Culture, Sexuality, and Women's Agency in the Prevention of HIV/AIDS in Southern Africa

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A B S T R A C T

Using an ethnographic approach, the authors explored the awareness among women in southern Africa of the HIV epidemic and the methods they might use to protect themselves from the virus. The research, conducted from 1992 through 1999, focused specifically on heterosexual transmission in 5 sites that were selected to reflect urban and rural experiences, various populations, and economic and political opportunities for women at different historical moments over the course of the HIV epidemic.

The authors found that the female condom and other woman-controlled methods are regarded as culturally appropriate among many men and women in southern Africa and are crucial to the future of HIV/AIDS prevention. The data reported in this article demonstrate that cultural acceptability for such methods among women varies along different axes, both over time and among different populations. For this reason, local circumstances need to be taken into account.

Given that women have been clearly asking for protective methods they can use, however, political and economic concerns, combined with historically powerful patterns of gender discrimination and neglect of women's sexuality, must be viewed as the main obstacles to the development and distribution of methods women can control. (*Am J Public Health*. 2000;90:1042–1048)

The tragic AIDS epidemic that is presently engulfing southern Africa is based on heterosexual transmission. An estimated 1 in 10 young uninfected women in southern Africa can expect to become infected each year (S. Abdool Karim, personal communication, 2000) in an epidemic that shows no signs of abating.[1] At a conservative estimate, an effective vaccine could be 10 years away.

Successive field studies were carried out by teams of anthropologists, including one or both of the authors, at 5 sites in southern Africa between 1992 and 1999 to explore women's awareness of HIV/AIDS and what they can do in heterosexual negotiations to protect themselves from infection. On the basis of questionnaires, interviews, and open-ended discussions concerning use of the male and female condoms and abstinence, and the circumstances under which each method was regarded as appropriate, we were persuaded of the urgent need for fresh approaches to prevention.[2]

Here we present some of our observations, which lead us to conclude that with regard to women at least, each community needs to be studied in terms of the local situation, and the preventive measures advised and facilitated for residents must take account of the differences between communities. These differences include employment and access to resources for men and women, level of political awareness, and a related issue—the perception of the boundaries of sexual authority for women and men. HIV/AIDS prevention will be successful only to the degree that the changing needs of women as well as men are recognized and responded to by local, national, and international policymakers.[3–8]

Background

The latest prevalence figures estimated by UNAIDS for the numbers of men and women in sub-Saharan Africa infected with HIV are 10.1 million and 12.2 million, respectively.[9] These estimates are even higher than those given for 1996, the midyear of our studies. AIDS is the leading cause of death in many of these countries. In the Republic of South Africa, where the statistics are the most complete, annual rates of seropositivity have shown the most alarming and consistent rise year by year, and those among young women, the steepest.

As noted above, statistical models based on the quoted rates estimate that at least 1 new infection occurs among every 10 uninfected women each year. By some counts, this is an underestimate: first, infected women, who tend to be less fertile than uninfected women, are underrepresented in prenatal clinics, which is where most cases are first diagnosed; second, direct estimates of recent cases, nowadays based on laboratory studies, have in some areas suggested a 20% annual infection rate. Mortality studies, too, are projecting substantial increases in deaths from AIDS, especially, again, among young women. We can assume from these data that the greatest risk of infection in the areas we studied is faced by young women, probably those in the 15- to 25-year-old age group.

Although tests for HIV/AIDS are often not accessible, counseling is rare, and confidentiality is not always maintained, it is also the case that medical treatments for HIV/AIDS are unavailable to most women in southern Africa. When available, treatment generally focuses only on the opportunistic

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diseases that often accompany infection. Thus, prevention has to be the focus of public health messages. Although breast-feeding is now known to transmit the virus from mother to child, the dilemma involved in discouraging breast-feeding and thus subjecting infants to the risks of fatal gastroenteritis or starvation has yet to be addressed on a community-wide level among poor populations. Nevertheless, preventive messages focusing on "one partner" and "love faithfully," the compromise solution frequently adopted by governments in southern Africa and elsewhere, overlook the realities of life for many.

