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By

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ABSTRACT

WOMEN AND AIDS IN AFRICA:

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By

Teresa Ann Swezey

This thesis examines epidemiological and feminist literature on women and AIDS in Africa. The two bodies of literature reflect differing degrees of recognition or denial, inclusion or exclusion of the socially constructed nature of the AIDS epidemic in Africa. Feminist challenges to the traditional epistemological foundations of anthropology raise new questions and analyses. Feminist theories and criteria are used to critique epidemiological studies of women and AIDS in Africa, which create largely decontextualized representations of the complex experiences and meanings of AIDS in women's lives. To understand the multiplicity of factors affecting women's ability to reduce their risk for HIV infection and AIDS, there is a need for research and analyses that are "context rich." Analyses that recognize the embeddedness of gender, class, and ethnicity and the role that culture plays in creating differential meanings and experiences of the epidemic have the most to contribute to AIDS prevention programs.

To my parents, Mary and Donald Swezey

and to Dr. Lynn Beatty

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and attendance at an AIDS conference in Uganda shaped both the arguments of this thesis and the direction of future dissertation research. I am especially grateful to the families and friends who opened their homes to me during my stay in their country.

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INTRODUCTION

According to the World Health Organization (WHO), "more than half the estimated [eight to ten million] AIDS cases have occurred in Africa and the number of adults now infected with HIV is estimated to be close to six million" (United States Agency for International Development 1991:4). Women comprise over one-half the AIDS cases in Africa. The original pattern of male to female heterosexual transmission rate "had by the end of 1989 changed to 1:1.5 with more women than men who were infected" (Ankrah 1991:971). For example, "in Zaire women have a higher infection rate until age 35. In Ghana among those diagnosed with AIDS, women outnumber men" (Bassett and Mhloyi 1991:146). Further WHO statistics state that:

> At the end of the 1980s about 2.5 million females in Africa were infected with HIV and they gave birth to about 2 million infants, of which 500,000 were estimated to have been infected with the virus. By the end of 1992 about 4 million infants will have been born to HIV-infected women and nearly a million more are expected to be infected. [Chin 1990:223]

Three key issues are evident in the statistics: (1) the discrepancies between male and female HIV infection rates and cases of AIDS in Africa; (2) concern for women's role as reproducers; and (3) concern for the high risk of perinatal

transmission of HIV. Yet, beyond the biological categories of male and female and women's biological and social "roles" as childbearers (and what is implied by concern over perinatal transmission statistics—an implication of women's "role" in transmitting the HIV virus to their infants) are the gender and class relations contributing to the discrepancies. Further, what is often obscured in abstract, quantitative reporting of AIDS statistics is the fact that the statistics themselves are based in human experiences of the AIDS epidemic. In other words, strictly statistical approaches to understanding the AIDS epidemic are not enough—they strip the human experience of AIDS from its social, cultural, political, economic, historical, and personal contexts. Statistics without the addition of human experiences of the epidemic limit our understandings of how AIDS differentially impacts people's lives.

In this thesis, I argue that in addition to asking how HIV infection is transmitted and making recommendations about how to slow its spread, AIDS reporting and representations must ask why the gender differences exist. The gender, class, and ethnic or cultural relations shaping women's multiple experiences of the AIDS epidemic in Africa must be viewed as a valid starting point in AIDS research. Women must be worthy of research efforts because of their humanness—not exclusively because of their reproductive function within societies.

The title of this thesis, "Women and AIDS in Africa: Unequal Experiences, Unequal Representations," is intended to convey a sense of the socially constructed experiences and representations of the AIDS epidemic in Africa. By socially constructed experiences, I mean the ways by which the epidemic is structured by gender, class, and power relations. As discussed in a later chapter, culture, in the form of ethnicity, also contributes to gendered differences in socially constructed experiences of the AIDS epidemic. By socially constructed representations, I mean the ways these relations are articulated in the literature on AIDS in Africa.

I examine mainstream epidemiological and feminist analyses of AIDS in Africa in this thesis and show how the two bodies of literature reflect differing degrees of recognition or denial, inclusion or exclusion of the socially constructed nature of the epidemic. Each is based in a different set of assumptions or conceptualizations about women and results in different sets of representations of the epidemic. Each also results in different implications for what should be the goal of any AIDS research project—the development of AIDS prevention and education strategies sensitive to the constraints and challenges of behavior change as shaped by both internal and external conflicting forces.

Chapter 1 presents a discussion of feminist

perspectives in anthropology, emphasizing the ways in which feminist challenges to the epistemological foundations of traditional anthropology raise new questions and analyses within the discipline. In Chapter 2, I evaluate the ways women are included in the epidemiological literature on AIDS in Africa. I have divided the epidemiological literature on women and AIDS in Africa into two sub-sections. The first treats women as reproducers and prostitutes (and to a lesser degree caregivers and producers). The second sub-section encompasses research that I have classified as "transitional." The transitional category encompasses representations with varying degrees of recognition and contextualization of the socially constructed aspects of the AIDS epidemic. Throughout each of these subsections, underlying and often implicit or unstated conceptualizations of women in the epidemiological research are identified and critiqued using the feminist criteria outlined in Chapter 1.

Chapter 3 presents feminist studies standing in opposition to standard epidemiological treatments of women and AIDS in Africa. The focus of this chapter is comparative. My intention is to raise issues that will highlight the implications for AIDS programs sensitive to the challenges many women face in negotiating AIDS prevention strategies. Identifying levels of recognition or non-recognition of the negotiated basis of AIDS prevention is key to analyzing epidemiological and feminist approaches

to AIDS prevention. Chapter 4 integrates the arguments made within this thesis with my reflections on the discourse on the sociocultural dimensions of AIDS research as articulated at the VIII International AIDS/STD Conference in Amsterdam and a conference on women and AIDS in Kampala, Uganda.

The discussion in Chapter 5 offers comments on the ways that feminist challenges to epidemiology as usual (to paraphrase Harding [1991]) are necessary and vital to the development of successful AIDS prevention programs. In this chapter, I also discuss the question of whether there has been a feminist revolution in regard to major paradigmatic shifts in mainstream approaches to AIDS in Africa.

The concluding chapter incorporates ideas and information gained during a five-week visit to Uganda in July-August 1992. This serves as a means of contextualizing how the experiences of the people I spoke with about AIDS in Uganda reflect many of the arguments set forth in this thesis. The insights gained during that period will also serve as the basis for questions to be raised in my dissertation research.

CHAPTER ONE

FEMINIST CHALLENGES AND CONTRIBUTIONS TO ANTHROPOLOGY

Issues of representation have been central to feminist scholarship in anthropology over the last twenty years. This section is not intended as a comprehensive overview of the literature on feminist challenges and contributions to anthropology, but rather, as a brief review of some of the issues raised by feminists and to show how feminists ask different questions and produce different analyses. It also sets the tone for the specific feminist critiques of representations about women and AIDS in Africa that follow. This section is not limited to contributions from feminist anthropologists; feminist perspectives from other social science disciplines that have or can contribute to new questions and analyses in anthropology have also been included.

Feminist challenges to the epistemological foundations of traditional anthropology brought about a rethinking and rewriting of both anthropological theory and practice (di Leonardo 1991; Gal 1991; Moore 1988). As Micaela di Leonardo notes, feminist anthropologists in the 1970s began "rewriting anthropology as if gender really mattered"

(1991:9). Objections to the androcentric construction of social experience and reality within the discipline raised key epistemological questions. Feminists challenged non-inclusive anthropological paradigms that presented knowledge about women, as well as about other societies and cultures, that was based solely upon the contributions of male informants. Some of the questions raised by feminists that are pertinent both to this thesis and more broadly to the anthropological endeavor include: what constitutes knowledge; how is it produced; what kinds of questions get asked and by whom; and who controls access to and distribution of knowledge?

The critical stance adopted by feminist anthropologists has contributed to a "reconsideration of entire subdivisions of the discipline" (di Leonardo 1991:8). For example, feminists challenged basic theoretical tenants of kinship studies, political anthropology, and Third World peasant studies. They also contested the hegemony of culture as the primary explanatory variable in constructing difference. As Moore contends,

> Feminist anthropology . . . formulates its theoretical questions in terms of how economics, kinship, and ritual are experienced and structured through gender, rather than asking how gender is experienced and structured through culture. [1988:9]

Feminist-based revisions in anthropological theory and practice contributed to new understandings of the concept of personhood. Feminists critiqued definitions of "work"

based on a non-recognition of "women's subsistence and domestic labor" (Moore 1988:43). In so doing, they drew attention to the sexual division of labor and motivated a redefinition of the concept of work to include women's work in social reproduction.

Feminist research has also challenged and contributed to a deconstruction of the notions of sexuality and reproduction through arguing against biologically determinist approaches to these topics. Similarly, feminists have deconstructed the concepts of sex and gender and demonstrated that sex and gender, like sexuality and reproduction, are not, in fact, paired identical concepts. Feminist anthropologists and other feminist researchers have shown the analytical error in naturalizing sex and sexuality and in conflating sexuality with reproduction (di Leonardo 1991; Moore 1988; Rapp 1992; Vance 1991). In commenting upon feminist anthropologists' approaches to studying sexuality, Rayna Rapp contends that:

> the social space in which "biological" experiences are constructed is intimately shared with other social relations. . . . our new focus on sexuality parallels our understandings of other power domains which in many ways invent and constrain both sex and gender. [1992:84]

Feminists have highlighted anthropology's inertia in situating studies of sexuality within the context of social structure (Vance 1991). Carol Vance classifies the conventional approach to sexuality studies within anthropology as "the cultural influence model" (1991:879). This model does

not question the concept of sexuality nor the assumptions made about it in anthropological theory and practice. According to Vance, the cultural influence model naturalizes sexuality. Moreover, it "recognizes variations in the occurrences of sexual behavior and in cultural attitudes which encourage or restrict behavior, but not in the meaning of the behavior itself" (1991:879). While critiquing the cultural influence model, Vance nonetheless recognizes that it has moved the analysis of sexuality away from a strictly biological approach and has contributed to understandings of sexuality by challenging the "more mechanistic theories of sexual behavior, still common in medicine and psychiatry" (p. 879).

Social constructionism shapes many approaches to feminism and, thus, the types of questions asked and analyses offered (di Leonardo 1991; Vance 1991). Vance's comments on the social constructionist approach to sexuality are especially pertinent to the different sets of questions raised and analyses produced in the literature critiqued in this thesis and within anthropology as a whole. Vance describes this approach as one that would:

> . . .examine the range of behavior, ideology, and subjective meaning among and within human groups, and would view the body and its functions and sensations as potentials (and limits) which are incorporated and mediated by culture. [1991:879]

Vance notes that feminist anthropologist Gayle Rubin's separation of sexuality and gender into analytically

distinct phenomena resulted in a new approach in which:

> . . . sexuality and gender are separate systems which are interwoven at many points. Although members of a culture experience this weaving as natural, seamless, and organic, the points of connection vary historically and cross-culturally. For researchers in sexuality the task is not only to study changes in the expression of sexual behavior and attitudes, but to examine the relationship of these changes to more deeply-based shifts in how gender and sexuality were organized and interrelated within larger social relations. [p. 876]

This observation is especially important in understanding the ways in which the women described in Chapter 4 of this thesis view unequal gender relationships and lack of control over their sexuality—and hence increased risk for HIV infection—through cultural (or ethnic) lenses.

Using a social constructionist framework, feminist researchers in anthropology and other disciplines explain gendered differences in experiences of social reality and the pervasiveness of male dominance and oppression throughout time and space. Dichotomous explanations such as culture/nature and public/private have yielded to a recognition that there is no single or universal explanation for women's oppression (di Leonardo 1991). Likewise, feminist perspectives now contend that there is no single definition of "women" or of "men" (Baca Zinn 1993). In this regard, Moore states, "there can be no universal or unitary sociological category 'woman' and therefore there can be no analytical meaning in any conditions, attitudes or views ascribed to this 'woman'" (1989:189).

The plurality of women's experiences as structured by social location and culture prompts Harding to state:

> . . . women come only in different classes, races, and cultures: there is no "woman" and no "woman's experience." Masculine and feminine are always categories within every class, race, and culture in the sense that women's and men's experiences, desires, and interests differ within every class, race, and culture. But so, too, are class, race, and culture always categories within gender, since women's and men's experiences, desires, and interests differ according to class, race, and culture. [1987:7]

This feminist perspective needs to be kept in mind when considering the gender, class, and cultural factors contributing to differentiated meanings and experiences of the AIDS epidemic in Africa. The forms that structural inequalities such as gender and class inequality take are influenced by culture. As highlighted by some of the feminist researchers reviewed here, and more explicitly in the discussion section, one of the most important cultural factors in the context of AIDS in Africa is the role that women's perceptions of ethnicity or tribalism play in their perception of cultural influences that increase their risk for HIV infection.

Feminist research is thus context rich. It recognizes the historical contingency and partiality of the representations created through academic inquiry. As Moore observes,

> [t]he term patriarchy is similarly deconstructed. This does not mean that women are not oppressed by patriarchal structures, but it does mean that the nature and consequences of those structures have

> to be specified in each instance and not assumed. [1988:189]

Feminist scholarship, whether in anthropology or in other social sciences, is not an uncontested terrain. Women of color, and Third World women in particular, have challenged feminist representations of social reality based upon white, middle-class feminists' experiences of the world (Hill Collins 1990; Hooks 1984; Mohanty, Russo, and Torres 1991). It is critical to recognize a plurality of feminisms. Women of color and Third World women "call for the expansion of theory and practice [to create] a number of feminisms that mirror women's different realities" (Ferguson and Gallin 1992:7).

Maxine Baca Zinn and her colleagues argue that "[t]he integration of race and class into the study of gender creates different questions and new conceptualizations of many problems" (1986:296). Baca Zinn terms this integration of race, class, and other structural axes of social organization and stratification "intersections analysis." Intersections analysis contends that race, class, gender and other structural axes of stratification are interlocking systems of oppression that must not be considered in isolation from one another (Baca Zinn 1993). As Margaret Andersen and Patricia Hill Collins observe, "race, class, and gender are inextricably intertwined, and they compel us to think about the structure of race, class, and gender relations in society" (1992:48). This type of feminist

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framework has much to offer anthropology and, as I contend in this thesis, is especially useful for understanding the complex experiences and meanings of the AIDS epidemic in African women's lives.

Intersections analysis encourages what Baca Zinn (1993) refers to as oppositional reading—that is, reading against the grain. In other words, in the tradition of feminism, it challenges the epistemological bases of conventional assumptions and representations of social reality within the academy. It conceives of gender, race, and class as "linked systems of control, domination, advantage, and privilege which are relational; that is, they are positioned and gain meaning relative to one another" (Baca Zinn 1993). Intersection analysis emphasizes the importance of social relations and social structure in shaping individual experiences of reality. It critiques approaches that conceive of gender as an individual, socialized attribute or set of social roles. Intersections analysis also questions additive analyses that treat gender as a variable and analyses that rank types of oppression in hierarchical order (Baca Zinn 1993). In this sense, intersections analysis argues against gender as the only axis of social organization that creates differential experiences of structural inequality (Baca Zinn 1993; Ferguson and Gallin 1992).

The feminist culture and political economy framework

within anthropology somewhat parallels intersections analysis. Di Leonardo (1991) identifies five key points of this framework. First, a "radical rejection of . . . social evolutionism" and an explicit recognition of the historical, cultural, social, and political-economic contingencies of gender. Second, an emphasis on social constructionism. This approach contends that gender, race, ethnicity, nationality, and so on "are not immutable characteristics of individuals but emergent and shifting social categories that can and do become the objects of intense political struggle" (p. 29). Third, the feminist culture and political economy framework emphasizes the "embedded nature of gender, both as a material, social institution and as a set of ideologies" (p. 30). Fourth, recognition of gender embeddedness leads to the "proposition that all forms of patterned inequality merit analysis" (p. 31). Finally, this framework stresses the importance of social location—of both the researcher and the researched (p. 31). It also recognizes the ways that the production of knowledge is a highly politicized, historically contingent, and profoundly ideological process.

In summary, many of the questions and issues raised by feminists—both anthropologists and others—provide a critical framework for approaching issues of representations of women and AIDS in Africa. As di Leonardo notes, "anthropology stands at the crossroads of knowledge production, embracing scientific, social scientific, and humanist modes of

interpretation" (1991:1). Using feminist frameworks, anthropologists in particular have contributed to more contextualized analyses of the AIDS epidemic in Africa.

