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Elizabeth T. Montgomery [a], Agnes Chidanyika [b], Tsungai Chipato [c] & Ariane van der Straten [a d]

[a] Womens Global Health Imperative, RTI International, San Francisco, USA

[b] United Nations Population Fund, Copenhagen, Denmark

[c] University of Zimbabwe-University of California San Francisco Research Collaborative Programme in Women's Health, Harare, Zimbabwe

[d] Center for AIDS Prevention Studies, University of California San Francisco, San Francisco, USA

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Sharing the trousers: gender roles and relationships in an HIV-prevention trial in Zimbabwe

Elizabeth T. Montgomery[a]*, Agnes Chidanyika[b], Tsungai Chipato[c] and Ariane van der Straten[a,d]

[a]*Womens Global Health Imperative, RTI International, San Francisco, USA;* [b]*United Nations Population Fund, Copenhagen, Denmark;* [c]*University of Zimbabwe-University of California San Francisco Research Collaborative Programme in Women's Health, Harare, Zimbabwe;* [d]*Center for AIDS Prevention Studies, University of California San Francisco, San Francisco, USA*

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Male and female gender roles and inequalities are important in contributing to the disproportionate burden of HIV experienced by women in sub-Saharan Africa. Within the context of an HIV prevention trial, we aimed to describe and understand male partner influence on women's use of HIV-prevention methods. Our presumption was not that regressive gender norms prevailed – rather, that a wide range of gendered attitudes and dynamics would be expressed among couples. Data from 16 focus groups with Zimbabwean female trial participants and their male partners and 4 in-depth couples interviews were collected, and form the basis of the analysis. Findings offer descriptions of how couples have adapted techniques for negotiating modern household economies and sexual decision-making in a manner that both preserves traditional gender roles, while accommodating women's entrance into new domains such as the workforce or an HIV-prevention trial. Women's agency to introduce novel female-initiated-method use into her intimate relationships is described. Men and women's accounts of method introduction and use suggest different perceptions about the locus of sexual decision making. The study provides unique insight into a gendered context that is dynamic yet sensitive to change, which in turn can provide useful information to more appropriately guide HIV-prevention activities in this setting.

Keywords: HIV prevention; gender; female-initiated methods; Zimbabwe; male involvement

Background

Male and female gender roles and associated inequities are important mechanisms fuelling the disproportionate burden of HIV experienced by women in sub-Saharan Africa (UNAIDS 2010). Historically, in many parts of the region, including Zimbabwe, African societies were organised along patrilineal lines – a married woman and the children she produced were considered to be the property of her husband (Caldwell, Caldwell, and Orubuloye 1992; Mbizvo and Bassett 1996). Within this cultural context, men dominated household, sexual and reproductive decision-making and access and control of resources. Civil laws prohibiting women's property ownership rights, traditional practices such as the payment of *lobola* or bridewealth, polygamy and the practice of wife inheritance reinforced the notion of women's subordination to the male head of household, even when

*Corresponding author. Email: emontgomery@rti.org

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practices were designed to ensure the basic survival needs of women, (i.e., if a husband passed away his brother or a male relative would be expected to provide for his wife) (Caldwell, Caldwell, and Orubuloye 1992; Preston-Whyte 1993).

Later experiences with colonialism served both to alter and reinforce this existing socio-cultural structure of male dominance. Colonialism ushered in a new patriarchy: native African's status and legal rights were both lowered, particularly for women. Economic and labour systems were reorganised in such a way that traditional rural agrarian households were disrupted: men increasingly migrated for work and women remaining in the rural areas were required to fulfil roles that had previously been filled by men (Lurie et al. 1997; Ulin 1992). In addition to disintegration of the traditional way of life and sustenance, sexual networking and risk of disease increased on an individual and population level. In the early-1990s (Jewkes, Levin, and Penn-Kekana 2003; Lurie et al. 1997) the gender inequalities that resulted from these socio-cultural, political and economic circumstances of the region were increasingly identified as important determinants of women's sexual health risk, particularly in regards to HIV (Amaro 1995; Ulin 1992; Susser and Stein 2000).

In response to women's disproportionate disease burden, for the past 15 years, much effort in HIV-prevention research has been focused on the identification of effective female-initiated methods (FIM), including chemical (microbicide) and physical barriers (cervical barriers, female condoms), that women can – theoretically – use autonomously. That said, most of the exploratory studies that preceded FIM trials in eastern and southern Africa reported that both genders want men to be involved in the decision and execution of product usage and several of these studies reported potential adverse consequences, such as domestic violence, if the male partner discovered FIM use after the fact (Bentley et al. 2004; Buck et al. 2005; Coggins, Blanchard, and Friedland 2000; Darroch and Frost 1999; Green et al. 2001; Mantell et al. 2005; Moon et al. 2000, 2002; Pool, Hart et al. 2000; Ramjee et al. 2001; van de Wijgert et al. 1999; WHO 2001). In Zimbabwe specifically, two formative qualitative studies reported that men were supportive of women taking part in microbicide trials and using investigational HIV-prevention products, provided they were consulted first for permission (Moon et al. 2000; van de Wijgert et al. 1999). Another study with NGO leaders, members of the Ministry of Health and community opinion-leaders corroborated these findings and acknowledged the gender and power imbalance in Zimbabwe, the realities of male infidelity and low male condom use. Numerous smaller clinical studies of microbicides and/or cervical barriers, and our larger observational male-involvement study in Zimbabwe (Montgomery et al. 2010), have subsequently reported that women who perceive that their partners are supportive or like the products are more likely to like the products themselves and be consistent users. Thus, somewhat paradoxically, the literature to date suggests that novel FIM for HIV prevention are not necessarily and solely under female-control, as the actual or perceived approval of male partners is reportedly essential to their acceptance and use by women.

