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"In HIV response in Tanzania no one should be left behind"

A Socio-Ecological analysis of civil society organizations' possibilities to prevent HIV infection among vulnerable girls and women in Tanzania

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Abstract

This study illuminates civil society organizations (CSOs)' possibilities to prevent HIV among girls and women in Tanzania, reflecting on policy implications. A qualitative case study was conducted with a purposively selected CSO, Mtandao. Departing from a Socio-Ecological perspective, its staff was interviewed to find out (i) what signifies girls and women vulnerability to HIV infection (ii) how Mtandao addresses those vulnerabilities and (iii) what are the opportunities and constraints for its work. Gender inequalities, poverty, lack of education, the taboo around sex, harmful traditional beliefs and practices, poor access to condoms and health services, and discriminatory policies are key determinants to girls and women vulnerability to HIV infection. Mtandao addresses it by providing resources for their empowerment – condoms, education and economic opportunities. Also, Mtandao seeks to build an enabling environment to their health. The overall strategy is promoting structural cultural changes by engaging Tanzanian society and the government on Mtandao's HIV prevention and health rights' agenda. Mtandao's shared background with vulnerable communities places it in a credible position to conduct those interventions. The Tanzanian government's hostile position hinders it in providing policy frameworks to fulfil CSOs' potential and effectively coordinate development partners, protecting CSOs autonomy in face of international donors.

Keywords: gender inequalities, HIV prevention, civil society organizations, Social Determinants of Health, Socio-Ecological framework, Tanzania

Acknowledgments

I would like to express my gratitude to the brave Tanzanians who enabled this thesis by sharing their knowledge and experiences with me. They do so much with little resources in an unfavourable environment and, thus, they certainly are an inspiration. I hope this study makes justice to their efforts to advance Tanzania. Second, I would like to thank my supervisor, Sara Gabrielsson, who carefully accompanied, supported and advised me throughout the research planning, fieldwork and thesis's writing processes. This final result would not be possible without her. Finally, I would like to thank my parents for always supporting my studies, and all my family, friends and boyfriend for their kindness and encouragement.

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List of acronyms and abbreviations

AIDS	Acquired Immunodeficiency Syndrome
CSO	Civil society organizations
GBV	Gender based violence
HIV	Human Immunodeficiency Virus
IO	International organization
LGBT	Lesbian, gay, bisexual and transgender
MHSW	Ministry of Health and Social Welfare
PEPFAR	President's Emergency Plan for AIDS Relief
R	Respondent
SDH	Social Determinant of Health
SRHS	Sexual and reproductive health services
SSA	Sub-Saharan Africa
STD	Sexually transmitted disease
UNAIDS	Joint United Nations Programme on HIV and AIDS
USAID	United States Agency for International Development
VCT	Voluntary counselling and testing
WB	World Bank

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1. Introduction

In 2016 the United Nations General Assembly met to discuss how to end the HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immunodeficiency Syndrome) epidemics globally. Considering 2010 as a baseline, 90% of new HIV infections and deaths related to AIDS shall be reduced by 2030, so it will no longer be considered a public health threat. United Nations current goal is reducing the number of new HIV infections to less than 50 thousand per year by 2020 (Joint United Nations Programme on HIV and AIDS (UNAIDS), 2018a).

In 2017, 1.8 million new HIV infections occurred and 940 thousand people died due to AIDS-related causes. The deaths' peak was in 2004 (1.9 million) while the new HIV infections' peak was in 1996 (3.4 million). However, in spite of the overall progress, the present advancements are not enough to achieve the above mentioned objectives. Vulnerable social groups are often left behind and there were backslides in some regions (ibid.).

According to UNAIDS (2018a), apart from Sub-Saharan Africa (SSA), the reduction on the number of new HIV infections in other regions was little or even went backward. In Eastern Europe and Central Asia, for instance, it doubled within two decades. Concerning AIDS-related deaths, the absolute numbers also increased in the Middle East, North Africa and Eastern Europe, doubling in twenty years.

Groups such as children, adolescent girls and young women, indigenous people, the poor and uneducated, and key population (the ones with higher risk of contracting HIV: men who have sex with men, sex workers, injected drugs users, prisoners and transgender) were overlooked by HIV prevention efforts. Around 47% of the new HIV infections in 2017 were among key populations and their sexual partners (UNAIDS, 2016b; UNAIDS, 2018a).

In Eastern and Southern Africa, where Tanzania is located, from 2010 to 2017 there was a 42% decrease in AIDS-related deaths and 30% decrease in new HIV infections. However, most of people living with HIV and AIDS still are in this region: 53%. It

corresponds to 36.9 million people. Also, HIV preventions and AIDS treatments packages are often limited to high-income areas, where national programmes and international donors are located. Primary prevention health care was not given sufficient attention (UNAIDS, 2018a).

Globally, due to gender imbalances, girls and women are at higher risk of contracting HIV when compared to men (Tarimo et al., 2018). In SSA, women aged 15 years or older are disproportionally affected. For instance, in 2017, they corresponded to 59% of the new HIV infections among adults (UNAIDS, 2018a). Girls were also 79% of the new HIV infected who are between 10 and 19 years old (UNAIDS, 2019).

In this way, addressing gender inequalities is fundamental to tackle the HIV/AIDS epidemics (Baylies, 2000; Gebre et al., 2013; UNAIDS, 2019; Tadele, 2013), given that the it is recognized as a social phenomenon as well, not just a biomedical one. Thus, prevention efforts shall combine multisector structural interventions (Baylies, 2000; Tadele et al., 2013) improving "human rights protections, gender equality and socioeconomic conditions" (UNAIDS, 2018a: 10).

UNAIDS (2016a) states that community's responses are key to end HIV/AIDS epidemics by 2030. Governments shall exercise leadership, seeking to build resilient health care systems by incorporating private and community-based partners (ibid). The Tanzanian health care system in particular suffers from limited financial and human resources (Mussau et al., 2011). Coupled with governmental actions' insufficiency to respond to the HIV/AIDS epidemics, civil society organizations (CSOs)' initiatives emerged. (Bujra and Baylies, 2000). Nowadays different authors – and also UNAIDS (2016a) – stress that health interventions with the potential to accomplish the most are those which benefit from both government and civil society's efforts (Mussau et al., 2011; Tadele et al., 2013).

1.1 Purpose, research questions and thesis structure

Departing from the background presented above, this thesis's purpose is illuminating civil society's sector possibilities to prevent HIV among vulnerable girls and women in Tanzania. In order to do that, a network of CSOs which addresses HIV prevention through

a gender sensitive framework was purposively selected to be studied. Due to security and ethical concerns, its identity is not unveiled[1]. Thus, a pseudonym is used, *Mtandao*, which means network in Swahili, a Tanzanian local language. In this study CSO is defined as a formal, self-governing, non-profit organization which mobilize resources for and act to respond to social problems (Gaist, 2010).

Three interdependent research questions are answered:

1. What signifies vulnerability to HIV infection among those girls and women targeted by Mtandao's activities?

2. How do Mtandao's activities address girls and women vulnerability to HIV infection in Tanzania from a Socio-Ecological perspective?

3. What are the opportunities and constraints to Mtandao's HIV prevention work?

As this study employs a Socio-Ecological perspective (which explores how interactions between the individuals and their environment determine health outcomes) the first research question aims to understand how social factors shape Mtandao's beneficiaries (girls and women) vulnerability[2] to HIV infection. Next, the second research question explores how Mtandao's activities address those vulnerabilities. Finally, the third research question is the base to reflect on policy implications for fulfilling CSOs' potential. This study does not measure Mtandao's effectiveness nor is an organizational analysis.

The second section presents background information concerning (i) the HIV/AIDS epidemics in Tanzania, focusing on girls and women vulnerability (ii) the Tanzanian health care system's limitations and the CSOs' rise and (iii) the use of Mtandao as a case study. The third section delineates the two theoretical frameworks used: the Social Determinants of Health (Skolnik, 2016) and the Socio-Ecological Model (Golden and Earp, 2012). The fourth section presents a methodological discussion, detailing how this qualitative case study was designed and conducted. The fifth section answers the research

[1] A comprehensive explanation is provided in subsection 4.4.

[2] What signifies one's vulnerability is highly contextual. That is why in this thesis girls and women vulnerability to HIV infection is defined through social factors rather than by a straightforward academic definition of vulnerability.

questions by presenting and discussing key findings. It also presents the literature review, so it can be readily debated in connection with this research's findings. Finally, the sixth section points out concluding remarks.

2. Background

2.1 HIV and AIDS in Sub-Saharan Africa and women's greater vulnerability to HIV infection in Tanzania

After three decades, HIV/AIDS still is a core concern in the African health agenda (Tarimo et al., 2018). In 2010, 68% of the world population with HIV lived in SSA, causing high morbidities and death (Mkumbo, 2013; Mubyazi et al., 2015; Sia et al., 2013). In 2018, UNAIDS stated that Eastern and South Africa remained the regions most affected by HIV "accounting for 45% of the world's new HIV infections and 53% of people living with HIV globally" (UNAIDS, 2018b: 22).

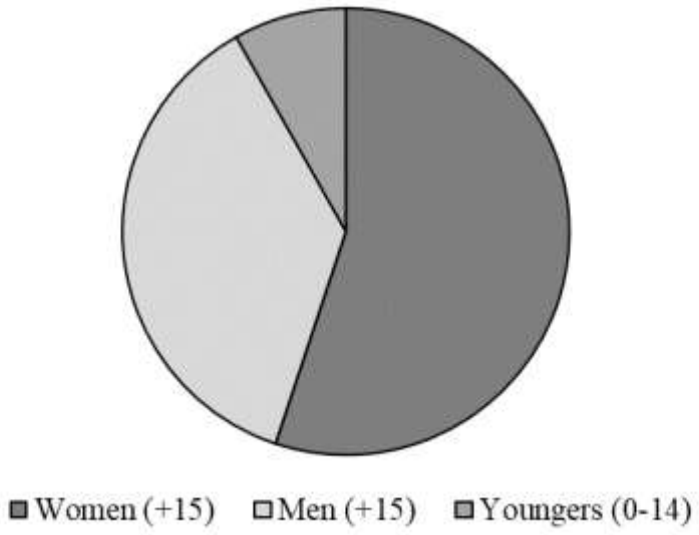
HIV/AIDS epidemics significantly impacts SSA social and economic development (Mkumbo, 2013). According to Gebre et al. (2013b:107) it threatens "the security, stability and social fabric" and developmental opportunities of SSA countries (Bujra and Baylies, 2000). High morbidity and mortality leads to economic hardships at the individual level and to the households, while the cumulative impact hinders SSA's human capital and the livelihood of future generations (ibid.).

Tanzania, a SSA country, is no exception to this reality. The first HIV/AIDS case was reported in 1983 (Mubyazi et al., 2015). Nowadays the Ministry of Health and Social Welfare (MHSW) estimates that each year around 80.000 people get infected by HIV (MHSW, 2015) with heterosexual intercourse transmission accounting for more than 80% of the new infections (Athley et al., 2018; Mkumbo, 2013). According to Mkumbo (2013) it is among the countries in SSA with a comparatively high HIV/AIDS's prevalence. In 2017, together with Mozambique and South Africa, Tanzania accounted for more than half of new HIV infections and deaths in the region. Also along this year, 32000 Tanzanians died due to HIV-related causes (UNAIDS, 2018b).

