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Gender equitable men's attitudes and beliefs to reduce HIV risk and gender-based violence in Tanzania

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Abstract
Background: While the prevalence of HIV in adults has slightly decreased in recent years, the variations in prevalence and risks to infection among men and women persist. These variations are partly explained by the social and structural conditions that predispose both sexes to HIV infection. Due to psychological and physiological conditions, literature indicates that HIV and gender based violence including intimate violence are related. This study aimed to assess how attitudes and beliefs respond to the spread of HIV and gender-based violence (GBV) in Tanzania.
Methods: We conducted a quasi-experimental study with a sample of 1,620 adult women and men; with an approximate ratio of 1:2. A Gender Equitable Men's scale was slightly modified to capture various psychometric domains on HIV related gender norms and attitudes among women and men.
Results: We found a substantial higher proportion of men having positive gender equitable norms and consistently positive attitudes in all four domains (GBV, reproductive health and disease prevention, sexuality and domestic life and child care) we assessed on.
Conclusion: Results from this study may probably imply that now men are taking positive roles in issues of domestic violence, reproductive health and disease prevention, sexuality and in domestic life and child care.

Key words: HIV, gender, violence, risk, Tanzania

Introduction

In Tanzania, the prevalence of HIV among adults aged between 15 and 49 years in 2011-12 was 5.1% and consistently about 80% higher in females than in males in all age groups and the risk is twice for women as compared to men (THMIS, 2013). Even in other sub-Saharan countries, 61% of people living with HIV are women. Increased risk of HIV among women has been discussed before (Silberschmidt & Rash, 2001; Glynn *et al*., 2001). Sexual violence against women has been suggested to explain increased vulnerability to HIV (Maman, *et al*., 2002; Maman, *et al*., 2004; Lary, *et al*., 2005). Among other things, the risks include engaging in sexual relationships with older partners and lack or difficulty to negotiate condom use. Furthermore, although recently there has been reported reduced mortality due to AIDS following the introduction of anti-retroviral therapy (ART) in Tanzania and neighboring countries (Herbst *et al*., 2009), literature also indicates mortality has been tremendously high (Glynn *et al*., 2014; Kajala *et al*., 2014). For that matter, major consequences of HIV morbidity and mortality include disability and reduced work-force (Rueda *et al*, 2012a; 2012b).

Gender-based violence (GBV) is defined by the United Nations as any act towards women (and men) that end up to physical, sexual, or psychological harm or suffering. It also includes threats of such acts and coercion or arbitrary deprivations of liberty and could occur in public or in private life (UNAIDS, 1993). GBV including violence by intimate partner are globally reported as high as up to more than 70% of women aged 15 to 49 years (Garcia-Moreno *et al*., 2006). In some countries like Zimbabwe, 30% and 27% of women reported physical and sexual violence, respectively (ZIMSTAT,

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2012). About 40% of ever-married women in Kenya, Tanzania and Uganda reported to have ever experienced some form of physical violence (20%) (TDHS, 2010; UBOS 2012; KNBS, 2010).

Due to psychological and physiological conditions, HIV and gender based violence including intimate partner violence are related (Lary *et al*., 2004; Baumgartner *et al*., 2014; Fontenot *et al*., 2014). Most of women having less physical strength as compared to men always have a horror against any type violence directed to them and as such they fail to protect themselves against HIV infection. It becomes seriously difficult for them to negotiate about having sex and safe sex. Unequal power distribution between men and women result into the latter being often weak in making decisions about safe sex (Sa & Larsen, 2008). The power inequality in negotiating condom use may subsequently increase women's risks of getting infected with HIV. Furthermore, once tested and confirmed being HIV infected, women especially in sub-Saharan countries do not disclose to partners and to relatives fearing discrimination and stigma (Asiedu & Myers-Brown, 2014).