In the present study, our underlying hypothesis was that male partners have an important influence on women's use of HIV-prevention methods. Of note, our presumption was not that regressive gender norms prevailed – rather that there were likely to be a wide range of gendered attitudes and dynamics expressed among couples. We aimed to understand and describe the range and scope of this influence using qualitative methods. These data provide first-hand accounts of how culturally defined gender roles and relationship dynamics are described and experienced by Zimbabwean women and their male partners in the context of FIM use for HIV prevention. This study provides unique insight into a gendered context that is dynamic yet sensitive to change, which in turn can provide useful information to more appropriately guide HIV/AIDS-prevention activities in this setting.

Methods

The MIRA Male Involvement Study was an observational ancillary study at the Zimbabwe site of a multisite phase III randomised clinical trial, the Methods for Improving Reproductive Health in Africa (MIRA) Study, to measure the effectiveness of the diaphragm and Replens™, a commercially available lubricant gel, in preventing HIV and STI acquisition. A full description of the study aims, study population, procedures, data collection and analysis of the main MIRA trial has been published elsewhere (Padian et al. 2007). In brief, the MIRA study enrolled 2502 women in Zimbabwe (50% of total sample) between September 2003 and September 2005. Women were randomised in a 1:1 ratio to receive a diaphragm, gel and male condoms ('diaphragm/gel arm'), or male condoms only ('condom arm'), and were counselled to use all applicable products each time they had sex. Follow-up continued at quarterly visit intervals for up to 24 months (median 21 months) until December 2006. Following trial completion, from August 2006 to June 2007 qualitative data were collected as part of social science research running in parallel to the main trial and the male involvement ancillary study (Montgomery et al. 2010; Padian et al. 2007). Data from 16 focus-group discussions (FGDs) with Zimbabwean female trial participants ($n = 81$) and their male partners ($n = 27$) and 4 in-depth couples interviews (IDIs, $n = 8$) were collected, and form the basis for this analysis.

The conceptual framework for this study is presented in Figure 1. We aimed to explore and describe the influence of male partners on female partners' HIV-prevention method use by first examining the broader context of gender roles and relations in Zimbabwe (current and historical), situated within a generalised HIV epidemic. Within this, we explored the more specific contextual environments of the household – notably the relationship dynamics and decision-making that are expressed among couples, as well as the more novel context introduced by engagement with a clinical research trial – particularly one that targets women and dispenses female-initiated products and/or male condoms. In regards to the latter, we explored the potential tensions and influences among the trial, use of the study products and participants' broader household and cultural contexts.

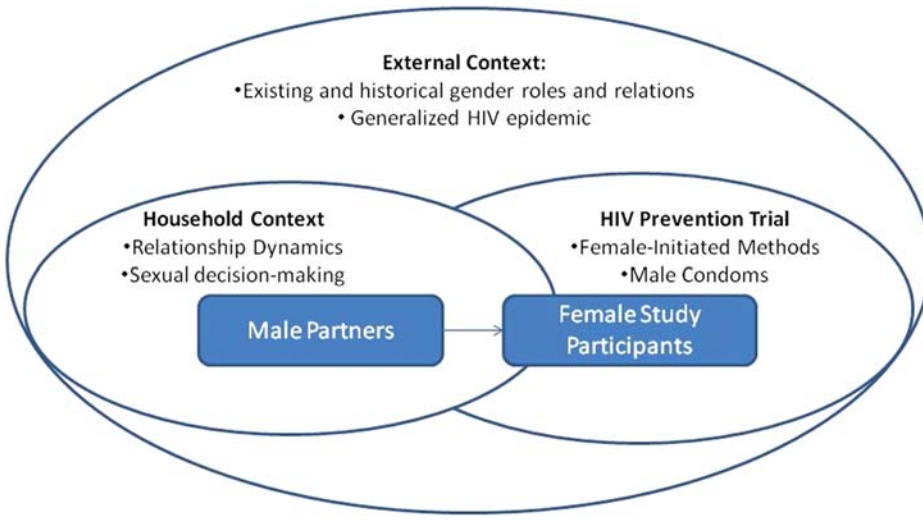

Figure 1. Conceptual framework.