Sia et al. (2013) point out that due to the gendered differences in the distribution of risk factors, women in SSA are more vulnerable to HIV infection when compared to men (Sia

et al., 2013). Mtenga et al. (2018) and Tarimo et al. (2018) stress biological, socio-economic and cultural factors as responsible for the higher HIV prevalence among women in SSA. According to UNAIDS (2018b: 22), gender imbalances, gender based violence (GBV) and physiological determinants put women at "huge risk of HIV infection" in Southern Africa. The graph below shows the proportion of women, men and women youngers living with HIV in 2017. Women accounted for 54% of the total (or 810 thousand out of 1.5 million) (ibid.).

Figure 1: Proportion of women (+15), men (+15) and youngers (0-14) living with HIV in Tanzania in 2017 (UNAIDS, 2018b).



In Tanzania, adolescent girls and young women are identified by the government as the group most at risk (MHSW, 2015). Moreover, although HIV/AIDS prevalence in Tanzania has decreased in the last years, different studies indicate that the burden of disease is still high among people aged from 15 to 49 years old (Mubyazi et al. 2015) and among women aged from 15 to 24 years old (Tolley et al., 2014). The Gender Operational Plan for HIV Response in Tanzania Mainland 2016-2018, points out that HIV prevalence has increased in eight different Tanzanian regions from 2008 to 2012 (Tanzania Commission for AIDS, 2016).

In 2014, HIV prevalence among young women was around 3% higher than in men in the same age (Tolley et al., 2014). The Tanzania Third National Multi-Sectoral Framework for HIV and AIDS 2013-2018 also validates this reality. For example, even though the prevalence in adults has declined, the transmission among women, key populations and

in certain regions of the country is not satisfactorily controlled. Also, prevalence decrease among women was not statistically significant, and in all age groups, prevalence is higher among women when compared to men. (Prime Minister's Office, 2013).

Given that in Tanzania HIV/AIDS's transmission occurs mainly through heterosexual intercourse (around 80% (Athley et al., 2018; Mkumbo, 2013)), it is questionable how HIV's spread relates to gender dynamics in Tanzanian society (Bujra and Mokake, 2000; Gebre et al., 2013). Tadele (2013) stresses that this fact calls for investigation on cultural traits of sexual behaviour. In this sense, Gebre et al. (2013a) affirms that the inequitable gender relations in SSA hinders women's welfare, being a major factor for their greater vulnerability to HIV infection. Thus, according to Baylies (2000):

> it is precisely the link between powerlessness and risk of HIV which is the key to understanding the sources of women's vulnerability (Baylies, 2000: 5).

As demonstrated by the extracts above, HIV/AIDS epidemics in Tanzania is recognized as a grave health issue, and as a gendered problem. Therefore, in the pursuance of mitigating new HIV infections and to tackle women's greater vulnerability, it is fundamental to investigate why those gender differences occur and how to address them effectively.

2.2 The Tanzanian health care system: lack of financial resources and skilled health workers

The literature highlights that the Tanzanian health care system suffers from limited financial[3] and human resources (Musau et al., 2011), and from an inequitable distribution of services and health care providers across the country. In general, health services' provision is better in urban areas, particularly Dar es Salaam (World Bank (WB), 2014). Also, Mussau et al. (2011) points out that in spite of the country's comprehensive health policy guidelines, translation to practice is challenging due to poor management. Often lower-level health facilities are not aware of the national guidelines (ibid.).

[3]Health financing comprises the mobilization and allocation of money to finance people's health needs at the individual and collective levels (Musau et al., 2011).

After independence, in 1961, the Tanzanian government sought to implement free universal health care. Until 1993 there was an increase on health financing through taxation and development assistance. However, due to the rise on health care costs and the economic struggles Tanzania was going through, financing free health care for all became a burden. Thus, from the 1990s Tanzanian government introduced user fees in public health facilities and private health insurances (ibid.). There are fee exemptions for some groups such as pregnant women, children under five years old, the poor and people with chronic diseases. However, the criteria used by the health facilities is unclear (WB, 2014).

Nowadays, health financing in Tanzania comes from different sources, besides the national government: foreign governments, multilateral organizations, private companies and individuals. And, besides public health facilities, there are also non-governmental and private for-profit provider facilities (Mussau et al., 2011). Table 1 shows the sources of financial capital for health expenditure in Tanzania in the year of 2015, indicating that not only the external expenditure is slightly higher than financing from the government but also that out-of-pocket expenditures (where patients pay for their health care themselves) is considerable and much higher compared to the mean for high income countries in this same year, which is 13.69% (WB, n.d.).

Table 1: Sources of health expenditure in Tanzania in 2015

Indicator	Value (% of current expenditure) in 2015
Domestic general government health expenditure	35.30
External health expenditure	36.64
Out-of-pocket expenditure	26.15

The shortage of skilled health workers negatively impacts the Tanzanian health system ability to provide high quality health care (Mussau et al., 2011; WB, 2014). According to WB (2014), the own Tanzanian government points out that investing in human resources should be a priority for improving health care's accessibility. The situation tends to be worse in remote areas and in lower level heath facilities (Mussau et al., 2011).

For instance, 45% of the doctors are in Dar es Salaam, Tanzanian biggest city, while just 10% of the country's population live there. On average, urban and private health facilities have more staff members than rural and public facilities. On the other hand, 70% of Tanzanian population and 85% of the poor live in rural areas, where just 28% of the health workers are located. Clearly, this figure reinforces income and health care quality's inequalities (WB, 2014).

Finally, health care providers' knowledge and abilities are not adequate, a problem aggravated by the HIV, malaria and tuberculosis epidemics and by the Tanzanian population increase[4]. 54% of the country's health workforce are nurses and from the 28% health care providers based on rural areas, just 9% are doctors (ibid.).

2.3 The rise of civil society organizations in Tanzania within HIV response

Given the significant limitations of the Tanzanian health care system, it is important to recognize the value of the CSOs to fill the health care provision gap. According to Gaist (2010) CSOs are in a privileged position to form linkages with the communities, identifying health issues and forging health services to those in need. They interact with governments to advocate for practices that better address communities' health interests, serving as bridges between decision makers and society at large. Furthermore, CSOs are often able to represent interests and groups that may be contentious or opposed by governments (ibid.).

Kelly et al. (2006) point out that CSOs play a relevant role to prevent HIV infection at a global level. While governments in general develop national plans, organize education campaigns and exercise surveillance functions, they lack experience and/or will to reach marginalized groups. Furthermore, government officials may not be trusted by vulnerable population – such as sex workers, drug users and youth in high-risk situations. On the

[4]According to the Government's National Population Projections, in 2035 it is expected that Tanzania will reach around 89 million people. In contrast, in 2013 the Tanzanian population was around 46 million people (National Bureau of Statistics and Office of the Chief Government Statistician, 2018).

other hand, CSOs originate from or are specifically conceived to serve the community. Also, they usually have a certain degree of autonomy from government's restrictive policies. Concerning HIV prevention, CSOs are particularly important given that governments may be reluctant to address sensitive sexual behaviours.

On the African continent, local and international CSOs targeting HIV prevention have flourished as a response to the state's withdrawal from public services – in lieu of global and national liberalization policies – (Bujra and Mokake, 2000). Given governments limited capacity to quickly respond to the HIV crisis, CSOs were promoted as alternative to state headed agencies, as more cost-effective and participatory. In this way, doors were opened for those excluded or marginalized from decision making, including women (Bujra and Baylies, 2000). In this context, Baylies (2000:16) observed that womens' CSOs may contribute to eliminate structural inequalities that make women especially vulnerable to HIV infection. As she argued:

> [women's] involvement in such collective activity may also increase their awareness and give them strength to change their own behaviour or increase their capacity to negotiate for increased personal protection (Baylies, 2000:16).

Health provision in SSA and in Tanzania is characterized by a significant presence of non-state bodies (Jennings, 2015). According to Tadele et al. (2013:164) the increase on the delivery and access to HIV/AIDS prevention, treatment and support along the decade of 2000 is an evidence of "collaboration among government, civil society and NGOs". In the subcontinent, non-state actors are critical to prevent new HIV infections by offering prevention education and counselling (Corbin et al., 2015). UNAIDS (2018b: 22) considers that community based efforts are "at the cutting edge of HIV service provision…and holds the key to future progress".

The Tanzanian government also *formally* recognizes CSOs' relevance on its official documents. For instance, the Tanzania Third National Multi-Sectoral Strategic Framework for HIV and AIDS 2013-2018, cites CSOs' role on advocacy, to complement the delivery of health care, and to ensure accountability (Prime Minister's Office, 2013). On its Gender Operational Plan for HIV Response in Tanzania Mainland 2016-2018, the Tanzania Commission for AIDS (2016) points out that those organizations are relevant

to advocate and monitor gender sensitive HIV policies and to assist on implementing them.

2.4 Using Mtandao as a case to study HIV prevention in Tanzania[5]

Using a selected CSO to study HIV prevention is a deliberate choice due to the significant role these organizations play within the Tanzanian health care system and due to their potential to improve access to health care, especially to marginalized groups. As argued above, the Tanzanian government's capacity to respond to the HIV epidemics is limited and thus, it is important that other actors' potential is recognized and leveraged. Mtandao was specifically chosen given its work targeting gender dynamics. As presented in subsection 2.1, different authors suggest that women's greater vulnerability to HIV infection is due to gender inequalities in SSA. Thus, to fight HIV infection among women, it is important to foster structural changes in Tanzanian society.

Mtandao's office is located in Dar es Salaam, Tanzania's biggest city, in a vulnerable neighbourhood. The organization was established in 2006. It is primarily a *network* for women living with HIV and AIDS, run by women from other twenty-three community based organizations, reaching twelve Districts in Tanzanian mainland. The organization is also a member of international forums, such as the International Community of Women Living with HIV East Africa and the Global Network of People Living with HIV. Mtandao has a focus on improving the quality of life of infected women and girls and on preventing new HIV infections. In an informal conversation, Mtandao's Executive Director informed that those two purposes are equally important for the organization.

The organization's official website informs that Mtandao conducts community interventions for HIV prevention. For instance, training grassroots stakeholders to implement sexual and reproductive health and HIV prevention responses are among Mtandao's interventions. It seeks to promote comprehension concerning the challenges

[5]The information about Mtandao were retrieved from the organization's website. The link will not be provided in order to protect Mtandao's identity, due to the ethical and security concerns. It will be further discussed on Section 4.

faced by positive women and by women at risk of contracting HIV/AIDS. Likewise, Mtandao advocates for the mainstreaming of HIV infection gender drivers in Tanzania's development plans, and for improvements on the quality of life of vulnerable communities. Thus, it raises women's voice at national level as well.

Mtandao explicitly points out in their information material and website that it fights gender oppression and promotes human rights. It does this through focusing on capacity building to empower women and communities. Endorsing gender equality and transformative leadership is among its key principles.

