

Poverty and Devastation of Intimate Relations: Tanzanian Women's Experience of Living With HIV/AIDS

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In Tanzania, women of reproductive age constitute the largest group infected by HIV. This study aimed to explore the lived experiences related to health and sexuality of Tanzanian women who had known their positive serostatus for 1 year. In-depth interviews with 10 women were analyzed using a phenomenological-hermeneutic approach and showed frustration and despair at not having resources to maintain daily life. The women needed regular medical treatment for themselves and for their HIV-positive children. Their sexual desires had declined or vanished, and they had come to view sexuality as a source of transmittable disease. For some women, casual sex was an option to solve urgent financial needs. Happiness was something for their children, not for them. Access to social support from the women's community would help prevent further HIV transmission and enhance survival so the children could grow up with at least one devoted parent.

Key words: health, HIV, sexuality, women, qualitative method, Tanzania

The socioeconomic inequalities and dependency imposed on women and their sexual subordination to men are two major reasons for women's rising rates of infection with HIV in sub-Saharan Africa (Mella, 2003). The prevalence of HIV infection in Tanzania is about 7%, and 56% of those infected are women between 15 and 49 years (UNAIDS, 2005). The most

vulnerable are young women between 15 and 24 years, who are about three times more likely to be infected than are young men in the same age group (Hargreaves & Glynn, 2002; Shelton, Cassell, & Adetunji, 2005; UNAIDS, 2004). One reason given for the high prevalence of HIV in both sexes is the custom of concurrent sexual partnerships—relationships that overlap in time—by which HIV can be transmitted more rapidly through a population than sequential monogamy (Halperin & Epstein, 2004).

A report from the Population Reference Bureau (PRB) (2004) describes women as less knowledgeable about AIDS than men and rural women as less

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knowledgeable than urban women. Only 4 in 10 adults in Tanzania were reported to believe they were at risk for contracting the disease. The main reason mentioned among women who believed they were at risk was that their partners had sex with other partners. Men who believed themselves to be at risk for HIV said they had sex without using a condom. The median age for women making their sexual debut is 16 to 17 years (PRB, 2004). By age 20, the majority of women (85%) had had sexual intercourse, and 67% were already married. (Tanzania Commission for AIDS, National Bureau of Statistics, & ORC Marco, 2005).

Several Tanzanian studies report that the transition from childhood to womanhood is a risky journey, especially because the marriage age has increased, which may lead to more adolescent sex. Girls in secondary school, far from home with little social support from their families and a wish to live a "modern" lifestyle, have an increased risk of being sexually exploited. (Chambua, Rwebangira, Liljestrom, & Urassa, 1994; Mgalla, Schapink, & Ties Boerma, 1998). "Modern life" for women in Tanzania is earning their own money, living more independently, and abandoning the moral rules of their society, for example, choosing to have premarital sex (Dilger, 2003; Haram, 2005). Women who have adopted a modern lifestyle are easily blamed for the cause and spread of HIV. This belief is not unique to Tanzania but is widespread in Africa (Bunting, 1996; Lawless, Kippax, & Crawford, 1996; Petros, Airhihenbuwa, Simbayi, Ramlagan, & Brown, 2006; Stalker, 2003).

Female sexuality is seen as dangerous, causing pollution and even death (Haram, 2001). The modern woman is often a single mother living in town, supporting herself and her children through a small business. She might from time to time cohabit with a man who has a family somewhere else. Through the exchange of services such as social and economic security for sex, she is freer than a married woman to negotiate with the man. She pursues her sexual, emotional, and economic wants, but the price is increased danger of being infected with HIV (Haram, 2004). Many African countries have moved from a peasant society to a more modern industrial one; this transition of traditions accelerated after independence from colonial rule. Such cultural change must be consid-

ered in understanding how HIV is spread. There is little information in the literature about social and cultural influences on Tanzanian women's experiences of living with HIV.

The aim of the present study was to explore the experience of Tanzanian women living with HIV to get a deeper understanding of their way of thinking and reflecting upon their health and sexuality.