The FGDs comprised 4–12 members each and, through a structured guide administered by a trained facilitator, explored product acceptability, feasibility and use and related issues of relationship dynamics, partner communication, contraceptive use, covert use of products, affordability and access of products. To facilitate appropriate exploration of product use issues, the 10 FGDs with women were homogenous by randomisation assignment in the main MIRA trial, such that 5 were with women in the diaphragm/gel arm ($n = 41$) and 5 were with women in the condom arm ($n = 40$). All 6 FGDs with men ($n = 27$) were with male partners of women in the diaphragm/gel arm. Women participating in the study were systematically selected for focus groups if they had given permission to be contacted and had exited the trial within the past nine months. Men were systematically contacted for participation only if their female partner granted permission. Among the 192 women who were eligible to participate, 154 were approached, of whom 81 participated (53%). No women refused to participate, although some did not turn up on the day of the FGD and their reasons for this are unknown. Among the 192 male partners for whom women gave permission to contact, 111 were approached, of whom 27 participated (24%). Although men's reasons for refusal were not systematically documented, staff anecdotally commented that the most common reasons for not agreeing to participate included busy work schedules, concerns about confidentiality in a group discussion and embarrassment to be seen attending a 'women only' clinic. Study staff administered a brief face-to-face, socio-demographic form to all participants prior to the start of FGDs.

The IDIs with couples, in which both members of the dyad were interviewed together, explored some of the same themes as the FGDs, but focused more on male and female roles in a relationship context, how roles have changed over time, how roles might be different in rural areas as compared to Harare and how men can be positively involved and supportive of women in research studies. Four couples were interviewed, all of whom had a female partner who: (1) was randomised to the diaphragm arm, (2) provided permission to be contacted after the study and (3) had a male partner who came to the clinic during the MIRA study. The original target sample for couples recruitment was 12–20 to offer enough breadth of representation to responses, while not reaching a point of 'data saturation' whereby additional data would not offer substantially new insights (Mack et al. 2005) and was devised to purposively select whether the male partner was classified as 'more' or 'less' involved, as defined by attendance at the clinic during the study period. Within each of the 'involved' stratum, couples were to be selected randomly, using a random number generator function. In practice, recruitment of couples after the trial was difficult, particularly for those couples in which the man had not come to the clinic. Although refusal reasons were not systematically recorded, only 4 of the 36 couples (11%) that were randomly chosen participated. A review of the data showed a fair amount of homogeneity of responses for those four couples that provided data, suggesting that more interviews with couples of this type would not have yielded much new information.

Participants signed written informed consent to participate in FGDs and couples IDIs. Interviews were conducted in the local language (Shona), audio-recorded, then transcribed and translated verbatim into English. Atlas.ti software was used for coding and analysis. The IDI coding was done by the primary author. Coding for the acceptability and feasibility FGDs followed a codebook that was designed and refined through an iterative group process among the coding team (5–6 research team members). To help establish consistency in coding across interviewers, a fraction of the transcripts ($\sim$5%) were double-coded by a secondary coder and discrepancies identified and resolved through consensus. Both FGD and IDI data were then summarised by themes of interest for this analysis.

Results

The characteristics of the female and male FGD samples are presented in Table 1. Female participants were on average just over 30 years old (range 20–50) and the vast majority (98%) were married. Male partners were several years older on average (mean 35.3, range 22–54) and all (100%) of this subset were married. A small number of women reported that their male partner had other partners: 3 (7%) in the diaphragm arm and 6 (15%) in the condom arm, whereas all men reported the perception that their female partners were monogamous. Overall, women reported bearing or looking after more than two children on average, whereas male partners reported fathering or looking after more than three on average. All participants spoke Shona at home. Over half of the women in each arm (54 and 70% in the diaphragm and condom arms, respectively) reported their primary source of income was their spouse. An additional one-quarter and one-third earned income from self-employment and a small number ($n = 1–3$) earned wages. By contrast, one-third (33%) of male partners earned wages and 63% were self-employed. Education levels were similar across the sexes, with between 71 and 80% having achieved secondary school education. The subgroup of women participating in FGDs did not differ substantially from

Table 1. Demographic characteristics of study sample.

	Female study participants		
	Diaphragm arm ($n = 41$)	Condom arm ($n = 40$)	Male partners ($n = 27$)
Age (mean, range)	30.1 (20–50)	31.1 (21–49)	35.3 (22–54)
Marital status			
Single	–	–	–
Married/cohabitating (%)	40(98)	39(98)	27(100)
Divorced	–	–	–
Widowed	1(2)	1(3)	–
Other	–	–	–
Spouse has other partners (%)			
Yes	3(7)	6(15)	–
No	38(93)	33(85)	27(100)
Don't know	–	–	–
Children ever born (mean, range)	2.2 (0–6)	2.6 (1–5)	3.1 (1–11)
Children looking after (mean, range)	2.3 (0–6)	2.4 (1–5)	3.7 (1–14)
Language(s) most spoken at home (%)			
English	2(5)	–	–
Shona	41(100)	40(100)	27(100)
Ndebele	1(2)	–	–
Other	–	–	–
Primary source of income (%)			
Salary/wages	3(7)	1(3)	9(33)
Self-employment	14(34)	10(25)	17(63)
Spouse/partner	22(54)	28(70)	–
Other relatives	2(5)	1(3)	1(4)
Social welfare	–	–	–
Other	–	–	–
Highest level of education completed (%)			
None	1(2)	1(3)	–
Primary	10(24)	7(18)	4(15)
Secondary	29(71)	32(80)	21(78)
Tertiary	1(2)	–	2(7)

all Zimbabwean women enrolled in the main study ($n = 2488$) in regards to age, marital status, native language, parity or education level (data not shown).