Feminist Criteria for Evaluating Representations of Women and AIDS in Africa

Feminist frameworks offer a means to evaluate and critique representations of women and AIDS in Africa. They also suggest alternative research strategies and analyses that move beyond the decontextualized shortcomings of epidemiological representations as discussed in the next chapter. Feminist standpoint thinking (Harding 1987; 1991), intersections analysis (Baca Zinn 1992; 1993), and the feminist political economy and culture framework (Schoepf 1992) each contribute components of the criteria used to critique epidemiological and feminist representations of women and AIDS in Africa. I also refer to discussion of the treatment of women as either mothers (i.e., "good" women) or whores (i.e., "bad" women) (Carovano 1991) as providing a useful basis for examining underlying conceptualizations of women in both epidemiological and feminist literature. My goal in synthesizing these feminist perspectives into a coherent framework in this thesis is to demonstrate how they might work together to locate people within the various contexts that influence their ability to reduce their risk for HIV infection and AIDS.

Standpoint thinking (Harding 1987:9) emphasizes the importance of grounding research problems in women's experiences, conducting research for the purpose of liberation or change, and locating the researcher and the researched in the same social plane. Intersections analysis somewhat parallels standpoint thinking but is more explicit about viewing gender, class, and race as structurally based interlocking systems of stratification that must be considered relationally rather than as attributes of particular individuals or groups of individuals. In the context of AIDS in Africa, ethnicity as generated through culture, needs to be incorporated as an axis of stratification in relation to gender and class in considering the impact of the epidemic in women's lives. In turn, the feminist political economy and culture framework places greater emphasis on the political economic and sociocultural contexts than on the interlocking nature of race, class, and gender. Feminists using this framework create analyses of AIDS "linking a macrolevel analysis to microlevel studies of social interaction [to show] how political economy, gender, and culture shape responses to disease" (Schoepf 1992:53).

The differences between these feminist frameworks are also a source of complementarity; when combined they have the potential for creating a context-rich analysis of women and AIDS in Africa. My conceptualization of context-rich

analysis is an expansion of Susan Hunter's (1990) definition. Hunter stresses the importance of involving indigenous researchers and people in the production of knowledge generated through AIDS research and analysis (1990:689). I use the concept of context-rich analyses to denote an approach that recognizes the epistemological and practical shortcomings of conducting AIDS research without a consideration of the multiple and interlocking contexts that create differential meanings and experiences of the epidemic. In other words, such an approach recognizes the need for AIDS research that considers the relationship between gender, ethnicity, class, and the political-economic, historical, personal, and cultural contexts rather than treating each of these related aspects of the socially constructed nature of the AIDS epidemic separately.

The following chapter examines the conflicts and complementarity between mainstream epidemiological and feminist approaches to understanding AIDS in Africa. The two approaches are not mutually exclusive. For example, feminist studies of AIDS in Africa often begin with epidemiological statistics, and some of the epidemiological reports hint at an awareness of the socially constructed nature of the epidemic. I contend, however, that feminist studies take AIDS research several vital steps further than current trends in epidemiology by grounding their analyses in women's experiences of the epidemic as structured by

social location. Feminist analysis thus exposes the limits of decontextualized approaches to AIDS prevention and shows the need for an analysis that relates all the factors affecting African women's experiences of AIDS and their AIDS prevention choices and strategies.

CHAPTER TWO

EPIDEMIOLOGICAL LITERATURE

Epidemiology is defined as "the study of the distribution and determinants of disease frequency in human populations" (Hennekens and Buring 1987:3). Empirically based epidemiological research of the AIDS epidemic in Africa is essential for gaining understandings of such determinants of disease frequency and distribution as HIV seroprevalence rates, numbers of AIDS cases, rates of perinatal transmission, and biological and behavioral variables contributing to the spread and distribution of the disease. According to Jonathan Mann, former director of the World Health Organization's Global Aids Programme, "epidemiological studies have created a coherent view of HIV transmission, for application by those working to prevent HIV infection . . . [however] a sufficient understanding of risk behavior has not yet been developed" (1991:555).

Epidemiological literature on AIDS in Africa is largely based on a biomedical, empiricist, quantitative approach to researching, analyzing, and reporting (representing) the AIDS epidemic. Models used to explain HIV transmission and AIDS are linear and behaviorally deterministic (Mann

1991:555). Gender relations and systems of social hierarchy are barely alluded to as possible explanations for the higher HIV infection rates in women and their infection at earlier ages. The challenges to negotiating AIDS prevention strategies are rarely acknowledged. The experiences of the epidemic that form the foundation of the AIDS statistics reported in epidemiology are frequently presented as decontextualized "facts" by the disembodied observers/researchers. Women are included in the epidemiological literature primarily out of concern for their "roles" as reproducers of children and infectors of men and children (Carovano 1991). This results in women not being viewed as active agents of change but as passive bearers of children and the HIV virus.

A survey of the epidemiological literature on AIDS in Africa thus quickly reveals, as one might expect, that it is not based in feminist conceptualizations of how gender, class, and power relations (e.g., patriarchy, differences in access to and control of resources) interact to create multiple systems of oppression and inequality. Nor does the epidemiological literature incorporate feminist challenges to positivistic, "objective," impartial science that contend that social location is central to creating socially situated, partial knowledge(s), where the view from the perspective of the powerful is more distorted than the view from the perspective of the oppressed (Harding 1991). As we

shall see, this perspective offers important advantages in studying the AIDS epidemic.

A feminist perspective is a critical perspective. As Harding notes, "gender relations in any particular situation are always constructed by the entire array of hierarchical social relations in which 'women' or 'men' participate" (1991:14). It is reasonable to ask whether it is fair to apply feminist lenses or value judgements to a body of literature that clearly never intended to incorporate a feminist perspective, much less a feminist standpoint. In answering this, it is important to emphasize that the use of feminist lenses reveals what is not seen in epidemiological understandings and representations of the AIDS epidemic. As Dorothy Smith states, "a critique is more than a negative statement. It is an attempt to define an alternative" (1987:78).

A critique should thus not only criticize, but offer suggestions for transformation or change. Feminist lenses applied to epidemiological literature provide a mechanism for this. Jane Flax's remarks in this regard are particularly salient, "a fundamental goal of feminist theory is and ought to be to analyze gender relations: how gender relations are constituted and experienced and how we think, or equally important, do not think about them" (1987:622). In other words, this type of analysis and critique offers what Flax terms the opportunity to think about how we

think—or in this case—to speculate on how epidemiologists think and how their ways of thinking shape their perceptions, discourse, representations, and recommendations.

This is especially important given that epidemiological analyses are usually presented as complete understandings and representations of the AIDS epidemic. Epidemiological approaches alone, however, create incomplete and thus inaccurate representations of the epidemic and are examples of the authoritarian stance of science that fails to recognize the "situated" nature of knowledge production (Haraway 1988:583). According to Haraway, there is a need to recognize the partiality of knowledge production and to strive for what she terms "feminist objectivity." Feminist objectivity "is about limited location and situated knowledge, not about transcendence and splitting subject and object. It allows us to become answerable for what we learn and how we see" (p. 583). Haraway's statement,

> I am arguing for epistemologies of location, position, situating, where partiality and not universality is the condition of being heard to make rational knowledge claims. <u>These are claims on people's lives. I am arguing for a view from the body.</u> [1988:589, emphasis added]

is especially powerful when applied to the question of formulating possible alternative approaches to standard epidemiological representations of AIDS in Africa.

It is foolish to suggest that epidemiology be abandoned in favor of more qualitatively based approaches; the hows

of the AIDS epidemic are as important as the whys. As mentioned previously, however, most epidemiological approaches are limited in their abilities to move beyond decontextualized representations of hows (and sometimes whys) to asking broader based questions of why. Further, they seldom explore the social, political, economic, and cultural contexts. Again, it must be stressed that epidemiology provides an important starting point for more contextualized accounts of the epidemic. Since estimates of future patterns of HIV infection and AIDS cases are vital to policy making, epidemiology provides necessary baseline data for developing impact analyses that are essential to the structure of AIDS programs. As Mann comments, however, epidemiology's ability to quantify behavioral risk factors using standard practices "may have reached its limit" (1991:555).

Representations of Women as Prostitutes and Reproducers in the Epidemiological Literature on Women and AIDS in Africa

In this section, I explore how women are conceptualized in the epidemiological literature. The material presented draws from the most recent epidemiological works on AIDS in Africa. The articles critiqued were selected from a list of 100 to 150 journal articles generated through key word searches (Africa, women, HIV, AIDS) in Core Medline and

Excerptis Medicus. In reducing the list to a manageable number, I attempted to select a representative sample. Only articles that included discussion of women in their analyses were selected. The articles included research on two of the five modes of HIV transmission in Africa—sexual and perinatal—and on the content and efficacy of AIDS prevention programs. HIV transmission by blood, by unsterile instruments, and by skin cutting or piercing are not included in the discussion.

To structure my discussion, I have grouped and analyzed the articles according to the extent to which they recognize the socially constructed nature of the AIDS epidemic. Specifically, how much recognition is given to the role of gender, power, and class relations in shaping the AIDS epidemic? In other words, I attempt to synthesize and reveal epidemiological literature's frequently unstated or merely implied conceptualizations of women. As will be shown, in most of the articles, gender is treated as a variable and/or gender is treated in terms of roles.

The groupings presented here are not intended to imply strictly bounded categories, for there are multiple layers of overlap between them. They are: (1) epidemiological studies in which women are treated as reproducers, prostitutes, and to a lesser degree, caregivers and producers; and (2) epidemiological studies that I have classified as "transitional"; i.e., studies that

incorporate varying degrees of recognition and contextualization of the socially constructed aspects of the AIDS epidemic. Concrete examples of epidemiological representations of women and AIDS in Africa are provided and critiqued using the feminist criteria outlined above. Consideration is given to the ways that feminist researchers might address and provide alternate explanations of the same issues.

Throughout the section, I echo Susan Hunter's statement that "AIDS research cannot be context poor. To be ethical and methodologically correct, it must be context rich" (1990:9). Additionally salient is the insight provided in Mary Bassett and Marvellous Mhloyi's statement: "Just as much as HIV is a requirement for the AIDS epidemic, so too are the social relations that mold, and even determine, the setting of each individual's exposure and susceptibility to infection" (1991:144).

Carovano's (1991) essay, "More than Mothers and Whores: Redefining the AIDS Prevention Needs of Women," provides a succinct criticism of approaches to AIDS research that categorize women in their "good" or "bad" sexuality and reproductive roles:

> throughout the world, women's sexual identities have long been defined on the basis of their reproductive capacity, and to a lesser degree, their involvement in commercial sex. Motherhood legitimizes a woman's sexuality--and very often her life—while prostitution provides women with a means of survival, though with a heavy stigma. Women in many societies have traditionally been

> identified sexually as either mothers or whores, 'good girls' or 'bad girls'. . . . [1991:132]

Carovano goes on to say that this dichotomy is used in AIDS research to "identify the risks posed to and by women" (p. 132).

Epidemiological research on perinatal transmission rates, on childhood survival of infants born to HIV positive mothers, and on prostitutes conceptualizes women in this good/bad dichotomy. The primary concern is not with women themselves but with children.

For example, a study of perinatal transmission rates in Brazaville, Congo, makes no mention of the impact, experience, meaning, and consequences of AIDS on mothers but chooses to focus on "the consequences for infants of maternal seropositivity with emphasis on survival" (Lallemant et al. 1989:643). Feminist researchers would identify this goal as important, but make clear that it neglects to consider the impact on women, who are reduced to passive carriers of children and of the HIV virus.

This study also falls short of any meaningful or contextualized analysis of women's socioeconomic conditions and social location. This is revealed through the categories that are used to indicate women's "occupations"; the choices are: "housewife," "student," and "active" (p. 644). There are several problems with this approach. First, the choice of occupational categories ignores the diversity of women's work in Africa. Second, the terms

"housewife" and "active" are not defined. Does housewife mean unemployed or employed in the informal sector? Does it reveal an underlying assumption that housewives do not work? Third, the term "active" is also problematic. Does it mean employed, or does it only refer to employment in the formal sector? How does one make a distinction between active and inactive? Finally, the three categories appear to be mutually exclusive. Are students not also possibly housewives or active?

The authors report finding no significant differences between what they term social variables (occupation, marital status, and pregnancy outcome) and children born to the two groups studied (HIV+ and HIV- women). Aside from noting whether women were single or married, and whether the length of the sexual relationship was over one year, information about the women's partners (such as socioeconomic status, sexual history, etc.) that would help to contextualize the results are also missing from the study. This results in the blame for perinatal transmission being placed squarely on the shoulders of the women themselves rather than a recognition of the types of socioeconomic and cultural conditions that put women at risk for HIV infection in the first place.

A variety of additional questions might be asked from feminist perspectives. How long, for example, had the women been living in the city? If they had recently moved to the

city, had they been separated from their partners when they were in the rural areas? Did their partners have a second family or other sexual partners in the city? What are the social, cultural, and historical conditions contributing to male control over female sexuality and reproduction, and how might that increase women's risk for HIV infection? Finally, no indication is provided of income levels or education for the two groups of women. What role might differences in income and education play in women's knowledge of HIV transmission and subsequent variation in infection rates?

Another study that is limited by its shallow exploration of socioeconomic factors in women's lives analyzes perinatal transmission in Zambia (Hira et al. 1989). This article follows the trend of viewing women in their reproductive function. Its depth of analysis is revealed by the authors' limitation of occupation to two categories: working versus non-working. This raises the question of what qualifies as work and reflects the same failure to contextualize the experiences and meanings of AIDS in women's everyday lives as did the article mentioned earlier (where women were regarded as "housewife" or "active").

Socially situating the concept of "working" in the experiences of women's lives would mean developing a perspective entirely different from that offered in this

study. Application of Harding's criteria of beginning from women's experiences and using them as a "test of adequacy of the problems, concepts, hypothesis, research design, collection and interpretation of data" (1987:11) are especially appropriate here.

The conceptualization of women as reproducers and transmitters of AIDS to children is present in every study of perinatal transmission reviewed (Braddick et al. 1990; Hira et al. 1989; Konde-Lule et al. 1989; Miotti et al. 1990). The studies differ in the extent to which they recognize and include non-biological factors as contributing to HIV infection in women, but they are consistent in their insistence that women need to be counseled against future pregnancies if they are HIV positive.

These studies are also consistent in their failure to address the negotiated aspects of sexuality and reproduction, including AIDS prevention. As an example, a study conducted in Kinshasa, Zaire, found the following variables

> significantly associated with HIV infection: unmarried status, age less than 16 years at the time of first intercourse, more than one sexual partner in the last 5 years, a history of prostitution, receipt of blood transfusion since 1980, consumption of alcohol during pregnancy, and travel to other African countries. [Braddick et al. 1990:1002]

The authors note that the study participants were poor women. They recommend that HIV positive women be educated, counseled, and advised to avoid future pregnancies (p.

1005). They do not, however, address the multiple meanings of children to women in African societies or the dilemmas women are faced with in being asked to choose between motherhood and avoiding HIV. As Carovano insists, "the argument that HIV-infected women should receive 'directive counseling' to avoid or terminate pregnancy denies the complexity and real importance of motherhood in many women's lives" (1991:139).

An example of a study that fails to contextualize the complex meaning of motherhood in Africa is "Impact of Single-session Post-partum Counselling of HIV Infected Women on their Subsequent Reproductive Behavior" (Temmerman et al. 1990). The authors report that a follow-up study conducted with HIV positive women one year after they received their test results and counseling against further pregnancies revealed that very few of the women had informed their partners of their seropositive status. Some awareness of gendered relations is revealed in the researchers' statement that sexually transmitted diseases are usually blamed on women. They observe further that "the majority of these mothers therefore preferred to keep the information to themselves. Most of them were in good health and not prepared to worry unduly about future eventualities" (p. 251). There is a tone of paternalism in these statements and no attempt to further explore why the women are preoccupied with the present.

The failure of these authors to consider context is evidenced in their statement that:

> the majority of these women, when confronted with the notion of a high risk of child mortality, expressed the desire to have more babies to increase the likelihood of uninfected children. On being informed that the risk of perinatal transmission may be as high as 30% or more, many women drew attention to the 70% chance of having an uninfected child. [p. 251]

Making this statement without exploring the reasons women want more children is not only irresponsible, but also carries the underlying message that women are ignorant and unwilling to change, even when confronted with the fact that they could infect their own children. There is no concern shown here for the women. But there is evidence of what Hunter refers to as a way of treating the "other in godlike ways that assume authority over things we know little about simply because we are not 'the other'" (1990:689).