Method

This study used a phenomenological-hermeneutic design, a qualitative methodology to interpret and better understand the experience of women living with HIV (Bergum, 1991). The research process is an interactive descriptive and explorative process based on the philosophy of Gadamer, who stated that coming to an understanding involves mediation, integration, and assimilation (Weinsheimer & Gadamer, 1985). The method is used to grasp meaning of lived experience by interpreting narrative interviews transcribed as a text (Lindseth & Norberg, 2004).

Study Setting and Procedures

The study was performed in Dar es Salaam, Tanzania, during January and February 2004. Three study settings were chosen. One was an outpatient department in a government district hospital. The second was a clinic run by a nongovernmental organization (NGO). The NGO clinic was located about 2 km from the government hospital in a residential area mainly for industrial workers. The third study setting was an NGO clinic located in the center of town in a busy commercial area with a mixed population of ethnic groups. Each of the study settings provided HIV counseling by specially trained HIV counselors. According to the Tanzanian national policy for voluntary HIV testing, a person being tested receives a precounseling session, and if HIV status is positive, the person is registered and referred to special clinics for continued HIV counseling.

Participants

The women attending the selected study settings during the study days who fulfilled the inclusion

criteria (positive HIV serostatus for more than 1 year and able to read and write in Kiswahili) were informed about the aim of the study by the HIV counselors. Those who agreed to participate were given a written and verbal explanation of the study before signing the consent form. All participants were informed that they could withdraw from the study at any time without risking loss of services. The women were also assured that participation in the study would have no consequences with regard to their future health care. In total, 10 women aged 28 to 45 years were invited and volunteered to participate. Their level of education varied from 4 to 11 years; 7 were Christian and 3 Muslim; 1 woman was married, 1 was single, 4 were widowed, 3 were divorced, and 1 was cohabiting. All except 1 had children; 4 of the women had children who were also HIV-positive. A total of 3 women had given birth to a child before marriage; these children were cared for by grandparents.

Interviews

In-depth interviewing was the chosen method for data collection. All interviews took place in private in the HIV counselors' rooms in the respective study setting. A female member of the faculty of nursing at Muhimbili University College of Health Sciences in Dar es Salaam trained in phenomenological-hermeneutic method conducted the interviews. Before the study took place, the interview guide was tested for its comprehensibility of the questions with help from one colleague. Only some of the question probes needed clarification. The interview process was based on the following principles: First, all interviews took place in privacy in the HIV counselors' rooms in the respective study setting. Second, all participants were interviewed by the same interviewer with the assistance of the first author (G.B.), who has lived and worked for many years in Tanzania. This assistance involved handling the tape recorder and taking field notes. Third, the in-depth interviews were conducted in Kiswahili. Fourth, the participants were asked to speak freely about the following questions:

- Can you tell me about how you perceive your health?

- Can you tell me about your sex life before and after you knew you were HIV-positive?

For each topic, additional question probes were added when the interviewer wanted participants to develop their stories or if a participant did not understand the question, failed to express herself, or seemed embarrassed. One example of an additional question probe is, "Did you or do you have a satisfactory sexual life?" The women talked with ease about themselves and their life situation, so few probing questions were needed. Each interview lasted about 60 minutes and was tape recorded. During the interview, the first author made nonverbal observations that were written down as field notes. Demographic information collected from the interviewees was age, education level, religion, and civil status.

Data Analysis

The recorded interviews were transcribed verbatim. The interviewer thereafter translated the text from Kiswahili into English. The second author (R.L.) later listened to the tapes, read the transcripts, and checked the translation for correctness and to ensure that none of its content had been omitted in the English version.

The text analysis started with a reading of the texts, and the authors' preunderstanding related to the topic of study was discussed within the research team. The transcribed interview text was then analyzed phase by phase using a phenomenological-hermeneutic method based on Ricoeur's theory of text interpretation (1976), further developed by Lindseth and Norberg (2004). The textual analysis involved three phases, described in the following paragraphs.

In the first phase, the first interview text was read through (naive reading) to grasp a sense of the whole and to gain ideas for further analyses. The first author performed the naive reading and discussed the result with all authors. The naive reading is presented in the Results and Interpretations section.