3. Theoretical framework

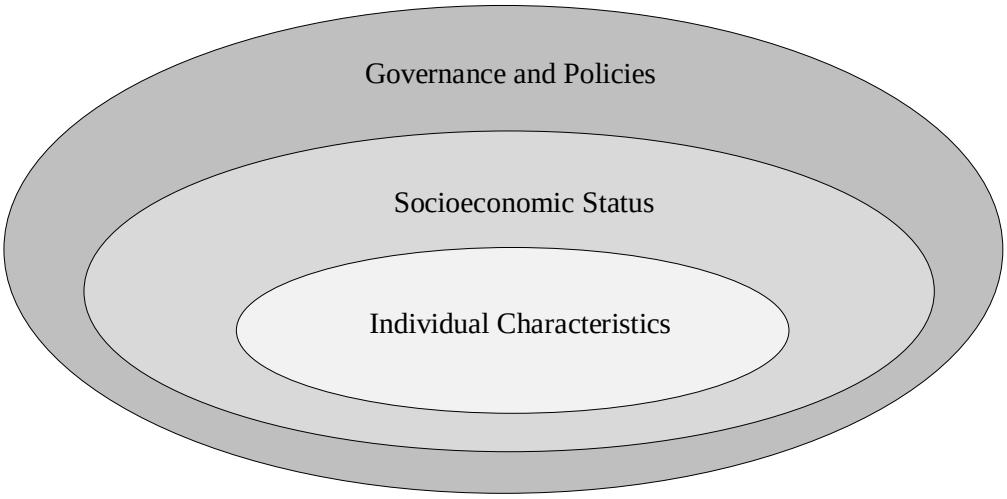
This section aims to present the theoretical framework selected and introduce how it assisted the accomplishment of this research's purpose. Two interlinked theoretical models are applied. The first, Social Determinants of Health (SDH), as presented in Skolnik (2016) guided the identification of factors that lead girls and women to be more vulnerable to HIV infection in Tanzania. The second framework, the Socio-Ecological Model, developed by Golden and Earp (2012) guided the compilation and cate0-gorization of Mtandao's activities.

3.1 The Social Determinants of Health

SDHs are used because HIV/AIDS is not just a biomedical issue, but a behavioural and social issue as well, which requires the investigation of the determinants driving the HIV/AIDS epidemics. Likewise, effective prevention efforts should target those SDHs (Baylies, 2000; Tadele, 2013). Hence, before analysing Mtandao's activities, it was fundamental to identify the SDHs that signify girls and women vulnerability to HIV infection in Tanzania. Accordingly, this study adopts a broad definition of health, the one advised by the World Health Organization in 1948: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (Skolnik, 2016:5).

In order identify the SDHs, first a literature review was conducted. Next, the SDHs were refined based on the fieldwork's results. Figure 1 is a visual representation of the three key SDHs (ibid.).

Figure 2: Key Social Determinants of Health, as presented by Skolnik (2016: 20-22)



The Individual Characteristics key determinant refers to individuals' personal and inborn characteristics, such as sex and age. The second key determinant, Socioeconomic Status, refers, for instance, to the individuals' economic resources, level of education and social support from family and the community (ibid.). Skolnik (2016) points out that people with higher economic status tend to have better control upon their lives and, thus, are abler to be healthier than those with lower socioeconomic status. Culture is another determinant within Socioeconomic Status, as it may define how people engage on health practices (ibid). The author stresses that gender roles may significantly impact health in societies where women are in disadvantageous positions concerning access to income and education. Finally, Governance and Policies critically impact people's health status. For instance, in a country where the government promotes and effectively implements universal access to education and health, people tend to be healthier (ibid.).

3.2 Socio-Ecological Model for health interventions

Socio-ecological models for health interventions proposes that both individuals and their environments should be targeted on health promotion's efforts (McLeroy et al., 1988). According to McLeroy et al. (1998) the interpersonal, organizational, community and public policies' spheres can reinforce unhealthy behaviours. In this way, this model assumes that promoting changes on the environment surrounding the individuals will produce changes in the individuals' health behaviour. It steps away from victim-blaming

approach (ibid.), exploring how interactions between the individuals and their environment determine health outcomes (Golden and Earp, 2012).

Within HIV prevention efforts, tackling individuals' vulnerability through structural approaches is "now recognized as an important, distinct area of HIV prevention" (Tadele et al., 2013: 149). This means creating an enabling social, economic, cultural and political environment, so people can adopt healthier behaviours, given that structural conditions may undermine one's agency (ibid.). In other words, if the environment does not favour healthier behaviours, the result of health interventions targeting individuals tend to be unsatisfactory (Baylies, 2000; Tadele and Amde, 2013). In this way, the Socio-Ecological model is a valuable tool to analyse Mtandao's activities to prevent HIV among girls and women in Tanzania.

Golden and Earp (2012) reviewed 157 articles upon health promotion programs to identify the intervention levels they target. The five identified intervention levels – Intrapersonal, Interpersonal, Institution, Community and Policy – guided the interviews conducted in this study. Next, they were used to analyse the data collected during fieldwork. The table[6] below presents the five intervention levels, identifying to whom each intervention level is directed to and how. It is a resume of the table elaborated by Golden and Earp (2012:366).

[6]The table is discussed along section 5, Findings and analysis

Table 2: Socio-Ecological levels identified by Golden and Earp (2012:366)

Socio-Ecological Model levels	Intervention activities included
Intrapersonal	- Education/training/ skills enhancement of *target population*
Interpersonal	-Education/training/skills enhancement of *people who interact with target population* (e.g., family members, friends, teachers, coworkers) - Modifications to home/family environments
Institution	- Education/training/ skills enhancement of *institution members beyond target population and immediate contacts, including institutional leaders* - Modifications to institutional environments, policies or services
Community	- Education/training/ skills enhancement *of general community beyond target population and immediate contacts, including community leaders* - Modifications to community environments or services
Policy	- Education/training/ skills enhancement of general community beyond target population and immediate contacts *specific to policy change* - Creation or modification of public policies

4. Methodological discussion

4.1 Philosophical assumptions

Philosophical assumptions refer to the ontological[7] and epistemological[8] perspectives used to interpret the social world (Bryman, 2012). As explained by Creswell (2007:15), those assumptions have "practical implications for designing and conducting research" and, thus, it is important to start any given qualitative study defining them. Or, in other words, the researcher shall define a paradigm, which is a "set of beliefs that guide action" (Creswell, 2007:19), encompassing ontology and epistemology (ibid.).

This research stands for the Social Constructivism paradigm (which can be also referred as Interpretivism). Departing from it, the researcher seeks to catch the multiplicity of views regarding the world (ibid.), assuming that there is not a single definitive truth. Instead, the researcher accepts that all knowledge is subjective and partial, relying on participants' view to conduct the study (Creswell, 2007; Tracy, 2010). Questions are general, so the participants have space to bring up their perspectives (Creswell, 2007). This paradigm mainly impacted positionality issues and the interview's conduct, which will be discussed in the following subsections.

4.2 Research design

Since this study explores how a single CSO addresses girls and women vulnerability to HIV infection in Tanzania, this is a case study, presupposing a single case's intensive investigation, capturing its complexity. Hence, this research applies qualitative methods, given that it is more appropriate for generating detailed, multifaceted data (Bryman, 2012). Furthermore, qualitative methods:

> play an important role in how we understand and describe the problem of health inequities and their determinants… [because] these approaches help illuminate social, cultural, and political factors that may underlie health disparities (Shelton et al., 2017: 816-817).

[7]Ontology refers to the reality's nature, whether it is external to the social actors or shaped by them (Bryman, 2012).

[8]Epistemology refers to what is regarded as appropriate knowledge (Bryman, 2012).

Thus, considering that there is a gendered health disparity on the HIV/AIDS incidence in Tanzania and that this research investigates the SDHs for girls and women vulnerability to HIV infection, qualitative methods are particularly suitable. As discussed on section 3, the HIV/AIDS epidemics is a social issue, not just a biomedical one.

Case studies are often criticized for not producing general, context-independent knowledge. However, as argued by Flyvbjerg (2006), generalization is overvalued within social sciences. First, because, in its essence, social sciences produce context dependent knowledge and, second, each case study ultimately contributes to a systematic knowledge accumulation in a given field. Moreover, as stressed by Tracy (2010) a research can significantly contribute by proving useful knowledge. In this sense, this research illuminates CSO's role to prevent HIV and offers a practical discussion on policy implications[9].

4.3 Data collection strategy

4.3.1 Entering the field

After deciding the research's topic and purpose, the next step was identifying an organization that would fit on the study's goals. Thus, Mtandao's selection was purposive (Bryman, 2012; Hammet et al., 2015). Mtandao's Executive Director was contacted through e-mail, in December 2018. In this e-mail I presented myself as a postgraduate student, introduced my research and expressed my interest in Mtandao's work. After a meeting, she allowed me to conduct fieldwork in Mtandao and acted as my gatekeeper. A detailed discussion on Mtandao's adequacy is on section 2.

4.3.2 Positionality

Positionality refers to the reflection on the researcher's personal, social and cultural background and how it impacts the research's process, biasing it. (Hammet et al., 2015). Different authors (Hammett et al., 2014; Kapoor, 2004; Rose, 1997; Sultana, 2007) point out that researchers shall accept that there is no neutrality within social sciences and seek

[9]Policy implications are discussed on subsection 5.3.

the best strategies to mitigate one's positionality negative impacts. Thus, researchers shall acknowledge their social position and reflect on how it shapes their world's interpretation (Creswell, 2007).

My main concern was that my personal beliefs regarding gender issues would bias the conduct of my fieldwork and data analysis. Hence, my main mitigation strategy was balancing power relations. In this way, I sought to allow respondents to exert their agency, moving from an object to a subject position (Kapoor, 2004), and putting myself as a learner. The idea was doing my research with the respondents rather than about them (Sultana, 2007). This highly impacted how I approached the interview's process.

4.3.3 Interviews

Given its flexibility, interview was the main technique[10] used to collect data (Bryman, 2012), allowing interviewees to bring up their subjective views (Hammet et al., 2015). Therefore, the interview method is aligned with the Social Constructivism paradigm, adopted by this study. In total, ten interviews were conducted. All of them took place in Dar es Salaam, along February 2019, and were recorded. Nine of the interviews were conducted in English and one in Swahili, with a translator's assistance. Five of the interviewees were female and five were male.

The interview guide, which can be found on Appendix A, consists of two parts: the first one was dedicated to understand respondents' view on girls and women vulnerability to HIV infection, based on the SDHs. Building up on the examples and arguments presented by the respondents, the second part, guided by the Socio-Ecological framework, aimed to understand how Mtandao's activities respond to those vulnerabilities. The discussion about opportunities and constraints was diluted within those two topics.

Questions were always adapted according to the conversation's flow, in order to address emergent relevant issues. Thus, the interviews were interactive and open-ended and my role was facilitating data creation and validating respondents' knowledge concerning their

[10]Others techniques would be employed but practical issues, which are discussed in the following subsections, prevented it.

own reality (ibid.). Hence, I sought not to interfere on the respondents' flow of thoughts, I was there to ask for clarifications and point out a new discussion topic when the one at stage was exhausted.

In this way, the interview process combined elements of semi-structured and unstructured interviews. On one hand, there was a set of general predetermined questions to be covered, which characterizes a semi-structured interview. On the other hand, those general questions' style was informal as their phrasing and sequencing varied from interview to interview (Bryman, 2012; Hammet et al., 2015).