The correlation between being female and having a higher risk for HIV infection is discussed in a study titled "Knowledge, Attitudes, and Practices Concerning AIDS in Ugandans" (Konde-Lule et al. 1989). This study found that

> women were more likely to be infected than males (12.5 % versus 8.8%, relative risk 1.42). Factors significantly associated with HIV infection . . . include multiple sexual partners, sexually transmitted disease (STDs), injections, <u>and being female</u>. [p. 513, emphasis added]

The authors go on to note that women are infected at an earlier age than men. Since women's period of higher risk occurs "at the peak of their reproductive potential it has

profound implications for perinatal transmission and child survival in Uganda" (p. 517).

Once again, women are conceptualized as reproducers. Explanations for the fact that being female is a risk factor for HIV infection are limited to the biological realm—that is, a more efficient mechanism of transmission from male to female, injections, or STDs. The question of why being female is a risk factor is never addressed, much less contextualized within a socially constructed framework addressing hierarchical power relations, differential access to and control of resources, and gender relations.

Another study by some of the same authors presents a model of factors possibly contributing to higher rates of infection in women. Especially interesting are their speculations grouped under the rubric of behavioral variables such as "females sexually active at younger ages; prostitutes-one female infects many males; older/richer infected males infect many females; and males have more sex partners" (Berkley et al. 1990:1240).

This set of variables is especially rich in what it reveals or obscures about the authors' ideas about gender relations. A primary distinction between feminist and mainstream epidemiological treatments of the topic is that feminist approaches would probably raise different sets of questions and thus provide different analyses. For example, feminist anthropologists grounded in the culture and

political economic framework or in intersections analysis would go beyond a mere listing of variables to attempt to contextualize and explain their research in terms of historically specific, social, economic, cultural, personal, and political circumstances.

A blatant conceptualization of prostitutes as reservoirs of infection (a commonly used term in the epidemiological literature on AIDS in Africa) is revealed in the researchers' portrayal of prostitutes as infecting many men. From a feminist perspective, the inclusion of a variable indicating that older men are having sex with younger women is important, but the question of why this variable is epidemiologically, much less socially, important is left unanswered by the authors of this study.

Also pertinent to an evaluation of this study are the demographic variables identified by the authors, including the possibility that "young men work[ing] in urban areas share a limited pool of women" (p. 1240). The social construction of the epidemic is hinted at in this model but not fully developed. The statement that men share a limited pool of women reveals the patriarchal nature of the researchers' conceptualizations about women and externalizes and objectifies women by portraying them as objects to be shared.

The researchers also comment on women's value as the primary agricultural producers and caregivers in Uganda (p.

1241). Implications of the higher transmission rate in women and the threat of a correspondingly large loss of producers is a valid point. It also can be viewed, however, as reducing women to their "roles" as producers rather than considering them as worthy of good health in their own right. Women are doubly blamed in this study: first, they are the carriers of the virus; and, second, they are the caregivers of children. The authors note that an increase in childhood mortality is expected even in children "who are lucky enough not to be infected themselves" because mothers sick with AIDS are unable to care for children (p. 1241).

Contrast the approach of Berkeley et al. with that of a feminist anthropologist such as Brooke Schoepf. Schoepf's approach (1991c), which is more fully discussed in the section on feminist representations of AIDS in Africa, emphasizes the sociocultural nature of gender relations, notes the fact that epidemics arise in times of crisis (p. 14); and links the "macrolevel political economy with microlevel sociocultural analysis" (1991c: abstract). According to Schoepf, "gender focused research demonstrates that epidemiology which ignores the social context of disease spread cannot claim to be a scientific account" (p. 14).

As previously mentioned, the term "prostitute" is included in nearly every study of AIDS in Africa. Yet, it is very rarely defined. Prostitutes have been targeted in

AIDS prevention campaigns, and most studies include questions about whether the males surveyed have had sex with prostitutes (Adamchak et al. 1990; Berkeley et al. 1990; Killewo et al. 1990; Wilson et al. 1989). Being a prostitute and having sex with a prostitute are clearly implicated in increased risk of HIV infection.

While the recent trend in the epidemiological literature is away from the concept of high risk group to a concept of high risk behaviors, the categorization of women as prostitutes and consequent implicit blame placed on them is an underlying theme in the literature. More informed approaches incorporate a recognition that all people are at risk for AIDS (Ankrah 1989; Bassett and Mhloyi 1991; Mann 1991). In this regard, Schoepf argues that:

> the notion that AIDS can be contained among high risk cohorts is illusory. It neglects the socioeconomic conditions that oblige many women to rely on sexual exchange for subsistence. It avoids the fact that due to widespread infection many spouses and other regular partners are at risk. It neglects the social, psychological, economic, and political motives for men's multipartnerism. [1991b:755]

The term prostitute is thus rarely problematized in the sense that Dorothy Smith (1987) develops the concept, that is, in the experiences of the everyday world. More situated and meaningful representations might emerge if epidemiologists made efforts to "develop a women's analysis, descriptions and understandings of their situation, of their everyday world, and of its determinations in the larger

socioeconomic organization to which it is articulated" (p. 88).

Feminist historical analyses also offer insight into the social construction of commercial sex work. In writing about prostitution in colonial Nairobi, anthropologist Luise White defines it as a form of domestic labor, "that labor which maintains and reproduces labor power that is consumed daily in obtaining a wage . . . domestic labor exists only in relation to wage labor" (1980:1). This definition, while being entirely materialist, has the benefit of showing the role of prostitution within the capitalist modes of production and reproduction. As Sharon Stichter and Jane Parpart point out:

> The core question in the domestic labor debate had been the relation of non-valoriosed labor to the value of capitalist surplus value. The labor of prostitution, on the other hand, is valorised petty commodity production . . . . [1988:18]

Paola Tabet, writing about the economic determinants of prostitution in Africa, draws attention to women's disadvantaged position in employment, stating few women have enough education to access wage labor (1988:204-226). In the cities, women support themselves through petty commodity production, beer brewing, or other small business activities. Additionally, according to Tabet, "all women can supplement their income or make a living entirely by engaging in different kinds of sexual-economic exchange" (p. 206). Tabet stresses that this exchange lies along a

continuum from marriage to occasional or longer lasting relationships and may or may not include domestic labor. The utility of this definition, Tabet contends, is that "the woman is giving sexual services and the man is paying, be it in money, food, rent, clothes, or access to material resources . . . ." (p. 206).

The preceding serves as a background for evaluating a study titled "HIV Infection among Lower Socioeconomic Prostitutes in Nairobi" (Simonsen et al. 1990) that found a 62% HIV seroprevalence rate among 418 women. This article makes some good points and could be grouped in the transitional category of epidemiological research. It remains in this section, however, as an example of the contradictions and challenges inherent in epidemiological approaches to AIDS in Africa. The research is part of an ongoing project to encourage peer education and AIDS prevention campaigns among prostitutes in Nairobi that has had some success in promoting condom usage among prostitutes.

As in most studies, the term prostitute is not defined. The study does, however, move beyond blaming prostitutes (clients are now included as reservoirs of infection and in need of AIDS prevention programs) to include the need to recognize and change the conditions that result in women's engaging in sex work:

> As prostitutes and their clients are probably a major reservoir of infection and thus serve to

> amplify the epidemic, strategies to decrease the prevalence of prostitution in African cities and to reduce HIV transmission among prostitutes and their clients are urgently required. Such strategies should include prevention education for AIDS and STDs, STD treatment programmes, promotion and distribution of condoms, and reduction of the social and economic circumstances which create the necessity for women to resort to prostitution. [p. 144]

One of the major risk factors for HIV infection identified in this study was being from an area in Tanzania that borders a high incidence region of AIDS in Uganda (p. 140). Unfortunately, the authors do not offer insight into the role that migration plays in some women's lives.

Contextualization of the possible connection between being of Tanzanian origin and a significantly increased rate of HIV infection can be drawn from feminist researcher, Paola Tabet's comments in an article subtitled, "Sexual Service, Migration, and Repression in Some African Societies":

> Many women leave their villages because they are widowed, divorced or repudiated and have to find some way to survive. Others go away because their husband doesn't provide for them. They migrate to escape an intolerable marriage, to get out of the control of their families, and/or to get economic autonomy. [1989:205]

To summarize, this section has focused on the representation of women in the epidemiological literature as reproducers and prostitutes and, to a lesser extent, caregivers and producers. An underlying conceptual thread in this type of research is an image of women as passive bearers of the virus, passive bearers of children, and

infectors of men and children. Very little attention or concern is directed toward the multiply constructed and socially situated experiences and meanings of AIDS in women's lives. Carovano (1991) argues that this splitting of women into "mothers" and "whores" is based on women's relationships to others. Accordingly, "in the context of AIDS these definitions reflect the needs of men and children, and it is in their relationship to the HIV-infected woman that she becomes a concern or a threat " (p. 132). Much of the epidemiological literature on AIDS in Africa supports Carovano's suggestion that "efforts to prevent AIDS among women have not been the result of a concern for women, but rather a concern that is primarily about protecting the health of men and children" (p. 132).

In contrast to epidemiological approaches that limit their conceptualizations of women to their roles as reproducers, producers, prostitutes, and caregivers, some approaches may be classified as "transitional" in their attempt to contextualize AIDS in Africa.

Transitional Representations of Women in the Epidemiological Literature on Women and AIDS in Africa

Many challenges presented themselves during the process of dividing the epidemiological articles into categories based on what I interpret as their underlying conceptualizations of women. I found myself constantly

referring to my list of feminist criteria and then searching through the articles for any indication that the researchers had even an inkling of how gender and class relations—much less, as Schoepf insists, macro and micro level political economy—construct women's experiences of the AIDS epidemic.

The articles included in this section also show evidence of conceptualizing women in their roles as reproducers. A critical distinction, however, is that they make an attempt to link women's higher levels of HIV infection and greater risk to the larger socioeconomic context. I choose to view this as an indication that the social as well as the biological construction of the AIDS epidemic is recognized by the researchers. The articles are thus classified as transitional. By transitional, I mean that they recognize, to varying degrees, the socially constructed nature of the epidemic. Consequently, the representations of women in these articles reflect at least some awareness of the multiple experiences and meanings of the AIDS epidemic in women's lives as shaped by gender and class relations.

The articles remain transitional because while they satisfy one or the other of the feminist criteria, they still retain the distanced, disembodied stance of the observer. At times they report on women's experiences of the epidemic, but they do not start from those experiences or work to transform and change the circumstances

contributing to the differential risks and challenges confronting women in the AIDS epidemic in Africa because of the intersecting inequalities of gender and class.

The first example of a transitional study is titled "Human Immunodeficiency Virus Infection in Urban Rwanda" (Allen et al. 1991). The authors treat gender as more than a variable, focus their research on a group of non-high risk women (that is, a representative sample of urban women as opposed to a focus on prostitutes), and touch on the importance of socioeconomic context. While relying on the classic epidemiological paradigmatic tenet of classifying women as "of reproductive age" (that is, in their roles as mothers), the study reveals the importance of behavioral variables attributable to women's partners as well as women themselves in creating risks for HIV infection.

Factors associated with higher rates of infection are identified as: (1) not being legally married (common law versus "legal" marriage); (2) sexual partnership of less than seven years; (3) women having more than one lifetime sexual partner; (4) a higher level of male partner income; (5) higher levels of alcohol consumption in male partners; (6) couples who had fewer than four children; (7) women who had a history of venereal disease within the last five years; (8) women who had received blood transfusions; and (9) women who had non-menstrual bleeding with intercourse (p. 1661).

The researchers speculate that the association between decreased risk for HIV infection in women and legal marriages and larger families "may be an indication that men in legal partnerships and those having large families (the average Rwandan women bears eight children) have fewer or lower-risk extramarital partners" (p. 1662). No further comment is provided on this observation.

Higher levels of male partner income correlate with "[male] socioeconomic status as a strong predictor of women's risk for HIV infection" (p. 1661). Higher levels of alcohol consumption are speculated to be associated with "drinking done in bars where prostitutes are readily available" (p. 1662). Unfortunately, this language reinforces the image of prostitutes as dangerous reservoirs of infection.

The authors offer the following explanation for the correlation between marriages of less than seven years and the increased risk of HIV infection for women:

> Men in Kigali become sexually active several years before taking a wife, and their sexual partners during this time are a small group of "free women" (often single mothers) who have many partners. In this setting, men may acquire the infection before marriage and transmit the virus to their wives. [pp. 1661-1662]

They go on to note that the prevalence of HIV in a "pool of 'free women'" in another Rwandan city was 88 percent in 1983. The authors conclude that given the patterns of male sexual behavior prior to marriage and the incidence of HIV

infection in "free women . . . this would explain the high prevalence of infection in wives whose partners had premarital sex in 1982 or later" (p. 1662). This study relied on women's knowledge of their partners' sexual behavior. The depth of analysis and interpretation would have been much improved if they had actually involved male partners in the research.

While Allen et al.'s research offers important insights, it is classified as transitional because of its representational language and imaging depicting women as "of reproductive age" and "pools of 'free women'." Additionally, it hints at, but does not fully explore, how gender and class relations shape women's economic vulnerability and consequent risks for HIV infection. The researchers are cognizant of some of the socially constructed aspects of the AIDS epidemic in Africa but neglect to further explore them in their analysis.

A second example of transitional research is a study titled "Knowledge of AIDS, Use of Condoms and Results of Counseling Subjects with Asymptomatic HIV2 Infection in The Gambia" (Wilkins et al. 1989). This study stands up well under the variety of feminist lenses applied to epidemiological research. It is classified as transitional, however, for three primary reasons. First, despite a clearer recognition of the socially constructed nature of the AIDS epidemic than the majority of epidemiological

studies, gender is still treated as a dependent variable. As Stacey and Thorne argue, treating gender as a variable creates analyses in which "gender is assumed to be a property of individuals and is conceptualized in terms of sex differences, rather than as a principle of social organization" (1985:307). Second, and more important, the authors' description of the research design indicates no recognition of the different types of knowledge, and thus analyses, that might have been produced had they chosen a woman as well as a man as their interviewer/counselor of both men and women. I am uncertain which of the factors listed in the following quote determined the choice of using only a male interviewer and counsellor in the project: "married . . . practicing Muslim from a rural community with 4 years of secondary education and 10 years of experience as a field assistant in epidemiological surveys" (p. 248) Perhaps all of them were determinant. Thus, a third and related point, is that while the authors identified the interviewer/researcher's social location, they failed to comment on how his social location influenced his interpretation of women's experiences of the AIDS epidemic.

The study was conducted in a largely Muslim area of The Gambia. Perhaps the researchers felt it would be more appropriate for a male to interview and counsel women than the reverse. Alternately, the interviewer's level of education and experience in working on epidemiological

projects could have been the deciding factor. It is also possible that the gendered relations in The Gambia might have limited the numbers of qualified female interviewers.

The researchers are especially sensitive to the psychological stress (and its sequelae) experienced by people upon receiving news that they are HIV positive. Counseling techniques focused on "the need to try to convey the information that was available rather than to be firmly prescriptive about issues such as future pregnancies" (p. 248). While the counsellor suggested that partners be notified of positive HIV serology, there was also a recognition of the possible adverse outcome of such a disclosure on relationships (p. 248).

The authors clearly recognize the constraints not only to negotiating AIDS prevention but also to carrying out effective counseling strategies. They observe that:

> the possibility of a free discussion of the implications of seropositivity between subject and partner(s) must depend on the nature and relative importance of the economic, reproductive, sexual, and emotional components of the relationship. These are likely to vary between cultures as well as between individuals in a given society. [p. 253]

Also articulated in the study are women's fear of rejection by their husbands and that, for some women, low levels of education make them economically vulnerable because there are "few economically viable alternatives to marriage in many societies" (p. 255). The authors suggest that even for women with higher levels of education,

> the nature of society may sometimes make a positive modification of behavior difficult; the position of a single woman is such that seropositive divorcees or the widows of men who die of AIDS face very great pressures not to inform a potential husband of their status. [p. 255]

This is also the first report I have encountered suggesting that religious beliefs, in the sense of fatalism and "acceptance of misfortune," might work against initiating behavioral changes to reduce AIDS risk.

As previously indicated, the researchers' attention to gender and class relations is evident throughout their report. In writing about and reflecting on their representations of women I realize that this report represents the most transitional approach of the three articles included in this section. I am, however, troubled by the authors' concluding remarks that the lack of behavioral change in couples with discordant serostatus necessitates a rethinking of using counseling as a technique in AIDS prevention programs because of counselling's "uncertain benefit" (p. 256). A feminist challenge to this conclusion would be to further address the structural factors that may mitigate against behavioral change and, in so doing, suggest ways that women can reduce AIDS risk. In addition, I am curious as to whether the results of their study would have differed if both male and female counsellors had been used.

