

*Stopping The Spread of AIDS among Women in Sub-Saharan  
Africa, What Works and What does not:  
A Comparative Study of Uganda and Botswana*

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*By Thomas P. Keene*

(ABSTRACT)

*Using feminist theory and comparative analysis, this thesis will investigate why women in sub-Saharan Africa are more vulnerable to HIV/AIDS than men. Among non-governmental organizations and inter-governmental organizations, HIV/AIDS has always been a gender issue because it is clear that women are more vulnerable to the disease, socially, culturally and biologically. Through two case studies -- one on Uganda where the HIV prevalence rate has dropped considerably in recent years, and one on Botswana, where the HIV prevalence rate has drastically increased in recent years – I will shed light on women’s vulnerability to HIV, how this vulnerability can be counteracted, and how these counteractive efforts are implemented by women and state governments (if they are implemented at all). It is hypothesized that the empowerment of women may stifle the spread of HIV.*

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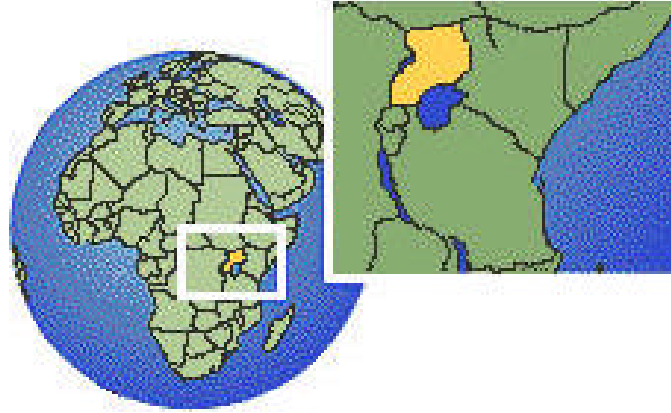
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## Acronyms:

|        |  |
|--------|--|
| ACFODE | Action For Development                         |
| AIDS   | Acquired Immune Deficiency Syndrome            |
| BDP    | Botswana Democratic Party                      |
| BNF    | Botswana National Front                        |
| CA     | Constituent Assembly                           |
| CIA    | Central Intelligence Agency                    |
| FIDA   | Ugandan Association of Women Lawyers           |
| FOWODE | Forum for Women in Democracy                   |
| GDP    | Gross Domestic Product                         |
| HIV    | Human Immunodeficiency Virus                   |
| IGO    | Inter Governmental Organization                |
| KIT    | Royal Tropical Institute                       |
| MUTAN  | Tanzanian – Norwegian AIDS Project             |
| NCW    | National Council of Women                      |
| NAWLA  | National Association of Women Living with AIDS |
| NGO    | Non-Governmental Organization                  |
| NRA    | National Resistance Army                       |
| NRM    | National Resistance Movement                   |
| PTA    | Parent Teacher Association                     |
| STD    | Sexually Transmitted Disease                   |
| SWAA   | Society of Women Against AIDS in Africa        |
| TASO   | The AIDS Service Organization                  |
| UN     | United Nations                                 |
| UNAIDS | United Nations AIDS Program                    |
| UNDP   | United Nations Development Program             |
| UNICEF | United Nations International Children’s Fund   |
| UPC    | Ugandan People’s Congress                      |
| WHO    | World Health Organization                      |

## *Maps and Facts*

### **Uganda:**

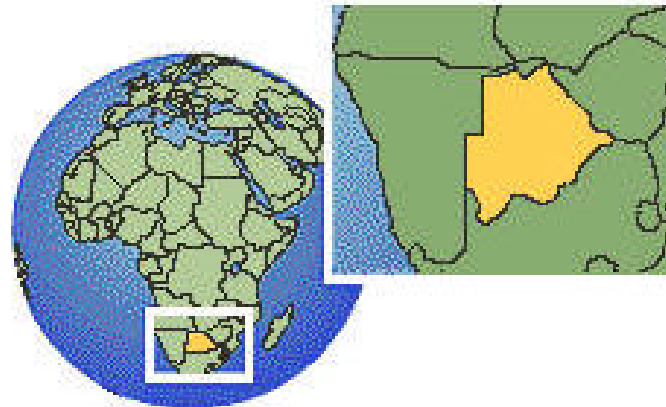


Capital: Kampala

Area: 236,040 sq km

Population: 23,317,560 (July 2000 estimate)

### **Botswana:**



Capital: Gaborone

Area: 600,370 sq km

Population: 1,576,470 (July 2000 estimate)

# *Chapter One: The General Conditions of Women's Vulnerability to HIV*

## *Introduction*

Perhaps the biggest threat to the world's population in the next few decades will be the spread of HIV/AIDS. The UNAIDS program describes the state of the disease:

There is still no cure and no vaccine for AIDS. In 1998, 16,000 individuals were infected with HIV every day, and by year end over 33 million people, a number that exceeds the entire population of Canada, were living with HIV – although we estimate that nine-tenths of them are unaware of their infection. Many people with HIV or AIDS have no access to medication, even to relieve their pain and suffering. More than 12 million adults and children have already lost their lives to the disease (UNAIDS, 1999).

Given that over 70% of all people with HIV/AIDS live in the developing world, it is apparent that this affliction will have far-reaching consequences on the state of international relations for years to come. In developing countries where significant portions of the working age population are infected with the disease it is clear that the spread of HIV will have widespread socio-economic consequences. For example, because of the recent spread of HIV/AIDS, Botswana fell 26 places on the Human Development Index between 1996 and 1997. Within 25 years it is estimated that the country's economy will be 31% smaller than it would have been in the absence of AIDS (UNAIDS, 1999; Garbus, 2000: 3-4). The developed world has definitely taken notice of the problems AIDS may present in the coming decades: the US government recently declared the international spread of AIDS presents a threat to international security, and last summer summits of international and African leaders dealing with the spread of HIV/AIDS garnered worldwide attention.

I will argue that the best hope for decreasing HIV rates in sub-Saharan Africa is to empower women. There has arisen a vibrant women's movement in Uganda over the past fifteen years and the HIV rate has recently dropped. Contrarily, in Botswana where HIV rates are now the highest in the world women remain repressed within the

workplace, the political realm and in the home. The position of women in each of these societies seems to undermine the United Nations' Gender Empowerment Index which places Botswana much further ahead of Uganda in terms of gender empowerment. However, I will show why women in Uganda are in a much better position to control the HIV status. Is there a correlation between women's empowerment and the decline in HIV rates in Uganda? Is women's empowerment – in the form of quality education, equal job opportunities, autonomy (the autonomy of women's organizations is most important, but women also need autonomy in the home and in the workplace), a voice in the political realm, and ability to negotiate their sexuality, – a necessary precondition for checking the spread of the virus?

HIV/AIDS has always been a gender issue. In 1997 an estimated 50% of those infected with HIV/AIDS worldwide were female, and the majority lived in Africa (Esu-Williams, 1997). According to Anne Arbuckle, author of "The Condom Crisis: An Application of Feminist Legal Theory to AIDS Prevention in African Women":

Women are the fastest growing population of HIV infected persons...The rate of HIV infection in African women is increasing, particularly in sub-Saharan Africa where four million women are believed to be infected...the rate of HIV infection in African women is thirty-five times higher than in European women and eighteen times higher than in women in the US...In urban Rwanda ninety percent of all deaths of women of childbearing age are caused by...HIV (Arbuckle, 1996).

At the beginning of the 21<sup>st</sup> century, HIV/AIDS will have its greatest impact on women in developing countries. This will remain true as long as unprotected heterosexual intercourse is the prevailing mode of HIV transmission. HIV's impact on women is also prevalent among developed countries where almost all HIV infections previously occurred in men:

While women comprised around 12% of the AIDS cases reported in France in 1985, ten years later this figure rose to around 20%. In Spain, women's share of reported AIDS cases more than doubled over the same ten year period – from around 7% to 19% (UNAIDS Best practice Point of View).

However, women in developing countries face a far greater risk of infection. In sub-Saharan Africa more women are infected than men and an "estimated...80% of all HIV-positive women in the world are currently found" there (Raffeala, Prancke 1995). In fact,



the rate of infection among men has stabilized over the past few years, whereas the rate among women has skyrocketed.

Until recently the effects of HIV/AIDS among women was not the subject of much research or debate. In the Western world this can be attributed to the fact that AIDS was originally defined as a homosexual male disease and the infection rate among females still remains relatively low. In the developing world the effect of HIV among most women has largely been ignored because of a tendency to perceive women as “vectors’ of transmission, with emphasis on their roles as mothers and commercial sex workers” (Ibid.). Many societies have difficulty recognizing AIDS as a women’s problem even today. AIDS awareness campaigns and public messages don’t generally incorporate women; or they do so only to a limited extent (Bianco, 1999). In the past when HIV/AIDS was primarily spread among the male population, AIDS prevention organizations and doctors/biologists may have underestimated female susceptibility to the disease (Treichler, 1999). This underestimation may be due to incomplete or faulty biological and quantitative analyses. According to R.J. Cook:

Statistics on...health status have limits...because they will generally indicate only a national average and tend not to be disaggregated by sex...Statistics will not necessarily indicate, for instance, the lack of health services for women in rural villages (Cook, 1994).

Cook’s research was originally prepared as a contribution to the WHO for the World Conference on Human Rights in 1993. Since that time it appears that the UN’s analyses, both statistical and general, have become more disaggregated, and specialized. Indeed, as the HIV prevalence rate has soared in southern Africa researchers, IGO’s and NGO’s have given more attention to the spread of HIV among women and the focus of their work has not been so myopic as to only investigate instances in which women can be perceived as “vectors of transmission.” Recent research conducted on the subject often asks why women are put in positions in which they are more vulnerable and in which they can easily spread the disease, and what can be done to counteract this vulnerability. Clearly IGOs, women’s NGOs, and independent researchers have begun to understand the implications of HIV/AIDS among women. IGOs and various women’s

NGOs are now in a position to formulate and, occasionally lobby for, and even enact policy that may counteract women's vulnerability to HIV.

The biggest factor leading to vulnerability to HIV is adverse socio-economic circumstances. In order to gain an understanding of how socio-economic constraints compromise the health of women, Linda M. Whiteford's 1996 essay "Political Economy, Gender and the Social Production of Health and Sickness" is invaluable. I want to take a few pages to discuss Whiteford's essay because in my case studies (chapters 2-4) I will be using many of the methodologies she advocates in order to explain why women are more vulnerable to HIV than men.

Whiteford expands on some of the ideas originally put forth by German pathologist Rudolf Virchow in the 1840's. Virchow believed that:

Political-economic analysis can advantageously be applied to understanding the social production of health today...[and] argued that the poor were often in bad health not from their own negligence, but from social conditions that systematically deprived them of resources, and historical conditions that isolated them... (Whiteford, 243). In recent decades authors have noticed that gender barriers have similar effects. Women have defined gender roles to which they are expected to adhere, and they are often "systematically deprived of resources." Briefly reviewing literature on the social production of health and illness, Whiteford finds that often authors will discuss just political economy and health/illness, or they will discuss just gender and health/illness, but rarely do they examine political economy and gender and the social production of health/illness. In this essay Whiteford explains to readers how to conduct an anthropological analysis of political economy, gender, and the social production of health in a way in which they "overlap and enrich the resultant analysis" (243).

Whiteford claims that in order to perform feminist analysis of culture and political economy we must operate under a few assumptions. We must discard the notion that some communities "represent life and culture from years before" (245). All cultures have changed over thousands of years and colonialism has much to do with this. Recognizing that cultures have changed allows the researcher to evaluate various possible gender

arrangements “through comparative ethnography” (245). For the feminist AIDS researcher this is very important because it allow us to examine differing gender arrangements throughout the world and throughout history. Through comparative analysis I can ask questions like what arrangements within the political economy allow women access to needed resources and guarantees women’s autonomy.

My analysis must also acknowledge and reassess “the cultural basis for well-established patterns of behavior” (245). Often elements of what we consider to be human nature are just products of social thought from a particular time and place. Social categories are often found to be nothing more than socially or culturally constructed labels. These labels and expected patterns of behavior are not just local or national constructions; they can also be attributed to external subjective representations (i.e. some Western discourse on the AIDS epidemic in the Third World). The construction of labels can also be attributed to the growing professionalization of knowledge. It is important to understand how patterns of behavior and social categories are constructed because it “tells us a great deal about the values present in [a] society” (245). We can better recognize a culture’s “social imaginary.”

When conducting a feminist analysis of culture and political economy we must also assume that gender is a social construction. More specifically we must acknowledge that “gender does not exist outside of, but is rather a reflection and product of, social identities” (246). Therefore we cannot study gender in isolation because there are also “appropriate categories of reference” we must consider. Whiteford takes this assumption a step further:

...women should be studied not only in relation to men, but also in relation to each other because embedded gender identities cross-cut other social boundaries (246).

I am critical of Whiteford’s endorsement of feminist comparative studies that transcend national and cultural boundaries for reasons best expressed by Arturo Escobar in *Encountering Development*. In his analysis of the work of Chandra Mohanty, Escobar writes that comparing and contrasting Western women to women from the Third World:

“implicitly assume[s] Western standards as the benchmark against which

to measure the situation of Third World women. The result...is a paternalistic attitude on the part of Western women toward their Third World counterparts and, more generally, the perpetuation of the hegemonic idea of the West's superiority (Escobar, 8).

There is a risk that studies of this sort could lead to feminist theories that are culturally imperialistic, but we should always be mindful of rigid social institutions that differentiate the status of women in the West from the status of women in the Third World.

After her extensive discussion of the political economy of gender, Whiteford moves on to discuss the political economy of health. She uses Lynn Morgan's definition of the political economy of health:

...a macroanalytical, critical, and historical perspective for analyzing disease distribution and health services under a variety of economic systems, with particular emphasis on the effects of stratified social, political, and economic relations within the world economic system (Morgan, 132).

This type of perspective has grown out of a Marxist response to the failures of modernization, well as out of the global systems approach (which was "a response to perceived inadequacies of studying medical systems in isolation". 247). Many of the theorists that utilize this type of approach hypothesize that the health or sickness of populations in the Third World is determined by the control of resources. People in the Third World will often not have control over their own health because "there is a pattern of control over the resources of those countries in which the majority of the population has no control over those resources" (247). In sub-Saharan Africa most people do not have of control over resources to treat AIDS. For example, pharmaceuticals produced in the West are too expensive for most HIV positive people in many African countries. In Burundi only about thirty AIDS patients can afford retroviral drugs. This minute percentage consists mostly of government elites and wealthy businessmen (*The Washington Post*).

A feminist political economic understanding of the social production of health requires that we use the basic assumptions discussed above to answer questions about the context of health and health care. But we need to take an anthropological approach when

we do this. We cannot just ask “How are women treated in different health care systems?” We must study “the history of the social relations that give rise to particular gender roles, and to relations between groups and the state [and NGO’s and IGO’s], and among social classes” (248).

This strategy for understanding the health or sickness of particular populations is invaluable. It is especially helpful for understanding why women in sub-Saharan Africa are vulnerable to HIV. A 1995 publication entitled *Young People at Risk* is filled with case studies that illustrate the reasons behind vulnerability to the epidemic. The type analyses carried out in this book are quite similar to what Whiteford advocates. Aud Talle’s case study of bar workers in northern Tanzania pays special attention to economic constraints placed on young women, and the social and cultural expectations and perceptions of these women (18-30). A case study performed by Liv Haram portrays the cultural, social, and economic constraints young Meru women face when attempting to negotiate their sexuality (31-48). Haram closely analyzes how the Meru tribe has changed socially and economically and the implications these changes have for women’s autonomy and vulnerability.

Women in sub-Saharan Africa do face many socio-economic constraints that compromise their health. These constraints have two major causes: lack of quality education (which leads to socio-economic vulnerability), and a culture that places excessive social expectations on the shoulders of women. I will discuss problems with women’s education in sub-Saharan Africa in some detail below. The shortcomings of education systems in Africa can be summed up in the following way: less than 52% of secondary school aged African women attend secondary school and less than 36% of primary school aged girls attend primary school (UNDP, 1999). The women that do not receive any formal education will often be illiterate and find themselves in a “situation of land scarcity and with few opportunities for employment outside of the agricultural sector” (Ndeki, Klepp, Irema, Lyimo and Msuya 1995). Essentially their future looks quite bleak because it is difficult to become educated in regard to your health if you are illiterate, and ignorance in this case will certainly lead to vulnerability to HIV. Also the

prospects for financial security are grim leading many women to rely on a man or a number of men for financial stability.

Traditionally underdevelopment and poverty have not been understood as gendered problems, but feminist theorists argue that they are gendered in that women are more likely to be victims of poverty and in the sense that women are the key to solving problems of poverty and underdevelopment (Buvinic, 2000: 402). State policies around the world have inadvertently served to obstruct women from providing for themselves and their families. Changing discriminatory policies would benefit not only women, but developing societies as a whole. Women are expected to care and provide for their families but often they do not have access to the resources needed carry out their expected duties.

One of the best ways to explain a woman's predicament and excessive expectations placed on a woman in a time of AIDS is to examine what the Society of Women Against AIDS in Africa (SWAA) calls "triple jeopardy" (Henry, 1999: 1-5). By "triple jeopardy" the Society means that:

As individuals, [women] are at risk of infection because of a host of biological, social and economic factors that make women particularly vulnerable to HIV. As mothers, they can infect their children with the virus. And as society's traditional caregivers, they are expected to care for husbands, sons and other family members with AIDS while somehow finding a way to support their families (ibid).

So women are expected to bear children (and often condom use is out of the question for this reason) even if they could spread the virus to their unborn child. And they are also expected to care for ailing family members even when they may have little access or control over economic resources.

The "triple jeopardy" that women face is the biggest reason why they need some degree of autonomy and empowerment in all sectors of society. Women can bear healthy or sick children and the conditions in which she exists will very likely dictate the health of the child. Women can take care of sick family members, but her access to resources and the reliability of male family members in the care giving process will dictate the

effectiveness of this home healthcare.

Nation-states in sub-Saharan Africa do not provide an environment for women's socio-economic advancements. Men rule all southern African states and many states do not offer women equal legal or economic status (Mansbach, Rhodes, 2000: 383).

Even in countries in which the state attempts to treat men and women equally, social institutions – typically dominated by men – tend to discriminate against women and limit their choices, denying them career and lifestyle options available to men. (Ibid.)  
Gender based discrimination adversely affects women's quality of life and their chances of survival. As this thesis will make clear, discrimination against women in the era of AIDS has horrible consequences not only for women but also for the whole of society.

Gender-based division and discrimination carried out by male-dominated states has led to women's exclusion from the political process of “developing and implementing solutions to” the state's problems (Ibid., 384). Because men predominantly control political and social power, women's insights tend to be ignored and problems (such as the spread of HIV) tend to be defined and addressed exclusively in ways that men perceive them. I argue that women's lower status in many African societies is one of the main factors in the spread of HIV. I believe that women's exclusion from the political process is a major problem because no one can understand what makes women vulnerable to HIV more than women themselves. Clearly, “the more that societies exclude women from decision making and limit their opportunities, the less able are those societies to cope with the problems they face” (Ibid.). I will argue that this is particularly the case when it comes to the spread of HIV (Ibid.).

NGOs and state governments will have to adopt gender-based policies in order to check the spread of the disease, especially among vulnerable populations. A gender-based response to HIV and STDs is defined by the Royal Tropical Institute (KIT) as an approach that:

Focuses on how different social expectations, roles, status and economic power of men and women affect and are affected by the epidemic. It analyzes gender stereotypes and explores ways to reduce inequalities

between women and men so that a supportive environment can be created, enabling both to undertake prevention and cope better with the epidemic (KIT, 1995/1996).

In the midst of a killer epidemic can women's equality be achieved? Is it possible for states that are occupied with implementing policy regarding socio-economic malaise and the spread of an epidemic to utilize a gender-based, multi-sectoral approach that leads to women's empowerment (in the political realm and in the home)? I will argue that this type of approach is realistic and may help stabilize or decrease the spread of HIV.

The empowerment of women in the face of a killer epidemic *is* a realistic public policy alternative. In practical terms state governments, local governments, educators, NGO's and IGO's can address the discrepancies between men and women when it comes to social, economic and power relations. In Uganda, for example, a women's movement has gained more and more power since the late 1970's. Ugandan women have a long history of organizing (even if they were often co-opted or counteracted by repressive governments) and the policies of president Yoweri Museveni's National Resistance Movement make for an atmosphere that is conducive to the formation of women's groups and the empowerment of women (Tripp, 2000). As women's groups have gained a political voice and more autonomy the rate of HIV infections in Uganda has dropped significantly. I will research women's vulnerability and I will ask whether or not women's empowerment may better allow states to stifle the spread of HIV. I propose to conduct this research by taking two approaches.