4.3.4 Respondents sampling

All respondents had experience on working in Mtandao in HIV prevention with at least some of the following groups: young girls and adolescents, sex workers, LGBT (lesbians, gays, bisexuals and transgender) and drug users. A table specifying respondent's work experience can be found on Appendix B. Respondents' selection combined purposive and snow-ball sampling. On one hand, I sought to interview people who were more experienced on dealing with girls and women. On the other hand, the gatekeeper and the respondents' introduced me to other potential respondents (ibid.).

The sample size was limited due to practical issues concerning my visa in Tanzania and due to ethical issues (to be discussed on the following subsection). Notwithstanding, I consider that I achieved data saturation – or in other words, thematic exhaustion – (Bryman, 2012) concerning heterosexual girls and women and female sex workers. However, data collection concerning lesbian, transgender and drug users was insufficient. Seeking to preserve the research's trustworthiness, that is why the discussion about lesbian and transgender' specific issues is limited; and why drug users' specific vulnerabilities and activities which address them are not presented.

4.4 Ethical considerations

The social and policy environment in Tanzania is often hostile to Mtandao's work. HIV/AIDS and sexuality issues are sensitive and a taboo (Tadele and Amde, 2013). Moreover, the Tanzanian government can be conservative and adopt discriminatory

policies. For instance, sex workers, same-sex sexual acts and transgender are criminalized (Leddy et al., 2018; Pangilinan, 2013; UNAIDS, 2018c). Respondents reported that they feel threatened by the police and fear being arrested, accused of promoting sex work and/or homosexuality[11]. Also, Mtandao's Executive Director expressed her concern that other members of the network could not understand or approve my presence in Mtandao and question her about it, causing trouble for her.

Therefore, following the ethical principle of causing no harm (Bryman, 2012; Hammet et al., 2015) a pseudonym was chosen for the organization in order to protect participants' identity and reduce the risk of possible retaliations from the government. As explained by Hammet et al. (2015) the researcher shall access the risks related to fieldwork and actively adopt strategies to mitigate them. I needed to be discreet and, thus, I also decided not to conduct focus group discussions given that inviting several people at once would call more attention. Likewise, I limited myself to interview respondents introduced to me by others' respondents. Naturally, my own security was also a concern.

This situation also impacted how I negotiated participants' informed consent. In order to protect their identity, their consent was given through oral agreement. It would not be reasonable to ask them to sign a paper, as it would further expose them. All respondents were informed that their participation was voluntary and that they had the right to withdrawn or deny to answer any question at any time, without further consequences. Also, they were informed about the research's purpose and that the data would be used for my master thesis, only. My contact was provided and they were told they are welcome to contact me at anytime in case of any concerns or doubts (Bryman, 2012; Tracy, 2010).

4.5 Limitations

As explained above, security concerns limited the data collection. Focus group discussions were not used and I avoided taking initiative to contact potential new respondents. Moreover, drug users' specificities are not approached in this study, although this a relevant vulnerability. Regarding lesbians and transgender, data was enough to point out some considerations but not for a comprehensive discussion.

[11] A detailed discussion on those social and political aspects is presented on section 5.

Also, it is relevant stressing that I decided not to use my fieldwork notes. First, most of the time the language used in Mtandao's office was Swahili, that I cannot understand. Second, I was suspicious that my presence may have interfered in Mtandao's work routine and on the behaviour of some of the staff, compromising data's accuracy. And third, some of Mtandao's partners (such as Embassies and international organizations' staff) were not aware that I was doing fieldwork, so it would be unethical use information provided by them.

Finally, the study's spatial scope is unclear, given that Mtandao's organizational structure and activities' reach is diffused around Tanzania. Even if the respondents are based in Dar es Salaam, often they travel to implement interventions outside this city, depending on the project they are involved and on the funds available. Alternatively, they may have representatives in other parts of Tanzania.

4.6 Data treatment

From the ten interviews conducted, eight were selected to be analysed. Two of the respondents were volunteers in Mtandao for less than three months and, therefore, they were not able to comprehensively answer the questions concerning Mtandao's activities. The eight interviews were transcribed by me together with assistants. A final review of the transcriptions was conducted solely by me. Next, the transcripts were coded using the software NVivo 11 Plus.

As explained by Bryman (2012) coding is a key basic process for qualitative data analysis and a tool to find analytical paths through qualitative data's richness. It consists of labelling and categorizing parts of the data that appear salient (ibid.). The SDHs (Skolnik, 2016) and the five health intervention's levels (Golden and Earp, 2012) based the codes' elaboration and refinement.

5. Findings and analysis

This section is structured according to the research questions. Also, the literature review is presented here, so it can be readily discussed in connection with the findings. The first subsection answers what signifies vulnerability to HIV infection among those girls and women's targeted by Mtando's activities. Considering that what signifies one's vulnerability is highly contextual, rather than providing a straightforward academic definition, this subsection is organized based on the SDHs for girls and women vulnerability to HIV infection. Departing from a Socio-Ecological perspective, the second subsection analyses how Mtandao responds to girls and women vulnerability to HIV infection in Tanzania. Finally, the third subsection discusses the constraints and opportunities to Mtandao's activities in order to fulfil its potential, and reflects on policy implications.

5.1 What signifies vulnerability to HIV infection among those girls and women targeted by Mtandao's activities?

The initial SDHs identified through literature review – individual behaviour, family and community relations, traditional beliefs and education, accessibility to prevention methods and services, and gender dynamics – were a starting point to discuss with the respondents how they view girls and women vulnerability to HIV. Next, this information was used to build up the investigation on how Mtandao's activities address girls and women's vulnerability to HIV infection and, by doing that, how they prevent HIV infection.

Table number 4 presents the final SDH's coding structure, refined along fieldwork (as new SDHs emerged) and findings' analysis. Also, it exemplifies how each SDH is unfolded. It is relevant to stress that this subsection does not discuss girls and women vulnerability in Tanzania in general. Rather, it discusses the context in which girls and women targeted by Mtandao (hereby, the beneficiaries) are inserted. Likewise, it is relevant noticing that SDHs are not independent. On the contrary, they are interlinked,

nurturing each other and that is why some of the SDHs were grouped in subsections. Some passages may overlap, showing the problem through different perspectives.

Table 3: Resume table of the Social Determinants of Health for girls and women vulnerability to HIV infection

Social Determinants of Health	Effects
Gender imbalances	- Women undervalued when compared to men - Different gender norms and roles - Gender based violence
Family relations	- Lack of sexual and reproductive education at home - Poor families encourage girls to be sex workers
Poverty	- Poor background - Lack of access to formal education - Lack of access to formal jobs - Having multiple partners or being a sex worker as a solution
Poor accessibility to condoms and prevention health services	- Unfriendly health services - Shortage of health care providers - Constraints to get condoms in health facilities and shops
Community relations	- Culture of silence and shame around sex - Harmful traditional practices and beliefs - Harmful religious teachings - Discrimination and rejection of vulnerable groups
Policy environment	- Conservative and discriminatory policy environment
Individual behaviour	- Shaped by the others determinants - Multiple sexual partners - Rejection of condom use - Drugs and alcohol use

5.1.1 How prevailing gender inequitable norms increase girls and women HIV infection risks

Within Tanzanian society being born as a woman is disadvantageous. There is a structural discrimination towards girls and women in the country, where girls' exploitation within the family and the community is normalized (Hagues, 2017). A respondent illustrated this reality:

> they [women] feel stigmatized, they feel discriminated, they feel humiliated…In our society, the way we are raised is to see a woman as just a tool at home to do everything… to take care of men, to take care of children, to take care of everything based home, domestic work (R8).

As presented on subsection 2.1, around 80% of the new HIV infection in Tanzania are through heterosexual sexual intercourse (Athley et al., 2018; Mkumbo, 2013). Accordingly, it calls for an investigation on sexual behaviours' cultural traits (Tadele, 2013) since inequitable gender norms influence men and women interactions on "HIV prevention, sexual intercourse and physical violence" (Gebre et al. 2013a: 46). Thus, this subsection will focus on women's relations with males, while the discussion concerning other relevant gendered aspects are diluted on the next subsections.

When girls become teenagers they are taught "how to behave around men, how to have sex with men… how to be housewife to man" (R7). A respondent explained that within Tanzania, women above eighteen years old are expected to be married and have children (R5). Societal norm thus dictates that men have the dominant role in relationships, and women are valued by being sexually passive and subservient to their male partners (Cawley et al., 2016, Tadele and Made, 2013; Wight et al., 2009). To a large extent, as a respondent pointed out, this makes women highly stigmatized, having no voice in the family or in the society. He highlighted this male dominance by saying: "Women are supposed to stay behind a man, the one supposed to make decisions" (R8).

Moreover, while female abstinence and sexual responsibility are promoted, males are expected to engage in frequent sexual activity (Mtenga et al., 2018; Wight et al., 2009), what increases women's risk to be infected. Landman et al. (2008), for instance, investigated the association between number of sexual partners and HIV infection among people taking part in Voluntary Counselling and Testing (VCT) services. They showed

that the risk of HIV infection increased with additional sexual partners: for participants with five partners or more, up to 45% for women and just 15% for men. In this way, the authors concluded that, due to male's concurrent relationships, monogamy has a limited protection effect to women (ibid.).

Mtenga et al. (2018) also validates that. According to them, on one hand, males' engagement in multiple relationships is normalized. And, on the other hand, cultural customs regarding marriage do not allow women to demand condom use or to discuss about sexually transmitted diseases (STD)'s prevention with their husbands. Tarimo et al. (2018) points out that, for Tanzanians, suggesting condom use within marriage leads to mistrust between the couple. Hence, inequitable gender norms are instrumental for how HIV is spread also because it hinders women's abilities to protect themselves (Wight et al., 2009).

It is indeed a challenge for women to negotiate condom use (UNAIDS, 2016b). Cawley et al.'s study (2016) shows that while men in general reported feeling satisfied and empowered after VCT sessions, women reported feeling anxious or indifferent, given that they feared that their partners wouldn't be willingness to debate about the advices and/or to put them in practice – for instance, using condoms. A respondent illustrated how girls and women may not feel empowered to demand condom use:

> I can give you an example, as for me we go to the lodge and maybe a client gets starting removing the clothes then if he doesn't show up with condoms then you keep quiet because you are a woman, you cannot ask it like that. (R1)

UNAIDS (2017) affirms that vulnerable groups are often powerless to avoid violence from intimate partners. This was extensively illustrated by the respondents. For instance, they affirmed that in Tanzanian society it is not acceptable for a woman to deny sex to her male partner. A respondent pointed out that women may not be able to recognize GBV. According to her, they assume as normal "whatever is happening to them, since they know nothing" (R5). Male partners can also be the ones obligating girls to do sex work, as boyfriends may escort girls to guesthouses, lodges or bars and force them into prostitution (R3).

Female sex workers face a greater risk to contract HIV, given that they are more exposed to inconsistent condom use and GBV, both physical or sexual (Leddy et al., 2018). A respondent affirmed that sex workers suffer a range of violence coming from the clients, as beating, forcing them not to use condom and collective rape (R7).

In Tanzania, sexual minorities (LGBT) are highly discriminated. Comparing to other groups, it is harder for them to obtain protection from physical and sexual violence and they are more vulnerable to engage on survival sex (Pagilinan, 2013). According to a respondent, transgender women face violence when clients realize they are not cisgender. Lesbians are targeted by men, since they assume that they did not have sexual relationships with other men, what is valued by males (R7).

