior STIs and observing the behaviours of others. According to social learning theory, positive reinforcement and experiences motivate individuals to repeat successful behaviour [185]. However, this study also found that negative experiences (STI acquisition or an unfaithful partner) can lead individuals to rethink future action including more careful partner selection and condom use with subsequent partners in order to reach desired positive outcomes such as decreased HIV/AIDS risk.

Outcomes

Risk assessment and the decision to modify behaviours are intimately linked to broader outcomes which not only influence HIV/AIDS risk reduction strategies, but take into consideration other factors. In some instances, the focus on broader outcomes may hold more intrinsic value than the reduction in HIV/AIDS risk. For example, men who do not provide finances to other women in exchange for sex may do so primarily to save money and ensure their family's well-being with potential mitigation of HIV/AIDS risk a secondary benefit. Similarly, some women who do not exchange sex for resources may be motivated by wanting to maintain a good social status and avoid 'bad behaviour' rather than out of direct fear of HIV/AIDS. In other cases, broader goals are balanced with HIV/AIDS risk, such as when women stay with their husband despite his risky behaviour in order to maintain financial security.

Policy and Programme Implications

The experiences of positive deviant cases in this study provided insight into the factors influencing risk reduction practices among a unique sub-group of men and women, regardless of their views on gender norms. As noted earlier, the extent to which positive deviant behaviour can successfully be replicated beyond the study setting appears promising given that it draws on the experiences of individuals living in the same conditions (i.e. gender norms, poverty) as other community members, yet barriers have been overcome to reduce HIV/AIDS risks. Such experiences therefore may resonate with men and women in surrounding areas. Although it is difficult to suggest for certain that practices within this study setting are replicable across other rural and matrilineal contexts in Mozambique, the PD approach has been shown to 'work' as evident through years of using it to improve nutritional outcomes among children: *"Such behaviours are likely to be affordable, acceptable and sustainable because they are already practised by at risk people and do not conflict with local culture, and they work" [227].* PD approaches have also been used across a variety of countries including Indonesia, Georgia, Egypt, Pakistan and Vietnam for breastfeeding, monitoring birth outcomes, newborn care and risk reduction among sex workers and injection drug users [358]. Moreover, in addition to the various programme evaluations that have occurred indicating that the PD approach has been successful, a randomized prospective trial in Northern Vietnam demonstrated that children and mothers receiving PD interventions experienced better health outcomes compared to the control group [359]. Therefore, given the breadth of PD use across different settings and sectors as well as positive evaluations emerging from the integration of this approach into wider programming activity, it is likely that similar results can be obtained if findings from this research are adapted and incorporated into HIV/AIDS prevention programmes in similar settings in Mozambique.

Positive deviant cases, or those men and women who take measures to reduce their perceived HIV/AIDS risk regardless of often gender imbalanced norms and social views in this study, are all influenced by a common set of factors noted in the HARAR Model including: individual characteristics, family advice and support, observation, learning from past experiences, fear of the disease, the need to protect oneself, a partner or children, the association of risk reduction strategies with

emotional intimacy and the desire to maintain a good social standing. These drivers of positive behaviour could be incorporated into localised HIV/AIDS responses and build on the specific ways men and women engage in risk reduction.

When designing HIV/AIDS prevention programmes, mediating factors that move in either direction should be carefully considered, with emphasis placed on factors indicating strong positive tendencies towards risk reduction. For example, the association between emotional intimacy and a partner's acceptance of risk reduction strategies indicates a shift in norms on safe sexual behaviour which should be focused on in prevention campaigns. There are some factors at the normative and social learning level that are specific to individual cases such as relationship dynamics, family advice, past experience and observation, which in turn affect both risk and risk reduction. Recognizing how such factors influence behaviour modification towards reduced risk should broaden their use including through the sharing of individual experiences with others via peer to peer approaches, and engaging in dialogue on how these experiences can be applied to other peoples' situations through modelling the positive behaviour of families or couples. In the policy realm, mediating factors which indicate a strong push to behaviour modification, such as access to education (which can in turn affect a women's negotiating power over safe sex or access to income) or social support services for women wanting to leave risky relationships should be promoted. Complementing this, concerted efforts should also be placed on linking risk reduction with other broad outcomes salient to the population such as 'containing income and resources' for the family's protection and financial well-being.

The ability to make generalizations is a key limitation of this study due to its small scale and use of purposeful sampling. As a result, future studies may want to test the model to ascertain whether significant relationships exist between different mediating factors, and if there are similar factors such as those found in this study, that influence men and women across various settings to reduce HIV/AIDS risk. Outcomes beyond just decreasing HIV/AIDS risk which motivate individuals to engage in risk reduction strategies should also be incorporated into local interventions and further explored in other contexts. Future research on the interaction between gender norms and HIV/AIDS in different settings would also be valuable to better understand the

specific responses to risk between men and women in gender balanced or imbalanced encounters. Such research can contribute to a more holistic understanding of the factors motivating individuals to reduce risk across various settings and help shape more tailored responses to HIV/AIDS.