## ***Methods***

First, I will examine the causes of women's vulnerability to the disease. I will discuss biological factors, problems with the education system, socio-economic factors, and women's overall lack of autonomy in the home and in public. For several reasons women are more susceptible to HIV. I will discuss this vulnerability in detail later in this chapter. Recent evidence suggests that a very few sub-Saharan African states have experienced success in stifling the spread of HIV/AIDS. Senegal and Uganda are the only two countries that have experienced any success in stopping the spread of the disease. In Senegal the HIV prevalence has never risen above 2%, and in Uganda the



prevalence rate has fallen over five percentage points in the past five years (UNAIDS, 1999). In most other southern African countries prevalence is increasing or continues to hover between 10-25% (UNDP, 1999). I will argue that these countries' inability to check the spread of HIV is largely attributable to the fact that women and men stand on unequal ground when it comes to income, education, sexual dynamic, and socio-economic status in general. Second, I will take a comparative approach in which I will contrast one state in sub-Saharan Africa that has achieved a degree of success in stopping the spread of HIV to a state that has been a relative failure in this regard. I will compare Uganda to Botswana. Uganda has recently been successful in its ability to check the spread of HIV. In the early 1990's:

HIV rates peaked at a staggering 14%...Now [Uganda] has nearly halved its HIV prevalence to around 8% by strong prevention measures...HIV infection rates among teenage girls dropped to 1.4% in 1996-1997, from 4.4% in 1989-1990. This was matched by a fall in teen pregnancies (UNAIDS 2000).

Studies have shown that the infection rate has also dropped among pregnant women in Uganda: "after peaking at 30% in 1992, HIV-infection rates for pregnant women at two clinics in Kampala fell to 15% in 1997" (Menaker, 1999). Conversely, Botswana has failed miserably in its efforts to stop the spread of the disease, especially among young women. According to UNAIDS:

Botswana's adult HIV prevalence at the end of 1999 was 35.8%, the highest in the world...Of infected adults, 54% were women. *Among females ages 15 to 24, the HIV prevalence rate ranged from 32.55 to 36.07%; for males in the comparable age group, the range was 13.68 to 18.00%* (UNAIDS, 2000, my emphasis).

The factors leading to vulnerability in each country may differ, but what is clear is that women are inordinately affected by these factors. Uganda's volatile recent history (1970-1986) led to conditions that made everyone more susceptible to HIV, but women were more adversely affected by this history than men. In Botswana the clash between traditional belief systems and modernity led to conditions of vulnerability for almost all Botswana, but again, women are inordinately affected by this clash.

I want to understand the discrepancies between success stories like Uganda and failures like Botswana. More specifically I will ask questions pertaining to the role of the

state governments, socio-economic factors, history, and culture in spreading or stopping the spread of the disease. I will ask whether culture and social mores have an impact on the spread of AIDS. It is quite possible that Botswana's HIV rate has increased because of other factors as well. I will discuss other factors such as mass migration, military deployments, and political turmoil that may have a role in the spread of the disease. But, most importantly, I will compare the role and status of women in Uganda to the role and status of women in Botswana. This will include an analysis of women's education, women's job opportunities and cultural and social expectations placed women. The post-colonial history of Uganda is extremely different than the post-colonial history of Botswana. Also, the countries' economies and politics are very dissimilar. Despite fundamental differences between Botswana and Uganda I will show that the many of the factors that make women vulnerable in each country are similar. I will also explain why a women's movement has gained momentum in Uganda but has failed to take root in Botswana. Ultimately, I hope to be able to answer the question of whether women's empowerment (or lack of empowerment) has anything to do with success or failure in controlling the epidemic.

Through this thesis I hope to make a significant contribution to the discourse on women and AIDS in sub-Saharan Africa. If women achieve some degree of power in the political apparatus of a state or community they have more control over resource allocation, education and women's legal rights. Thus they become less vulnerable and gain more control over their destiny. According to Aili Mari Tripp these trends can already be seen in Uganda (Tripp, 2000). Complete autonomy and equality for women in most African states is far from becoming a reality, but I suspect that in states where steps toward empowerment have been taken HIV-infection rates will decrease or at least stabilize.

### ***The Factors of Vulnerability***

In this portion of the chapter I will discuss sub-Saharan African women's biological and social vulnerability to HIV, and why women are so important when it comes to checking the spread of HIV. It is important to understand the reasons why

women are contracting HIV at a higher rate than men in sub-Saharan Africa. After exploring the reasons behind women's vulnerability to HIV it will become reasonably apparent that women need to reach a higher level of empowerment if the spread of AIDS is to be checked in southern Africa.

## **Biological Factors and Health Care**

The chance of becoming infected with HIV during unprotected vaginal intercourse is two to four times higher for women than men because females have a larger surface area exposed to their partners' sexual secretions. Also, semen that is infected with HIV contains a higher concentration of the virus than a woman's sexual secretions. Young women face an even greater biological risk because their cervix can be physiologically immature and they secrete less vaginal fluid. Thus, they put up less of a barrier to HIV infection. (UNAIDS 1997)

Tearing and bleeding of the vagina or anus during unprotected intercourse multiplies the chances of contracting STDs. Women in developing countries face a higher biological risk because they are more often the victims of "Rape, 'rough sex,' or prior genital mutilation (female "circumcision"), which multiplies the risk" of tearing or bleeding and of infection (Ibid.). Coercive sex facilitates the transmission of HIV, and is especially efficient in doing so when the violations are against young women or girls because the risk of extensive damage to the genital mucosa is high (Botswana Human Development Report, 2000: 29). Women also run a risk from unprotected anal intercourse ("sometimes preferred because it preserves virginity and avoids the risk of pregnancy") because it can easily tear delicate tissues allowing for the easy entry of the virus (UNAIDS 1997).

Untreated STDs in either partner also increases the risk that HIV will be spread during sexual intercourse. The risk of HIV transmission when either partner has an untreated STD may increase by up to 10-fold. This is especially troubling for women because their STDs very often go untreated. Because symptoms are not as easily recognized, they are often absent or hard to see, health care in many areas is often

ineffective at diagnosing or treating STDs, especially in women. Even when STDs are symptomatic they frequently go untreated. Often women in the developing world perceive their “ill health and especially ‘women’s troubles’ as their lot in life, and in general have poor access to appropriate health services” (Ibid.). Women who are monogamous may never suspect that they are at risk of contracting an STD from their partner, who may not be.

Studies conducted in both developed and developing countries have suggested that “factors – including gender and race...[can] influence quality of care” (Doyal 1995; Whiteford 1996; Cook 1994). STDs carry a heavy social stigma (less so for men), so women may avoid STD clinics out of fear that community members may recognize them. The health workers to whom women do have access, “in primary health or maternal and child health clinics, are often unsympathetic, judgmental, and unprepared to diagnose and treat STDs” (Cook, 1994; UNAIDS 1997). The prevalence of HIV/AIDS among African women may force medical scientists and technicians to reevaluate the field of medical research and health care with gender-based conceptions in mind. In other words, health workers and humanitarians need to understand that diseases and conditions often affect men and women differently: some are unique to women, some are more prevalent among women, some are more serious among women or among certain groups of women and risk factors may be different among women. There is still a real need for more specialized female health care around the world. Obviously in the poorest of states this need may not be addressed due to a lack of resources. Unfortunately, effective health care and medicines are too expensive for a majority of women *and* men in sub-Saharan Africa, and even newly constructed treatment centers in sub-Saharan Africa do not focus on women’s particular needs (Cook 1994).

Biological vulnerability can be counteracted by education about how the disease is spread, safer sex and abstinence. Unfortunately for many women in developing countries it is extremely difficult to act on their knowledge about how HIV is spread because they are not in a position where they can negotiate their sexuality with their male partners (i.e. they have no power to determine where, when or how they have sex and

their demands for safer sex may be ignored, or responded to with violence and/or rape). Programs that endorse safe sex, abstinence and fidelity through education are rendered ineffective if women have no personal autonomy. (Cook, 1994; UNAIDS, 1997)

## **Education**

Education serves a very important role in individual and public health. Those who are literate will have “easier access to health information since they read and understand about risks to their health and how to prevent them” (Cook 1994). Primary schools represent one of the most important HIV/AIDS prevention spots because a large number of students can be reached at an age before they develop the behavioral patterns that put them at risk of contracting AIDS (Inge, Biswalo, Talle, 1995: 134). In many African countries children who attend primary school may not necessarily go on to secondary school, so AIDS education in primary school also enables a larger percentage of young people to be reached (Ibid.; UNDP Education Statistics, 2000).

In the past sex education was not the responsibility of the education system in southern Africa: there existed more “traditional communities [that] exhibited a system of sexual socialization that emphasized the role of society rather than that of the individual” (Inge, Biswalo, Talle, 1995: 134; MacDonald, 1996: 1328). Through rituals, songs and initiation ceremonies young men and women socialized in a way that would make them conform to accepted community norms and deviations from these norms were not common. As a result of colonialism, socio-economic hardship, and urban migration, many traditional socialization systems have crumbled or become obsolete. However, with the demise of these sexual socialization systems it is not clear that African school systems are seriously taking on the responsibility of educating young people about sex and STDs. Discussing schools in the Arusha and Kilimanjaro regions of Tanzania, Ndeki, Klepp, Irema, Lyimo and Msuya claim that:

While initiation rites still exist in some societies, in general, the role of community elders in teaching young people about traditional family values and reproduction has become less important. At the same time, it seems evident that schools have not taken on education regarding family

life, reproduction, and prevention of sexually transmitted diseases to the extent that adequately prepares adolescents to safely navigate the AIDS epidemic (p. 135).

Even in schools where reproductive education is on the curricula the effects of the curricula are not clear. Will the students be more or less promiscuous? Will they still have unprotected sex? Will AIDS education change the student's present and/or future behavior?

In order to address the vacuum of AIDS education in the Arusha and Kilimanjaro regions the Tanzanian-Norwegian AIDS Project (MUTAN) formulated and implemented an HIV/AIDS education program for sixth and seventh graders in 18 schools (Ibid.). Based on surveys given to all students before and after the education program was implemented it is apparent that the program had a significant effect on male students: their attitudes toward people with AIDS changed, as did their attitude about engaging in sexual intercourse. The program did not have the same effect on young women, however:

Overall, girls reported stricter attitudes and less intention to be sexually active than did boys at both intervention and comparison (control group) schools. The lack of intervention results among girls points, however to the need for designing educational activities specifically addressing the needs of these young women (Ibid.).

These are just the results of one particular educational program and broad generalizations cannot be made based on this. The unfortunate reality in sub-Saharan Africa is that many young men and women are taught little or nothing about sex, the reproductive system, or the spread and prevention of sexually transmitted diseases (UNAIDS 1997). Increasingly states are pushing for AIDS education to appear on primary and secondary school curricula, but even in the few schools where these issues are on the curriculum, girls may never become informed because they are usually forced to end their education much earlier than boys. We can ascertain that women in Africa are generally at a disadvantage when it comes to advancing within academia. This disadvantage will lead to many women's socio-economic vulnerability and an increased susceptibility to HIV/AIDS for the rest of their lives.

**Fig. 1.1 Various UNDP statistics regarding women and education in Africa (1998).**

| Country (put in order of Human Development Index) | Female Literacy Rate (age 15 and above) | Literacy Rate as % of male rate | % of primary school age girls enrolled in primary school | As % of male ratio | % of secondary school age girls enrolled in secondary school | As % of male ratio | Female tertiary students per 100,000 women | As % of male ratio |
|---|---|---------------------------------|--|--------------------|--|--------------------|--|--------------------|
| Botswana  | 78.2                                    | 107                             | 82.6   | 106                | 91.3   | 106                | 545  | 87                 |
| Ghana   | 59.9                                    | 76                              | 41.8   | 93                 | NA   | NA                 | 53   | 27                 |
| Zimbabwe  | 82.9                                    | 90                              | 92.2   | 98                 | 56.3   | 91                 | 386  | 41                 |
| Cameroon  | 67.1                                    | 84                              | 59.1   | 92                 | 34.7   | 77                 | NA   | NA                 |
| Kenya   | 73.5                                    | 84                              | 66.6   | 105                | 57.4   | 89                 | 79   | 39                 |
| Congo   | 71.5                                    | 83                              | 75.8   | 94                 | 74.3   | 79                 | 192  | 22                 |
| Cote d'Ivoire                                     | 35.7                                    | 68                              | 50.3   | 76                 | 23.6   | 53                 | 263  | 31                 |
| Senegal   | 25.8                                    | 57                              | 53.6   | 82                 | 15.5   | 65                 | 140  | 32                 |
| Uganda  | 54.2                                    | 71                              | NA   | NA                 | NA   | NA                 | 118  | 49                 |
| Malawi  | 44.1                                    | 60                              | 99.7   | 102                | 53.9   | 59                 | 34   | 42                 |
| Mozambique  | 27.0                                    | 46                              | 34.3   | 76                 | 17.1   | 62                 | 19   | 31                 |
| Sub-Saharan Africa                                | 51.6                                    | 76                              | 51.8   | 85                 | 35.8   | NA                 | NA   | NA                 |

According to UNDP statistics only slightly more than half of girls primary school aged in sub-Saharan Africa are enrolled in primary school (see fig. 1.1). There is also a significant drop in the percentage of girls enrolled in secondary school. From these statistics we may surmise that compared to men not as many women are enrolled in primary school, and even less women are in enrolled in secondary school. Also the ratio of women to men enrolled in tertiary school (college) hovers around 30 – 40% in most African countries (Botswana is an exception). Currently there are 82 million more boys than girls enrolled in primary and secondary levels of education worldwide, and in developing countries, more than half of the women over the age of 25 have never been to school (Girls Global Education Program, 2000).

In Africa there are a few major reasons for why women are often forced to end their education much earlier than boys. Often familial obligations will fall on the shoulders of young women and these obligations may force young women to leave school in order to care for their families. Young women may have to tend to the health of sick family members and/or work for the socio-economic stability of the household. In many families (especially migrant families) it is imperative that all working age family members labor for the economic well being of the household. A woman who must strive in this type of family may not have the time, money, or energy to attend primary or secondary school. In studies on education in Kampala, Uganda only 15% of women aged 15 – 19 from migrant communities were attending school, compared to 41.7% and 43.1% of girls from market communities and permanent housing areas respectively (Wallman 1996: 68).

Perhaps the biggest reason young people are forced to end their education is its high cost. According to Sandra Wallman:

School fees are one of the most pressing financial demands on family budgets and a constant source of anxiety at all social levels. In general, if children...do not attend school it is because they or their families cannot afford the fees (1996).

This may affect poor men and women in similar ways, but among women high school fees may push them into transactional adolescent sex. Many girls in sub-Saharan Africa will have sex with wealthier men in order to gain gifts. These gifts may often come in the form of necessary financial support for schooling or training (Botswana Human Development Report, 2000: 27; Caldwell, Caldwell, Guiggen 1989: 204; UNAIDS, 1997). A 1980's study of girls' education in a small town in southern Ghana found that market work and transactional sexual relations were necessary to cope with exorbitant school fees (Akuffo 1987: 159-161).

Among girls over 15 years of age, 93 percent had boyfriends who were in employment and most said that they could not otherwise stay at school; one-third of them reported that their mothers had encouraged these relationships, saying they would have to learn to provide for themselves (Ibid).

Using transactional sex to gain financial incentives is a trend that often begins when many girls reach secondary school age. These types of relationships are risky because



women often do not trust their boyfriends and believe that several men may be necessary for financial stability (Caldwell, Caldwell, Guiggen 1989: 205, Pellow 1977: 210). Exorbitant school costs prevent many women from enrolling into secondary schools and the women who do enroll may compromise their health by engaging in risky transactional relationships.

By most standards the education systems around most of sub-Saharan Africa are not doing a good job of retaining and educating students. Deficiencies in education are leading to a bleak socio-economic outlook in many parts of Africa:

Since only a small percentage of those who complete primary school are able to continue on to secondary school, the majority of those who complete primary school find themselves in a situation of land scarcity and with few opportunities for employment outside the agricultural sector (Ndeki, Klepp, Irema, Lyimo and Msuya 1995: 135).

While the system is not working well for either young men or women it is clear that women have a tougher time staying in school. A larger percentage of men further their education, attending secondary and tertiary schools, thus they stand a much better chance of holding positions of authority (or at least of attaining financial stability). Because this inequality is made apparent at a young age when they are impressionable the discrepancy between boys' and girls' education may lead to a culture or reinforce a culture in which gender roles are inherently unequal.

In many societies, it is considered inappropriate for women to become educated on matters related to reproductive health or sexuality, while men are expected to have a great deal of knowledge concerning sexuality (UNAIDS 1997). This type of culture is not only reinforced by “formal authority systems [such as the education system] but also by religion, and by mindsets that are assumed to reflect the natural order of things” (Patterson 1996). This type of society is essentially a patriarchy because the construction of gender roles concentrates knowledge (and therefore social and political power) in the hands of men and perpetuates gender-based stereotypes (Mansbach, Rhodes, 2000: 384). Societies grounded in double standards have detrimental consequences which place a woman at risk of infection for her *entire life*: women are forced to become dependent on more educated and job-qualified males, they often leave decision-making initiative to

males and, for women who have very little or no education and are not married, prostitution may be the only way to earn a living.

## **Sexual Dynamics**

The frequency of non-marital sex in Africa appears to be very high by international standards (Caldwell, Caldwell, Guiggen 1989, Philipson, Posner 1995). The frequency of these relationships is often related to women's need for financial stability. As mentioned earlier, many young women rely on transactional sexual relations: they rely on the gifts of a man or a number of men in order to pay school fees and gain basic necessities. This puts women at great risk of contracting HIV as well as other STDs. According to research conducted in urban areas of Mozambique many women who work in the industrial sector were single mothers working in factories who did not earn a high enough wage to survive (Turshen 2000). In order to cope many of these women sought out various multi-partner transactional sexual arrangements. These arrangements are now tolerated even though they go against traditional Mozambican gender roles and social values. Because of socio-economic hardships norms and social expectations may be undergoing a transformation as households rearrange to accommodate new coping strategies (Ibid.).

According to an essay entitled, "Women and AIDS: UNAIDS Best Practice Collection Point of View":

...for girls and women in many cultures, sex is the "currency" in which they are expected to pay for life's opportunities, from a passing grade in school to a trading license or permission to cross a border...Lacking economic resources of their own, and fearful of abandonment or violence on the part of their male partners, [women] have little or no control over how or when they have sex and hence over their risk of becoming infected with HIV. *This is the meaning of vulnerability* (my emphasis). Survival through transactional sex exposes women to a double risk of contracting STDs as both their own and their partners' behavior increases the risk. If women are compelled to improve their lot by engaging in transactional sex they create an "economic dependence and moral engagement that forces [themselves] to surrender...completely" (Turshen 2000). Because of legal disadvantages and pervasive discrimination, the

African woman's bargaining power appears on balance to be very poor (Philipson, Posner 1995: 842). Many women feel they have no right to assert their needs or wants in situations where in which they are attempting to gain material wealth and in which society or culture deems a male partner's wants as paramount. In these relationships women are often forced into a position where they have no authority to request safe sex, fidelity or abstinence.

In urban settings men who engage in these transactional sexual relationships are not usually looking for wives or long-term relationships because they are often migrant workers that have left their spouses back home (Ibid.). Because many urban men are not looking for long-term relationships (but rather cheap and easy sex) and because there are restrictions on women's employment, an African woman's job opportunities may often be confined to sex work. This is especially dangerous because:

prostitutes have a much larger number of sexual partners on average than do promiscuous men...a small number of prostitutes can infect a large number of men even though the disease is more easily transmitted from men to women than vice versa (Ibid.).

It would seem that sex workers would insist on safe sex because they are much more likely to be exposed to HIV due to their large number of sexual partners. Prostitutes may have little incentive or power to protect themselves from HIV because they will often face violence or a loss of earnings if they demand condom use and many of them are already infected (or believe in all probability that they are infected), thus they perceive little benefit in requesting or demanding protected sex. When prostitutes have little power or incentive to adopt safer sexual practices, the responsibility of utilizing protection in the form of condoms will fall on their clients. Of course if these clients know (or believe) they are infected with HIV they too will see little incentive in using protection (Ibid. 843).

The male condom is the most effective type of protection from HIV, but many women in the developing world are not in the position to demand that their partner use a condom. Often a woman faces violence or abandonment if she requests that her partner use a condom. According to the testimony of a rural woman in Kenya:

I told my husband that it was better to use condoms, the doctor said so. The doctor had also given me some to use [at] home. My husband became very angry and asked who gave me permission to bring those condoms home (UNAIDS 1997).

Condoms are also incompatible with pregnancy, which leads to a major dilemma for couples that wish to raise families. UNAIDS is hoping to address these problems by creating HIV prevention devices that women can administer without the knowledge of a male partner. These methods would include female condoms, and vaginal microbicides that would kill viruses, but not sperm (Esu-Williams, 1997; UNAIDS, 1997).

For a variety of reasons, sexual networks are growing in southern Africa as well. The expansion of sexual networks is troublesome because it allows HIV to become more widespread. Because of urban migration (and other forms of migration attributed to economic reasons) and the movement of armies sexual networks are expanding. For example, the initial spread of HIV from Tanzania to Uganda can be attributed to the movement of the Tanzanian and Ugandan armies in the late 1970's and the rapid spread of HIV in Botswana can be attributed to Tswana cultural values that place a high value on social migration (MacDonald, 1996: 1230). Migration splits families apart. When men leave their villages to work in urban centers, or to fight a war in a neighboring country, they face ample opportunities to have sex with other women besides their wives or girlfriends left behind. Likewise, women left in villages have more opportunity to have sex with other men besides their husbands or boyfriends (Colclough & McCarthy, 1980: 175). Obviously this leads to disastrous consequences in the era of AIDS.

