21. The vulnerability of women: is this a useful construct for policy and programming?

C. Desmond Cohen and Elizabeth Reid

"*For us, women's liberation has to start from where we' re at, not you're at!*"

Introduction

The revealed evidence of the continued spread of HIV infection of women in Africa, particularly sub-Saharan Africa, is not evidence that all efforts to reduce transmission have failed. For we do not, as is usual in the social sciences, have evidence of the counter-factual: what would have happened in the absence of the HIV policies and programmes actually followed. Or what might have been the experience if a different set of policies and programmes had been implemented. We simply do not have the technical capacity nor the resources for estimating with any acceptable degree of accuracy what would have been the level and distribution of HIV infection under different conditions. But the data we do have, imperfect as it undoubtedly is, portrays a situation which is deeply disturbing. HIV prevalence for women attending antenatal clinics in many countries of East, Central and Southern Africa of 20-40 percent and higher is perhaps evidence enough, if any was needed, of the probable failure of most of the prevention activities of the past decade.

We say 'probable' because there can be no certainty about any conclusions in this area, where much that is worthwhile has been done, and communities and governments have responded with compassion, and with resources, to the challenges posed by the epidemic. But the facts remain facts: high and continuing infection of men and women, independently of social class [and its correlates], in both urban and rural populations, and with personal and socio-economic consequences which threaten the basic structures of social and economic organisation. That the HIV epidemic has a capacity to undermine social and economic development in Africa is now readily accepted by many, although acceptance of this conclusion does not seem to carry with it much by change in development practice, in the *how* of development. Nor does it in itself provide much guidance about how to design and undertake those specific policies and programmes for HIV and AIDS which might hold out a greater chance of success. These are, in our view, the same thing: better development practice generally is also what is needed for HIV programming in the same way

as it would be for activities for poverty reduction, gender, the environment and so on (Banuri *et al.* 1994).

The purpose of this paper is not to describe the epidemic as it affects women in Africa nor is it a scientific analysis of the situation. It is deliberately 'non-social-scientific' in its methodology and approach and its conclusions are practical and, in that sense, clearly neither testable nor generalisable. The paper is much more prosaic in its objectives than most social scientific research on the epidemic. It builds on our own experience of working on the epidemic, alongside others who are day by day responding in their personal and professional lives. Thus, the paper has its starting point with the quotation above: the need for policies and programmes, some of the things that get done, to start '*where people are at*' (Chambers 1994). It cannot be said that generally, not everywhere to be sure, this principle has sufficiently informed the response to the HIV epidemic.

In what follows, we have taken a number of episodic descriptions and inductively analysed these so as to draw out what seems to us to be observations important for any response to the epidemic in Africa. In doing so, we have aimed to distinguish between culture and cultural practices; to give support to those who emphasise responsibilities rather than rights; to argue that social change and transformation have their origins in 'where people are at', and that the aim of development is to release this potential in individuals, communities and states (Joy and Bennett 1995). The analysis is the antithesis of the approach so common in this area that emphasises the 'vulnerability' of women [individually or as a group], and we reject the very foundations for much of that analysis and the policy prescription which follows. If we are right —maybe only half right— then a re-evaluation of what is currently being done, and its praxis, is urgently needed.

No individual solutions

Analysis which begin from the realities of women's daily lives create a textured and intricate understanding of what needs to be changed. However, strategic development —the attempts to answer the question of 'How?'— which encompasses *only* women will often just create safe havens or intermissions in a continuing context of disempowerment, discrimination, and humiliation. For the quality of women's lives is determined not only by their own actions but by the attitudes and behaviour of husbands, children, mothers-in-law, employers, public servants, and also by the economic, cultural, and political values of their countries.

To understand this better, let us join Helen, Stephan, Miriam, and other friends who are sitting around in the evening, chatting over a glass or two of beer. Helen, not long returned from her fields, is presiding behind the counter. The setting is rural Uganda.

> "Stephan, smartly dressed, an electrical technician, exclaims that he wants to marry. But, he laments, none of the possible brides is going for less than

five cows and his father says that times are hard and he cannot afford more than two and so his son must wait.