5.1.2 How family relations, lack of education and poverty drive girls and women to engage on risky sexual practices

Cawley et al. (2016) highlight that, in Tanzania, family and community play a more prominent role in determining one's health and well-being than individual agency. Sanga et al. (2015) shows that in this country not only the immediate family but also the extended one are important as a source of support and education. Respondents stressed families' role to take care, educate and guide children. For instance, they said "Family engagement on the issue of girls' vulnerability, it is very important. Everything originates from the family" (R4) and "family has a big role… [it] is the first institution to frame the child" (R6).

However, traditionally in Tanzania, sex education is not a topic for conversation between parents and children, "it is rare, for sure" (R4), because "the tradition and customs, they do not allow to talk about the issue of sex in front of children" (R2). In this regard, Tadele and Amde (2013) points out that there in SSA there is a culture of silence between parents and children concerning sexual issues. In this way, without knowledge on sexual and reproductive health, the youth is unable to protect themselves (ibid.). This is the first way through which relations with family can make girls more vulnerable to HIV infection.

The second reason is related to poverty. Respondents explained that poorer families do not have money to pay for their children school fees, so they end dropping out.

Respondent 3 told that most of the girls and women she works with did not have access to formal education. And, according to the literature, people with lower levels of formal education have lower levels of knowledge about HIV infection (Athely et al., 2014). Likewise, they are less likely to take VCT services (Sanga et al., 2015). Athley et al. (2018) investigated the challenges faced by nurses who work on HIV prevention. The authors identified: limited information and stigmas concerning HIV/AIDS and misconceptions about condom use. Also, they pointed out that people among 15 to 24 years old have lower levels of knowledge about HIV/AIDS.

Moreover, within poorer families, girls may be encouraged to become sex workers, so they can bring money to home. A respondent told the case of a teenager girl who is a sex worker. The neighbours were complaining to her mother:

> "Why are you allowing your daughter to do this business?". Then she answered that "If you find my daughter is getting more money, go and join her so leave my daughter alone" (R3)

UNAIDS (2017) points out that HIV and poverty are interlinked. In the absence of economic opportunities (which is also related to lack of formal education) they engage on transactional sex (Tarimo et al., 2018; UNAIDS, 2017). In this way, poverty constrains one's agency to avoid intimate partner violence and consistent use of condom (Tadele and Amde, 2013; UNAIDS, 2017). A respondent illustrated:

> So, it they are living the streets, even three meals per day is hard… If someone comes and says "I can give you maybe 10 USD, can we go to have sex?" …And if they are in the room, they can say "ok, so I will give you 10 more USD, can we have sex without condom?", she will do it (R2)

Other women, who are not sex workers, may have more than one sexual partner due to financial reasons:

> what makes a lady not having only one partner in the context of our country, is financial status. They may think that having one partner may not fulfil her needs. So, in order to fulfil her needs, maybe she needs to have two or three partners. (R4)

Mtenga et al. (2018) validate that by affirming that women in Tanzania engage on concurrent relationships to assure their financial security, and that traditional gender roles

presupposes women's economic dependence on men. Female participants on their study affirmed that economic hardship and lack of support from husbands are the reasons why they start and keep extramarital relations, while a high income facilitates men's extramarital affairs.

5.1.3 Cultural taboos, traditions and religious practices reinforce gender inequalities and discrimination

When relating with the community, girls and women' vulnerability to HIV infection is reinforced since traditional practices and religious discourses reproduce gender imbalances. Sexuality and condom use in particular, are determined by social values and norms, undermining individual agency. Moreover, open dialogue about sexual issues is considered inappropriate (Tadele and Amde, 2013). A respondent illustrated: "all related to sex is private, should not be disclosed in public" (R2). Teaching sexual education to young people is wrong. It is often considered indecent, unhealthy and unacceptable. People are afraid that talking about sex with young people will make them immoral (Oluga et al., 2010). Concerning religion, a respondent explained:

> we have two big religions here, the Muslims and Christians. They do not promote the use of condom. What they promote is abstinence… But if I get married and I also continue to have multiple partners, what else, ok? Religions don't give the woman a right to say no, ok? ... That is how religions teach: don't dare to reject sex to your husband, even the community. (R2)

Within Mtenga et al.'s study (2018), participants affirmed that men's dominance is endorsed by religious books. In Tarimo et al.'s research (2018) respondents pointed out that, from a religious perspective, condom use is immoral. Morgan et al. (2014) showed that faith-based organizations, which traditionally provide HIV prevention services in Africa, may differ from secular approaches. For instance, part of the organizations investigated (including a Catholic, an Anglican and a Muslim one) condemn condom use, promoting abstinence instead.

Respondents noted harmful traditional cultural practices such as female genital mutilation, early marriage, polygamy, wife inheritance and sexual cleansing – the belief that a HIV infected person can be cured by having sex with a virgin girl. Tadele and Amde (2013) point out that those customs reflect male domination on sexual issues, aggravating

girls and women vulnerability to HIV.

Finally, concerning community relations, it is relevant to stress that community members stigmatize and discriminate vulnerable groups, worsening their situation (UNAIDS, 2018b). A respondent stated that the community at large do not understand the reality of vulnerable groups and exclude them. They do not understand that "this is a human being, they have their rights" (R6). Another respondent explained:

> there is this community missing multiple services…Because of the stigmas, because of the hate speeches, because you are taking them as criminals…These people need services, they need your help. (R8)

5.1.4 Poor accessibility to condoms and unfriendliness of HIV prevention services

Respondents argued that accessibility to condoms and health care services can be hard. They mentioned the services' unfriendliness and the difficulties to buy condoms. In this sense, it is relevant stressing that condoms are a cost-effective tool for preventing STD, being on the centre of HIV prevention approaches (UNAIDS, 2016b).

Mubyazi et al. (2015) showed that accessibility to condoms is negatively impacted by their price. Furthermore, people are embarrassed to be seen buying condoms as retailers use bad language towards condom buyers. A respondent illustrated this reality:

> when I was growing I did not go to the shops and say "Can you give me condoms?". People are like: "What are you talking about? How a young girl like you comes into the shop asking for condoms?" So, you may end up doing unprotected sex because you fear to go to the shop asking for condoms. (R1)

According to respondent 5, even for older women it is not simple to buy condoms. She said "if you are not strong enough you'll be like 'sorry, I said vaseline instead of condom'" (R5). Respondent 4 pointed out that condoms are available for free in health centres, positioned somewhere where one can take it by oneself. However, people feel embarrassed to do so. Within the Tanzanian context, it is important to notice that due to the taboo around sexual issues, people feel embarrassed to be seen buying condoms,

embarrassed that others will find out they have an active sexual life, worried about what others will think. This point was very emphasized by the respondents.

Concerning access to prevention health services, there is a generalized lack of information on how to practice safe sex, particularly among youngers (Amde and Tadele, 2013). Nyblade et al. (2017) identified stigmas around unmarried young people sexuality as an obstacle for them to access sexual and reproductive health services (SRHS). Young people reported going through excessive questioning and scolding. They were often required to bring their parents or sexual partners in order to access those services (ibid.).

Sanga et al. (2015) explored factors impacting VCT's low acceptance by secondary students in Tanzania. When questioned what could be improved, participants pointed out employing knowledgeable health care providers. The authors concluded the study criticizing VCT services' unfriendliness and the poor prioritization of adolescents' issues (ibid.).

A respondent stated that the lack of friendly user services to young girls and sex workers in Tanzania is "a very common problem" (R3) because within Tanzanian culture it is not well accepted to provide sex education for people under eighteen years old. Even for adults it is challenging to access SHRS due to the taboo around sex in Tanzanian society. Another interviewee explained that in Tanzania SHRS are for women not girls. And women are those who are married and have at least one child (R1).

Tolley et al.'s (2014) concluded that adolescents were at similar or even at higher risk of being infected by HIV when compared to the adults. However, adolescents underuse preventive services, such as HIV testing and gynaecological exams. Another issue is that patients may feel embarrassed and fear being judged when discussing their sexual behaviours' with the counsellors. Also, they are concerned if the confidentiality of their private information will be indeed respected (Cawley et al., 2016).

Finally, respondents pointed out the shortage of health workers (discussed in subsection 2.2) and that health care providers may discriminate some groups and voice "hate speeches" (R8). In the case of transgender women:

> when they go to the health facility and they find out that they are not cisgender, they will just start to preach them about God…when they experience that they don't want to go again (R7).

5.1.5 The conservative and discriminatory policy environment reinforces girls and women's vulnerability to HIV infection

According to UNAIDS (2018b) punitive laws, police harassment and widespread discrimination are barriers to address HIV/AIDS incidence among vulnerable groups, while Governance and Policies is a key SDH (Skolnik, 2016). In this sense, the interviewees explained how the Tanzanian policy environment may reinforce girls and women's vulnerability to HIV infection. They cited politicians' discriminatory and conservative positions, which create a hostile environment for determined groups.

One of them argued: "some beautiful programmes are being introduced in the country" but they are disrupted by political leaders (R8). Respondent 1 remembered when the current Tanzanian president, John Magufuli, in power since 2015, urged women to stop using contraceptive methods. Also, he affirmed that families who use birth control "do not want to work hard to feed a large family" (BBC, 2018a). Clearly, he condemned the use of condoms.

Respondent 7 explained that statements against the LGBT community prevents this group to seek care in public health facilities, as they fear to be reported to the authorities. In October 2018, Paul Mokonda, a politician based in Dar es Salaam, announced that governmental officials would scrutinize social media platforms in order to identify same sex couples and arrest them. Also, Tanzanians were encouraged to denounce gay people to the government (BBC, 2018b). In Tanzania, selling sexual services, same-sex sexual acts and transgender are criminalized, fostering stigmatization towards those groups. Due to their sexuality, they are under risk of suffering physical harm and being arrested. Also, they experience further difficulties to access health and education services (Leddy et al., 2018; Pangilinan, 2013; UNAIDS, 2018c).

Finally, respondents pointed out that who are under eighteen years old should be accompanied by the parents or guardians to access health services. Clearly, this is a barrier

to girls to access sexual and reproductive counselling in health care facilities, discouraging youngers to seek SRHS (UNAIDS, 2018b).

5.1.6 The relevance of the Social Determinants of Health to understand individual behaviour

A survey conducted by the Tanzanian National Institute for Medical Research (2009) showed that having multiple sexual partners and extramarital sex are behaviours associated to a higher risk of contracting HIV (Mpondo et al., 2017). The academic literature indicates that young age, having multiple sexual partners, inconsistent condom use and alcohol abuse are associated to HIV infection risk (Landman et al., 2008; Leddy et al., 2018; Mpondo et al., 2017; Tarimo et al., 2018; Tolley et al., 2014;).

The respondents corroborated that by pointing out numerous sexual partners, alcohol abuse and rejection to condom as risky behaviours. Also, they pointed out drug use. However, as discussed above, taboos around sex, poverty, and gender imbalances may lead girls and women to not use condoms. Likewise, women's socioeconomic status and cultural aspects shape their behaviour.