Increased risk of HIV infection among women in sub-Saharan countries is confounded by culture and norms. The notion of men having extreme coercion and strong controlling behaviors than their counterparts, for example in sexuality, is widely acceptable in many African societies and across cultures (Lusey *et al*., 2014; Rosenthal *et al*. 2012; Mboya *et al*., 2012). Masculine tendencies favour men to use or not use a condom during sexual intercourse even if the partner demands one and beating a wife/partner in case she refuses to have sex has been reported (Jesmin & Cready, 2014; Kayibanda *et al*., 2014). Therefore, all preventive strategies and efforts to reduce GBV have effects towards minimizing the risk of HIV, specifically for women. Based on this link, such strategies should consider the existing powers that favour men as compared to women. The unbalanced powers put women at an elevated risk of HIV. The objective of this study was to assess Gender Equitable Men's (GEM) attitudes and beliefs towards reducing the risks of both HIV and GBV. Since GEM's attitudes and beliefs are intended to respond to the spread of HIV, GBV and to improve reproductive health outcomes, it is important to study these norms as they affect sexual and reproductive health outcomes among partners.

Materials and methods

Study settings and design

This study was carried out in selected six regions of Mainland Tanzania, namely, Dar es Salaam, Kagera, Mbeya, Mwanza, Tabora and Ruvuma. From each region, we purposefully selected one urban district. We further selected two wards (a ward is the lowest Tanzania government administrative structure at the community level that represent between 1,000 to 21,000 people. In urban settings, wards represent a portion of town or of a larger city).

Data were extracted from a larger study intended to evaluate a project known as Channeling Men's Positive Involvement in a National HIV/AIDS Response (CHAMPION) in which the study design was quasi experimental. We estimated a sample of 1,620 adult (aged between 25 to 50 years) women and men. Adulthood was considered to be an important exposure age enough to experience GBV. The main focus for this study was men; nevertheless we also considered a ratio of one woman to 2 men per site to gather information related to women.

We randomly (using systematic sampling of households; alternating one adult man and one adult woman) selected study participants from each of the selected wards with equal allocation per selected ward. Eligibility of study participant was based on age, residence of the street (at least one year), and literate in Kiswahili and willing to participate in subsequent CHAMPION's group education workshops without receiving monetary compensation.

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Measures and GEM Scale

Among variables that were collected included background information of the respondent, intimate partner violence (reported occasions within the previous one month and within past six months), HIV risk sexual behaviour, utilization of reproductive health and HIV services and gender equitable attitudes and beliefs measured by the Gender Equitable Men's (GEM) Attitude and Beliefs Scale.

A GEM scale developed by Pulerwitz and Baker (Pulerwitz & Baker, 2008) was slightly modified to capture various psychometric domains on gender norms about GBV, reproductive health and disease prevention, sexuality, domestic life and child care. This modified scale was similar to that used in Ethiopia (Pulerwitz, *et al*., 2010). An example of such minor changes was in attitude statements about sexuality with a statement/, *"It is the man who decides what type of sex to have"* that was changed to *"It is the man who decides when to have sex with a partner"*. Box 1 shows 24 items of the GEM scale that was used in Tanzania Mainland. Participants were to respond: Agree =1; Partially Agree =2; or Do Not Agree=3 for each of the item of GEM scale.

Box 1: Gender equitable men's (GEM) scale items

Violence

There are times when a woman deserves to be beaten
A woman should tolerate violence in order to keep her family together
It is okay for a man to hit his wife if she won't have sex with him
It is alright for a man to beat his wife if she is unfaithful
If someone insults a man he should defend his reputation with force if he has to
A man using violence against his wife is a private matter that shouldn't be discussed outside the couple

Reproductive health and disease prevention

It is a woman's responsibility to avoid getting pregnant
A real man produces a male child
Only when a woman has a child is she a real woman
Women who carry condoms on them are easy
A man should be outraged if his wife asks him to use a condom

Sexuality

Men need more sex than women do
You don't talk about sex, you just do it
Men are always ready to have sex
Real men do not immediately go a doctor when they are sick
It is the man who decides when to have sex with a partner
Men need other women even if the things with his wife are fine
Employed women do not make a good wife
A woman should not initiate sex

Domestic life and child care

A man should have the final word on decisions in his home
A woman's most important role is to take care of her home and cook for her family
Giving the kids a bath and feeding the kids are the mother's responsibility
A woman should obey her husband in all things
A man should not take his child to the clinic without the child's mother

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Data analysis

For each participant, responses to the GEM scales were added together to form composite discrete variable that were categorized into Low Equity = 24-39, Moderate Equity = 40-55 and High Equity = 56-72. Therefore, the proportion of participants with moderate to high equity is calculated as (number of participants scoring at least 40/Total participants) x 100. Data analyses involved descriptive statistics on the main variables of interest. Tables were created to show distributions of characteristics associated with required indicators. Statistical tests that were performed include t-test, chi-square (χ^2), Gamma and Analysis of variance.

