NOTE TO USERS

This reproduction is the best copy available.

UMI[®]

Sex, Trust and Consequences:
Rethinking HIV Prevention in Sub Saharan Africa

Catherine Macnab
Institute of Political Economy
Carleton University

Funded by the International Development Research Centre, Ottawa

*Fieldwork conducted in partnership with the Controlling STD/HIV Control Project in Nairobi, Kenya.
Conclusions are those of the author and do not reflect the opinions of the STD Project*

© Catherine Macnab 2004

National Library
of Canada

Bibliothèque nationale
du Canada

Acquisitions and
Bibliographic Services

Acquisitons et
services bibliographiques

395 Wellington Street
Ottawa ON K1A 0N4
Canada

395, rue Wellington
Ottawa ON K1A 0N4
Canada

Your file Votre référence

ISBN: 0-612-93908-1

Our file Notre référence

ISBN: 0-612-93908-1

The author has granted a non-exclusive licence allowing the National Library of Canada to reproduce, loan, distribute or sell copies of this thesis in microform, paper or electronic formats.

L'auteur a accordé une licence non exclusive permettant à la Bibliothèque nationale du Canada de reproduire, prêter, distribuer ou vendre des copies de cette thèse sous la forme de microfiche/film, de reproduction sur papier ou sur format électronique.

The author retains ownership of the copyright in this thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without the author's permission.

L'auteur conserve la propriété du droit d'auteur qui protège cette thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

In compliance with the Canadian Privacy Act some supporting forms may have been removed from this dissertation.

Conformément à la loi canadienne sur la protection de la vie privée, quelques formulaires secondaires ont été enlevés de ce manuscrit.

While these forms may be included in the document page count, their removal does not represent any loss of content from the dissertation.

Bien que ces formulaires aient inclus dans la pagination, il n'y aura aucun contenu manquant.

Canada

Abstract

In Sub Saharan Africa, the AIDS epidemic is characterized by heterosexual and perinatal transmission of HIV and the staggering assertion is that 80% of HIV-positive women are infected by their husbands. Using a case study of women living Nairobi slums, this study investigates the HIV-risk of married women through a Political Economy lens.

Predominant models of prevention, described herein as the Negotiation Model and the Economic Empowerment Model, are challenged by integrating women's stories with theoretical feminist debates on the material basis of women's subordination. The findings redefine women's risk as a consequence of:

- (a) women's inability to know if they can trust their husbands; and
- (b) women's responsibility for sustaining the reproductive economy.

The redefinitions lead to alternative prevention models, the Trust Model and the Reproductive Economy Model, that suggest novel directions for developing HIV prevention strategies.

Acknowledgements

It takes a community to raise a thesis, and this one is no exception. I am delighted to take this opportunity to publicly acknowledge the immense support I received from those who share my interest and enthusiasm for the project and those whose belief in me keeps me going.

This work could not have happened without the support of the *International Development Research Centre (IDRC)* that provided funding and research support via my Internship Award through the Gender Unit. Words cannot express my gratitude for the opportunities this provided.

My fieldwork was undertaken in collaboration with the *Strengthening STD/HIV Control Project* in Nairobi, Kenya. The STD Project generously contributed all of the staff time required to support this research. This partnership granted access to the clinic staff and to the women who participated in this study. I am deeply indebted the STD Project for their willingness to work with me and for maintaining such a strong and deserved reputation in the community.

In OTTAWA, I would like to express my gratitude:

- to **Hugh Armstrong**, my accommodating academic advisor who sensed exactly the support I needed and gently shepherded me into and through a maze of theory that I finally grew to accept as necessary. For being there when and how I needed you, Hugh, I thank you;
- to **Pam Golah**, my treasured IDRC lifeline and confidante who provided wise counsel on research and life with startling acuity, honesty and wit; like a gift delivered from a better place to guide me along my garden path. For being so genuine, clever and true, Pam, I thank you;
- to **Rob Tripp**, a generous and joyful friend, my greatest champion, whose unflagging belief in me provides buoyancy when my own falters. For this and so much more, Rob, I thank you;
- to **Blair Rutherford**, associate professor in the Department of Sociology and Anthropology, who cheerfully stepped in as second reader; to **Rianne Mahon**, the director of the Institute of Political Economy at Carleton University; to **Donna Coghill**, the IPE program administrator who repeatedly bailed me out of administrative nightmares; to **Michael O'Connor** and **Rosemary Forbes** at the Interagency Coalition for AIDS and Development (ICAD) for introducing me to the STD project; at IDRC, to **Claudie Gosselin**, the Gender Unit Coordinator, who provided tremendous support for my work; to **Pam Scholey**, the former Gender Unit Coordinator who offered me the internship that made so much possible, and for her zany laugh through the wall; to my close Gender Unit colleagues **Adila Abusharaf** and **Carla Yanez** for their daily support and friendship over the last couple years; to the Awards team, **Jean-Claude Dumais**, **Rita Bowery** and **Esther Matharu** who launch careers and quietly make miracles happen; to the library staff, in particular **Sachiko Okuda** and **Barbara Porrett** who tirelessly helped me figure out what I needed then magically made it appear; to other friends and colleagues at IDRC; **Christina Zarowsky**, for getting me in the door and for so much else; to the ubiquitous **Jean Woo** for being so delightful; to **Margaret Emokor** and **Irina Pinkney**, gracious grant administrators, for smoothly navigating behind the scenes where I dare not go; and, at home, to **Sean O'Connell**, my big-hearted, gentle giant of a flatmate, who kindly took Sawyer and me in and patiently endured the chaos we wrought in his life.

In NAIROBI, I would like to express my gratitude:

- to **Professor Ngugi**, the Kenyan Co-director of the STD Project; a formidable pillar of strength and wisdom who is remarkably able to earn the respect of dignitaries and the love of sex workers alike. For generously supporting my work in your project, Professor, I thank you;
- to **Aine Costigan**, the (Irish-)Canadian Co-Director of the STD Project, a beloved friend who warmly welcomed a stranger to Kenya, into the STD Project and into her life; who provided a sweet safe oasis in the midst of Nairobi. For making dreams come true, Aine, I thank you;
- to **Alan Ferguson**, the STD Project's Evaluation and Monitoring Specialist, whose charming Scottish irreverence provided welcome levity. For your critical input to the research development and execution, Alan, I thank you;
- to **Cecilia Kariuki**, my commendable and priceless co-researcher and friend whose ready laughter, easy-going nature and compassion made every day a pleasure to work alongside. For your rich insight and for going way beyond the call of duty as a research partner, Cecilia, I thank you;
- to **Mumbi Kimani** who helps to keep the STD Project running smoothly, whose warm nature helped to break barriers and made me feel like part of the team. For being an open and accepting friend, Mumbi, I thank you;
- to the **Project Drivers**, in particular the kind and wise **Njoroge**, who ferried us through the Nairobi slums and provided me with rich insight into Kenyan life, history and politics. These men are heroes. For keeping me safe, gentlemen, I thank you;
- to **Njeri Kagundu** the contracted moderator who came on board, rolled up her sleeves and jumped into the project as a full team member. For your commitment and for sharing your research expertise, Njeri, I thank you;
- to the **STD Project staff** who offered varying levels of tolerance for the inconvenience I inevitably caused, who adeptly juggled me into the physical space and tight schedules of their lives. It could not have been easy. For this, I thank you;
- to the **Clinic Staff** in Dandora, Babadogo, Riruta and particularly in Kariobangi who gave us their precious time. I know that you are underpaid and overworked and it was an immense gift you gave by answering our questions. For this, and for doing such good and important work, I thank you;
- and of course, to the **women**; the women, my dear reader, that you will find in the following pages, who humble me with their strength and resiliency, who shared their often heartrending stories with astounding frankness and honesty; who somehow trusted that it was safe to tell their stories to this stranger from Canada, and trusted that somehow I may use their stories to make the world a better place. Although they have filtered back into the slums and I will never cross their paths again, may this work, and any good that comes from it, be a tribute to them.

Finally, I must express my complete and utter gratitude to my family
who love me enough to let me go.

Catherine Macnab
May 2004

Table of Contents

ABSTRACT	i
ACKNOWLEDGEMENTS	ii
CHAPTER 1: TOWARD A POLITICAL ECONOMY OF GENDER AND HIV	1
HIV/AIDS AND GENDER IN SUB SAHARAN AFRICA	4
HIV/AIDS IN KENYA	6
STRENGTHENING STD/HIV CONTROL PROJECT	7
KARIOBANGI	8
THESIS OVERVIEW	10
CHAPTER 2: RESEARCH METHODOLOGY	13
WHAT IS FEMINIST METHODOLOGY?	14
DEFINING THE RESEARCH QUESTION	18
DESIGNING THE RESEARCH: GENDER AND HIV/AIDS	19
ABCs OF HIV/AIDS PREVENTION	20
GENDER AND HIV/AIDS	22
POWER	24
BUILDING THE PARTNERSHIP	29
METHODS	31
ANALYSIS AND REPRESENTATION	39
CHAPTER 3: I DON'T KNOW	41
DO YOU FEEL YOU CAN GET AIDS?	41
UNDERSTANDING RISK AND THE ABCs OF PREVENTION	45
NOT KNOWING	47
THE TRUST FACTOR	48
HIV/AIDS AND OTHER THREATS	56
MARITAL CONTEXT	57
THE PRICE OF TRUST	60
SURVIVAL STRATEGIES	64
CHAPTER 4: BEYOND NEGOTIATION AND ECONOMIC EMPOWERMENT	67
THE NEGOTIATION MODEL	68
ECONOMIC EMPOWERMENT MODEL	70
ECONOMIC DEPENDENCE AND FEMINIST THEORY	74
ECONOMIC LEVERAGE: FACT OR FICTION?	82
THE LENS OF POLITICAL ECONOMY	89
CHAPTER 5: SEX TRUST AND CONSEQUENCES	91
A POLITICAL ECONOMY OF GENDER AND HIV	92
RECOMMENDATIONS/IMPLICATIONS FOR FURTHER RESEARCH	96
LIMITATIONS	102
CLOSING REMARKS AND OPEN-ENDED QUESTIONS	104
BIBLIOGRAPHY	107
APPENDIX A: SURVEILLANCE QUESTIONNAIRE	113
APPENDIX B: ETHICS CLEARANCE	115

CHAPTER 1

Towards a Political Economy of Gender and HIV

... to this catalogue of horrors, there must be added, in the case of Africa, that the pandemic is now, conclusively and irreversibly, a ferocious assault on women and girls. We all understood that the percentages were rising. We all understood that women were particularly vulnerable. We all understood that the pandemic was feasting on gender inequality. I'm not sure, however, that any of us understood until now, the full magnitude of the accelerating catastrophe for women... the toll on women and girls is beyond human imagining; it presents Africa and the world with a practical and moral challenge which places gender at the centre of the human condition. The practice of ignoring a gender analysis has turned out to be lethal.

Stephen Lewis¹ (All Africa 2002)

The AIDS epidemic in Sub Saharan Africa is characterized by heterosexual and perinatal (mother to fetus) transmission of HIV (Wilson 1992); it is clearly advancing along gender lines (UNAIDS 2002). This study investigates the gendered nature of HIV risk and illustrates how HIV/AIDS prevention discourse largely overlooks the complexities facing women who are most at risk for HIV infection.

Prevention programs are arguably based on biomedical models of what people *should* do and how to make them do it, rather on an understanding of *why* people do the things they do. Technically speaking, sexual transmission of AIDS is largely preventable. When used properly and consistently, condoms are highly effective in preventing HIV infection. However, as we enter the third decade of the AIDS epidemic, it is increasingly obvious that condoms are not the panacea for HIV protection; prevention programs are trying to fit women to the condom solution because it is the only proven solution thus far. AIDS

¹ Secretary-General's UN Special Envoy on HIV/AIDS in Africa

research needs to start with the dynamics of sexual relations as the focal point for analysis, not with condom usage as a focal point. The fundamental problem is not that women cannot enforce condom use with their husbands; this study argues that the problem requires a more nuanced definition – namely the problem is that women have unprotected sex with infected, or potentially infected partners. The determinants of this phenomenon and its contribution to the HIV/AIDS epidemic are what must be understood before solutions are proposed. To investigate women's inability to use condoms is a researcher-introduced definition of the problem; to discuss HIV risk with women and to learn how they define "the problem" ensures that solutions are based on their lived experiences. In essence, to investigate the complex realities of women's lives, it is essential to begin where women are (Smith 1989).

This study set out to explore and illustrate microdetails of the political economy of gender and HIV/AIDS as perceived by women participants. The original assertion behind the study was that women's high-risk behaviour can be understood in terms of rational survival strategies; women have real reasons for their behaviour.² The goal was to use a gender analysis to understand and document the systemic nature behind these strategies and how they contribute to HIV risk. In this thesis I use the stories women shared about their lives and their perspectives on HIV risk to describe how HIV prevention strategies often conflict with other survival strategies. The methodology for collecting this information was based on a theoretical framework of sexual bargaining power that I developed to help illustrate that women's risk behaviour cannot be reduced to individual failure in response to personal risk.

² The study did not investigate motivations behind men's high-risk behaviour in the context of HIV/AIDS.

In partnership with the *Strengthening STD/HIV Control in Kenya Project* (hereafter the STD Project; it will be fully introduced later in the chapter), this research used a collaborative case study in Nairobi, Kenya to collect qualitative information that helped to contextualize women's HIV-risk. The research entry point was an investigation into what women mean when they respond DON'T KNOW to the question: "Do you feel you can get AIDS?" The research findings demonstrate that it is necessary to reframe the heterosexual transmission of HIV by using a gendered analysis and to, at least temporarily, divorce prevention discourse from technological solutions that obscure the socioeconomic determinants of HIV risk. By engaging women in discussions about the essential factors that prevent them from confidently assessing their risk of HIV infection (i.e., what do they mean when they say they DON'T KNOW?), the study exposed how a range of interconnected conditions based on social, economic, political and personal arrangements prevent women from knowing their risk and from being able to take preventative action.

The research findings provide an alternative perspective from which to approach HIV prevention strategies. By viewing HIV through a lens of political economy, the 'problem' of women's HIV-risk becomes redefined as a consequence of (a) women's inability to know whether it is safe to trust their husbands not to infect them with HIV; and (b) the vulnerability that arises from women's sole responsibility for sustaining the reproductive economy. From these definitions emerge nascent HIV prevention models (the Trust Model and the Reproductive Economy Model) which are discussed as alternative models to inform HIV prevention discourse.

This chapter provides a brief background of HIV/AIDS in Sub Saharan Africa in general and Kenya in particular. It introduces the STD Project and describes Kariobangi, the informal settlement³ in Nairobi where the study was conducted. Finally, it provides an overview of the thesis.

HIV/AIDS and Gender in Sub Saharan Africa

The AIDS epidemic claimed more than 3 million lives in 2002, and an estimated 5 million people acquired the human immunodeficiency virus (HIV) in 2002 – bringing to 42 million the number of people globally living with the virus.

UNAIDS 2002:4

With an estimated 29.4 million people living with HIV/AIDS, Sub Saharan Africa is home to 70% of the people living with HIV/AIDS globally (UNAIDS 2002). In the absence of effective prevention, treatment and care efforts, UNAIDS (2002) predicts that the worst of the epidemic's impact is yet to be felt as people currently infected with HIV develop full-blown AIDS, fall ill and die. In a number of countries, the HIV prevalence has risen higher than previously thought possible: 38.8% in Botswana, 31% in Lesotho, 33.4% in Swaziland, and 33.7% in Zimbabwe (UNAIDS 2002b). As the HIV prevalence continues to increase in Sub Saharan Africa, women make up a growing percentage of people living with HIV/AIDS across the region (Mitchell 2001). In 1997, 50% of all people living with AIDS in Sub Saharan Africa were women (UNAIDS 1998); just five years later, in 2002, that number increased to 58% (UNAIDS 2002b).⁴

These numbers provide an alarming indicator that the HIV/AIDS epidemic in Sub Saharan Africa is advancing along gender lines. While a range of targeted interventions exists for sex workers, for women in the workplace and for adolescent girls (Wilson 1990, Harrison

³ The term "slum" is the commonly used reference for urban informal settlements in Kenya.

⁴ This increase may represent changes in surveillance procedures, for example an increase in antenatal testing.

et al 2000, Bassett 1995), the staggering assertion is that 80% of HIV-positive women in Sub Saharan Africa are infected by their husbands (Action Aid 2001, Bassett 1995).⁵ This is invariably linked to the more than half a million HIV-positive infants that are born each year, 90% of whom are in Sub Saharan Africa (Cohen 2000). This places the HIV/AIDS epidemic squarely within the dynamics of sexual relations in the household.

Women who are wives or who are in long-term monogamous sexual relationships in Sub Saharan Africa have a different investment in sexual relations than women who engage with casual sexual partners. Their evaluation of HIV-risk is infused with ideologies of affection and mutuality, and further complicated by the socio-cultural values surrounding sexual relations in the household (Kabeer 1995). Although social factors shaping the marital contract combine with biological factors to form structural barriers that obviously place women at risk (Erban 1990), it is more difficult to mobilize women as wives than other identifiable high-risk groups. For example, mobilizing sex workers may lead to a socially condoned re-engineering of the “institution of sex work”;⁶ mobilizing wives, however, refocuses the critical gaze on the institution of marriage. Although the social organization of marriage and its consequent gender inequality undermine efforts to fight HIV/AIDS (Lawson 1999), it also provides benefits to society as a whole and to women and men individually.

⁵ A recent report argues that unsafe health care procedures (e.g., reuse of needles) are contributing more to HIV transmission than heterosexual sex (Gisselquist et al 2003). Given the lack of infrastructure and funding for primary health care, this would be unsurprising. Nonetheless, it does not diminish the risk faced by women who lack sexual autonomy in their intimate relations.

⁶ Referring to the *institution of sex work* removes the predominant focus from women who sell sex for income and draws attention to all facets of the industry that should be included in reform: the clients, the police, the laws, hotels and bars that profit from the sex trade, etc. (Aine Costigan, personal contact).

HIV/AIDS in Kenya

The first officially recognized case of HIV/AIDS in Kenya was reported in 1984 and was exposed in an article published in the East African Medical Journal (Kenya AIDS Institute 2001). In 1999, the president officially declared AIDS a national disaster:

AIDS is not just a serious threat to our social and economic development, it is a real threat to our very existence... AIDS has reduced many families to the status of beggars ...no family in Kenya remains untouched by the suffering and death caused by AIDS ...the real solution to the spread of AIDS lies with each and everyone of us.
-President Moi 25/11/99 (Kenya AIDS Institute 2001)

At the time of the declaration, HIV prevalence was 13.1% and the President created the National AIDS Control Council (NACC) to formulate and implement a strategic plan. It was optimistically believed that the rate would stabilize at 14% or even begin to decline (Gender and HIV/AIDS Technical Sub-Committee, 2002). This was not to be the case; in 2002, UNAIDS reported a national prevalence of 15%. This suggested that if “a natural HIV prevalence limit does exist, it is considerably higher than most people originally thought” (Gender and HIV/AIDS Technical Sub-Committee, 2002:iv).

At the end of 2001, it was estimated that there were 1.4 million women and 0.9 million men between the ages of 15-49 living with HIV/AIDS in Kenya (UNAIDS 2002). In 1997 a World Health Organization (WHO) study found that infection rates for women are five times that of men in the 15-19 age group; and three times that of men in the 20-24 age group (WHO 1997).

The Kenyan strategic plan recognized some of the gender dimensions of the epidemic – such as that “the incidence among women was rising at a shocking rate and that women were being infected at a younger age than men were” (Gender and HIV/AIDS Technical

Sub-Committee, 2002:iv). However, the development of policies and programmes did not include gender-specific strategies. The Gender and HIV/AIDS Sub-Committee was established in 2001 by NACC in recognizing the crucial role of gender in the epidemic. The Sub-Committee was tasked with formulating guidelines and developing a strategic framework to ensure that positive outcomes could be equally shared by all women, men, girls and boys (Gender and HIV/AIDS Technical Sub-Committee, 2002).

Strengthening STD/HIV Control Project

The *Strengthening STD/HIV Control Project*, operating out of the campus of the Kenyatta National Hospital in Nairobi, Kenya, is jointly managed by the University of Manitoba and the University of Nairobi. It has been in operation since 1991. With funding from the Canadian International Development Agency (CIDA), Family Health International (FHI) and the Bill and Melinda Gates Foundation, the project objectives are (Ferguson 2002):

1. to institutionalize training in STD/HIV management at the Medical Training Colleges of Kenya through curriculum development and evaluation;
2. to institutionalize effective STD/HIV management and control within primary health care facilities;
3. to encourage sexual behaviour change and provide risk awareness among high-risk groups, in particularly via community-based programs for sex workers and their clients.

Since 1991, the STD Project has been involved in a number of interventions designed to help curb the HIV/AIDS epidemic in Kenya. Among these, the STD Project has conducted surveillance of women attending four antenatal clinics run by the Nairobi City Council in informal settlements and it supplies annual prevalence rates to the National AIDS and STD Coordination Program as part of the national HIV/AIDS surveillance system. Antenatal women presenting to the clinic for the first time are recruited for surveillance

which includes a “healthy talk”⁷ delivered by the STD Project’s surveillance nurse, followed by blood tests, vaginal swabs and administration of a standardized questionnaire.⁸ The women are screened for chlamydia, gonorrhea and HIV, with results being returned approximately one week later with referrals for treatment. Women found to be HIV-positive are referred to a Prevention-of-Maternal-to-Child-Transmission Programme (PMTCT) to protect their infants from vertical transmission.⁹ The questionnaire collects basic socio-demographic background and information on sexual behaviour, condom knowledge and use, and history of STDs.

A survey round consists of a sampling of approximately 1200 women and roughly corresponds to a calendar year. Each clinic is visited daily by the surveillance nurse until 300 women are recruited, a process that generally takes two to three months, before moving to the next clinic. Over 95% of the women identified agree to participate in the study (Ferguson 2002). The four clinics are located in Dandora, Babadogo, Riruta and Kariobangi. They all have catchments of low-income populations and include women from other nearby settlements. Kariobangi was the site of the clinic where most of the data collection for this study was undertaken.

Kariobangi

Kariobangi lies in the west of Nairobi. In Kariobangi, “water, sanitation, basic services, and housing are severely restricted, and disease and malnutrition are common” (Action

⁷ The “healthy talk” provides information on the signs, symptoms, transmission, and prevention of STDs and HIV.

⁸ See Appendix A.

⁹ Affordable treatment for mothers is not available. I witnessed a debate between two nurses on whether it was ethical to protect infants from HIV if they were inevitably going to become orphaned by the death of their mother from AIDS.