Hence, it is relevant to stress that, when talking about individual behaviour, respondents proceed to explain how others factors frame it or even disagreed that individual behaviour should be considered among the factors that lead girls and women to be vulnerable to HIV infection. For instance, a respondent blamed peer pressure, lack of education and support from the family:

> individual behaviour can be due to peer pressure specially for young girls and adolescents because sometimes, especially for those…who are not in schools or those who are not in college, you may find a person who has [not]…a good caring from parents, so she ends up not having a good behaviour (R1).

Another respondent stated:

> By saying individual behaviour…I am getting quite confused because I believe no one can have an individual behaviour…factors which leads them to be vulnerable, for me, I believe separation of parents, poverty, lack of education can make young girls be vulnerable (R5).

In this way, those examples show the adequacy of the SDHs framework to understand why girls and women are vulnerable to HIV infection in Tanzania. The locals themselves minimize individual behaviour's relevance. This is in line with the most recent researches on HIV epidemics, which recognizes it as a social problem, shifting away from solely biomedical approaches (Tadele, 2013).

5.2 How do Mtandao's activities address girls and women's vulnerability to HIV infection?

This subsection answers how Mtandao's prevention activities address girls and women vulnerability to HIV infection. The Socio-Ecological model for health interventions proposed by Golden and Earp (2012) was the starting point to compile and categorize the activities carried out by Mtandao. Next, two key findings emerged. On the Interpersonal level, Mtandao focus on providing condoms, knowledge and incentives for girls and women's behavioural change. On the Intrapersonal, Community, Institutional and Policy levels, Mtandao employs a holistic approach, contributing to push long term structural changes. Those two key finding will be discussed and problematized on the next subsections.

Table 5 below resumes Mtandao's activities in each health intervention level. The levels Community and Institution are analysed together, given that the institutions' members (such as churches, mosques, schools, health facilities and local government authorities) are also part of the community and the main holders of power to make environmental changes. Also, activities are focused on particular members of institutions and not on overall institutional changes. In this way, within this research's context, it makes more sense to combine the analysis of those two categories. The table is discussed within the above mentioned two key findings.

Table 4: Resume table of Mtandao's activities to prevent HIV infection among girls and women, from a Socio-Ecological Perspective

Health intervention level	Activities directed to	Mtandao's activities
Interpersonal	Target population (vulnerable girls and women, female sex workers, transgender)	- Distribute condoms - Educate on HIV, DSTs and condom use - Educate on human, child and health care rights - Educate on how to recognize and handle GBV - Provide entrepreneurial training - Support girls to go back to study
Intrapersonal	People who interact with target population (families, male partners and female sex workers clients)	- Advise and encourage parents to provide sexual education to their children - Educate parents on family planning - Educate transgenders' families to be tolerant to them - Mediate conflicts between girls and families - Educate men to stop GBV - Engage men on HIV prevention - Educate female sex workers' clients on condom use
Community and Institution	General community (community leaders, religious leaders, teachers, health care workers)	- Sensitize general community on HIV epidemics - Sensitize general community to stop discrimination and harmful traditional practices - Engage religious and community leaders, teachers and health care workers - Form school clubs - Educate health care workers to provide a friendly user service
Policy	National policy makers and international forums	- Sensitize policy makers about vulnerable girls and women's reality - Advocate for amendments on discriminatory policies - Advocate for an increase of resources invested on girls and women - Monitor policy's formulation and implementation - Push Mtandao's agenda on international forums

5.2.1Facilitating the access to condoms, education and economic opportunities within the current cultural constraints: to which extent Mtandao's activities empower vulnerable girls and women?

Within Golden and Earp (2012) model, Intrapersonal level interventions are those directed to the target population (or beneficiaries), which in this case are girls and women vulnerable to HIV infection. Activities on this level seek to improve target population's knowledge in order to change their perceptions and behaviour.

Empowerment means "a process where, with resources and through agency, choices are made" (Goldman and Little, 2015: 763). In this sense, Mtandao provides education on HIV prevention and on girls and women's right, and distribute condoms. Those resources certainly can lead to empowerment since they strengthen girls and women's agency.

Considering the gender dynamics in Tanzania society, it is important that HIV prevention activities are planned to empower girls and women, by addressing males and females unbalanced power positions (Baylies, 2000). For some of the respondents, accomplishing this is one of Mtandao's ultimate goals. For instance, a respondent stated that Mtandao aims to:

> transform that patriarchal systems…we empower women…we try to build their capacity …build their confidence so they can speak out…we are empowering women; we are empowering girls. So we want to see a big number of women who are aware of their rights. So what we do, we do feminism movement building (R1).

Education is a tool for empowerment as it enables people to adopt healthier practices (Skolnik, 2016). When investigating gender differences in HIV infection in northern Tanzania, Landman et al. (2008) argued that the ABC prevention approach – urging abstinence, being monogamous and using condoms – should be coupled with educating and empowering women in relation to condom use.

This is what Mtandao is doing. Condoms are typically distributed by Mtandao's staff on hotspot areas where they know sex workers can be found. Alternatively, some beneficiaries may come to the organizations' office to ask for the condoms. In this way,

they facilitate the access to a cost-effective tool to prevent HIV, that otherwise would be challenging to access – as discussed above –, clearly exemplifying Mtandao's relevance. Promoting condom use is one of UNAIDS's five pillars for achieving less than fifty thousand new infections by 2020 (UNAIDS, 2016b).

Coupled with condom distribution Mtandao provides education on its use and on HIV and DSTs prevention, endorsing a positive perception about it. Respondent 3 illustrated:

> It is not about distributing only condoms but it goes with messages, key messages of behaviour changes…when we meet we try to tell our members about how they can change their behaviours. Even if they have to sleep with people to get money, how they can always stay protected. (R3)

Thus, Mtandao also facilitates the access to sex education, fighting the taboo around it. Furthermore, Mtandao delivers education on human and child rights. Beneficiaries are told that it is their right to access a high quality health care and that the health care providers are not allowed to discriminate and stigmatize them. They are also assured that it is their right to negotiate condom use and they are informed about the legal age to get married in Tanzania. Clearly, Mtandao is tackling not only the SDH lack of education but also the SDH gender dynamics by boosting girls and women's self-worth.

Also, Mtandao seeks to enable women to earn their own income and be economically independent. It provides entrepreneurial training, on how they can be self-employed, how they can start their own business. Beneficiaries are taught how to make goods that they can sell, such as purses, baskets, earrings, bracelets and soap. By providing economic opportunities to vulnerable women, Mtandao contributes to raise their income and improves their Socioeconomic Status, a key SDH (Skolnik, 2016). Likewise, it contributes to balance gender inequalities since in SSA women are traditionally economically dependent on men (Gebre et al., 2013a). In this way, individual risky behaviours are indirectly tackled, such as having multiple sexual partners and condom rejection (as discussed above, girls and women may engage in risky sexual behaviours due to financial reasons).

Regarding GBV, it is unclear to which extent Mtandao is directed to empower vulnerable girls and women. On one hand, Mtandao teach girls and women what it is, how to recognize if you are a GBV victim, how and where to get support. So, in this case,

information is also used as a resource for empowerment. Mtandao's outreach workers raise awareness that forced sex or beating is a violation of girls and women's rights. They teach that if "the husband takes a glass and smash o the wall…kicks things within the house, that is a signal that you are going under GBV" (R2). A respondent explained that some women which are suffering GBV say "[I] would never knew if you haven't told...I thought it was normal" (R5).

However, other passages suggest that Mtandao deals with GBV in a way which leaves structural gender imbalances untouched. For instance, a respondent said that they orientate women to handle GBV by negotiating with their partners "in a very diplomatic way, because they don't have power, they can't fight" (R2). These women are not encouraged to leave their abusing partners but to accommodate the situation, to "have the capacity to stay and endure these matters" (R2). Within this second example, women are held accountable to learn negotiation skills to deal with the violence they are going through. Confronting intimate power relations seems not to be encouraged.

Notwithstanding, it is relevant stressing that balancing short term and long term goals within HIV prevention efforts can indeed be challenging given that vulnerable women need to be protected now, within the current structural gender inequalities (Baylies, 2000). However, it is important to assure that long term goals are not constrained by short term activities (ibid.). How well Mtandao is able to balance that is an object for further research.

5.2.2 "In HIV response in Tanzania no one should be left behind". Building an enabling environment for girls and women's health

> In HIV response in Tanzania no one should be left behind… So, we have interventions, activities to [with] the community leader, community itself, clients, those who are around the clients...So, everybody should understand the context of what we are talking about. (R2)

This passage summarizes Mtandao's efforts to involve all relevant actors on HIV prevention efforts. As discussed previously, it is fundamental to create an enabling environment in which people can exercise their agency and adopt healthier behaviours (Baylies, 2000; Tadele and Amde, 2013, Tadele et al., 2013). Accordingly, through

activities on the Interpersonal, Community, Institution and Policy levels, Mtandao contributes to push structural changes, on cultural, social and political aspects. In this way, within this study, preventing HIV is also fostering social well-being, in line with the health concept[12] adopted in this study (Skolnik, 2016).

Within Interpersonal, Community, Institution and Policy health intervention levels, the activities are directed beyond target population. Interpersonal activities are directed to people who interact with target population; Community and Institution activities are directed to people beyond those who interact with target population; and Policy activities are specific to promote changes on policy (Golden and Earp, 2012). Below, it is discussed how Mtandao's activities in each level pushes a holistic change within the Tanzanian society.

Building a supportive home environment, encouraging sex education and fighting harmful traditional notions of masculinity

Mtandao's activities targeting girls and women's immediate contacts seek to improve their home and female sex workers' work environments. Interventions are focused mainly on families, more specifically on the parents or guardians. Also, there are activities directed to male partners and to sex workers' clients, but in a smaller scale. The respondents highlighted the difficulties to engage males.

Mtandao contacts poor and vulnerable families to encourage them to provide sex education to their children, to not be shy to talk about HIV prevention and condom use. They guide parents on how to be more open and friendly around those issues. Or in other words, Mtandao tells parents "how to raise kids" (R3). This is the key message, according to Respondent 3. Respondent 5 provides condoms to the parents, so they can be the first ones to give condoms to their children. As discussed previously, respondents stressed families' role to educate and protect young girls. In this way, this study strengths previous literature which points out that HIV prevention interventions in Tanzania should be

[12]The health concept adopted in this study was presented on Section 3: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (Skolnik, 2016:5).

family oriented, valuing relatives' role as resources and educators (Cawley et al., 2016; Eustace et al., 2017; Tadele and Amde, 2013).

That is clearly a way to push a cultural change, given that in SSA the silence around sex put youth in risk, as they often do not access information about how to protect themselves from DSTs (Tadele and Amde, 2013). Accordingly, those activities tackles lack of education and the taboo around sex, particularly towards youngers.

Family planning is another topic discussed with vulnerable girls' families, given that poor families with many kids are "creating them to be vulnerable" (R5). Poor parents will most likely not be able to sustain them. As a respondent illustrated "eight kids in one room and you can only support them with one meal" (R5). In this way, Mtandao is indirectly addressing vulnerable girls' poor background, and contributing to improve their Socioeconomic Status, a key SDH (Skolnik, 2016).