## **Conclusion**

HIV/AIDS is certainly a gender issue because women are now contracting the disease at a very rapid pace and women in many developing countries have little control over how or when they have sex (thus they have little control in protecting themselves). According to the UN, women must become politically empowered within their own communities and their voices must be heard in global governmental entities in order to

achieve any autonomy. The global governmental system is male dominated, but there is now a growing number of women's NGOs. There needs to be a change in the balance of power from a system of governance dominated by men, to a system that is more egalitarian. However,

negotiations leading to change in the balance of power must involve both women and men, and must be satisfactory to both, so that whole groups and whole communities may go forward together, in response to a shared need" (Patterson, p. 32).

Although these negotiations may seem impossible in places where a patriarchy has always existed, once a disease as debilitating as AIDS spreads through a society, many are left to reassess traditional values. As a result of overwhelming HIV outbreaks and the efforts of the UN and/or (women's) NGOs, this reassessment is starting to occur in some communities in sub-Saharan Africa. Recently it has become clear that policies formulated by women and for women are not very successful. As I will discuss in Chapter Three, women can make efforts to empower themselves but they must often make these efforts in male dominated state structures, so cooperation and compromise is essential. Feminist efforts to combat HIV/AIDS must incorporate the ideas of men as well. Efforts should also be made to help men understand that:

In the AIDS game there are no winners and losers, just losers...by protecting [women], they are protecting themselves (UNAIDS 1997).

The roles of men, and the impact these policies will have on men, need to be taken into account. According to Gillian Paterson, when performing a gender analysis of policy:

the crucial questions to be asked at every stage are: 'What about the women? Where are the women?' And maybe also: 'What will become of the men?'

This is always a crucial question when formulating policy meant to empower women. Many African Women's NGOs that deal with the spread of HIV have realized this. In 1998 these NGOs held a conference in which they sought to involve men in their efforts.

## *Chapter Two: Case Study of Uganda*

### **Introduction to Uganda Case Study:**

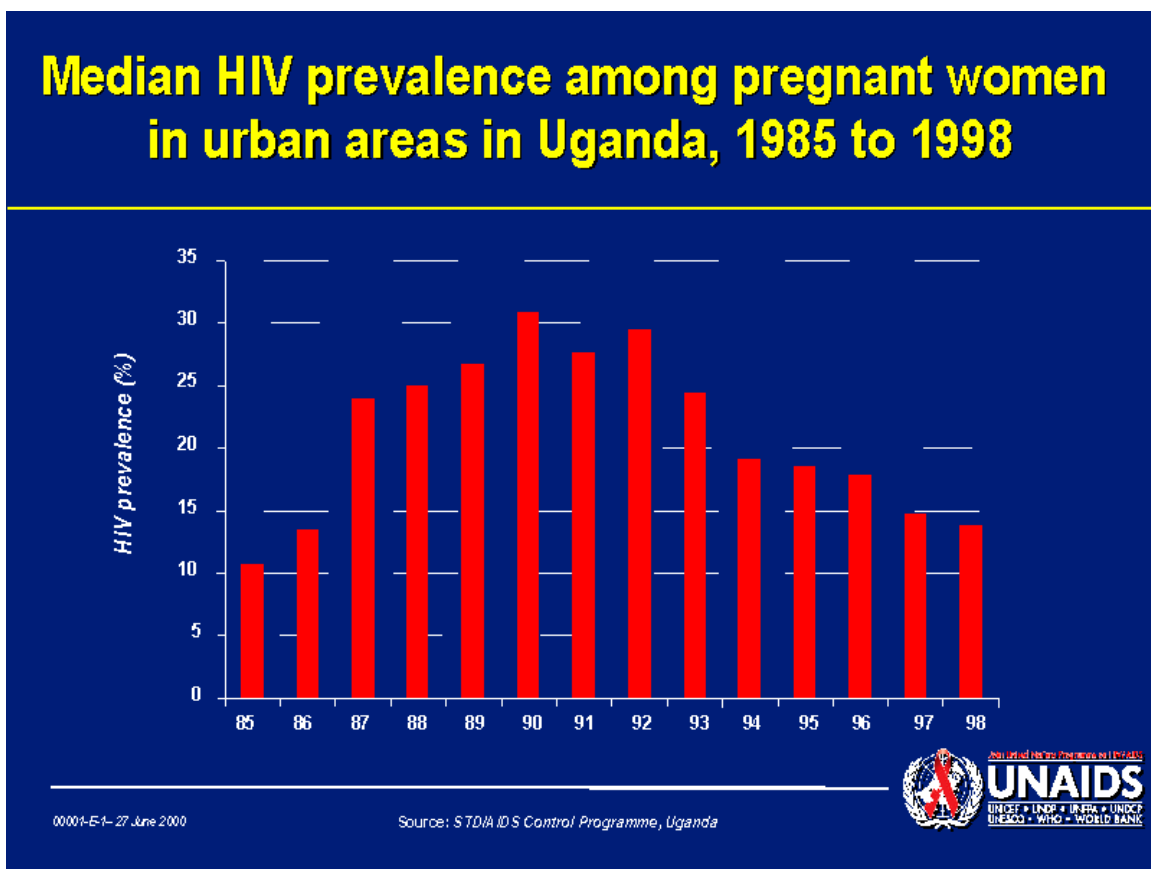
In the first part of this case study I will examine the history of Uganda that made the country vulnerable to HIV. I will discuss social, political, and economic factors that facilitated the spread of HIV/AIDS in Uganda. I will argue that the biggest facilitators of the spread of the disease were the breakdown of state social services and the oppressive regimes of Amin and Obote. These regimes left everyone vulnerable to disease; however, women became one of the most susceptible populations in terms of HIV due the legacy of these regimes. When examining the historical and political factors that made Uganda vulnerable to the spread of HIV, I will also pay close attention to the position of women within this political and historical framework. I will show that women's economic marginalization, the social expectations placed on women and women's roles during this era contributed to the spread of the disease.

HIV infection was first noted in Uganda in 1979 and it is one of the first countries in which HIV surfaced. According to local people in the Rakai district of Uganda, "AIDS is supposed to have made its way in to the lakeside communities in Rakai from Tanzania during the late 1970's and early 1980's" (Barnett & Blaikie 1992: 73). Uganda's national HIV prevalence rates peaked at 14% in the early 1990's, but in recent years it has become the first country in sub-Saharan Africa to decrease HIV prevalence rates (UNAIDS 2000: 1). In comparison to a country like Botswana in which 35.8% of the adult population is HIV positive, Uganda's peak rate of 14% may not seem very high. However, it is important to note that Uganda is more densely populated than many southern African countries. Uganda is a country of almost 23.5 million and although the adult HIV rate has now dropped to 8.3%, 770,000 adults are still living with HIV/AIDS. Botswana with a rate of 35.8% has 280,000 adults living with the virus (UNAIDS Epidemiological Fact Sheets for Uganda and Botswana: 2000 Update). Thus, directly or indirectly almost everyone in Uganda has been affected by HIV/AIDS.

The history of Uganda (especially the past twenty-five years) led to conditions that made everyone vulnerable to disease, but women were more adversely affected than men. Since the late 1970's when HIV first appeared in Africa women have been very vulnerable to the disease. This vulnerability can be linked to socio-economic factors and conditions shaped by Ugandan history. Even now as HIV prevalence rates decrease, 54.5% of the adults living with HIV/AIDS are women. However, there are signs of progress:

After peaking at 30 percent in 1992, HIV-infection rates for pregnant women at two clinics in...Kampala, fell to 15 percent in 1997 (Menaker 1999: 1; see Fig. 2.1).

**Fig. 2.1**



Among almost all populations within Uganda progress like this can be seen. Infection rates are falling all over the country among diverse groups of people. Rates in urban areas have fallen by 50% and reversals of up to 30% are being reported from the

countryside (Bhagat: 2000). Why has such progress occurred in almost all populations in Uganda? Ultimately this is the question I will answer in this case study. I will show that the two major factors influencing the decrease in HIV/AIDS rates in Uganda is a strong women's movement (vis-à-vis greater input into state policy making structures, the formation of grassroots organizations and greater autonomy from the state) and the relative stability and openness of the Museveni regime.

Uganda is a compelling country to examine in terms of AIDS research because it is an example of a country that has seen extremely high HIV/AIDS rates decline. It is also a country that was subjected to extreme economic and political hardship from 1971 to 1986, but is now enjoying some degree of freedom and stability. Through the 1960's and early 1970's the economy was slowly growing and rural and urban development schemes were proving successful. As of 1971 the country was a Third World success story in terms of public (particularly health) services. However, the brutal regimes of Idi Amin, Milton Obote II (Obote's second regime) and Tito Okello led to the downfall of public services, economic and political instability, and a loss of personal freedoms. I will argue that by 1979 Ugandan society was highly susceptible to HIV as a result of inept governance. This era (1971-1986) in Ugandan history is marked by "civil disruption, war, smuggling, [and] unequal access to economic resources" (Ibid.). This was an opportunistic time for such a disease as HIV to permeate Ugandan borders. Just as AIDS infects the body making it weak to fight off opportunistic illnesses, Uganda has been infected by a brutal and unstable governance which made it unable to avoid a host of social problems and the spread of disease. According to Barnett and Blaikie when discussing Uganda:

[the question is] less one of certain sexual behaviours being risky, but of all sexual behaviour being risky because the environment itself is one of high risk (1992: 68).

It is not just sexual behavior in Uganda during the 1970's and the early 1980's that can be characterized as risky; almost all aspects of life in Uganda during this era can be characterized as risky. Diseases spread, sanitary conditions were poor, the economy was in shambles, there was no social stability, and what compounded all of this was that



social services, particularly public health services, were devastated by ill advised policies of the Idi Amin regime and the second Milton Obote regime.

In recent years the state has become increasingly stable and has made progress both socially and economically. According to Aili Mari Tripp, the policies of Yoweri Museveni and his National Resistance Movement (NRM) may be responsible for this progress (Tripp 2000). More so than past administrations in Uganda, Museveni's regime has attempted to transcend tribal and party lines while taking a multi-sectoral approach to solving with the countries social ills. I also plan to examine the effect of the Museveni regime asking questions such as: What does his multi-sectoral approach entail? Has his regime led to an atmosphere conducive to women's empowerment? How has he dealt with the problem of HIV in Uganda?

### **Making Uganda Vulnerable to Disease: The Downfall of Health Services in the 1970's**

From the mid-1930's to 1970 central government showed its commitment to health services as it consistently allocated a minimum of 6.5% of the total recurrent and capital budget to health services (Dodge, Wiebe 1985: 27). Local government also shared this commitment as local government expenditures on health services raised 3.5% of their budget in 1947 to nearly 20% by 1970 (Ibid.). As a result of this commitment to health services Uganda's health system was the envy of many third world countries. By 1971 (the year Amin seized power) Uganda's health services delivery system had developed far beyond the level reached by other developing countries at an equivalent stage of economic development (Scheyer and Dunlop 1981: 31).

With a total of well over a hundred health units...dispersed all over the country, there was some form of medical center within a reasonable distance of every household, and the records showed that a rapidly increasing number of people actually did make use of these facilities. The basic health services were provided free to all. A number of once major scourges such as smallpox, sleeping sickness, meningitis, and certain venereal diseases had been reduced to only occasional incidence, while others such as tuberculosis, poliomyelitis, river blindness and leprosy were under control...these indicators pointed to considerably improved health conditions compared to those of a decade or so earlier (Ibid: 29).

This health care system was not very advanced, and it may be seen as somewhat primitive to westerners accustomed to the cutting edge in medical technology. But, by 1971 the Ugandan public health care system could at least guarantee everyone free basic health care. And although 75 to 80 percent of expenditures on health services in Uganda were directed toward curative as opposed to preventive services (Ibid.), most Ugandans had access to important vaccines.

At the time of the Amin coup in 1971 experienced teams of doctors, nurses and paramedical staff were employed in Ugandan clinics and hospitals. These health facilities had access to basic and essential medical supplies and could guarantee clients free or inexpensive treatments. Within three years of the coup Uganda's excellent medical infrastructure was in a steep decline (Ibid.; Kyemba, 1977: 129). Under the Amin regime the resources to which the health sector once had access contracted while the demands on the health system expanded. Experienced health manpower fled or were kicked out of the country, government revenue going towards the health sector stagnated (and in constant prices it decreased drastically), and health facilities deteriorated from neglect.

Amin dealt the biggest blow to the country and particularly the health and private sector when he expelled all Asians from Uganda in November 1972 (Scheyer and Dunlop 1981: 32; Tripp, 112; Barnett and Blaikie, 71-72). Asians living in Uganda made up a very large percentage of the professional and technical class, many were physicians, and they comprised an important segment of the economy. Prior to the Asian expulsion there had been approximately 1200 doctors in Uganda, and the pharmaceutical industry was almost entirely controlled by Asians (Williams 1985: 60). Not only did all of the Asians leave the country, but also many other expatriate professionals suspected of views antithetical to those of the regime were killed or left the country, as they saw economic conditions worsen and their personal freedoms become more limited. By 1973 almost half of all of the physicians had departed the country and only six registered pharmacists remained (Ibid.). This obviously led to serious problems in the health care delivery system. The regime appealed to other countries for help in staffing medical facilities, but

the meager amount of physicians and dentists sent by Egypt and Russia did not do much to remedy the situation (Scheyer and Dunlop, 1981).

In late 1974 Amin placed a ban on the private practice of medicine. This led to the departure of even more physicians and medical technicians. A tremendous strain was put on the health system since Ugandans could not go to private physicians; they had no other choice than to consult physicians in drastically understaffed government facilities. Several weeks later Amin lifted this ban on everyone except those who worked for the government, but the damage had already been done and all but a few of the Egyptian and Russian doctors had left (Ibid.).

At first, as medical facilities experienced a shortage in manpower they became inundated with patients. Between 1971 and 1973 the number of admissions in government hospitals increased 2.5 times (Rep. Of Uganda Ministry of Health). However, it seems Ugandans quickly lost faith in their once successful medical system: by 1975 the number of Ugandans visiting hospitals plummeted by nearly 50% and this was certainly not because the population had suddenly become healthy (Ibid.). It is difficult to gauge the health status of Ugandans during this medical crisis because so many stopped going to medical facilities, hence their ailments often went undiagnosed and untreated. However, from government and voluntary hospital data we can tell that case fatality rates for measles, tetanus, and pertussis all increased. Perhaps the biggest increase in fatalities was seen among measles patients. By 1981 25.6% of all deaths in these hospitals were attributed to measles patients, whereas in 1971 only 5.4% of deaths were attributed to measles patients (Alnwick, Stirling, Kyeyune, 1985: 82).

Not only did the infrastructure of the health system decline, but infrastructure in general was neglected during the Amin regime. Roads and transport facilities of all kinds deteriorated from 1973 onwards making it increasingly difficult for patients to travel to medical facilities (Williams 1985: 61). The deterioration of infrastructure also led to unsanitary conditions that made the bodies of many Ugandans more vulnerable water borne illnesses and more susceptible to HIV. When the body is inundated by less serious

illnesses, when one is forced to drink unsafe water and is malnourished the immune system is stressed and the body becomes more susceptible to more serious ailments (Haslwimmer, 1996: 4).

According to Scheyer and Dunlop, by late 1981:

The...delivery capacity of the Uganda health care system is roughly half of what it was at the beginning of the decade – equal to what it was in the early 1960's. Just as significant in this reduction of capacity and the shortage in trained manpower, however, is the drastic reduction in the fiscal and physical resources possessed by the system...The last decade has seen the real purchasing power of the health budget dwindle to nearly 6% of what it was in 1968-1969 (32).

The lack of trained workers and a deficiency of resources were the major causes of the downfall of the Ugandan health system. So in 1981 around the time HIV first appeared in Uganda, the health system was left totally unprepared for the burden of such a devastating disease. The shortcomings of the Ugandan health system as result of Amin's policies had severely weakened its effectiveness set the tone for the next two decades. Currently, access to all kinds of health services –particularly HIV/AIDS care – is limited for Ugandans because of a lack of trained staff and shortages of essential drugs and health facilities (Henry, 1999).

### **Ugandan Socio-Economics: The Structures of Vulnerability**

Socio-economic circumstances in Uganda, especially since the 1960's, have shaped certain population's vulnerability to HIV/AIDS. According to Barnett and Blaikie:

...we see that Ugandan society has had, and continues to have with it, certain social, political and economic cleavages – Buganda and non-Buganda, north and south, African and 'Asian', large rural farmers and agricultural labourers. As these divisions became more pronounced in the period for 1960 to 1986, so *they constituted structures of vulnerability within the social body: structures that could facilitate the spread of epidemic illness* (1992: 73, my italics).

One of the most significant social cleavages that can lead to vulnerability is the socio-economic discrepancy between men and women and this type of divergence is prevalent in Uganda. But, first it is important to understand the history of Uganda's social cleavages because it this history that eventually led to an economy characterized by high

risk and an environment risky to human survival.

The story of these social cleavages begins at the start of the colonial era when British colonizers sought to put trade and cotton ginning in the hands of Asian migrants, “who were seen as both a link between the British and the people of Uganda and also a barrier to the development of an indigenous Ugandan trading class” (Ibid. 70). Because Asians in Uganda were seen as foreign it was assumed that they would always be involved in the import-export business and less concerned with the development of the country. By the late 1930’s the British colonizers essentially handed Asians control over cotton-ginning, trade and commerce and the Ugandan economic elite consisted primarily of Asians from that time until the Amin coup in 1971. This led to a rift between African peasants/landowners, and the Asian commercial sector and the Buganda government. The Baganda are the largest ethnic group in Uganda and have historically held more political clout and have controlled more resources than other indigenous ethnic groups. In the Ugandan context and more generally, ethnic differences alone do not result in conflict. However, if power and privilege coincide along ethnic lines then conflict is almost inevitable (Horowitz, 1985; Tripp, 2000:126). Since the 1940’s this type of tension has been evident in Uganda as political opposition against Asians and the Buganda-led government turned into violent riots, destruction of property and boycotts of Asian produced goods (Barnett, Blaikie, 1992: 71).

Tensions between Asians and non-Asians, Baganda and non-Baganda were made worse by Uganda’s deteriorating economic circumstances in the late 1960’s. The international prices of Uganda’s two main exports -- cotton and coffee -- rapidly decreased. Facing domestic ethnic tension, and a faltering economy President Milton Obote (his first regime) felt compelled to take fast decisive action (Barnett, Blaikie 1992, Mamdani, 1975: 48). The state took a turn toward more socialist policies. Banks became subject to a plethora of new regulations, and there was a wave of nationalization of banks and other once private industries. The state also granted citizenship to the elite Asian commercial class, and made it clear that the governing bureaucracy preferred an Asian as opposed to an indigenous petty bourgeoisie because the Africans presented a political

threat while the Asians did not (Ibid.). As evidenced by several failed coup attempts in the mid to late 1960's, these political actions were not popular among a majority of Ugandans. However the country did appear to be progressing. Although this era in Ugandan history is marked by political clientelism and social tension, the health care delivery system was the envy of the developing world and there were numerous infrastructural improvements. The rate of growth of Uganda's GDP was 4.8% per year during 1966-1970 (Scheyer, Dunlop 26). Compared to other sub-Saharan African countries in the postcolonial era Uganda appeared to have a stable, growing economy that was becoming increasingly diversified.

All progress within Uganda came to a halt in 1971 when a coup attempt finally proved successful and Idi Amin assumed power. Under the Amin regime Obote's political and economic agenda was abandoned. It is the terror and economic mismanagement of the Amin era that led to Uganda becoming a high-risk society. The *magendo* (black market) economy that arose under Amin was perhaps the biggest contributor to the endangerment of Ugandan society. Barnett and Blaikie describe the *magendo* economy thus:

...[an] understanding [of] the creation of a high-risk area...lies in the creation of the *magendo* (literally the 'pilgrimage of greed') economy. In addition of the expulsion of the Asians and thus the destruction of established systems of distribution, Amin's economic policies froze agricultural prices and drew large quantities of cash crops into the black market...This was of particular importance in Buganda which supplied much of the food needs of the major towns of Kampala and Jinja. In addition, the *mafutamingi* (literally 'fat ones' – the operators in the illicit economy) also began to move into transport. The essence of the *magendo* economy was the smuggling of coffee, paraffin, sugar and gold out of the country, vehicle spares and other necessities into the country and food within the country (72).

In order to survive within an economy such as this, one had to operate within the black market to gain access to necessities such as food because most people's regular wages could only buy a fraction of their most basic consumption needs. Between 1970 and 1974 GDP per capita declined an average of 2.7% annually. Real investment fell sharply, "inflation surged and production decline[d]...in the modern [industrial] sector, as imports decreased". (Scheyer, Dunlop, 29) It is also important to note that the population still

continued to grow during these difficult times. Men and women needed to find a way to support their families. It is in these types of conditions that the crime rate increases and many disadvantaged women are forced into risky transactional sexual relations or even prostitution.