AID 2001). Located on a fairly spacious compound in the center of the slum, the antenatal clinic is housed in a long low building adjacent to the curative services clinic. Women come without appointments and wait on the long benches in the shade of the low overhanging roof. They come to get weighed, to get their babies weighed in the Health Baby Programme and to see one of the chronically understaffed nursing staff. After waiting for hours, they may learn that it is the wrong day for what they need, so they leave and return the next day. Most women come late in their pregnancies for their initial contact with medical care. During our study, two women we met were in labour and were sent to the hospital – it was their first prenatal visit.

The clinic is worn. The benches lining the walls creak and the eye can trace where thousands of bodies have leaned against the walls. Paint is faded; some windows are covered to protect clients from the gaze of curious children peering through the low windows. Some of the exam rooms in Nairobi City Council clinics do not have cots and women have to stand, sit or lie on the bench or floor during exams and while specimens are taken. Space is at a premium; everything is at a premium. The nurses are tired. They have not been paid for three months. They went on strike during our study; our inconvenience seemed a small price to pay.

Between 1991 and 2001, a total of 11,155 women were screened in the STD Project's surveillance programme;¹⁰ 2771 of these were seen at the Kariobangi clinic. The mean age of the women seen at Kariobangi is 23.2 years. Eighty-five percent of them were

¹⁰ Quantitative data used in this study were obtained from Ferguson 2002., an unpublished summary of the surveillance programme.

married¹¹ – 96.4% of these married women lived with their husbands.¹² Twelve percent of the women were single. Sixty percent of the women have five to eight years of education, 23% had more than eight years. These statistics are consistent with the women who were seen at the other clinics. The women who participated in the study were recruited from among this population.

Thesis Overview

A large part of this thesis is dedicated to a case-specific question that was proposed by the STD Project: *What do women mean when they respond DON'T KNOW to the question: Do you think you can get AIDS?* Chapter Two describes the methodology behind this research. It begins with a discussion of feminist methodology, then it provides background for the theoretical development of the Sexual Bargaining Framework which helps to conceptualize the determinants of women's HIV-risk. It explains the negotiation process with the STD Project and describes how the research moved from theory to practice. This process included the formation of a partnership with the STD Project and the collaborative development of the research methodology for investigating the question. It describes the qualitative methods used and provides rationale for the data collection design. Finally it explains the analysis of the data.

Chapter Three presents the findings of the case study. What *do* women mean when they respond DON'T KNOW to the question: Do you think you can get AIDS? The chapter begins with a presentation of the quantitative data collected by the STD Project over ten

¹¹ Women are asked for their marital status; women who self-identified as married are taken at their word. This may mean they were married in the church, married by traditional ceremony or living common-law.

¹² This is reportedly a very different situation from the rural areas. It would be interesting to investigate how urbanization and nuclearization of the family are affecting HIV prevalence. This is further considered in Chapter 5.

years that led to the identification of the changing trend in women's responses to the question. These data raised the question as an important research problem. The chapter is then organized thematically to explain that the response DON'T KNOW was found to mean that women *do not know* if they can trust that their partner's behaviour will not put them at risk for HIV infection. The chapter introduces trust as "having the confidence that a sexual partner is being faithful." This is followed by a discussion of the Trust Factor in sexual relationships using the information provided by participants to explain how gender expectations, social institutions and interpersonal dynamics affect the assessment of trust in a relationship. The Price of Trust is then discussed in terms of the costs and benefits that the participants identified for trusting and mistrusting partners in cases of uncertainty. The chapter finishes with a discussion of how women weigh these costs and benefits in deciding what to do.

Chapter Four integrates the findings of the case study with feminist theory to provide an overview of the political economy of gender and HIV prevention. It critically reviews how the failure of the *negotiation model* (with its focus on condoms, education and skill development) is explained by the *economic empowerment model* (with a focus on the increased economic independence of women). Using individual case studies from the Nairobi research it is demonstrated how the economic empowerment discourse overemphasizes the role of economic dependence in putting women at risk for HIV. The chapter then proposes that it is essential to analyze HIV risk in the context of a more general social order that includes economic organization as but one of the factors which conditions and is conditioned by the broader social arrangements that create an environment of risk.

As the concluding chapter, chapter Five revisits the original research objective of using a gendered analysis to reveal the systemic nature of women's HIV risk. It reviews the research findings and redefines the 'problem' of women's HIV risk as viewed through the findings. The chapter introduces two emergent models of prevention: the Trust Model and the Reproductive Economy Model and makes recommendations about how they may prove useful to inform HIV prevention discourse. The chapter reviews the limitations of the research and suggests future directions for study.

CHAPTER 2

Research Methodology

Feminist philosophers... need to develop methods and approaches that can address the fact that producing knowledge is less a matter of face-to-face confrontation with data than of negotiation within an epistemic community... of manoeuvring through mazes of experiential, conversational and testimonial deliverances, in which credibility is always an issue (Code 1995:28).

In spite of a growing international focus on the HIV/AIDS epidemic, the world has entered the third decade without effective solutions for prevention. Are researchers asking the right questions? Are they asking the right people? Through what filters are they hearing the responses? There is a strong belief in the notion of objective science; people believe that if something is “real” its determinants will become clear through application of systematic investigative techniques and if the applied methods do not reveal new information, it is because there is nothing new to uncover (Code 1995). Has this faith in traditional scientific methodology helped to fuel the AIDS epidemic?

Researchers frame the research topic, then they collect, arrange and analyze the facts that they have the capacity to elicit, that they believe are important or that they can receive funding to support. The first section of this chapter introduces feminist methodology and places the researcher within the research; individuals are faced with theoretical choices about the research frame, the events, the arrangement of facts and the analysis of them; the knowledge that is generated is inevitably shaped by the decisions they make (Stoecker 1991). My methodological approach attempted to challenge this ‘objective’ model of research by including a range of people and perspectives in the framing, the

data collection and the analysis.

As anticipated, the research process was not linear or systematic. Instead, it was like a jig-saw puzzle with different pieces of the puzzle coming together to eventually form a whole picture. Parts of the picture included the partnership with the STD Project, the research question, academic requirements, personal politics, research ethics, theory, methods, and analysis. The background was filled in by the search for funding, administrative details, and personal preparation for and adjustment to three months in Kenya. The second section of this chapter explains how I identified the broad research topic and theory, established a collaborative partnership, developed the research methods and undertook the investigation.

What is feminist methodology?

Idiosyncrasies of person and circumstances are at the heart not the periphery of the scientific enterprise (Johnson in Stanley and Wise 1991:267).

Broadly speaking, feminist methodology attempts to reveal particular problems in standard research practices (Devault 1999). It seeks to understand how gender-based power and privilege is manifested in everyday events and relations (Code 1995). While researchers practicing 'feminist methodology' are bound by core commitments, such as equality and social justice, there are three specific principles:

- It should produce knowledge that can be used by research participants;
- It should use methods of gaining knowledge that are not oppressive;
- It should continuously question dominant intellectual traditions and reflect on its own development (Acker et al. 1991:133).

The decision to use feminist methodology is explicitly political; to understand the political economy of HIV/AIDS requires the overt recognition of gender as a key social prescription determining women's and men's behaviours. The topic of this research is

political economy, the methodology is feminist. Because there is a large volume of research that is considered legitimate in spite of glaring gender-blind or gender-neutral bias, feminist researchers are compelled to acknowledge and address the inherently political nature of all research – including their own. To do this, feminist methodology cannot be distinct from questions of epistemology – the theory of knowledge (Code 1995), or more precisely, “the study of assumptions about how to know the social and apprehend its meaning” (Fonow and Cook 1991:1). Far from being an esoteric branch of academia, epistemology lies at the core of feminist methodology and should be at the forefront in defining any social research (Code 1995). What do we know? What is important to know? Whose knowledge counts? Whose knowledge reflects reality? Whose reality? How is their reality related to the problem under investigation? Questions like these should frame any research project but have traditionally been skimmed over in deference to the idea that “knowledge is just knowledge; it does not matter whose it is, who has made it, who knows it” (Code 1995:13). This traditional approach to research assumes that it is possible and preferable to be “distant, rational, uninvolved, hierarchical and unrelated” in order to uncover some kind of universal truth through tried and true research methods (Wolf 1996:4).

The researcher cannot objectively be separated from the outcome of social science research. The knowledge produced by any research will to a large part reflect the context created by the personal interaction of the researcher and the researched.¹³ Feminist

¹³ A revealing example of researcher and researched interaction was found in a study conducted on a nude beach by male and female researchers. When asked about their motivation to frequent the beach, opposite-sex responses tended to be along the lines of an interest in freedom and naturalism while same-sex responses were more likely to include a discussion of sexual interests (Warren and Rasmussen cited in

methodology attempts to apply methods and processes that reveal and neutralize the inevitability of bias in research. As a result, feminist research has been described as “contextual, inclusive, experiential, involved, socially relevant,... complete but not necessarily replicable” (Nielson in Wolf 1996:4). For if the researcher, as an integral element in the research, must be able to “see, judge and interpret the life and meanings of his/her subjects” (Wolf 1996:4), how can it be guaranteed that a different person can reproduce the same research context and results? As Stanley observed:

The researched “may like, dislike, sexually desire or despise the researcher” and this will obviously affect their participation and contribution (Stanley 1991:268).

The power hierarchy that exists in the researcher/researched relationship represents one of the major dilemmas facing feminist researchers, potentially undermining feminist goals and challenging the validity of research results. In most social research, there is an inherent personal power imbalance due to gender, race, class, nationality, and/or life opportunities of the researcher and the researched (Wolf 1996). This power imbalance is played out in many ways including the researcher’s definition of the research problem, the micropolitics of personal interaction, and the power of writing and representing (Wolf 1996). Because the common goal of feminist research is to empower women/marginalized populations, the inherent power imbalance between feminist researchers and their research participants sets up a paradoxical context for their work: they inadvertently establish the relationship that feminists strive to dismantle in order to reach their goal. In feminist research, this paradox stands alone as problematic because it undermines the feminist ideology of equality. Additionally, however, it must be

Silverman 1993). While both of these responses likely represent true motivations, the individuality of the researcher elicits a particular version of “truth” thereby shaping the research results.

recognized that there are fundamental methodological flaws in the creation of a power hierarchy because: (a) research participants will choose whether or not to share their experiences accurately, thus controlling the validity of the study results (Bernard 1995); and (b) if people feel ownership over the research process, they are more likely to be interested in working towards a representative outcome (Wolf 1996). If, however, participants become resentful about being suppressed under a power imbalance, they are likely to build strategies of resistance, such as refusal to participate or providing incomplete or incorrect information that distorts or nullifies the research results. Thus, dismantling power hierarchies can be seen not just as a goal of feminist research, but as a goal for building more critical social research regardless of methodological underpinnings.

In an attempt to redress the power imbalance, feminist researchers have adapted many strategies that are designed to empower research participants. One of the primary strategies used by feminist researchers is to include participatory approaches to research. Participatory approaches are numerous and they are outlined in a well-developed body of literature (Chambers 1994a, 1994b, 1994c; White 1996, Devault 1999; Maguire 2001). It will suffice, therefore, to explain that feminist research tends to use (or idealize) participatory approaches to create a partnership with the researched community that places some degree of decision-making power in the hands of the research participants. This is done by working together with the researched population to define the research question, to collect and to analyze the data, and to produce the results. Ideally, the researcher is the learner and co-interpreter. This allows the researcher and researched to form a partnership for exploring different social perspectives of reality. This, however,

carries “profound ethical obligations because it is a relationship based on trust and mutual understanding of a common goal” (Ulin et al 2002). The individuality and personal ethics of the researcher come into play; the research methodology alone cannot reveal the micropolitics of the research context above and beyond what the researcher has the capacity and proclivity to acknowledge.

Defining the research question

Traditionally, the starting point for research is determined theoretically (Stoecker 1991). It is claimed that a theoretical framework is essential to prevent the production of description without meaning (Hartely in Meyer 2001). It is also believed that theory provides a preunderstanding that saves time that is often spent gathering basic information (Gummeson in Meyer 2001). By grounding research in theory, researchers gain from “general knowledge such as theories, models, and concepts or from specific knowledge of institutional conditions and social patterns” (Meyer 2001:331). There is, however, an inherent epistemological dilemma in using theory to build a foundation for research of a participatory nature. It validates the knowledge on which theory was created and assumes that legitimate knowledge and judgment resides in the perspectives of the theorists. This does not privilege the knowledge and experiences of the participants. For example, to enter a gender and HIV project, as I did, with assumptions about women’s economic dependence on men risks engaging in lines of inquiry that may overlook other significant determinants of women’s behaviour. Without seeking participant input to frame the issues, the research would likely elicit material to substantiate economic theory and may misrepresent other key determinants of women’s HIV risk.

Researchers, therefore, have to distinguish between using theory to create a research question and using research to confirm a theory: “theory should not be used to produce hypotheses so we can simply go out and confirm or disconfirm our theory” (Stoecker 1991:104). Instead, researchers have to strike a balance between (a) emphasizing the theory in their research at the risk of missing essential idiosyncrasies or new knowledge, and (b) emphasizing the idiosyncrasies at the risk of missing generalizable conditions (Stroecker 1991). Overemphasizing theory may produce data that could be used to justify policies and programs which fail or cause damage.

Part II. Designing the Research: Gender and HIV/AIDS

Structural gender inequality was the essential foundation for this research. The conditions of the HIV/AIDS epidemic in Sub Saharan Africa¹⁴ highlight fundamental elements of gender inequality and provide a specific platform to analyze how sexual and reproductive politics are integral to women’s subordination. This section describes how the research project took shape, including an explanation of the theoretical development, a description of the project collaboration, a discussion of methods used and the process of analysis.

Pre-field preparation included the theoretical development of a sexual bargaining framework to ground the research. The framework draws from existing literature and research and from personal experience working with women in Canada in the context of sexual and reproductive health/politics.¹⁵ The framework development will be explained

¹⁴ Sub Saharan Africa was chosen for a number of reasons, including: the advanced AIDS epidemic, the established AIDS programs, a notable gender imbalance and a largely English-speaking population which was desirable given my own language limitations.

¹⁵ Personal experience includes working as a sexual health counsellor for Planned Parenthood, as a social worker in a shelter for homeless women and children, and as a labour partner for homeless pregnant teenagers. These roles gave an overview of the structural gender inequality facing women in Canada.

by providing a brief review of the predominant HIV-prevention approaches and the critical research on gender and HIV. The understanding garnered from this material was combined with a Weberian definition of power and intrahousehold bargaining models to develop a theory of sexual bargaining that provided a starting point for negotiating with potential collaborating partners in Sub Saharan Africa.

ABC's of HIV/AIDS Prevention

Years of the prevention paradigm that focuses on the individual, rather than social structures and the family, have not worked for us in Africa (Esu-Williams 2000:124).

In the absence of an effective vaccine or cure, the only route to stemming the HIV/AIDS epidemic is prevention. Given that the primary mode of infection in Africa is through heterosexual sex, prevention requires abstinence from sexual activity or engaging in sexual activity in such a way that no bodily fluids are exchanged with an infected partner. Because of the mechanics of prevention, HIV/AIDS prevention is seen to fall within the category of sexual *health* and it has largely been left to Public Health to promote the necessary sexual behaviour change to prevent transmission (Farmer 1999). Prevention programs have focused on how to reduce risk behaviour, which is approached in largely individualistic terms (Parker 2000) as in: *only YOU can prevent HIV/AIDS*. The biomedical goal of these programs is to prevent the exchange of HIV-infected body fluids during sexual activity.

The proposed solution is as easy as ABC: Abstain, Be faithful, use Condoms (USAID 2002). The message is clear:

"A" has been defined by different people to mean delay among youth, postpartum abstinence, "revirginization" (secondary abstinence), nonpenetrative sex..., and abstinence among divorced or other unmarried adults.

“B” includes being faithful, reducing the number of partners, and being careful in partner selection.

“C” is particularly important when not practicing “A” and “B” behaviours. The conditions of condom use might vary with marital or extramarital partners.

USAID 2002: 12

The choices are to engage in non-penetrative sexual activities (if any), to practice monogamy with an HIV-negative partner, or to use a male or female condom for every sexual encounter (UNAIDS 1999). Technically speaking, these objectives will prevent HIV transmission. A number of strategies used to promote these choices have become integral to prevention efforts and are believed to have contributed to a reduction of high-risk behaviours (Harrison and Smit 2000). These include:

- information, education and communication programmes;
- condom promotion;
- behaviour change initiatives encouraging people to reduce the number of sexual partners;
- delaying age of sexual initiation;
- mass media messages promoting awareness of HIV/AIDS;
- targeting specific risk groups.

Yet the continuing rise of the infection rate indicates that these strategies are too limited to achieve a significant impact. As Dr. Kevin DeCock, (Country Director, Division of HIV/AIDS Prevention - Surveillance and Epidemiology for Centers for Disease Control and Prevention, Kenya) noted in his keynote address to the AIDS researchers retreat in Nairobi (2003): “No one here believes that if we keep working as we are now, we’ll turn Kenya’s AIDS epidemic around.” Many studies have shown that these programs may create a change in knowledge and attitudes, but fewer studies have shown any corresponding behaviour change (Harrison 2000). Two decades into the epidemic, it is quite clear from the prevalence rates that women cannot simply apply the ABCs of prevention to protect themselves. Women in Sub Saharan Africa generally claim that they *cannot* Abstain from sex with their husbands, that they *are* Being faithful and that they

are *unable* to introduce Condom use with their husbands (Gollub 1999; Susser and Stein 2000; Wilson 1990). Public Health responses that promote behavioural change, without tackling the social norms that lead to particular behaviour, are inappropriate or inadequate in the context of women's HIV risk (Gollub 1999). Within these behavioural models of prevention, "culture" and "society" are conceived as structurally separate from sexual decisions made by individuals – what happens in the bedroom and in the home is seen to be unconnected to what happens outside these spaces. The advancing rate of HIV transmission to women quite clearly indicates that:

The actions required to block the spread of HIV cannot be divorced from the context of sex inequality and its ensuing dependencies, power imbalances and threats of violence – in short the effects of women's status worldwide as second-class citizens.
(Gollub 1999:1480)

Behavioural change models, with their messages focusing on *one partner* and *love faithfully*, are inadequate because they overlook the social realities of at-risk populations (Susser and Stein 2000). Responses to the epidemic must address gender-related needs and challenge adverse social norms that contribute to the spread of HIV (UNAIDS 1998).

Gender and HIV/AIDS

The biological link between sex and AIDS is well understood and it is widely known that condom use protects against infection. Yet in spite of monumental public health efforts to inform populations about condom use and to make condoms available, the rate of HIV transmission continues to grow (Mitchell 2001).

Physiologically speaking, women are at a biological disadvantage in terms of HIV risk. During intercourse, women have a greater surface area exposed than men – this is compounded by the higher concentration of HIV in semen than in vaginal fluids and a

larger volume of semen being exchanged than vaginal fluid. Vaginal tissue is more prone to abrasion or tears during intercourse, especially in young women with maturing genital tracts, and this increases women's susceptibility to HIV infection. Likewise, women are more likely to experience asymptomatic sexually transmitted infections – this prevents women from seeking early treatment and makes them more likely to have open sores along their genital tract that allow the transmission of HIV.

Biomedical models examine the sex difference between men and women to develop prevention strategies such as the female condom, microbicides, antenatal treatments, etc. However, it is essential to note that sex differences making women biologically more vulnerable than men to HIV infection are identical in all cultures, yet the sex-segregated prevalence of HIV is inconsistent across cultures, including across cultural/national boundaries in Sub Saharan Africa (UNIDS 2000a). This indicates that women are not at higher risk than men because they have vaginas. There are factors beyond biology that distinguish women from men and that place women at greater risk.

Gender is the social expression of being a woman or a man. This is largely expressed through the roles people perform. Some of these roles are consistent across cultures, such as the nurturing role of women and the providing role of men, and are often attributed to biological 'hard-wiring' rather than social construction. Other roles vary across cultures – for example, the roofing industry in Canada is male-dominated, but in some African tribes, roofing a house is unmistakably women's work. What is fairly consistent across cultures is “that there is always a distinct difference between women's and men's roles, access to productive resources, and decision-making authority” (WHO 2002:5). In ways

that are both explicit and subtle, people are generally rewarded for adhering to appropriate gender roles and rebuked for resisting them.

The HIV/AIDS epidemic in Sub Saharan Africa is characterized by heterosexual transmission of HIV that occurs in a context where female and male sexuality reflect the gender power imbalance of social and economic domains (Wilson 1990). Cultural practices that accept male entitlement to sexual relations and that deny women's sexual autonomy reflect the differential sexual bargaining power of women and men.

Power

While it must be recognized that women's and men's sexual experiences are driven by a wide range of factors including romance and sexual desire, the capacity for sexual decision-making and follow-through requires a degree of power in a relationship. Weber defined power as:

the chance of a man or a number of men to realize their own will in a communal action even against the resistance of others who are participating in the action (Weber 1958:180).

Weber did not believe in producing monocausal theory thereby "reducing the multiplicity of causal factors to a single factor theorem" (Gerth and Wright Mills 1958:47), instead he saw a complex social order that arranges the distribution of power in a given community in a non-linear fashion. For example, he linked power to social honour, considering power as both a source of social honour and a result of social honour. While recognizing the emergence of economic power and the existence of a "naked money power" he also noted that economic power "may be the consequence of power existing on other grounds" (Weber 1958:180). Weber's definition of power realizes an interrelation

between economic, political and legal order – noting that economic order conditions the social order, and reacts to it, but essentially economic order is just “the way in which economic goods and services are distributed and used” (Weber 1958:181). Likewise, he observed that legal order may or may not guarantee or enhance the acquisition of power when applied. The power that stems from one’s involvement in any particular order, therefore, is intrinsically connected to an overarching expression of power that is granted by one’s involvement in the various other economic/social/political/legal orders. It is the interaction of this web of factors that is constructive in conceptualizing the power required for sexual bargaining.

Power within household/family relations¹⁶ is unlike any other form of power. Within this relationship Kabeer notes that women face “risks and constraints which penalize autonomous behaviour for women but also offer them provision and protection if they remain within its parameters; this is the basis of the ‘patriarchal bargain’” (Kabeer 1995:35). This trade-off also plays out in sexual relations where the overall balance of power determines the outcome of negotiation. This is of particular interest in the context of AIDS because the ‘provision and protection’ traditionally offered to women is eroding and the stakes of the negotiation process have been raised – raised by premature AIDS deaths of husbands and by refusal of families to assume responsibility for (often HIV-positive) widows and children. This can be seen as a transformation of the social order which shapes the distribution of power in communities.