Ethical consideration

The evaluation protocol was reviewed and approved by the Muhimbili University of Health and Allied Sciences Institutional Review Board (MU/DRP/AEC/VOL.XVIII/6). Permission to enter the study areas and locations were sought and granted by respective regions, districts and local government authorities. Each respondent was invited to participate after signing the consent form. Interviewers emphasized that participation was voluntary and participants were at liberty to withdraw at any time. Each study participant was assured of confidentiality. No personal identifiers were collected from interviewees. Also to enhance freedom of expression, a male interviewer interviewed a male participant and a female interviewer interviewed a female participant. Interviews were conducted in privacy.

Results

Description of study participants

Eligible participants with complete data were 1,289 (79.6% of the calculated sample size). There were 818 (63.5%) males and 471 (36.5%) females. The majority, 487 (66.0%) were married, 1252 (97.2%) had completed at least primary education. Their mean age was 34.4 (SD = 7.7) years.

Analysis of GEM's attitudes and beliefs scale

The average total GEM scores was 52.0 (SD = 11.6), males having significantly (t=11.94, p<0.001) higher average score, 54.9 (SD = 11.0) than females, 47.0 (SD=10.9). In all four (violence, reproductive health and disease prevention, sexuality and domestic life and child care) domains, consistently men scored significantly higher than females. The mean scores for males and females for each domain were 14.0 (SD=3.4) against 21.1 (SD=3.6); 11.8 (SD=2.8) against 10.3 (SD=2.7); 19.7 (SD=3.8) against 16.8 (SD=4.2) and 9.6 (SD=3.0) against 8.1 (SD=2.7), respectively. Furthermore, consistently more men reported positive gender equitable norms than women and in 21 out of 24 items; these differences were statistically significant (Table 2). Although all selected background characteristics were significantly correlated with level of equity, education and occupation were positive moderately correlated with level of equity. For example, an increase in the level of education suggests an increase in the level of equity (Table 3). Also, sex (0=Male; 1=Female) and level of equity was negatively moderately correlated suggesting being a female leads to the decrease in level of equity (Table 3).

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Table 1: Distribution of study participants by background characteristics

Characteristic	Number (%)*
Sex	
Male	818 (63.5)
Female	471 (36.5)
Current age (years)	
25 – 29	439 (34.1)
30 – 34	269 (20.9)
35 – 39	218 (16.9)
40 – 44	177 (13.7)
45 – 50	186 (14.4)
Education	
None/Informal education	36 (2.8)
Primary education	858 (66.6)
Above primary education	394 (30.6)
Current marital status	
Never married	230 (17.9)
Married/cohabitating	948 (73.8)
Previously married†	106 (8.3)
Occupation	
Small-scale farming	405 (31.4)
Business	550 (42.7)
Artisan	116 (9.0)
Formal employment	84 (6.5)
Other‡	134 (10.4)

***** = Numbers do not add up to 1289 due to missing information; † = Divorced/widowed;
‡ = Housewife, unemployed, small-scale business or student

Discussion

In this paper, we assessed Gender Equitable Men's (GEM) attitudes and beliefs in Tanzania as a way towards reduction of HIV and gender based violence (GBV). On one hand, in sub-Saharan countries variations in gender attitudes and beliefs often lead to GBV and on the other, much structural vulnerability like GBV put an individual at elevated risk of HIV (Murphy, et al., 2006; Blanc, 2001). Although assessing gender equitable norms on attitudes and beliefs was designed for men, in this study we used a similar GEM scale for both women and men. The use and assessment of GEM scale among women has been previously reported in a Bangladesh study (Sayem & Nury, 2013). In this study, the scale was very much reliable to both women and men (Chronbach's alpha = 0.882 and 0.887 respectively).