This is also an era that is characterized by increased travel. The transporters (or *mafutamingi*) carrying goods on basic supply routes that started in Mombasa, went through Nairobi and into Uganda. These transporters also moved through Sudan, Rwanda, Burundi and Zaire (Southall, 1980: 627). Truck drivers were often delayed for hours or days (roads in sub-Saharan Africa are not always passable for a variety of reasons) and they would often spend these hours drinking in bars, eating in hotels, and sleeping in the brothels that lined these trade routes (Ibid.). Before the era of AIDS, this behavior may not have been as risky, but by 1978-1979 these transporters began fueling something much more menacing than the black market economy. But it was not just truck drivers and *mafutamingi* that led to an increase in travel. Many Ugandans had to cross state borders in order to acquire basic necessities. This travel was risky because Amin imposed many roadblocks and patrolled Lake Victoria. There was also an increased health risk as more Ugandans traversed borders because sexual networks expanded.

While Idi Amin may have addressed economic and social discrepancies between Asians and non-Asians by simply expelling all Asians from Uganda, it is clear that other social cleavages were created or became worse during his regime. The socio-economic discrepancy between Ugandan men and women became much more apparent during this era. The origins of inequality between men and women “lie both in pre-colonial society and in the ways in which colonialism affected that society” (Barnett and Blaikie, 75). Throughout Ugandan history it was generally expected that the women’s role was to provide carbohydrates and vegetables for the household through farm work (usually subsistence farming). It was the man’s role to provide protein and consumer goods through cash crop sales and other market activities (Ibid.). However, men and women differ in their access to resources. The Amin era can be characterized as one in which

both men and women were adversely affected by landlessness, however landlessness most adversely affected women. Women have never really been able to own land in Uganda and when they did it was usually through inheritance, but “it remains the case from pre-colonial times that most women have only use-rights obtained through their relationship with a man” (Ibid.).

Because it is traditionally accepted that women’s work involves food crops and the domestic sphere whereas men are more concerned with market transactions, it follows that if men were to experience a sizable increase in income the relationship between men and women would be drastically altered. Women’s economic insecurity would increase, as would their dependence on men for resources and consumer goods. These particular circumstances did indeed arise as a result of the *magendo* economy. While per capita GDP did significantly decrease during this time, women were inordinately affected. It was almost exclusively men who were actively involved in the black market economy. During the Amin period, according to Barnett and Blaikie:

...the existence of illicit economic activity...had a serious destabilizing effect on the already unequal balance between men and women. Those men who participated in the trade were in receipt of grossly inflated incomes. Their purchasing power grew greatly as compared to that of women who remained locked into the economic circuit of the village economy...Women’s landlessness...meant that they could not share directly in the economic boom, particularly as the main cash crop, coffee, remained largely in men’s hands. One of the few ways in which they could gain access to the new cash and goods appearing in the system was through sexual relationships (77).

Women reacted to these economic conditions in numerous ways. Many became prostitutes and others entered relationships with one or a few visiting men who granted them favors that assisted women with their household requirements and others entered marriages. Whether explicit or not the core of these relationships was one of economics. Because women had unequal access to economic resources they utilized what few other resources they had (i.e. their sexuality and their reproductive potential) to gain material necessities. As explained in chapter one, these types of transactional relationships become extremely risky in the era of AIDS. (Ibid.)



The one “bargaining chip” that many women had in this situation was their sexuality and reproductive potential. Traditionally, an African woman’s “status depended on her ability to influence the size and strength of her family” (Microcredit 1999: 5). However, a woman’s ability to fulfill this expectation was undermined by a failing health infrastructure. The downfall of the public health system under Amin disproportionately affected women. In Uganda during the 1970’s and 1980’s women could not ensure their reproductive health, they could not always have their children immunized, and when her or anyone else in the family got sick treatment was not always available. Because of a woman’s inability to ensure her reproductive potential she loses her one “bargaining chip.” Because of her inability to secure a sizable and healthy family her status is weakened.

## **Civil Unrest**

Above I briefly discussed social cleavages that have historically been found within Uganda: Asian vs. non-Asian, Baganda vs. non-Baganda, the north vs. the more prosperous south. The foundations for these cleavages are usually economic in nature and can often lead to social unrest. In the past three decades Uganda has been a state plagued with armed conflict and civil war. Amin gained power through a coup backed by his northern supporters. His regime was one marked by institutional violence. If Amin’s political enemies or economic competition was not driven out of the country, they were taken prisoner or killed off. It is estimated that he ordered the torture and execution of 500,000 Ugandans, about 3% of the population, during his eight-year reign (Garrett, 2000: 1). Amin’s reign of terror did much to compromise the state’s public health services and this may have left Uganda in a vulnerable position once AIDS began to spread in 1979. But, it was the full-scale warfare of the late 1970’s and 1986 that may have had the biggest direct effect on the spread of HIV.

The Liberation War of 1979 and the skirmishes that led up to it may have been the most pivotal moment in the modern history of Uganda for two reasons: it put an end to the inept Amin regime, and it exposed the country to HIV. In this conflict invading exiles with the assistance of the Tanzanian army defeated Amin’s troops and ousted him

from power (Barnett and Blaikie, 81). What made this particular conflict extremely dangerous from a health standpoint is the combination of an invading army moving through the area from the Tanzanian border, together with fatalities among local men. These are prime conditions for the spread of disease and particularly for the spread of sexually transmitted diseases because times of conflict are often times of decreased sexual control (Ibid.; Enloe, 1993). Numerous informants reporting on this conflict discuss how soldiers often robbed and killed local men and raped local women. Tanzanians were raping Ugandans, but there is also evidence that suggests that NRM soldiers were raping fellow Ugandans.

In Uganda [after]...its long civil war, women made rape by both sides a political issue, refusing to write it off as merely a natural element of warfare...The National Resistance Movement, though publicly committed to human rights reforms, had neither charged nor punished NRM soldiers who had committed more than a dozen rapes during routine security checks...(Enloe, 1993: 283)

This failure to prosecute rapists is still prevalent in Uganda today as I will argue below.

Even after Amin was ousted from power certain factions within the his army continued their devastation. In October of 1980 Acholi members of the army invaded the West Nile to gain revenge on the Lugbara, Kawa and Madi tribes for being associates of Amin, who is a Kakwa (Gurr, 1994; Horowitz, 1985; Williams 1985: 63). This invasion is marked by a period of unrestrained slaughter, rape, and looting. Infrastructure was left in ruins as a result of the conflict. All of the hospitals in Arua were destroyed, as were many health facilities around the country. A large number of Lugbaras, Kakwas and Madis fled the country for Sudan or the former Zaire further expanding sexual networks (Ibid.).

By the time this conflict had ended Uganda had replaced one repressive ruler for another as the militarist Milton Obote ascended to power for a second time. Obote's second regime would last from 1980 until September of 1985 when Tito Okello seized power in a coup. The 1979 Liberation War had no positive legacy: the state remained authoritarian, the country's already faltering infrastructure was left in shambles, and there was increased ethnic tension. This war was also devastating to the overall health of

Uganda. A health infrastructure, already in decline was, in many areas, left in ruins. Numerous (probably several thousand) women had been raped by members of the Tanzanian army, and Tanzania was one of the first countries to report HIV cases in the late 1970's. Migrations like the one led by several ethnic groups from the West Nile, further compromised the health of the entire continent because sexual networks expanded from being just local, to being transnational. 100,000's of young Ugandan men died during this conflict, which placed an even greater burden on poor, landless Ugandan women and their families.

The movement of armies throughout the country expanded sexual networks and spread HIV. As noted earlier, times of warfare are often times characterized by decreased sexual control. We see an increase in the incidence of rape in these times. Men are killed off and/or robbed, and women are often raped and/or robbed when armies sweep through an area. There was an increase in brutality, and particularly sexual brutality, during the Amin period. For example, Amin directed much of his cruelty toward the Baganda people of the Rakai District. For three years Amin's soldiers occupied the district, exacting tributes in the form of sex with village women (Garrett, 2000: 1). In late October of 1978 Amin's army invaded and seized Tanzania's Kagera District.

Six months later, the Tanzanian army reclaimed Kagera...upon seeing the destruction, rape and brutality Amin's soldiers had exacted upon their fellow countrymen, descended upon hapless Rakai with a vengeance. 'They stayed there a very long time,' Serapio Semanda, age 75, recalls in Kibumba village in Rakai. 'They were just brutal, taking the women, roaming like vagabonds.' Amin retreated to Kampala, recalls attorney Sophia Mukasa-Monico [subsequently Mukaso-Monico became the Executive Director of The AIDS Support Organization (TASO) and recently she was hired by The International Council of AIDS Service Organizations (ICASO) to be its Vaccine Policy Coordinator], who was then a student at Makerere University. Even then, according to Mukasa-Monico, Amin said, 'There is a very, very bad disease that is passed by sex and it is from Tanzania. It is venereal and it is incurable' (Ibid.). Clearly this disease was not just spreading among Tanzanian soldiers. Soon after Museveni's ascension to power in 1986 word came from Cuba that an astounding number of his soldiers that arrived there for training were HIV-positive (Ibid., Menaker, 1999).

By the 1979 War of Liberation and the 1986 conflict to topple Okello, many of the Ugandan and Tanzanian soldiers traversing Uganda were HIV positive and they were having their way with large numbers of women.

Internal violence and civil war did not cease as a result of Obote second ascension to power nor did it stop after Obote government was toppled by Tito Okello's coup. With the exception of northern Uganda, the country was still in an era of instability. Through the early 1980's armed guerilla movements aimed at defeating Milton Obote were common in Uganda. Finally, in 1986, Yoweri Museveni, at the head of an armed movement, the National Resistance Army, defeated and expelled Okello and took office as president (Barnett and Blaikie, 73). Fifteen years of conflict left over 800,000 people dead, 200,000 exiled and millions displaced within the country (Watson, 1988: 14).

Out of these crises two positive trends emerged: Uganda achieved some stability due to the new Museveni regime, and "new spaces for associational life emerged" (Tripp, 108). The Museveni regime has undoubtedly established a higher level of civil and political order than was the case during the preceding two decades. There is no doubt, however, that Uganda remains a troubled society. There still exists ethnic tension and up into the early 1990's there were ambushes on government soldiers and the civilian population and hundreds of thousands of Ugandans were living in camps for the displaced, population displacement and food insecurity are also problems (Barnett and Blaikie, 73). Yoweri Museveni's National Resistance Army remains active and often repels guerilla forces and other invading armies. These crises also paved the way for "associational life", and particularly for the emergence of a strong women's movement, because the fall of state services led groups of Ugandans (particularly women) to fill in where the state had failed.

The years of ceaseless conflict in Uganda also thrust women into new roles and situations that laid the foundation for a women's movement years later.

Rural women found themselves talking to Tanzanian soldiers, harboring and feeding soldiers, and hiding their weapons in their homes during the war in which Tanzania helped the Ugandans oust Amin...In the cities,

husbands sometimes taught their wives to drive and how to run their businesses in the event that they themselves might have to disappear into the bush (Tripp, 110).

The National Resistance Army (the group responsible for ousting Okello in 1986) also affected the way in which women were perceived. At the beginning of the conflict women were assigned transporting jobs, and they also treated casualties. By the end of the war women were on the front fighting alongside men. Some women had risen through the ranks of the military and were giving orders to large numbers of male troops.

The sight of women carrying both a gun and a baby on their back left an indelible impression on many. Women soldiers were impressed by the fact that women were treated the same as men in the NRA, which was markedly different from their experience with previous armies. Many women soldiers found the army a refuge from the problems they encountered at home including poverty and oppressive husbands (Ibid.). The new roles experienced by women in the NRA may not have had a direct impact on their ability to organize a women's movement, but it did have a psychological effect on both men and women because it changed perceptions of women's capabilities and positions in society.

## **The Expansion of Sexual Networks**

The expansion of sexual networks during the 1970's-1980's also made women much more vulnerable to HIV. Of course, the expansion of sexual networks made everyone more vulnerable. But, women were more susceptible because they did not have much decision making power. Men could choose whether or not to have safer sex, whether or not to rape, whether or not to sleep with a prostitute, but often women were in no position to make decisions regarding their sexuality and welfare. Several factors can be attributed to the expansion of sexual networks: expansion of trade routes, the movement of armies through the state, and internal urban migration. As mentioned above, trade routes expanded throughout central and southern Africa and many truckers would stop at brothels and bars that lined many of these routes (Southall, 1980: 627). These truckers were quite likely the first major vectors of HIV transmission in Uganda. The HIV rate among sex workers is alarmingly high and it is likely that trade routes were among the first "hot spots" of HIV transmission. In rural Uganda the HIV prevalence

rate among sex workers was measured at 65.9% in 1997 (UNAIDS Epidemiological Fact Sheet: Uganda, 2000) and most of the areas trade routes cross through are now facing significant AIDS problems. Undoubtedly some of these truckers brought back the HIV virus to their unsuspecting wives or significant others. The expansion of trade routes and the movement of armies through Uganda in the 1970's and early 1980's were the most important initial factors in the spread HIV.

From the mid-1980's as Uganda has become increasingly urbanized, one of the most damaging trends is the pattern of migration that has developed. As men leave rural communities to seek employment in urban centers such as Kampala or Tororo, social relationships and familial ties are weakened and new sexual networks are formed (Microcredit: 2000, Hunt: 1989). These men may find themselves exposed to a variety of STDs. STD rates are significantly higher in urban areas of Uganda than in rural areas (See fig. 2.2).

**Fig. 2.2: STD Prevalence Among Young Ugandan Women (UNAIDS Epidemiological Fact Sheet: Uganda, 2000)**

| Year | Area  | Age   | STD Rate | N= |
|------|-------|-------|----------|----|
| 1997 | Rural | 15-24 | 2.0%     | NA |
| 1997 | Urban | 15-24 | 15.0%    | NA |

**Note: Data on young men was not available.**

However, it is not just men that are affected by these migration patterns. Studies have shown that as men move home to the countryside, “they often return with the HIV virus and infect their wives who are usually unaware of their husband’s urban infidelity” (Microcredit: 2000; Tlou, Norr, McElmurry: 1995). In these situations women are often not in position to request safer sex. A woman with such a request is often viewed as promiscuous, and safer sex limits reproductive prospects. According to a member of National Association of Women Living with AIDS (NAWLA) a Ugandan NGO:

The Disease has effected everybody – babies, adolescents, young women and even grandmothers who are victims of their husbands’ indiscriminate sexual activities...What is the difference between a woman forced into prostitution being denied protection against STD/HIV infection by her client and a wife confronted by the same problem by her husband? In both

cases the spread of HIV is fuelled and tragically, both could have been prevented. Mutual caring between the sexes is very important to combat the infection (Bhagat, 2).

## **Education**

Universally, education is extremely important because (among other things) it lays the foundation for future socio-economic advancement. People who are educated in Uganda tend to be in a much better economic position than those who are not (Tripp, 1999). Education also allows people to become more financially independent. This is extremely important in the era of AIDS in Africa because many women must frequently rely upon a richer man (or men) to gain necessities and these relationships are often transactional sexual relationships. Education is also important because primary and secondary schools provide a forum in which health and sexual education can be provided.

Up to 1974, the Ugandan educational curriculum was very much influenced by the British system for most subjects. The efficacy of the Ugandan educational system was comparable or better than the systems in place in many other developing countries at that time. However, all sectors within Uganda suffered major set backs as a result of the policies of the Amin regime and the educational system and the health sector were no exceptions. The Amin government, in 1975, proposed a new curriculum. At first, local publishing companies were able to produce textbooks and materials for the new curriculum, but continued violence and instability of the late 1970's and early 1980's destroyed local publishing and exam scores dropped significantly (Byrnes, 1992: 68). The civil strife from the early 1970s until 1986 severely damaged the country's education system, but the education system was able to survive the political turmoil by using local and regional-based administrations supported by a national school inspectorate and standardized, nationwide examinations. The education system suffered from destruction of buildings and materials. Schools closed, teachers were killed or drafted into the army or rebel groups, and pupils stayed away or fought as child soldiers. The education system was also adversely effected by the expulsion of Asians and also because many teachers fled the country. Improvements in the late 1980s have led to an overall literacy rate of

61.8% which is still low even by sub-Saharan African standards (UNESCO, 1995 estimate).

The socio-political strife of the Amin period hurt everyone, but it was particularly damaging to young people. The economic circumstances of the era forced many families to pull their children out of school so that they could supplement the family income, assist in agriculture, or care for the family. Often it was young women that were expected to fulfill these roles. But even young men were pulled out of school for this reason or to fight in the many conflicts of that time. These trends obviously effected school attendance throughout 1970-1986 (see fig. 2.3).

**Fig. 2.3: School Enrollment in Uganda (Byrnes, 68)**

| Educational Level | 1970    | 1985      | 1989      |
|-------------------|---------|-----------|-----------|
| Primary           | 727,000 | 2,117,000 | 2,532,000 |
| Secondary         | 37,000  | 160,000   | 265,000   |

School attendance did increase throughout these years but the increase in attendance failed to keep up with the remarkable growth of the population of young people. In 1991 roughly 50% of the entire Ugandan population (which at that point was 17.6 million) were in the 0 – 15 age group (Ugandan Census: 1991). This suggests that there are many young Ugandans that have a much more difficult time achieving financial stability. There is also a likelihood that many young Ugandans are not educated about HIV, how it is spread and how to avoid contracting it.

### **State Co-optation of the Women’s Movement (1971-1985)**

Most women felt that the Amin era was particularly oppressive. Besides Amin’s economic policies that made life considerably more difficult for women, he enacted some laws aimed directly at women. Early in his rule he banned women from wearing wigs, miniskirts, pants, and from using perfumes or deodorants (Tripp, 49). Amin attempted to impose a stilted sense of morality on the country. One of the major parts of this crusade



was his initiative to clear all streets of unmarried women and his military officers tried to force single Ugandan women to marry. Amin also supported institutionalized rape:

Amin encouraged his Muslim officers to rape Christian girls with the intention of impregnating them. Moreover, it was not uncommon for military personnel to organize collections of girls from the university, high schools, training centers and hospitals for the 'entertainment' of Amin's men (Ibid.).

These are just a few of the types of policies that Amin enacted or supported during his rule. Obviously these policies were degrading to women's psychological and mental wellbeing, but perhaps the most damaging of all of Amin's actions was his attempts to abolish independent women's organizations and to co-opt the women's movement.

Amin decreed the abolishment of all independent women's organizations and attempted to formulate a national administrative agency that would unite all women and women's organizations. Women's groups led by the Uganda Association of Women's Organizations requested that Amin leave independent groups alone and that he concentrate on ways to allow women to participate in government. The objections of women's groups were disregarded. In 1978 Amin abolished all independent women's organizations and established the National Council of Women (NCW). The NCW was a state apparatus not accountable to its constituency, but to the "Ministry of Community Affairs, which controlled its staff and budget" (Tripp, 50). Independent groups either dissolved for good, remained dormant for years, or operated underground. Thus the only chances most women had for associational life was through the state, and this often allowed the state to determine the goals and the bounds of the women's movement.

The NCW and the ban on autonomous women's groups still existed after Amin was ousted. In the early days of the Obote II regime the NCW did experience increased decision-making power. However, as Obote became more organized he began trying to use the NCW as a Uganda People's Congress (UPC) organ. Women UPC members tried to dictate the actions of the NCW. UPC meddling in the affairs of the NCW led to a major turning point in the women's movement in Uganda. The UPC handpicked the NCW delegation to the 1980 UN conference for women and the 1985 Nairobi Conference. The women who were originally representing Uganda at the UN conference

had a disagreement with Vice-President and UPC member, Paulo Mwanga, and were promptly dismissed and replaced. For the Nairobi conference NCW members attempted to raise funds in order to attend, but the UPC stopped them and selected its own delegation for the conferences (Ibid.). According to Aili Mari Tripp, these two abuses of power by the UPC led to the formation of an autonomous women's movement. The women's movement within state government was not so much organized around particular issues, rather it arose because women realized that autonomy was an absolute necessity. Women understood that very little could be accomplished if the state dictated and co-opted all of their actions. A real, effective women's movement would have to be free from state and partisan interference. (Ibid.)

Shortly following Tito Okello's September 1985 coup, the NCW organized a large demonstration in the "streets of Kampala for peace and against the mistreatment of women by the military" (Tripp: 51; Ankrah:15). During the short Okello regime kidnappings and rape carried out by the military was on the rise. There was also an increase in factional fighting. The NCW demonstration of over 2000 women was significant for two reasons: it was the only organized peace march of that era and the NCW was openly demonstrating against some of the state's actions. According to Tripp:

They had made a bid for autonomy by asserting their opposition to the regime. Their action laid the basis for the emergence of a truly autonomous women's movement after 1986 (51).

By the time Museveni gained power in Uganda, the foundations for a strong women's movement had been laid.