¹⁶ While households and family relations may in some cases be synonymous, quite often they are distinct. This is especially seen in communities where migrant workers are separated from their families. Some of the women we met in our research were living in rural homes with their in-laws and had infrequent visits from their husbands who worked in the city.

Intrahousehold bargaining models reveal that traditional economic models of the family have neglected the gendered power differentials that exist at the household level (Kevane 2000; Hanmer and Akram-Lodhi 1998; Lundberg and Pollak 1993; Seiz 1991; Katz 1991, 1997). An individual's bargaining power is defined by:

...a range of factors, in particular the strength of the person's fall-back position (the outside options which determine how well-off she/he would be if cooperation failed), also termed the 'threat point'. An improvement in the person's fall back position (better outside options) would lead to an improvement in the deal the person gets within the household (Agarwal 1997:4).

In her work on intrahousehold bargaining and gender relations, Agarwal (1997), like Weber, recognizes that many complex factors shape bargaining power. While some can be incorporated into formal models and empirically tested, others, especially qualitative ones, are more difficult to measure or even define. These include ideological, social and political variables that normally fall outside the realm of economics (Katz 1991). The elusive nature of these factors, however, does not diminish their significance. Conversely, overlooking or ignoring these factors because they are difficult to define or measure could prove to be misleading. In the interest of illustrating how power is shaped, I needed an analytical framework that could be used to expose how intersecting and compounding variables limit the sexual bargaining power of women.

As seen in the schematic diagram to the right, the sexual bargaining framework integrates aspects that are critical for understanding the scope of sexual bargaining. It includes a complex range of factors that can be grouped under four

Sexual Bargaining Framework

interconnected orders: Economic, Political, Sociocultural, and Personal.

The table below provides some general examples of factors that would have an impact on the power that could accrue within each order:

Order	Examples of factors shaping power
Economic	Access to income; control over household finances
Political	Access to service; protection from harm
Socio/cultural	Women's social role; perception of domestic rape
Personal	Self-esteem; level of education

The framework is intended not simply to categorize the different types of factors that inform bargaining, but to demonstrate the complex intersection of contradicting and compounding issues that women face when making decisions about sexual behaviour. Just as Weber (1958) recognized that economic power both conditions and is conditioned by social order, it is the intersecting nature of factors that must be exposed to understand the limitations of women's agency due to the imbalance of sexual bargaining power. A basic example would be a woman's decision to control the number of children she has. The table below illustrates examples of how individual orders impact decision-making for this woman:

Order	Example: controlling number of children
Economic	If she has no access to income, husband could withhold financial resources if he disagrees with her decision.
Political	She requires access to contraception/health services; she must be protected (legally and physically) if refusal of sexual advances from her husband sparks violence.
Socio/cultural	Women may be more highly valued if they have more children; men may be entitled to sexual relations with their wives.
Personal	She may rely on strong social approval; she may fear the consequences of challenging social norms.

Yet, none of these examples stands independently; the examples within the different orders are mutually constitutive. For example, there is a dialectical relation between the social/cultural perception of domestic violence and the political/legal machinery for protecting women from violence - to some degree, each conditions the other. Similarly, it may be socially condoned for men to withhold economic resources from their wives (indeed, women may personally accept this threat as a deserved consequence) and there may be no political/legal recourse for women in this situation. The sexual bargaining framework is not meant to provide an exhaustive model that highlights all issues, but it demonstrates that various issues (for example, the economic dependence of women on men) cannot be considered in isolation and that prevention programs must consider the entire context of sexual bargaining power beyond the individualized mechanics of sexual negotiation. The interrelationships between social organization and socio-economic gender inequality need to be fully understood to overcome this pandemic (Lawson 1999). By seeking to understand how systemic issues play out for women on a variety of interconnected levels, prevention programs can be designed to meet specific needs and advocacy efforts can be directed towards making the changes required for women to protect themselves.

The Sexual Bargaining Framework provided a point of focus for the research, though not a specific research question; I wanted to collect qualitative material that could contextualize how different variables of sexual bargaining power play out as women make sexual decisions. To do this, I sought an opportunity to conduct a case study that would address an HIV risk-related question proposed by a local group. The case study could then serve the dual purpose of meeting an immediate research need of a local

organization while providing material to illustrate sexual bargaining power.

Building the Partnership

My dialogue with the STD Project began in August-September 2002. While I expressed that I had a general interest in research on women's risk within marriage, I conveyed that I was open to shaping the topic around a research question proposed by the STD Project. It required considerable perseverance to get the opportunity off the ground. Debates grew around whether my research was relevant to the STD Project and whether a study could be developed to meet everyone's interests. As was expected, the STD Project did not see a need to contribute to a study on Sexual Bargaining Power. They were, however, interested in more specific questions about women's risk. Mid-December 2002, the STD Project's management committee proposed a couple of questions/tasks they felt would fulfill everyone's interests:

- Begin an investigation of the psychology of trust in sexual liaisons: husband/wife, wife/husband, sex worker/regular client/lover.
- Further interview a sample of the many women replying DON'T KNOW in the surveillance questionnaire when asked whether they feel at risk of HIV/AIDS.

The Project invited me to join them if I found these questions interesting. They were indeed interesting to me; they required the use of qualitative methods designed to understand intimate heterosexual relations. I realized that the material that needed to be collected to address these questions would help to elucidate the micro-details of women's risk in a manner consistent with the gender analysis that I was proposing.

The research question remained relatively undefined until I arrived in Nairobi and met with STD Project staff. I worked closely with Aine Costigan, the Co-Director and Alan Ferguson, the STD Project's Monitoring and Evaluation Specialist, to develop the

question. As the topic took shape, I wrote a proposal that I presented to Professor Elizabeth Ngugi, the Kenyan Co-Director. We agreed that the main focus of the study was to investigate what it means when women respond that they DON'T KNOW to the question: "Do you feel that you can get HIV/AIDS?" This focus emerged because there had been a notable change in the response rate to the question over the ten years that the STD Project had been conducting surveillance.¹⁷ Because the STD Project primarily conducted research of a quantitative nature and the qualitative nature of this study was novel for them, they accepted the general methodology that I had developed before arriving.

I was fortunate to have the support of the STD Project because I felt it was methodologically unsound for me to single-handedly design and execute the research into HIV-risk of Kenyan women. When I expressed an interest in having a Kenyan counterpart, Professor Ngugi readily agreed and named Cecilia Kariuki, the Project's surveillance nurse, as the most appropriate choice. I spent time with Cecilia, traveling to the four clinics located in Nairobi slums and learned about her surveillance work – this provided familiarization with the STD Project and with the communities; it also helped Cecilia and I build a working partnership.

After the research question was defined and the Project staff reviewed the proposal, I worked closely with Cecilia to build the specifics of the methodology and to conduct the research. We hired an experienced moderator to assist us with the discussion groups and sought her input to the structure and content of the sessions. The partnership with the

¹⁷ The quantitative foundation for this question is more fully discussed in the following chapter.

STD Project was ideal. Staff recognized that I was working on a question posed by the project, therefore everyone was quite generous and welcoming. I had the assistance of the project drivers during working hours and had use of project vehicles after hours. I became an honorary staff member and was good-naturedly juggled around to available desk space and given Internet access. Senior staff met with us regularly and read through drafts of the proposal and the findings, offering useful suggestions, recommendations and support.

Methods

Qualitative research is not a solution, but rather a route to better understanding of the human condition, with the hope of contributing to more rational decision-making for improved health program effectiveness and impact (Ulin et al 2002:6).

The Strengthening STD/HIV Control Project houses a massive database of quantitative data which helped to identify a changing trend in risk perception, but the existing data cannot provide an explanation for the “why” or the “how” of this trend: Why *do* women say they DON’T KNOW if they’re at risk? This question is qualitative in nature because it seeks to understand the interpersonal dynamics and the socio/political dimensions that affect women’s capacity to protect themselves from HIV/AIDS. This information is stored in the conscious and subconscious understandings of women. Qualitative research is needed to understand how people make sense of the world (Ulin et al 2002).

There is no universal blueprint for qualitative research. Instead, it is a research framework that focuses on complex relations between: 1) personal and social meanings, 2) individual and cultural practices, 3) the material environment or context (Ulin et al 2002). It reflects “a mixture of the rational, serendipitous, and intuitive” which in turn reflects the personal experiences of the researchers (Van Maanen 1983:10), which in this

case includes researchers with extensive research and counseling backgrounds. While quantitative research identifies behaviour trends, qualitative research generally aims to understand the link between an observed behaviour and the context within which the behaviour occurred and tries to understand the perspective of the person exhibiting the behaviour (Van Maanen 1983).

Predetermined disciplines, topics and methods for research do not necessarily correspond to women's experiences (DeVault 1999:63). To access the information required to understand this question, we needed research methods that could capture the knowledge of women that has not been previously encapsulated as "information". We wanted to understand experiences in the "complex, interrelated way life usually asserts itself" (Reid 1992:6). Rather than use traditional linear question-and-answer information collection that forces artificial order onto women's experiences, we wanted to find ways to uncover activities and realities that "women take for granted, activities that are normally only partly conscious, learned without explicit attention" (Devault 1999:64). We wanted to open a dialogue that might uncover the knowledge and strategies that make up meaningful day-to-day activities for virtually all women, albeit usually talked about indirectly and not usually labeled as information (Devault 1999).

There were two levels of participation in this study: (1) collaboration with the STD Project staff and (2) participation of women as informants. While participation at the project level was fully engaged at all levels, time and money were limited to allow fully engaged research at the local level with individual women. The goal was to regard women as more than objects for observation – instead they were invited as active

participants who were capable of identifying their own needs and could “identify relevant research topics and to find ways and means of dealing with the problems of women’s subordination” (Ostergaard 1992:4). The objective was to select methods of information gathering that allowed “women’s perceptions, experiences and capacities... to be expressed, valued and understood” (Reid 1992:6). The methods had to allow the participants to name the issues and to contribute to the analysis in a way that their lived-experience became a ‘phenomenon’ for consideration in HIV/AIDS dialogue.

Three distinct though overlapping steps were used to collect qualitative data. These included:

- i. Semi-structured interviews with clinic staff
- ii. Client discussion groups
- iii. Semi-structured interviews with prenatal clients.

These methods were applied in an accumulative manner, meaning that each set of data collected was used to inform the subsequent stages of data collection. These methods included approximately 65 woman-hours of discussion (including each woman’s participation in discussion sessions).

Step I – Semi-structured Interviews with Clinic Staff

When asked what they meant by DON’T KNOW, clients confided to the surveillance nurse that they were uncertain how their sexual partner’s behaviour contributed to their own risk. To establish/confirm the meaning behind the DON’T KNOW response, we decided to investigate other possible opinions regarding this risk uncertainty before speaking with the women. To do this we conducted semi-structured interviews with staff from each of the four clinics. Respondents included seven nurses working in the STD/HIV rooms and

one HIV counselor. Counselors and health workers have a variety of insights about women's risk behaviour as a result of working in different contexts with clients. The staff were asked what additional reasons might lie behind the DON'T KNOW response and they were asked to reflect on the costs and benefits for women who decide to either trust or to mistrust their partners. Staff ideas on the significance of trust in relationships were used to help structure client discussion groups.

Steps II & III – Client Discussion groups and Interviews

Antenatal clients who responded DON'T KNOW to the question “do you think you can get HIV/AIDS?” were invited to participate in discussion groups and personal interviews. Two groups, with eight women in each, were assembled and discussion sessions were conducted with each group before the women participated in follow-up personal interviews. All the women were married (by their own definition of married) and were between the ages of 18 and 25. The discussion groups were conducted in Swahili and taped, with the moderator later translating the sessions. The interviews were variously a combination of English and Swahili simultaneously translated so that I could participate actively in the interview sessions. The original plan was for each group to join us for three consecutive mornings: the first group session, the second group session and the individual interviews. Due to time constraints, the second group only participated in one discussion session prior to the interviews. The two groups were convened two weeks apart. This gave us time to reflect on the outputs from the first group and to design the second set of sessions and interviews based on information accumulated from the first.

One of the objectives of the discussion sessions was to build a community response from

the women to specific questions. The discussion sessions, however, were designed to fill several purposes besides providing raw data. The group work acted as a framing device, for the participants and for the researchers. We recognized that women were being asked to explain topics which they may never have considered in any detail and which they may not be prepared with ready answers. The discussions and interviews, therefore, were seen as a way to produce meaning rather than just to provide ready information. The discussions helped create awareness of the topic so that women could weave fragmented stories into useful coherent descriptions and could share the meanings behind their experiences by incorporating a new frame of analysis into their narratives. In essence, the group work was an attempt to prepare women to “think and speak of [their] lives in the terms relevant to the research at hand” (Holstein and Gubrium 1995:49). Their reality was seen as “an ongoing, interpretive accomplishment” as women were asked to reflect on everyday life in new ways and if necessary, to reconstruct the topic in a way that is relevant to their own experience (Hostein and Gubrium 1995:16).

The first meeting was an interactive session on HIV/AIDS. The surveillance program’s very brief “healthy talk” was delivered to all the participants during their initial contact with the clinic; therefore the first discussion session provided an opportunity for participants to recall and build on the information they already knew about HIV/AIDS transmission and prevention. In the company of a nurse trained in STDs and HIV/AIDS, women were able to ask questions and to develop a broader understanding of the issues. This session also invited a critical discussion about the ABCs of HIV/AIDS prevention. To aid in generating discussion, we provided each woman with a condom to open and examine – most of the women had never seen a condom out of its package, let alone

handled one. A female condom was also passed around and discussed.

The aim of the first session was to provide a non-threatening forum to engage women in topics that are quite sensitive in nature--namely HIV/AIDS and sexual health. One of the goals of these sessions was to facilitate women's overall participation. The sessions did this by:

- creating a sense of shared experiences with other women;
- providing women with a new framework of issues that affect their lives;
- encouraging women to think about systemic issues affecting decisions they make;
- 'normalizing' issues to make it more comfortable for the interviews that followed;
- familiarizing women with the researchers who met with them for individual interviews.

Another goal of the first session was to benefit the women who participated. They have little access to adequate and accurate sexual health information. They were able to ask questions and to discuss issues with the support of a health professional in a low-pressure environment, compared to the rushed pace of regular visits in a resource strapped clinic. Indeed, for some of the women who were HIV-positive, it may have been the most comprehensive opportunity possible to learn about their health status. The detailed information, together with realizing they share their difficulties with other women, may allow women to take more ownership over their decisions to challenge certain behaviours.¹⁸

Following from developments of the first session, where the concept of trust was introduced, the second session of the first group was designed to investigate trust in one's partner and to learn how women make decisions based on trust. This session provided

¹⁸ Indeed, one woman reported that she went home and told her husband she did not trust him. Although he denied any wrongdoing, she said that she had noted a change in his behaviour of late and the discussion helped her to realize that this change may be putting her at risk. Ideally, the group would be able to continue providing support for the woman, however such continuity is impossible to facilitate with such a small-scale project. Unfortunately this woman was already positive.

useful information to determine whether the clinic staff and the clients have similar understanding of the context of women's risk. The following questions were used to guide the session:

- What is the meaning of trust in relationships?
- What are the benefits when a woman trusts her partner in cases of uncertainty?
- What are the costs when a woman trusts her partner in cases of uncertainty?
- What are the benefits when a woman *mistrusts* her partner in cases of uncertainty?
- What are the costs when a woman *mistrusts* her partner in cases of uncertainty?
- How does a woman decide?

The following day, we conducted semi-structured interviews with all the participants from the discussion sessions. Rather than being seen as suppliers of information, respondents were engaged as constructors of knowledge and the interviews attempted to consciously engage women in the process of meaning production. Women's responses were further questioned and probed so that they actively pieced experiences together and provided not only descriptions, but also interpretations of what they described. "They [were] seen as ethnographers in their own right" (Holstein and Gubrium 1995:16). This set of interviews followed-up with the women to build a clearer picture of the marital context in which trust has to be determined. The following questions acted as an interview guide:

- Why do women/did you get married?
- What do you think makes a good marriage/husband?
- What pressures do you face from inside/outside your marriage?
- What strategies do you or others use to stay safe or to get your own way in the relationship?
- What would make things easier for you/wives?

The second group followed two weeks after the first group. This was a function of recruitment as well as to allow for consideration of the material from the first group of women. Due to time restraints, the second group only participated in one discussion session prior to the interviews. The single session included the basic information section

to provide women with the opportunity to ask questions and to build group dynamics.

While the first discussion group explored the costs and benefits of various decisions, the second group investigated more specifically how women know if a man is being faithful and what women “should” do about it. The following questions provided a general guide for the session:

- What are the reasons for a man moving outside the relationship?
- What are the threats of a man moving? What fears do women have?
- How could you know/be sure what he is doing?
- What do ‘people’ think a woman should do if she knows he’s moving?
- What do *you* think she should do? What does she need to do this?
- Are there circumstances that she should leave? What does she need for this? Whose support does she have?
- Why do women stay?

The interviews with the second group of women explored how their own personal decisions and behavior led to a DON’T KNOW response. Most of these interviews became unstructured narratives that were sparked by the first question: Tell us a bit about your marriage history. Women provided information about how and why they got married, how their expectations compared to reality, etc. The narratives clearly provided women with a subjective sense of their contribution to meaning-making (Holstein and Gubrium 1995). Most of the women developed the context of their story freely within the frame of the preceding discussion group and they were able to reveal the complex ways that their different perspectives were connected, i.e., how their roles as wives, mothers, daughters, daughters-in-law, etc., complicate their capacity to make and follow through with decisions. The following questions acted as an interview guide:

- Tell us a bit about your marriage history.
- What makes you unsure of your husband’s behavior?
- What do you do about it?
- What would you like to do about it? What things do you wish you could change?
- Is there any way you can discuss his behavior with him? Why or why not?

- Is there anyone else you can discuss it with? What do they say?
- Are you able to talk to him about things that worry you? Can you give examples?
- Are there parts of the relationship you feel you control?
- Do you ever think of leaving?
- What options do you have?
- If you left, whose support would you have? How would you support yourself?
- When you think of all these things: HIV/AIDS, your children, your husband, your family, yourself, etc., what are the most important things to you?

Analysis and Representation

Methodologists obviously prefer to spend more time on such matters as gaining access, interviewing, choosing informants, handling reciprocities and so on, rather than on the intellectual work of analysis (Sieber in Miles 1983:125).

The data analysis occurred in the same flexible, accumulative style that characterized the project design. While formal approaches such as content analysis and coding were used to identify themes, much of the analysis was intuitive and conversationally based. Contributions from the Kenyan partners were essential to give meaning to the information collected. After each session, we reflected on the material we collected and decided how to connect the new material with what we already knew. We also worked together to determine what other information we needed to help complete the picture of how women construct and manage their choices around HIV risk. By using this accumulative analysis, in effect we brought our findings back to the women in the next session for substantiation. After each session, we felt we had a stronger idea of what women meant when they responded DON'T KNOW to the question: Do you feel you can get AIDS? We also realized that besides understanding what DON'T KNOW means, we understood some of the reasons why women DON'T KNOW and the determinants that make it difficult for women to act on their perception of risk. Throughout this process, it became clear why it was essential to understand this phenomenon.

In terms of the sexual bargaining framework, content analysis of the material allowed

themes to emerge that demonstrated many determinants that have an impact on women's capacity for sexual bargaining. The case studies provided by women's narratives clearly illustrate the relationship between a woman's capacity to act and her social-political environment. The discussion sessions helped women locate their experiences within what appeared to be inevitable gender roles and women participated in the analysis by telling their stories and sharing their limitations in a way that was meaningful and connected. For example, one woman started the story of her marital history by explaining that her mother died before she can remember; she understood that her family status (or lack thereof) is an essential detail for the research at hand. We did not need any further analysis to understand that marriage was her only option for social connection and survival. It was an analysis that she conducted and owned in deciding what to include in the telling of her story.

CHAPTER 3

I DON'T KNOW:

The Role of Trust in Assessing Risk

The goal of the collaborative partnership with the STD Project was to investigate the meaning of DON'T KNOW as a response to the question, "Do you feel you can get AIDS?" This chapter presents the findings from the exploration of the meaning behind DON'T KNOW. It begins with a presentation of the STD Project's quantitative data that shows why an investigation into the meaning of DON'T KNOW was an important research question.¹⁹ It then presents the findings from the qualitative exploration of what participants meant when they responded DON'T KNOW to the question. The findings help demonstrate the contradiction in women's survival strategies.

Do you feel you can get AIDS?

One of the questions asked on the HIV surveillance questionnaire is: Do you feel you can get AIDS? Over the ten-year period that the Project has conducted surveillance, it has noted a change in the responses. While in earlier rounds, clients generally responded either YES or NO to the question, in the last four years there has been a notable increase in the number of DON'T KNOW responses (see fig.1).²⁰

¹⁹ Quantitative data obtained from Ferguson 2002.

²⁰ The reason for the change was not investigated; a retrospective study would be largely speculative. Perhaps, for example, public health education campaigns changed women's awareness of risk and consequently their perception of risk. The data required to address this question would require a longitudinal study or the collection of qualitative data throughout the years that the response changed.

Fig. 1: Do you feel that you could get HIV/AIDS?

From the first round of surveillance in 1991 to the most recent in 2001²¹, the percentage of women responding YES to the question dropped from 55% to 4%. Those responding

Fig. 2: 2001 Surveillance Round:
Do you feel you can get AIDS?

DON'T KNOW increased from 15% to 58% over the same period. The statistical switch from “YES, I could get HIV/AIDS” to, DON'T KNOW, flags a significant trend in risk perception: are fewer women willing or able to regard themselves as being at risk for HIV/AIDS? In the

most recent surveillance round (2001), the DON'T KNOW response was clearly the stock answer (see fig.2). Only 4% of the women felt that they *could* get AIDS, 38% of the women felt they *could not* get AIDS, while 58% of the women reported that they *did not know* if they could get AIDS.

When women responded YES or NO to the question “do you feel you can get AIDS?”

²¹ For a full description of the STD Project's surveillance work, please see Chapter 1. Survey rounds only roughly correspond to calendar years. The first three surveys were collected in 1991-92. No data were collected in a 20-month period between April 1997 and Feb 1999, i.e., after survey six. A total of 11 155 women were interviewed and screened for STDs and HIV in the period represented by Figure 1.

they were asked how they assessed whether or not they were at risk (see table 1).