The broader social context—which includes widespread poverty and unemployment, particularly among women; a history of men's crossing national boundaries in battles for independence or other military actions; social disasters; and the increase in intra-Africa economic exchanges, which are based on colonial patterns of production reinforced by uneven regional investment in the global economy—is heavily incriminated in the spread of HIV/AIDS in Africa. Advice to be monogamous is hardly likely to be heeded in such circumstances.[10] Polygyny has been the rule in many African societies and is still common in many. In addition, the involuntary migration associated with men's employment away from home, experienced by almost all families in rural and semirural areas, is associated almost inevitably with casual and extramarital encounters, and not only for the men. As a result of all these factors, extramarital sex is frequent among men and widely tolerated, if not enjoyed, by women. This statement is derived from comments made both on formal questionnaires and in focus groups.

There is at least one sad circumstance that favors preventive behavior: as people observe the deaths of family members, infants, and neighbors infected with HIV/AIDS, their awareness of their own risk becomes more firmly internalized. Although this awareness occurs rather late in the epidemic, it is a stimulus for women to take action and search, sometimes desperately, for steps they can take, individually or collectively, to protect themselves and their community. This was certainly a phenomenon we observed during our visits.

Two points emerge from this analysis, and they were validated in our work. First, under the threat of the AIDS epidemic, seeing kin and neighbors succumb and knowing these victims are no different from themselves, women are demanding methods of prevention and are willing to use them. Second, there are approaches that informed communities can develop collectively both to care for those infected and to limit the further spread of infection. The women in communities such as the ones we visited are neither unaware nor passive. They are ready to express their views and ready to mobilize to achieve realistic goals.

Field Sites

The field observations were carried out by the first author (I.S.), joined by Eleanor Preston-Whyte and Quarraisha Karim on the South African visits, Richard Lee on all the visits in Namibia and Botswana, and Karen Brodkin in Namibia in 1997.

The research at the 2 sites in Durban, South Africa, was part of a larger community education project dealing with HIV/AIDS, with ongoing evaluation both through questionnaires and through participants' comments about community groups and political avenues of representation for men and women. In 1992, with the participation of Z.S., observations were conducted in an agricultural village outside Durban and an informal settlement on the outskirts of Durban. In 1995, Eleanor Preston-Whyte and I.S. returned to the informal settlement to follow up on the research of 1992. (The agricultural village could not be revisited at that time because it was the site of intense political violence.) We conducted 3 public meetings with women who had participated in the original community education efforts.

The research in Namibia was conducted with Richard Lee as part of a larger project that was concerned with training students from the University of Namibia in anthropological research with respect to HIV/AIDS. In 1996 we interviewed informants in the Ovambo-speaking region Okavango. In 1997, with Karen Brodkin, we conducted similar interviews and observations in Rundu along the Okavango River. In 1996 and 1999, Richard Lee and I.S. conducted interviews along the border between Namibia and Botswana, the home of the Ju/'hoansi, a Bushman people living in the Kalahari Desert. At each site, we were accompanied by translators who were familiar with the area as well as the language.

The research at each of the 3 sites in Namibia included interviews with health care providers and other institutional representatives, such as church officers, teachers, and representatives of local and international nongovernmental organizations. We also talked with both men and women at public meetings and in their homes. Although our inquiries and discussions on each occasion were informal, when talking with women alone or with mixed groups we did ask questions about their understanding of HIV, what they thought about possibilities of preventing infection, and how they perceived their sexuality in response to the risk. We also asked people whether they had seen or used either a male or a female condom.

Although the focus of the research was not use of the female condom, our interviews were open-ended, and as it turned out, the reactions of women respondents frequently brought this method to the forefront of the discussion. Nevertheless, the discussions did not always take the same form, and certainly both the level and the nature of the response differed widely from site to site, a point to which we return in the conclusion.