Finally, a study titled "AIDS-related Knowledge, Sexual

Behavior, and Condom Usage among Men and Women in Zaire (Bertrand et al. 1991) does an excellent job of recognizing the importance of socioeconomic context, barriers against women's honest reporting of numbers of sexual partners, and showing differences in women and men's attitudes towards perceived risk of infection (pp. 54-56). The authors make several recommendations for AIDS prevention. For example, they urge that AIDS prevention efforts "should reinforce the idea that the two main means of protection from sexually transmitted HIV infection and AIDS are total mutual fidelity within monogamous couples and, where that is not possible, use of condoms" (p. 57). As further discussed in the next chapter, feminist approaches would emphasize that this type of recommendation while biologically plausible is not always sociologically plausible. Further, feminists using the culture and political economic approach to anthropology would stress the need to ground such recommendations in analyses of the ways the socially constructed aspects of the AIDS epidemic result in a multiplicity of experiences that create challenges, but not absolute barriers to AIDS prevention strategies.

CHAPTER THREE

FEMINIST REPRESENTATIONS OF WOMEN AND AIDS IN AFRICA

This chapter presents feminist challenges to mainstream epidemiological approaches and representations of AIDS in Africa. Some of the literature cited does not identify itself as explicitly feminist. The question then becomes what qualifies as feminist literature? I have not developed rigid categorizations of feminist criteria. While some of the criteria were presented in the introduction, they are repeated here to remind the reader of the types of value judgements I used in selecting material.

Literature included in this section had to first satisfy at least one of Harding's (1987) three criteria (ideally all three) of what constitutes the best in feminist literature. To review, these criteria include: (1) recognition of and explicit representations of the socially constructed aspects based in women's experiences of the AIDS epidemic; (2) locating the researcher and the researched in the same social plane; and, (3) most importantly, recognizing and making explicit the circumstances contributing to women's different experiences of the epidemic and offer suggestions for change or transformation

of these circumstances. Second, implied in Harding's criteria is the requirement for an intersections analysis approach to researching and analyzing AIDS in Africa. Third, Schoepf's (1992) feminist political economy and culture approach of linking macro political economy to gender and class relations at the micro level is an additional criteria in looking for evidence of some recognition of how these factors interact to create different levels of experience and meaning in the AIDS epidemic in Africa. Finally, Carovano's (1991) insistence that women need to be conceptualized in their own right rather than being categorized by their sexual and reproductive capacities in relation to men and children provides a further value-laden judgement.

One of the primary ways that these criteria are addressed is through the evaluation of the types of questions researchers asked. The previous chapter presented a detailed critique of the epidemiological literature using feminist lenses. That chapter focused more on the questions epidemiologists failed to ask. My critique involved showing how feminists might ask a different series of questions and might search for different answers. Susan Hunter, in writing about AIDS in Africa makes the observation that "the way we define a problem and visualize solutions depends on our world view, our political and social belief systems, and our resulting purposes and motives" (1990:688). This

section presents selected examples of the types of questions asked by feminist research on AIDS in Africa. Examples are chosen to reflect the criteria outlined above. Epidemiological literature that contextualizes the multiple factors affecting women's experiences of the AIDS epidemic is included in this section along with explicitly feminist approaches to the issue.

A rare example of an epidemiological study that problematizes the AIDS epidemic and situates it in the experiences of everyday life is an article focusing on AIDS prevention and education for commercial sex workers in Bulawayo, Zimbabwe (Wilson et al. 1990). What distinguishes this research from other epidemiological studies on AIDS in Africa is the authors' attention to the socially constructed determinants of the epidemic in the lives of commercial sex workers. Unlike other studies, this one provides a definition of commercial sex work and presents the heterogeneity or demographics of sex work within the city. Commercial sex work is described and analyzed within the sociocultural, economic, and historical contexts affecting its production and reproduction. The study also describes women's economic vulnerability, as shaped by such factors as labor migration and urbanization, that results in their using sex work as an economic survival strategy. Rather than classifying women as prostitutes and leaving it at that, the authors ask questions about the women's "life

histories," "the social organization of sex work," "motivation for behavior change," and "psychological responses to the threat of AIDS" (pp. 610-615).

Salient examples of gender and class relations shaping the AIDS epidemic include the fact that nearly one-half of the women in this study were divorced, the majority had at least one child, and that 98% of the women said that they had started sex work to support themselves or their children (p. 610).

The researchers' awareness of social construction is further revealed in their inclusion of occupational categories reflecting the realities of poor women's lives (e.g., whether employed in the formal or informal sector and in what capacity). Further, women were asked whether they would take another job if offered, and 91% responded that they would (p. 611).

Feminist approaches of orienting research for women are evident in the authors' change of plan to include clients in the study—a change that was motivated by requests from the women participants. As a result of this suggestion, clients were interviewed and encouraged to attend AIDS education focus groups. The authors note that research directed at health interventions for high risk groups must include equal attention to sex workers and their clients (p. 616).

The authors incorporate their recognition of the negotiated basis of sexuality and AIDS prevention throughout

their article. They identify the ultimate goal of AIDS prevention as structural change of the socioeconomic conditions putting certain groups of women at high risk (p. 615), but recognize the difficulty of implementing this goal and offer a number of alternatives. Providing commercial sex workers with the opportunity to work other part-time jobs is suggested as a way of reducing women's use of sex work as a survival strategy. Income from another source would enable women, in the authors' view, to be less reliant on clients and to have increased economic flexibility to reject clients if they refused to wear a condom or had visible genital ulcers. Building upon the strong social networks among sex workers, the researchers recommend peer-education counseling about HIV and AIDS risks. The authors stress that encouraging all sex workers to insist that their clients use condoms will, in essence, produce a united front that will act against clients playing off sex workers against each other. Reducing clients' resistance to condoms and involving sex workers' boyfriends or partners in AIDS prevention programs (sex workers frequently report not using condoms with non-paying partners) also needs to be incorporated into AIDS programs. Finally, changing AIDS prevention and education messages from those that instil fear (often accompanied by feelings of "stigmatization, denial, and fatalism") to those that empower is identified as crucial to addressing the meanings and experiences of the AIDS epidemic

in this group of commercial sex workers' lives (pp. 615-617).

An unusual opportunity to evaluate the types of questions asked in an AIDS research project is provided by the authors of a study titled "Knowledge, Attitudes, and Beliefs about HIV Infection among Healthy Factory Workers and their Wives, Kinshasa, Zaire (Irwin et al. 1991). The questions asked in separate focus groups for men and women are included in the article. The research was conducted as a preliminary step in establishing an AIDS prevention program at the factory. The authors' awareness of gender and class relations is evident throughout the article in statements framing social, economic, and health care inequities between men and women in this region of Zaire.

Particularly relevant to issues of social construction are the questions asked about counseling of HIV-positive individuals. For example, when asked "should the spouse of the person with a positive test also be notified of the test results?" (p. 921), more than one-half of the men stated that they would not want their wives informed. Men are reported as expressing fear of marital instability, which they felt could be avoided by finding ways to avoid infecting their wives. The majority of the women, on the other hand, stated that they would want their husbands informed of their test results. The authors explain this as due to many women's need for permission as well as money to

seek medical treatment. Most of the women indicated that they would want to know if their husbands were positive "so they could protect themselves from becoming infected, initiate separation, or help their husband seek medical care" (p. 921).

Questions asked under the heading "predicted social dynamics of couples with discordant HIV serostatus" (p. 922) are also revealing. When asked to predict potential changes in a couple's relationship if the husband was HIV+ and the wife HIV-, the majority of women indicated that, "they would stay with their husbands to care for him, but would refuse to have sex with him or share the same bed" (p. 922). Clearly, by predicting that they would abstain from sex, the women surveyed express a fear of HIV infection. It is also possible, in my opinion, that women's unwillingness to continue a sexual relationship with their husbands could be interpreted as a sign of resistance to male control over female sexuality and reproduction. The authors note that not all women agreed that the couple would stay together. Several women predicted that the couple would separate or divorce. Reasons included the following:

> the wife would not want to become infected, she would believe her husband had been sexually unfaithful, she or her husband's family would urge her to leave her husband, or she would want to have children and could only do so safely with another man. [p. 922]

When asked about the reverse scenario (HIV+ wife, HIV- husband), men were evenly divided in their responses.

One-half stated that they would separate or divorce and the other half stated that they would stay with the woman but avoid sex. In contrast, a majority of women predicted that the couple would stay together but abstain from sex. Several women stated, however, that women might be accused of having extramarital sex and be accused by the husband of adultery, thus further underlining women's vulnerability through the "threat of being thrown out of the house, and separated from her children or of being physically abused" (p. 922).

The patrilineal nature of many African societies means that women are socially and economically dependent. Further, in these societies, children belong to the husband's kin line. Many researchers (Bledsoe 1991; Schoepf et al. 1991; Ulin 1992) stress that women express fears that introducing the subject of a condom as HIV prevention into a relationship is tantamount to risking divorce or rejection. These fears are reflected in the responses of the men and women surveyed as part of the research by Irwin et al. When study participants were asked to anticipate what would happen to children if a couple separated or divorced, most people predicted that the children would stay with the father or his family (1991:923). Answers to the questions of how families would respond if they knew a couple had different test results also reflect gendered differences. In a scenario where the woman was HIV+ and the man HIV-,

most of the study participants predicted that the husband's family would react more strongly than the wife's, including "extreme anger, accusations of infidelity, demands for divorce, and death threats" (p. 923). In contrast, there was unanimous agreement that the husband's family "would not abandon him or refuse to care for him" if he were HIV+ (p. 923). A potentially important research direction that has yet to be articulated in the literature is whether or not (and how) women in matrilineal societies perceive the relationship between risk of infection and risk of rejection or divorce.

The study's recommendations and implications for the development of AIDS prevention programs emphasize the need to empower both men and women in sexual negotiation skills. The authors' suggestions for further research demonstrate their understanding of the complex nature of the AIDS epidemic. As an example, they recommend research into the possible conflict between the "high social value placed on parenthood in Africa" (p. 927) and couples' decisions to have children even if one or both of the partners is infected with HIV. Unlike the epidemiological report cited in the previous section that fails to investigate the connection between motherhood, potential economic security, and women's desire to have children, this study asks the question: "would an HIV seropositive woman who relied on her children's father as her sole source of financial support

choose to have a child even if she knew the risks of vertical transmission?" (p. 927).

This is a pertinent concern as shown in Carovano's (1991) essay. She cites the work of the AIDS Support Network (TASO) in Uganda. TASO's director, Noerine Kaleeba, reports on one woman's reasons "for not adopting measures to protect herself from HIV despite recognizing her potential risk" in the following manner: "Babies and condoms don't go together. Nonpenetrative sex is no sex at all for a man, and it is a woman's responsibility to bear a child" (cited in Carovano 1991:135.)

The difficult challenges faced by women as a result of the AIDS epidemic are also addressed by Marble Mageze in an article titled "Against a Sea of Troubles: AIDS Control in Uganda" (1991). Mageze is also associated with TASO, an organization that has been instrumental in listening to, involving, and empowering women as AIDS educators and peer counsellors in Uganda. In asking the question of why women are at greater risk for HIV infection than men, Mageze argues convincingly that answers can be found in cultural factors as well as gender and class relations. She points out that "the social and economic status of women in a male-dominated community means that they are more frequently infected than men" (p. 305). She identifies this higher rate of infection as linked to a variety of cultural factors including prescriptions against women discussing sex in

public, imbalances in power relationships involving negotiating changes in sexual behavior that might facilitate AIDS prevention, and a double standard that allows men to remarry but mandates that women should not remarry (p. 305).

The trend toward empowering women at all levels is evident in Mageze's statement that "the status of women cannot be improved unless they are educated about their rights and empowered to use them" (p. 305). According to Mageze, women who are HIV positive are faced with multiple challenges. They are expected to be the family caretakers and, as such, experience great concern for their children's future. Gender relations structure society in such a way that women are often economically vulnerable and their own and their children's security is vested in the husband's family. Women whose husbands die of AIDS are at risk of losing familial possessions through in-laws reclaiming them after the husband's death. Mageze notes that if a woman dies first, the children are at risk for receiving diminished care. The human side of the epidemic is reflected in her statement that this combination of concerns affects women both psychologically and physiologically. Mageze identifies improvements in health care as an essential prerequisite to effective AIDS prevention programs and stresses the need for activism at the grass-roots level to empower women to demand improved health and social services (pp. 305-306).

Anthropologist Susan McCombie, in an article titled "Beliefs about AIDS Prevention in Uganda" (1991), asks whether it is only women who experience difficulty in negotiating AIDS prevention. McCombie challenges the portrayal of the woman as the only partner in a sexual relationship fearful of introducing condoms as AIDS prevention. When asked what they would say to a partner if they wanted to use a condom and whether they felt it would be difficult to do so, over one-half of the men and women interviewed refused to answer the question, stating that "they would never want to use a condom." McCombie points out the importance of the fact that equal numbers of men and women replied in this way. The same discomfort was revealed by those who responded that it would be difficult to ask a partner to use a condom. Both men and women, according to McCombie, thus experience difficulty in negotiating AIDS prevention.

McCombie provides excerpts from interviews with men who "often state that it is women that do not want to use condoms, because they see it as an accusation of infidelity or an indication of lack of respect" (p. 7). I wonder about the generalizability of these statements, but they are germane to McCombie's point and provide insight into gendered relations in negotiating AIDS prevention. McCombie's inclusion of men's voices is an important and rare published example of situating men's as well as women's

experiences of the epidemic in the AIDS discourse.

The question of the need to empower men to change gender perceptions and relations that encourage them to treat women as subordinate is addressed by Maxine Ankrah (1991) in an article focusing on the social aspects of health and AIDS. In describing the disadvantaged position of women in Africa, Ankrah states, "the multiple social, economic, and cultural burdens carried by the African woman of childbearing age, much more than her choice of sexual behaviors, may pose the major threat to her health" (p. 971). Empowerment for women is a vital part of AIDS prevention, but according to Ankrah, given the gender-based inequities in social organization that put women at higher risk, men too must be empowered to change. Ankrah argues that there is a general level of fear in addressing African men about their sexuality and attitudes towards women as subordinate beings (p. 922). While the following excerpt is lengthy, I include it in its entirety for its unusual approach to suggesting that men as well as women must be empowered and for its emphasis on the need for change of gender relations in developing increased AIDS awareness and prevention:

> In understanding the family and male-female relationships there is a need and an opportunity to reorder perceptions and actions. In particular, the critical problematic of male-female relationship and its impact on the spread and control of AIDS need to be re-examined. Additionally, the concept of maleness which hinges on the subordination of women must be exposed so

> that the danger such subordination poses to society in terms of facilitating the spread of AIDS can be realistically investigated. Male sexuality should be studied in depth as a matter of priority for clues as how to best bring about a more rapid change in male attitudes and behavior. The concept of empowerment may be viewed as a strategy to reinforce efforts of the African male to new perceptions of his female partner—as an equal and as a collaborator in a renewed struggle to preserve life in the Africa region rather than as an inferior person. The empowerment of men is expected to be a function of enactment of laws; it should result from new forms of education, defined broadly as socialization. [p. 978]

In "Women and AIDS in Zimbabwe: The Making of an Epidemic" (1991), Mary Bassett and Marvellous Mhloyi question mainstream approaches to researching and representing women and AIDS in Africa. Using an approach they identify as "the political economy of family structures" (p. 149), the authors trace historical, political, cultural, and socioeconomic factors contributing to the types of familial change that put women at higher risk for AIDS. Here I attempt to outline their formulation to demonstrate how it contextualizes the development of AIDS in a significantly different manner than does mainstream research.

The links between political economy and the gender and class-based construction of the AIDS epidemic also form the cornerstone of Brooke Schoepf's arguments, which are presented below. Like Bassett and Mhloyi, Schoepf presents a description of the multiplicity of factors contributing to poor women's increasing economic vulnerability and to the

spread of AIDS in Africa. Here I will summarize these changes, relying principally on Bassett and Mhloyi as a reference point. While there are variations in the description of change provided by Bassett and Mhloyi based on historically, geographically, and cultural specific factors, similar processes have been noted by many authors (Burja 1986; Hansen 1989; Mbilinyi 1989; Obbo 1980; Parpart 1989).

According to Bassett and Mhloyi, colonialization created forced male labor migration and a cash economy, as well as a hut tax based on a cash payment. The authors note that prior to colonization, patrilineal societies had a standard dictating that while men did not necessarily have to be sexually faithful to their wives, they were responsible for financial support of women and children (p. 149).