Bitterly, Stephan points to the Health Ministry anti-AIDS poster above the refrigerator: 'Love Carefully! Stick To One Partner!' Why, he demands, is there no poster telling parents how to behave. Miriam points out that, since coming to power, President Museveni has repeatedly begged parents to bring down the bride price but without success, at least, Miriam adds, around Bushenyi.

Well, ventures someone from outside, the notion of buying a wife is barbarous and must change if women are to be equal.

You don't understand, bursts out Helen, you think a woman feels bad if she's exchanged for cows or money. But if there's no exchange she feels worth nothing. I cost my husband ten cows. I had a good education from Irish nuns at Mbarara, I speak English and can run a business. My father spent money on me, why give me avay for nothing? You want a healthy, educated bride, you pay for it.

Stephan raises his voice: I only want my own woman. I'm not crazy, I know all about AIDS. With a wife I wouldn't live risky. Why must men pay to make women feel better? A wife costs money, you have to keep her. Her family would have to keep her if she didn't marry. Why must I pay to get her so she costs her family no more?

That's bad thinking, retorts Helen. Women must feel valued or we can't look for equality. If my husband got me free, I couldn't start a revolution. A free bride's a slave —no worth, no status, no respect. Everyone knows my bride price was ten cows. When I talk revolution they listen, with respect.

So you see, Jill smiles softly at the outsider, for us, women's liberation has to start from where we're at, not where you're at"! (Murphy 1994: 17-128).

And so the evening ends but the problem remains unresolved. Stephan and other men in Bushenyi remain bitter and scared. Helen and the other women continue to demand that women be valued. And similar conversations are occurring in communities around the world.

In this situation, there might be some women who individually can negotiate or demand protection from HIV infection. They may be able to refuse to have intercourse with their husbands if they do not trust them, or to leave with their children. However, such a strategy would not slow down the spread of the virus among men. And such women are few and far between. Most women are economically, socially, and emotionally dependent on their husbands in such a way as to make them unable to negotiate safety.

Helen has given a great deal of thought to this problem, as have many women. She sees it as a question of survival. The evening before she had argued that women have to say no to risky husbands but they can't, on their own. They are scared but they reject divorce. So, she said, we get together. A husband living risky comes home and sees not only his scared wife, waiting to obey. He sees a *group* of women, all with the same problem, all saying the same thing! This is revolution. It is bigger than our political revolution. It is men being compelled to hear women.

However, strategies of women individually or collectively attempting to protect themselves and their children, even if effective, can only be short-term stratagems. A decision to forego sexual expression or relationships which have a sexual dimension may not be sustainable over the longer term, or the personal price of sustaining it may not be acceptable. It also means that these women must forego the creation, nurturing, and raising of children. This is a form of emotional deprivation that few women would wish to endure for a lifetime. Women-centred strategies show that women can empower themselves in certain ways but there are limits to what they alone can achieve.

Thus, in both the shorter term and more particularly the longer term, any strategy will have to encompass the Stephans of the world as well. The men and women of the community will have to start discussing women's value and men's behaviour and come to some decision about how the impasse might be broken. Consensus will have to build throughout the community, and decision-making will need to be collective. It is not just a question of *how* to build communities and sanctuaries, it is also a question of *where*, that is, *with whom*, to build them.

Women-focused strategies need to be complemented by strategies that bring together and transform the lives of all those who yearn for and dream of a better way of living *now*. Certain changes can be brought about by women together. Other changes will require that men work together to develop a language that names some of the tragedies and distortions of their own growing up in a sexist society, a society where they are both oppressed and oppressing. Others will require not only broader-based alliances but also inclusive collectives of men and women, rich and poor, young and old, healthy and unwell, the articulate and the inarticulate.

Is silence golden?

A recent workshop for NGOs asked the participants, men and women separately, to prepare a group map of a village they were familiar with and to identify on it places of 'situational risk' for HIV. Much time was spent on the niceties of cartography [where precisely was this road or that road] which has, fairly obviously, nothing to do with mapping accuracy, but something else. Finally, the two groups came together and displayed their maps. There was much similarity but one significant difference. Both groups identified brothels/bars and both thought that the streets where traders gathered might be important. But the big difference was that the women, but not the men, placed a question mark over the houses where they and their families lived. The men's response to this difference was not that of denial that risk of infection might be present at what is for many communities the core social institution. Instead, there occurred a period of non-verbal communication: neither denial nor confirmation.