Four couples, all with male partners who were identified as 'involved', were interviewed together by two facilitators between February and June, 2007. All four couples were married (for 5–21 years) and living together in one of the two study clinic catchment areas of Chitungwiza (3) or Epworth (1). Socio-demographic data were not captured from couples.

External context

Male and female 'roles'

In couples IDIs, both female and male partners spoke of men as the 'head of the household' and described their primary role to 'take care of his family' and 'work for his family' (Figure 2). This responsibility included providing for the health, survival and basic goods of the household or responding to problems in the household. Men's family responsibilities may also extend beyond the nuclear family to include other relatives. In addition to providing material goods and stability for his family, some of the male partners responded that men have a responsibility to be faithful, engaged in the well-being of the family and provide love to the wife and family. With this component of men's role, there was expression of respecting women by listening to them, discussing problems jointly and being a harmonious team.

Women's roles were described in complementary terms, with less emphasis on providing material goods (see Figure 2). Women, too, were expected to be 'well-behaved', which included not being promiscuous or having affairs. In addition, their role was to take care of the family and the husband and to be 'hard-working and do what the husband expects'. Examples of how women could show love and respect included domestic tasks such as washing and cooking. It was also commonly described that it was women's role to communicate the problems of the household to the husband.

Male roles:

- A man should help his family by looking for food and wealth so that his family survives. (Man, couple 2)
- Taking care of the family … (this) means making sure the children have enough clothing and [responding to] other problems in the family. (Woman, couple 4)
- The biggest role is to take care of the family he is the head of … he is the one who is burdened with all the problems either from in the family, or it could be his sisters or his mother … (Man, couple 4)

Female roles:

- I should love my husband because he is the one I chose … wash and iron clothes for him and if he goes to work I should tell him that things are like this and that … I should sweep the house and [do] household chores and [respect] him. (Woman, couple 3)
- To cook for the family, to treat your husband nicely, to wash and give him everything that he wants.… When we are talking about love, you should give him enough love, if he says I want something you have to do it for him. Sometimes your husband won't be there, and the child is sick. A woman should take action … it is a woman's role. You then tell the husband that we had such a problem. (Woman, couple 4)

Figure 2. Male and female gender roles, as expressed in couples IDIs.

Changing roles

Among respondents in the couples IDIs, there was general agreement that gender relations were more equitable now than in the past. While traditional Zimbabwean society was largely organised around rural, agricultural homesteads with little opportunities for women, couples described increased educational and employment opportunities for women in the capital city, Harare. Participants explained that this shift may also impact on household gender roles. For instance, a wife may now be the only spouse employed and consequently described as 'taking care of the family', whereas her unemployed husband may take on the role of 'reporting' household happenings – a role previously ascribed to women.

Two couples described a modern phenomenon whereby increased economic opportunity for women was causing an additional shift in partnership dynamics: when women worked, their traditional domestic duties (and the associated emotional meaning behind these tasks) were delegated to a maid, which in turn led to household and relationship problems. The maid, in fulfilling the traditional roles of the Zimbabwean wife, is perceived as a 'second wife' in the household, as described below:

> It's different because women don't wash anymore, they have maids who do the laundry and cook. So the maid will be cooking for you and washing your clothes so you will end up taking her as your wife and then you have two wives. (Tendai, male, couples IDI 3)

> It's only they will be looking for money to survive otherwise it [women working] is not nice because the love from wife to husband is minimal. You expect the wife to cook but it will be the maid who will be doing the cooking. (Simba, male, couples IDI 4)

> I wanted to say the wife may lose her husband to the maid … homes are breaking up because of this. The advantages of women to work are that they help out in the family. The wife can help the husband on the other hand, if she is working her husband will look for a maid and the maid takes over the house. (Precious, female, couples IDI 4)

Household context and the HIV-prevention trial

Participation in an HIV-prevention study: permission and disclosure

Situated within the external gendered context described above, we explored women's interest and decision-making ability to join an HIV-prevention study in which they would be regularly tested for HIV and asked to use prevention products – female-initiated and/or male-initiated – during sex. The data suggested that introduction of, and engagement with, an HIV-prevention trial introduced several potential changes into a household context and a relationship. Indeed, from women's narratives, expressing interest in or actually joining a study, raised several sensitive and potentially contentious relationship issues, including knowledge of HIV status and the introduction of condoms and/or the diaphragm and gel into the couple's sex life. Both of these issues, in turn, introduced suspicions amongst husbands about their wife's HIV status and level of fidelity and concerns about her learning about his possible infidelity. At the same time, women expressed awareness that non-disclosure of study participation would be taken poorly by their partners (Figure 3). Consequently, many women described mindful strategies for approaching the topic of disclosing study participation: some hid it first, others used the consent forms or the dispensed study products (post-enrolment) to initiate the conversation and others still discussed it straightforwardly, but delicately.