A woman's economic security and rights were vested in her husband's family, although she did have the right to remuneration for her "own handiwork, to plots on which to grow family food, and to certain gifts of motherhood" (p. 149). The combination of enforced changes in family structure as a result of colonization, European patriarchal ideology, and existing systems of patrilineal organization resulted in the reduction of women's traditional rights. Bassett and Mhloyi note that "[women] were reduced to perpetual minority status in the guardianship of either

their fathers or their husbands" (p. 149). The authors highlight the difference between ideology and reality in observing that, in the early 1980s, about one-half of the rural households were headed by women (p. 149). They point out, however, that "responsibility does not translate into control" (p. 149) and that women's access to and control of resources in Zimbabwe remains limited. The separation of families as a result of male labor migration resulted in changes in sexual relations including men's "form[ing] other liaisons in towns" (p. 150). The impact on women left behind in rural areas was profound, with the possibility that town relationships "might even supersede the rural wife, leading to divorce or a reduction in remittances" (p. 150). The loss of material support from town-based husbands significantly increased rural women's economic vulnerability (p. 150).

Patterns of multiple relationships that emerged in urban settings should be distinguished from traditional polygamous relationships. What Bassett and Mhloyi term "the artificial settlement of men without their families" resulted in changes "in where both men and women live as well as in their patterns of sexual interaction" (p. 150). While women were initially prohibited from urban migration both legally and by the lack of employment prospects, some women in fact migrated to "meet the demand for sexual services" created by the separation of families. Bassett

and Mhloyi connect the longstanding cultural stereotyping of urban women, especially single or divorced women, as equivalent to prostitutes to a contemporary focus on prostitutes as a high risk group in AIDS control programs (p. 150).

Given the historical conditions that have contributed to women's economic vulnerability and changes in family structure, Bassett and Mhloyi contend that the "exchange of sex for money or for other goods and services covers a broad range of arrangements" (p. 150). The scope of reasons women exchange sex for money includes mothers' needs to pay school fees and provide material necessities for themselves and their children. Additionally documented is the pattern of "younger, even . . . school age" women receiving money for sex from older men, seasonal women laborers supporting themselves in the off season by selling sex, and employed women "forced to exchange sex for job security" (p. 150). The authors point out that the exchange of sex for money is not limited to urban areas. For example, rural areas at the crossroads of major transportation routes are also the sites of this means of survival strategies for women (p. 151).

As reflected by the above evaluation, Bassett and Mhloyi build a strong argument for the connection between women's subordinate position in patrilineal African societies and their correspondingly greater risks for HIV infection. According to the authors, women's subordinate

position makes it difficult for them to initiate AIDS prevention. Consequently, they note that "for many women faced with dire poverty on the one hand and the risk of HIV on the other, the choice becomes one of 'social death' or biological death" (p. 146). Bassett and Mhloyi also question and challenge mainstream treatments of women as vectors and vessels. They note that the emphasis on "high risk groups" such as prostitutes has created the mistaken representation that without women there would be no AIDS epidemic (p. 146). Further,

> if not depicted as a dangerous source of infection, women are of interest to those conducting AIDS research or designing interventions mainly in their pregnant state . . . the image of women becomes one of a contaminated vessel bearing condemned babies . . . . This reinforces the notion that the mother is solely responsible for the child's serostatus. [p. 146]

Bassett and Mhloyi move beyond stating the obvious reality that women are caregivers in African society to consider this social fact in the everyday experiences of women's lives. In other words, they do not leave it at a simple statement of decontextualized "facts" or statistics. They point out the strain that the role of caregiver places on women not only in caring for others but in trying to care for their own health as well. They ask the important question of whether traditional coping mechanisms within the family can be sustained under the pressures of having one or both parents sick with AIDS and the possibility of sick children. Women's caregiving responsibilities take on a new

light when framed in this manner.

The authors argue that "efforts to increase women's options" must be built into AIDS prevention and education strategies (p. 147). One of these options must be the recognition of the importance of motherhood in Africa and the need for women-controlled AIDS prevention technologies. The complexities of the motherhood-womanhood-economic security triad, as well as the fact that many women want to have children, creates the need for AIDS prevention methods that prevent infection but also "possibly permit conception" (p. 154). This is one of the few articles that identifies the social location of the authors. In this instance, they are involved in providing health care to women in Zimbabwe. From this perspective, they observe that "no one involved in the caring for HIV-infected women in Zimbabwe, and presumably elsewhere, can fail to be struck by the limited opportunities that women have in negotiating their sexual relations" (p. 146).

As mentioned previously, Brooke Schoepf (and her colleagues) have written extensively about the socially constructed basis of the AIDS epidemic in Africa as shaped by the interaction of political economy and gender and class relations (1991a; 1991b; 1991c; 1991d; 1992; and Schoepf et al. 1991). This work strongly challenges and questions mainstream research on AIDS in Africa, as reflected in the statement that "the classic epidemiological paradigm of

interacting host, disease and environment provides a part-truth which serves to obscure more complete understanding" (1991a:754). As opposed to simplistic recommendations that ignore the realities of women's lives that shape challenges to AIDS prevention, Schoepf et al. observe that "increased knowledge is necessary but seldom sufficient to change behavior" (1991:189). At every point, she and her colleagues are involved in basing their search for why women are at greater risk for HIV infection in the experiences of people's (most particularly women's) everyday lives. Schoepf's work—alone and with her colleagues—is presented as the last example in this chapter because it satisfies the vast majority of the feminist criteria established as evaluative judgements for literature reviewed in this thesis. It is particularly strong in basing research in the experiences of women and in working toward transformation or change of socially constructed risk factors for AIDS in women's lives.

Schoepf identifies her research approach as "cultural politics," meaning an approach "used to frame the context in which a biologically and socially constructed epidemic is endowed with meaning by actors variously situated socially" (1991d:9). The research produced by Schoepf and her colleagues is based on research conducted by members of CONNAISSIDA, an action-oriented AIDS research project in Zaire over a five-year period from 1985-1990. This group sought to develop a broad understanding of the

> spread of HIV infection and ways that AIDS is perceived and reacted to by the population--the cultural construction of AIDS. In the process, researchers worked with informants to develop culturally appropriate means of limiting the epidemic. [Schoepf et al. 1991:2]

Like Bassett and Mhloyi, Schoepf stresses the

> reshaping of women's lives differently from those of men in the process of incorporation in colonial capitalism . . . . Women's poverty, their family responsibilities, their lack of access to resources and inability to negotiate in sexual relations are central to HIV spread. [1991b:791]

Schoepf et al. (1991) expand on Bassett and Mhloyi's formulation of the political economy of family structure to situate the AIDS epidemic in the word economic crisis. They state,

> throughout the continent, poor women and children have experienced most severely the effects of structural adjustment policies and the deepening [economic] crisis. In Zaire as elsewhere in the region, economic crisis and the structure of employment inherited from the colonial period contribute to the feminization of poverty and consequently to the spread of AIDS. [p. 190]

Schoepf, as previously mentioned, links poor women's economic vulnerability and increasing inability to earn income in the informal sector to their use of sexual exchange as a survival strategy—which, because of the AIDS epidemic, has transformed into a potential "death strategy" (1991d:9). Multiple partnerships are common in Africa for both men and women, according to Schoepf and her co-authors (1991). In this regard, they observe that "it is the fact of multiple partners, rather than the type of relationship, however socially categorized and labeled, which puts people

at risk" (p. 192).

Schoepf (1991d), uses case studies as "vignettes [that] lend texture to epidemiological data" (p. 27). The use of case studies eloquently reveals the many experiences of the AIDS epidemic in women's lives. At the same time, they also reveal how the larger political economy constructs different experiences of the AIDS epidemic based not only on gender but also class. According to Schoepf (1991d), the challenges to women negotiating AIDS prevention are "social, psychological, and material":

> Most women are at risk because their economic and social powerlessness in the overall organization of Zairian society and their subordinate position to men circumscribes their options. Few are able to practice safer sex. Some do not feel able to open dialogue with sexual partners on the subject. Others who have attempted to do so have experienced rejection and retaliation. Those who have reduced their risk are women with decision-making power based on their capacity to support themselves and their dependents without resort to sex within or outside of marriage. [p. 28]

In an article titled "Gender, Power, and Risks of AIDS in Zaire" (1991), Schoepf and her colleagues describe AIDS risk-reduction workshops conducted by CONNAISSIDA in Zaire as based on the concept of experiential training. Experiential training is described as "begin[ing] with the principle that people already know a great deal about their situation" (p. 193). The focus is on empowerment, which is situationally defined as "the capacity to control risky situations" (p. 192). Two examples of workshops conducted are provided—one with sex workers and another with a group

of churchwomen. Schoepf and her colleagues describe the steps in the training process and the different, but overlapping, experiences of the AIDS epidemic as well as the empowerment needs among these two divergent groups of women. Role playing, demystifying condoms (e.g., "demystifying what is an unfamiliar, uncongenial, unnatural, unwanted foreign technology"), and situating AIDS prevention in a broader community and health context are key elements of the CONNAISSIDA approach (pp. 194-196).

The collaborative nature of the action-oriented research process is reflected in the fact that both the sex workers and the churchwomen requested additional workshops. The sex workers asked for peer counseling training. The churchwomen asked for workshops for "husbands, adolescents, and young adult members of their households" (p. 200). The authors note that "the most pressing need identified by both women's groups is for income-generating activities so that women who cannot depend upon men to support them and their children can survive without providing sexual services to multiple partners" (p. 200).

Finally, this study concludes with a classic feminist statement:

> AIDS prevention is both personal and political . . . . In the final analysis, effective AIDS control in Africa will require changing the economic and social status of women. Women's economic independence, their personal autonomy, and their control over interpersonal relations, including the power to negotiate sex, must be increased in order to stop AIDS. [pp. 202-203]

Schoepf's work can be classified as standpoint thinking, major conceptual pieces that give new explanations and advance theory (Baca Zinn 1992). According to Baca Zinn, feminist theorizing consists of integrating the multiple hierarchical systems of inequality such as gender, race, and class into explanations that: (1) open the concept of gender to analyses of historical, cultural, and structural differentiation; (2) see gender relations as a part of the myriad of social relations in any society; and (3) think about gender as being inseparable and interconnected, that is, intersected with other forms of inequality (1992). The work of Schoepf and her co-authors satisfies all these requirements.

Further, the research of Schoepf et al. meets the operating guidelines for feminist research used as criteria in this thesis. They may not achieve the "ideal" of reflexivity, that is, giving voice to her (or their) experiences of the research process and how they are shaped by and shape the interpretations achieved. They do identify, although they do not reflect on, their own social location. The research is collaborative, emphasizing the redistribution of power and making the research relevant to the communities studied. The research process of CONNAISSIDA and the intent of their approach is summarized by Schoepf as:

> The process of constructing a contextual framework to situate sexual behavior involves listening to

> people in many different social locations. Experience with participatory risk assessment shows how ethnography can build upon local social knowledge, concepts, and organizations to develop a consensus in support of risk reduction. When those who are at risk play an active role in the research process, culturally constructed meanings can be shared and changed. [1991d:15]

In summary, the approach of Schoepf and her colleagues to community based action research can and should provide a model for transforming current mainstream approaches to AIDS research and prevention into approaches more inclusive of the socially constructed realities of the AIDS epidemic in Africa.

CHAPTER FOUR

INTERNATIONAL AND UGANDAN AIDS CONFERENCES

In 1992 I attended international and Ugandan AIDS conferences and spent five weeks in Uganda as a part of predissertation research. These experiences allow me the opportunity to more fully contextualize the insights of this thesis. My goal is to demonstrate whether and how the arguments I have presented are reflected in the international, national, and local levels of AIDS discourse and praxis. The chapter is divided into two sections. The first presents my reflections on information from the VIII International AIDS/STD Conference in Amsterdam. The second addresses issues raised at a conference on women and AIDS in Kampala, Uganda.

VIII International AIDS/STD Conference

The sessions at the VIII International AIDS/STD Conference in Amsterdam in July 1992, were divided into four tracks: (1) basic science; (2) clinical care and science; (3) epidemiology; and (4) social impact and response. I attended several of the epidemiology sessions and a large number of the social impact and response sessions. As will

be shown below, there is a gap in the direction and content of the research and analyses produced in these two tracks. Speakers at the opening ceremony articulated a need for more fully contextualized accounts of the AIDS epidemic. Despite this, the epistemological differences in how knowledge is produced and what counts as knowledge remains a profound line of demarcation between researchers in the epidemiological and social impact and response tracks.

Since I attended only a few of the epidemiology sessions, my interpretation of the nature of the epidemiology track as a whole is obviously very partial. In the sessions I attended, the epidemiological context was presented, but not the other range of contexts—social, political, cultural, economic—identified in this thesis as important to the construction of more representative analyses of the AIDS epidemic. An important exception to this, however, was the session on "Epidemiology of HIV in Women", where a prominent AIDS researcher from Kenya, Elizabeth Ngugi, and her co-presenters stressed all these contexts as important to understanding the epidemiology of the AIDS epidemic.

Women with HIV/AIDS, as well as women researchers and activists from around the world, were very active both in contributing to and being a presence at the conference. The participants at the first international pre-conference titled, "Workshop for Women Living with HIV/AIDS," developed

a list of statements concerning the needs of women living with HIV/AIDS globally. The list of statements, which is included here as Appendix I, reflects the diversity of needs and concerns of women from both developed and developing countries.

One of the most moving and powerful parts of the international AIDS conference occurred when 33 HIV-positive women from different countries filed in front of the eight to ten thousand delegates at the opening ceremony. Each woman identified herself by her country and by the fact that she was an HIV-positive woman. Every third woman read one of the statements on the list of needs developed by the women living with HIV/AIDS workshop. I interpret the power of these women's actions as linked to their purposes of making women with HIV/AIDS visible to the international research community, speaking with their own voices, and making their needs known.

At a follow-up session to the international pre-conference, those attending agreed to raise the issues on the pre-conference list of statements at each of the sessions we attended at the larger international conference. Our purpose was to alert the international community to the differing meanings, experiences, and needs of women living with HIV infection and AIDS. People attending the follow-up session were given copies of the "Women Program Guide," which is included as Appendix II. The Women Program Guide

supplemented the official international AIDS/STD conference guide and highlighted conference sessions devoted to women's issues.

An example of AIDS research protocol that was challenged repeatedly by women attending the epidemiology sessions was the non-inclusion of possible gynecological manifestations of HIV infection and AIDS in women. At the time of the international AIDS conference, the clinical case definition of AIDS was based on the manifestation of symptoms in men. This can, in part, be explained by the fact that the clinical case definition is based on the development of AIDS in homosexual men. In an epidemiological session on "Gender-Related Variations in Natural History," gender was repeatedly referred to only in the biological sense (as in male or female) by all but one of the presenters. All but the last presenter treated gender as a variable; no gender-related differences in the natural history were discovered because the researchers relied on a male-based clinical case definition of AIDS in their research of HIV infection. This approach does not allow for recognition of gender-variations since the research design itself precludes the possibility. In the final presentation of the session, the social construction of gender was acknowledged and made a central part of the research design and analysis. The presenter of that paper placed a great deal of emphasis on how variations in the

social construction and meaning of gender has the potential for increasing women's risk of HIV infection.

The question and answer portion of that session was taken up by challenges from the women present (to all but the last researcher) asking why gynecological symptoms, such as cervical dysplasia (a pre-cancerous condition), have not been included in either the WHO or the CDC (Center for Disease Control) clinical case definition of AIDS. In answer to the presenters' circular reasoning that possible indications of AIDS in women were not included in the study because they are not part of the case definition, the women who were posing questions asked whether the international research community realized the implications of their exclusionary practices. For example, if gynecological symptoms that might be indicative of a progression from HIV infection to AIDS are not included in the case definition, then women are effectively excluded from AIDS research programs. They can not receive government-sponsored financial support for treatment of AIDS if they do not fit the definition of what constitutes, in epidemiological language, an AIDS "case."

This example demonstrates the epistemological drawbacks to creating definitions of social (and physical) reality based solely upon the experiences of men. Perhaps as a response to the challenges brought by women at the international AIDS conference, the CDC recently announced

that they changed their clinical case definition of AIDS to include gynecological manifestations such as invasive cervical cancer.