The chaos and brutality of the Amin, Obote II, and Okello regimes left the country extremely vulnerable to a host of diseases. The damaging trends of the 1970's and early 1980's are slowly being reversed in Uganda today. In regard to the spread of HIV, Uganda is truly a victim of its political history. War, migrations, and the decline of infrastructure, all played integral roles in perpetuating the spread of HIV. Given Uganda's destructive history some may wonder if it was the marginalization of women in Ugandan society that made the country so vulnerable to AIDS, or whether Uganda's susceptibility is just a product of a tumultuous political history. I have just discussed how

post-colonial Ugandan history made the state vulnerable: Amin ran the country's infrastructure in to the ground, socio-economic cleavages led to conflict, urban and military migration, the *magendo* economy. Couldn't it be argued that it was this history that made the state susceptible to disease? Of course this history played a large part in the story of AIDS in Uganda, but did women's marginalization play a significant role in that history? Did certain aspects of Uganda's history exacerbate socio-economic discrepancies between men and women? Truly Uganda's political and economic history is indelibly tied to the place of women within society and the treatment of women during this time period allowed for more opportunities for the spread of HIV.

When Museveni seized power in 1986 he inherited a country left in shambles from the policies of prior Ugandan leaders. He took control of a country in which the HIV prevalence rate was above 14%. In 1986 shortly after women came to the realization that they needed to organize in a way that was free from state influence, they obviously faced these same problems. I will show that from 1986 Museveni and the women's movement (in the form of women's ability to influence state decisions, and the rise of grassroots organizations) were the two most pivotal political actors in the fight against the spread of HIV in Uganda. Both political actors worked together and dealt directly with the country's problems. It is because of these actors that the HIV prevalence rate in Uganda has fallen dramatically.

In the second part of this case study I will discuss how in recent years there has arisen a vibrant feminist movement within Uganda and women are becoming more financially independent. I will argue that increased power for women has led to the decrease in women's vulnerability to HIV, and a decrease in the whole country's HIV rate.

## **Chapter Three: The Ugandan Women's Movement and the Decrease of HIV Prevalence Rates**

The women's movement in Uganda began to gather force in 1985-1986, before HIV prevalence rates had hit their zenith. Most of the small women's groups that made up this movement did not deal directly with the spread of HIV. Most groups were established out of economic necessity. While the women's movement did not initially attempt to fight women's vulnerability to the disease, the actions women's groups did take (such as helping women become financially independent and fighting discriminatory laws) counteracted women's susceptibility indirectly. The biggest hurdle the women's movement faced in the mid-1980's was to establish autonomy from the government.

Above I discussed the ways in which party politics and rulers like Amin, Obote and Okello attempted to co-opt and compromise the decision making power of the only state recognized women's association (the NCW). In the Ugandan context it was very important for women to gain some level of empowerment if the state was going to be successful in fighting the spread of HIV. However, if women's associations are used as a tool for political parties to expand dominance we can expect a truly feminist agenda to be swept aside, or at least it will be forced to make numerous concessions. In a speech concerning a proposal for a Women's Day in Uganda President Obote "blasted women as mothers of the rebels in the bush, i.e., Museveni's National Resistance Army, which at the time was mounting a guerilla war against the Obote government" (Tripp, 51). In 1985 at a peace seminar organized by a number of women's associations the commander of the army, General Basilio Okello told "women that they deserved to be raped" (Ibid, 52). When government elites such as the president and the leader of the military harbor these types of opinions how could it be expected that any nationalized or semi-nationalized women's associations could achieve some level of empowerment?

When Museveni seized power in 1986 he had two immediate challenges: he had to rebuild institutions of sound governance and he had to unite a country that was sharply

divided along ethnic lines. By the time of his takeover women's groups had begun to network internationally and some women's groups like Action for Development (ACFODE) had begun mobilizing before the NRM takeover. When the NRM came to power it was preoccupied with its immediate goals and it did not have a clear policy regarding women's groups or NGOs. Women's groups asserted themselves as soon as Museveni came to power and because of the lack of a clear policy toward these groups they were able to shape the NRM agenda regarding women's groups (Ibid. 69). Eventually Museveni eventually began to see that he could promote some of his own goals through women's organizations. Unlike previous regimes that sought to stifle women's organizations because they were perceived as an opposition to state power or that utilized women's associations to expand party power, the Museveni regime cooperated with the women's movement in order to accomplish his two primary goals: to rebuild the state and to reunite the country. Under the NRM the state rarely attempted to co-opt the women's movement, rather Museveni encouraged the growth of an independent women's movement and also supported women's grassroots organizations. According to many women leaders Museveni was genuinely in support of women's emancipation. After all, if it were not for the contributions women made to Museveni's National Resistance Army it is doubtful that he would have ever gained power. Many men within the NRM carried profound respect for women after fighting alongside them in the war of liberation. (Ankrah, 1987; Tripp, 1999; Watson, 1988)

Once the women's movement gained the support of the NRM it could accomplish its feminist agenda. There are several main points in this agenda that not only helped to empower women but also hindered the spread of HIV. Some of the major elements of this agenda were: to increase women's political representation, to reform the constitution, to toughen laws against rape and child molestation, to reform the education system, to allow women more economic opportunities and to unite women of different ethnicities and religions. These are the elements of feminist reform that I will discuss in this portion of the chapter through the efforts of the women's movement in these goals women became increasingly liberated and less vulnerable to HIV.

## **Women's Political Representation and Legislative Reform**

Not long after the Museveni takeover over twenty leaders of various women's councils and organizations requested that Museveni make a concerted effort to ensure that women were represented in government leadership positions. Museveni immediately took action. He asked these women to identify women who would be qualified for government positions, and adopted their recommendations for these posts. By 1995, almost a decade into the NRM regime:

Women constituted 17 percent of all ministers, 21 percent of all permanent secretaries, 35 percent of all Under Secretaries, and 16 percent of all District Administrators...There was a woman on the six member Human Rights Commission; three women on a 27-member Education review Commission; and two women on the nine-member Public Service Reorganization Commission. By 1994 there were also four women judges and five chief magistrates (Tripp, 70; Busharizi and Emasu, 1995; Kakwenzire, 1990).

According to UNDP statistics women currently comprise 17.9% of parliamentary seats in Uganda (UNDP, 2000). The average percent of seats held by women in all of sub-Saharan Africa is 11%. As women have gained more representation within government they have had more ability to shape the NRM agenda and have been able to ensure that women's issues are not forgotten or ignored by largely male dominated state structures. They are also put in a position in which it is easier for them to initiate constitutional reform and to enact or repeal laws that effect the fate of women in Uganda.

As opposed to just individual women with aspirations of holding political offices, entire women's groups also became politically mobilized beginning in the late 1980's. Since a majority of women's groups are grassroots organizations, their increased mobilization has meant that they have raised their political activity at the local level. This mobilization increased the number of women voters and also led to more women competing in local elections (Watson, 1988).

As women began to gain more political power and representation they were in a better position to change state structures and regulations. In December 1986 Action for Development (ACFODE), a women's organization, held a major conference and publicly pressured NRM officials for:

a ministry for women, for every ministry to have a women's desk, and women's representation in local government at all levels. It also pushed for the repeal of the 1978 Decree which had created the National Council for Women (NCW) under Amin, and for an umbrella organization independent of government funding that was not housed in the Ministry of Local Government as had been the case with the NCW (Tripp, 75). The NRM agreed to most of these recommendations and by 1991 the Ministry of Women and Development became a full ministry when it merged with the Ministry of Youth and Culture (Ultimately, in 1994 it became the Ministry of Gender and Community Development). No matter what other groups the women's ministry was merged or what it was officially called, it sought equal rights for women through changes in the law and state institutions. The Ministry also sought to improve women's economic circumstances by fostering income-generation opportunities and enterprises, and through integrating women's concerns with national and district development programs (Ibid.). Eventually other ministries not associated with the women's movement began working for more equality. For example, the Ministry of Health created programs that targeted women's participation (Kakwenzire, 1989). AIDS treatment and education for women was part of some of the major programs initiated by the Ministry of Health. The coordinator of the Ministry of Gender and Community Development also worked closely with the head of the Ministry of Agriculture to develop a cooperative policy to ensure women's food security (Ibid.).

Once women began to hold political offices and once an independent women's ministry was established, women were put in a much better position to change legislation and state institutions so that the state could better guarantee women's equality. In 1995 Uganda adopted a new constitution. Women's organizations and individual women were integral to the constitutional process. 18% of the delegates in the Constituent Assembly (CA), the body responsible for the creation of the constitution, were women (Tripp, 77). It was important that women were represented in this assembly because not only did questions of national concern arise, but also many issues that were of particular concern to women came up. Women in the assembly fought to include clauses that would end discrimination based on sex. To eliminate institutionalized sexism would entail the

“repeal of marriage, divorce, inheritance and property laws that discriminate against women” (Ibid.).

One of the most important legislative concerns for women was land and property laws that were traditionally discriminatory toward women. Women have never really been able to own land in Uganda and when they did it was usually through inheritance, but “it remains the case from pre-colonial times that most women have only use-rights obtained through their relationship with a man” (Barnett and Blaikie, 77) and when that man divorces his wife or dies, the woman is left with little or nothing. Land and property laws are extremely important in the context of AIDS because many men have died and will die from the disease and will leave their families with nothing. Many women must rely on their husband’s land to feed the family. When a widow or divorcee is left with nothing she will have to find various other ways to support a family and this can be extremely difficult for women in Uganda. As discussed above, many women in these grim situations find themselves relying on transactional sex to support themselves and their families. So for the women’s movement it was very important that land laws were amended. An example of women’s newfound legislative power can be seen in how women’s associations like the Uganda Association of Women Lawyers (FIDA) and the Forum for Women in Democracy (FOWODE) clashed with male government leaders including Museveni, over a proposed Land Bill in 1998. This particular bill would codify discriminatory traditions of land inheritance. However, because of arguments presented by FIDA and FOWODE the Land Bill incorporated clauses that urged District Land Tribunals to consider the rights of women and their children to land security, that certificates and occupancy and ownership be issued in the names of husbands and their wives, and that barred men from selling their land without consent from their wives (Katunzi, 1998; Tripp, 2000).

Other important laws (in the context of HIV) lobbied for by women’s groups were rape, child molestation, and prostitution laws. And:

Uganda’s women parliamentarians were instrumental in passing amendments to the penal code that made rape a capital offense and



punished hotel owners for allowing prostitution on their premises. (Tripp, 79). This law also made child molestation a capital offense. In the context of HIV it is rather obvious why these laws are important. In Uganda where HIV prevalence was once so high, some men were molesting young girls out of the belief that they were less likely to be infected, and men who were infected were found to be raping women (Ibid). So it was very important that stricter laws be adopted and enforced. The amended rape law had little initial effect, however. Even though reported rape cases actually increased after the passage of this law, no cases were taken to trial and state institutions took little action to quell the rise in reported rapes. Government inaction in the face of capital offences has led to the formation of an anti-rape coalition that has worked for greater rape awareness, and that publicizes and follows up on cases of rape and other forms of sexual abuse (Ibid.).

Indeed, when women worked to repeal or change laws, or when they worked on the formulation of the 1995 Constitution, many of their provisions were not strictly followed in reality. However, it is significant that the Ugandan Constitution lays the foundation for their struggles. Some of the other laws or constitutional provisions that have been adopted and pertain to women include equal protection under the law regardless of sex, race, ethnicity, tribe, and religion, women's rights to equal opportunities in political, economic and social activities and the right for women to work the same jobs as men for the same pay. The list of new laws and constitutional provisions meant to protect the rights of women could go on for several pages and it was the women's movement since 1985 that has led to the state's adoption of these provisions.

## **Women Changing Uganda's Education System**

Above I discussed the discrepancies between boys and girls in the realm of education. These discrepancies are important to understand in the time of AIDS because they place men at a socio-economic advantage for the rest of their lives and lead many poorer, less educated women toward financial dependence on richer men. These

relationships are often marked by risky transactional sex. Primary and secondary school is where many children are taught about human sexuality and HIV, so if women are not exposed to this education they may be ignorant of how the disease is spread and how to avoid contracting it.

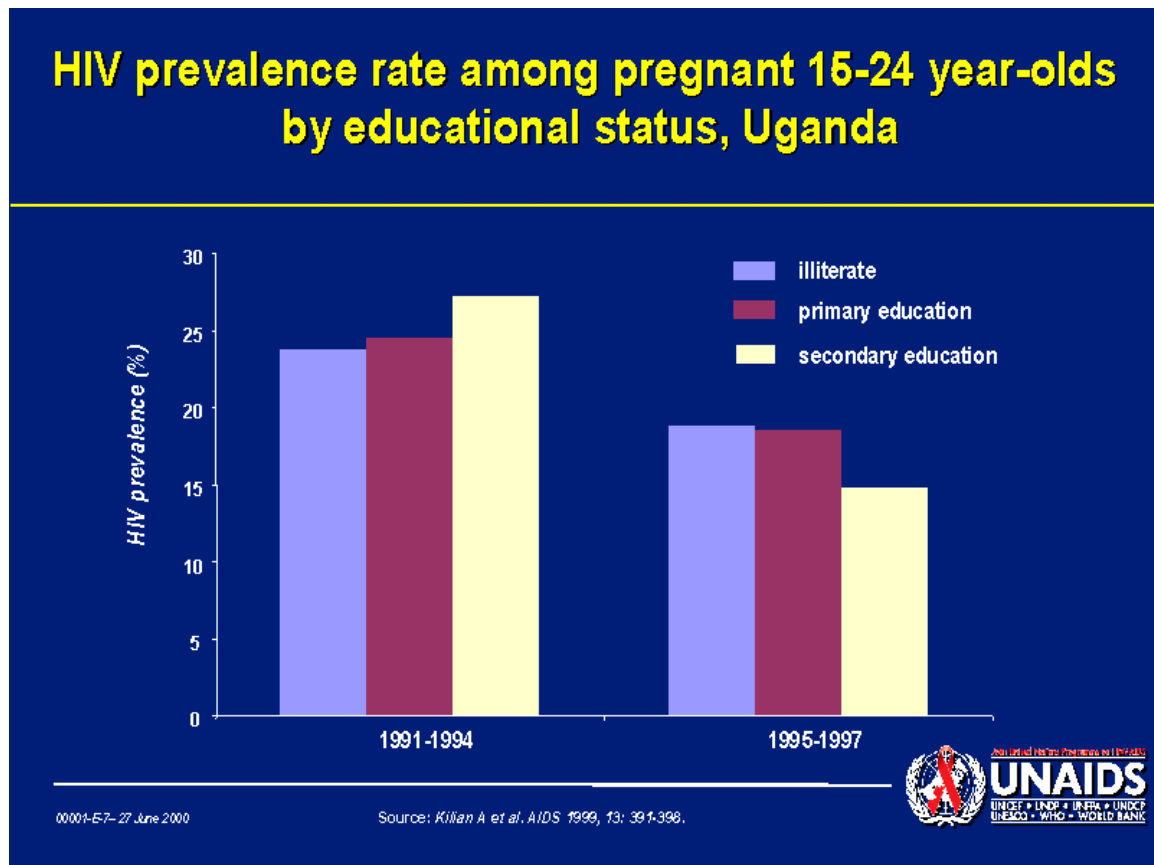
The biggest discrepancies in men and women's enrollment in schools exist in secondary schools and universities. For the women's movement, "changes in education policy have been viewed strategically as the key to getting women into leadership positions" (Tripp, 80). The biggest reforms the women's movement has pushed for are reforms in university education because it is college-educated women that will make the most significant contributions to the movement in the future. In the late 1980's several women's groups lobbied Makerere University (Uganda largest public university) to change its admissions standards for women entering the school. In June, 1990 the university senate decided to slightly lower women's admission standards (Kamya, 1996). As a direct result of this change in policy the percentage of females enrolled at Makerere University rose ten percent between 1991 and 1996 (Tripp, 80; Kamya). Women's associations also pressed Makerere University officials and international donors to establish a Women's Studies department. The Women's Studies masters program was opened in 1990 and Makerere University is now the only African university to offer a degree in the subject (Tripp, 81).

In 1985 Erisa Kironde, chairman of the Uganda Red Cross Society wrote: Local schools are numerous and education is now the only opportunity for upward social mobility. Hence schools have ample local support. But what do schools teach that is of benefit to village people as regards health and welfare? (Kironde, 66)

The relation between education and one's future "social mobility" has never been doubted, but not since the 1940's have subjects dealing with health arose in the academic setting (Ibid). Perhaps the most important educational reform in terms of the AIDS epidemic are reforms that are meant to educate youth about AIDS and the spread of HIV. The women's association ACFODE has been leading the way in pressing for sex education in upper primary schools (equivalent of American junior high schools). Youth sex education is very important in Uganda because such a high proportion of the Ugandan population is young. Roughly 50% of the population is in the 0-15 years age

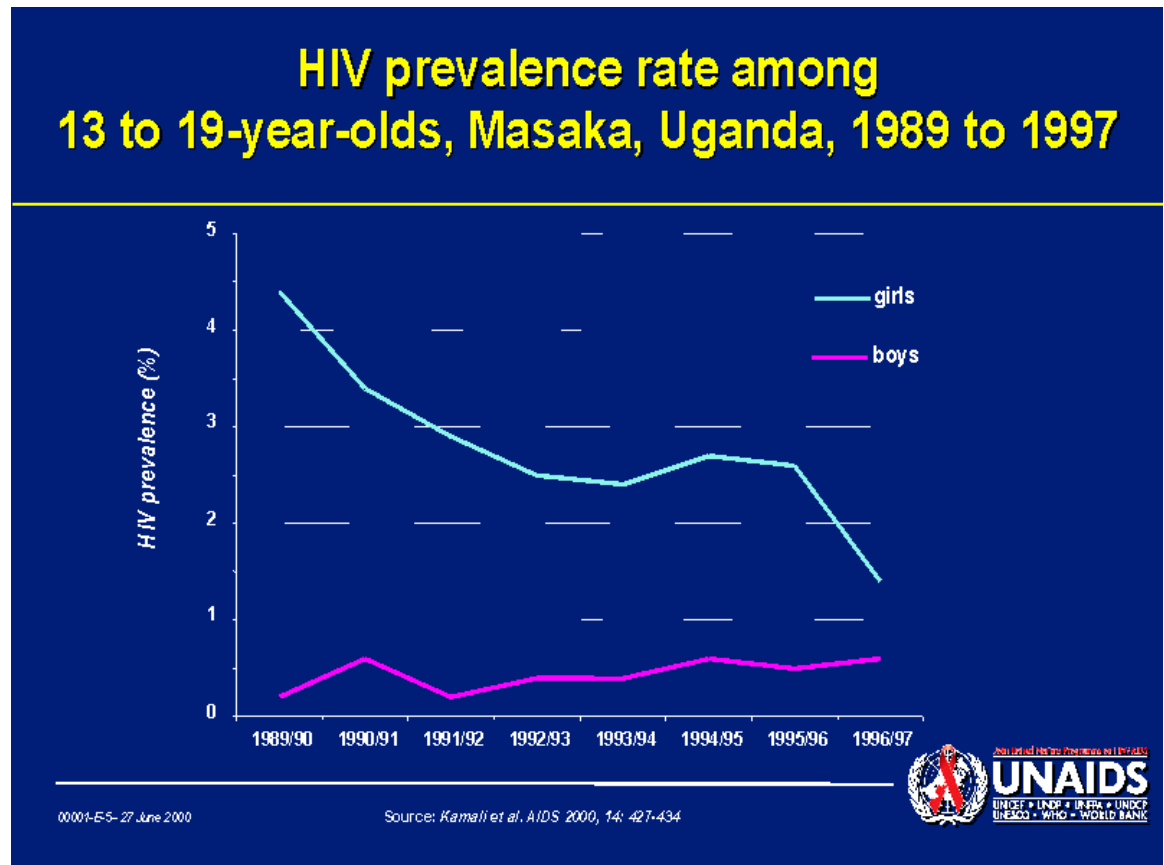
group (Census, 1991). And it is right around the ages of 13-15 that many Ugandans become sexually active. Young girls are especially vulnerable at a young age: in 1993 almost six times as many girls as boys have AIDS in the 15-19 year age group (UNICEF, 1993). As result of the lobbying of women’s groups and the efforts of international NGO’s many upper primary schools now include in their curriculum sex and AIDS education. Students learn some the biological properties of the disease, how to avoid the disease (i.e. condoms, abstinence), how to help people infected with the disease. In many sex education programs like the one initiated by the Institute of Public Health and Makerere University in July 1993, girls discuss why they are particularly vulnerable. In these discussions issues like transactional sex are brought up and girls discuss what they can do to protect themselves form HIV. In the past women’s education had little or no bearing on their likelihood of contracting HIV, but in recent years with the advent of sex and HIV education, more educated Ugandan women are less likely of contracting the disease (see fig. 3.1).

**Fig. 3.1**



Museveni also made the restructuring of the education system one of his top priorities. The Museveni government has attempted to improve the educational system by repairing and improving existing schools, building new schools, improving the quality of teacher education, and refocusing the curriculum away from an emphasis on academic subjects towards vocational and technical training. Since 1986 there has also been a drive for gender equality in primary education. Because many more young women are now gaining education regarding HIV/AIDS the HIV prevalence rate among young women has dropped considerably (see Fig. 3.2).