In contrast to women, men in both the FGDs and couples IDIs more often described these initial discussions and disclosures about study participation in terms of 'giving permission' for the female partner to join the study, Men's narratives confirmed women's descriptions that men would be angry, suspicious and perceive it as disrespectful if she

Women say:

- [If I did not ask permission to join] My husband would think that I am having a relationship with someone else. (Woman, couple 4)
- Yes she should ask her husband first that I am doing this then he will tell you to go because it is not possible to join without telling your partner and you just end up doing that.(Woman, couple 3)

Men say:

- What would happen is I would be angry that why would she just go without asking for permission I would then want to come on my own to understand what this study is all about. (Man, couple 2)
- It would be a problem for someone to join the study without explaining to you that she is now doing that. Your mind won't be settled and you will be thinking that she might be hiding something and she wants to keep secrets now. So she explained to me [about the study]. If she had done that [lied] and if I discovered it later we were not going to be in good books [he was going to be angry with her]. (Man D, FGD 2)
- The day that I was told about the study by my wife, I became very angry. Very angry! I fumed, 'what are you trying to do? What exactly do you want to do?' But when I was given and explained to, that was when I slowly accepted. And she kept on explaining many times. I saw no difference when I first used it [study products]. It's the same [feeling of sex] and I don't see any reason why one would ask his wife why she uses it. I actually asked for forgiveness that 'sorry my wife, I did not know that that is what it's like. I thought it was different from what we do every day. I saw it as something new. (Man A, FGD 10)

Figure 3. Women joining the research study: permission, implications and consequences of non-disclosure.

joined the study without his knowledge and that this may lead to his insistence that she stop study participation. A couple of men expressed their feelings that it would be 'impossible' for her to join the study without his knowledge (Figure 3).

Only one male partner commented on his support of his wife's autonomous decision to join the study and her inherent knowledge or confidence in his support. Furthermore, only one male partner described that permission-seeking might go in both directions, giving the example that if he was to join a study, he would discuss with his wife first, just as if he was going to withdraw cash from the ATM, he would discuss with her first. This de-emphasised the unidirectional 'permission' aspect of the process.

Decision-making about prevention-method use

In FGDs, women and men were asked who decides if and when to use the HIV-prevention products – diaphragm, gel and condoms – provided by the study. While most respondents expressed that it was ideal that partners discussed the use of study products and made a joint decision, several respondents described clear sentiments that either the man or the woman made the sole decision to use products. However, the data suggest different interpretations of the concept of decision-making. For instance, women perceived that it was their decision to use male condoms because they introduced or initiated the concept of their use in the household – largely in response to suspicions about their male partner's behaviour. This is well described in the following comments during a focus group:

> But the woman is the one who chooses because men just do not want to use condoms. She is the one who stands and says 'I don't want this. I want to use condom. I want to prevent diseases. I do not know what you do or where you will be'.
>
> I am the one who chooses because I won't know [where] he will be during the afternoon. So I am the one who is supposed to choose on condoms so that we can be satisfied.
>
> We as women we are the ones who choose to use condoms in the house because we know that our partners are too mischievous. (Mavis, Taurayi and Chiedza, respectively, female FGD 3)

Many men described the benefit of discussing prevention methods as a couple and deciding on use together. Nonetheless, several comments from male participants

suggested that following the introduction of an HIV-prevention method, and potential joint discussion of its use, men have the final decision-making power:

> It's the way you agree in the home, [the mother] and the father, both of you. So that what you want happens to make you feel that you are having sex. But mostly, the husband says that what really goes well for him. So that is what will be used mostly. (Innocent, male FGD 2)

> We discuss [condom use]. But then when you are unable to agree, I then have the final decision. (Allen, male FGD 9)

> I refuse to wear? There is nothing she can do. (Enson, male FGD 8)

Product negotiation with men

A common theme throughout FGDs with both men and women was that if men clearly understood the benefits of using HIV-prevention methods – including male condoms and study product under investigation – they would not refuse to use them. However, they often do not have a full understanding. Women's descriptions of condom negotiation techniques often equated male partners to 'babies' and 'children' who need to be educated both from the start (of the study) and in a carefully calculated manner in order to be convinced. Several men corroborated this perspective:

> What is needed is to persuade the husband nicely. A man is like a baby, even a woman is like a baby. If you buy a sweet today and give her and tomorrow you buy two and the next time you buy more, if you send her anywhere, she will not refuse. So a man should be persuaded. (Lovemore, male FGD 10)

> One – what normally happens is that they are not used to it yet. Two – they wouldn't have been explained to fully. He was just told, 'Use this condom'. He will refuse. If it is explained fully, he will use. (Michael, male FGD 8)

Further, men and women commonly expressed the preference that male partners should be given health education and information about HIV-prevention methods and clinical trials at the beginning of the study, and directly from research staff, rather than hearing information through their wife.

Importantly, many women also stressed the importance of maintaining respect for men's dignity when introducing HIV-prevention/study products and not usurping his traditional role as the head of the household. As vividly described below, one woman stated how to negotiate condom use by being 'cool' (calm) and not to be too assertive or threatening (like a man in trousers):

> Continuing teaching him is good because these men are like children. That's what I realised. They don't understand sometimes but you have to keep cool [rather] than to put on trousers as well. Keep cool and tell him that, look my friend how life is, look what's happening so it's important to keep ourselves safe so that we can stay together. If you do that he would understand. There are some men who are difficult. … If you are harsh and say, 'If you continue like that I [will] go home to my parents' … for sure he would be angry as well or you can be beaten. (Rumbi, female FGD 1)

Indeed, women engaged in spirited conversations during FGDs about how to negotiate condom use, in some cases attributing much of the responsibility for male unwillingness to use condoms to the inadequacy of their own negotiation techniques or approach. Both men and women's traditional gender roles are echoed in the following descriptions, where women describe the importance of taking care of and catering to their male partner and respecting his 'position' in the household:

> If we take good care of our husbands, they would agree to continue using condoms. But if we show to be arguing with them and being harsh, they end up refusing saying they think that it's us women who would be unfaithful, having sex with other men.