The majority of the arguments set forth in this thesis were strongly reinforced in the presentations at the opening ceremony and in the Social Impact and Response Sessions that I attended. Many of the presentations stressed that biomedical, socially decontextualized approaches to AIDS research, care, and prevention are inadequate to the task of responding to the epidemic. Jonathan Mann, former head of the WHO Global Programme on AIDS and Conference Chairperson, stated in his opening remarks:

> It is necessary to change our current vision of AIDS because it is outdated . . . . The basic issue before us is . . . how we see AIDS, how we understand it, what we think it is really about—determines both what we do about it and how successful we will be. . . . societal inequity and discrimination fuel the spread of the pandemic . . . to be effective against AIDS we would have to address these issues. [1992:5-6]

Mann went on to note the importance of situating AIDS prevention and care efforts in lessons "grounded in the experience, knowledge, and lives of people [living with HIV/AIDS] worldwide" (p. 6). He did not explicitly frame his comments in intersections analysis or the feminist cultural and political economic framework. Nonetheless, the following excerpt reflects aspects of these feminist frameworks for approaching AIDS research:

> HIV exploits societal weaknesses, and the major fault lines in society along which it proceeds are

> those of inequity and discrimination: belonging to any marginalized or stigmatized social group creates an increased risk for HIV infection as well as an increased risk of receiving inadequate care and support. Therefore, to approach the individual as if her or his behavior was independent of economics, culture and politics—or independent of human rights and dignity—would be to deny the reality we know. [p. 6]

Women's increased vulnerability to HIV infection due to social, economic, political, and cultural factors surfaced as a dominant theme at the conference. Eka-Esa Williams, president of the Society of Women and AIDS in Africa, stated in her comments at the opening ceremony that two out of three people diagnosed with HIV worldwide are women. She attributed this to social factors of poverty, discrimination, and the subordinate status of women around the world.

Many of the Social Impact and Response sessions focused on factors that constrain or enable people to negotiate a reduction in their risk of HIV infection and AIDS. The authors of the Conference Summary Report of the Social Impact and Response Sessions observed that the focus of AIDS research is slowly shifting from the individual to the societal level. Specifically, the "blame for HIV acquisition and transmission [has been] shifted away from the individual, onto the underlying structures that limit or prohibit choice in decision making" (van den Boom and Gostin 1992:34).

The issue of women's economic dependence was raised

repeatedly at the sessions, particularly by women researchers and activists from the Third World. Considering the "socio-cultural context as a possible risk context in which people exist and have to survive" leads to a recognition that women's economic dependence and unequal relationships of power between men and women put women at greater risk of acquiring HIV (p. 35).

The multiple meanings and experiences of the AIDS epidemic as structured by gender, class, race and so on were reflected in the titles of some of the sessions: "Gender, Power, and HIV; Barriers to Condom Acceptance; Prevention Programs for Women; Making Choices: Women, Reproductive Rights and HIV; Women's Access to Prevention and Care; Changing Male Heterosexual Attitudes and Behaviors; Empowering Heterosexual Women; and Intravaginal STD/HIV Prevention Technology Controlled by Women."

Participants in the session on prevention programs for women stressed that current recommendations for reducing risk of HIV infection—reduction in number of partners, condom use, and asking your partner's sexual history—all ignore the reality of gender and power relationships. Condoms, as was noted in this and other sessions, are a male controlled technology; women have to rely on the cooperation of their partners in order to reduce their risk of HIV infection. Women activists and researchers thus called for increased research into HIV prevention methods that are

woman controlled. The need for a viricide that is not a spermicide was suggested as a possible solution to the dilemma that many women face in choosing between HIV prevention or contraception.

Finally, as in many of the feminist analyses and critiques presented in this thesis, there was a call in the Social Impact and Response Sessions for greater attention in research and prevention programs to the many difficult decisions that women are confronted with when trying to reduce their risk of HIV infection. Researchers and activists from both developing and developed countries insisted that the meaning of motherhood in societies that may only define women as women when they have one or more children needs to be more explicitly recognized. As previously noted, asking a woman to use a condom for HIV prevention means that you also ask her to contracept. In societies that place a heavy emphasis on women's childbearing, women who have been informed of the high rate of perinatal HIV transmission may still choose to have children. Papers presented on this topic stressed that women's decisions about HIV prevention have to be seen within specific cultural contexts.

Mobilization Workshop for HIV/AIDS Prevention, Control, and Patient Care for Women Leaders

In many ways, the conference that I attended in Kampala on women and AIDS in Uganda addressed issues of the cultural determinants of HIV risk for women more than the international conference in Amsterdam. Sponsored by the Uganda chapter of the Society for Women and AIDS in Africa (SWAA), the conference was titled "Mobilization Workshop for HIV/AIDS Prevention, Control, and Patient Care for Women Leaders." Attended by women leaders of the 35 districts of Uganda, as well as by other individuals and organizations involved in AIDS research, the conference had a number of goals. The first goal was improving education and awareness about HIV, AIDS, and STDs with particular reference to women. This goal was directed at improving attendees' ability to communicate this information to people in their respective districts. The second and third goals directly reflected many of the issues highlighted in this thesis: specifically, to "explore and discuss gender issues/roles pertaining to HIV transmission and care of people with AIDS; and to foster a more creative approach to community participation and income generating projects" (SWAA 1992). The fourth goal encompassed district leaders making plans for community based care projects within their districts.

The tone and focus of this conference was substantially different from those of the Amsterdam conference. While

there were many presentations by expert AIDS educators, counselors, activists, and researchers, the organizers of the conference stressed that it was the women themselves who were the experts on issues of gender, power, and HIV/AIDS. In this sense, the organizers followed the feminist standpoint principle of doing research, for and with women. A recognition of the different forms of knowledge and knowledge production was also a key aspect of this conference. Participants expressed and shared their knowledge, creating a dialectical exchange and creation of knowledge among attendees, presenters, and conference organizers.

One of the most memorable examples of this dialectical exchange occurred during a session entitled "Traditional Practices that Put Women at Risk of HIV Infection." The group facilitator, is an AIDS counselor and trainer with The AIDS Support Organization. Rather than telling the conference participants what traditional factors increase risk for HIV infection, he recognized the women's expertise and knowledge and proceeded within that framework. The participants were first asked to define culture. A variety of explanations were offered, but the following four items were agreed upon: (1) group behaviors found among certain people in a community; (2) behaviors accepted by the group; (3) such behaviors were described as entailing practices, beliefs, religion, values, customs, morals, and attitudes;

and (4) it was noted that different tribes in Uganda each have different cultural behaviors.

Conference participants were then asked to name cultural behaviors that put women at risk for HIV infection. A very long list, with contributions from each district, was developed. There was some overlap in the behaviors listed. From an anthropological viewpoint, one of the most revealing aspects of the process was the exclamations of surprise when cultural behaviors identified by participants from the different districts fell outside the realm of individual and collective (as in being a member of a tribe with a particular set of cultural behaviors) experience. For example, rape—defined by a conference participant as women having to "play sex" against their will—was identified as occurring in her tribe or culture. This led to outbursts of surprise by conference participants from other tribes. I am using the term tribe, rather than other anthropological constructs of ethnic and cultural identity, because it is the term the participants themselves used to describe one aspect of their social identity.

I am including the majority of the list developed by conference participants to provide an example of how culture (in the form of ethnicity), as well as gender and class create different meanings and experiences of the AIDS epidemic for women (and for men). Polygamy, wife inheritance, ritual cleansing of widows, and the fact that

women do not have control over their own bodies or sexuality were at the top of the list. The lack of control over their bodies and sexuality was listed and relisted. As one participant stated, "women are expected to play sex whether they want to or not." Women's lack of knowledge about HIV and AIDS also contributes to increased risk, as do religions that prohibit the use of condoms. Marriage rites among some tribes that encourage the prospective groom to "play sex" with a maternal aunt were euphemistically phrased as "marriage initiation ceremonies." Ceremonies such as funeral rites and twin ceremonies were identified as times when many people "play sex."

Definitions of womanhood that define women as women only if they have children were also characterized as contributing to the spread of AIDS. Women who are unable to conceive with their partners might engage in "child seeking behavior" with other men, which puts them at risk for infection. The fact that prevention of HIV means prevention of births was agreed upon by all as "women's dilemma." Forced marriages, in which there is no HIV testing prior to the marriage, was also mentioned by several district representatives.

The double standard that allows men, but not women, to have extramarital partners, and women's perceived inability to control their partners' behavior were identified as major risk factors for infection. Some districts have

discriminatory divorce laws, preventing women from seeking divorce to protect themselves. One conference participant stated that in her district, men only have to prove adultery in order to be granted a divorce, whereas women have to prove cruelty and desertion.

According to several of the women's leaders, women's lack of control over their own sexuality leads to limited foreplay. The resulting vaginal trauma and tearing due to "dry sex" increases the risk for HIV infection. An example of how placing women at the center of research can lead to new forms of knowledge was provided by one participant's observation that female circumcision also creates the same effects and consequences for increased infection.

This contribution was particularly striking because in all the reading that I have done on risks for HIV infection, I have never encountered this observation in the literature. Female circumcision is often identified as a risk factor in terms of unsterile instruments, for example, but not in terms of the ways that it changes women's sexual experience and thereby potentially increases the risk for HIV infection. One of the conference participants brought up the topic of oral sex as a cultural behavior that puts women at risk for AIDS. This led to a long and frank discussion about what oral sex is (many of the participants were unfamiliar with the concept). Several participants asked how oral sex was done. The participant who identified it as

a cultural behavior attempted to explain it, but was interrupted several times by outbursts of disapproval by other attendees. When the session facilitator explained how oral sex is performed he described it as something that is done between "two women having oral-genital contact in the 69 position". He did not include the possibility of women and men having oral sex in his definition. This led to more exclamations of disapproval and the ice-breaking question from one conference participant of "if 69 is the number for two women having oral sex, what is the number for two men having oral sex?" To which another participant replied, "99". I am including a detailed description of this particularly contentious contribution to the list to show the ways that sexuality is filtered through individual and collective lenses that are structured by social relations. It also challenges cultural stereotypes that contend that Africans find it difficult to talk about sex. As illustrated in this example, not only did the women at the conference talk frankly about oral sex, they did so with humor.

The issue of oral sex led to heated debate about what constitutes cultural behaviors. There was disagreement about whether oral sex, which most agreed is an imported behavior, is really part of Ugandan culture. The conference participants were fairly evenly divided between acknowledging that it is a part of culture and arguing that

such an obviously imported behavior cannot be considered to be a cultural behavior. This is an example of how people view certain behaviors as part of their own cultures, as part of other cultures in the country, or as so foreign that they could not be part of the perceived larger indigenous, or Ugandan culture. There are implications for AIDS prevention of this dichotimization of behaviors into "part of our culture"/"not part of our culture." For example, people may engage in high risk behaviors and not consider themselves at risk, because the behavior is not conceptualized as part of a cultural or a sexual identity.

My position of otherness as a guest at this conference was especially acute during this session. [I had joined SWAA while attending the international AIDS conference in Amsterdam.] I was one of the only non-Ugandans present and certainly qualified as someone from another culture. In the earlier sessions, I had shared some information about my background, interests, and reasons for attending the conference during the initial introductions. During the discussion and debate about what oral sex is, how it is done, and whether or not it is a part of culture, I observed several of the conference participants looking my way. I wondered what their expectations of the outsider were and debated about whether or not to contribute to the discussion. I was wary of appearing to be the expert and also did not want to contradict the facilitator's definition

of oral sex as limited to homosexuals. I chose to stay silent, having gone into the conference with the aim of learning from the people attending. After the session, three conference participants asked me why I did not participate in the discussion and expressed hopes that I would share my perspective and knowledge about women and AIDS.

Unequal power relationships between men and women were frequently identified as a cultural risk factor that increases women's exposure to HIV infection. Manifestations of these inequalities that put women at risk for HIV infection were identified as women seeking favors (material goods) from chiefs or employers. Student-teacher sexual relationships, which were said to be pervasive at all levels of education, also contribute to women's increased vulnerability to infection. School-age girls, who are especially economically vulnerable, may exchange sex with teachers for money or material goods.

There was also a great deal of heated discussion about the trend of older men having sex with younger women or girls as a perceived means of protecting themselves against HIV infection. The participants were outraged that this practice in fact results in a high likelihood of older men infecting younger women. Their observations are reflected in the gender and age disparities in the AIDS statistics from Uganda. Statistics from July 1992 show that there are

six times as many cases of AIDS among 15 to 25-year-old women than among men the same ages. The pattern is reversed in the 25 to 49-year-old age group, with more men than women with AIDS (AIDS Control Programme 1992). These statistics are grounded in people's experiences of the epidemic. As reflected in the comments by conference participants, they show how the AIDS epidemic is differentially experienced based along the axes of gender, age, class, and power. The statistics reflect only diagnosed cases of AIDS rather than overall prevalence of HIV infection. Since it can take up to several years for HIV infection to progress to AIDS, women who are represented in the AIDS statistics at age 15 were probably infected several years earlier.

At the close of the session, the facilitator shared his perspective and posed some questions to those attending. He stated that current approaches to HIV prevention, such as using condoms, clearly are not working. Cultural behaviors he stated, are learned behaviors; just as they are learned they can be unlearned. He acknowledged the central role that women play in promoting behavior change. At this point, several conference participants challenged his statement, arguing that while women in fact are changing their behavior, the real power in sexual decision making is with men. The facilitator then asked participants whether women have a right to say no to unprotected sex with their husbands. Participants responded in the negative, stating

that culturally, that right is conferred by men.

In closing, the facilitator asked a series of key questions. First, does culture really exist? Second, what does it mean to say that culture does not allow women to control their own bodies and sexuality or that cultural attitudes contribute to women's economic dependence? Third, if culture prevents AIDS risk reduction behavior, what does this mean? Finally, if the cultural behaviors listed during the session increase women's risk for HIV infection, are those aspects of culture worth protecting?

Two additional themes of this conference merit mention in regard to the content of this thesis. The first is a reiteration of the numerous times that women's economic dependence was raised as a major risk factor for HIV infection in women. Representatives from all of the districts stated many times over that women hesitate to ask their husbands to use a condom for fear that they will be rejected. Rejection in this case was identified as being forced to leave their marriage, children, and any material or economic security behind. Women, according to the participants, often choose economic security over even communicating concern about risk of HIV infection to their husbands, much less taking action by insisting on a condom. Everyone in attendance agreed that if women had increased opportunities to earn and control their own incomes, they would feel more economically secure. In turn, women who

feel more economically secure would feel more secure about protecting themselves against HIV infection. This was also a theme at the Amsterdam Conference on AIDS.

The women leaders attending this conference seemed very committed to the conference organizer's goals of mobilization and action to empower women to reduce their risk of HIV infection. All the representatives developed action plans for educating women in their districts about HIV and AIDS and for initiating income generating projects. Most of the women leaders represented women in rural districts, and while it appeared that many were probably fairly well educated and not part of the rural poor, they nonetheless took their mission of representing the needs and concerns of low income women in their rural districts seriously.

I present this information as a background to make a final point about the importance of placing marginalized groups at the center of knowledge production and analyses. As previously noted, by placing conference participants at the center of knowledge production, the conference organizers showed an explicit recognition of the fact that knowledge is produced in different ways, by different knowers, with different results.

At the close of the conference, the conference organizers announced that annual dues for membership in the Society for Women in AIDS in Africa amounted to a 2,000

Ugandan shilling joining fee and 5,000 shillings per year membership fee (a total of US$ 7.00). This is more money than the great majority of poor rural women have at their disposal to spend on something like membership fees, particularly given most women's economically and socially disadvantaged position in Uganda.

The conference organizers were clearly hoping to reach women in rural areas through mobilizing their district representatives. A great deal of discussion and debate was generated over the issue of the proposed fee, with many of the women leaders arguing that it was too high for low income women living in rural areas. This debate illustrates the importance of using a context-rich approach, grounded in social location emphasizing the relational nature of gender, class, and race or ethnicity.

My description and analysis of the events at the conference is obviously filtered through my own experiences and social location. My location as an outsider and as a graduate student familiar with feminist and critical perspectives in anthropology shapes my analysis. In reflecting on what I have written, I am very aware that it is only a partial account. And, I am concerned about how this account would compare with the interpretations of other people attending the conference. I would expect that each person would have a different interpretation based on her or his social location.

CHAPTER FIVE

SUMMARY AND DISCUSSION

I have argued in this thesis that standard epidemiological approaches alone are an insufficient depiction of the AIDS epidemic in Africa because they do not create socially contextualized representations of women's many experiences of the epidemic. As noted in the introduction, statistics on the AIDS epidemic are rooted in the human experiences they are drawn from. Standard epidemiological reports tend to produce what Krieger and Margo refer to as "numbing numbers" (1990:584). In contrast, feminist approaches often take AIDS statistics as their starting point, problematize them in the everyday lives of women, and in so doing, reinsert experience into AIDS discourse and representations.