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Table 2: Number (%) of study participants with positive Gender Equitable Norms by sex

GEM Scale Item	Women Number (%)	Men Number (%)	χ^2, p-value
Violence			
There are times when a woman deserves to be beaten	268 (57.0)	494 (60.8)	1.87, 0.172
A woman should tolerate violence to keep her family together	208 (44.2)	534 (65.3)	54.73, < 0.001
It is okay for a man to hit his wife if she won't have sex with him	299 (63.6)	664 (81.4)	49.65, < 0.001
It is alright for a man to beat his wife if she is unfaithful	124 (26.4)	2395(48.5)	61.40, < 0.001
A man he should defend his reputation with force if insulted	237 (50.4)	529 (64.8)	26.09, < 0.001
A man using violence against his wife is a private matter that shouldn't be discussed outside the couple	220 (46.8)	504 (62.0)	16.51, < 0.001
Reproductive health and disease prevention			
It is a woman's responsibility to avoid getting pregnant	135 (28.8)	465 (56.9)	94.00, < 0.001
A real man produces a male child	388 (82.4)	715 (87.6)	6.7, 0.01
Only when a woman has a child is she a real woman	223 (47.3)	473 (58.1)	13.88, < 0.001
Women who carry condoms on them are easy	316 (68.4)	585 (72.0)	1.97, < 0.161
A man should be outraged if his wife asks him to use a condom	118 (25.1)	425 (52.0)	88.69, < 0.001
Sexuality			
Men need more sex than women do	124 (26.6)	440 (54.1)	91.70, < 0.001
You don't talk about sex, you just do it	366 (78.7)	737 (90.5)	34.14, < 0.001
Men are always ready to have sex	117 (25.0)	455 (55.8)	114.0, < 0.001
Real men do not immediately go a doctor when they are sick	220 (47.3)	522 (64.4)	35.96, < 0.001
It is the man who decides when to have sex with a partner	247 (52.6)	555 (67.8)	26.03, < 0.001
Men need other women even if the things with his wife are fine	186 (39.6)	526 (64.5)	69.41, < 0.001
Employed women do not make a good wife	423 (89.8)	739 (90.7)	0.26, 0.607
A woman should not initiate sex	297 (63.2)	644 (79.2)	38.61, < 0.001
Domestic life and child care			
A man should have the final word on decisions in his home	105 (22.4)	229 (28.2)	5.0, 0.025
A woman's most important role is to take care of her home	70 (14.9)	262 (32.1)	46.4, < 0.001
Giving the kids a bath and feeding are the mother's responsibility	82 (17.4)	396 (48.4)	123.0, < 0.001
A woman should obey her husband in all things	105 (22.4)	244 (29.9)	8.25, 0.004
A man should not take his child to the clinic without the child's mother	311 (66.6)	620 (76.3)	14.14, < 0.001
Mean	47 (SD = 10.9)	54.9(SD= 11.0)	t=11.94,p< 0.001
Chronbach's Alpha	0.882	0.887	

In this study, both women and men scored above the expected cut-off score of 36. This suggests that women and men in Tanzania have positive attitude towards equitable gender norms. Nevertheless, surprisingly men indicate having very significant positive gender equitable norms than their counterparts. This phenomenon has been previously reported in a study involving unmarried women and men of Kenya and Ethiopia (Stephenson *et al*., 2012). As reported, there is a possibility that gender differences in reporting gender equitable norms is real or men are generally increasingly becoming more rejuvenated than women.

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Table 3: Gender equity levels by background characteristics