Table 1: Reasons for risk perception of HIV/AIDS 2001 (1183 respondents)

YES - at risk because:	% citing	NO – not at risk because:	% citing
<i>Husband has many partners</i>	67.3	<i>Husband monogamous</i>	90.6
Condoms not used	13.3	Few partners	7.2
All at risk	10.8	Small risk	0.8
Other reasons	4.9	Other reasons	0.7
She has many partners	3.7	Use condoms	0.6

The women cited the sexual behaviour of husbands²² as the most common reason behind their perception of either being at risk or not at risk: of the women who do perceive themselves to be at risk, most (67.3%) know or believe that their husbands have other partners; only 4% of these respondents cited their own behaviour as a risk factor (of these, most were single, widowed or divorced, i.e., did not have a husband). Of the women who do not consider themselves at risk, 90% of them credited the perceived faithfulness of their husbands for this assessment. The women who responded DON'T KNOW to the question in the surveillance questionnaire were not probed for reasons behind their uncertainty.

Table 2 and Figure 3 show the relationship between women's reported HIV risk and their HIV status in the most recent surveillance round (2001). Thirty-eight percent of 1183 women screened reported that they did not feel at risk; 8% of these women were HIV-positive. Four per cent of the women reported that they felt they were at risk; 30% of these women were HIV-positive.²³ Fifty-eight percent of the women reported they DON'T KNOW if they are at risk, 16% of these women were HIV-positive.

²² 87% of women screened were currently married.

²³ Conclusions cannot be drawn from this group given the small sample – some of these women may have known their HIV status before reporting their 'risk'.

Table 2: Risk perception and HIV status

Risk Perception	HIV+ve (%)	HIV -ve (%)
Not at Risk n = 455 (38%)	36 (8%)	419 (92%)
At Risk n = 46 (4%)	14 (30%)	32 (70%)
Don't Know n = 682 (58%)	108 (16%)	547 (84%)
Total n = 1183 (100%)		

**Fig. 3. Risk Perception and HIV Status
Round 9 - 2001**

The Kenyan national HIV prevalence rate for urban antenatal clients is estimated to be 15% (UNAIDS/WHO 2002). Women who DON'T KNOW, with 16% prevalence, fall just above the national average, while women who feel they are not at risk fall significantly below the national average at 8%.

Thus, in summary, the data show that women who do not feel at risk trust that their husbands are faithful (the reason given by 90.6% of them) and their lower HIV prevalence (8%) suggests that they may have strategies or communication skills for being certain.²⁴ Women who responded that they DON'T KNOW if they are at risk make up the majority of the respondents and they have a higher HIV prevalence (16%) than the women who believe they are not at risk. The surveillance data provide quantitative information to isolate the DON'T KNOW response as a phenomenon worthy of further investigation, but it cannot provide insight into *why* the majority of women might respond

²⁴ This study did not investigate the characteristics of these relationships and how they are different from others.

DON'T KNOW²⁵ and cannot explain how *not knowing* effects HIV risk. The remainder of this chapter presents the qualitative findings from the investigation.

Understanding Risk and the ABCs of Prevention

During the discussion sessions, the participants provided information that demonstrated a clear understanding of HIV transmission and prevention. They were quite knowledgeable about the different modes of transmission and they were aware of prevention methods; they could rhyme off the ABCs of prevention. These women *did* know what contributes to HIV-risk and seemed able to apply the knowledge to their own circumstances, therefore it was apparent that participants had not replied DON'T KNOW because of a lack of understanding about risk factors and prevention strategies. This corresponds to other work that reveals that within many populations, knowledge about HIV transmission is not the primary barrier to sexual behaviour change (Meursing 1999; Susser and Stein 2000; Carovano 1995; Smith and Cohen 2000; Worth 1989). Rather, as Farmer stated:

We know that the risk of acquiring HIV does not depend on knowledge of how the virus is transmitted, but rather on the freedom to make decisions (1999:xxv).

When the discussion touched on condom use as one effective way of preventing transmission, all the women expressed extreme skepticism about the practicality of introducing condom use with one's husband.²⁶ According to the participants, men tend to be completely dismissive of any suggestion that women may make about condom use. Since most men are perceived to be opposed to condoms, it is very difficult for a woman

²⁵ Clinic staff and research partners suggested women may say DON'T KNOW for a number of reasons – including to avoid further questions or reluctance to acknowledge their own behaviour. Women who chose DON'T KNOW as an avoidance technique may have self-selected out of the study. These findings are not a quantitative representation of the meaning of DON'T KNOW. Further study is required to determine if these findings are representative

²⁶ Obviously, if condom-use is not an option, abstinence is also not an option – it was not discussed.

to broach the subject without the fear of encountering opposition and possibly hostility from their partners. One HIV nurse in Nairobi said quite plainly: “Of course they can’t tell their husbands to use condoms, but I don’t know what else to tell them.” The reluctance or inability of women to introduce condom use with their partners is widely reported in the research literature (Rivers and Aggleton 1999; Susser and Stein 2000; Rao Gupta 2000, 2002, Bennett 1990; Dodoo 2001). Aside from men’s aversion to using condoms, the women said that using condoms as a means of HIV prevention implies infidelity and they fear that their husbands will accuse them of either not having faith in him or of being unfaithful herself. The implicit link between condoms and infidelity is acknowledged in the prevention literature (Rivers 1999; Worth 1989; Bennett 1990)

The women reported that men often do not want their wives to use any form of contraception, and are unwilling to use condoms even to control pregnancy. One woman explained that immediately after the delivery of her third child, she brought condoms home from the clinic and told her husband that the nurse had suggested they use them until she was able to use another birth control method. He ridiculed the idea and said in his lifetime he never had to use “socks” (condoms) and does not see why he should start now. Neither of them wanted another child, yet he did not offer another way to prevent pregnancy. She said her only solution was “to pray to God that I don’t get pregnant again”. Her fourth pregnancy followed soon after.²⁷ The participants felt that most women will resort to either secretly using a contraceptive method (and suffer the consequences should her partner find out) or else just wait to get pregnant, even if she is completely unprepared to have a child. Routine condom use is not a valid option for

²⁷ This woman tested HIV-positive. Her youngest child, who was not tested, is ill with symptoms of AIDS.

women who believe, as one said “it is even laughable to imagine that one can go back home and ask one’s husband to use a condom.”

The women knew about risk factors and they understood about prevention: their primary risk was having unprotected sex with their husbands.²⁸ They were concerned about the possibility that their husbands may have other sexual partners and they knew they are not in a position to make him stop nor to protect themselves. They asserted that the ABCs should be applied to both men and women, not just to women; they understood that the ABCs cannot offer them effective protection because the decision to use monogamy as an HIV prevention technique cannot be unilateral.

Not Knowing

The women who participated in the study explained that they responded DON'T KNOW because they *do not know* if they can trust that their husbands’ behaviour will not put them at risk. While they may be practicing monogamy themselves, they said that they cannot know with certainty whether or not their husbands are engaging in high-risk behaviour. They want to presume that their husbands are also monogamous, but report that they are unable to conclusively confirm whether or not this is the case. Women offered the following examples:

A man will go with other women if his wife is unable to meet his sexual demands or if she refuses to grant him his conjugal rights because he is too ‘demanding’.

Men are like children, and always need to have all their needs, especially sexual needs, satisfied.

A woman has to make her husband as comfortable as possible, to keep his interest.

If a woman loses sexual interest during pregnancy, he’ll go with others.

²⁸ Also discussed by Smith and Cohen 2000 that married women who rely on monogamy for protection are at risk because of the sexual behaviour of their steady male partner.

A man may move if his wife is unable to bear him children. If, say, after a year she has not had a child, he will get into another relationship that will fulfill this need.

If he's working away from home in the urban center while his wife is living in the rural area, then he's likely to look for a 'town wife' to keep him company.

When he has made it [i.e. money], the tendency is to spend it on other women.

If his wife constantly nags, for instance always demanding to know where he's been or where he's going, and with whom, he may go with other women.

In an environment where the majority of HIV-positive women are infected by their husbands (Action Aid 2001), women must determine if they can trust that their husbands will not put them at risk for HIV infection. The assessment of HIV risk, therefore, is at least partly based on the trust factor in a relationship: women who feel they are not at risk trust their husbands, women who feel they are at risk have reasons to not trust their husbands (or know their own behaviour places them at risk) – women who participated in the study said they *do not know* if they can trust that their husbands are not engaging in high-risk behaviour. Asking women to assess their HIV-risk, therefore, may be asking them to assess the trust factor in their relationship.

The Trust Factor

In the context of HIV/AIDS, trust refers to the implicit faith that your partner will do you no harm (Lane and Viney 2002). The discussion group participants had concrete ideas about the meaning of trust in relationships: trust translates into having confidence that a sexual partner is being faithful. One woman said:

Trust means having respect and love for that person. In turn, if he also loves you, he will be satisfied with what you can give him and will have no reason to go looking for it outside the marriage.

During the discussion sessions and interviews with women, it became apparent that building trust in a relationship is not simply a private and individualized process, rather it is determined in part by gender roles and other social pressures that affect the dynamics

of a relationship. The content of the discussion sessions and interviews has been organized thematically to help unravel the factors that shape the dynamics of trust in relationships and to understand how the trust factor affects women's capacity to protect themselves from HIV. The themes include gender roles and expectations, social institutions and interpersonal dynamics.

Gender roles and expectations clearly complicate the trust factor. While monogamy may be outwardly favoured in most cultures, infidelity tends to be tolerated and even expected from men (UNIFEM 2001; Rivers 1999; Carovano 1995). Particularly in societies that were traditionally polygynous, "there are wide-spread beliefs that males are biologically programmed to need sexual relations regularly with more than one woman, and often concurrently... Research has found that these beliefs are held as strongly by women as by men" (Leclerc-Madlala in Gilbert and Walker 2002:1106). While some women who participated in the study had concrete suspicions about their husband's fidelity, other women, who had no overt reasons to mistrust their husbands, responded DON'T KNOW because they do not know what their husbands do when they leave the house. One woman gave an example to show how it is difficult to know:

He claimed that his job as a mechanic took him away to work for two days at a time. When he came to the house later, he said he'd been away – and he was wearing different clothes from when he'd left.

There was a general consensus that "men will be men" and the women seemed to have little confidence that their husbands will behave in a way that runs counter to widely held gender expectations for men.

The gender expectations for women complicate this further. While men are entitled to

engage in extramarital sexual relations, women are not expected or permitted to challenge their husbands' behaviour (Rivers 1999); the women expressed that they are supposed to work to please their men. A lively debate grew during the discussion sessions about the reasons that men "move" outside the relationship and the participants shared ideas and strategies that women use for keeping their men. While the women expressed anger and frustration at their powerlessness to change their husbands' behaviour, they seemed to accept the inevitability of men having sexual affairs with other women²⁹ and felt the onus was on themselves to ensure that it was unnecessary for men to stray away from the marriage (discussed in Bassett 1995). One woman said:

It is up to me to make sure that I provide what he is lacking; to make sure he's getting everything he needs so he stops looking for it from other women – more love and caring, physical needs, good food... He should always be kept happy.

When asked why men seek extra-marital sexual relations, women did not discuss the pressure of masculine norms in shaping men's behaviour, rather they mostly placed the 'blame' on women for being unsatisfying, for being pregnant and not interested in sex, for being unattractive or inattentive. Strategies for keeping a man mostly focused on ways to make the relationship more pleasing and satisfying for men (see Box 1):

Box 1. How to keep a man:

- *Find out what you're doing wrong to make him unhappy and change it;*
- *Stop nagging;*
- *Do everything you can to keep him satisfied;*
- *Be welcoming and receptive when he comes home;*
- *Make sure you're well-groomed and pleasant company at all times;*
- *Encourage him to take another wife if you cannot satisfy him sexually.*

- Comments from client discussion groups

²⁹ Rao Gupta and Weiss (1993) noted women's resignation to male infidelity in a study of women from over ten countries. It was also discussed in an *Africawoman* editorial: "Even though they may live in a regime that means they must accept that their men will not be monogamous, these same women often bear the brunt of social prejudice that is quick to apportion blame to them" (2002:4).

While strategies varied among the women, the participants made it quite clear that the role of relationship maintenance belongs to women and if a man needs to find fulfillment outside the marriage, it is widely believed that it is because his wife is unable or unwilling to meet his needs. One woman, who was a second wife, implored the other women to be careful about their grooming and their treatment of their husbands because she knew from her own experience how easy it is to distract married men from inattentive wives. Another woman advised that if a woman learns that her husband is with another woman:

She should not resort to physical force or aggression, but instead should talk to him and find out why he's moving. Thereafter, she should rectify what she is doing wrong to make him move.

The Trust Factor, therefore, is implicitly connected to a woman's performance as a wife. If she is a "good wife," her husband will not need to seek satisfaction elsewhere and he will be trustworthy. If he "needs" more than he receives in the relationship, however, it is seen as a reflection of *her* suitability, not of his trustworthiness. These gender expectations may reduce a woman's capacity or sense of entitlement to be critical about her husband's behaviour in assessing her HIV risk.³⁰ The women were asked why they think men still go with other women even when their wives do all the things that a wife should do. They had no ready answer and one responded:

This kind of behavior can only be caused by mashetani (evil spirits).

Social institutions such as extended families and the church were said to endorse these gender expectations. A number of women explained that they decided that they would be better off if they left their husbands and returned to their families. Whether they

³⁰ Other work suggests that the pervasive nature of the gender expectations also affects the capacity of highly educated middle class women to negotiate safer sex with their husbands, not just poor women (Wolff, Blanc and Gage 2000).

sympathized with the woman or not, however, their families did not eagerly offer refuge for the women and their children. This occurred for a number of reasons – families may not be able to afford the extra mouths to feed, or they may fear the stigma of having a daughter with a failed marriage. A number of the participants were orphaned as children and found that extended family members did not want to take responsibility for the well-being of the women and their children. Additionally, they may be asked to return the dowry³¹ to the husband's family if the marriage contract fails (also discussed in Wolff et al 2000). One woman explained:

It is not easy to leave since marriage is tied up with the whole dowry system. Once a dowry has been paid, the parents of a girl will do anything to make sure that she stays in the marriage since leaving will mean refunding the dowry.

The family may believe that a woman's place is with her husband, regardless of the circumstances, and believe that she has failed. Family members offered the advice to return to their husbands because "at least he's not violent" or because "at least he is providing for the family" or because "you no longer have a mother to care for you here".

Women said:

Her family is likely to blame her as the one who failed and urge her to go back and stick it out. She may see no way out and decide to stay.

A woman who opts to leave may be regarded by her relatives as having 'deserted' the marriage, and is unlikely to get much support from them.

Frequently, women explained, when men followed their wives to retrieve them from the family home, various members of the family gathered together to discuss his actions, to provide guidance, and to encourage the husband to improve his behaviour. This delivered the message to women that family and communities will provide support for women to

³¹ Technically, the price paid to a woman's family by the groom is the bridewealth; dowry, however, was the term used by the research partners and in translation.

stay rather than to leave a marriage because that is where they belong.

The role of the church figured largely in the interviews with the clinic staff. Many were frustrated with how much trust their clients place in God or the church to keep them safe.

As one HIV-counselor explained:

God is very powerful. Women say to me, "I have known for a long time that my husband has been moving with others and I go on my knees and pray God not to let him bring it home to me!"

While the church advocates that husbands should be faithful and trustworthy, it comes as a separate decree that women should trust and serve their husbands. Staff explained that although women may understand that their husband is wrong, they will allow themselves to be "misused" because the church sanctions women's sacrifice for the benefit of relationships. It seemed that promoting behaviour that conforms to social norms (e.g., selfless and subservient wives) is more effective than promoting behaviour that counters norms (e.g., faithful and devoted husbands). Even if women manage to personally override the gender expectations that emphasize their own performance as a key determinant of a husband's trustworthiness, often they decide to stay with their husbands because they have no other options – they may be able to overcome individual personal pressures, but they cannot ignore the pervasive social pressures they face. Consequently, women's capacity to establish a realistic sense of their husbands' trustworthiness and to assess their HIV-risk is undermined as concerns about their safety and well-being are not validated.

Interpersonal dynamics within relationships are clearly shaped by these gender roles and expectations. In the discussion groups, some women said they might confront their

husbands if they felt they were with other women, but most said that infidelity cannot be discussed in a relationship. Generally speaking, husbands do not overtly engage in extramarital sex because they do not want to jeopardize their marriage. This means that an unfaithful husband will behave in ways that will not draw attention to extra-marital activity. One woman said:

It may not cause friction or conflict between us. Since he wants to retain good relations with me, he can even be more loving and attentive than before as a way of allaying my suspicions.

Likewise, he will flatly or angrily deny any accusations or questions about whether he is sexually active with others. The women expect their husbands to become angry or agitated if they dare to broach the topic of HIV and high-risk behaviour. Women do not know, however, if this reaction occurs because they have offended his integrity or if it occurs because they have stumbled onto their husband's secret. Denial of guilt is an integral part of infidelity and is the expected response to direct questioning. It seemed from the discussions that regardless of whether or not a man is sexually engaged with other women, fervent denial of infidelity does not quell a woman's suspicions – she still does not know *with confidence* what he is doing. If he is faithful, he will deny extra-marital activity; if he is unfaithful, he will do the same. A woman faced with this dilemma must decide whether or not to trust his response. Fear of provoking his anger, however, often prevents women from raising the topic at all. One woman captured this contradiction when she said:

His reaction to my questioning is what would determine what action I will take – whether to just stay and trust him or whether to leave. If I think he is going to react angrily and violently, then I may decide to not raise the issue and instead just trust that he will stop.

There are few ways for women to know with absolute confidence that their husbands are

trustworthy. Instead, women's confidence often stems from negative evidence, such as finding condoms in his pocket³² or being told about his infidelities. In the absence of negative evidence, and without having any positive verification, women see their men overtly ascribing to male gender roles and they DON'T KNOW how to determine whether this means that they are at risk. During the discussions and interviews, women asked for and exchanged ideas that could help them determine if their husbands were being faithful (see Box 2).

Box 2. How to know if your husband is unfaithful:

- *If he loses sexual interest in you;*
- *If he is quiet and withdrawn, not wanting to engage in conversation;*
- *If he is defensive and avoids any questions;*
- *If you get an STD;*
- *If he's Luo³³, he will not touch the children before he has a bath;*
- *If he's Luhya, sex with him will cause a miscarriage;*
- *If he acts more devoted because he doesn't want to get caught.*

- Comments from client discussion groups

One woman explained that she has good communication with her husband and can talk about everything, but he goes out every night with his friends to watch videos somewhere on the estate where they live. She cannot know for sure where he is going or what he is doing and she knows his friends are typical men like others who have affairs. They can talk about HIV, but she does not know for sure what he does. She says she loves him and wants to believe him, but how can she know if she is safe?

Another woman, Wanza (not her real name; her story will be introduced in the next

³² Women agreed that finding condoms would make them very angry, and they would not find any satisfaction in that knowing he was taking steps to protect himself from STDs and HIV.

³³ The Luo and Luhya are two of the many different ethnic groups represented among the women who participated.

chapter), talked at length with her husband about HIV-risk. She is his second wife and they were nervous about the activities of his first wife who was unhappy when he brought Wanza home and reacted by sleeping out of the home occasionally. Wanza believed that her husband was using condoms with his first wife and felt comfortable with their efforts to conceive. She is now eight months pregnant and just learned that she is HIV-positive. The act of trusting her husband may cost her life and perhaps that of her child – how could she have known?³⁴

HIV/AIDS and Other Threats

Women face threats in their relationship as a consequence of their own decisions and those of their husbands. Some of these threats are directly related to HIV risk; many are related more generally to their social security. Women who insist on negotiating safer sexual practices with their husbands “may risk impoverishment or assault, may be legally unable to divorce their husbands or may be certain of losing their children in the process” (UNIFEM 2001:13). To get a better understanding of the link between HIV risk and other threats related to relationships, we asked the participants to share their ideas about marriage and collected marriage histories. This allowed the women to articulate their stories in a way that illustrated the contradictory threats they face in the context of HIV/AIDS. These stories demonstrate the internal conflict faced by women. They painted marriage as essential and they clearly showed how HIV prevention techniques threatened to jeopardize their marital stability. To illustrate this internal contradiction, this section

³⁴ We did not track the history of her HIV status and whether she may have been infected prior to marriage. It is possible that her husband did not infect her. This case demonstrates the need to increase the incidence of Voluntary Testing and Counseling. However, even if Wanza and her husband tested negative prior to marriage, it does not necessarily provide protection because the Trust factor and HIV status are subject to change.

presents the findings from women's marital histories and discusses the threats women feared from their uncertainty about their husband's behaviour.

Marital Context

Marriage is a vehicle for a woman's sense of selfhood. To be a person, for both men and women, involves entering the cosmology of ancestors. In line with patrilineal inheritance, this process must take place within the male lineage. Not having a husband has spiritual as well as material significance. Furthermore, women without men face a host of economic and social disadvantages (Bassett 1995:2).

When asked why women get married, the women responded with a self-assurance that raised a strong awareness about the meaning of marriage in their society. A number of themes emerged explaining the reasons women get married.

One of the main reasons offered for getting married was the social expectation that women will marry: culturally, women do not stay alone. As one woman said, "it's the next stage in life, a milestone one has to go through." Women said they get married because it makes their parents happy to see them following the cultural plan; because their mother was married so they must be married like their mother; and because that's what they learned in school. Quite simply, women said they get married because "it's what is done in society." It is seen as becoming responsible; it gives women a home of their own and allows them to stop being dependent on their parents. They said that being married is important because it gives women a title – becoming a "Mrs." carries significant social capital.³⁵

Another main reason mentioned was the link between being married and having children. Several women drew this link very matter-of-factly – they got married to have children.

³⁵ During introductions in a discussion group, I introduced myself as being single. A woman made a quick remark that brought the room down around us. She had said, "We knew that!" – an observation that acknowledged my low social status as a single woman.

Others responded that it is better or easier to bring up children if there is both a mother and father, rather than a mother struggling alone. Women explained that because of customary law in many communities, the estate of the father belongs to his sons, therefore being married is the only way for women in those communities to ensure inheritance for her children. Several women also reported that they became pregnant as a result of premarital sex and their sexual partner agreed to marry them.

Most women directly or indirectly discussed the link between marriage and sex. It was said that men and women need to have sex; as they mature, they will become sexually active therefore they should have a partner to be sexually active with. Several women claimed that having one partner rather than many reduced the likelihood of contracting STDs. In the women's responses, there appeared to be a sense of inevitability about becoming sexually active and, subsequently, becoming pregnant. Since this is seen to be the normal course of events, a woman should prepare for motherhood by having a husband.

Several women said that marriage was God's plan. They said "people are made to be married" and "God said that man should get a wife to help him in life."

A couple women felt that marriage was better than the alternative – namely that if women do not get married, they are "thrown out" of the family home and without a husband to support them, they end up in sex work. When asked why she got married one woman responded: "Because it's better to be married than to be a prostitute."