At its best, feminist research is not only by and for women, but also works toward the transformation of socially constructed, interlocking systems of inequality. The majority of the examples of feminist research on women and AIDS in Africa met most, if not all, of the criteria set out in the introduction. In contrast, all but the transitional category of mainstream epidemiological literature failed to

meet the feminist criteria. As previously stated, however, applying feminist lenses can be a tool to reveal what is not visible as well as what is clearly visible. In this manner, underlying, often implicit conceptualizations of women in the epidemiological literature on AIDS in Africa are revealed.

Epidemiological literature on AIDS in Africa tends to conceptualize and represent women in what I have termed their roles as reproducers and passive carriers of the virus and children. Little concern is shown for women's rights to health care and AIDS prevention apart from their relations to men and children. Researchers remain disembodied and detached from the process and the results of research. This is reflected in the objectifying of women as "reservoirs of infection," "pools of free women," "women of reproductive age," and other linguistically distancing images created in epidemiological representations of AIDS and its impact on women.

There is a profound need for contextualization on all levels in epidemiological accounts of AIDS in Africa. Susan Hunter offers suggestions about how researchers might go about conducting what she terms "context-rich research":

> A context-rich, self-conscious research programme avoiding self-and other-alienation has some necessary and simple dimensions: stay awhile; teach, live, share; incorporate indigenous researchers in your projects; facilitate them with money and resources; work by their side; train them during the project execution; take the pain to transfer your skills; listen to their ideas,

their conceptualizations, their pain. [1990:689]

I classify Hunter's approach, like that of Schoepf et al., as grounded in standpoint thinking. Schoepf and her colleagues and Hunter offer invaluable guides to conducting participatory research that should, in an ideal world, be incorporated into mainstream paradigms of epidemiological research on AIDS in Africa.

The question of whether there has been a feminist revolution in the sense that Stacey and Thorne (1985) set out is debatable. There has certainly been an increase in what I have identified as feminist analyses of AIDS in Africa over the last three to four years. The driving force behind this increase is unknown. One of Stacey and Thorne's criteria of a feminist revolution is whether or not there has been a paradigm shift—that is, have feminist analyses made their way into the mainstream discourse? I tend to think that they have not. For example, Mann's (1991) criticisms of the weaknesses of mainstream epidemiological approaches are almost mirror images of many of the feminist arguments presented in this paper. Yet no feminist authors are cited in Mann's bibliography (1990). On the one hand, this <u>could</u> be interpreted as a sign that there has been a paradigm shift. It is more likely, however, the paradigm shift is yet to happen. Additional support for this perspective comes from the fact that none of the articles I have identified as feminist in this paper have been

published in mainstream epidemiological journals. Social Science and Medicine and the International Journal of Health Sciences (a more radical publication) are the two richest sources of feminist research on women and AIDS in Africa. Thus, the lack of feminist representation in mainstream epidemiological literature can be further interpreted as a lack of paradigmatic shifting.

Despite what I interpret as the "missing feminist revolution" in mainstream discourse, the benefits of feminist approaches are obvious. I anticipate that feminists' emphases on the social construction of the AIDS epidemic in Africa will gradually influence the ways mainstream thinkers and researchers not only design and conduct research, but will also change the ways women are conceptualized. Feminist perspectives and standpoints will lead to more informed, realistic, and socially situated AIDS prevention campaigns sensitive to the many challenges women are faced with in negotiating AIDS prevention in Africa.

Indeed, as the chapter on the international AIDS conference and the conference on women and AIDS in Uganda demonstrated, there is increasing recognition by some within the international and national research communities of the need for more fully contextualized accounts of the AIDS epidemic. And, as reflected in the knowledge produced by the women at the AIDS conference in Kampala, gender, class, and culture all shape Ugandan women's perceptions of their

risks of HIV infection and AIDS.

I have used Harding's three criteria for feminist standpoint thinking throughout this thesis. Harding states, "one distinctive feature of feminist research is that it generates problematics from the perspective of women's experiences. It also uses these experiences as a significant indicator of the 'reality' against which hypothesis are tested" (1987:7). There is a need for research on AIDS in Africa that incorporates both women and men's standpoints, yet most of the AIDS literature reveals that men are members of the oppressor group when it comes to issues of sexual negotiation in AIDS prevention strategies. Is it possible, then, for men to research the gender, class, and cultural differences that create different experiences of the AIDS epidemic in people's lives based on social location? Harding writes:

> if we start thinking and researching from the perspective of the lives of oppressed people. . . . [t]he understanding that they are oppressed, exploited, and dominated—not just made miserable by inevitable or social causes—reveals aspects of the social order that are difficult to see from the perspective of their oppressors' lives. [1991:126]

Harding thus argues that it is inaccurate to suggest that men cannot conduct feminist research. However, men claiming to conduct feminist research must meet the following criteria:

> Are women's experiences used as the test of adequacy of the problems, concepts, hypothesis, research design, collection, and interpretation of

> data? Is the research project <u>for</u> women rather than for men and the institutions men control? Does the researcher or theorist place himself in the same class, race, culture, and gender-sensitive critical plane as the subjects of his study? [1987:11]

Feminist research tends to uncover and struggle against hidden social structures contributing to oppression and exploitation in social relations (Baca Zinn 1993). As shown in this thesis, it is also critical to uncover the cultural factors that contribute to exploitation and oppression. Social science research that is not generated out of an explicit recognition of the need to struggle "against exploitation of women in everyday life [is] unlikely to produce. . . research about any subject at all that is undistorted by sexism and androcentricism" (Harding 1987:12).

An answer to the question of whether men can produce feminist analyses and representations is contained in Harding's statement: "The issue here is not so much the right to claim a label as it is of the prerequisites for producing less partial and less distorted descriptions, explanations, and understandings" (1987:12).

The final chapter addresses the need to consider the relational nature of the factors influencing differentiated experiences of the AIDS epidemic in Africa. It also outlines future dissertation research directions.

CHAPTER SIX

FUTURE RESEARCH DIRECTIONS

During my predissertation visit to Uganda, in addition to attending the conference on women and AIDS, I met with a large number of individuals and organizations involved in AIDS research. I also learned a great deal about the impact of AIDS on people's lives through informal discussions with Ugandans. I had the privilege of accompanying an AIDS counselor from The AIDS Support Organizations on home and hospital visits to people with AIDS.

A theme in all of these meetings and discussions, as well as in the two AIDS conferences, was a concern over low income women's economic dependence and their increased risk for HIV infection and AIDS. It has been suggested that income generating projects for women would provide increased economic security and thus empower women to take the risk of asking their partners to use a condom. Many researchers and all the people I spoke with about this issue in Uganda contend that when faced with the risk of HIV infection or the risk of rejection, most women, because of their economically vulnerable position, will risk infection rather than rejection. Yet women's economic dependence does not

occur in a social vacuum and must be contextualized along a number of axes.

Noerine Kaleeba, founder and director of The AIDS Support Organization (TASO), in discussing the relationship between women's economic dependence and HIV infection, informed me that there is a need for research into this area. She stated that TASO had conducted a very informal and unscientific survey of some of their women clients. Women were asked what factors would make them feel more secure about asking a partner to use a condom in order to prevent HIV infection. The majority of the women stated that they would feel more secure if they had increased economic security. They also expressed an interest in income generating projects.

The issue of economic dependency and its relationship to women's risk for HIV infection is very complex. The participants at the conference on women and AIDS framed women's economic dependency, women's lack of control over their own bodies and sexuality, and unequal power relationships between genders in terms of cultural factors that put women at risk for HIV infection. The relevance of this perception in many women's lives will guide my dissertation research. As Schoepf and others cited in this thesis argue individual behavior is embedded in social relations. Harding summarizes this view in her statement that:

> All of us must live in social relations that naturalize or make appear intuitive, social arrangements that are in fact optional; they have been created and made to appear natural by the power of the dominant groups. [1991:286]

The knowledge produced by the women at the AIDS conference in Kampala indicates that culture is the dominant lens through which women attending the conference view their risks of acquiring HIV infection. A number of feminist researchers presented in this thesis point to the importance of culture in the social construction of the AIDS epidemic in Africa. While it is important to look at the wide range of contexts influencing differences in the ways the epidemic is structured by social location, it is also important to avoid cultural determinism. As reflected in the discourse of the women at the Kampala conference, culture takes on particular structural manifestations in particular contexts. For example, structural factors such as women's lack of control over their own sexuality and economic dependence take on what the women see as cultural forms. Likewise, other structurally-related aspects of social relations, such as inheritance patterns, place of residence after marriage, and what happens to women after they are widowed or divorced, take on different shapes in different cultures.

My dissertation research will focus on women's perceptions of factors that either constrain or enable them to negotiate AIDS prevention behaviors. I hope to contribute to an understanding of how individual responses

to the epidemic are embedded in social relations. I believe that feminist standpoint thinking, intersections analysis, and Schoepf's approach to "linking macrolevel analyses to microlevel studies of social interaction [to show] how political economy, gender, and culture shape responses to a disease" (Schoepf 1992:53) provide the most productive frameworks for producing knowledge and representations of the AIDS epidemic in women's lives. Combining these feminist frameworks into a context-rich approach and implementing such an approach in epidemiological research has the potential to create the types of analyses that will make a real impact on AIDS education and prevention programs in Africa.

The hypothesized relationship between women's economic dependence and vulnerability to HIV infection raises a number of interrelated questions. First, is the relationship as simple and neat as it appears? Obviously, the vast majority of the women in Africa are economically disadvantaged in relationship to men. Yet, there are also class differences among women. Do women who are economically independent feel more secure in asking or insisting that their partners use a condom? Is it an issue of economic dependence or, rather, an issue of women's social dependence in terms of limited access to and control of what Schoepf terms "strategic resources" (1992:69)? Are there differences in the ways that women from matrilineal

versus patrilineal societies view the relationship between economic security, HIV infection, and risk of rejection (Ferguson, personal communication)?

What does economic security mean to women who express a desire to be more economically independent? What does it mean to AIDS researchers and activists who suggest it as a possible approach to decreasing women's risk for HIV infection? How do perceptions of the need for economic security before asking your partner to use a condom vary by age or marital status? What kinds of income generating projects will enable women to gain increased economic security? Do poor rural women or women who are struggling to survive in urban areas really have the time to engage in income generating projects? If they do, will they be able to control the income earned; if so, how will the income be spent? If women use the income to pay for school fees or the subsistence needs of their households, will they then feel more economically secure? How will increases in women's income affect family dynamics? What kind of resistance can be expected from husbands or male partners? Does an increase in economic security necessarily translate into an increase in control over the social and personal realms? In other words, is income generation and economic security enough of an answer? Few studies, aside from those of Schoepf and her colleagues, focus on different classes' sexual decision making and approaches to AIDS prevention.

The social expectations that women are women only if they are wives and mothers creates difficult decisions for women in regard to HIV prevention. The list of questions presented above touches on the more practical relationship between an increase in economic security and a hypothesized decrease in risk of HIV infection. In societies in which being a wife and mother are expected and valued social statuses, will women, even if economically more secure, want to leave a husband who refuses to use a condom? Do women who may make this choice envision remaining single, or if they decide to remarry, will they practice HIV prevention? What are the possibilities of remarriage for women who make these decisions?

Long term structural change is needed if efforts to empower women to reduce their risk of HIV infection are to be successful. This is very clearly not a goal that can be achieved in a short time. Yet, as Schoepf states, "empowerment strategies that incorporate a deep understanding of local cultures and social group dynamics have the potential to bring about changes in sexual behavior and the social relations in which they are embedded" (1992:68).

This thesis has focused on issues and representations of women and AIDS in Africa. Unequal gender and power relationships mean that women are less able to protect themselves from HIV infection and AIDS than are men (Bledsoe

1992; Seely et al. 1992; Schoepf 1992; Standing 1991; Ulin 1991). Suggestions that women be empowered to reduce their vulnerability to HIV infection run the risk of placing the entire burden of responsibility for HIV prevention on women's shoulders.

Feminist perspectives and frameworks argue that gender is inclusive of both women and men. There is a need for research into the meanings and experiences of the epidemic in men's lives. Since condoms are a male-controlled technology, men have more control over sexual and HIV reduction decisions than do women. What explanations do men who are resistant to using a condom for HIV protection offer? How do these explanations vary by class or ethnic group? How can men be empowered to change their approach to HIV prevention? A barely explored area of AIDS research in Africa is the potential relationship between ethnicity and attitudes toward AIDS prevention. Do ethnic groups (or tribes) that expect women to be more subservient have a higher incidence of HIV infection?

The pervasive theme of this thesis, and one that surfaced in the AIDS conferences in Amsterdam and Kampala as well as in discussions during predissertation research in Uganda, is the critical need for AIDS research and analyses that are context rich. Anthropologists, particularly those who use feminist frameworks, are at the forefront of contributing contextualized analyses of how the AIDS

epidemic affects people's lives. There is a need for more analyses that incorporate an understanding of how gender, class, ethnicity and culture (along with other factors) intersect to create different meanings and experiences of the AIDS epidemic. It is these types of analyses that have the greatest potential for contributing to prevention programs sensitive to the challenges that people face in negotiating HIV and AIDS risk reduction strategies.

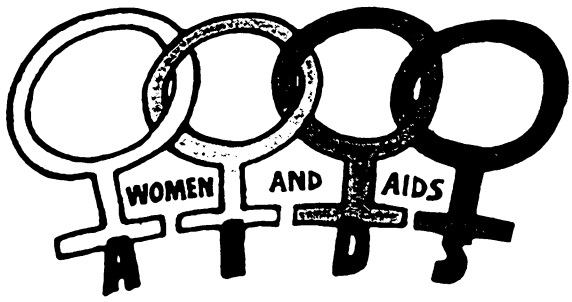
APPENDICES

APPENDIX I

Statements: International Pre-Conference Workshop

Women Living with HIV/AIDS

INTERNATIONAL
PRE CONFERENCE
1992



WORKSHOP
WOMEN LIVING WITH
HIV / AIDS

STATEMENTS

TO IMPROVE THE SITUATION OF WOMEN LIVING WITH HIV/AIDS THROUGHOUT THE WORLD, WE NEED:

1. encouragement, support & funding for the development of self-help groups, local and international networks of women living with HIV/AIDS

2. the media, not to stigmatize, but to realistically portray us

3. equitable, accessible and affordable treatments for and research into how the virus effects women,
   covering: psycho-social and medical aspects
   complementary and allopathic treatments

4. funding for services and support for women living with HIV/AIDS, to alleviate their isolation and meet their basic needs. All funding directed to us needs to be evaluated and monitored to ensure that we get it

5. the right to make our own choices about reproduction and to be respected and supported in those choices. This includes the right to have children and the right not to have children

6. recognition of the right of our children/orphans to be cared for and the importance of our role as parents

7. education and training of health care providers and the community at large about women's risk and our needs. Up to date, accurate information concerning all issues about women living with HIV/AIDS should be readily available

8. recognition of the fundamental human rights of all women living with HIV/AIDS, with special consideration for women in prison, drugusers and sexworkers

9. research into woman to woman transmission, recognition of and support for lesbians living with HIV/AIDS

10. decision making power and consultation on all levels of policy and programs affecting us

11. to provide economic support for women living with HIV/AIDS in developing countries to help them to be self-sufficient and independent

Members of the Steering Committee:
HIV Association Netherlands - ACT UP! Amsterdam - Bureau WOMEN and AIDS
Section Positive Women
Postbus 15847
1001 NH Amsterdam
Telephone (31) 20 6644076

Predikherenkerkhof 2
3512 TK Utrecht
Telefax (31) 30 334064
Telephone (31) 30 334064

APPENDIX II

Women Program Guide

Note: Shaded areas represent topics the conference organizers thought of interest to women.