The second phase, the structural analysis, was performed with the aim of identifying parts and patterns that had meaningful consistency and an explanation of the text including validation of the naive

Table 1. Themes and Subthemes Outlining the Comprehensive Understanding of Women's Experiences Living With HIV and Consequences for Health and Sex Life

Theme	Subthemes
Unawareness or denial of being at risk of infection	• The necessity of being tested because of sickness/death of husband/partner
Health and wellness requiring financial resources	• HIV testing as an offer/demand from health service/employer
	• "Health" meaning being able to maintain basic needs
	• Bodily demands and medication
	• Being accustomed to the virus apart from distress because of reduced income
	• Wishes and thoughts about the future
	• Children give meaning to life and contribute to health
Intimate relationship no longer being a reality	• Talking about sex meaning "speaking openly"
	• Sex meaning love but endangering health
	• Loss of sex life and sexual satisfaction
	• "A woman who cares" being faithful or sexually abstinent

reading. During this phase, the transcripts were analyzed for subthemes that were assembled into themes by comparing and contrasting the emerging themes. These themes and subthemes are presented in Table 1. The first and second author conducted this phase together.

The third phase was a critical in-depth interpretation of the text as a whole, in which the naive understanding and results of the structural analysis, the literature, and the researchers' preunderstanding were brought together in a comprehensive understanding. All four authors participated in the third interpretation.

Ethical Approval

Ethical approval was obtained from the ethical committees of the National Institute for Medical Research, Dar es Salaam; the Tanzania Commission for Science and Technology; and the Karolinska Institute, Stockholm.

Results and Interpretations

Naive Reading

The in-depth interviews with the women indicated strong determination to go on with their life. Despite the loss of husband, secure income, and a normal life, as well as the smaller possibility of remarrying or having another partner, the women were living pri-

marily for their children and other family members. Sexuality had a lower priority in their lives; some participants reported that all sexual desire had vanished, or they strongly denied having sexual feelings. The women reported deep frustration at being alone and not having enough resources to support their children; this was their deepest concern and worry. The stories told by the various women had similarities in content and meaning.

Structural Analysis

The structural analysis of the data revealed the following three interrelated themes regarding the women's experiences living with HIV and influences the disease had on their health and sexuality: (a) unawareness or denial of being at risk of infection, (b) health and wellness requiring financial resources, (c) intimate relationships no longer being a reality. Table 1 summarizes the three themes and respective subthemes of the analysis.

Theme 1: Unawareness or denial of being at risk of infection. The women's narratives of how they came to know of being HIV-infected led to two subthemes.

Subtheme 1: A necessity to be tested because of sickness/death of husband/partner. The frequent illness and, later, death of a husband made relatives and friends suspicious about what could have caused the

husband's death. Rumors were spread that one woman's husband had died of AIDS, and she was urged to be tested.

Another woman's partner felt weak, decided to be tested, and was found to have seropositive status. He immediately informed the woman and told her to go for a test, which showed that she was also infected. The couple decided not to marry, but both joined an organization for people living with HIV/AIDS.

One of the women went for health examinations because of her husband's sickness; her story is as follows:

I knew that I was infected after my husband, who was infected. He used to be sick frequently. I asked him why he had fever. He had no answer. I advised him to go for a test. He refused. Later, he went alone without my knowledge. He found that he was HIV-positive. He did not tell me the result. He started visiting WAMATA [Walio Katika Mapambano na AIDS Tanzania, or People in the Fight Against AIDS in Tanzania; WAMATA was founded in 1989].

This woman had been contacted by a counselor from one of the organizations for people living with HIV/AIDS, who informed her of her husband's serostatus.

Subtheme 2: HIV testing as an offer/demand from the health service/employer. One woman's story did not involve family matters. She was studying evangelism at a church, and the administrator demanded that she go for an HIV test before she could do any work for the church, because it was not recommended that one preach without knowing one's serostatus. She was found to be seropositive. The woman finished her story by saying, "I then just left for home."

In 1995, Temeke hospital in Dar es Salaam started a program to prevent HIV transmission from mother to child during pregnancy. During a visit to an antenatal clinic, one of the participants was offered the opportunity to join a research program. She had some knowledge about how to prevent her unborn child from being infected. She accepted the offer, was

tested, and the results showed that she was HIV-positive.