Discussions of marriage contained little language of love and companionship. Instead the

primary focus was on security, social approval, custom and tradition. One woman, who was orphaned as a child, was sent to live with a family in Nairobi that promised to apprentice her as a tailor; when she stepped off the bus, however, she learned that she was to be married to their son. As she had no home to run to, she became a married woman at 13 years of age. Another woman, who was living independently in her own home, became very sick with an illness that lasted for a year. A man sent his sister to care for her and when she became well, she married him because she felt it was better than the isolation she experienced when she was struggling alone. Another woman said in her tribe³⁶ it is essential for a woman to be married so there is a proper place for her body to be buried – otherwise her spirit will have nowhere to rest.

During the discussion sessions and interviews, we spoke at length with women about the question of trust and about knowing if husbands are involved in extra-marital sexual relations. Although the context of the discussion was primarily related to HIV risk, when we asked the women what the threats were if their husbands ‘moved’ outside the marriage, there was acknowledgement of HIV risk and STDs, but the focus of the discussion shifted away from HIV towards more general, and perhaps more immediate, threats that the women faced. Women were afraid men may abandon them for other women. This would mean she would lose the financial support he provided and she would be left to care for the children without his help. Even if he did not leave, they would have to share his limited resources with the other woman and her family. If he had a new love/sex interest, the women feared the loss of emotional support from him and

³⁶ While the term “tribe” was used by participants and in translation, it is a contested concept that is replaced by the term “ethnic group”.

worried that he would start treating her with disrespect. If he is publicly seen to be involved with other women, the participants feared loss of respect by peers and society, and felt they would be regarded as inadequate or as the one who failed in the marriage.

The Price of Trust

While these women DON'T KNOW if they can trust their husbands, they must function day-to-day in the face of uncertainty: they DON'T KNOW if they are at risk for HIV. They must consciously or subconsciously weigh the costs and benefits of actions required for survival. To begin unraveling the threads of this decision-making process, we asked them to discuss the costs and benefits of trusting partners in cases of uncertainty.

While I believe trust is not a rational decision one makes, rather a gut-instinct based on the confidence one has in one's partner, women must decide how to act based on this level of confidence. Clearly women who choose to act as if they trust their husbands have the immediate effect of harmony in the relationship. By trusting her husband, a woman does not jeopardize her marriage and is more assured of enjoying the continued material and financial support for herself and her children. Participants felt that this allows a woman to retain her elevated status as a married woman and not shame her family nor be stigmatized as a separated woman that has to leave her home. This allows the children to continue having a home and support – having a father means they are less likely to be neglected. The women saw security in marriage – however bad it may seem, it is better than the uncertainty that might be found “out there.”³⁷ Once a woman gets married, she is

³⁷ Earlier it was mentioned that 96% of the urban married women surveyed were living with their husbands in contrast to rural living. It would be interesting to investigate how the relative isolation/nuclearization that occurs with urbanization has affected the institution of marriage and consequently HIV risk; the notion of

expected to put up with whatever conditions the marriage brings, whether good or bad. Women said that the sense of security brought about by trusting in the relationship may be false but this is better than living with the stress caused by suspicion and insecurity. Trusting in the relationship allows women to experience the social benefits of marriage as discussed earlier (i.e., getting married is what women are supposed do to achieve adult status, it is a secure space to have children, etc.). One woman said:

The necessity of retaining that relationship with him, no matter the odds, influences my decision of how to act.

Trusting in the relationship also suits the strategies that women discussed for keeping a man (e.g., keeping him happy, making sure he does not need to seek fulfillment elsewhere). Maintaining a marriage is one of the primary ways that women find security and validation (Bassett 1995; WHO 2002; Esu-Williams 2000).

When asked for the costs for women who choose to act as if they trust their partner in spite of being unsure of his behaviour, women discussed the risks associated with HIV infection and the psychological effects of living with the uncertainty. The primary risk for these women is the risk of becoming infected with HIV. This risk has many implications aside from the fatality of AIDS – the most pertinent for this group of pregnant women was the risk that their baby could be infected perinatally or through breastfeeding and they could continue to have HIV-positive babies if they are unable to engage their husbands in discussion about HIV. If they learn that they are already HIV-positive but are afraid to talk about it with their husbands, they may risk home-delivery rather than hospital delivery where appropriate preventative measures could be taken to reduce the

“out there” from the perspective of an isolated urban wife may be different from that of a woman within the extended family context.

risk of infection for the baby and the caregivers. Women were also concerned about the financial and social implications of becoming sick for their own survival and for that of their family. These women know that if they become HIV-positive, they may not live long enough to raise their children.

All the women interviewed spoke of the potential psychological risks for women who chose to act as if they trust their partner in spite of uncertainty. These include living in fear, stress and depression, physical/psychosomatic illnesses, reduced sexual interest, and self-doubt. The mistrust, therefore, carries through to all aspects of relationship.

The women discussed benefits for women who choose to outwardly mistrust their partner in cases of uncertainty. The most obvious of these relate specifically to HIV risk-reduction for the woman and her unborn child. By refusing unprotected sex, she reduces the HIV-risk for herself and her unborn child; if she is already HIV-positive, then she will not risk increasing her viral load and she reduces the risk of contracting other infections. If she is not trying to hide her awareness of her HIV-positive status, she can seek proper counseling and care, and can openly discuss delivery options, reducing the chance of infecting others (i.e., care givers). She can also reduce the number of pregnancies and the risk of HIV-positive children. If she remains HIV-negative, she will live longer to care for children.

The women also discussed how the benefits might extend to husbands. Refusing to have unprotected sex might generate discussions about the relationship in general and about risk-reduction in particular. Her husband might start to look at his own behaviour and realize he should take steps to change it and the couple might start using safety measures.

If he is sexually involved with others he might take precautions and reduce his and their risk and he might disseminate risk reduction information to others. There is a chance that possible behaviour change of her husband resulting from her refusal might improve the relationship overall. Additionally, if a woman takes proactive steps to protect herself, her stress level may be reduced because she is not living with the fear of contracting HIV. It may raise her self-esteem to stand up for herself and she will be sure of her risk-status. In the long term, participants suggested she may gain social respect for being strong and for surviving if her husband becomes ill or dies of HIV/AIDS and she may be able to give advice and/or support to other women.

The costs for women who chose to overtly mistrust their partner are numerous. The primary risks mentioned related to the breakdown of the relationship. If a woman suggests the use of protective measures, there is a risk that her partner will accuse her of being sexually active with others. It is expected that he will refuse to use condoms because “African men cannot use condoms with their wives”³⁸ and to be asked by a wife to use one is a grave offense. The women identified the effects that they feared: he could subject her to psychological abuse; he might withdraw financial support; he could resort to physical violence and/or rape if she resists. An HIV nurse warned:

He might rape her; it is believed that a man has the right to sex with his wife whenever he wants.

He could abandon her and her children – leaving her without support and she could face stigma for being a divorced/separated woman. Additionally, if he realizes that she knows about his extra-marital behavior, he could openly take on other women or increase his

³⁸ Mentioned repeatedly by participants and discussed in other studies (e.g., Wojcicki and Malala 2001, Schoofs 1999)

sexual activity outside the relationship – thereby increasing the risk of infection. One woman said quite emotionally:

If she confronts him, he may be openly hostile and unfaithful without caring about hurting her in order to teach her a 'lesson'. He might resort to such nasty behaviour as bringing other women to the house and making her sleep on the floor while he sleeps with another woman on the bed!

Survival Strategies

Not only is the epidemic intensifying the socio-economic inequality of men and women, it actually involves a death sentence for women as a result of following the rules of 'normal' monogamy (Smith and Cohen 2000:2)

The HIV epidemic raises the conflicting nature of women's survival strategies. It emerged throughout the study that the day-to-day strategies required for survival can be seen in opposition to the strategies required for HIV prevention.

Becoming a married woman is a feminine ideal in many cultures (WHO 2002); it is also a survival strategy. In most African cultures, "women still live in a world where they have to first and foremost prove their worth by being married, having children and caring for their families" (Esu-Williams 2000:1). Single women are often seen as a burden to their families and need to get married to have their own home and to become responsible adults; women said that single women engage in casual sexual relations and become pregnant;³⁹ the women knew of many single women who end up with children from different fathers. The women said that single mothers that do not have the support of a man have little hope of securing income and they said these women often must turn to sex work for survival. This sequence of events, they noted, is not only socially precarious

³⁹ We did not delve into the sense of inevitability of sexual relations for single women. It was mentioned that sex was a human need but sexual motivations for single women (e.g., transactional sex, pleasure) were not discussed. It is taboo for single women to seek information and services on sexual health and contraception. Additionally, I was told, it is preferable to be a single mother than a woman without children.

and economically unstable for women, but it also places them at greater risk for HIV infection due to an increased chance of exposure.

Marriage, therefore, is part of a strategy to avoid social isolation and the prospect of engaging in sex work for survival. Participants saw it was in their interest to be married and to work to maintain the marriage. As was discussed, the work of marriage maintenance belongs to women and this includes providing for their husbands' needs so that men do not have to seek fulfillment outside the marriage. The threat of his doing so raises the risk of HIV infection but also many other socioeconomic risks that have been discussed (such as the division of limited resources with other women, abandonment, etc.). Essentially women face either the risk conferred by conforming to predominant gender expectations, or the risks that result from failing to conform (Rivers 1999).

It is into this context that HIV prevention strategies must be inserted. Women need husbands and feel they must make sacrifices to keep them happy otherwise there is a risk of losing the security they provide. The interaction required for HIV prevention, therefore, threatens to jeopardize the relationship – asking a husband to use a condom may provide ample justification for him to seek fulfillment outside the marriage because he believes his wife is 'unwilling' to meet his needs. This is overlaid by a marital convention explained by an HIV counselor and asserted by several of the women:

A woman is to be told; she's not to tell her husband. He's the one to make decisions.

Thus in the interest of protecting herself from HIV infection, a woman may place herself at risk for other negative consequences and may even increase her risk of being infected with HIV.

Perhaps women who know with absolute certainty that their husbands are at risk for infection are able to weigh the risks and benefits in a way that favour their own health status and longevity over the pressure to conform to the status quo.⁴⁰ However, few women actually know with certainty that they are at risk for HIV infection. According to the surveillance data, the majority of women DON'T KNOW if they are at risk (58%). While there is explicit evidence for women to know if their husbands are unfaithful, there is no corresponding evidence to confirm he is faithful. In the absence of any mechanisms that increase the transparency of men's behaviour, women must make decisions based on the information that is available to them.

The women said they *do not know* if they are at risk for HIV infection from their husbands. They do know, however, that challenging men's behaviour or trying to introduce condom use will likely trigger costs which may, with a painful irony, actually increase their risk of HIV infection either through the extra-marital behaviour of their husbands or through the survival strategies they may have to resort to (e.g., sex work). Thus, a woman has to weigh the unknown (and perhaps nonexistent) risk of HIV infection from her husband against the likelihood of upsetting him and raising the other threats that have an impact on a day-to-day basis. One risk (i.e., HIV infection) is unknown. The other risk (i.e., marital disharmony) is well known. For the participants, the decision seemed to make itself: given the unknown risk, survival today is more urgent than prevention for tomorrow. One woman summed it up by saying:

It just gets too complicated to leave. When you weigh all that you'll lose, it's just easier to stay.

⁴⁰ This study did not investigate the characteristics of these relationships.

CHAPTER 4

Beyond Negotiation and Economic Empowerment: *HIV through the lens of political economy*

This chapter integrates the findings of the Nairobi case study with feminist theory to provide insight into the political economy of gender and HIV that can be used to critique and to suggest guidance for prevention efforts. In particular, this chapter critically reviews how the failure of the 'negotiation model' (with its focus on education and skill development) is explained by the 'economic empowerment model' (with a focus on the increased economic independence of women). It critically presents threads of Marxist Feminist analysis of women's subordination in the capitalist system and argues that focusing on women's economic dependence on men risks overlooking or downplaying other social orders that contribute to women's subordination and consequently to their HIV-risk. It is demonstrated in this chapter, by using individual case studies from the Nairobi research, that the economic empowerment model overemphasizes the role of economic order as a key factor that places women at risk for HIV. The case studies show that women are at risk for HIV not necessarily because they are economically dependent on husbands but because A) they do not know if they can trust their husbands, and B) because of a range of social conventions, of which economic arrangement is but one.

The Negotiation Model

The naivety of “behaviour change interventions”- including condom promotion strategies, which account for a significant proportion of the (US-inspired and – funded) AIDS campaigns in developing countries – can only be explained in terms of a quite unjustified faith in human behaviour’s susceptibility to manipulation by social engineers (Vogel 2002:4).

Extensive education programs have been developed to teach women skills that will enable them to negotiate condom use or other low-risk activities (Harrison 2000). For the purposes of this discussion, this approach will be called the ‘Negotiation Model’ of prevention.⁴¹ Essentially, the negotiation model draws on the capacity of women to negotiate protection from HIV without challenging a full range of factors that inhibit women’s ability to do so, such as adverse norms and systemic human rights violations (Gollub 1999). These efforts to increase women’s individual agency may attempt to raise women’s awareness of oppressive structures, but they do not change some of the basic pressures facing women.⁴² Although they may know that using condoms will prevent the transmission of the virus, women are often unable to insist on their use. Sexual negotiation is infused with power dynamics that highlight the conflicting practical and strategic interests of women. Strategically, women may know condom use will reduce their risk of HIV infection – practically, however, insisting on condom use may place their status in the family and, consequently in their community, at risk (Tallis 2002). For these women, “the potentially negative social consequences of adopting preventative behaviour appear to be more significant than the health consequences of HIV/AIDS” (Weiss et al 2000:239). The rising rate of women infected with HIV suggests that rational

⁴¹ Discussed more fully in Chapter 2.

⁴² A very limited number of programs have addressed social and economic status of women as a determinant of HIV/AIDS risk. However, behaviour modification programs – based on the negotiation model – remain central to prevention efforts (UNAIDS 1999).

behaviour may call for women to meet immediate practical needs by engaging in sex with a potentially infected partner.

It was clear from the Nairobi case study that the negotiation model cannot address the needs of the participants. During the discussion sessions that focused on HIV-risk and prevention, the benefits of condoms were extolled and the women countered with the adamant assertion that men will not use condoms with their wives. One said:

Men can't use condoms with wives – they have a right to sex with their wives whenever they want. He'd say "I'll use condoms with other women, but not with my wife!"

Most of the women felt strongly that condom use with husbands is simply non-negotiable, as is abstinence from sex. Authors attempting to explain women's inability to negotiate safer sex have argued that increased skill and information is not akin to increased power (Farmer 1999; Harrison 2000). Critics assert that when trying to protect themselves from HIV/AIDS, women face a range of compounding factors, including economic dependence on men, gender violence, gender norms, poor enforcement of legislation, etc., that undermine their capacity to negotiate safer sex (Erban 1990). Critical literature on women's HIV risk argues that the economic control of men over women shapes personal perspectives on sexual relations and consequently on women's perception of their capacity and entitlement to negotiate safer sexual activity (UNAIDS 1999; Susser and Stein 2000; Lawson 1999; Rao Gupta 2000, 2002). For the purposes of this discussion, the focus on economic independence of women as an HIV prevention strategy will be called the "Economic Empowerment Model".

Economic Empowerment Model

While most accounts recognize that economic dependence combines with other social structures to lead to inequality between women and men, economic dependency and the frequently related sexual coercion are identified as leading contributors to the spread of AIDS (Weiss et al 2000). Women clearly have less ability to achieve economic independence than men. From an early age, girls are socialized for a domestic role. This is often reflected in their lower access to education and information, their reduced literacy, their limited training opportunities, and fewer marketable skills (UNIFEM 2001; Rao Gupta 2002; UNAIDS 1998; Erban 1990). Due to women's reproductive responsibilities and other social factors, their mobility tends to be reduced, they are less likely to travel in search of employment opportunities and they are less likely to be offered work that pays a living wage. Additionally, the state and its instruments often do not actively support the economic independence of women. This can be seen, for example, in the issue of land inheritance in many Sub Saharan countries. Although women's right to land inheritance may be written into statutory law, the customary or local enforcement of such laws infrequently translates legal rights into actual rights and women generally have scant access to legal channels that would allow them to pursue economic justice (Bassett 1995).

Before and after marriage, therefore, "women are perceived to be and often perceive themselves to be totally dependent on men" (van Niekerk 2001). This translates into women's lifelong financial dependence on men, be they husbands, male relatives, employers or other men (UNIFEM 2000). This dependence on men is considered economic vulnerability because women's inability to secure the funds necessary for

survival means that they are more likely to exchange sex for money or favours from the men in their lives (Rao Gupta 2002). The economic empowerment model contends that because women have few economic alternatives, they are forced to stay in risky relationships where the fear of violence and abandonment may place them in the position where they feel unable to negotiate condom use, discuss fidelity with their partners, or refuse unwanted sexual relations that they perceive to be dangerous. This inability to be proactive exposes them to the risk of sex abuse, rape, and infection with HIV or other STDs. Indeed, women have reported that the health risks of remaining in the relationship are much less than the economic risks of leaving the relationship (Weiss et al 2000; WHO 2000). In the absence of marketable skills, commercial sex work is often the only option - a solution which provides economic, health *and* safety risks. Fear of destitution or of having to resort to sex work makes economically vulnerable women less likely to leave risky relationships (WHO 2000). It follows from this dependence that women do not have the economic leverage to make demands that may displease or anger their husbands. Even if they know their partners are engaging in high-risk behaviour, many women fear jeopardizing the source of economic support for themselves and their children.

Above and beyond access to information or negotiation skills, I expected to find from the case study that a primary source of women's inability to negotiate lies in the economic factors that shape the power dynamics of sexual relations, particularly those structures that favour men's control over resources and consequently over women. The research findings, however, did not strongly support this argument. While the subordination of women will continue as long as women have little or no economic independence, the case study shows it is ineffective to use a liberal feminist argument that asserts that economic

oppression of women is a primary source of women's HIV vulnerability. The economic empowerment model risks applying theory in a non-contextual way that converts "important feminist insights and theories into feminist epistemological dogmas" (Narayan 1989:28). In so doing, there is a risk of overemphasizing established theory and overlooking or downplaying some of the key factors that may lead to the large-scale failure of HIV prevention programs.⁴³ While economic oppression is invariably linked to sexual oppression, each is perpetuated in a system that can and should be examined independently from the other.

Arguably, the focus on women's economic empowerment arose out of early conceptualizations of the epidemic that saw blame placed on the people most vulnerable to HIV infection - on homosexual men, on injection drug users, and on women who sell sex in exchange for the necessities of living (Farmer 1992, 1999; Cohen and Alexander 1995; Alexander 1998; Brock 1989; Wills 1991). Commercial sex workers were (are) characterized as primary vectors for the virus because HIV-positive sex workers place multiple clients and their families at risk by accepting money to have unprotected sex. It is largely recognized that women turn to commercial or informal sex work because they lack economic alternatives and these women are therefore economically dependent on the favours of men. There are innovative programs targeting commercial sex workers that have proved to be very successful in redirecting women's income-generating away from commercial sex work, although these programs highlight some very complex issues in human sexuality and risk behaviour. Evaluations of a number of these programs have shown that the fewer clients a sex worker has, the lower she perceives her risk and less

⁴³ This risk was addressed in Chapter 2: Methodology.

likely she is to insist on protection from the few clients she keeps.⁴⁴ This indicates that the economic empowerment of these women is not necessarily directly linked to a reduction in HIV risk.

It is essential to remember, however, that 80% of HIV-positive women in Sub Saharan Africa are infected by their husbands (Action Aid 2001, Bassett 1995). While some of these women are undoubtedly exchanging sexual favours outside their primary relationships, it is “women-as-wives” who make up the majority of at-risk women, not “women-as-sex-workers”. This redirects the discursive gaze onto the household as the locus of women’s HIV vulnerability; it is the relationship between women and men in the household/family⁴⁵ which becomes the point of analysis.

The case study shows that arguments linking HIV-risk to economic dependency, while striving to promote the essential goal of economic empowerment for women, miss some of the essential ingredients of women’s HIV vulnerability. By placing the economic empowerment argument into a framework offered by Marxist feminist debates (Benston 1997[1969]; Secombe 1973; Mitchell 1971; Dalla Costa 1997 [1972]; Rowbotham 1972, 1973; Ehrenreich 1990 [1984]; Eisenstein 1990 [1977], Rubin 1990[1976]), it can be seen that economic dependence intersects with social and biological factors that are likely to remain unchanged by women’s economic independence in the absence of concerted interventions. While economic dependence is clearly a factor contributing to women’s HIV risk, it might be argued that the mechanics for women’s economic empowerment

⁴⁴ An STD Project assessment of an economic alternative project showed 64% decline in average number of weekly sexual partners, and a reduction of condom use with all sexual relations from 86.3% to 60.8% (Strengthening STD/HIV Control Project 2002).

⁴⁵ See footnote in Chapter 2, page 25.

(e.g., work opportunities, living wages, land inheritance, child support, maintenance after divorce), form an essential infrastructure that can only be developed alongside social projects that give women autonomy to determine how to live their lives and how to use their bodies. As predicted by the sexual bargaining framework proposed in Chapter 2, the case study illustrates that economic power both conditions, and is conditioned by, the degree of power that is accrued (or diminished) within all social orders. According to the findings of the case study in tandem with critical feminist theory, the subordination of women and their consequent increased HIV risk should not automatically be traced to economic factors.

Because women's primary HIV risk in Sub Saharan Africa is unprotected sex with their husbands, I believe HIV has consequently become a new platform for the western feminist project of seeking to understand the material basis for women's subordination; economic dependence is the predominant framework used for this analysis.

Economic Dependence and Feminist Theory

Western feminists, despite their critical understanding of their own culture, often tend to be more a part of it than they realize. If they fail to see the contexts of their theories and assume that their perspective has universal validity for all feminists, they tend to participate in the dominance that western culture has exercised over nonwestern cultures (Narayan 1989:263)

In the case of HIV, understanding women's capacity to make sexual decisions requires an understanding of how economic dependence and social practices interact and how a range of social practices informs sexuality. To propose that it is primarily economic dependence that prevents women from remaining HIV-negative overlooks the multi-layered gender implications of HIV risk. I suggest that the case of women and HIV must be seen first and foremost within a system that views human engagement with sexuality

as a social product that is produced and reproduced by human intervention and social convention (Rubin 1990[1976]) of which economic arrangement is but one of the social conventions. Debates in feminist theory are instrumental in comparing and contrasting economic oppression with sexual oppression; main threads of this debate provide a useful framework for the analysis of women's HIV risk.