Characteristic	Equity level			Gamma, p-value
	Low	Medium	High	
Sex				
Male	81 (10.7)	255 (33.6)	423 (55.7)	
Female	115 (26.6)	205 (47.5)	112 (25.9)	-0.505, < 0.001
Current age (years)				
25 – 29	54 (13.4)	133 (32.9)	217 (53.7)	
30 – 34	52 (20.6)	112 (44.3)	89 (35.2)	
35 – 39	32 (15.8)	75 (36.9)	96 (47.3)	
40 – 44	29 (18.2)	62 (39.0)	68 (42.8)	
45 – 50	29 (16.9)	78 (45.3)	65 (37.8)	-0.110, 0.035
Education				
None/Informal education	15 (42.9)	9 (25.7)	11 (31.4)	
Primary education	163 (20.7)	343 (43.5)	283 (35.9)	
Above primary education	18 (4.9)	107 (29.2)	241(65.8)	0.520, 0.041
Current marital status				
Never married	27 (12.7)	65 (30.7)	120 (56.6)	
Married/cohabitating	150 (17.1)	352 (40.0)	377 (42.9)	
Previously married*	19 (19.8)	42 (43.8)	35 (36.5)	-0.198, < 0.001
Occupation				
Formally employed	12 (14.8)	30 (37.0)	39 (48.1)	
Peasant	75 (20.6)	136 (37.4)	153 (42.0)	
Business	84 (16.5)	232 (45.5)	194 (38.0)	
Artisan	7 (6.7)	27 (25.7)	71 (67.6)	
Other†	18 (13.7)	35 (26.7)	78 (59.5)	0.139, <0.001

* = Divorce or widow; † = Housewife, unemployed, small-scale business or student

In all four domains of the GEM scale in this study (GBV, reproductive health and disease prevention, sexuality and domestic life and child care), consistently more men report positive attitudes than females. For example in this study, significantly more men than women indicate to disapprove GBV against women. However, in some communities of sub-Saharan Africa, for example in South Sudan, tend to accept some form of violence towards women (Scott *et al*., 2013). But since no speculation can be made as to why more men than women disapprove GBV against women, an in-depth qualitative study could provide some explanation of the reported trend.

Furthermore, significantly more men than women report having positive attitudes towards reproductive health and disease prevention in statements: "It is a woman's responsibility to avoid getting pregnant", "A real man produces a male child", "Only when a woman has a child is she a real woman", "Women who carry condoms on them are easy", and "A man should be outraged if his wife asks him to use a condom". In this study, more men disapprove inequitable norms than women and these results are similar to those found in South Sudan community-based study of 2013 (Scott *et al*. 2013). However, as it is in other domains, it may be difficult to gauge gender equity with respect to reproductive health and disease prevention using only the four statements.

In this study, we have a couple of limitations. First, although we intensively trained interviewers and sex-matched the interviews, we are not able to assess how the interviewer's attributes (age and outlook) influenced the respondent's opinion. Furthermore, the tool was not self-administered because of possibility of illiteracy among respondents. Therefore, the use of interviewers may potentially lead respondents offering socially desirable answers causing desirability bias. Second, gender roles are, at times, coiled within culture context. While data in Tanzania show

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that a considerable proportion of women (about 40% of ever-married aged 15-49), and sometimes women are conditioned to accept violence (NBS, 2011; Leach, 2003). We could not assess how gender norms reflect cultural practices; for example what men and women consider to be culturally acceptable. This was compounded by the use of quantitative methods such that we were not able to gather reasons for the self-reported responses. Third, recruitment of study participants was done by CHAMPION's counselors and trainers for subsequent inclusion in the programme. It is not certain whether response to the tool was influenced in one way or the other by their expectations.

Based on the study findings, it is clear that although the GEM scale was originally developed for men and originally tested for men's spouses, in this study the tool performed well with women. Interestingly, we found a substantial bigger proportion of men having positive gender equitable norms in all four domains we assessed on. This may probably imply that now men are taking positive roles in issues of domestic violence, reproductive health and disease prevention, sexuality and in domestic life and child care. Furthermore, this may be interpreted as an increased participation of men in HIV prevention and other risk reduction behaviors.

Men's and women's beliefs and attitudes about sexuality, reproductive choices and power have a role in explaining HIV and AIDS related risk practices. Findings from this study are likely to suggest the need to promote interventions to continually revise the cultural frames within which gender is expressed in the context of HIV transmission. Furthermore, findings from the GEM scale suggest that the sexual transmission of HIV between men and women is mediated by the constantly shifting gender relations, attitudes and norms within society. They also underline the need to focus on the broader circumstances in which gender inequities within society may structure beliefs and norms that perpetrate differential exposure/risks of HIV infection. Whatever strategies that have been used in Tanzania, more enhanced efforts are considered necessary targeting women and re-enforcing men too.

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