> I just want to say that what has been said that we should take good care of our husbands is good. Our husbands want to be loved more than what we do to our child … I should love him. Everything he wants should be done at that time. We should give them their place like the men. This is what I see would not make us argue with our partners about condoms. Because if I don't give him his place, he can also refuse to use condoms so we should do good things.
>
> I think it's me, the woman, who chooses, but he would agree to use the condom because I would have explained. The way I talk, the approach to the men, if you are able to explain to him, he would agree to use it. (Veronica, Tsitsi, Olivia, respectively, female FGD 5)

Negotiation of diaphragm and gel use was described in different terms than condom negotiation, for several reasons. Firstly, women did not have to convince their partners to put something on themselves. Secondly, because diaphragms and gel are not widely known or used, for contraceptive purposes or otherwise, there were not as many preconceptions about the implications of using them (i.e., disease stigma, promiscuity). Most women's descriptions regarding negotiation of diaphragm and gel use involved explaining what the study was about and how the products worked. As described earlier, several women showed the informed consent document and the product insertion instructions to their partners to help explain the process. Some women demonstrated the insertion in front of their husbands, while others inserted the products, had sex and then removed the device afterwards in front of him to first demonstrate that the products did not alter sex:

> I would say that I did not have any difficulties in my use. I used it secretly at first as I hid it from my husband. He did not even know that I had done that. One day when we were all very happy, I removed it when he was present. 'What is that?' and I told him saying, 'how come you did not feel that I had something inside me? So it's the same.' He showed interest in it, even to today he likes it. So I did not have any difficulties. (Loveness, female FGD 7)

Discreet product use

The female-initiated products in this study could theoretically be used covertly or discreetly without the express permission or knowledge of a male partner. This would obviate the need for permission-seeking from, or negotiation with, the male partner. However, most women in FGDs did not advocate discreet use and, although they spoke of circumstances where it would be useful or warranted, they generally expressed an appreciation for transparency. If the husband accepted the diaphragm and gel completely – if they reached an agreement – there was no need for covert use. That said, some women described how they used the diaphragm and gel secretly when their husbands refused to use the diaphragm, either on occasion or all the time:

> Like what I said before your husband will be refusing to use all the products so you use it without him knowing.
>
> Yes I had that problem, I used it without his knowledge and he wouldn't know that I had a diaphragm and gel he did not know what I was doing. (Tarisai, Angela, respectively, female FGD 1)

In FGDs with men, facilitators asked men what their impressions would be if they discovered their wives were using the diaphragm and gel secretly. Similar to their reactions of women joining an HIV-prevention study without permission, a common response among men was that discreet was 'impossible'. This could have multiple meanings including impossibility because he would physically feel the products or impossibility because it would be culturally unacceptable for a wife to use without his knowledge. One respondent suggested that perhaps it would be possible in some partnerships, but not with one's 'real wife'.

> No, that is impossible. If she does that, she is a thief [laughter]. (Man D, FGD 9)
>
> It won't happen with your real wife. (Edmore, male FGD 3)

The concepts of being a 'thief' correlate with men's interpretations of what discreet use might imply, for example a lack of trust in the relationship, problems at home or beliefs that there is 'something she has [meaning disease]' or that there is something she is 'indulging in' [promiscuity], as described in the following discussion:

> You might just think that there is a reason why she is using it.
>
> I would think that there is something that she has. … That would have made her use without informing me. Because it is the same as me if you see me, the father [male partner], wearing the condom. [They all laugh.] We have never used condoms ourselves so it is a problem there now.
>
> One can actually be sent back to their home [to divorce the wife]. … We think that maybe my woman there is something that that she is doing or she is being unfaithful or she has suspicions on me. So it's a bit difficult. (Patrick, Jabu, Sizemore, respectively, male FGD 6)

However, male respondents in FGDs also offered possible explanations or understanding as to why women might use diaphragms and gel discreetly. For example, one FGD respondent said he knows some men get angry and refuse to allow such things, and beat women if they present something new, so that is why women might use secretly:

> She will be protecting herself because she knows the ways of her husband. So she will be afraid that, 'if I tell my husband, I have shot the lion's leg. Let me keep quiet'. (Franklin, male FGD 10)

Other male respondents downplayed the importance of disclosing use and in their partnerships seemed to feel there were 'innocent' explanations, or explanations not warranting anger or suspicion. Some men explained that their wives were shy to tell them (at first) or wanted to test him to see if he noticed a difference. Another man explained that his wife did not tell him at first because she was afraid he would then not use condoms.