The debate on women's subordination has largely centered on women's participation in capitalist society as feminists used Marxist categories of analysis to explain women's oppression (Benston 1997[1969]; Seccombe 1973; Mitchell 1971; Dalla Costa 1997 [1972]; Rowbotham 1972, 1973; Ehrenreich 1990 [1984]; Eisenstein 1990 [1977]). Feminists found a compelling methodology in Marx's "scientific understanding of historical change" and found appeal in his vision of a truly just society in which "equality, realization of human potential and the true fulfillment of people's needs" were the cornerstone for social arrangement (Philipson and Hansen 1990:13). While Marx did not consider gender to any great degree, Engels noted that:

the husband is obliged to earn a living and support his family, and that in itself gives him a position of supremacy without any need for special titles and privileges... then it will be plain that the first condition for the liberation of the wife is to bring the whole female sex back into public industry (Engels 1942 [1884]:65).

And he showed the contradiction that:

if she carries out her duties in the private service of her family, she remains excluded from public production and unable to earn; and if she wants to take part in public production and earn independently, she cannot carry out family duties (Engels 1942 [1884]:65).

By integrating the category of class (as the relation to production) with an analysis of women's domestic labour and its contribution to the capitalist system, feminists illustrated that women's oppression is part of capitalist exploitation (Philipson and

Hansen 1990:13). It is essential to understand women's relation to production and reproduction, as Armstrong and Armstrong (1985:4) write, to understand that while human reproduction does not produce surplus value, it is "fundamental to the understanding of how the capitalist production system operates at all levels of abstraction." Feminists have intersected class divisions with a gendered analysis of the family and the labour market to demonstrate how gender parallels the exploitation of class system, such as in the classic work by Hartmann:

Job segregation by sex... enforces lower wages for women in the labour market. Low wages keep women dependent on men because they encourage women to marry. Married women must perform domestic chores for their husbands. Men benefit, then, from both higher wages and the domestic division of labour. This domestic division of labour, in turn, acts to weaken women's position in the labour market (Hartmann 1990 [1976]: 147).

Thus, women's subordination is framed through their engagement in the capitalist system and therefore the solution is seen to be based on addressing the nature of this engagement: "any emancipatory movement must still concentrate on the economic element – the entry of women fully into public industry and the right to earn a living wage" (Mitchell [1971] in Philipson and Hansen 1990:14).

In 1976, long before the discovery of HIV, Rubin launched into the Marxist feminist debate with a frame of analysis of women's oppression that provides a methodology to distinguish between economic and sexual oppression. She observed "what is important is to develop concepts that adequately describe the social organization of sexuality and the reproduction of the convention of sex and gender" (Rubin 1990 [1976]:82). She proposed a sex/gender system that recognizes that human sex and procreation are composed of 'biological raw material' which is shaped and satisfied by human social intervention.

While economic convention is one of the significant interventions shaping sexual relations, it cannot be used to fully express sexual oppression:

to explain women's usefulness to capitalism is one thing. To argue that this usefulness explains the genesis of the oppression of women is quite another. It is precisely at this point that the analysis of capitalism ceases to explain very much about women and the oppression of women (Rubin 1990 [1976]:78).

Rubin's sex/gender system recognizes the failure of Marxist models to fully analyze women's oppression because it divides humanity into workers, peasants or capitalists, not into men and women (Rubin 1990 [1976]). Marxist analysis generally positions women in relation to the economic system dominated by men rather than positioning women in relation to men more generally (Hartmann 1990[1976]:173). While this approach provides a compelling analysis of women's subordination in the capitalist system, in the case of HIV it is more useful to begin the analysis by examining the broader social order that is indeed partly conditioned by economic order, as proposed by the sexual bargaining framework, while also conditioning the economic order.

It is essential to move upstream from the capitalist exploitation of women as a starting point to begin with the perhaps too obvious fact that economic dependence is not what puts women at risk for HIV – it is the exchange of potentially infected body fluids that puts women at risk. This elementary distinction is essential in the discussion of HIV because the “needs which are satisfied by economic activity... do not exhaust fundamental human requirements. The needs of sexuality and procreation must be satisfied as much as the need to eat” (Rubin 1990 [1976]:80). Regardless of the nature of economic order in a particular community, humanity depends on a social order in which women and men have children. The exchange of body fluids, therefore, can be viewed as

a social imperative and cannot be regarded as a wholesale failure of HIV prevention programs which, pursued to their logical conclusion, raise a fundamental threat to this order. It is the critical reproductive capacity and reproductive value of women (and men), their relation to sexuality, and how these are socially constructed that places women at risk for HIV quite independently from how this capacity intersects with the capitalist system. The economic independence of women does not change this reality; it will not render unnecessary the exchange of body fluids and it will never ensure that women can assess whether or not semen is safe without the full cooperation of their partners.

From the Nairobi case study a number of examples arose that illustrate how women's engagement in an economic order combines with their experience in a system of sex and reproduction to shape the determinants of their behaviour and, consequently, their HIV risk. The following examples from the case study provide powerful accounts of how the economic order that contributes to women's dependence on men is closely integrated with other social orders that govern women's activity overall.

*Mapenzi*⁴⁶

A year passed since Mapenzi heard from her husband. She ran her shoe business single-handedly after her husband went to Nairobi for training, leaving her behind with their two small children. Not knowing where to find him, she went to his father's house in Nairobi where she learned that his training had finished and he was now living and working in Nairobi. His father reluctantly took her to where her husband was working. At first the man refused to take her to his house, but when she insisted, he relented. When they

⁴⁶ Names have been changed to protect identity of the participants. They are randomly selected local names that do not reflect the tribal lineage that may be associated with them.

arrived at his house, she found a woman there. Her husband refused to speak to either of them. She learned from the other woman that they had married while she waited for him to return to her. The other woman heard for the first time that he was already married. For one week they stayed together, the two wives and the husband. The second wife slept on a chair in the living room while Mapenzi shared her husband's bed. After one week, the second wife left. Having reestablished her place with her husband, Mapenzi went to close her business and returned to take her rightful place alongside her husband. She is now twenty years old, pregnant with her fourth child and HIV-positive.

Wakio

Wakio's child lived with her mother so she could work in Nairobi. She kept her own home and lived independently. A couple of years ago she became sick with an undisclosed illness that lasted for about a year and she was very grateful to a man who sent his sister to care for her. Being ill made her realize that "being alone is lonely". He had shown that he was a good man and she decided to be with him. Things were fine when she moved into his house but his behaviour changed shortly thereafter – he came home drunk and got angry when she asked where he'd been. One day a pregnant woman came to the house screaming that he was the father. He denied this. Wakio fears becoming infected -- but she is afraid to be left alone, especially after her experience with being sick. During this time she left him and went to her parents in their rural home planning to ask her aunt for a job, but he followed before she had a chance. He left money and a message for her to meet him at his rural home. When she arrived, she found him with his uncle who said she should go home with him but to report back to the family if there are any problems.

Since then, things have improved; support from the extended family seems to have had an effect. Wakio knows she is could support herself, as she did previously, but now that she is pregnant again, she worries about putting a greater burden on her mother if she were to leave a second child with her so she could return to work. She has discussed this all with her husband and warned him that if he becomes involved with another woman, she will leave and let him go to her. Wakio feels this warning has changed his behaviour; if she stays quiet, everything is “fine”. When she is annoyed with him about anything, however, he drinks and she fears him becoming violent. She is HIV-negative.

Wanza

Wanza was working in a fish processing plant when she met and married her husband. She is his second wife. When the first wife heard that he remarried, she went to his parents to complain and threatened to kill herself. The parents, not wanting trouble, advised him that it is better if they stay together. They tried to live in the same house, but the first wife caused problems by practicing witchcraft. Wanza was being affected; she became very thin and could not get pregnant. Now they stay in two separate homes in the same building and she was able to get pregnant after they had their home cleansed with prayers by the pastor.

Most of the problems in the relationship stem from the first wife. Wanza is afraid that the witchcraft will harm her pregnancy. She strategizes with her husband about ways to get rid of her and they pray for her to leave. When she discussed this with her mother, her mother advised her to maintain her marriage and to be faithful. Wanza feels free to discuss all these things with her husband. The most important thing to her is her husband and the trust he has for her – and also her trust for him. She would not think of leaving

him because of the other wife. The woman comes and goes, however, and they DON'T KNOW where she's been or whom she's been with – and her husband still goes to her for sexual relations. Wanza said she has seen condoms in the other wife's home and asked her husband if he uses them with her; she is confident that he does. He trusts Wanza with his money and they keep it in her account because the other wife steals it. Wanza controls the money and takes care of the household finances. Now she is pregnant with her second child and HIV-positive.

Nyakio

Nyakio met her husband in the community where they live. They courted for a year while they slowly got to know each other before getting married. They discuss HIV risk and he agrees that it is important for people to protect themselves from HIV; he told her that he used condoms before getting married but had not been with anyone since they married. While her husband works as a casual labourer, Nyakio works nights at the airport and is keeping a secret bank account that she doesn't want her husband to know about. She has a child from a previous relationship and is saving the money in case anything should happen to her she will know that the child can be taken care of. She fears that if her husband knows she has savings, it might affect his motivation to seek the work that he gets occasionally. She hasn't observed anything unusual about his activities but she remains suspicious about his behaviour – she fears becoming infected. She can't put her finger on the reason she is suspicious but finds herself feeling uncertain because she doesn't know what he does while she's away from the house overnight. Nyakio asked for advice how she could know if her husband is with someone else. She is HIV-negative.

Bibi

Bibi, an orphan, met her husband when she was working as house help in Nairobi. She became pregnant immediately and they married very shortly after meeting. She was 15; he was 30. Because his salary was not enough to keep her and their son in Nairobi with him, she went to live with his parents rurally and she saw him only every two months. She eventually learned that he kept a woman in his house in Nairobi and he became verbally abusive when she challenged him about it. She moved back to Nairobi with him and recruited support from extended family members to pressure him to change his behaviour -- this created some change: he stopped sleeping out and was less abusive to her. They occasionally discuss risk and fidelity, but she does not actually want to encourage discussion. She fears making him angry and having him become violent. She feels they can live in peace as long as she does all the work of the relationship: the cooking, boiling water for his bath, giving him the food he wants – and he just gives the money for food.

She had thoughts of leaving him before she found herself pregnant again; she thought about terminating the pregnancy so she would be freer to leave; she's had fleeting thoughts of suicide. But she loves her son and her unborn infant. She knows she could leave and support herself with work as house help, but the salary would not be enough to also support her children – they would have to be left behind. She decided to stop making decisions based on her own needs because she does not want her children to suffer. Bibi is HIV-positive.

Economic Leverage: fact or fiction?

The economic empowerment model is used to argue that women need economic

autonomy to acquire sexual autonomy and with sexual autonomy women have an increased capacity to maintain their HIV-negative status; if women are economically independent, they will increase their economic leverage for exerting influence in the household. The economic empowerment model overlooks key factors that are illustrated by the above case studies. Like the ABCs of AIDS prevention discussed earlier, economic empowerment is a technical or theoretical model which misses the substance of women's lives; it could *theoretically* give power to women. Economic independence decreases a woman's reliance on her husband; with access to her own financial resources, there is an implicit threat that a woman could leave her husband if he puts her at risk and this increases her bargaining power in the home. As the case studies clearly show, however, simply having the potential for economic independence cannot give leverage to this threat – all the women were earning income and were demonstrating their economic potential prior to having children. The usefulness of the implicit threat can only become a reality if enough criteria are in place to make this possible. Some of these criteria include:

Knowing HIV-Risk: As discussed in the previous chapter, few women actually know they are at risk of HIV infection from their husbands. The majority of women believe that they are not at risk or they do not know if their husband's behaviour places them at risk - few men are overt about their extramarital activities. While all the women interviewed said they DON'T KNOW if they are at risk, the stories of Wanza and Nyakio in particular illustrate this complication. Wanza believed her husband was using condoms with his first wife, and they discussed this at length. Perhaps her control over household finances gave her the confidence to discuss these issues openly but it did not protect her from becoming infected with HIV - she believed that she was safe and proceeded to have

unprotected sex in order to become pregnant. Nyakio, who works nightshift at the airport, is the primary breadwinner in her household and is able to secretly keep savings. She simply does not know, however, what her husband does when she works nights and he is alone in the house. She has no specific reason to mistrust him but lives in fear of becoming infected nonetheless. These stories illustrate that while economic independence may alter the power dynamics within the household, it does not increase the transparency of a husband's risk-behaviour.

Cost of Reproduction: Raising children and running a household (i.e., reproductive labor) is expensive and time consuming. Most of the cost, however, is absorbed by the unpaid labour of women (Smith 1989). Wherever women are the primary caregivers for children (i.e., virtually everywhere), women's economic dependence on men is commonplace. Advocating for women's increased access to the labour market overlooks the essential unpaid contributions of women. This is illustrated in the individual case studies above; all the women stopped or reduced their income-earning activities when the need for reproductive labour arose in their families. Wakio and Bibi clearly framed this dilemma in how they chose to share their stories. Wakio was able to live independently before marrying because her mother cared for her first child. Now that she is expecting her second child, she does not feel that she can burden her mother with the care of two children if she decides to leave her husband. Bibi also knows that she can support herself on the salary she can earn as house help, but she cannot afford the reproductive labour required to sustain her family and would have to leave her children behind. If women are to be mothers *and* to be economically independent via paid labour, they must either (a) have someone to perform the reproductive labor for their families, or (b) count on their

husbands' cooperation to absorb the extra labour. The economic dependency argument overlooks the reality that men with low income can have a family because they have someone (usually a wife or women kin) to absorb the reproductive cost of a family through unpaid labour.⁴⁷ This basic economic equation equally applies to women; women could more easily be economically independent if someone cared for their children and converted their meager income into useful commodities. Short of men becoming more responsible for reproductive labour, women's economic independence from men implies they must be able to afford the reproductive costs of a family without the support of a partner; are men able to do this?

Social status: African societies put a heavy emphasis on women's demonstration of fertility by getting married and becoming mothers (Maundeni 2002). Measures of success, therefore, include "being a Mrs."⁴⁸ and having children. Mapenzi provides a strong illustration of this reality. Running her shoe business and living independently with her children was fine until she realized that the conditions of being economically independent meant she was abandoned by her husband who had taken another wife. For Mapenzi, economic independence risked the social status conferred by having a husband. It seems that aside from any particularities of the husband, being married in itself is important, as one woman said:

We get married because girls follow the plan of their culture. We're made to get married.

Personal perception: From a personal perspective, leaving a marriage could prove to be worse than the consequences of staying. This was demonstrated by Mapenzi who felt a

⁴⁷ This is suggested as an area for further study in Chapter 5.

⁴⁸ It was reported by most participants that great value is placed on the title bestowed by marriage.

sense of outrage, and perhaps also shame and failure, to learn her husband replaced her with another wife. Additionally, as highlighted by Wakio's story, the discourse of economic independence does not include language to address the prospect of being alone and lonely in a culture that has a focus on family and community.

The women expressed inevitability that they will have men in their lives and will become pregnant, therefore it is logical to marry to have support for themselves and the children. The implicit threat offered to men by women's economic independence may mean a woman is able to leave her husband if she knows she is at risk. However, people want (are expected) to marry and they want (are expected) to have children as products of the marriage. If the social order demands that women be married and have children in order to attain and maintain adult status, is it not reasonable to presume that a woman, after leaving her husband, will eventually become sexually active with another man, reestablishing the risk relationship regardless of her economic status? The meaning of sexual relations in marriage is infused by the social value placed on fertility; if idealized marital sex is connected to the value of conception as a possible and desired outcome of sexual relations, clearly people in new marriages/relationships would be reticent to view unprotected sex as an HIV risk factor. In this context, how will economic independence help a woman assess whether or not any man will be faithful to her or will use condoms with all his other sexual partners?

The UNAIDS Technical Update on Gender and HIV (1998) offers an assessment of responses that have reduced HIV risk, including expanding HIV and STD services,

promoting condoms, developing new technologies, etc.⁴⁹ It was reported that programs designed to increase women's economic potential through education and resources such as training, legal reform and credit schemes have all showed positive results in the reduction of fertility and an increase in women's overall decision-making potential in the household (UNAIDS 1998). This increase in decision-making potential was said to lead to more equal decision-making power in sexual relationships between women and men. Empirical evidence from the case study suggests that it is premature to construct a theoretical risk-reduction model based on the assumed relation between increased economic potential, reduced fertility and HIV risk (i.e., the Economic Empowerment Model).⁵⁰

(A) Increased decision-making cannot be assumed to lead to a reduction of HIV risk. There are two decisions required to reduce HIV risk: to practice monogamy or to use condoms with multiple partners. Determinants of this decision-making are distinct from decisions that stem from an economic base. Perhaps a wife can withhold financially if her husband *visibly* disagrees with her about an issue such as whether or not to send girl children to school.⁵¹ Can a woman's independence, however, keep a man from seeking illicit unprotected sexual gratification from commercial sex workers or others?

B) Reduction of fertility is not directly related to a reduction of HIV risk. Certainly

⁴⁹ The Technical Update offers a summary of responses but the specific projects or programs that offered these responses were not listed in the Update to allow the reader to evaluate exactly how the project outcomes affect HIV risk reduction.

⁵⁰ I would suggest that this may be used as evidence of success of economic empowerment because goals of various agendas are being conflated. The HIV/AIDS epidemic began in an era of western-driven population control which aimed to reduce fertility, alongside the Women in Development movement which aimed to increase women's empowerment. This modelling demonstrates the necessity to directly and carefully link the objectives of a project to its wider long term goals.

⁵¹ This is based on the assumption that a woman maintains control over the income she earns.

income-generation may reduce fertility as women learn to find personal value outside the traditional mothering role; becoming pregnant and mothering interferes with a woman's desire to earn income or to develop a career. This may offer incentive to some women to avoid pregnancy. Fertility, however, is not primarily controlled by condom-use. As asserted repeatedly by participants: husbands will not use condoms with their wives. If a woman wants to control her fertility she likely uses hormonal methods such as Depo Provera (the "injection"), Norplant (inserted rods) or "the pill". These are methods that women control and that are nearly 100% effective in preventing pregnancy. Critically important, however, is the fact that hormonal birth control methods have allowed women to control their fertility in a large part because of the temporal distance between contraception and sex. Unlike condoms, which can only be used after a man gets an erection, hormonal birth control does not interrupt the physical intimacy leading to sexual intercourse and does not interfere with men's entitlement to sexual pleasure from their wives. While hormonal birth control may give women control over fertility, there is no direct link between women controlling their fertility and women controlling how their bodies are used; protection against pregnancy, for example, cannot prevent marital rape. Quite simply, there cannot be a presumed link between a reduction in fertility and a reduction of HIV risk. Additionally, while no forms of hormonal birth control provide HIV protection, the use of them paradoxically reduces the windows of opportunity to introduce HIV protection with sexual partners. The story of Tabu is a prime example:

Tabu

Tabu, a middle-class woman in Nairobi, shared the importance of being economically independent because she witnessed the suffering of her mother at the hands of her father.

She is well-employed and shares a love-marriage with her husband. They dated for many years and lived together before deciding to marry. He was proud of his successful wife and he supported her use of hormonal birth control because he understood her desire to build a career before having children. His family, however, did not. Much more 'traditional' than their son, they have begun to put immense pressure on him to provide children to be their namesakes. Now, after many years of being patient, he is beginning to transfer this pressure onto Tabu. She is desperate to avoid pregnancy until she has completed her education and has a strong career. Lately, however, she is aware of a growing distance with her husband. Tabu uses Depo Provera (the "injection") as protection from pregnancy because condoms are unreliable. They have never used condoms because they have never needed them. She loves him and eventually wants to have a family with him. What would you do in her place?⁵²

The Lens of Political Economy

This chapter illustrates that a gender analysis is essential to make explicit the links between perceived determinants of women's HIV risk and the actual mechanics of HIV risk and prevention, otherwise the link may be theoretically presumed but not empirically substantiated.

The negotiation model proposes that women need to gain the skills necessary to convince their sexual partners to use condoms during intercourse. A more rigorous assessment of HIV risk, however, suggests that what must be indirectly negotiated, aside from actual

⁵² Paradoxically, perhaps the success of population control and empowerment programs have increased women's risk by making hormonal contraception de rigueur, thereby giving women control over pregnancy and allowing men to renege responsibility for their sexual consequences.

condom use, are thorny concepts like women's sexual autonomy and bodily integrity, infidelity, masculine and feminine norms. These are pervasive socially determined factors that clearly fall outside the bounds of intimate relationships and beyond the capacity of individual women to negotiate single-handedly.

Simple models of HIV risk lead to simple solutions that fail; the last two decades provide evidence for this although the same solutions are still being applied. To suggest that women need to be economically empowered to increase their negotiating capacity emphasizes one element of the sexual bargaining power framework and risks overlooking or downplaying other significant factors that influence women's HIV risk, such as personal, cultural and social determinants. The individual case studies from the Nairobi women provide powerful accounts illustrating that women's relationship to an economic order is far from linear. Instead, this relationship is mediated through a complex political economy that is informed by other factors, including elusive, immeasurable factors such as the importance attached to fertility, family status, trust, tradition, spirituality, even, in some cases, witchcraft.

HIV risk is complex and layered, shaped by gendered social factors that govern people's lives, their communities and their economies. Analysis of this risk must be focused under a lens of political economy in an attempt to understand how the dialectical web of risk determinants might respond positively or negatively to social engineering. In many ways, the HIV epidemic is indeed providing a critical platform to realize feminist debates concerning the material basis of women's subordination; tragically, however, the tremendous cost of inaccuracy and failure is accumulating in human lives.

CHAPTER 5

Sex, Trust and Consequences:

Rethinking HIV Prevention

This study set out to explore and illustrate microdetails of how the HIV/AIDS epidemic is being driven by the intersection of gender and political economy. A gender analysis helped to illustrate how HIV risk and a range of survival strategies are propagated by a social order that governs people's lives and behaviour. The research findings provide a novel lens with which to consider HIV prevention by integrating the perspectives and stories of women at risk for HIV with feminist theory in a manner that challenges predominant thinking about HIV prevention.

This chapter reviews the research findings and explains how HIV, as seen through a lens of political economy, demands a redefinition of the 'problem' of women's HIV risk. In this chapter, the 'problem' of women's HIV risk is defined as a consequence of (a) women's inability to ascertain whether it is safe to trust their husbands not to infect them with HIV; and (b) the vulnerability that arises from women's sole responsibility for sustaining the reproductive economy (i.e., the essential labour and production required to care for children and other members of a household). These redefinitions provide an alternative perspective from which to approach HIV prevention strategies; if solutions are based on the determinants of the 'problem' of HIV risk, then it is critical that the problem is defined accurately. Subsequently, the chapter introduces two emergent models of prevention: the Trust Model and the Reproductive Economy Model. These models use

the definitions of risk that surfaced in the research findings and they are useful to inform HIV prevention discourse; recommendations are made in this chapter to further their development. This chapter also addresses the limitations of the study.