Fig. 3.2



By 1989 (three years into the Museveni regime) only 29% of primary school children were girls (Ibid.). Although the discrepancy between boys and girls is no longer so large it is apparent that it still exists. Whereas in the past almost everyone suffered

from a lack of education it seems today that women are more likely to receive less education. In 1995 the women's literacy rate was over 20% less than that of men's (UNAIDS, 2000). This has obvious effects on women's ability to find work outside of the informal sector. However, the lack of young women in the primary education system is even more troubling because it is in these schools that most young people receive education about HIV and how it is spread.

## **Women's Economic Conditions Since 1986**

Ironically, in the long term the adverse economic conditions of the 1970's and early 1980's may have served to benefit women's conditions. According to Tripp, it was partly these economic conditions that led to the formation of a vigorous women's movement in Uganda. It was this crisis that forced women to find new and innovative income-generating activities and it also led them to "seek collective means of coping with new economic constraints" (Tripp, 111). In short, in order to survive women had to be creative and work together in the form of small economic associations. Perhaps the biggest obstacle in the fight against AIDS in Uganda was women's reliance on men in order to gain access to resources. Because of discriminatory land owning laws that put women at a disadvantage, women often have to marry to gain land, or engage in transactional relationships or prostitution. In Uganda it became imperative that women gain some autonomy from men (particularly economic autonomy, but also political autonomy), and the state, if they wished to survive. It was no longer safe to rely on men to gain needed resources. Perhaps up into the mid-1970's transactional relationships were not risky, but with the advent of HIV/AIDS these relationships become extremely high-risk. For these reasons it was imperative for women to form financial associations. Women in these associations could:

Share contacts, exchange business and other ideas, provide financial assistance for income generating activities, and give financial and other help in emergencies. The women saved money to pay for school and health fees, and to reinvest in their businesses. (Ibid, 115)

The contemporary women's movement in Uganda grew out of these economic collectives that began forming in the early 1980's.

After Museveni's take over women's economic conditions became more favorable. Women are now more able to become involved in a diverse range of enterprises (Kabuchu, 1990; Ssemirembe, 1993; Tripp). Many women still make a living in the informal sector, but with improvements in women's education and the NRM regime's educational focus on vocational training, many women are now employed in jobs that were traditionally held by men. These trends can be seen in rural Uganda where landlessness is still a major problem for women. In Uganda women grow 60% of all crops sold for profit and 90% of food crops (sustenance farming), yet they own only 7% of the land (Watson, 1988). This has led many women to leave the agricultural sector for the informal sector and has also led many to join savings clubs like the ones mentioned above. Because of the retreat of the state from the economy and social services during the Amin/Obote era in Uganda there still remains feelings of suspicion and indifference toward:

authority, hierarchies and salaried employment...[that] further manifests itself in [Ugandans'] astuteness in joining voluntary organizations. Many...have joined organizations where few benefits can be identified individually but where much is possible for the common good. (Kironde, 1985: 68)

Recognizing the necessity of working together for the common good has been at the heart of the Ugandan women's movement.

## **Conclusion**

The relative stability that characterized Uganda after the NRM takeover allowed the country to deal with the AIDS crisis in ways that were impossible before 1986. Uganda was able to decrease its HIV prevalence rates in large part due to the commitment of Yoweri Museveni. In 1986 when Museveni learned that a large number of his soldiers were HIV-positive he "started talking about AIDS every chance he had and ensuring that his ministers did, too" (Menaker, 1999: 2). Museveni also attempted to enlist Uganda's best academicians to fight the disease and also requested international assistance, "attracting Western scientists, do-gooders and donors who chose Uganda's receptive atmosphere over African countries where the leadership was silent" (Ibid.).

In the Ugandan context it is clear that there needs to be sustained cooperation between the state and the women's movement in order to fight the spread of HIV. In most developing countries the state cannot afford to act alone in the fight against AIDS. In many cases the state simply does not have the resources, expertise, or infrastructure to act alone. In the Ugandan case the health infrastructure was not in place to deal with the disease, and economically the state could not fight the disease. The NRM regime was in a position in which they could not afford to suppress the women's movement. Women's organizations replaced the state in many circumstances because the state's infrastructure and economy was left in such bad condition after the Amin and Obote regimes. Instead of impoverished women looking to the state for assistance many turned to savings clubs. Instead of run down local schools looking for state funding, many were repaired and run exclusively by local PTA chapters. Instead of AIDS patients turning to state health services for assistance many had to turn to NGO's like The AIDS Service Organization (TASO), for care. Instead of relying on the state to rebuild and staff health clinics that were left in shambles due to past conflicts locals women's groups often rebuilt and staffed new health centers. The PTA and TASO are not organizations exclusively for women, but they are made up mostly of women (Henry, 1999). According to Tripp, "volunteerism is...a key characteristic of women's organizations in Uganda" and when the state cannot adequately provide for the welfare of its people it is this sense of volunteerism that fills the void (159).

Because the Museveni regime was receptive to women's NGOs Uganda may have been in a better position to decrease HIV prevalence rates. Women's associations were able to reform laws so that sex discrimination was not as prevalent in Uganda. Because of legislative reform women face less obstacles when attempting to acquire or inherit land and when seeking employment, thus they may be less dependent on men for financial security. Legislative reform also made the punishment for rape and child molestation more severe. Which may eventually slow the spread of AIDS. Women's associations also made progress in educational equality between girls and boys, and helped to introduce AIDS and sex education to upper primary school curriculums. If women's groups were suppressed to the point where they were incapable of filling in for

state deficiencies, if they were not allowed some influence in government, it is very likely that Uganda's HIV prevalence rates would still be increasing.



## *Chapter Four: Case Study on Botswana*

### **Introduction to Botswana Case Study**

Botswana does not have the expansive history of HIV transmission that Uganda has. Whereas HIV was first detected in Uganda in the late 1970's, the disease was not publicly recognized in Botswana until 1985 although it is likely that the disease entered the country earlier than that (MacDonald, 1996: 1326). Even in 1985 when the disease was first recognized, Botswana media downplayed the significance of the disease. The appearance of HIV in Botswana was attributed to foreigners and homosexuals.

*The Botswana Guardian* of 15<sup>th</sup> February 1985, for example, reported one AIDS case, an American citizen, and implied that there was no AIDS among the Botswana. An official reply to *The Guardian's* story reportedly said "It's not a problem in Botswana, AIDS is primarily a disease of homosexuals and there are no homosexuals in Botswana." (MacDonald 1996: 1325)

The spread of HIV in Botswana did not start having detrimental effects on the country until 1990 (by that time the HIV prevalence rate was around 5%), so as HIV was ravaging other parts of the continent throughout the 1980's the severity of the disease was not apparent to many Botswana. If Botswana media dealt with the issues concerning HIV/AIDS they were usually discussed in the context of another neighboring country like Uganda or Tanzania. Botswana still talk of AIDS as the "radio disease" because the disease's effect on the continent as a whole has been widely publicized, but only began to affect Botswana very recently (Ingstad, 1990; MacDonald, 1996: 1331; Treichler, 1999: 151). Contrarily, in Uganda HIV was very real; from the first time HIV ever surfaced on the continent, Ugandans were forced to deal with the disease. Uganda's history also led to an atmosphere in which social strife and disease were viewed as inevitable. In Botswana where warfare and disease has not been the norm throughout the past few decades there was much denial when such a disturbing disease first appeared in the country. The initial denial and ignorance of HIV in Botswana may have resulted in the steep increase of HIV rates throughout the late 1980's and early 1990's. Although HIV was virtually non-existent in Botswana in the early 1980's it is now the most HIV

infected country in the world; between 28% to 36% of adults (between the ages of 15 and 49) are believed to carry the AIDS virus (Leopold, 2000: 1; Swarns, 2001: 1; UNAIDS).

Botswana's history leading up to the AIDS pandemic is extremely different in comparison to Uganda's. The biggest difference lies in the culture and the importance of traditional beliefs in each country. There are also big differences in the politics and socio-economics of each state. Whereas Uganda suffered through inept and despotic regimes characterized by ceaseless conflict and the decline of social services and the economy, Botswana established itself as a semi-liberal democratic state with a stable, open market in the post colonial era. According to Abdi Samatar the Botswana state:

plans and manages its affairs in ways that are characteristically superior to all other postcolonial regimes. Political economists writing on Botswana...noted the social arrangement among the state, mining capital, and passive-civil society. This arrangement facilitated the emergence of both a strong state and liberal democratic polity. (1999: 177)

In the previous chapters I showed how the Ugandan state made the country (and women in particular) vulnerable to HIV. Given the condition of Uganda's social services and economy, ceaseless migration and conflict within the country's borders it is to be expected that Uganda would be susceptible to the spread of HIV in the late 1970's and early 1980's. But how does HIV ravage a relatively stable, liberal democratic state, with one of the strongest economies in southern Africa?

The HIV prevalence rate in Botswana is now just as high, if not higher, than it ever was in Uganda. I will show that in countries that are different in terms of economics and politics the spread of HIV can be attributed to similar factors. Just as in Uganda, the socio-economic position of women has much bearing on the spread of HIV/AIDS in Botswana. Particularly, cultural expectations placed on women in Botswana puts them in a vulnerable position. Another similarity between the two countries is the way in which migration patterns have stimulated the spread of disease.

In Botswana there exist several major factors that propagate the spread of HIV that I will discuss in this chapter. First, I will examine the interactions and rifts between modernism (i.e. urbanization, industrialization, development) and traditional Tswana

belief systems. The interaction between these ways of thinking has had detrimental effects on Botswana, particularly in the context of HIV/AIDS. The traditional beliefs that have influenced contemporary attitudes, behaviors and laws have placed women at a disadvantage economically, and have led to women being more vulnerable to HIV. Second, I will discuss the contradictions and inequities that lie beneath the seemingly liberal state of Botswana. Although Botswana has a stable (relative to the rest of sub-Saharan Africa), growing economy, there exists a wide gap between rich and poor and women are much more likely to suffer economic hardship. And although the state may seem to run according to democratic principles (i.e. free elections, universal suffrage, parliamentary system), there exists little room in Botswana's polity for the representation of women. Third, I will show how migration has led to the spread of HIV in Botswana. The Batswana have always been a highly mobile people (MacDonald, 1996). In the past the movement of people may not have been detrimental to society, but in the era of AIDS migration has had devastating effects on the Batswana.

In this chapter I will discuss Botswana's relatively short HIV history and compare this history to Uganda's recent past. Specifically I will show how the position of women in Botswana society leads them to be vulnerable to disease, and perpetuates the spread of the HIV throughout the country. HIV prevalence rates have decreased significantly in Uganda. Can Botswana apply any of the lessons learned from the Uganda experience to its own HIV problem? More specifically, I will discuss whether a women's movement like the one in Uganda is possible in a country like Botswana

### **The Clash of Tradition and Modernity in the Time of AIDS**

There are five major ethnic groups in Botswana, the largest of these, the Batswana, make up 95% of the population. Close to 50% of the population adheres to Tswana or other indigenous beliefs. (CIA World Fact Book 2000) Botswana is an interesting case because there exists a clash between traditional beliefs and the country's modern aspirations.

Traditional cultural beliefs and values are still...very strong influences on the behaviour of many Batswana, further exacerbating the tensions and uncertainties underpinning the rapid transition to a more modern society.

(MacDonald, 1996: 1327)

Tswana cultural traditions are extremely important to our understanding of the “contemporary position of women in society and its connections with the transmission...of HIV” and I will discuss this issue below (Ibid.). These traditions are also important to our understanding of how the Batswana perceive AIDS. In contemporary Botswana the dynamic between the traditional and the modern is interesting because there are instances in which traditional beliefs may lead to misperception about AIDS, but there are also instances in which the erosion of the traditional has made Tswana society more vulnerable to the spread of HIV.

Many traditional healers believe that the human body can become polluted when cultural taboos are violated (in Botswana this pollution of the body is called *meila*). The only form of *meila* recognized by many Tswana that can contaminate both males and females is called *boswagadi*. Traditional healers claim that *boswagadi* can occur when a man or woman is widowed. Certainly *boswagadi* is most likely AIDS. Recently in Botswana men and women have become widowed in many cases because his/her spouse died of AIDS and the “*boswagadi*” the widow has as a result of being widowed is really HIV (Green, 1999: 61; Schapera, 1940: 194-195). A belief in *boswagadi* is dangerous because it has provided the Batswana a possible cultural opportunity for the development of patterns of denial and rationalization for the non-existence of AIDS in Botswana (Ibid. 1329 & 1331; Treichler, 1999: 151). The treatment for this traditional disease is to abstain from sex for a short period of time, and to be purified through ritual. So it is possible that one could be cured of the traditional disease, but then pass on HIV after a period of sexual abstinence. According to Treichler, HIV “will need to become more common before traditional healers can decide whether it should be diagnosed as a traditional (Tswana) disease or as a “modern” disease” (1999: 151). However the HIV prevalence rate in Botswana is now over 30% and traditional healers are still making *boswagadi* diagnoses for which the only treatment is the short period of abstinence and ritual purification. It is very possible that people who believe they have been “cured” of their case of *boswagadi* are spreading HIV in Botswana.

Botswana president Festus Mogae has condemned traditional attitudes toward sex, which he believes, makes it difficult to spread awareness of HIV (Baxter, 2000). However, the spread of HIV in Botswana is much too complicated and multi-faceted to just be pinned on the promulgation of some traditional beliefs. We can only make educated speculations that *boswagadi* and HIV are the same ailments. It can even be argued that it was partly the *degradation* of traditional beliefs and mores due to modernization and colonization that made Botswana vulnerable to the disease. Throughout the twentieth century traditional initiation schools (known as *bogwera* for boys and *bojale* for girls) have disappeared. The initiation process “instilled a sense of group unity and trained the young about Botswana tradition...” (Samatar, 41). This coming of age ritual was run by community elders (Kgosi) and prepared “young people physically, morally and psychologically for adulthood” (MacDonald, 1328). More specifically *Bogwera* and *Bojale* set normative principles and cultural expectations and constraints regarding sexual behavior and sexuality (Ibid.). Up until the middle of this century Tswana traditional communities had a system of sexual socialization in place that emphasized the role community and society rather than the individual (Ndeki, Klepp, et al., 1995: 134). According to Ndeki and Klepp:

The AIDS epidemic has occurred at a time when the traditional socialization system has, to a large extent, broken down...in general, the role of community elders in teaching young people about traditional family values and reproduction has become less important. At the same time, it seems evident that schools have not taken on the education regarding family life, reproduction, and prevention of sexually transmitted diseases to an extent that adequately prepares adolescents to safely navigate the AIDS epidemic. (135)

Although these authors write specifically on Tanzania, much of what they argue is relevant to many traditional societies in Southern Africa. Indeed, in Botswana the propagation of normative guidelines and constraints passed down through traditional societies has not been replaced by schools, the church, or parents (MacDonald, 1328). The result of this lack of any type of initiation into sexual maturity has had serious consequences, such as a steep increase in teenage pregnancies and the spread of HIV among young Botswana.

## **Cultural Reasons for Women's Vulnerability to HIV in Botswana**

In this thesis I have argued that women must achieve some level of autonomy and/or decision-making power in the home, the workplace, and in civil society in order to effectively avoid contracting HIV. When women have no representation in government, when they are discriminated against in the workplace, when they cannot control when or how they have sex, they will be vulnerable to HIV. In Uganda, I argued, that women have historically lacked autonomy or any sort of power, but they have recently made large strides toward achieving more power particularly in the political and economic realm. Even in Botswana, a seemingly liberal democratic society, women lack power in the political and the economic realm, and a women's movement of the scale seen Uganda does not seem to be a reality for Botswana women.

Much of women's oppression in Botswana can be attributed to cultural constraints. Cultural (traditional) beliefs and expectations about women pervade almost every segment of society in Botswana. In most of southern Africa traditional beliefs are a large influence on contemporary life, however, it could be argued that these traditional expectations and beliefs are especially strong in contemporary Botswana. By comparison, in Uganda women were forced to overcome their tribal loyalties and their religious affiliations in order to work with other dissimilar women (Tripp, 1999). Museveni has also played much lip service to the idea that his regime would not have tribal favorites (Ibid.). Whether or not the Ugandan government is living up to this ideal is doubtful. However, it is undeniable that traditional mores that are inherently discriminatory will have to be changed if women are to achieve any sort of autonomy. In Uganda women have fought to change many of these mores, contrarily in Botswana not much has changed since its independence in 1966.

Once again, it is not just traditional mores that have led to women's vulnerability to AIDS. More precisely, it is the *interaction between the traditional and the modern* that has had the most detrimental effect on women in Botswana and the negative consequences of this interaction can be felt in all segments of contemporary Botswana society. Women have been most damagingly effected by this trend since the time of

colonization. According to Van Hook:

The colonial powers used the subjugation of women as part of their general strategy to maintain control over people and their resources. This system was reinforced by disparaging colonial attitudes toward Africans, especially African women. Patriarchal views toward women among the colonial powers and the African tradition itself further supported this system. (1994: 289)

These patriarchal views are prevalent in the legal, economic, political and domestic spheres in Botswana, thus making Tswana society a dangerous place for everybody (particularly women) in the time of HIV. The legacy of Botswana cultural traditions is extremely important for an understanding of the contemporary position of women in society and its connections with the transmission and rapid spread of HIV.

## **Family Life in Botswana**

Increasingly family life in Botswana is characterized by an unwed woman and her child(ren) (Van Hook, 1994: 299; Wood Wetzel, 1987). As discussed above, unwed mothers are put at a huge disadvantage when it comes to economic advancement and they have little ability to continue or hone their educations. However, even married women are put in very compromising situations in Botswana. Women have historically been perceived as socially inferior to men, and within customary Tswana law women were treated the same as minors (MacDonald, 1996: 1327; Schapera, 1970). Women were under the guardianship of their fathers until they got married and the guardianship was transferred to the husband. Essentially, women were legally and socially regarded as children for the entirety of their lives (Ibid.).

In Botswana the subjugation of women is most commonly due to the clash between traditional and modern values, and a legal system that is discriminatory toward women. Contemporary laws in Botswana are very much influenced by traditional values. The legal system in Botswana is complex because:

it consists of two semi-independent legal systems: the customary and the general. The general laws (Dutch-Roman laws) were created by the colonial governments and applied only to Whites; persons of African descent were governed by the traditional customary laws that were derived from the oral tradition. Since independence, the general laws have applied to everyone...the general legal system is equally available to all persons and frequently provides women with more rights... (Van Hook, 1994: 290-291)

However, according to a recent report legislation since independence has ingrained the subordination of women in Tswana society by “incorporating discriminatory elements of customary law into the statutory [general] legal system” (Human Rights Watch: Africa, 1994; MacDonald: 1996: 1327). Both customary and general law is still important in the Botswana context, because while general law may guarantee women more rights, “women tend to seek help within the customary courts because these courts are less expensive and legal aid is not provided in the general courts” (Van Hook, 291). The amalgam of traditional and modern law is particularly apparent in the family and marriage laws (Ibid.). In some instances, even though some customary laws are antiquated the idea behind them still prevails. For example, the payment of *bogadi*, or a bride price by a man to the father of his future wife “is diminishing under customary law, [but]...the social pressures to present *bogadi* are still very strong” (MacDonald, 1327). *Bogadi*, itself, is dangerous in that many men believe that they have paid for their wives and that it gives them a license to control their wives’ lives (Ibid.).

If a woman is to marry under either general or customary law, she becomes subject to her husband’s authority in financial and property matters and women may not open a bank account or business without the permission of her husband. This is dependent on the type of marriage: women married under the community property arrangement lose their right to own property, whereas those who marry under a non-community-property arrangement retain their legal status as adults. Even when a woman shares property with her husband she has very little power to control what is done with it and is often granted very little in the way of ownership rights in the event of a divorce. Women can lose much of their property at the time of divorce because Botswana judges do not have the ability to divide property more equitably (Van Hook, 293). This can put divorced women at economic disadvantages (thus making her more susceptible to HIV)



for the rest of her life.