Through the use of participatory approaches, interventions can address widespread criticisms of some existing HIV/AIDS methods which fail to incorporate localised understandings of gender, social and cultural norms. Programmes can use participatory methods through a group session format to help identify positive deviant men and women who are already practicing risk reduction strategies. Further interviews and probing can then lead to greater insights into the contextual factors influencing individuals to engage in HIV/AIDS risk reduction measures against prevailing social and gender norms. Once such factors have been identified, they can be used as a basis to develop more tailored and localised messaging for the intended target group. Positive deviants can also serve as effective role models in their communities, as they live in similar conditions to others. Through the use of peer education approaches or incorporating factors influencing positive deviants into broader risk reduction campaigns, there is a greater likelihood that the behaviour of the positive deviant will be accepted than if such behaviours are communicated externally.

Since gender norms are not static, but rather in constant flux, the ability of men and women to work within and challenge these norms to reduce HIV/AIDS risk needs to be understood and included into programmes and policies. Although in some cases, gender norms which balance out disparities between men and women may heighten HIV/AIDS risk, efforts should continue to promote gender equality in its own right and as a means to facilitate HIV/AIDS risk reduction among men and women. Building on what men and women already do to reduce their risk will aid programme and policy initiatives in different settings as HIV/AIDS responses will be grounded in local contexts and social situations.

Dissemination of Findings

One of the important elements for undertaking the research was to ensure that findings are translated from academia into programme and policy forums. As such,

preliminary findings have already been disseminated to staff at the host organization in Pemba and Maputo to facilitate the incorporation of results into on-going programmes. In addition, a policy dialogue meeting was organised by the Aga Khan Foundation (Mozambique) where findings were shared with a diverse group of stakeholders working on HIV/AIDS and gender including the Canadian International Development Agency, Centres for Disease Control, Family Health International, Save the Children and the Ministry of Health (HIV/STI Unit). The findings were also shared with UNAIDS Mozambique to inform a Modes of Transmission study, synthesizing information on HIV/AIDS prevention. An abstract of the research was peer reviewed and accepted to be presented under the HIV/AIDS and Gender working group session at the International Association for Media and Communication Research in July 2010. Findings will also be written up for publication in international health journals.

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Annex 1: Training Schedule

Day 1	Topics
8:30-10:30	▪ 1.1: Overview of Topics to be covered during Training ▪ 1.1a: Ice-Breaker, getting to know each other ▪ 1.2: Presentation of Research and Questions
10:30-10:45	Break
10:45-12:00	▪ 1.2: Continuation of Research Overview ▪ 1.2: Ensure understanding of research methods ▪ 1.3: Overview of topic guide for traditional leader interviews
12:00-13:00	Lunch
13:00-14:30	▪ 1.4: Basic HIV/AIDS Information ▪ 1.5: Impact of Gender on HIV/AIDS Exercise
14:30-14:45	Break
14:45-15:45	1.6: Introduction to participatory research (PR) methods ▪ What are participatory methods and approaches ▪ Principles
15:45-16:30	1.7: Practice Ice-breaker Game
Day 2	**Topics**
8:30-10:00	2.1 Roles and responsibilities of assistant ▪ Knowledge and attitudes ▪ Explanation of debrief forms
10:00-10:15	Break
10:15-12:15	2.2 PRA Skills ▪ Active Listening Exercise ▪ Effective Questioning Exercise ▪ Facilitating Group Discussions Exercise ▪ Practice skills through PR Tools
12:15-13:15	Lunch
13:15-14:00	PR Tools: Overview
14:00-15:00	PR Tool 1 Explanation
15:00-15:15	Break
15:15-16:30	Practice PR Tool 1 (Female Assistant)
Day 3	**Topics**
8:30-9:45	Practice PR Tool 1 (male assistant)
9:45-10:45	PR Tool 2 Explanation
10:45-11:00	Break
11:00-12:15	Practice Tool 2 (Female Assistant)
12:15-13:15	Lunch
13:15-14:30	Practice Tool 2 (Male Assistant)
14:30-15:30	PR Tool 3 Explanation
15:30- 15:45	Break
15:45-16:30	Review