Yet, of course, the data on HIV transmission supports the women's suspicions that the home is a primary centre of 'situational risk'. To put it more bluntly, that most married women in Africa get infected as

a consequence of normal marital sexual relations with their husbands. It is estimated that some 60-80 percent of African women in steady relationships who become infected with HIV have one, and only one, sexual partner —their husband or regular partner. Understanding why this is so is essential for effective responses to the epidemic. Further, unless support for women [and men] is generated somehow for changing the status-quo, then we stand little chance of reducing transmission of the virus. Endogenous factors which are leading to positive changes must be present, but these are almost certainly too slow in acting, and will need support from exogenous forces.

But while the constraints on social change within the cultural setting of many African communities are great, they are not insuperable (Hope *et al*. 1995). Social change in the face of the epidemic is taking place slowly, to be sure, but it is there. So the purpose of policy and programming [often viewed as exogenous, but they need not be] is to support the forces which are demanding changes, and to recognise the capacities which are present for bringing these about. The emphasis needs to be on the possibility for change; the capacities already present in families and communities which can bring these changes about, and how to support these processes.

Let's turn to a brief personal history which is rich in elements important for understanding the problems faced by women and which provides signposts for future analysis and response. The story is that of Aimée Mwadi, a Zairian professional, and goes as follows.

> "The story I am going to tell you is true. I have loved and perhaps I have betrayed... I carry the weight not only of the years, but rather of what is unsaid and everything that has been hidden.
>
> I married wen I was nineteen years of age; now I am mother of three boys. Our home was a modest one, and we were full of love for each other. However, as time passed, I became increasingly more insecure because my husband did not allow me to express myself or to have basic rights as an individual. Even, for example, in the face of my husband's infidelity. That is why I decided to continue my education, despite his disapproval. After I completed my university studies I had the good fortune to go to France to train as a specialist in HIV diagnostic research techniques.
>
> Upon my return, my husband announced that he was officially a polygamist and planned to have as many wives as he could afford. I did not become jealous, but rather indignant and scornful...
>
> I spent days absorbed in thought and inner conflict. I could see the negative and positive consequences of my decision. Finally I regained my bearings because of a recurring thought: 'This is a matter of life and death'. With this in mind, I gathered the courage to begin an open dialogue with my husband...
>
> He remained firm in his resolve to practice polygamy and refused to change his decision. It was upon this refusal that I demanded he agree to an HIV test before I continued any sexual relations with him, or that he use a condom. He rejected both requests and that was the beginning of our duel. He tried many things to change my mind. Blackmail, threats, and sometimes physical abuse, but I stood by my decision to protect myself and my children from his high-risk sexual behaviour...

> I often wondered if I had made the right decision and I asked myself if I was not suffering from HIV-related phobia. However, reality made my decision firmer, in spite of the constraints, arguments, threats, and false accusations of infidelity made by my husband's family. I thought of leaving my home but concern about my children's future kept me from doing so, especially now that their father had rejected us.
>
> Finally my husband spoke openly with his brothers about our conflict. They then held a family meeting to decide on the punishment they would impose upon me. I had humiliated their brother, even though, in accordance with African tradition, he was the one who had paid the dowry... My husband officially left me in August of 1988.
>
> Through my personal experience and the experiences of others, I learned that many women suffer in silence. We have been educated to respect the African tradition of resignation: a wife is at the service of her husband and his family. If one only knew how many of our sisters have been sent to the hereafter by the very resignation which our grandmothers and mothers have taught and continue to teach us. Now HIV has changed many aspects of our lives and humanity is facing a plague which requires that we reassess and reform some of our cultural and traditional values" (Mwadi 1995: 131-135).