Also, respondent 3 mediate conflicts within families, so girls rejected by their relatives can be reunited to them. Concerning transgender women, respondent 7 dialogues with their families looking forward to educating them to be more tolerant. In this way, Mtandao is enhancing beneficiaries' social support and well-being and thus, promoting their health (Skolnik, 2016). Furthermore, it is worthy stressing that, by promoting transgender people's acceptance, Mtandao pushes an important cultural change, as in Tanzania sexual minorities are systematically discriminated (Pangilinan, 2013). In SSA in general, even their existence is denied (Tadele and Amde, 2013).

Concerning male involvement, activities mainly seek to sensitize men to stop GBV. Considering the gender imbalances in Tanzania and that most of HIV transmission occurs through heterosexual intercourse, male engagement is important to bring positive structural changes for women. Baylies (2000) points out that women only approaches are insufficient. As a respondent illustrated:

> In African countries men are the ones who make decisions… So, if you need to see a real change, you have to put something called male engagement. (R2)

In this sense, outreach workers try to sensitize men that they should not force women to

make sex (the word rape was not used) and that women have the right to demand condom use. Respondents emphasized that engaging males is tough, given that men tend to assume that HIV prevention is a women's business and that "women are more likely to transmit HIV when compared to men" (R4). In this way, "they [men] are not much involved in these prevention programmes, compared to women" (R4).

Within this unfavourable context, Mtandao general strategy is raising awareness that all members of the society are responsible to prevent HIV infection. Or, in other words, they urge men to assume their responsibility share to prevent HIV infection (Baylies, 2000). Hence, Mtandao challenges the harmful notions of masculinity (Mtenga et al., 2018), calling men to review their sexual behaviours and act responsibly towards their family and community (Baylies, 2000).

With the sex workers' clients, the approach is different. As they often deny to use condoms, Mtandao educates them on the importance to use condoms to prevent STDs. However, the focus is not on sex workers' safety but on the clients themselves: "so the first message they give them is not about protecting girls, but the guys" (R3). This case also illustrates Mtandao's struggle to balance long term and short term goals. On one hand, clients are not explicitly called to take responsibility towards sex workers well-being; but on the other hand, they are encouraged to use condoms.

Building a favourable community environment: fighting harmful traditional beliefs and practices, sensitizing the community towards marginalized groups' health rights

Health interventions within the Institution and Community levels are directed beyond target population and its immediate contacts. It aims to modify institution and community environments, respectively, by educating and enhancing the skills of community and institutions' members, including their leaders (Golden and Earp, 2012). The levels Community and Institution will be analysed together, given that the institutions' members (such as churches, mosques, schools, health facilities and local government authorities) are also part of the community and the main holders of power to make changes.

"If we need changes, everyone should understand" (R2). This passage resumes Mtandao's

sensitization efforts towards the community. In order to perform their work effectively, especially when dealing with young girls, Mtandao needs the community's support. So, everyone should understand Mtandao's aim in a given community, should understand the threat posed by HIV/AIDS and how to prevent it, should understand that no one should be discriminated or stigmatized, that everyone has the right to access information and to high quality health services. In a society where groups such as LGBT (Pangilinan, 2013) and sex workers (Leddy et al., 2018) are discriminated, those claims push deep cultural changes. As discussed, social well-being is a health status's dimension (Skolnik, 2016).

The approach towards religious leaders illustrates it and, also, Mtandao's efforts to balance short term and long term goals, acting within the current constrains (ibid.) As some issues concerning HIV/AIDS prevention can be challenging to discuss with religious leaders (e.g. condom use (Morgan et al., 2014; Tadele and Amde, 2013; Tarimo et al., 2018)) Mtandao select agendas that they are willingness to hear and accept. Hence, Mtandao seeks to sensitize religious leaders about the difficulties faced by vulnerable population, about GBV and engage them on the idea that "health rights are for all, regardless of who you are" (R2). Condom use, for instance, is not approached. Once religious leaders are convinced, they might spread those messages to their religious communities.

Likewise, Mtandao advocates against harmful traditional practices, such as forced early marriage and female genital mutilation, by raising awareness within the community of how those practices violates women human rights. Here, Mtandao promotes long term goals, through a gender sensitive frame (Baylies, 2000).

Mtandao engages with health workers in order to guide them on how to provide friendlier health services, improving the services' quality and health care facilities' environment. Mtandao helps them to recognize practices and discourses that they may judge as adequate but that in fact are discriminatory. In this way, those professionals realize how some of their attitudes or speeches may negatively impact patients, and they are guided on how to treat vulnerable people in a respectful and welcoming way.

Organizing school clubs is another manner through which Mtandao impacts communities and pushes its agenda. First, Mtandao approaches teachers to raise awareness about HIV

epidemics and how young girls are vulnerable to be infected, so they can understand what Mtandao is working for. After obtaining their consent, Mtandao form the clubs, where the students are given information and discuss about what is HIV/AIDS and how to protect themselves. In this way, Mtandao addresses the taboo to provide sex education to youngers and fosters improvements on schools' environments.

Finally, it is relevant to stress that often Mtandao staff itself is part of the community they serve. The peer educators and other volunteers are members of the community. Mtandao's staff are themselves sex workers, homosexuals, HIV infected or former drug users and/or come from vulnerable backgrounds. In this sense, Mtandao's staff turn out to be the target's population source of social support. A respondent explained that they have or create a mutual friendship with the beneficiaries, which is the entry door to implement the activities (R3). It is worthy stressing that coming forward as members of discriminated groups is another way through which Mtandao challenges prevailing cultural aspects.

Building an inclusive policy environment: advocating for fair public health policies to girls, women and marginalized groups

Within Golden and Earp (2012) model, Policy level activities are those specific to promote policy changes. Mtandao's first challenge is to sensitize decision makers and law enforcers to understand the context of vulnerable girls and women in Tanzania. This is a similar approach to community's sensitization and engagement at large, as discussed in the last subsection. In this way, Mtandao seeks to fight the Tanzanian discriminatory policy environment, which hinders the development and implementation of gender sensitive policies.

Once within the government structures, Mtandao dialogues with its representatives on how to establish "comprehensive guidelines on health services delivery" (R1) for young girls and women. Or, in other words, they provide advices to decision makers on how they can amend discriminative policies. Moreover, it advocates for an increase of investments on young girls and adolescents' health, including HIV prevention programmes. Finally, it keeps monitoring the implementation of governmental policies. Hence, Mtandao pushes improvements on the delivery of health services, an important determinant for health (Skolnik, 2016).

Respondent 1 answered that they were able to create good relations with determined governmental agencies and that they participate on policies development, reviewing and amending them. On the other hand, Respondent 8 questioned to which extent they are indeed being heard: "sometimes they invite us somewhere and they bring the document already done…which lead you to think that you are just there to endorse" (R8). Considering the unfavourable Tanzanian socio-political environment to advocate for vulnerable groups, it is likely that Mtandao's impact on governmental decisions is quite limited. Furthermore, it is relevant stressing that while Mtandao can influence governmental decisions, as a CSO it cannot make political decisions itself (Bujra and Baylies, 2000; Gaist, 2010). The extent and quality of Mtandao's cooperation with the Tanzanian government is an object for further investigation.

Among the international forums Mtandao engages with, it can be cited the UNAIDS; the Global Fund to Fight HIV, Tuberculosis and Malaria; and the United States Agency for International Development (USAID), through the President's Emergency Plan for AIDS Relief (PEPFAR) (the most cited ones). In the case of PEPFAR, for instance, Mtandao could participate on meetings for the elaboration of the operational plans in Tanzania. There, Mtandao role is to "make sure that CSOs issues are presented and accepted well" (R2). In this way, Mtandao has the opportunity to push its agenda and indirectly influence the Tanzanian government policies. Indeed, as pointed out by Aveling (2010), international organizations are often able to exercise greater political and economic influence over national governments. As showed on Table 1, considerable part of Tanzania's health expenditure comes from external sources.

5.3 Handling constraints and opportunities for Mtandao's work: policy implications

Table 5: Opportunities and constraints for Mtandao's work

Opportunities	Constraints
- Membership in a network of CSOs and international organizations - Close connection to vulnerable groups and communities	- Lack of funds - Lack of autonomy -Unfavourable social and political environment

The table above summarizes the constraints faced by Mtandao and the opportunities for its work expansion. Based on its case, this subsection reflects on policy implications for the Tanzanian health sector. Among the constraints, the most cited ones were lack of funds and the policy environment, often not conducive to Mtandao's work. The main opportunities are posed by the network of local and international organizations (IOs) which Mtandao is part. Mtandao shared background and close connection to the vulnerable communities they serve are a source of opportunities as well.

5.3.1 The Tanzanian government's conservative and discriminatory position hinders it in fulfilling the CSOs' possibilities to prevent HIV infection

Cargill (2010) points out that dealing with sensitive issues can be one of the challenges faced by CSOs. As discussed previously, Mtandao deals with socially and politically marginalized groups. As two respondents illustrated:

> the direction of what we are working, that is a problem, specifically when we ae working with key and vulnerable populations, the problem starts from there. (R2)

> In order to get funding in Tanzania we could no longer just stay straight to our profile or to our constitution that we work with female sex workers or lesbian women in Tanzania. So, what we did, we told them that we were working with marginalized women. (R5)

Respondent 7 stated that “the main problem is that we can’t work freely”. She explained that she has to act discreetly, approaching just individuals or small groups because

> At any time when you are teaching, maybe transgender people, the police may come and arrest you for promoting homosexuality or for promoting sex work. Even if they don’t have proof, even if you say you are teaching about HIV. (R7)

On the other hand, as a CSO closely connected to vulnerable girls and women, Mtandao has credibility to identify their needs and advocate for their health rights (Gaist, 2010). It is relevant to keep in mind that Mtandao’s staff may be themselves part of the community they represent: sex workers, infected by HIV, homosexual, transgender, former drug addicted. As at least part of Mtandao’s workers were born and raised in a vulnerable context, they have contacts and nourish friendships with others members from the community. They experienced the difficulties the community faces, so they have a better comprehension of the beneficiaries’ problems. Furthermore, as they have a certain degree of autonomy from the Tanzanian government’s conservative position, they are able to raise issues that may be ignored by those who hold political and economic power. In this way, Mtandao is a bridge between vulnerable groups and the national and international decision making arenas, and other relevant agencies and donors. (Gaist, 2010; Kelly et al., 2006; UNAIDS 2016a).

Moreover, Mtandao’s closeness to the communities they serve enable them to provide friendlier HIV/AIDS prevention services. The unfriendliness of the SRHS in Tanzania, especially for the youth, is a problem stressed by the literature and by the respondents. Likewise, Mtandao is contributing to fill the gaps left by the shortage of health workers in the country (as discussed on the background section).

Finally, it is relevant highlighting the significance of locally-driven efforts to promote gender equality, so the interventions are based on local people real needs and interests. (Dutt and Gambe, 2017; Gaist, 2010). As discussed, Mtandao’s staff are part of the community they serve, where they promote cultural changes (e.g. by fighting harmful traditional practices and by breaking the taboo around sex education). Thus, their actions assure locals’ ownership and responsibility over the interpretation and adjustment of cultural norms, a fundamental requisite for cultural changes’ sustainability (ibid.).