Under traditional laws men can legally lead a polygamist lifestyle, whereas a women's infidelity is grounds for divorce (Ibid. 294). However, polygamy is seen as an antiquated custom and many married modern Botswana men choose to carry on relations with a *nyasti* (a concubine, or mistress). Indeed, according to MacDonald:

...within contemporary Botswana it is deemed culturally acceptable for men to have more than one sexual partner and for married men to have...mistresses. One household survey reveals that among sexually active males including those that are married, 40% currently had two or more partners. (1328, the study to which he refers: *Men and Sex*, Government of Botswana, 1993)

It is very easy for women to be treated inhumanely in a society in which cultural norms dictate that it is acceptable for men (married or unmarried) to have several sexual partners, in which men have legal (or even perceived) guardianship over their wives and in which men pay a *bogadi* or bride price. Some of the work carried out by Schapera in the 1940's argued that men were considered superior in sexual relationships in Botswana (Schapera, 1940). Sexual satisfaction was considered a domestic duty of Botswana wives. Many of the women Schapera interviewed in his study claimed that if they refused or resisted sexual intercourse they were usually beaten into submission (MacDonald, 1996; Schapera, 1940: 213). Although Schapera's work is most applicable to Tswana tribal society in the early half of the 20<sup>th</sup> century, it does not seem that much has changed in contemporary Botswana society. According to more recent studies 20% of young, sexually active women were forced into their initial sexual encounter (WHO, 1992; MacDonald, 1996: 1328). This percentage could possibly be much higher, because it is:

...conceptually problematic to ascertain what constitutes 'physical force' in a cultural context where women are not meant to 'say no' in any case and where answers in the research context may be mistranslated or misconstrued to include verbal force or emotional coercion, this indicates that for a significant number of young women in Botswana their first experience of sexual intercourse is technically that of rape. (MacDonald, 1328)

Indeed, it is quite easy to see how women lack any autonomy or decision-making power if she must live in a society where she is "not meant to 'say no.'" MacDonald claims that

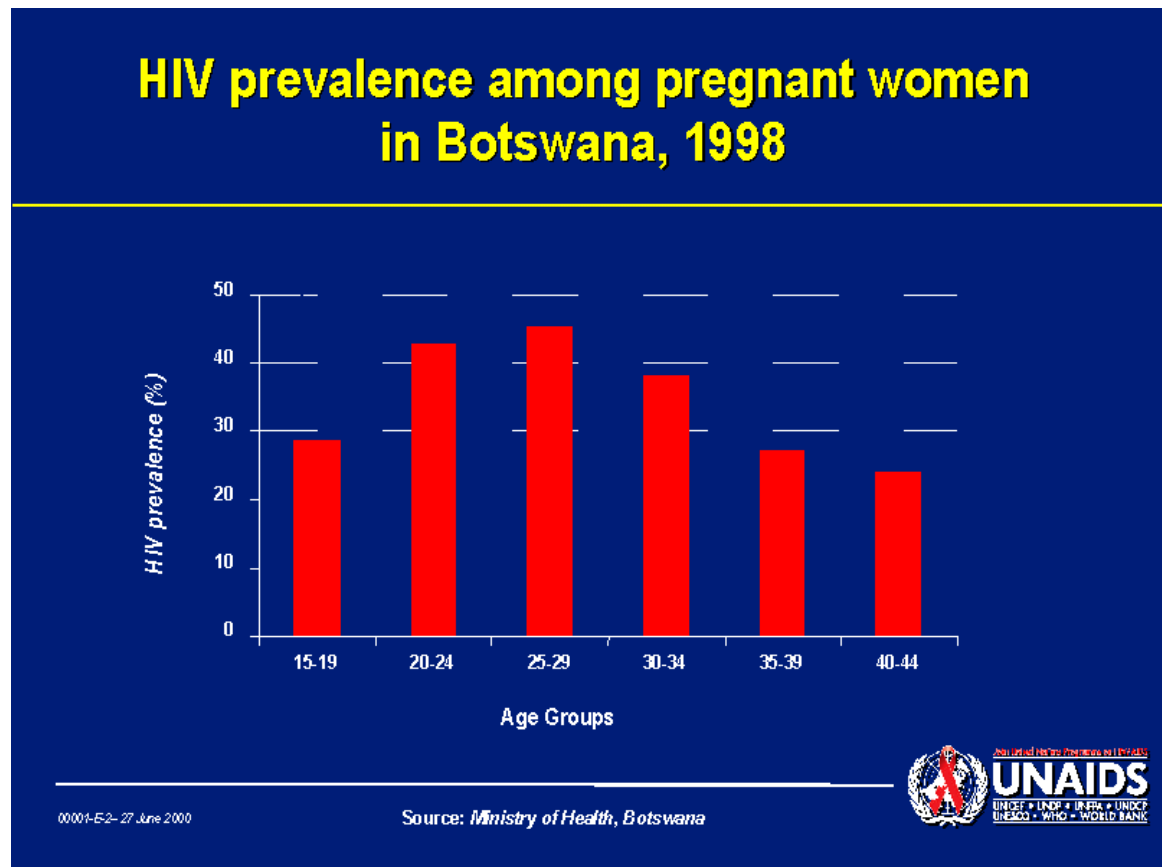
it is partly this type of society that has led to the staggering increase of AIDS cases in Botswana. In studies carried out by the WHO, the University of Botswana and the Botswana Government women claimed to feel especially vulnerable to HIV “because of cultural expectations to provide sexual satisfaction to their husband or boyfriend and [their]...powerlessness in demanding of negotiating for safer sex” (Ibid.).

In terms of HIV the most vulnerable population in Botswana are young women. This vulnerability is reflected in the staggering numbers of teenage pregnancies and sexual abuse in Botswana.

### **Teenage Pregnancy and the Exploitation of Young Women**

Teenage pregnancy is a significant problem in Botswana where 50% of the dropouts of young women from junior and senior secondary schools are due to pregnancy (Alexander, 1989; Van Hook, 1994: 296). Results from several studies indicate that the problem is much more severe than is commonly assumed. Unprotected sex that leads to pregnancy can easily also serve to spread HIV (see Fig.4.1).

Fig. 4.1



AIDS has hit Botswana's young educated labor force hardest, so it could be argued that young people are not being educated about the AIDS virus and safer sex.

Adolescent pregnancies can put women at a socio-economic disadvantage for the rest of her life. Schoolgirls who become pregnant have fewer opportunities to complete their education after the birth of their first child and have fewer opportunities for socioeconomic advancement (Meekers, Ahmed, 1999: 195). Many times fathers of Botswana children relinquish their relationships with the mothers in a short period of time. In Botswana there is an increasing number of unwed women with children. Nearly 80% of all unmarried women in Botswana are mother (Van Hook, 1994: 299; Wood Wetzel, 1987). The staggering rate of teenage pregnancies in Botswana can be attributed to the fact that many Botswana women are not completely sure of how to use contraception, but it also can be linked to older men sexually exploiting younger women.

The Botswana government has recently recognized the vacuum that exists when it comes to teenage sexual education. In a government report, released on the eve of World AIDS Day 2000, said the country's best hope in stopping the spread of the disease to the next generation lies in a strong campaign of sex education (Lederer, 2000). The Botswana government announced it would work closely with the UN Development Program (UNDP) to incorporate AIDS education into the school curricula (Ibid.).

According to Sylvia Muzila the District Commissioner of Kweneng District, most Batswana are aware of the existence of HIV, but "they are still confused [about] how it is transmitted and how they can protect themselves" (Africa News Service, 2000). However, according to UNAIDS 80% of 18-25 year olds in Botswana could name at least two acceptable ways of protection from HIV infection (UNAIDS Epidemiological Fact Sheet: Botswana, 2000) and condoms are available in Botswana. The high teen pregnancy rate in Botswana can only mean a high degree of unprotected sex. AIDS is not spreading in Botswana due to ignorance about the disease. Most people know how to avoid HIV and they have the ability to have safer sexual intercourse, however they choose not to act on their knowledge. Women often do not have the ability to act on their knowledge: they do not have the ability to demand safer sex or negotiate their sexuality.

Many Batswana choose not to use condoms because there is a high cultural premium placed on fertility in Botswana. According to MacDonald:

...there are several reasons for the high fertility rate in Botswana, one of the most significant with in the context of HIV transmission is the cultural imperative for a single woman to have a child to prove that she is fertile and to endorse her relationship with a man. (1996, 1328)

In contemporary Botswana women know that if they are unable to bear children they are not desirable wives or are likely to be divorced, so they often try to get pregnant before marriage to prove their fertility (du Pradel, 1983 Quoted in MacDonald, 1996). Studies carried out by du Pradel found many contradictory beliefs regarding fertility among the Batswana. A majority of men of men felt that women should become pregnant before marriage to prove their fertility, but a majority also felt that women often become

pregnant in order “to trap their boyfriends into marrying them” (Ibid.). Over 75% of both men and women believed that men tended to abandon their girlfriends as soon as they become pregnant. Other studies have shown that Botswana men are unlikely to utilize condoms because they feel pressure to prove their virility by impregnating women (Botswana Ministry of Health, 1993; UNAIDS, 1996; MacDonald, 1996: 1329). Some cultural beliefs regarding fertility are more prevalent in rural areas than in the cities of Botswana. For example, a majority of women in rural areas (but very few in urban areas) believe that pregnancy cleanses the womb, and that women that do not bear a number of children are unclean (DuPradel, 1983: 50). The value Tswana culture places on fertility and the contradictions in the way the Batswana perceive fertility are two of the major factors fueling the spread of HIV.

The same government report that mentioned the lack of sex education in Botswana also noted another major factor in the spread of HIV and the rate of teen pregnancies in Botswana: older men sexually exploiting young women. To stop the spread of HIV the report argued that Botswana:

must focus on stopping the transmission of HIV from older generations to those under 15, and that society must take a strong stand against sex between men over 25 and women under 18 and anyone having sex with youngsters under 16. (Ibid.)

Sexual relationships between older men and younger women is very troubling on Botswana because the population of sexually active men between the ages of 25-40 are the people most likely to be HIV-positive in the country (UNAIDS Epidemiological Fact Sheet: Botswana, 2000). It is primarily because of these types of relationships that young women are much more susceptible to HIV than boys. For every HIV positive boy under the age of 14, there are two HIV positive girls of the same age and this ratio rises to 1:3 in the age group 15-29 before converging towards 1:1 in older age groups (Botswana Human Development Report, 2000: 26). These statistics seem to suggest that for many girls their first sexual experience, and first exposure to HIV is with an older man. When these girls become sexually involved with males their own age the virus is able to move completely from one generation to another. For several reasons older men are having sex with much younger women. This trend is prevalent throughout the entire southern part of

Africa and can be attributed to several factors. In many cases it occurs due to socio-economic circumstances: women carry out sexual relations with older, economically established men to gain money for school fees, or for important commodities. In the era of HIV some men also prey upon younger and younger women in the belief that they are less likely to carry the disease (Tripp, 199: 78). Young women are also often forced into sexual relationships with older men. A study on 13-16 year old female students carried out by UNICEF found that::

...38% of the girls questioned reported that they had been touched in a sexual manner without their consent. 17% reported having had sex, with 50% of these saying it was forced. 34% of the students said they had sex for money, gifts or favours and of those sexually active, 48% said they had never used a condom. (Woods, 2000:1).

Transactional sex is a big problem in Botswana, because women are in more dire economic situations than men. In the UNICEF study 34% of the sexually active 13-16 year old female students claimed to have engaged in transactional sex. We can estimate that this percentage is much higher for older sexually active women because they often face more severe socio-economic circumstances. 80% of all unmarried women over age 25 in Botswana are mothers and if these women became pregnant as teenagers there is a good chance that they had to drop out of school (Van Hook, 1994, 299; Wood Wetzel, 1987).

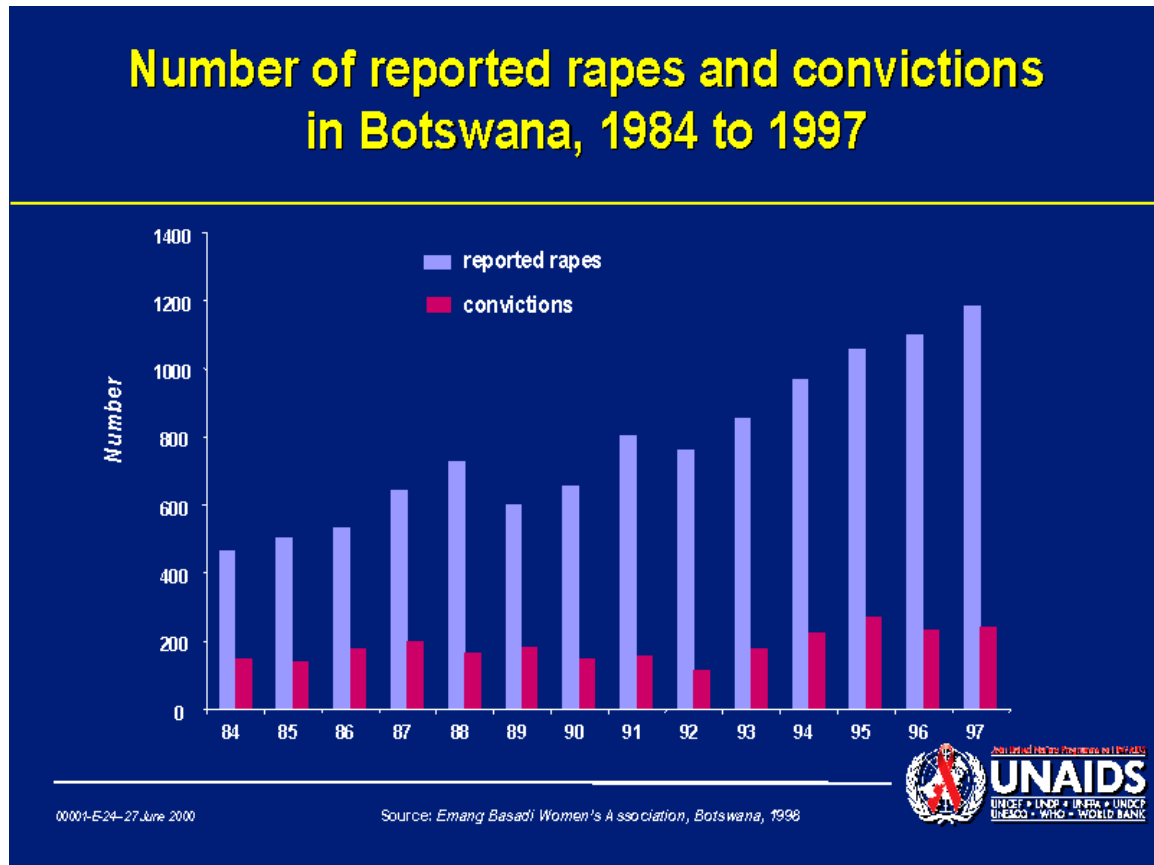
## **The State's Ineffectiveness in Prosecuting Violence Against Women**

Violence against women is not just confined to younger women. Women of all ages face sexual exploitation and violence, which makes them very vulnerable to HIV throughout their lives. Domestic abuse is a large area of concern in Botswana. Human rights activists in Botswana estimate that six out of ten women are victims of domestic violence at some point in their lives (Botswana Human rights Report, 1999: 1). Under customary law and in common rural practice, men have the right to 'chastise' their wives and police rarely intervene in cases of domestic violence (Ibid.). Often domestic abuse goes unreported, so it is difficult to detect, but even when such violence is reported, there is often failure to protect victims or punish perpetrators (Government o Botswana, 1995:

31). As discussed earlier, much domestic violence occurs as a result of women refusing to sexually satisfy their husbands and domestic violence often comes in the form of rape. Most women who are victims of violence are married to or live with the perpetrators. The home environment is simply not safe for many women (Botswana Human Development Report, 2000: 29).

Rape is another grave national problem, and the government acknowledged in April 1999 that, given the high prevalence of HIV/AIDS, sexual assault has become a more serious offense. Yet it is still too early to tell if the state and local police forces have indeed begun to take rape more seriously. In rape cases the Botswana government has been chided for its ineffective prosecution attempts. According to Anne Sandenbergh Women Against Rape (WAR), Botswana's only rape crisis center, police do not have the proper training to apprehend and successfully build a case against rapists (Davies, 1999: 1). The government has not been able to provide victims with qualified prosecutors that can match the quality of defense lawyers (Ibid.). This results in a very small number of rapists actually being convicted for their crime (See fig. 4.2).

Fig. 4.2



The state's April 1999 acknowledgment of the severity of rape in the time HIV rings hollow as more rapists continue to walk free in Botswana. Some of these rapists are knowingly spreading HIV. There is evidence to suggest that those few rapists who are caught and found guilty will face stiffer penalties if they are HIV positive. In a landmark case in March 2000, a magistrate in Botswana reserved passing a sentence and ordered a man found guilty of raping a teenage girl to undergo an HIV/ AIDS test (Africa News Service, March 10, 2000). However, reports of rape are increasing in Botswana. Between 1997 and 1998 the reported cases of rape increased 11% (Botswana Human Development Report, 2000: 29). According to the UNDP:

Coercive sex, including rape facilitates the transmission of HIV, and is especially efficient in doing so when the violations are against young women and girl children, amongst whom the risk of extensive damage to genital mucosa is high. These acts of violence against women and children persist in part because of the socio-economic conditions in



Botswana and the justice delivery system create conditions that are ripe for such abuse. (Ibid.)

In Botswana there are few places in which a woman can feel safe from violence or sexual harassment. Harassment and violence is a common occurrence in schools, in the workplace, and in the home. In this sense women in Botswana no matter their age or socio-economic circumstances are vulnerable to harassment, violence, and HIV.

## **Economic Conditions in Botswana**

Up until 1966 when it gained full independence, Botswana was a British protectorate. The fact that Botswana was never fully colonized shows that Britain considered Botswana to be an important region in a strategic sense, but not valuable in the economic sense (MacDonald, 1996; Samatar, 1999). After Botswana had gained its full independence Britain invested very little in the infrastructure of the country, leading Botswana to become one of the ten poorest countries for nearly a decade following independence (Ibid.). However, with the discovery of diamonds in the late 1960's Botswana soon became one of the fastest growing economies in the world. Botswana's economic growth over the past three decades is unprecedented in southern Africa. According to the World Bank:

Botswana is one of a small group of counties in the contemporary era...that has sustained rapid economic growth over an extended period. Over the past three decades, Botswana's real per capita income grew by more than 7% per annum, which is comparable to rates of growth achieved by countries like [South] Korea and Thailand...The record of three decades of rapid economic growth has few parallels in modern economic history. What is exceptional is the fact that the initiating source of the growth was mineral wealth, for even fewer countries have been able to transform mineral wealth into sustained economic growth. (The World Bank, 2000: 1)

Statistically, Botswana now has one of the more stable economies in sub-Saharan Africa (See Fig. 4.3).

**Fig. 4.3 Major Economic Indicators: Botswana and Uganda**

| <b>Country</b> | <b>GDP – Growth Rate</b> | <b>GDP – Per Capita</b> | <b>Population below Poverty Line</b> | <b>Budget Revenue</b> |
|----------------|--------------------------|-------------------------|--------------------------------------|-----------------------|
| Uganda         | 5.5%                     | \$1,060                 | 55%                                  | \$959 millions        |
| Botswana       | 6.5%                     | \$3,900                 | 47%                                  | \$1.6 billion         |

*Source: CIA Factbook 2000. Note: all figures based on 1999 estimates.*

Botswana has had a stronger economy than Uganda for years, but economic inequality in Botswana is far worse than it is anywhere in the world (MacDonald, 1996: 1327). Since its independence Botswana's development plans were guided by a dominant class that was unified by "shared economic experience...and their common economic base in the cattle, petty trade and civil service" (Samatar, 1999: 181). Botswana's mining and cattle economy has created an ever-widening gap between a wealthy class of ruling Tswana families and urban elites and a poor, ethnically diverse, and mostly rural population (Hermann, 2001:1).

For many reasons women may be in the worst position within this economy. For the most part women are employed in traditionally female jobs and in the informal sector. Many women work as maids, secretaries, nurses and typists. In the home women are often subordinate to their husbands or live-in boyfriends, by virtue of cultural conventions and the male's higher income generating ability. Within the home women carry disproportionate burden of household work (Botswana Human Development Report, 2000: 28) and they are sometimes completely responsible for the family's nutritional needs (subsistence farming). According to the UNDP women are generally more susceptible to job and asset deprivation than men and yet they usually have more dependents. They are also relatively poorer than men, "constituting only 37.5% of all cash earners in 1993/94" (Ibid.). In Botswana there exist inequalities in access to development programs and resources, as well as the increasing burden on women of caring for relatives including children, the aged and terminally ill family members (Division for the Advancement of Women by the Government, 2000: 2). This translates

to women having lower incomes but more dependents. In the time of AIDS this burden has become more salient as women must care for increasing numbers of family members that contract HIV and die of AIDS.

The biggest factors in the economic suppression of women are legal and cultural conventions that restrict women's access to and control of productive resources. Customary and contemporary laws make it much more difficult for married women to own and control property (particularly land). Even in instances in which a married woman shares legal ownership of land with her husband, it is often the husband who has exclusive control over the land (Van Hook, 1994: 293). This inability to have ownership rights and/or controls over land compromises a woman's ability to provide for the family. But, even women that attempt to work outside the home face many legal and cultural obstacles. Employers in Botswana are legally bound to pay men and women equally for similar work, however laws do not forbid discrimination in hiring practices (Ibid.). Women are forbidden to hold certain jobs, such as working in mines. Women that are employed as domestic workers or are working in the informal sector have much less legal protection than people employed within the formal economy (Ibid., 294). Hence, women are much more likely to be over-exploited in the work place.