Day 4	Topics
8:30-9:45	Practice PR Tool 3 (Male Assistant)
9:45-10:00	Break
10:00-11:15	Practice PR Tool 3 (Female Assistant)
11:15-12:15	PRA Tool 4 Explanation
12:15-13:15	Lunch
13:15-14:30	Practice PR Tool 4 (Male Assistant)
14:30-14:45	Break
14:45-16:00	Practice PR Tool 4 (Female Assistant)
16:00-16:30	Address questions and concerns on all PR Tools to be used in the study
Day 5	**Topics**
8:30-10:00	▪ Dealing with Difficult situations in PR Groups ▪ Strategies on how to deal with dominant/excluded individuals in the group setting
10:00-10:15	Break
10:15-12:15	Brainstorm session: Ideas on potential issues that can arise and how to deal with each
12:15-13:15	Lunch
13:15-14:30	Ethical Considerations ▪ Domestic Violence ▪ Support ▪ Questions that come up during PR or inaccurate HIV/AIDS information
14:30-14:45	Break
14:45-16:00	Identification of individual for in-depth interviews and use of probing questions
16:00-16:30	Brainstorm on types of questions to ask during in-depth interviews
Day 6	**Topics**
8:30-10:00	Continuation: Brainstorm on types of questions to ask during in-depth interviews
10:00-10:15	Break
10:15-12:15	Transcription and Translation Overview
12:15-13:15	Team Lunch
13:15-14:30	▪ Recap of training session. Ask Assistants to provide answers to key questions. ▪ Recap: Research: aims and objectives, types of questions to probe with, identifying individuals during group sessions
14:30-14:45	Break
14:45-16:00	Recap: PR and Ethics Importance of PR, what skills they will need, how to deal with difficult PR sessions
16:00-16:30	Final Questions

Annex 2: Questionnaire for Leaders

1. What is the main language spoken in your village?
2. Which tribes and ethnic background live here?
3. At what age do women and men normally get married?
4. Can you please describe this process of marriage (how do they meet, what happens during initiation rites)?
5. What are the roles and responsibilities of women in the village?
6. What are the roles and responsibilities of men in the village?
7. How are these roles and responsibilities for men and women learned?
8. Have these roles/responsibilities changed over time for men and women? If so, in what ways?
9. In this community, who usually makes decisions in the house regarding: a) financial resources; b) buying food; c) going to the health centre and school;
10. What happens to property and other household goods if the husband or woman in a marriage dies?
11. Do you know of methods to prevent HIV/AIDS? If so, can you describe these?
12. How did you find out about these prevention methods? Do you think other people in your community have the same knowledge?
13. Have you told other people of ways to prevent HIV/AIDS?
14. Who is most vulnerable/at risk to HIV/AIDS and why?
15. What are the advantages and disadvantages of being a man or a woman in relation to protection against HIV/AIDS?
16. What can men do to protect themselves against HIV/AIDS?
17. What can women do to protect themselves against HIV/AIDS?
18. Is there anything that can be done at the family and community levels to decrease HIV/AIDS vulnerability/risk?

Annex 3: Participatory Exercises

<table>
<tr><th colspan="2">Octopus (Vulnerability Flow) Diagram</th></tr>
<tr><td colspan="2">Overview: Understand participant knowledge and perception of HIV/AIDS risk</td></tr>
<tr><th>Information Gathered from Tool</th><th>Approach</th></tr>
<tr><td>▪ Identify participant views of HIV/AIDS risk
▪ Explore factors that place people at risk of HIV infection
▪ Identify ways people are already trying to decrease HIV/AIDS risk or vulnerability
▪ Explore ways people could reduce HIV/AIDS risk or vulnerability</td><td>1) Ask participants to identify HIV/AIDS risk behaviours
2) Encourage participants to identify the factors that can place them at risk or make them vulnerable to these risk behaviours (i.e. having sexually transmitted infections). These become the start of the tentacles of the octopus emerging from its head.
3) Select one of the factors. Ask participants to identify the issues that make people vulnerable to taking that risk (i.e. poverty, lack of information). Draw/write these issues along the tentacle.
4) Repeat the process for the other factors.</td></tr>
<tr><td colspan="2">Outputs: Diagram of an octopus with risk factors for HIV/AIDS in the centre. The legs of the octopus would contain those factors that increase/decrease HIV/AIDS risk behaviours</td></tr>
<tr><td>Questions:</td><td>▪ What are the factors that make men and women behave in a way that increases their vulnerability or risk of HIV/AIDS?
▪ Are there common issues that make people vulnerable or at risk to HIV/AIDS?
▪ What can be done to address these factors (i.e. making women and men less vulnerable or at risk to HIV/AIDS?)</td></tr>
</table>