Discussion

This analysis describes how men and women participating in the MIRA study view gender roles and sexual decision-making in regards to HIV-prevention method use in modern-day Zimbabwe. In as much as HIV may be exacerbated by gender imbalances, the virus also presents a challenge to pre-existing gender roles, in many ways. HIV/AIDS-related morbidity and mortality alter household dynamics and therefore the socio-cultural foundation on which gender norms are rooted. Knowledge of one's status, HIV testing, disclosure of results and discussion of prevention methods introduce complex issues of trust, stigma, risk and loyalty into relationships. Indeed, a nuanced understanding of how couples negotiate gender roles and sexual decision-making emerged. These occur in the context of a generalised HIV epidemic and its accompanying culture of research studies – prevention and treatment programs and health education messaging. The findings offer important insight into the use of FIM in this context and underscore the importance of addressing male partners and couples when offering HIV-prevention methods to women. Although this was a research setting, these findings may also have relevance to program implementation.

Primary data from all four couples regarding perceptions of male and female gender roles were consistent, and suggested a strong cultural stereotype of men as the 'provider' of food, shelter and clothing for his family and women as 'the nurturer' who takes care of the cooking, cleaning and domestic duties. Couples suggested that traditional gender roles were now changing in response to increased educational and economic opportunity for women. However, this was not necessarily viewed as a positive trend. Two of the four

couples spontaneously mentioned the phenomenon of female domestic workers taking over traditional female duties. Thus, while there may be a shift in gender roles for the (original) wife, generally another woman with less education and opportunity is brought into the household, suggesting that traditional roles are not so much re-defined, as being re-delegated. Indeed, narratives describing the domestic workers as becoming 'second wives' harkens back to Zimbabwe's polygamous heritage. While other studies in Zimbabwe have not explored gender roles and shifts so directly, several have reported findings framed within the context of gender power inequities and hegemonic notions of masculinity (Hindin 2000, 2003; Skovdal et al. 2011).

Thus, despite men and women's comments that gender roles are changing somewhat in response to changes in economic opportunity, both genders concurred that it was important for women to disclose study participation to the male partner, and perceptions of the meanings of non-disclosure were similarly defined by the sexes as leading to suspicions of infidelity and generating anger. For several participants, particularly men, disclosure of study participation was described in terms of granting 'permission', suggesting that the male partners have decision-making authority over their female partners' actions. Further, expressions of hypothetical or experienced anger about joining a study without 'permission' suggest that men may psychologically interpret this behaviour as a personal offense. Indeed, as depicted in our conceptual framework, the HIV-prevention trial (for women) is nested within a household and external context that is male-dominated, and it stands to reason that the approval and/or involvement of male partners would be important. Additionally, as highlighted by these data, and discussed by other authors (Campbell 1995), male partners may prefer to receive information about a study directly from research teams rather than through their female partners. This may be preferable to female study participants as well. At least two large research networks, the Microbicide Trial Network (MTN) and the International Partnership for Microbicides (IPM), as well as other smaller study teams, have acknowledged the cultural importance of men in many African settings and have staff dedicated to community engagement, which includes outreach to male partners and men in the community. That said, clinical trials are generally expensive and complex, and taking on the task of involving male partners or couples would add considerable additional effort and financial commitment that may not be feasible for investigators and research teams. Nonetheless, the investment may be worth it: the Partners PrEP study of oral pre-exposure prophylaxis, for example, recently reported early effectiveness of Truvada among serodiscordant couples in East Africa (International Clinical Research Center 2011). The counselling and study engagement experienced by both couple members, as well as the inherent support for product adherence afforded by enrolment of the couple, likely played a substantial part in the trial's success.

These data also suggested that men continue to play an important role in the decision to use HIV-prevention products, including those that are female-initiated. Indeed, in the MIRA parent trial and other trials in this setting, intentional secret use of products was rare (Kang et al. 2007; Pool, Whitworth et al. 2000). More than 95% of the women participating in MIRA in Zimbabwe (96% of whom were married) disclosed study participation to their male partners. In these qualitative data, discreet or covert use of products was not overtly endorsed, although many men and women acknowledged and condoned circumstances where disclosure of product use might be intentionally or unintentionally obscured. Despite this, women also described clever and nuanced methods to present prevention products, or negotiate their use, in such a way that their partners would more likely be supportive. Taken collectively, women described an understanding of the importance of being respectful, tactful and perhaps even subservient to men so as to

get what they wanted. In this way, the status quo is preserved and men's traditional gender-defined role as the 'decision-maker' and 'head of the household' is not challenged. At the same time, women's persuasive agency to achieve her method-use agenda is also achieved. A formative research study that explored partnership dynamics in relation to acceptability and use of a placebo gel (used for four weeks) amongst 45 couples in east and southern Africa reported a similar interplay among couples around permission-seeking and granting, product use negotiation and trust, concluding that, in the end, use is most often a joint decision between the male and female partner (Montgomery 2008).

Additionally, discussions of 'decision-making' in this study revealed that there were different dimensions and interpretations of this concept. In general, the data suggested that decision-making incorporated both a decision to introduce prevention methods into a relationship, which was more often ascribed to women, as well as a decision to use them, which was ascribed either to both members of the dyad or to men. Again the nuances offer potentially important insight into the dynamics between male and female partners when presented with new information or products. In future research it may be helpful to address these decision-making distinctions when discussing product use strategies in counselling with women or couples.