A probing question was how the information of being seropositive was presented to them. One of the women did not believe the results given because she felt healthy. Some women revealed nothing about how they felt.

Theme 2: Health and wellness requiring financial resources. The second theme focused on how the women experienced their health and what health meant when living with HIV. Five subthemes were identified.

Subtheme 1: "Health" means being able to maintain basic needs. The first reflections about the women's health addressed social and economic matters. To be able to maintain health, it was important to think about what health could mean. One of the women described her situation as follows: "It is painful, even my business is now shaky . . . I have nothing that can help me to live comfortably, although at the moment I don't have any health problems."

The women said that to improve health they needed to eat a well-balanced diet that contained all nutrients. The women's thoughts and concerns about their health had a direct connection with their bodies harboring the virus. One woman's thoughts about health were as follows:

I am thinking about nutritious food; this helps me especially when I am seriously sick, because I get sick frequently, it is so hard to get money for food and medicine . . . I always think about getting money for taking my child to school. I know there is no treatment for AIDS, so once I die, my child will suffer the consequences.

For all of the women, health meant having a body free from the disease, negative blood tests, and all required nutrients. A good environment, such as clean surroundings, was also important, especially to prevent other diseases. Access to health services when the women felt sick was also an indicator of what health ought to be.

Subtheme 2: Bodily demands and medications.

At the time of the interview, all participants felt well except for one who had recently been treated for fever. The women spoke frankly about their bodily changes, which were weight loss, skin rashes, numbness of feet, and frequent fever. None of the women used medications apart from various skin ointments and traditional medicine. Locally made drugs and Chinese traditional medicines were popular and were taken for various symptoms. The women said that they sometimes had to prepare their own ointments to treat skin problems because of inadequate money to buy them from a pharmacy. One woman received pharmaceutical treatment for tuberculosis, but none of the women had access to antiretroviral drugs. One of the women had decided to live alone and not involve herself in "intimate matters" any more, which she believed had helped to improve her health. Strikingly, all the women expressed their frustration at not having enough resources to maintain their health. One woman said, "Apart from the word of God, I have nothing." Another woman mentioned that to be able to improve her health, she had to follow instructions and principles on how to live with the virus. The principles she named were, "If a woman is not married, she should not practice sex often, and she should be advised to use condoms." She believed that to have a good diet and avoid muscular activities was also important.

Of 10 women, 8 said that they no longer had the need to feel attractive and regarded grooming as only a matter of their own well-being or hygiene; for example, to feel good or get rid of skin rashes. One woman believed she was missing something and said, "I am not feeling well because I miss love in the house." She was describing needing to feel attractive to someone. She was not talking about sexual intercourse; instead, she was describing loneliness and the lack of intimacy and closeness with another person.

Being troubled or in agony could sometimes be overwhelming, and as one woman said, "I am not satisfied with my looks. . . because I don't understand being satisfied, I am not OK. I have changed. I am weak and even my thoughts are different from those of early times."

Subtheme 3: Being accustomed to the virus apart from distress because of reduced income. The women were accustomed to living with the virus. They had no fear about their own situation but expressed great sorrow if their child was affected by the virus. Most of the women had lived with the virus for some time and expressed no shame even if others disapproved of them. Generally, they believed it was easy to be open about being HIV-positive. A belief stated in all of the women's stories and conversations, as expressed by one woman, was the following:

I have become accustomed to the situation. Nevertheless, what weakens us; I don't have any income to sustain my life As long as I live, I get more experienced And even those who are not infected by the virus, they will also die.

Some of the women expressed deep sadness during the interview and spoke with low and whispering voices, although they said they had accepted living with the virus. Depression was explained as being caused by joblessness, financial problems, discrimination, missing love, and living with a lifelong disease without any possible treatment. As one woman explained, "Life is tough. At the beginning I was married and I was employed; at present I am jobless and divorced in a strange land. Even my rights to that man have been difficult to get." The woman was in legal proceedings with her former husband to claim her shared property.

Another woman expressed her frustration as follows:

Yes, my husband is dead and has left me alone with two children, one being uninfected. Therefore, sometimes the infected kid is sick and I do not have money to buy medicine. Sometimes I don't get money to buy food.