There are many reasons to suggest a link between the low socio-economic status of women and the susceptibility to HIV. According to the UNDP, the sense of "low esteem that discrimination and poverty visits upon women circumscribes their right reproductive health choices, thus predisposing them to HIV infection" (28). Poverty has similar effects on women throughout southern Africa, especially when poverty is stratified by sex (i.e. men are wealthier than women). Generally, in conditions of poverty many women in Botswana are compelled to exchange sex for material support from men and to seek casual sexual partners to help meet family needs. The fact that 80% of all unmarried women in Botswana are mothers compounds this problem (Van Hook, 1994: 299). There is also evidence to suggest that transactional sex is being used in order for women to gain employment or promotion (Botswana Human Development Report, 2000: 28; UNAIDS – Gender and HIV/AIDS, 2000: 15).

Adverse economic situations sometimes force women into commercial sex work. Commercial sex workers are a particularly vulnerable group in Botswana and in the whole of southern Africa. However, Botswana authorities and international NGO's lack reliable information regarding "the size and dynamics of the commercial sex sector, in part because commercial sex work remains illegal and substantially underground" (Botswana Human Development Report, 2000: 29). According to MacDonald, commercial sex workers exist in Botswana and are scapegoated as the main transmitters of HIV, but the more significant trend in terms of the spread of HIV is the number of women who sell "sex on a much more informal and casual basis "who would consider themselves prostitutes (MacDonald, 1996: 1331).

### **Migration and the Spread of AIDS in Botswana**

One of the characteristics of the spread of HIV in Botswana that distinguishes the country from many other African countries where HIV rates are high is that the AIDS epidemic has been spread to all areas of the country in an extremely short period of time. The disease has hit the urban centers of Botswana particularly hard, but in the countryside HIV rates are also above 20%. In small mining towns the disease is prevalent and even in some of the most remote areas of the country the HIV prevalence rate is above 10% (MacDonald, 1996: 1329; UNAIDS Epidemiological Fact Sheet, Botswana, 2000). The fact that AIDS proliferated throughout all areas of the country is mostly a result of the highly mobile nature of Tswana society. In many ways the high rates of social migration in Botswana can be attributed to the country's modern economy that leads many lower class workers to move to urban areas, to mining areas, or to South Africa. Migration is an indelible part of the Tswana lifestyle and it is not just the modern economy that drives social migration.

The Batswana have always been characterized by their mobility. Most families have traditionally kept several homes throughout the country which they migrated between. Many families own one home in the village, one at the farm and one at the cattlepost, for example (MacDonald, 1996: 1329; Botswana Human Development Report

2000: 36). Botswana's modern infrastructure reflects how much the Batswana value mobility. In 1966 at independence, Botswana had only 12 km of paved roads, "by 1994 this had increased to 4668 km" (MacDonald: 1330; Alverson, 1978: 82). Currently there is an estimated 80,000 private automobiles and 4 airports in Botswana. Compare this to the 24,400 private vehicles, and one airport in Uganda (World Almanac, 2000: 778, 868). Traditionally this mobility may not have had any detrimental effects on Tswana society, but in the era of AIDS mobility can be dangerous.

...the traditional shuttling between village homesteads, land areas and cattle posts, and more recently urban areas, renders the urban/rural distinction largely insignificant when probing the dynamics of HIV and AIDS in the country. Botswana has developed a strong transport system that links most of the populated centres of the country. These factors partly explain why there is little difference between urban and rural HIV prevalence rates – and why HIV has been transmitted so widely, so quickly. (Botswana Human Development Report 2000: 36)

In contemporary Botswana, specifically, many men are leaving their families and villages behind to work in urban centers or in mines. This type of economic migration can very easily fracture family structures and it can also lead to opportunities for men and women to take other sexual partners (MacDonald: 1329). Social migration can have detrimental effects on both men and women, but often when it comes to migration because of economic reasons women are left in a more vulnerable position. Women do not migrate to work in mines because they cannot legally work in the mines. They do not migrate to take white-collar jobs in urban areas because women rarely hold white-collar jobs in the formal economy. When men leave their villages to pursue work elsewhere women are often left behind to care for the family. Men often contract HIV in urban centers or mining towns and spread it to their unsuspecting wives in rural villages. But when men leave their wives or girlfriends behind there are more chances of infidelities by *both* partners. According to MacDonald and Colclough & McCarthy, economic migration in Botswana is associated to an increase in the number of women bearing children with more than one man (Colclough & McCarthy, 1980: 175; MacDonald, 1996: 1329).

The Botswana Ministry of Health has targeted truck drivers that travel routes through Botswana, Zimbabwe, Zambia and South Africa as a 'high risk group.' Just as in Uganda, Botswana can attribute it spread of HIV to truck driving and economic

migration. However in Botswana the problem seems to be much more serious because Botswana is a country that is perpetually moving, hence sexual networks shifting and increasing in size.

## **Women and Politics in Botswana**

Women face adverse conditions in almost every facet of life in Botswana. The state has proven ineffective in addressing many of the inequalities and abuses that women face. In order to successfully address inequalities that make women more vulnerable to HIV women will have to infiltrate the state, and they will have to work apart from the state in NGO's and/or grassroots organizations. In Uganda women were able to put aside their ethnic and religious differences in order to organize and work within the state structure. Independent women's groups also played a big part in state reforms since the NRM takeover in 1986 in Uganda. As a result of this women's movement in Uganda, women have more freedom, a louder voice in government, and their conditions have improved so that they are not as vulnerable to HIV as they were under more restrictive and ineffective regimes. This type of movement has not occurred in Botswana for several reasons. The history of Uganda makes it more suitable for a women's movement: women gained acceptance through their contributions to the National Resistance Army, adverse economic and infrastructural conditions led women to cast aside their ethnic and religious differences and cooperate, the state had withdrawn from many aspects of Ugandan life and relied on independent women's groups to fill some of the voids.

Because women are so vulnerable to HIV in Botswana it would seem that a women's movement like the one in Uganda would help the entire country slow the spread of HIV. However, the social and historical conditions that allowed women to gain some power in Uganda are specific to Uganda. Currently a robust Botswana women's movement that operates within and outside of state structures seems quite unlikely to occur. The best Botswana policy makers can do at this point is to break down barriers that keep women from working in government. State sponsored HIV programs should focus less on treatment and more on addressing socio-economic conditions and inequalities that lead to the spread of the disease.

In a country in which women face large socio-economic and cultural disadvantages, women need to be a part of the policy-making process in order to improve their lives. Women have never been a part of the policy-making process in Botswana and their absence is largely attributed to cultural attitudes regarding the position of women in society. A Tswana adage, often quoted by Botswana to explain women's absence from political leadership maintains that 'cattle are never led by a cow, or they will fall into a pit' or, more simply, 'cows never lead the bull' (Geisler, 1995: 545). According to Geisler, Botswana women's political participation is "little more than an extension of their submissive domestic role" (Ibid.). In many post-colonial states the struggle for independence drew women into the political arena, Botswana however, never had to struggle to gain their independence and women tended to keep their distance from politics. It was not until 1987 that the largest, most powerful political party in Botswana, the Botswana Democratic Party (BDP) formed a women's wing (Ibid.). The largest opposition party, the Botswana National Front (BNF) formed their women's wing in 1977. But these women's groups were not autonomous from the state or political parties. These groups were dominated by wives of politicians and were concerned most with fund raising activities for the party. According to the founder of the BDP women's wing, Clara Ohlsen, the group was established because the BDP displayed hostility toward women and the group was meant to be a forum to discuss what concerned women within the BDP and how to influence government policy. According to Ohlsen:

'When it came to discussing issues that were pertinent, we got a hostile reception, most of all from women', mainly the wives of ministers and parliamentarians, who were in the party 'by virtue of being wives not by virtue of being persons in their own right'. (Interview with Clara Ohlsen featured in Geisler, 1995: 545)

Clearly the women's wings of the BDP and BNF are far from autonomous, but the major problem made clear by the Ohlsen interview is that many Botswana women prefer not to separate their wishes and opinions from those of their husbands. In Botswana there exists a very small class of educated professional women, but they are not welcome in the organizations. According to many of the organizations members and outsiders, promotion within the women's wings is based on "the doubtful merit of being ignorant, ineffectual and loyal to the party leadership" (Geisler, 1995: 545). For women the safest

and the most restrictive form of political participation is involvement in women's wings of the two major political parties. Within these organizations they are kept under the party's control and under the immediate direction of their legal guardians (their husbands). For women in these organizations "political activity is truly an extension of their domestic role" (Ibid.). For these reasons demands for gender equality cannot be addressed in the BNF or BDP women's wings.

Serious, well-educated women politicians rarely involve themselves in party women's wings because their integrity is compromised. Women's representation in Botswana's parliament and state structures has always been quite low, but there are signs that women are making advancements. After Botswana president Festus Mogae was reelected in 1999 he nominated several women to be cabinet ministers. After the nominations Mogae:

Was taken to task over the competence and suitability of some of his women cabinet members. But Mogae, who had just promoted a number of women to positions of power and influence in his government, made a telling response. At a recent marathon news conference, the president stated that the women he had chosen were some of the best qualified and competent specialists not only in Botswana but in the region and beyond where their expertise has been recognized and utilized. As a parting shot, he quipped that under his leadership Botswana should start getting used to seeing women occupying position of influence because his appointments would henceforth be based on merit and not gender. As expected, Mogae's critics were men with misgivings on gender issues. (Owino, 2000)

Truly 1999 was a good year for women in Botswana as Mogae did not hesitate to appoint qualified women to high governmental posts, women doubled their seats in parliament in the October elections and there are now eight women in parliament and the National Council of Women was formed under the ministry of home labour and home affairs (however the autonomy of this council is still in question). And although women made many strides in 1999, many men in government still do not take women in government seriously (Ibid.).

A number of interviews conducted by the Panafrican News Agency on women in Botswana government suggested that their most important concerns were health issues,



particularly the spread of HIV/AIDS (Owino, 2000). The main issues that are of concern to women politicians in Botswana are the ones that have a direct impact on the vulnerability to HIV: rape, single parenthood, teenage pregnancy. Part of these women's strategy to liberate themselves is to change laws and attitudes that discriminate against them. One example of women's attempts to change laws are their efforts to amend rape laws. Women have called for tougher legal punishment for rape and have even suggested that rapists who knowingly infect their victims with HIV face capital punishment. Male dominated Botswana courts seem intent on loosening rape laws, however, and they recently ruled that the amended law denying rape suspects bail was unconstitutional (Ibid.). Clearly women politicians are making strides in Botswana even if state structures like the judicial system is contradicts some of their advancements. At the very least women in parliament and in cabinet positions are able to influence the political agenda.

Until recently one of the best ways for Botswana women to fight for equality and become politically active is to work outside of state structures in NGOs. NGOs have been on the front lines in the fight against AIDS in Botswana and are able to perform tasks that the state will not or cannot perform. According to Rosalind Saint-Victor, head of the UNAIDS mission in Botswana:

Government has a key role to play to provide funds, to provide advice, leadership, to egg people on and so on. But the change is going to happen in our homes and our communities, and that is where private organizations come in. We cannot allow them to atrophy. (Nessman, 2000)

NGOs are also better organized to address the gender issues of HIV/AIDS (Moloi, 2000). Unfortunately some of Botswana's top AIDS fighting NGOs have become starved for funds. The headquarters of two of Botswana's top AIDS NGOs have been moved into a small trailers that they now share. As Botswana's economy grew and the country became more prosperous international donors abandoned Botswana for its more impoverished neighbors, leaving many private humanitarian groups desperate for funds (Nessman, 2000). The Women and AIDS Project and the Botswana Christian AIDS Intervention Program now share a trailer and may be kicked out soon because they cannot afford rent. The Women and AIDS Project is now rendered nearly useless because its staff must now spend most of their time raising money rather than educating women about AIDS (Ibid.).

Increasing international aids is now reaching Botswana: The pharmaceutical company Bristol-Myers Squibb announced in December 2000 that it would provide over \$100 million over five years to help a number of countries, including Botswana fight AIDS and the Bill Gates Philanthropic foundation in cooperation with the pharmaceutical company Merck and Co. have donated another \$100 million over the next five years to strengthen Botswana's health system (Ibid.). It is doubtful rather any of this money will reach women's NGOs and/or NGOs involved in preventative work, because the funds are meant to strengthen Botswana's ability to treat AIDS victims and are not directed toward preventative measures.

## **Conclusion**

In September 1999 the UNDP slammed Botswana's AIDS program as having failed to curtail the country's growth in the HIV infection rate (Botswana Gazette, 1999). Specifically the UNDP Country Review criticized Botswana's national AIDS program because it has focused on treatment, home-based care, counseling and an orphan program, but has neglected prevention mechanisms (Ibid.). In response to these criticisms President Mogae launched the AIDS Coordinating Agency (NACA), a multi-sectoral body charged with monitoring, evaluating facilitating and coordinating the national response to HIV/AIDS in October, 2000 (Owinom, 2000). At the same time Mogae also announced an intensified information, education, and communication campaign targeted at several sectors of society, including sex workers and schools. Education on HIV/AIDS will form part of the syllabi's from primary to university level schools (Ibid.). Mogae and the Botswana government is definitely committed to fighting the spread of HIV: Mogae is certain to mention HIV/AIDS in every speech he delivers and the Botswana government is responsible for over 85% of all expenditures to fight HIV within the country (Simokoko, 1998: 12). It may be years before these actions have perceivable consequences. The Ugandan government began to take steps to stop the spread of HIV in 1986 after the Museveni takeover. An autonomous women's movement in Uganda did not begin until 1986 either. Yet it took several years to see the effects government action and the women's movement had on the spread of HIV in Uganda and

the prevalence rate got much worse before it started to decrease. HIV rates peaked at about 30% in Uganda in 1992 and fell to about 15% in 1997. While the Botswana state may have recently taken decisive actions to fight HIV, it may take years before we see the positive results of these actions. However, Botswana has very little hope of preventing the spread of HIV if women are put in positions in which they cannot negotiate their sexuality and achieve some independence from men. As long as women face violence if they refuse a man sex, as long as women cannot control whether or not they have safe sex, as long as women must rely on richer men to survive, as long as women face harassment or the threat of rape at school, the workplace and the home, the spread of HIV will continue to be a major problem in Botswana.

## *Chapter Five: Conclusion*

In this thesis I have attempted to show the causes of the spread of HIV in Botswana and Uganda. These countries are very different in terms of political history, the influence of traditional culture, and economics. In some instances different factors led to the spread of HIV in both of these countries. Uganda is more of a victim to its post-colonial history of ineffective governance and civil strife, whereas Botswana has experienced a relatively stable post-colonial era but has become vulnerable to HIV due to denial, the clash between traditional belief systems and modernity and internal migration. However there are many similarities between these countries and from these similarities we can better make generalizations about the spread of AIDS in southern Africa.

While a plethora of factors make African countries susceptible to the spread of HIV, I argue that women are inordinately affected by these factors and are therefore more vulnerable to HIV infection. My main argument is not so much that the subjugation of women has led to the spread of HIV (even though it has). More specifically my argument is that the factors that have made everyone susceptible have been inordinately damaging to the health of women. This idea can be applied to both Uganda and Botswana. In Uganda for example, the *magendo* (black market) economy made life more risky for everybody, however women were more detrimentally affected by the *magendo* economy because the only people who gained income during this time were men. Women were put into a position in which they had to depend on men in order to gain access to needed resources. Cultural expectations more severely affected women in Uganda since the 1970's because women have always been expected to raise a healthy family, but since the 1970's women frequently did not have access to the resources needed to support a well-fed, healthy family and with the decline of state health services it became increasingly difficult to ensure the health of the family. In the 1970's and early 1980's Uganda was an extremely dangerous area of the world and the appearance of HIV in the late 1970's made things much worse. But for women life in Uganda was even riskier because they lacked decision-making power in the home, the workplace and in

matters of sexuality, they were largely reliant on a man or a number of men, and for the most part they lacked education (or they were less educated than men).

In Botswana I argue that the spread of HIV is mostly due to the clash between the traditional and the modern. The belief in *boswagadi* perpetuated by traditional healers may lead many to deny their HIV status and all HIV-positive Batswana that ascribe to the traditional belief in *boswagadi* are equally affected. Batswana are also equally affected by the fact that traditional initiation rites in which community elders explained the virtues of being sexually responsible have largely disappeared since the advent of colonialism and modernism. However, women are made much more susceptible to HIV by cultural expectations regarding fertility, and marriage. In the research I conducted for my case study of Uganda I did not find that traditional or ethnic beliefs played a significant role in the spread of HIV. This may be the case because the social strife experienced in the 1970's and early 1980's forced many Ugandans to cast aside their ethnic differences in order to better cooperate with one another. One of the factors in the success of the women's movement in Uganda was that while the state may get involved in ethnic clashes and may play favorites when it comes to ethnicity, most women's groups are all inclusive and encourage diversity. Is it possible that as women cast aside their ethnic divisions that they began to perceive traditional and ethnic beliefs as less important? May this have an effect on HIV prevalence rates? Cultural constraints, post-colonial history, and to some extent economics may be very different in both Uganda and Botswana, but when it comes to the spread of HIV there are some similarities as well.

Although Botswana and Uganda have different economies in terms of size and GDP per capita, adverse economic circumstances drive women toward transactional sexual relationship in both countries. Often dissimilar social and historical factors have similar consequences in these countries. An example of this phenomenon is that sexual networks expanded in both Botswana and Uganda, but for different reasons. In Uganda sexual networks expanded as a result of the *magendo* economy of the 1970's and because of the ceaseless movement of armies through the countryside up until 1986. In Botswana

sexual networks have expanded as well, but as a result of high rates of social migration and the high cultural premium Batswana place on mobility.

But there also exist legal similarities between the countries that lead to comparable consequences. In both Uganda and Botswana the legal system often fails to protect the rights of women. Prosecuting rape and sexual abuse offenders is not a responsibility that either countries' legal systems take seriously. Sexual offenders often face no repercussions for their actions, so women face a greater risk of sexual assault beginning in their early teens and all through their lives. Both countries have legal impediments for women's property ownership. The legal difficulties women face when attempting to exercise property or inheritance rights are particularly salient issues in the era of AIDS because inability to own property or gain inheritance may push some women into risky transactional sexual relationships.

The adverse conditions existing in Uganda in the 1970's and early 1980's (particularly economic malaise and civil unrest) gave rise to cooperation and organization among women and the acceptance of women in more positions of power. Conditions of civil unrest pushed women to take up arms and fight alongside men in the bush. Women who were left behind during times of war looked after businesses and often solely responsible for the household. In recent years women have made significant strides toward influencing Uganda's state agenda, they have fought to reform the education system, they have achieved some economic independence and some grassroots women's organizations have filled in where the state's influence has receded (i.e. in clinics and schools). During the past few years as women have attempted to empower themselves HIV rates have fallen significantly.

The decrease in HIV prevalence rates in Uganda could be attributed to the proactive approach taken by the Museveni regime after 1986. But the regime's approach was always mindful of how women would be affected, and Museveni himself realized how important women were if we wished to fulfill many of his political aspirations. Botswana's President Festus Mogae has begun to take a more proactive approach that is

in some ways reminiscent of Yoweri Museveni's approach. It is important to remember that in the context of AIDS Botswana got a late start compared to Uganda: the disease hit the country several years after it surfaced in Uganda, and state institutions only recently began to take action. So it may take several years before initial government efforts to stop the spread of AIDS in Botswana take root (this was certainly the case in Uganda). Already Mogae's appointment of several women to cabinet positions shows initiative similar to Museveni's, but it remains to be seen if Botswana men will support the more widespread empowerment of women.

A women's movement of the scale existent in Uganda cannot be expected to occur in Botswana. Botswana's history does not lend itself well to the organization of a women's movement. The state has not receded from social services as they did in Uganda, so there is not so much of a necessity for women to organize and fill in for the shortcomings of the state. While women's economic circumstances in Botswana have not always been favorable they have never been as dire as they have gotten in Uganda, so there is less of a need for women to organize savings clubs as they did in Uganda. Botswana's transition from colonialism to the post-colonial era was remarkably peaceful and successful, so there were little political issues for women to rally around. War and adverse economic conditions had unforeseen positive consequences in Uganda because these factors forced women in Uganda to take on new positions of authority and to organize and cooperate. In Botswana it would be ridiculous to advocate that a war or an economic depression be initiated in order lay the foundation for a women's movement. However, the strife in Botswana caused by the spread of HIV may lead the Botswana to reassess cultural norms that facilitate the spread of HIV. It may also force women to work together and to fight for more decision-making power in the home, workplace and in government. As mentioned above the most salient issues for the few women involved in Botswana state structures are issues of health. They are particularly concerned about the factors that make women highly susceptible to HIV infection.

Obviously not *all* women face strenuous socio-economic, cultural conditions in which they are not free to make their own decisions. But as long as a significant

proportion of the female, southern African population faces conditions in which they are at educational, socio-economic, cultural disadvantages HIV will continue to spread. If members of a significant portion of the population must rely on transactional sex with one or several men to gain access to needed resources it is to be expected that HIV will spread through the entire population. Likewise, if a significant portion of the population cannot always control when or how they have sex we can expect the entire population to be vulnerable to the spread of HIV. Women's vulnerability to HIV leads to everyone's vulnerability to HIV.



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