There at several limitations to this study. The first is the selection bias, as the women, men and couples who agreed to participate, and were available to come at the scheduled time in the case of group discussions, may have been different from the rest of the clinical trial population from which the women were recruited and the general population. For example, female focus group respondents may have differed from other study participants in ways related to their experience in the trial (i.e., women who were unhappy with their research experience may have declined further contact) or participating male partners may have been different from other male partners in important ways (i.e., more supportive, self-employed). The study faced challenges recruiting couples, particularly those in which the male partner had not previously come to the clinic. Thus these data are biased in that the majority (3 of 4) of couples contained a male partner who had come to the study clinic. Secondly, this study relied on interpretation of qualitative data and it is recognised that there are several important biases with focus group and in-depth interview data. The samples (as discussed above) are small and selective and (in focus groups) respondents are answering questions in a group environment. Focus groups may be dominated by a small number of talkative participants and thus data are even further biased by unequal representation of viewpoints within one group. Thus, responses are socially conditioned and, while they can provide useful information about group norms or beliefs (or socially desirable expressions of such norms and beliefs), they may not be accurate representations of individual behaviour or action.

The data here underscore the important role that men play in both the external socio-cultural context as well as the proximate context of the HIV-prevention trial and the female-initiated study-products it introduced. On the surface, these findings are consistent with much of the historical and ethnographic evidence of male dominance and gender imbalances in heterosexual relationships in Zimbabwe. However, this conclusion is not meant to suggest that these Zimbabwean women should be categorised as disempowered or 'vulnerable' – a paradigm that is frequently over-emphasised in regards to HIV in this setting (Higgins, Hoffman, and Dworkin 2010) and is an over-simplification of relationship dynamics. Rather, these qualitative data provide descriptions of how couples have adapted techniques for negotiating modern household economies and sexual decision-making in a manner that both preserves traditional gender roles – notably men's decision-making power – while accommodating women's entrance into new domains,

for example the workforce or an HIV-prevention trial and her agency to introduce and use novel FIM within the intimacy of the couples sexual domain.

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Résumé

Les rôles et les inégalités de genre contribuent considérablement au poids excessif du VIH que portent les femmes en Afrique sub-saharienne. Dans le contexte d'une recherche sur la prévention du VIH, nous avons voulu décrire et comprendre l'influence des partenaires masculins sur l'usage des nouveaux outils de prévention du VIH parmi les femmes. Nous ne partions pas du principe que les normes de genre rétrogrades étaient prédominantes – mais plutôt qu'une grande diversité d'attitudes et de dynamiques déterminées par le genre s'exprimerait parmi les couples. Les données provenant de seize groupes de discussion thématique auxquels avaient pris part des zimbabwéennes qui participaient à la recherche, ainsi que leurs partenaires masculins, et de quatre entretiens en profondeur conduits avec des couples, ont été collectées pour constituer la base de cette analyse. Les

résultats décrivent comment les couples ont adapté des techniques de négociation des économies dans les foyers modernes et autour de la prise de décision sexuelle, pour préserver les rôles de genre traditionnels, tout en prenant en compte l'entrée des femmes dans de nouveaux domaines, comme le marché du travail ou une recherche sur le VIH. La capacité des femmes à introduire de nouveaux outils de prévention choisis à leur seule initiative dans leurs relations intimes est décrite. Les récits des hommes et des femmes sur l'introduction et l'usage de ces outils laissent entrevoir différentes perceptions sur la compétence en matière de prise de décision sexuelle. L'étude offre un aperçu unique du contexte déterminé par le genre qui est dynamique – néanmoins perméable au changement – et qui peut en retour apporter des informations utiles pour guider l'élaboration d'activités de prévention mieux adaptées à cet environnement.

Resumen

Los roles de los diferentes sexos y las desigualdades entre hombres y mujeres son factores importantes que contribuyen a la carga desproporcionada del virus del sida entre mujeres del África subsahariana. En el contexto de un ensayo para prevenir el VIH, nuestro objetivo fue describir y entender cómo influyen las parejas masculinas en las mujeres cuando ellas utilizan métodos para prevenir el VIH. Nosotros no suponíamos que prevalecieran las normas regresivas relativas a los diferentes sexos, sino más bien que las parejas expresarían un gran variedad de actitudes y dinámicas con respecto a las diferencias entre los sexos. Para este análisis se recabaron datos a partir de dieciséis charlas en grupo con mujeres de Zimbabue y sus parejas masculinas, y de cuatro entrevistas exhaustivas con parejas. Los resultados ofrecen descripciones sobre el modo en que las parejas han adaptado técnicas para negociar las economías en hogares modernos y para tomar decisiones con respecto a las relaciones sexuales de modo que se puedan mantener los roles tradicionales de los diferentes sexos a la vez que se adapta a la entrada de las mujeres en nuevos dominios, tales como la fuerza laboral o un ensayo para la prevención del VIH. Describimos la capacidad de acción de las mujeres para introducir nuevos métodos iniciados por las mujeres en sus relaciones íntimas. Los relatos de los hombres y las mujeres sobre la introducción y el uso de métodos indican diferentes percepciones sobre el punto de enfoque en la toma de decisiones en material sexual. El estudio ofrece una perspectiva única en el contexto de ambos sexos que es dinámico pero a la vez sensible a cambios, lo que a su vez puede aportar información útil a una guía más apropiada para las iniciativas en la prevención del VIH en este entorno.