Subtheme 4: Wishes and thoughts about the future. The women's wishes for the future were nonexistent, modest, or grandiose, from having her own room to a cure for HIV/AIDS for all people in the nation. Others wished for employment, good health services for HIV-affected people, or assurance

about basic needs for widows and orphans. They wished that families of the deceased would recognize the woman left behind without any kind of discrimination or embarrassment.

One woman said, "I want to start my own business, to have employment and my own house so my children can be comfortable, not like me." She hoped that her son would be employed or be able to assist her with her business. She saved money for her son's future and believed that he lived on hopes. "If God wishes, I am planning to do business with my children until the day I am taken by God."

Subtheme 5: Children give meaning to life and contribute to health. Those women with young children believed that life was important and that there was meaning in living as long as possible to see their children grow up. They asserted that life is important because their presence enabled the relatives who were willing to do so to help the child: "If I die, such help will be very little."

The women hoped that relatives would take care of their children when they could not. One woman stated that, "As a human being I am supposed to live on earth. I regard life as important to me, because my presence is a help to my relatives."

Theme 3: Intimate relationships no longer being a reality. When the women were asked about what sexuality meant to them, the four subthemes described as follows emerged.

Subtheme 1: Talking about sex meaning "speaking openly." The participants used the phrase speaking openly when they talked about sex, and conversations about sex could start by asking, "Do you speak openly?" or "Are you open about sex?" which was an indirect question implying, "Can we talk about sex?" All of the women talked in group sessions and believed this was satisfactory.

However, talking about sexuality was not a custom for any of the women, except for a few who talked to young children about HIV/AIDS, telling them how to protect themselves from infection. The content of such discussions did not include moral issues such as waiting to have sex until marriage. One woman expressed that she had only talked about sex with her husband and no one else, but after

learning she was infected with HIV, she had taken the initiative to talk to youths of various ages.

"I try to tell them the realities about AIDS. . .that it is here and has no cure, and I speak openly."

Those women who did not talk about sex said it was because of a lack of interest in the topic. One woman said, "Love affairs in general are out of my mind."

Subtheme 2: Sex meaning love but endangering health. When the subject turned into what sexuality meant for the women, it was as if all the women spoke simultaneously. They expressed similar thoughts about intimacy and love and sex being conditions expressing the relationship between a man and a woman. What had changed most in the women's view about sexuality was its danger of affecting health. One woman said, "I understand that sex is no good. I can easily infect other people. Secondly, sex can endanger my life, and I can die before my days as it makes my body tired."

The women said that too much sex was not good because of its great convincing power, and it could lead to falling in love. Sex was perceived by the women as the causative agent for AIDS, and sexuality was the source of transmittable diseases. The women said that it was best not to participate in sexual behavior at all, and one believed that it was a mistake from the beginning to be involved in a sexual relationship. She regretted that she had trusted a man just because he looked healthy, when he was in fact sick and did not take the precaution of using a condom. One woman took a firm stand against sex, saying that she was prepared to "beat a man with an iron bar" if he dared to suggest it.

Subtheme 3: Loss of sex life and sexual satisfaction. A sex life was no longer part of daily activities for the participants being interviewed. Abstaining from sex had become the rule, at least for those women living alone or without a sexual partner. Even for the women who still had a sex life, sessions with their partners had become rarer. One woman stated that she had abstained from sex because she was afraid to find herself in a love relationship in which it would be impossible to abstain. Some women abstained from sexual intercourse because of poor health; they believed caring

about one's health was more important than being involved in "dangerous things." Before knowing about their seropositive status, all had lived in a sexual relationship and regarded themselves as having a normal and natural sex life.

The women who declared abstinence were unhappy about it. They had been taught that sex strengthens the virus and causes tiredness. For those women who were not married, sex was a sin and risky, because the partner could also be HIV-infected. Some of the women adhered to the role they had been taught, and others who still lived with a partner did not enjoy their sex life for various reasons, for example, because of problems reaching orgasm or a lack of attention from the partner. One woman explained as follows:

Some men do not know what to do to satisfy their partner; they do consider themselves, but once they have ejaculated, they don't have any time to think of whether their partner is satisfied. Sometimes they are driven by alcohol so they might force sex; to make peace, you have to accept at that juncture you find that you have satisfied him while you yourself are not satisfied.