A full exegesis of the above scarcely seems needed and it could be argued that the key elements in the story are self-evident. It could also be argued that little can be learnt from it of relevance to the lives of ordinary African women who have not had the benefit of higher education, exposure to metropolitan life and culture, and do not have the financial and economic independance derived from formal sector employment. All this may be valid —Aimée faced possibilities which are not part of the decision set normally available to most African women. From this, one could conclude that ameliorating the social and economic lives of women ought to be a central objective of development, from which everyone gains [this is not some sort of zero sum game since men, women and children are better off than otherwise]. Undoubtedly a Pareto efficient solution, and one which is the basis of most policies aimed at reducing gender inequalities. No one would object to policies for ameliorating the lives of women and everyone would accept that in time these would create conditions favourable to a reduction of HIV transmission. But this is a 'good' in itself and countries should pursue policies and programmes because this is a moral [equitable] and efficient thing to do.

What is being argued here is that policies and programmes which improve well-being may not, in themselves, be the way to prevent HIV infection in women. Indeed, Aimée's story confirms that changing what some commentators call 'contextual factors' may not fundamentally change the position that women find themselves in —that education and economic independence may leave largely unchanged the relationships within a marriage and many of the external factors which affect the functioning of it. People are culturally conditioned for good or ill, and in a world of HIV, many aspects of culture are life threatening. Thus the question Aimée poses for herself, 'I often wondered if I had made the right decision...?', and the guilt that remains, 'I have loved and perhaps I have betrayed'.

Internal to any relationship are feelings and emotions which, to a degree, are independent of objective factors, including assessment of risks. Thus, what Aimée is seeking from her partner is valuation of herself as a woman. It is this issue of valuation of women's lives which is the core of the problem.

These feelings are central to the human condition and are not much changed by processes of personal and social amelioration [the well-being agenda of development practitioners]. It is ultimately not a matter of 'rights', and seeking this route as an avenue of social change will be fraught with problems and conflicts. This is not to argue that 'rights' are unimportant, for they clearly are [the rights of children, property rights, etc.]. But a rights-based approach to HIV transmission within marriage will probably achieve little and cause much conflict. Isn't responsible behaviour what, ultimately, Aimée's story is about? The lack of it in her spouse and his unwillingness to recognise what the consequences are for himself, his family and others of unchanging behaviour [both sexual and non-sexual].

'A Tora Mousso Kele La': A call beyond duty [1]

It is a shameful fact that hundreds of thousands of women die every year unnecessarily during chilbirth. Isn't this evidence enough of the low value put on women's lives? 'It is estimated that globally some 585,000 maternal deaths [pregnancy related] occur every year... about 99 percent of these deaths occur in developing countries... 40 percent in Africa [which has 20 percent of the world's births]... most maternal deaths can be prevented...' [WHO 1996: 13]. This is not news; we have long known that huge numbers of women die during childbirth and that this is preventable. It is also worth noting that many more women die in this way than from HIV-related illnesses— but both, of course, are preventable.

How is the continuation of this level and pattern of maternal mortality in Africa to be explained, and is it simply and only a matter of access to appropriate medical services? Or are there much deeper determinants at work, and will the unravelling of these help us to understand issues which are at the core of HIV transmission— of the causes of morbidity and death? In asking these questions we obviously feel that the answer is 'Yes', that there is much to learn which is relevant to HIV prevention from a deeper understanding of the socio-cultural context of maternal mortality.

Which leads, naturally, to the Bambara expression, '*a tora mousso kele la*', which can be translated as 'she fell on the battlefield in the line of duty'. Societies have, over time, developed and adopted systems of beliefs, customs and norms of behaviour which become the elements of their culture. Only if these are understood and their implications for maternal mortality identified, will it be possible to define the framework within which programmes for reducing maternal

---

[1] Much of this section is based on *A Tora Mousso Kele La* (Diallo 1991).

mortality can function. Diallo [1991: 3] has argued that the assumptions underlying the expression are :

- *Childbirth is assimilated to a battle.*
- *Any battle, in essence, has inherent and unavoidable associated risks. Among the risks are casualties and deaths.*
- *It is the duty, not to say destiny, of women to have to go through this battle in order to achieve the ideal familiy size required by the norms of society.*
- *As a 'warrior', the pregnant woman is valued for her bravery, expressed in terms of stoicism.*
- *In preparation for the battle, the major emphasis is centered around psychological coping strategies for achieving the stoic stance.*
- *Society, for its part, develops strategies to transcend the adversity of and eventual casualty; in this instance, maternal death.*