A Political Economy of Gender and HIV

Rather than approaching women's HIV risk from an investigation into determinants of their 'failure' to apply HIV prevention strategies (i.e., the ABC's), the study was based on an assumption that women's risk arises within the context of a political economy that demands certain survival strategies that conflict with the available means of protection. Due to the unmistakable acceleration of HIV infection among women in Sub Saharan Africa, I believed that women's risk must be traceable to some kind of explicit social vulnerability to HIV infection rather than to the large-scale failure of individual women to apply existing preventative measures. I wanted to understand how factors imposed by political economy affect women's lives; how do women perceive the political/economic structures, institutions, traditions, roles, expectations, etc., that combine, or could combine, to create barriers and/or opportunities for their protection from HIV?

The research entry point was an investigation into what women mean when they respond DON'T KNOW to the question: "Do you feel you can get AIDS?" While I hoped this question would serve as a practical starting point for collecting qualitative information to investigate sexual bargaining power, in itself it provided a wealth of rich material to contextualize women's HIV risk within the marital relationship. In finding that women do not know if they can trust that their husband's behaviour will not put them at risk for HIV infection, I validated the approach taken in this study: women felt they were applying the

ABCs to the best of their ability, but this is simply not enough. The prevention strategies available for married women (essentially monogamy or condoms) cannot actually be applied by women in their given capacity. Monogamy, perhaps the most popular or the only feasible choice for women's protection within marriage in Sub Saharan Africa, cannot be unilateral; to provide HIV prevention, monogamy requires complete agreement from both partners. Condoms, which are reportedly not an option for married couples, require full compliance from a male partner to either use them with all his sexual partners or, at least, with all his partners except for the one(s) with whom he has agreed to have 'safe' unprotected sex; over this a woman has no control and little influence. Yet she cannot refuse sexual relations with her husband. At this point, it is useful to summarize the findings:

- Women who fully understand HIV-risk find it difficult to protect themselves;
- Men are generally not expected to be monogamous;
- Women don't know if they can trust their husbands will not infect them with HIV;
- Men are entitled to sex with their wives when/however they want;
- Women are expected to serve their husbands and they get little support if they challenge their rule;
- Women feel they need to provide for all their husbands' needs, otherwise they may seek fulfillment outside marriage;
- Women need/want to be married and to have children - they need unprotected sex for this;
- Prevention strategies that involve exerting sexual autonomy (e.g., demanding condom use) conflict with other survival strategies (e.g., satisfying one's husband);
- Social systems do not support women who apply prevention strategies and women risk losing the social/economic security provided by marriage;
- Prior to becoming mothers, women were able to attain and maintain financial independence, although being single and/or childless is socially undesirable;
- Women require economic and social support to raise children;
- Even if women want to leave their husbands in order to protect themselves, they often feel

they have to choose between their own safety (i.e., independence) and keeping their children (difficult or impossible without support).

Rather than finding the source of the 'problem' in women's inability to negotiate condom use with their husbands, the methodology allowed two alternative definitions of the problem of women's HIV-risk to arise from the research findings:

1) **TRUST**. Women who participated in the study are at risk because they do not know if they can trust that their husbands' behaviour will not put them at risk. This largely stems from permissive masculine norms that entitle men to have sexual relations with multiple partners. Women have no means to verify whether or not their husbands have other sexual partners or if they are practicing safer sex by using condoms regularly with the other partners. Regardless of this dearth of knowledge, however, women cannot refuse unprotected sex with their husbands and, as married women, they want and are expected to have children. If a woman does not wish to become pregnant, either because she has enough children or because she wants to delay motherhood, she turns to a reliable hormonal form of birth control rather than asking her husband to use condoms. This means that condoms, as the only barrier to HIV transmission, are explicitly linked to infidelity in most cases.

2) **REPRODUCTIVE ECONOMY**. The women who participated in the study are entirely responsible for the care of their children and they require economic and social support; it is exceedingly difficult for one person to do the unpaid reproductive labour required to maintain a family while also being the primary breadwinner. Aside from the physical labour directly related to reproduction (i.e., bearing children and breastfeeding), unpaid

reproductive labour also includes the time- and energy-consuming activities of maintaining a family, such as gathering wood for fuel, collecting water, processing/preparing food, childcare, care of sick and elderly family members, regular household upkeep, etc. (Smith and Cohen 2000). These activities are predominantly performed by women and are essential economic contributions to the survival and well-being of families and communities. Rather than claiming inaccurately that women are economically dependent on men,⁵³ perhaps it is more precise to focus further upstream to say that children require fulltime care *and* the economic contribution of someone who works to provide the money necessary to support the essential reproductive labour - to provide money for the food that is purchased and prepared, for the medicine that is administered, for the home that is cared for, for the clothing that is washed and mended, etc.

While prevention requires a range of strategies targeting a variety of risk determinants, for the purposes of this discussion it is useful to separate prevention strategies into distinct models to understand how the definition of the “problem” of HIV-risk determines the solutions proposed. The “Negotiation Model” defines the problem of HIV-risk in terms of women’s inability to enforce condom use with their husbands, therefore the solutions focus on increasing women’s capacity to negotiate condom use without addressing the systemic factors that make it virtually impossible for women to do so. The “Economic Empowerment Model” defines the problem as women’s economic dependence on men, therefore the solutions focus on ways to increase women’s access to

⁵³ Maundeni (2002) asserts that women’s economic dependence on men is based more on a perception of women’s economic capacity rather than on the reality of it.

income and other economic resources while apparently disregarding the essential unpaid labour that women contribute to the family and community. The two redefinitions of the problem of women's HIV-risk stemming from the research findings suggest the need for alternative models for addressing the determinants of HIV-risk. These we will call the "Trust Model" and the "Reproductive Economy Model."

Recommendations/Implications for Further Research

These two emergent models of HIV prevention require considerable investigation to understand how the redefinitions could lead to targeted risk-reduction strategies. The determinants of HIV risk need to be fully understood so that proposed strategies are directly linked to specific determinants or causes of the risk factors rather than trying to ameliorate the effects of them, leading to ambiguous or potentially harmful results. What follows are recommendations for approaches to begin to elaborate the models into useful strategic tools for HIV prevention.

The Trust Model

Women who participated in the study do not know if they can trust that their husbands will not infect them with HIV. Women felt they had little choice but to continue to have sexual relations with men who might be engaging in high-risk activities; they cannot negotiate condom use, they cannot refuse to have sex. This is the worst case scenario, and it is the reality for all of the women in the study – they continue to have sex with their husbands regardless of their degree of trust. If the Trust Model defines the 'problem' of women's HIV-risk as women's inability to know if they can trust their husbands, then solutions need to counter the determinants of this specific risk: why don't women know

whether or not to trust their husbands? What strategies can be designed to support women who DON'T KNOW if they can trust their husbands? What strategies might make men more trustworthy or transparent in their actions? Following are examples of some of the questions/concerns that need to be unraveled for this definition of HIV-risk to lead to a prevention model:

1) *How can women protect themselves in spite of uncertain trust?* Clearly, at the most fundamental level, these women need a method to protect themselves from HIV that can be used covertly or, at least, that can be used discretely so as to not interrupt the sexual experience. This substantiates the urgent call for development of a microbicide that does not need to be applied or inserted directly before sexual intercourse.⁵⁴ Just as hormonal contraceptives protect only against pregnancy, however, microbicides will not give women control over their sexuality or their bodies, it will only reduce their risk of contracting HIV.

2) *How do some women "know" that they are not at risk?* From the STD Project's quantitative data, it emerged that some women felt that they are not at risk for HIV (see chapter 3). Only 8% of these women are HIV-positive, while 16% of the women who answered DON'T KNOW are HIV-positive. What distinguishes the trust factor in the relationships of DON'T KNOW women from the "not at risk" women? What are the features of their relationships, their communication skills, their characters, their husbands' behaviours, lifestyles, etc., that give them a lower rate of HIV? Is there a

⁵⁴ Microbicides are substances that can reduce the transmission of HIV when applied to the vagina or rectum. It is expected they may become available by 2007. One of the products under development is a vaginal ring that slowly releases an active microbial ingredient over time. It will be inserted and left in the vagina for weeks or months.

particular social order within which these couples are embedded that reduces the women's risk? Are these characteristics somehow transferable or teachable in a manner that could contribute to a prevention strategy?

3) *Can the transparency of men's behaviour be increased?* Men are not accountable for their sexual behaviour to their wives nor are they held accountable for their sexual consequences more generally. There is no systematic positive evidence that can help women presume that their husbands are trustworthy; women discussed that there is only negative evidence to inform them about their husbands' behaviour, such as finding condoms in his pocket or being told of his actions by an informant. Is it possible that social structures can be manipulated to make men accountable for their sexual behaviour in such a way that reduces HIV risk, or that increases the likelihood of men accepting responsibility for their sexual consequences? What stakeholders might have suggestions for different ways of increasing the transparency of men's behaviour? An example might be increased public health engagement with sex workers and clients to increase the likelihood of condom-use.⁵⁵ Another possible example is holding men legally and financially responsible for the children they sire. While the path of HIV transmission cannot be traced, paternal lineage can be and men can only guarantee control of their own fertility by using condoms. How feasible would paternity testing be in HIV/AIDS endemic areas? Could an argument be made to compare the cost of testing to the costs incurred by mothers and children without economic support? What support exists to write and/or

⁵⁵ Considerable research and programming efforts do address sex workers (Wojcicki and Malala 2001). In this case, the focus would not be on removing women from the sex trade, the focus would be instead on reducing risk in the sex trade. The sex trade, however, often responds in unexpected ways to interventions (White 1996) and any programming would require active involvement from both workers and clients.

enact legislation giving women legal recourse to economic support from the fathers of their children? If active structures like these were in place, would women find support for their need to know/hope their husbands are protecting themselves from HIV if they engage in extramarital sex?⁵⁶ How would men respond?

For the Trust Model to be used to develop prevention strategies, the determinants of trust in relationships would need to be fully understood, as the recommendations above suggest, to address (a) what women can do if they find themselves in an uncertain-trust situation; (b) what can increase the likelihood of trust being warranted in relationships; and (c) what can women do if other proposed strategies to protect themselves fail or are not applicable – is there a way to create an escape route?

The Trust Model is a response to the failure of the Negotiation Model to protect married women. While the latter attempts to increase the use of condoms without systematically addressing the range of social determinants that make it virtually impossible for women to do so, the Trust Model offers a way to understand the underlying sources of women's risk and to direct strategies at the core determinants of risk rather than at the effects of risk. Quite simply, the trust factor in marital relationships creates very real obstacles which cannot be addressed through individual attempts to negotiate. Because marital trust is constructed within a broad social order, change requires concerted social action backed by considerable political will.

⁵⁶ Like the microbicide example above, these strategies helping women trust that their husbands are not being infected by HIV are not empowering for women who are wives – it does not in any way contribute to their control over their bodies or sexuality. It may, however, help empower the “other” women.

Reproductive Economy Model

Women who participated in the study performed all the unpaid labour required to maintain children and the household. Husbands provided money for basic food and shelter and most of the women told us about very specific strategies that they used to save money for other essential costs, such as scrimping on the food budget, participating in merry-go-rounds,⁵⁷ or lying about needing money for medication for the children. A number of women said they could find work to support themselves if they chose to leave, but that they would not be able to support their children alone on their salary. This perspective significantly shifts the analytical focus from notions of women's economic dependence on men to the vulnerability of women that results from their responsibility for the undervalued reproductive economy that is operated and maintained by women for the benefit of everyone. If the reproductive economy model defines the 'problem' of women's HIV risk as the vulnerability that arises from their sole responsibility for (re)producing, maintaining and caring for families, then solutions need to focus on the determinants and opportunities that can be drawn from this risk. To more fully understand how the reproductive economy contributes to women's HIV risk, and to suggest strategies to neutralize this risk, the following questions are examples that can guide the development of a risk reduction model based on determinants of the reproductive economy:

1) *How do different family structures mediate the reproductive economy?* Generalizations are often made about family structures that involve some form of male breadwinner and

⁵⁷ Women told us about contributing pennies a day to a pool of savings accumulated by a community of women who were turn given the grand total each week or month. I was told by middle class women that this was also a common way to get a large sum of money for necessary purchases. Often, I was told, husbands are unaware of this activity.

female care-giver; how accurate is this picture of family and how does it demarcate the reproductive economy? How do different permutations of families/households and various roles contribute to the reproductive economy: women-headed households, various kinship arrangements, extended families, polygamy, dual incomes, casual labourers, migrant workers, etc? In particular, is there a phenomenon of single-father households? If so, how are they characterized? Rather than comparing the economics of mother-headed households to those of single men, how are single father households different from mother-headed households?

2) *How have urbanization and nuclearization of the family affected the reproductive economy?* As workers migrate to urban areas, family structures change as they are either separated, removed from extended families, nuclearized, etc. How do women, men and children experience the change in the reproductive economy as a result of urbanization, migration, nuclearization and other family changes? How might perception of urban and rural reproductive economies vary? Are there links between the components of the urban reproductive economy and the higher HIV prevalence in urban areas?

3) *What alternative models exist/are possible to help women/families mediate the reproductive economy?* How do people (women/men/children) experience the reproductive economy? What alternatives do they see? How can the non-monetary value of the reproductive economy become more visible or valued? How can the reproductive economy become more gender equitable? Can people engage with the reproductive economy without being subordinated? What links can be drawn between the reproductive economy and the orphan crisis in Sub Saharan Africa to raise its visibility (e.g., the

phenomenon of grandmothers assuming responsibility for the reproductive economy to sustain their orphaned grandchildren)?

The Reproductive Economy Model is, in many ways, a response to the Economic Empowerment Model because it demands that attention is given to the invisible and essential unpaid labour of women which is necessary for reproducing society. The unpaid reproductive work that women perform is essential; even if women are routinely enabled to fill other economic roles, someone has to raise children and to run households. While women's connection to the home and children is socially constructed and not inevitable, the essential nature of the work itself cannot be erased as women are 'elevated' into economically valued opportunities. Feminists who struggle to relieve women from their traditional reproductive roles may inadvertently deepen social divides by reducing reproductive roles to an even less desirable status than they may currently occupy, meaning the people (likely poor women or subordinate relatives) who fill those roles will be further marginalized. This reality must be integrated into any strategy that focuses on women's subordination.

Limitations

The outcome of this study exceeded my expectations in terms of the richness of the material collected, of the willingness of women to share their stories, of the readiness of the STD Project to collaborate in the data collection, of the usefulness of the findings to my research interests and of the incredible wealth of knowledge and understanding that I personally gained through designing, conducting, analyzing and even writing up the research.

The study was not without its limitations, however. The study was very small, including only 26 participants. The qualitative nature of the data provides an excellent and invaluable snapshot of a specific place and time; it represents the “voices” of the target community, but it cannot be generalized to a whole community apart from how the personal accounts can be used to support theoretical developments. The study does, however, provide a solid foundation for the future evaluation and development of prevention strategies; it provides a noteworthy starting point for continued conversations about women and HIV risk.

Due to the limited time and resources for conducting the study, the scope of the research was necessarily narrow. While a wealth of information about HIV risk was collected, we targeted a very specific population of women: poor, pregnant, young, ‘married,’ informal settlement residents. These defining parameters obviously excluded input from other groups, including men, older women, single women, middle class women, sex workers, etc. In an attempt to turn a limitation into an opportunity, I would suggest that each of these groups could provide distinct versions of political economy that could be compared to understand how the various perspectives intersect.

The scope was limited to prevention. Defeating the HIV/AIDS epidemic clearly requires attention to the prevention-care continuum. For example, it is known that promoting voluntary testing and counselling as a prevention strategy can only be successful if people can be offered treatment, otherwise there is little incentive to be tested. Voluntary testing and treatment were among the topics not discussed in this study.

The data collected were of a particularly sensitive nature shared by young women with

strangers, much of it was delivered through an interpreter and it is recorded and represented by my writing. While triangulation of qualitative methods was used, the accounts provided have inevitably been altered from the women's original meaning as the stories passed through the various filters of people who played different roles in the research.

Unfortunately, I could not remain on-site throughout the duration of this study. After developing the methodology, collecting the data and discussing the essence of the information with partners in the STD Project, I returned to Canada to write the findings and to continue the analysis. In spite of repeated attempts to generate comments on draft reports from members of the STD Project team, this thesis, in the end, represents my own analysis with little input from the research partners beyond their participation while I was still in Nairobi. The methodology wanted more input from women who live closer to the issues discussed. Clearly investing time in research is very expensive and the (mostly) women with whom I worked have many demands on their time; after all, they work in both the visible economy and in the Reproductive Economy. They gave generously to this study, I cannot demand more from them.

Closing Remarks and Open-ended Questions

Condom-use has been, and continues to be, an essential ingredient in HIV prevention strategies. Their use must be rigorously promoted, particularly for sex that falls outside what might be loosely, though perhaps strategically, called the "reproductive unit". By reproductive unit, I refer to a man and a woman who have agreed, explicitly or implicitly, to engage in unprotected sex and who accept responsibility for the consequences that may

have an impact on each other's lives as a result of the exchange of body fluids. This is by no means a return to a moralistic claim that sex must be linked to procreation, instead it reflects the reality of sexual relations in Sub Saharan Africa that often result in unintended pregnancy as well as the transmission of HIV. Both of these consequences occur via the same mechanism; yet, while both the man and woman live with the consequences of one (i.e., being infected with HIV) only the woman necessarily bears the consequence of the other (i.e., pregnancy). The term reproductive unit implies in very explicit terms that a man accepts responsibility for the potential consequences of his sexual behaviour; theoretically, his singular means of controlling both types of sexual consequences is to use a condom.⁵⁸ Implicitly, however, a woman who has access to hormonal contraception has control over the likelihood of pregnancy.⁵⁹ If men were held accountable for their sexual consequences (i.e., pregnancy), might this not provide women with a strategic advantage over men who have to decide whether or not they can trust women to prevent pregnancy?

Because every act of sex in HIV/AIDS endemic areas cannot and should not be protected, perhaps prevention strategies should begin with an analysis of the reproductive unit. This is in recognition that:

- men are unlikely to respond overnight to public health persuasion to be monogamous;
- women are unlikely to stop wanting children or to always choose a career over motherhood;
- infants will continue to be born needing social and economic support from more than one person;

⁵⁸ Of course, in a continuing sexual relationship, his alternative could also be to coerce a woman into using hormonal contraception.

⁵⁹ Recognizing, of course, that contraception at times fails.

- infants will continue to be born HIV-positive;
- the number of orphans is going to increase; and
- the family, as a socio-economic unit, is essential and is disintegrating under the wrath of HIV/AIDS.

Rather than flogging condoms to women who are unable to enforce their use, might it not be more effective to beseech men to account for the lives they create; to demand that they stay alive so their children do not become orphans who bear the tremendous cost of men's sexual consequences? If women knew that men generally understood and practiced HIV prevention, could they not continue to be wives and mothers in trust that these life-affirming roles will not lead prematurely to death?

Bibliography

- Acker, Joan, Kate Barry and Johanna Esseveld. 1991. "Objectivity and Truth: Problems in doing feminist research" in Eds., Fonow and Cook, Beyond Methodology: Feminist scholarship as Lived Research Bloomington and Indianapolis: Indiana University Press.
- Action AID. 2001. "HIV/AIDS: Introduction". Citizenship Briefings. www.actionaid.org/schoolsand youth/citizenship/hiv.pdf (2004/03/19).
- Africawoman. 2002. "Let African Women Live" Africa Women Special Report on HIV/AIDS, Dec, www.coldtype.net/assets/africawoman/AW08.pdf (2003/12/02).
- Agarwal, Bina. 1997. "'Bargaining' and gender relations: within and beyond the household" *Feminist Economics* 3(1), p.1-51.
- Alexander P. 1998. "Sex work and health: a question of safety in the workplace". *Journal of the American Medical Women's Association*; 53(2), p.77-82.
- allAfrica.com. 2002. "Statement by Stephen Lewis, the Secretary-General's UN Envoy on HIV/AIDS in Africa". <http://allafrica.com/stories/printable/200207030681.html> (2002/07/16).
- Armstrong, Pat, Hugh Armstrong, P. Connelly and A. Miles. 1985. Feminist Marxism or Marxist Feminism: a Debate Toronto: Garamond Press.
- Bassett, Mary. 1995. "Zimbabwe: the social roots of AIDS", *UNESCO Courier*, June, Vol.48(6), p.17-19.
- Bennett, Olivia. 1990. Triple Jeopardy: Women and AIDS. Budapest, London, Paris, Washington: Panos Dossier, the Panos Institute.
- Benston, M. 1997 [1969]. "The Political Economy of Women's Liberation" in Eds., R. Hennessy and C. Ingraham Materialist Feminism. New York: Routledge.
- Bernard, H. Russel. 1995. Research Methods in Anthropology: Qualitative and Quantitative Approaches, 2nd Edition. Walnut Creek Ca, London, New Delhi: Altamira Press.
- Brock D. 1989. "Prostitutes are Scapegoats in the AIDS Panic". *Resources for Feminist Research/Documentation sur la recherche feministe (RFR/DFR)* 1989; 18(2): 13-16.
- Carovana, Kathryn. 1995. "HIV and the Challenges facing Men", Issue paper no. 15, UNDP HIV and Development Programme. Jan 1995.
- Chambers, R. (1994a). "The Origins and Practice of Participatory Rural Appraisal." *World Development* 22(7), p. 953-969.
- Chambers, R. (1994b). "Participatory Rural Appraisal (PRA): Analysis of Experience." *World Development* 22(9), p. 1253-1268.
- Chambers, R. (1994c). "Participatory Rural Appraisal (PRA): Challenges, Potentials and Paradigm." *World Development* 22(10), p. 1437-1454.