MONDAY, 20 JULY 1992

	Basic Science		*Clinical Science and Care*		*Epidemiology*		*Social Impact and Response*			
8:30	Drug Therapy & Pathogenesis	Viral Assembly	Hemopoietic Growth Factors	Stress, Stress Reduction, and Coping	Epidemiology of STDs	Scenario Analysis	Gender, Power & HIV	Prevention Programs		
9:30	1: State-of-Art	2: Oral Abstract	3: Oral Abstract	4: State-of-Art	5: State-of-Art	6: State-of-Art	7: State-of-Art	8: State-of-Art		
9:45	Elicitation of Immune Responses	Viral Spread Within a Host	New Antiretrovirals: Non-Reverse Transcriptase Inhibitors	Prophylactic HIV Vaccines	STD & HIV Interactions	Gender-Related Variations in Natural History	International Cooperation	Sex & Drugs in Prisons	Building Partnerships for HIV Prevention & Care in the Workplace	Issues in HIV & Hemophilia Care
11:15	9: Oral Abstract	10: Oral Abstract	11: Oral Abstract	12: Oral Abstract	13: Round Table	14: Oral Abstract	15: Round Table	16: Oral Abstract	17: Round Table	18: Round Table
11:30	Longitudinal Trends in the Epidemic				HIV & STD: Biological, Clinical, Epidemiological & Programmatic Interactions					
13:00	19: Multidisciplinary Problem-Based Plenary				20: Multidisciplinary Problem-Based Plenary					

Lunch and Poster Discussion Sessions (see detail below)

14:30	Neutralizing Antibodies (part I)	Virus/Cell Interaction	Combination Antiretroviral Therapy	HIV-Related Malignancies	HIV Testing for Prevention	Natural History of HIV Infection in Different Groups	National Policies on International Mobility	Impact of HIV on Family Systems	Impact of Homophobia & Denial on HIV Services	Pelvic Inflammatory Disease
16:00	21: Oral Abstract	22: Oral Abstract	23: Oral Abstract	24: Oral Abstract	25: Round Table	26: Oral Abstract	27: Round Table	28: Oral Abstract	29: Round Table	30: Round Table
16:15	Mechanisms of CD4 Depletion	Viral Variation	Clinical Use of DDI/DDC	Care for Care Providers	Markers for Progression of HIV Infection	Transmission of HIV Through Blood & Blood Products	AIDS & Street Children in Brazil	Evolution of Community-Based Organizations	HIV & Nutrition	Clinical Training in AIDS & STDs
17:45	31: Round Table	32: Oral Abstract	33: Oral Abstract	34: Round Table	35: Oral Abstract	36: Oral Abstract	37: Case Study	38: Round Table	39: Round Table	40: Round Table
18:00										
19:30	41: Recent Report		42: Recent Report		43: Recent Report		44: Recent Report			

Poster Discussion Sessions

13:00	Horizontal Transmission	Epitope Presentation	Monitoring Surrogate Markers	Descriptive Epidemiology in Asia & Oceania	Condom Use Among Commercial Sex Workers & Their Clients	Utilization of Different Models of Care	Impact of High Mortality on Communities	NGO/CBO Contributions to National Policy
	200: Poster Discussion	201: Poster Discussion	202: Poster Discussion	203: Poster Discussion	204: Poster Discussion	205: Poster Discussion	206: Poster Discussion	207: Poster Discussion
	CD4-Depletion	Combination Antiretroviral Therapies	Indicators Measuring Quality of Life	Definitions of AIDS	HIV Transmission in Health Care	Costs & Benefits of Prevention Programs	Representing the Epidemic	
14:15	208: Poster Discussion	209: Poster Discussion	210: Poster Discussion	211: Poster Discussion	212: Poster Discussion	213: Poster Discussion	214: Poster Discussion	215: Poster Discussion

TUESDAY, 21 JULY 1992

	Basic Science		*Clinical Science and Care*		*Epidemiology*		*Social Impact and Response*			
8:30	Animal Models	Cellular Immunity & Oncogenesis	Developing Country STD Clinical Services	Clinical Lessons – Pediatric Studies	Epidemiology of HIV in Women	Natural History of HIV–2	Laws, Regulation, Human Rights & Public Policy	Human Sexuality		
9:30	45: Oral Abstract	46: State–of–Art	47: State–of–Art	48: Special Presentation	49: State–of–Art	50: State–of–Art	51: State–of–Art	52: State–of–Art		
9:45	Molecular Basis of Drug Resistance	Neutralizing Antibodies (part II)	STD Treatment Regimens for PWAs	Management of Pediatric HIV	Definitions of AIDS	STD & HIV Related Partner Notification	Responding to Discrimination	AIDS Programs & Family Planning	HIV Multiple Losses: Impacts and Solutions	AIDS & Breast Cancer: Shared Lessons
11:15	53: State–of–Art	54: Oral Abstract	55: Round Table	56: Oral Abstract	57: Round Table	58: Round Table	59: Oral Abstract	60: Round Table	61: Round Table	62: Round Table
11:30	Development of a Preventive Vaccine				Tuberculosis & HIV					
13:00	63: Multidisciplinary Problem–Based Plenary				64: Multidisciplinary Problem–Based Plenary					

Lunch and Poster Discussion Sessions (see detail below)

14:30	New Antiviral Approaches	Role of Neutralizing Antibodies	Clinical Manifestations of HIV in Women	Tuberculosis	Impact of STD Control on HIV	Selecting & Evaluating Interventions	Care for Orphaned Children	Maintaining Safe Behavior Among Gay Men		The Role of Nursing, Home–Care and Self–Help
16:00	65: Oral Abstract	66: Round Table	67: Oral Abstract	68: Oral Abstract	69: Round Table	70: Round Table	71: Round Table	72: Oral Abstract	73:	74: Round Table
16:15	Cytokines & Virus Replication	Assessment of Viral Load	Therapeutic HIV Vaccines	Efficacy of Different Approaches to Counselling	HIV Infection & Tuberculosis	Long–Term Survivors	Economic Impact on Households	Safe Sex Programs for Youth	STD Case Management in Developing Countries	Drug Addiction & Human Rights
17:45	75: Oral Abstract	76: Oral Abstract	77: Oral Abstract	78: Round Table	79: Oral Abstract	80: Round Table	81: Round Table	82: Oral Abstract	83: Round Table	84: Round Table

18:00 MINICOURSES PART I:

- 85: Diagnosis and Management of Opportunistic Infections for Countries with advanced Health Care Infrastructures
- 86: Clinical Management of Persons with HIV Infection in Developing Countries: Part I – Testing and Evaluation
- 87: Pediatric HIV/AIDS Part I – Epidemiology
- 88: HIV Clinical Trials: Methods and Ethics
- 89: Applying New Diagnostic Methods to Epidemiology: New Advances in Antibody Testing
- 90: Epidemiologic Methods for Surveillance and Prediction: Measuring AIDS Incidence and Prevalence
- 91: Creating Effective HIV Prevention Programs: Effective Approaches by Target Audience
- 92: International Cooperation and HIV/AIDS: Multilateral Organizations
- 93: HIV/AIDS and the Commercial Sex Industry: What is Sex Work?
- 94: Alternative, Complementary and Traditional Therapies: Prevalence
- 95: The Future of STDs: Treatment Issues

19:30

Poster Discussion Sessions

13:00		Virus Entry	Hepatitis and Other Co–Infects	Descriptive Epidemiology in Latin America & Caribbean	Descriptive Epidemiology in North America & Europe	Risk Behaviors Among Drug Users	Models of Care	People with HIV as Educators
	216: Poster Discussion	217: Poster Discussion	218: Poster Discussion	219: Poster Discussion	220: Poster Discussion	221: Poster Discussion	222: Poster Discussion	223: Poster Discussion
	Neutralizing Antibodies	Co–Factors	Impact of HIV on STDs	Diagnostic Methods Using Samples Other Than Blood	Interventions for Men Who Have Sex With Men	Infection Control in Health Care Settings	Resource Allocation	
14:15	224: Poster Discussion	225: Poster Discussion	226: Poster Discussion	227: Poster Discussion	228: Poster Discussion	229: Poster Discussion	230: Poster Discussion	231: Poster Discussion

WEDNESDAY, 22 JULY 1992

	Basic Science		*Clinical Science and Care*		*Epidemiology*		*Social Impact and Response*	
8:30	Viral Variation & Immunity	Human Papilloma Viruses	Variations in Clinical Manifestations by Population	Long-Term Studies of Early AZT Use	Demographic Impact of HIV	Epidemiology of Injecting Drug Use	Macroeconomic Impact of AIDS	Barriers to Condom Acceptance
9:30	96: Oral Abstract	97: State-of-Art	98: State-of-Art	99: State-of-Art	100: State-of-Art	101: State-of-Art	102: State-of-Art	103: State-of-Art

9:45	Active & Passive Immunotherapy	Viral Regulatory Genes	New Antivirals: Reverse Transcriptase Inhibitors	PCP Diagnosis Therapy & Prophylaxis	Genetic Variations & Epidemiology of HIV	Alcohol, Other Drugs & Natural History of HIV Infection	Prevention Programs for Women	Measuring & Modelling Economic Impact	AIDS and the Future of Public Health	Global Epidemic of Antimicrobial Resistance of STD Pathogens
11:15	104: Round Table	105: Oral Abstract	106: Oral Abstract	107: Oral Abstract	108: Oral Abstract	109: Oral Abstract	110: Round Table	111: Oral Abstract	112: Round Table	113: Round Table

11:30		
13:00	HIV Disease Progression, Co-Factors & Clinical Practice 114: Multidisciplinary Problem-Based Plenary	HIV/AIDS & Development Issues 115: Multidisciplinary Problem-Based Plenary

Lunch and Poster Discussion Sessions (see detail below)

14:30	Epitopes & Sustained Immune Response	Mechanisms of Immunopathology	Treatment & Diagnosis of STDs	Diagnosis, Therapy & Prophylaxis (non-PCP)	Vertical Transmission	Transmission & Natural History of HIV-2	School-Based HIV Education	Prevention for Injection Drug Users	Mayors of Cities of the Developing World Impacted by the AIDS Epidemic	
16:00	116: Oral Abstract	117: Oral Abstract	118: Round Table	119: Oral Abstract	120: Oral Abstract	121: Oral Abstract	122: Oral Abstract	123: Oral Abstract	124: Round Table	125:

16:15	Nervous System Dysfunction	Variations in HIV & SIV	Syndrome-Based STD Management	Major Opportunistic Infections	Discordant Couples	Modelling the HIV Epidemic	Planning Terminal Care	National Condom Promotion	Making Choices: Women, Reproductive Rights and HIV	Indigenous Peoples Respond to AIDS
17:45	126: Round Table	127: Oral Abstract	128: Case Study	129: Round Table	130: Oral Abstract	131: Oral Abstract	132: Round Table	133: Case Study	134: Round Table	135: Round Table

18:00	MINICOURSES PART II:	
	• 136: Diagnosis and Management of Opportunistic Infections for Countries with advanced Health Care Infrastructures	• 140: Applying New Diagnostic Methods to Epidemiology: Quantification Techniques in Therapeutic Trials
	• 137: Clinical Management of Persons with HIV Infection in Developing Countries: Clinical Management I	• 141: Epidemiologic Methods for Surveillance and Prediction: HIV Surveillance
	• 138: Pediatric HIV/AIDS: Diagnosis	• 142: Creating Effective HIV Prevention Programs: Effective Prevention - Selecting A Strategy
	• 139: HIV Clinical Trials: Methods and Ethics	• 143: International Cooperation and HIV/AIDS: Bilateral Agencies
		• 144: HIV/AIDS and the Commercial Sex Industry: The Impact of Law and Policy
		• 145: Alternative, Complementary and Traditional Therapies: Research and Credibility
19:30		• 146: The Future of STDs: STD Vaccine Challenges

Poster Discussion Sessions

13:00	Virus-Host Interaction	Virus Variation	Clinical HIV Manifestations by Geographic Area	Decreasing Sexual Transmission in Women	Epidemiology of HIV/STDs Among Prisoners	Costs of Different Models of Care for PHIVs	Female Drug Injectors	
	232: Poster Discussion	233: Poster Discussion	234: Poster Discussion	235: Poster Discussion	236: Poster Discussion	237: Poster Discussion	238: Poster Discussion	239: Poster Discussion
			Lab Diagnosis of Chlamydia & Gonococcal Infections	Interventions Among IVDUs		Prevention Efforts in the Workplace	Homophobia, Denial & HIV Programs	
14:15	240: Poster Discussion	241: Poster Discussion	242: Poster Discussion	243: Poster Discussion	244: Poster Discussion	245: Poster Discussion	246: Poster Discussion	247: Poster Discussion

THURSDAY, 23 JULY 1992

	Basic Science		*Clinical Science and Care*		*Epidemiology*		*Social Impact and Response*			
8:30	Mother-Child Transmission	Host-Virus Interactions	STD Diagnosis in Resource-Poor Settings	HIV Neurologic Disease	Legal/Ethical Considerations in Epidemiology	Socioeconomic Factors & HIV Spread	Community Identity & Sustainable Community Action	Determinants of Risk-Taking Behavior		
9:30	147: State-of-Art	148: State-of-Art	149: State-of-Art	150: State-of-Art	151: State-of-Art	152: State-of-Art	153: Oral Abstract	154: State-of-Art		
9:45	Protease Inhibitors	Pathogenesis	Mixing Therapeutic Approaches	Neurological Manifestations of HIV Infection	Role of "Core Groups" in STDs/HIV	Role of Breast-Feeding in HIV Transmission	Change Male Heterosexual Attitudes & Behavior	Roles for PHIVs/PWAs	The Response of Youth to AIDS	Public Health Human Rights and the HIV & TB Epidemics
11:15	155: Oral Abstract	156: State-of-Art	157: Round Table	158: Oral Abstract	159: Oral Abstract	160: Oral Abstract	161: OralAbstract	162: Round Table	163: Round Table	164: Round Table
11:30	Human Rights				Treatment Priorities					
13:00	165: Multidisciplinary Problem-Based Plenary				166: Multidisciplinary Problem-Based Plenary					

Lunch and Poster Discussion Sessions (see detail below)

14:30	Reverse Transcription & Integration	T-Cell Repertoire & HIV Infection	Management of Malignancies	Clinical Implications of Antiviral Resistance	Transmission & Natural History of HIV Infection Among IVDUs	Determinants of Sexual Risk Behavior	National Program Response to AIDS	Approaches to AIDS Activism	Intravaginal STD/HIV Prevention Tech. Controllable by Women	The Hemophilia Community: Responses & Challenges
16:00	167: Oral Abstract	168: Oral Abstract	169: Oral Abstract	170: Round Table	171: Oral Abstract	172: Oral Abstract	173: Oral Abstract	174: Round Table	175: Round Table	176: Round Table
16:15	Antiviral Drug Resistance	Epitopes of T-Cell Immunity	Oral Manifestations	Choosing Therapies for Individual Treatment Strategies	Early HIV Diagnosis in Infants	HIV Transmission in Health Care	Patterns & Structures of Male Homosexuality	Perspective of Religions	Women's Access to Prevention & Care	STDs & Adolescents: Biological & Behavioral Risks
17:45	177: Oral Abstract	178: Oral Abstract	179: Round Table	180: Round Table	181: Oral Abstract	182: Round Table	183: Round Table	184: Round Table	185: Round Table	186: Round Table

18:00	**MINICOURSES PART III:**
	• 187: Diagnosis and Management of Opportunistic Infections for Countries with Advanced Health Care Infrastructures
	• 188: Clinical Management of Persons with HIV Infection in Developing Countries: Clinical Management 2
	• 189: Pediatric HIV/AIDS: Treatment/Case Management
19:30	• 190: HIV Clinical Trials: Methods and Ethics
	• 191: Applying New Diagnostic Methods to Epidemiology: HIV Lab Techniques for Non-Lab Personnel
	• 192: Epidemiologic Methods for Surveillance and Prediction: AIDS Projections
	• 193: Creating Effective HIV Prevention Programs: Policy, Planning and Evaluation
	• 194: International Cooperation and HIV/AIDS: Non-Government Organizations
	• 195: HIV/AIDS and the Commercial Sex Industry: Prevention Education
	• 196: Alternative, Complementary and Traditional Therapies: Organizing Communities and Networking
	• 197: The Future of STDs: STD Program Management

Poster Discussion Sessions

13:00	Maternal-Infant Transmission by Population	Cellular Immunity & Protection	Approaches to Clinical Training for HIV/STDs	HIV & STDs	Descriptive Epidemiology in Africa	Evaluation of Prevention Programs	Empowering Heterosexual Women	Cultural Sensitivity in HIV Prevention
	248: Poster Discussion	249: Poster Discussion	250: Poster Discussion	251: Poster Discussion	252: Poster Discussion	253: Poster Discussion	254: Poster Discussion	255: Poster Discussion
		Most Current Immune-Based Therapies	Resistance to Antiviral Therapy in HIV-1 &HSV	Epidemiology of HTLVs	Rapid Testing Diagnosis of HIV/STDs	Access to Care Systems	Government Policies on Blood Safety	
14:15	256: Poster Discussion	257: Poster Discussion	258: Poster Discussion	259: Poster Discussion	260: Poster Discussion	261: Poster Discussion	262: Poster Discussion	263: Poster Discussion

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