All of the women had experienced decline of their sexual satisfaction compared with before knowing their HIV serostatus. They believed that their sexual feelings had declined and their interest in sex was gone; sex did not matter any more. Still, one woman said with sadness in her voice that she was missing love.

Subtheme 4: "A woman who cares" being faithful or sexually abstinent. The women believed that to go outside marriage to find a partner meant not to care; "a woman who cares" stays with her husband. The women knew that without care, the virus could increase and cause trouble, such as more frequent periods of illness. One woman stated that she had cared, because after her husband's death she stopped having sexual intercourse. The women described that the caregiver also needs to be counseled, educated, and cared for with regard to his or her health by abstaining from sex.

According to the women, caring and showing love might also mean protecting oneself during intercourse by using a condom. None of the married women said they had done so because they had lived with one husband and had been faithful to him, and in doing so had shown that they cared. To demand that the husband use a condom would have been difficult or impossible, because it would suggest suspicion of unfaithfulness.

Just 2 of the women believed they had not cared. One said that she had wanted sex to such a great extent that she had misused her body. She explained, "I was so rough during sex I could run over the needs of my body. I saw sex as a very important practice that I could not miss." The other woman said she had agreed to sex only because she wanted money.

Comprehensive Understanding and Discussion

The third phase of the analysis was a critical in-depth interpretation of the text as a whole, whereby the naive understanding and results of the structural analysis, field notes, literature, and the researchers' preunderstandings have been brought together in a comprehensive understanding.

Theme 1: Unawareness or denial of being at risk of infection. The women's narratives showed indifference to being infected with the virus. None of them expressed worry or anxiety before testing for HIV. Instead, they had to be told by relatives or neighbors to be tested after their husbands had died. Some women were offered testing at an antenatal clinic; none had taken the initiative to be tested. In a study from northern Tanzania, half of a group (125) of pregnant women who were offered prevention measures for maternal-to-child transmission did not want to be tested for HIV. The study also reported that women with a partner who had a recent history of sexually transmitted disease or who had had another sex partner in the past year did not easily accept HIV testing (Urassa, Gosling, Pool, & Reyburn, 2005). Another study in the same area indicated that women's acceptance of voluntary counseling and testing seemed to depend upon the benefits testing would give, primarily for their unborn child. Feeding strategies to prevent the baby from being infected (termed *vertical transmission*) could be one

of the benefits women receive to encourage agreement to be tested (de Paoli, Manongi, & Klepp, 2004). At an antenatal setting in Dar es Salaam, higher socioeconomic status was also associated with increased rejection of testing (Westheimer et al., 2004).

The studies mentioned report women's reluctance to voluntary testing. If the chances of testing seropositive are high, the acceptance of testing seems to be low.

In the present study, the women reported that they had poor knowledge about their husband's or partners' serostatus, and their reluctance to be tested could have been fear of facing their own seropositive result and all of the consequences. Fearing accusations of adultery and, still worse, being left alone with limited recourses to support themselves and the children, could be a reason for denying the risk of infection.

Theme 2: Health and wellness requiring financial resources. All of the women clearly stated what it meant to have good health: nutritious food, a body free from disease, good environment (especially cleanliness) to prevent disease, and access to health services when they felt sick. In order to maintain health, financial resources were required. Studies about socioeconomic factors related to health and psychosocial problems for people living with HIV are few. One study from Uganda by Withell (2000) described women living with HIV. Despite struggling with loss and adversity, the women were able to live constructively because of well-attendance by medical assistants. Bunting, Bevier, and Baker (1999) concluded that women in various countries living with HIV confront related problems and have similar psychological needs. Bunting et al. (1999) studied poor women from a population in the United States who were living with HIV, and 369 needs were identified. Most reported needs were psychological, physical, legal, and financial. Psychological needs were described as support from support groups, relatives, and friends, but needs like confidentiality, love, and understanding were also important. Concern for children's futures and counseling were also needs labeled as psychological (Bunting et al., 1999). Another study from the United States indicated that women's most urgent needs are emo-

tional and that they are at risk for depression; therefore, the need for support to increase emotional well-being is very important (Hudson, Lee, & Portillo, 2003). These observations highlight the psychological aspects so obvious in affluent societies but may not show easily in a resource-constrained country such as Tanzania. The women in the present study showed varieties of moods, and some showed signs of depression. A sad face and low-intoned voice indicated that this could have been the case for at least 2 of the 10 women. Sadness and depression could very well be a consequence of poverty as a result of the women's life situation. Marriage problems could be a cause of depression as well when some of the women narrated about being in conflict with their husband.