Gender Boxes	
Overview: Identifying behaviours expected of men and women and what happens if a man or a woman breaks away from the gender norm	
Information Gathered from Tool	**Approach**
▪ Understand expected behaviours of men and women and how they link to HIV/AIDS ▪ Explore where these behaviours are derived and the pressures they bring ▪ Explore what happens when men or women do not follow prescribed behaviours ▪ Explore effect of power and cultural traditions on gender norms	1) Draw a 'typical' woman and man inside a box. 2) Discuss the qualities, roles and behaviour that society expects of the 'typical' woman or man, and draw or write the key points inside the box. 3) Ask the participants to discuss where those expectations come from. 4) Ask the participants what happens if the 'typical' woman or man is not how society expects. Draw or write this outside of the box. 5) Compare boxes for men and women and discuss what the gender boxes have shown.
Outputs: Diagram Inside the box would be characteristics and roles that define a typical man or women in the village. Outside the box would be those roles and behaviours that are not typical for men and women in the village (whether positive or negative)	
Questions	▪ What pressure are people under to stay in their gender box? ▪ Where do those pressures come from? How do gender boxes affect HIV/AIDS? ▪ What are the advantages of people coming out of their gender boxes in relation to HIV/AIDS? What are the disadvantages? ▪ Are their characteristics of men and women which make them more vulnerable or at risk to HIV/AIDS? ▪ Are there factors that can make women and men less vulnerable or at risk to HIV/AIDS? Do you know anyone who is doing this? Can we speak to them? ▪ Is there anyone you know who has these characteristics that do not fit into the typical ideal of what it means to be a man or a woman? Would we be able to speak to them?

Gender Table	
Overview: Identifying various social roles of women and men at different levels and how these may affect the lives of men and women in relation to HIV/AIDS	
Information Gathered from Tool	**Approach**
▪ Discuss sensitive issues related to gender (culture traditions) ▪ Explore roles of men and women in relation to peers, family, community, sexual relations ▪ Identify how different roles affect and are affected by HIV/AIDS ▪ Explore changing gender roles	1) Draw a large chart and draw/write the column headings 'Individual', 'Family', 'Friends' ,'Community/Social', 'Sexual Relations', and the row headings 'Women', 'Men' on the chart. 2) Discuss what roles women and men play in each category. Draw/write the key points on the chart. Encourage the participants to discuss the following: ▪ Why do women and men play those different roles? ▪ What negative and positive effects do those different roles have on women and men's lives in general?
Outputs: A chart with the roles and responsibilities of men and women under each of the broader headings.	
Questions	▪ How do the different sets of roles relate to each other? (How do men's roles in the economy relate to women's roles in sexual relations, for instance?) ▪ Who has most power in the economy, community, family and sexual relations? ▪ Does this power need to be changed? Why or why not? ▪ What negative and positive effects do those different roles have on women and men's lives in relation to HIV/AIDS? ▪ Can these roles be changed in order to reduce HIV/AIDS vulnerabilities or risk? Is anyone currently doing this in your community? Can we speak with them?

Annex 4: In-Depth Interview Guide

1. Can you tell me about key events in your life from when you were born until now (i.e. marriage, children, illnesses, deaths, etc)?
2. Do you have a partner (i.e. husband, wife, girlfriend, boyfriend?). Do you have other partners? Please describe each one
3. Who generally makes decisions in the household (i.e. purchase of household goods, managing money, accessing health services)?
4. Do you think men and women in this village have the same opportunities to go to school? What about working/earning an income? What is your experience?
5. Do you think it is advantageous to be a man or woman in this village and why?
6. Do you think that the roles of men and women need to change?
7. Are there men and women in this village who you admire? Why?
8. Is there a couple in this village whose relationship you admire? How come?
9. Where did you learn about HIV/AIDS?
10. Do you know ways to prevent it? Do you practice these methods? Why or why not?
11. Do you feel at risk of HIV/AIDS? Why or why not?
12. What are you doing to combat this risk/vulnerability?
13. Do you think men and women in this village have the same knowledge of HIV/AIDS?
14. Do you think that men and women are both equally vulnerable or at risk to HIV/AIDS?
15. Are there differences between the prevention strategies that can be used by men and women? What are your experiences?
16. Do you think the different gender roles and responsibilities of men and women affect their vulnerability or risk to HIV/AIDS?
17. What can be done to reduce HIV/AIDS in this village? Do you have any experiences?

Annex 5: Ethics Approval

LONDON SCHOOL OF HYGIENE
& TROPICAL MEDICINE

ETHICS COMMITTEE

APPROVAL FORM
Application number: **5352**

Name of Principal Investigator	**Sarah Bandali**
Department	**Epidemiology and Population Health**
Head of Department	**Professor Laura Rodrigues**

Title: **Exploring Intersections between Gender Equitable Practices and HIV/AIDS Vulnerabilities in Rural Mozambique**

This application is approved by the Committee.

Chair .....[redacted].....
Professor Tom Mead

Date .....4 August 2008.....

Approval is dependent on local ethical approval having been received.

Any subsequent changes to the application must be submitted to the Committee via an E2 amendment form.