Implicit in the above is a perception that childbearing is analogous to a battle, and in battles there are always going to be casualties. It becomes the duty of women, in the interests of continuing the lineage, to accept stoically the burdens [and sometimes the pleasures] of childbearing. So maternal mortality, long experienced by families and communities, becomes a part of the normal functioning of West African societies. Furthermore, since maintaining the lineage becomes the primary purpose of childbearing it follows that fertility becomes a virtue to be celebrated, and infertility something to be denigrated and shunned.

This then is the framework of values, norms and expectations within which 'modern' attempts to reduce maternal mortality have to function. And, not surprisingly, the attempt to introduce new medical solutions have rarely been successful because they do not take account of the extant socio-cultural conditions. As Diallo observes, 'along the path all the factors that contribute to maternal health are interrelated, and a viable programme has to take these into consideration for strategies to be effective. It is therefore essential not to omit the root causes'.

It is a pity that the warning contained in this quotation from Diallo has not been much heeded by those developing HIV prevention strategies. Too often, if they have taken culture into account at all, and often they haven't, they have interpreted culture as 'cultural practices' which is not at all the same thing. While such practices as ritual cleansing or circumcision have a role in HIV transmission, and changes are desirable, they are more or less insignificant in the total picture of HIV transmission where 80-90 percent of infections are sexual. There is little or no evidence of sustained behaviour change in Africa, which has been the primary aim of more or less all HIV prevention programmes. But is it surprising that this is so if the analysis given above is anything like a picture of reality ?

Norms, values and behaviours are deeply embedded in society and generally change, but slowly. Thus women are expected to endure pain in childbearing and to die in large numbers in the supposed interest of the group [lineage]. They are expected to submit to the sexual demands of their spouses under conditions which will maximise fertility. Being fertile is for women in such societies a badge of honour, a source of status and position within the family, the extended family, and the village. How could one ever have imagined that changing such fundamental elements in ways that change social positioning was feasible through the kinds of interventions so typical of HIV policies and programmes? In this world where so much is culturally determinate it was always unlikely that providing information on HIV and urging men to use condoms would fall on deaf ears and be generally ineffective.

But culture is not constant, and can change. So the object of policy is to understand it and to try to work with the forces which are changing norms, values and behaviours. In the hope that leaning into the wind [going with and supporting change] will at least be going in the right direction. It may not. There is some evidence from East Africa that the high HIV-related mortality amongst women is leading among men to scapegoating which blames women for the epidemic. This has to be countered, for it is simply untrue. All the evidence supports the proposition that most women, certainly married women, are infected by men and that it is men's behaviour which has to change. But this is Catch 22 yet again: men's sexual and other behaviours are culturally determinate and can be changed only slowly, if at all. But change it must for lineages to survive and communities to prosper. For men, as for women, the present state in non-sustainable —both are dying unnecessarily because of HIV and AIDS. Where there are only gainers and no losers from social and cultural change then surely there can be hope and something for policy makers and programmes to work with?

Conclusions

This not the kind of paper which lends itself to simple conclusions. It has been more of an exploration of ideas than a formal presentation, with observations [hopefully well-founded] as and when they appeared apposite. The authors feel strongly that descriptions of problems do matter and the terms that are used that become common parlance are also important. Too much of policy and too many programmes have not heeded the warning at the outset of this paper —they have not '*started from where we're at*' but from '*where we are at*'.

Therein lies the source of much of the difficulty and the apparent weakness of many well-intentioned actions by many people. This is not confined to HIV-related activities, and other critical areas of public policy have been similarly accused. Thus Chambers, surely the best grounded and most perceptive writer and practitioner, has argued that the praxis of development requires major changes in approach. 'If

poor people's realities are to come first, development professionals have to be sensitive, to decentralise, and to empower, enabling poor people to conduct their own analysis and express their own multiple priorities'. Those working on HIV and AIDS have been slow to heed Chambers' advice and many of our problems have their origins in our own practice.