According to Sarna, van Servellen, Padilla, and Brecht (1999), quality of life in women with symptomatic HIV/AIDS scored lowest in the psychosocial domain, and married or cohabiting women had more anxiety and symptoms of distress than did women who lived alone (Sarna et al., 1999).

Theme 3: Intimate relationships no longer being a reality. The women's awareness of sexuality and sexual matters was that sex was the same as love and was a condition expressed in a relationship between man and woman. It could start at school and result in marriage after serious promises from both persons. Sex could also mean being lovers without necessarily having sexual intercourse. One woman believed that sex could also have great convincing power that affects the brain. For most of the women, sex had become two things—namely, careless sex and safe sex. Participating in careless sex could easily bring HIV or other sexually transmitted infections. Sex was seen as a cause of transmittable diseases, and many people were dying because of sex. Performing safe sex meant not participating in any sexual activities. Sex had become something they wanted to forget about because it had become a source of disease, and the women stated in unison that their sexual feelings were ancient history.

Maticka-Tyndale, Barry, and Choen (2002) propose in their study that sexual desire declines and thoughts about sex could even bring feelings of revulsion shortly after the diagnosis. However, sexual desire returned over time except in persons who

had HIV symptoms either because of antiviral therapy or the HIV infection. One important reason for not wanting sexual intercourse was the fear of passing the virus to the other person (Maticka-Tyndale et al., 2002). A study from the United Kingdom by Bell, Richardson, Wall, and Goldmeier (2006) concluded from a retrospective analysis of clinical notes that about 50% of the women of African descent visiting the HIV clinic had sexual problems, and data suggest that women with HIV are at particular risk of developing sexual problems (Bell et al., 2006).

Although the women in the present study had taken a firm stand on sexual matters, one woman admitted that she would accept sex for survival. According to Mallory and Stern (2000), the risk taken by women engaged in survival sex was outweighed by the need to produce food, shelter, money, or other necessities. Lockhart (2002) stated that survival sex has been reported in some African countries and is practiced mainly among young street boys. How common this practice is for women living with HIV in Africa is not known.

None of the women in the study spoke of a particular interest in learning more about sexuality for its own sake. Some of the women assumed the role of educating others to contribute to the fight against HIV and the search for new knowledge. The other women felt sexuality was for them in all aspects a closed book.

Conclusions

The women who participated in this study described serious consequences of being infected with HIV. It had made them poorer, and some of the women had been abandoned by their husbands. They had no expectations of being remarried, little hope for the future, and constant worry about their children's well-being and future education. The main problem was not having resources for daily living. HIV infection had made the women much more vulnerable, and poverty had increased the risk that they would use casual sex for survival. Sex lives for the women living in a relationship had declined, and one woman had no desire, deciding to practice abstinence. Typical approaches were to abstain from sex or to be faithful to one partner, which meant being a

“caring woman,” and from that aspect, most of the women were caring. What the women meant by caring, in a real sense, was taking responsibility for one's actions. From their own point of view, they primarily thought of their children.

Implications for Nursing Practice

The women's needs for financial and social support were great and absolutely necessary for daily living and being there for their children. HIV-positive women living with young children should be given priority for antiretroviral therapy, and nurses in AIDS care must be aware of these vulnerable women and their special needs when caring for them. It seems inevitable that the social and health care systems in their community must provide more effective support for this group of women, who may also have a great task of custodial care as single parents. To give this group of women with young children extra attention during educational meetings with health personnel would help them, in return, to care for their children. To meet the women's special needs for emotional support would reduce suffering as well as increase safety and security when caring for patients living with HIV.

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