- Code, Lorraine. 1995. "How do we know? Questions of Method in Feminist Practice" in Ed., Sandra Burt and Lorraine Code, Changing Methods: Feminist Transforming Practice. New York and London: Broadview Press.
- Cohen J, Alexander P. 1995. "Female Sex Workers: Scapegoats in the AIDS Epidemic" in Eds., O'Leary, Jemmott Women at Risk: Issues in the Primary Prevention of AIDS .. New York: Plenum Publishing Corporation.
- Cohen, Jon. 2000. "The Mother of all HIV challenges" *Science*, 06/23, Vol. 288, p. 2160-63.
- Dalla Costa, M. and S. James. 1997 [1972] "Women and the Subversion of the Community" in Eds., R. Hennessy and C. Ingraham, Materialist Feminism. New York: Routledge.
- Devault, Marjorie L. 1999. Liberating Method: Feminism and Social Research. Philadelphia: Temple University Press.
- Dodoo, F. Nii-Amoo. 2001. "AIDS-Related Knowledge and Behaviour among married Kenyan Men: A Behavioral Paradox" *JHSA* 24(2) p. 199-233.
- Ehrenreich, Barbara. 1990 [1984]. "Life without Father; Reconsidering Socialist-Feminist Theory", in Eds., Karen Hansen and Ilene Philipson Women, Class and the Feminist Imagination: A Socialist-Feminist Reader. Philadelphia: Temple University Press.
- Eisenstein, Zillah. 1990 [1977]. "Constructing a Theory of Capitalist Patriarchy and Socialist Feminism" in Eds., Karen Hansen and Ilene Philipson Women, Class and the Feminist Imagination: A Socialist-Feminist Reader. Philadelphia: Temple University Press.
- Engels, Frederick. 1942 [1884]. The Origin of the Family, Private Property and the State. New York: International Publishers.
- Erban, R. 1990. "The Special threat to women." *World Health*, Nov/Dec.
- Esu-Williams, Eka. 2000. "Gender and HIV/AIDS in Africa – our hope lies in the future." *Journal of Health Communications* Apr-June Supplement, Vol. 5(2) p. 123-6.
- Farmer, Paul, Margaret Connors, and Janie Simmons. 1996. Women, Poverty, and AIDS: Sex, Drugs, and Violence. Monroe: Common Courage Press.
- Farmer, Paul. 1992. AIDS and Accusation: Haiti and the Geography of Blame. Berkley, Los Angeles, London: University of California Press.
- Farmer, Paul. 1999. Infections and Inequalities: the Modern Plagues. Berkley, Los Angeles, London: University of California Press.
- Ferguson, Alan. 2002. "Strengthening STD/HIV Control Project Kenya" Report on HIV/STI Surveillance in Nairobi 1991-2001. April. Unpublished Project Report.
- Fonow, Mary Margaret and Judith Cook. 1991. "Back to the future: a look at the second wave of Feminist Epistemology and Methodology" in Eds., Fonow and Cook, Beyond Methodology: Feminist scholarship as Lived Research Bloomington and Indianapolis: Indiana University Press.
- Gender and HIV/AIDS Technical Sub-Committee of the National AIDS Control Council. (2002). Mainstreaming Gender into the Kenya National HIV/AIDS Strategic Plan 2000-2005. Office of the President, Nairobi, Kenya.
- Gerth, Hans H and C. Wright Mills (eds., trs). 1958. From Max Weber: Essays in Sociology. New York: Oxford University Press, c1946.

- Gilbert, Leah and Liz Walker. 2002. "Treading the path of least resistance: HIV/AIDS and social inequalities – a South African case study", *Social Science and Medicine* 54(7) p. 103-1110.
- Gisselquist, David, John Potterat, Stuart Brody, Francois Vachon. 2003. "Let it be sexual: how health care transmission of AIDS in Africa was ignored" *International Journal of STD & HIV/AIDS*, Vol 14(3) 148-61.
- Gollub, Erica. 1999. "Human rights is a US problem too: the case of women and HIV." *American Journal of Public Health*, Vol 89(10) p. 1479.
- Hanmer, Lucia, A. Haroon Akram-Lodhi. 1998. "In 'the house of the spirits': toward a Post Keynesian theory of the household?" *Journal of Post Keynesian Economics*. Spring, Vol 20(3) p. 415.
- Harrison, A., J.A. Smit, L. Myer. 2000. "Prevention of HIV/AIDS in South Africa: A review of behavioural change interventions, evidence and options for the future." *South African Journal of Science*, Vol. 96(6) p. 285-290.
- Harrison, Kelsey. 1997. "Maternal Mortality in Nigeria: the real issues." *African Journal of Reproductive Health*, 1(1) p. 7-13.
- Hartely, J.F. 1994. "Case Studies in Organizational Research" in Eds., C.Cassell, G.Symon Qualitative Methods in Organizational Research: A Practical Guide. London: Sage.
- Hartmann, Heidi. 1990 [1976]. "Capitalism, Patriarchy and Job Segregation" in Eds., Karen Hansen and Ilene Philipson, Women, Class and the Feminist Imagination: A Socialist-Feminist Reader. Philadelphia: Temple University Press.
- Hostein, James and Jaber Gubrium. 1995. The Active Interview Thousand Oaks: Sage.
- Kabeer, Naila. 1995. "Necessary, Sufficient or Irrelevant? Women, wages and Intra-household Power relations in Urban Bangladesh" Working Paper 25, Sussex: IDS.
- Katz, Elizabeth. 1991. "Breaking the Myth of Harmony: Theoretical and Methodological Guidelines to the study of rural Third World Households". *Review of Radical Political Economics*. Vol. 23 (3&4) p. 37-56.
- Katz, Elizabeth. 1997. "The Intrahousehold Economics of Voice and Exit". *Feminist Economics* Vol. 3(3). p. 25-46.
- Kenya AIDS Institute. 2001. Website: <http://kenyaaidsinstitute.org>
- Kevane, Michael. 2000. "Extrahousehold Norms and Intrahousehold Bargaining: Gender in Sudan and Burkina Faso" in Ed., Anita Spring, Women Farmers and Commercial Ventures: Increasing Food Security in Developing Countries, Boulder and London: Lynne Rienner Publishers.
- Lane, Lisbeth and Linda Viney. 2002. "Toward Better Prevention: Constructions of Trust in the sexual relationships of young women." *Journal of Applied Social Psychology*, 32(4) p. 700-718.
- Lawson, Agathe Latre-Gato. 1999. "Women and AIDS in Africa: Socialcultural Dimensions of the HIV/AIDS Epidemic." *International Social Science Journal*, Sept, Vol. 51(161) p. 391-400.
- Lundberg, Shelly, Robert A Pollak. 1993. "Separate Spheres Bargaining and the Marriage Market". *Journal of Political Economy*, Vol. 101(6) p. 988-1010 .

- Maguire, Patricia. (2001). "Uneven Ground: Feminisms and Action Research" in Eds., P. Reason and H. Bradbury, Handbook of Action Research: Participative Inquiry and Practice, Chapter 5.
- Maundeni, Tapologo. 2002. "HIV/AIDS and Violence against Women: Insights from Botswana" presented at 8th International Interdisciplinary Congress on Women Kampala, July 21-26. www.makerere.ac.ug/womenstudies/full%20papers/tapologo.htm (2003/11/19)
- Meursing, Karla. 1999. "Barriers to sexual behaviour change after an HIV diagnosis in Sub Saharan Africa" in Eds., J. Caldwell, P. Caldwell, J. Anarfi, K. Awusaabo-Asare, J. Ntzi, I.O. Orubuloye Resistances to Behavioural Change to Reduce HIV/AIDS Infection Canberra Australia: Australian National University.
- Meyer, Christine. 2001. "A Case in Case Study Methodology". *Field Methods*, Vol 13(4) p.329-352.
- Miles, M. B. (1983) "Qualitative Data as an Attractive Nuisance: The Problem of Analysis" in Ed., J.V. Maanen Qualitative Methodology Beverly Hills: Sage.
- Mitchell, Claudia, Ann Smith. 2001. "Changing the picture: Youth, gender and HIV/AIDS prevention campaigns in South Africa" *Canadian Women's Studies*, Vol 21(3), p. 56-61
- Mitchell, Juliet. 1971. Women's Estate. New York: Vintage Books.
- Narayan, Uma. 1989. "The Project of Feminist Epistemology: Perspectives from a Nonwestern Feminist" in Eds., A.M. Jaggar and S.R. Bordo, Gender/Body/ Knowledge. New Brunswick NJ: Rutgers University Press.
- Nielson, Joyce MacCarl. 1990. "Introduction" in Ed., Joyce MacCarl Nielson, Feminist Research Methods: Exemplary Readings in the Social Sciences, Boulder: Westview.
- Ostergaard, Lise. 1992. "Gender", in Ed., Ostergaard Gender and Development: a Practical Guide.. London, NY: Routeledge.
- Parker, Richard. 2000. "Administering the Epidemic: HIV/AIDS Policy, Models of Development and International Health" in Eds., L. Whiteford, L. Manderson, Global Health Policy, Local Realities: the Fallacy of the Level Playing Field. Boulder, London: Lynne Rienner Publishers.
- Philipson, Ilene, Karen Hansen. 1990. "Women, Class and the Feminist Imagination: An Introduction" in Eds., K. Hansen and I. Philipson Women, Class and the Feminist Imagination: A Socialist-Feminist Reader. Philadelphia: Temple University Press.
- Rao Gupta, Geeta, and Ellen Weiss. 1993. "Women's lives and sex: implications for AIDS prevention." *Medicine and Psychiatry* Vol 17(4) p. 399-412.
- Rao Gupta, Geeta. 2000. "Gender, Sexuality and HIV/AIDS: the What, the Why and the How." Plenary Address, Global Congress on HIV/AIDS, Durban, South Africa, July 12, 2000. <http://www.icrw.org/docs/DurbanSpeech.pdf>. (2002/08/12)
- Rao Gupta, Geeta. 2002. "How men's power over women fuels the HIV epidemic" *BMJ* Vol 324, p, 183-4.
- Rao Gupta, Geeta. 2002^a. "Gender Issues in HIV/AIDS Research" Plenary address at Global Forum for Health Research, Arusha, Tanzania, Nov12-14.
- Reid, Elizabeth. 1992. "Gender Knowledge and Responsibility" Issue Paper No. 10, HIV and

- Development Programme, UNDP.
www.undp.org/hiv/publications/issues/english/issue10e.htm (2002/12/12)
- Rivers, Kim and Aggleton, Peter. 1999. "Men and the HIV Epidemic". HIV and Development Programme, UNDP. www.undp.org/hiv/publications/gender/mene.htm (2003/04/12).
- Rowbotham, Sheila. 1972. *Women, Resistance & Revolution*, London: Allen Lane.
- Rowbotham, Sheila. 1973. *Woman's Consciousness, Man's World*. Harmondsworth: Penguin.
- Rubin, Gayle. 1990 [1976]. "The Traffic in Women: Notes on the 'Political Economy' of Sex" in Eds., K. Hansen and I. Philipson *Women, Class and the Feminist Imagination: A Socialist-Feminist Reader*. Philadelphia: Temple University Press.
- Schoofs. 1999. "Death and the Second Sex." Village Voice, 12/07/99, Vol. 44(48).
- Secombe, Wally, 1973. "The Housewife and her Labour under Capitalism". New Left Review vol. 83, p. 3-24.
- Seiz, Janet. 1991. "The Bargaining Approach and Feminist Methodology". Review of Radical Political Economics, Vol 23(1&2) p. 22-29.
- Silverman, David. 1993. *Interpreting Qualitative Data: Methods for analysing talk, text and interaction*. London, Thousand Oaks, New Delhi: Sage Publications.
- Smith, Dorothy. 1989. "Feminist Reflections on Political Economy", Studies in Political Economy Vol. 30, Autumn, p. 37-59.
- Smith, Sheila and Desmond Cohen. 2000. "Gender Development and the HIV Epidemic". UNDP Publications. www.undp.org/hiv/publications/gender/gendere.htm. (2002/07/08).
- Stanley, Liz and Sue Wise. 1991. "Feminist Research, Feminist Consciousness and Experiences of Sexism" in Eds., Fonow and Cook, *Beyond Methodology: Feminist scholarship as Lived Research*, Bloomington and Indianapolis: Indiana University Press.
- Stoecker, Randy. 1991. "Evaluating and Rethinking the case study". Sociological Review, Feb, Vol. 39(1), p. 88-112.
- Strengthening STD/HIV Control Project. 2002. "Annual Report to CIDA, April 2001-March 2002" STD Project, Nairobi.
- Susser, Ida, Zena Stein. 2000. "Culture, Sexuality and Women's Agency in the Prevention of HIV/AIDS in Southern Africa." American Journal of Public Health, July, Vol 90(7), p. 1042-1048.
- Tallis, Vicci. 2002. "Gender and HIV/AIDS: Overview Report." Bridge, IDS, UK.
www.ids.ac.uk/bridge/reports_gend_cep.html (2003/04/12).
- Ulin, Priscilla, Elizabeth Robinson, Elizabeth Tolley and Erin McNeill. 2002. *Qualitative Methods: a field Guide for Applied Research in Sexual and Reproductive Health*. North Carolina: Family Health International.
- UNAIDS. 1998. "Gender and HIV/AIDS: Technical Update". *UNAIDS Best Practice Collection*. September. UNAIDS.
- UNAIDS. 1999. *Gender and HIV/AIDS: Taking Stock of research and programmes*. Geneva: UNAIDS.
- UNAIDS. 2002. *AIDS epidemic update*. UNAIDS. December.

- UNAIDS. 2002. Report on the Global HIV/AIDS Epidemic. UNAIDS. July.
- UNIFEM. 2001. Turning the Tide: CEDAW and the Gender Dimensions of the HIV/AIDS Pandemic NY: UNIFEM.
- USAID. 2002. The ABC's of HIV Prevention: report of a USAID Technical Meeting on behavioural change approaches to primary prevention of HIV/AIDS ABC Experts Technical Meeting. Washington D.C. September 17, 2002.
- Van Maanen, John. 1983. "Reclaiming Qualitative Methods for Organizational Research: A preface" in Ed., J. Van Maanen, Qualitative Methodology, Newbury Park, London, New Delhi: Sage.
- Van Niekerk, Anton. (2001) "Moral and social complexities of AIDS in Africa". *Journal of Medicine and Philosophy* Vol 27(2), p. 143-162.
- Vogel, Ulrich. 2002. "AIDS at the end of 2001: Why is combating AIDS so difficult?" *Agriculture and Rural Development* Vol 2.
- Weber, Max. 1958. From Max Weber: Essays in Sociology. Eds., Trs., Hans H. Gerth and C. Wright Mills. New York: Oxford University Press, c1946.
- Weiss, Ellen, Daniel Whelan, Geeta Rao Gupta. 2000. "Gender, sexuality and HIV: making a difference in the lives of young women in developing countries." *Sexual and Relationship Therapy*, Vol. 15(3), p 233-245.
- White, Sarah. 1996. "Depoliticising Development: the uses and abused of participation", *Development in Practice*, Vol 6, p 6-15.
- WHO (1997) "Multicentre Study. Kisumu, Kenya" from Gender and HIV/AIDS Technical Sub-Committee.
- WHO. 2002. Briefing Note: Expert consultation on integrating gender into HIV/AIDS programmes. Prepared by Geeta Rao Gupta, Daniel Whelan and Keera Allendorf, ICRW. July 18. Geneva.
- Wills AE. 1991. "Public Health, AIDS and Sex Workers in New South Wales". [Australian] *National AIDS Bulletin* November, p. 39-43.
- Wilson, D. Alwyn Zenda. 1992. "Predicting Zimbabwean Women's ability to tell their partners to use condoms." *Journal of Social Psychology*, Apr92, Vol. 132(2). P. 261-3.
- Wilson, D.S. Lavelle. 1990. "HIV/AIDS in Africa." *AIDS Care*, Sept 90, Vol. 2(4).
- Wolf, Diane. 1996. Feminist Dilemmas in Fieldwork. Boulder, Oxford: Westview Press.
- Wolff, Brent, Ann Blanc, and Anastasia Gage. 2000. "Who decides? Women's status and negotiation of sex in Uganda" *Health & Sexuality* Vol. 2, p. 303-322.
- Wojcicki, Janet, Josephine Malala. 2001. "Condom use, power and HIV/AIDS risk: sex-workers bargain for survival in Hillbrow/Joubert Park/Berea, Johannesburg". *Social Science & Medicine* 53 (201), p. 99-121.
- Worth, Dooley. 1989. "Sexual Decision-Making and AIDS: Why condom promotion among vulnerable women is likely to fail". *Studies in Family Planning* Vol. 20(6). P 297-307.

Appendix A: Surveillance Questionnaire

STD/HIV SURVEILLANCE FORM FOR ANTENATAL CLINIC WOMEN

1. DATE ____/____/____ 2 HEALTH FACILITY _____
(DAY) (MONTH) (YEAR)
3. PATIENT NO: _____ 4. SUBJECT CODE ____/____/____
YEAR /MO/ NUMBER
5. MONTH AND YEAR OF BIRTH ____ MONTH ____ YEAR (If Unknown: AGE ____ YEARS)
- 6a. AREA OF RESIDENCE _____
- 6b. HOME PROVINCE _____ 6c. HOME DISTRICT _____
7. POPULATION ANC ☐ FP ☐ OTHER ☐
8. YEARS FORMAL SCHOOL ☐ ☐ ☐ ☐ ☐
0 1-4 5-8 >8 DK/NA
9. MARITAL STATUS ☐ ☐ ☐ ☐ ☐
MARRIED SINGLE DIVORCED SEPARATED WIDOWED
(If not currently married, skip to Q11)
10. ARE YOU THE ONLY WIFE? ☐ FIRST WIFE? ☐ SECOND WIFE? ☐ THIRD WIFE + ? ☐
LIVING WITH HUSBAND? YES ☐ NO ☐
11. HOW MANY MONTHS PREGNANT ARE YOU? ____ MONTHS
12. HAVE YOU HEARD OF CONDOMS? YES ☐ NO ☐ (If "NO", skip to Q. 17)
13. HAVE YOU EVER USED THEM WITH ANY PARTNER? YES ☐ NO ☐ (If "NO", skip to Q. 17)
14. IF YES, WHEN YOU USE / USED CONDOMS, WHO USUALLY PROPOSES / PROPOSED THEIR USE?
YOU ☐ PARTNER ☐ BOTH ☐
15. WITH WHOM DO / DID YOU USUALLY USE CONDOMS?
HUSBAND ☐ REGULAR PARTNER ☐ CASUAL PARTNER ☐
16. DID YOU USE CONDOMS AT ALL IN THE THREE MONTHS BEFORE YOU BECAME PREGNANT?
YES ☐ NO ☐ (If "No", skip to Q.17)
IF YES, WHY ?
CONTRACEPTION ☐ PREVENT STD/HIV ☐ BOTH ☐
PARTNER INSISTED ☐ OTHER (SPECIFY) _____
17. ESTIMATED NO. OF LIFETIME SEXUAL PARTNERS (Include Husband): _____ PARTNERS
18. NUMBER SEX PARTNERS IN THE PAST 3 MONTHS (Excluding Husband)
☐ ☐ ☐ ☐ ☐
0 1 2-5 6-10 >10

19. HAVE YOU EVER RECEIVED MONEY/BEEEN PAID FOR SEX? YES ☐ NO ☐ (If "NO" skip to Q.21)

20. IF SO, HAVE YOU RECEIVED MONEY FOR SEX WITHIN THE PAST THREE MONTHS? YES ☐ NO ☐

21. HAVE YOU HEARD OF STDs? YES ☐ NO ☐ (If "NO", skip to Q.23)

22. IF SO, DO YOU FEEL YOU CAN GET AN STD? YES ☐ NO ☐ DON'T KNOW ☐

IF YES, WHY?

EVERYBODY IS AT RISK ☐

HAS MANY PARTNERS ☐

PARTNERS DON'T USE CONDOMS ☐

HUSBAND HAS MANY PARTNERS ☐

OTHER ☐

IF NO, WHY NOT?

RISK IS SMALL OVERALL ☐

HAS ONE OR FEW PARTNERS ☐

PARTNERS USE CONDOMS ☐

HUSBAND IS FAITHFUL ☐

OTHER ☐

23. HAVE YOU HEARD OF AIDS? YES ☐ NO ☐ (If "NO", skip to Q.25)

24. IF SO, DO YOU FEEL YOU CAN GET AIDS? YES ☐ NO ☐ DON'T KNOW ☐

IF YES, WHY?

EVERYBODY IS AT RISK ☐

HAS MANY PARTNERS ☐

PARTNERS DON'T USE CONDOMS ☐

HUSBAND HAS MANY PARTNERS ☐

OTHER ☐

IF NO, WHY NOT?

RISK IS SMALL OVERALL ☐

HAS ONE OR FEW PARTNERS ☐

PARTNERS USE CONDOMS ☐

HUSBAND IS FAITHFUL ☐

OTHER ☐

25. HAVE YOU EVER HAD AN STD? YES ☐ NO ☐ (If "NO", skip to Q.28)

26. IF SO, WHEN WAS THE LAST TIME YOU HAD ONE _____ MONTH _____ YEAR

27. IF SO, DO YOU KNOW WHICH KIND OF STD YOU HAD?

VAGINAL DISCHARGE ☐ GENITAL ULCER / SORE ☐ PID (LOWER ABDOMINAL PAIN) ☐

OTHER (SPECIFY) _____

28. EXAMINATION (CIRCLE)

VULVA NORMAL ULCERS WARTS BARTHOLINS OTHER _____

VAGINA NORMAL ULCERS WARTS DISCHARGE OTHER _____

CERVIX NORMAL ULCERS WARTS DISCHARGE OTHER _____

PELVIC NORMAL PREGNANT CX. TENDERNESS ADNEXAL TENDERNESS

29. LABORATORY (CIRCLE)

GONORRHEA CULTURE	NEGATIVE	+PPNG	-PPNG	NOT DONE
HIV SEROLOGY:	NEGATIVE	POSITIVE	INDETERM	NOT DONE
SYPHILIS SEOLOGY	NEGATIVE	POSITIVE	INDETERM	NOT DONE

30. RESULTS REQUESTED? YES ☐ NO ☐

31. PARTNER ATTENDED? YES ☐ NO ☐

32. PARTNER (CIRCLE):

HIV SEROLOGY: NEGATIVE POSITIVE INDETERM NOT DONE

SYPHILIS SEROLOGY: NEGATIVE POSITIVE INDETERM NOT DONE

Appendix B: Ethics Clearance

21 February 2003

Dear Ms. Macnab,

The Carleton University Research Ethics Committee has reviewed your application entitled *Sex, Power and AIDS* and given it approval.

The guidelines in terms of an ethics clearance from the Carleton University Research Ethics Committee are as follows:

1. Ethics clearance is valid for one-year (from date of this letter). If you do not complete the interviews indicated in your proposal within that time frame you must contact the ethics committee so the research project can be considered for an extension.
2. If there are any significant changes to the proposal you are obligated to contact the committee with the changes.
3. Should any participant suffer negatively from the research please report this to the committee and indicate what steps you have taken to resolve the situation.
4. Finally, this office will contact you annually to review the status of the research project, and if necessary the committee will convene to review any problems that have occurred over the course of the year.

If you have any questions please do not hesitate to contact me. On behalf of the committee I wish you the best of luck with your research.

Yours truly,