Nowhere is this more evident than in our understanding and our responses to the problems faced by women in Africa. There have been too many preconceptions and too many preconceived answers. Our analysis of problems and of the day-to-day reality of the lives of most women have been largely based on what we believed and what we thought possible. In doing so, we often closed out possibilities for social change and, in doing so, have disempowered those who most need our understanding and support. Women can be 'the dynamic promoters of social transformation that can alter the lives of both women and men' (Sen 1995: 105) but, as argued above, there are 'no individual solutions'. Men have to be active agents of social change as well as women, for unless this is so, then women-only strategies can, at best, be only partial and short-lived solutions.

Bibliography

BANURI Tariq *et al*. 1994. *Sustainable human development: from concept to operation.* New York: UNDP.

CHAMBERS Robert. 1994. *Poverty and livelihoods: whose reality counts?* London: Intermediate Technology Publications.

DIALLO Boucacar. 1991. *A Tora Mousso Kele La*: a call beyond duty -often omitted root causes of maternal mortality in West Africa, New York: UNDP/HIV and Development Programme (Issues Paper No.9).

HOPE A.S. Timmel and HODZI C. 1995. *Training for transformation*, Gweru, Zimbabwe: Mambo Press.

JOY Leonard and BENNETT Sherrin. 1995. *Process consultation for systemic improvement of public sector management*, New York: MDGD - UNDP.

MURPHY Dervla. 1994. *The Ukimwi road: from Kenya to Zimbabwe*, London: Flamingo/Harper Collins.

MWADI Aimée. 1995. "The power to silence us", *in* Elizabeth REID (ed), *HIV and AIDS: the global inter-connection,* West Hartford: Kumarian Press: 131-135.

SEN Amartya. 1995. "Agency and well-being: the development agenda", *in* Noleen HEYZER (ed), *A commitment to the world's women: perspectives on development for Beijing and beyond*, New York: UNIFEM.

WHO. 1996. *The World Health Report 1996,* Geneva: WHO.

C. Desmond COHEN and Elizabeth REID, *The vulnerability of women: is this a useful construct for policy and programming?*

Summary — At the core of the dominant explanation of HIV infection amongst girls and young women is the concept of 'vulnerability'. It is argued that women are vulnerable to HIV for cultural, social, economic and physiological reasons such that changing these conditions will affect in significant ways the levels of HIV infection. The paper proposes that both the modelling of HIV transmission and policies and programmes which are based on the concept of vulnerability are too simplistic. That this approach fails to capture the complexity of the relationships between men and women. A brief exploration of some of the neglected factors and evidence throws doubt on the conceptual base of 'vulnerability' as a construct. In conclusion the paper calls for analytical structures which are both more complex and based on the reality of women's lives.

Keywords: vulnerability • women-focused strategies • social change • valuation of women • well-being agenda • culture • social norms/values • maternal mortality.

C. Desmond COHEN and Elizabeth REID, *La vulnérabilité des femmes : est-ce une bonne base pour une politique et une planification ?*

Résumé — Au cœur de l'explication dominante de l'infection à VIH chez les filles et les jeunes femmes, on trouve le concept de la vulnérabilité. On affirme que les femmes sont vulnérables au VIH pour des raisons culturelles, sociales, économiques et physiologiques. Changer ces conditions affecterait de manière significative les niveaux de l'infection à VIH. L'étude avance que la modélisation de la transmission du VIH, aussi bien que les politiques et les programmes fondés sur le concept de vulnérabilité, sont trop simplistes ; que cette approche n'a pas réussi à saisir toute la complexité des relations entre hommes et femmes. Une brève exploration de certains facteurs négligés a manifesté des doutes quant à la base conceptuelle de la "vulnérabilité" comme une construction. Enfin, le document invite à proposer des structures analytiques à la fois plus complexes et davantage fondées sur la réalité des vies des femmes.

Mots-clés : vulnérabilité • stratégies visant les femmes • changement social • valorisation de la femme • bien-être • culture • normes et valeurs sociales • mortalité maternelle.