In conclusion, Mtandao is uniquely positioned to raise attention to the girls and women's vulnerabilities and propose gender sensitive solutions. This is clearly a Mtandao's differential to be leveraged by the Tanzanian government in order to improve the country's public health. However, if in one hand the government *formally* recognizes – in its official policy documents – that the HIV/AIDS epidemics is gendered and CSOs' role to respond to it (as presented in subsection 2.1 and 2.3); on the other hand, the translation of formal policies to practice is not straightforward. Hence, the government's conservative and discriminatory positions hinders it in fulfilling CSO's potential to prevent HIV infection and contribute for the improvement of the national health system. As pointed out by UNAIDS (2016a:6) community based services "provide a greater impact in terms of better access and wider coverage than do other types of service provision".

5.3.2 The Tanzanian government's hostility hinders it in providing effective frameworks to coordinate development partners

The collaboration with international and others local organizations is another source of opportunities that enables Mtandao's activities. All Mtandao's funds come from regional and international donors and organizations, such as the Global Fund to Fight HIV, Tuberculosis and Malaria, PEPFAR and UNAIDS (the most cited ones). Also, respondent 2 cited AVAC Africa (AIDS Vaccine Advocacy Coalition), the AIDS and Rights Alliance for Southern Africa (ARASA), the International Treatment Preparedness Coalition (ITPC) and the International Community of Women Living with HIV (ICW). It is worthy to highlight that a considerable share of Tanzanian health expenses' come from external sources (see table 1). That is another reason for the Tanzanian government to strengthen its collaboration with the civil society sector.

Besides funds, those IOs provide capacity building and technical assistance (R4) as well, and help to legitimize Mtandao's agenda. As illustrated by a respondent, "in the Global Fund, transgender are recognized as key population" (R7). Cargill (2010) points out a range of advantages of cooperating with other CSOs, whether local or international ones. For instance, join efforts to address the beneficiaries' multiple needs, and the expansion of networking and funding possibilities. Also, IOs have more legitimacy to assist pushing sensitive agendas (Aveling, 2010). Mtandao itself is a network of local CSOs that support

each other. In this way, through networking, it can combine resources to achieve a determined goal (Corbin et al., 2011).

Notwithstanding, the relations with others organizations can bring constraints as well. The cooperation between IOs and local organizations is widely documented and problematized by the literature, while the advantages and disadvantages of cooperation among local organizations is a topic for further research. Different authors stress the lack of funds, which leads to a dependency on external donors, as a limitation for local organizations (Aveling, 2010; Corbin at al., 2011; Gaist, 2010; Grantham and Baruah, 2017; Jennings, 2015; Shivji, 2004). The situation is not different for Mtandao.

Six respondents stated lack of funds as one of the greatest constraints faced, since they depend on those IOs to perform their activities. Respondents 5 and 8 expressed the wish to act or to open offices in other Tanzanian regions, but they could not due to the lack of funds. Furthermore, the dependence on donors hinders Mtandao's autonomy:

> Donors, they come with their own ideas according to their fund. So, it becomes difficult to apply such fund, they don't want us to do this and "you know what? You need it for your country". You know, maybe what is good in South Africa can't be good in Tanzania. (R5)

Therefore, besides causing financial instability (Kelly et al., 2006), the dependence on donors may lead local CSOs to align themselves to donors' rationale and preferences (Grantham and Baruah, 2017; Jennings, 2015). In this way, donors may excessively interfere on local organizations agenda, reorienting them (Shivji, 2004). Moreover, as it is not always clear how much and for how long international donors will commit, those circumstances hamper the development of national long-term sustainable solutions (Jennings, 2015: 1).

Within this context, an adequate policy framework would be valuable to coordinate the different development partners, defining their roles and entitlements (Grantham and Baruah, 2017). According to different authors (e.g. Mussau et al., 2011; Tadele et al., 2013) and UNAIDS (2016a) health interventions with the potential to accomplish the most are those ones which benefit from both government and civil society's efforts.

Within the Tanzanian context, coordination between different partners is key to ensure the country's health care system's effectiveness and sustainability.

Accordingly, the Tanzanian government shall act as a facilitator to harmonize all health development partners' contributions. Efforts shall be combined for an effective HIV prevention and to address the health care services' inequities across the country. However, it is likely that the Tanzanian government's hostile position towards local CSOs hinders the provision of policy frameworks that protect CSOs' autonomy and financial security, looking forward to leveraging their unique position to address girls and women's vulnerability to HIV infection.

6. Concluding remarks

Based on Mtandao's case study, this thesis had as its purpose illuminating CSOs' possibilities to prevent HIV/AIDS among vulnerable girls and women in Tanzania. Also, it discussed policy implications for the fulfilment of CSOs' potential. Although it is likely that Mtandao's case is not representative of all CSOs in Tanzania, this study contributes to a systematic knowledge accumulation. Moreover, all findings were discussed in light of previous researches in the area, largely validating them.

It was presented how the HIV/AIDS epidemics is still a grave gendered health problem in Tanzania, not adequately controlled. Given that women are more vulnerable to be infected by HIV and that around 80% of the new HIV infections occur through heterosexual sexual intercourse, it is relevant to investigate the link between HIV infection and gender inequalities in Tanzania.

The limitations of the Tanzania health care system – notably shortage of funds and human resources – coupled with the State's inability to respond to the HIV/AIDS epidemics, opened doors for CSOs to emerge and, consequently, for those excluded from decision making, including women, to act. Mtandao was selected as a case study because it is a well-stablished organization which deals with HIV prevention through a gender-sensitive framework.

The SDHs were used to identify the social factors which determine girls and women vulnerability to HIV infection, given that the HIV/AIDS epidemics is recognized as a social phenomenon as well, not just a biomedical one. Thus, within this study, health is conceptualized as a state of physical, mental and social well-being. The Socio-Ecological model presupposes that promoting changes on the environment surrounding the individuals impacts individuals' health status. Those two theoretical frameworks orientated the literature review, the interview guide and data coding.

Departing from the Social Constructivism paradigm, the fieldwork's aim was constructing knowledge together with the respondents, placing them as subjects. That is why the interviews were interactive, and the general questions adapted according to the conversations' flow. Looking forward to mitigating the risk of governmental retaliations,

Mtandao and respondents' identities are not revealed.

Subsection 5.1 answered the first research question, *what signifies vulnerability to HIV infection among those girls and women targeted by Mtandao's activities?* Gender imbalances put girls and women in a disadvantaged position in comparison to men. Thus, females' ability to protect themselves is hindered: they face difficulties to negotiate condom use and to avoid GBV. Sex workers and transgender are particularly affected. Traditional practices and religious beliefs reinforce gender inequalities and taboos around sex education and condom use. Furthermore, the community's and political discrimination towards sex workers and LGBT deepens their vulnerability.

Tanzania families in general due not provide sex education to children, so the youth lacks information to practice safe sex. Within poor families, girls are encouraged to be sex workers to bring money to home. Lack of formal education and job opportunities perpetuates women's economic dependence on men and poverty cycles. Due to the taboo around sex, accessing condoms and SRHS is challenging, especially for the youth. Discriminatory and conservative policies and politicians contribute to create a hostile environment for girls, women and marginalized groups. Finally, respondents' perspectives about individual behaviour highlighted the SDH's relevance.

Subsection 5.2 answered the second research question, *how do Mtandao's activities address girls and women vulnerability to HIV infection in Tanzania?* From a Socio-Ecological point of view, on the Intrapersonal level Mtandao provides resources for girls and women's empowerment: education, condoms and economic opportunities. However, particularly regarding GBV, it is unclear to which extent Mtandao's interventions indeed empower women by defying structural gender imbalances. This illustrates Mtandao's struggle to protect girls and women within the current structural constraints.

On the Interpersonal, Community, Institution and Policy levels, Mtandao seeks to build an enabling environment for girls and women's health. The overall strategy is promoting cultural changes by sensitizing and engaging all Tanzanian society on Mtandao's agenda. In this way, families are encouraged to provide sex education to their children and to accept their LGBT's relatives. Males are encouraged to take responsibility over

HIV/AIDS epidemics and to act consciously towards their partners and families' health. Hence, traditional harmful masculinity norms are challenged.

Within the community, Mtandao advocates against harmful traditional practices and beliefs and promotes marginalized groups' rights. They orientate health care workers on how to provide more friendly user SRHS and intervene in schools to provide sex education. Approaching religious leaders is particularly challenging, given that they are often not willingness to endorse condom use. At the policy level, Mtandao advocates for inclusive policies that contemplate girls and women's needs. It indirectly pressures the Tanzanian government by promoting its agenda within international forums. The quality of Mtandao's cooperation with the government was not totally clear.

The subsection 5.3 answered the third research question, *what are the opportunities and constraints to Mtandao's work?* and reflected on policy implications. Given that Mtandao depends on international donors to operate, the lack of funds and autonomy are main constraints. On the other hand, Mtandao's shared background with and closeness to the communities they serve place their staff in a credible position to identify girls and women's vulnerabilities to HIV infection, propose solutions and provide user friendly SRHS. However, the Tanzanian government conservative and discriminatory position and policies hinders it in providing effective policy frameworks to fulfil CSOs' potential. Moreover, in order to protect CSOs' autonomy in face of external donors, the Tanzanian government should act to facilitate development partners' cooperation, delimitating roles and responsibilities in order to leverage CSOs' role.

Due to data's insufficiency, this study did not approach girls and women's drug users' specific vulnerabilities and activities to address them. Likewise, the discussion concerning lesbian and transgender specific issues was not comprehensive. Therefore, those are topics for further research. Also, (i) the effectiveness of Mtandao's interventions, (ii) the scope and quality of their collaboration with other local CSOs and with the Tanzanian government, (iii) how they adapt gender equality discourses and (iv) how they balance short term goals (protecting girls and women now within the current cultural constraints) and long term goals (promoting structural cultural changes) are objects for further investigation as well.

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Appendixes

Appendix A: interview guide

Part 1: Respondents' view on girls and women vulnerability to HIV infection in Tanzania

Examples of general questions:

In your opinion, does *SDH* make girls and women vulnerable to HIV infection?

How does factor *SDH* make girls and women vulnerable to HIV infection?

Is there any other SDH that you consider important that I did not mention?

SDHs approached:

Accessibility to prevention methods

Family and community relations

Gender dynamics

Individual behaviour

Religion

Traditional beliefs and education

Economic opportunities (emerged along fieldwork)

Policy Environment (emerged along fieldwork)

Part 2: How Mtandao's activities address girls and women vulnerability to HIV infection in Tanzania

Examples of general questions:

Does Mtandao have any activity that addresses the *specific vulnerability* you mentioned before?

How does Mtandao respond to *specific vulnerability*?

Is there any activity that engages *vulnerable girls and women/sex workers/parents/male partners/husbands/boyfriends/clients/community leaders/religious leaders/political leaders/health workers/schools*?

Appendix B: respondents' identification number and professional experience

Respondent Number	Target Groups	Time of Experience in February 2019 (approximately)
1	Young girls and adolescents, and female sex workers	4 years
2	People living with HIV and AIDS, men who have sex with men, transgender, female sex workers	15 years
3	Young girls and adolescents, and female sex workers	6 years
4	People living with HIV and AIDS, young girls and adolescents, female sex workers	3 years
5	Vulnerable young women, female sex workers, lesbians	13 years
6	Drug users	7 years
7	Transgender women and sex workers	1 year and a half
8	LGBT, female sex workers and drug users	5 years