Agricultural Village Outside Durban, South Africa (1992)

The first visit was to a rural village, scattered over a series of hills, and was a 3-hour bus ride from Durban. It was, in 1992, part of the area designated to the control of the Zulu king. Both men and women went to Durban for work. However, transportation was expensive and difficult, and the common pattern was for men to go to town for the week and return on weekends. Most of the women participated in a communal gardening project 3 days a week when the irrigation was turned on. Although the women earned some money by selling fruit, vegetables, and old clothes and through child care and domestic work, many relied on men for cash contributions.[2] At the time of the initial fieldwork, laundry and bathing were done in the river at the bottom of a hot, dusty hill upon which the mud and ashbrick homes were built, and drinking water was carried up by women and children from the same source. In 1991 and 1992 a public works project was instituted that introduced electricity and running water to the village.

Residents were represented at civic council meetings, and in 1992, all civic council members were men. All members of the tribal court were men, and many of these were the same men who represented the village in African National Congress (ANC) regional meetings. Although there were 120 organizations among the approximately 10 000 residents, women did not often speak publicly. Field researchers reported that in 1992 women were not expected to speak up in front of men in this rural community, which was under the control of the largely male hereditary chiefdoms.

Through answers to our questionnaires and through the public discussions we observed outside one clinic, it became clear that AIDS was associated with witchcraft and with the disease that, according to folklore, a man contracts if he sleeps with another man's

partner. At the meetings held by researchers outside the clinic, the women scarcely spoke; the few men on the periphery of the group of women actually attending the clinic were much more vocal than the women. A survey of 200 households in the village indicated that the women did not know how to identify sexually transmitted diseases or the names of any such diseases. In contrast, the men were very well informed.

It appeared difficult, in this setting, to involve women in meetings and for women to negotiate safe sex with men or even to talk about their own health issues.[2]

Informal Settlement on the Outskirts of Durban (1992, 1995)

The informal settlement north of Durban consisted of about 5000 homes inhabited by an estimated 30 000 people. This population had only begun to move to the area after the pass laws that restricted African residence in urban areas were revoked. In 1992 the area had no sanitation, running water, or public services such as garbage collection, roads, or lighting. People walked and drove along winding, dusty, narrow, and precipitous paths. As a result of the efforts of the women's community organization, 7 faucets had been built in scattered locations around the settlement. People could collect water for use in their households from these faucets.

Children had to travel to neighboring municipalities to attend school, and educational levels were low. Most residents spoke Zulu; many also spoke some English. Among this large population, still disenfranchised at that time, a vibrant informal economy existed. Bricks were made in the settlement and used to build houses. Although men still had more options for paid employment, women in the settlement, because of their proximity to the Durban markets and service opportunities, had more ways to support themselves than women in the rural village. Because of these opportunities, women who migrated to the new informal settlements on the periphery of the city were often single heads of households. They found work as household servants or babysitters to support their families. Many also tried to generate cash by making candles, baskets, and clothes and selling them locally or in Durban.

Although the informal settlements lacked electricity, nearby townships were sources of information and television. It is important to note that people in the area did have access to international media. During one informal discussion, a group of young people asked about riots that were occurring in New York City at the time we were talking with them—they had seen coverage of the riots on CNN. They were exposed to a wide variety of topics through the international media. Thus, in general, people in the informal settlements were aware of HIV and other issues.

The researchers made contact with the community through a sewing cooperative organized by and for local women. As noted above, this cooperative had also worked to bring water to the community. They had begun to weave baskets for sale and were concerned with developing ways to tie into the informal economy.

In terms of discussion of sexuality and HIV infection, the women in this cooperative presented a contrast to the women in the rural community. In a 1992 meeting, members of the research team discussed HIV with about 50 women and 3 or 4 men. Even before the meeting started, the room was in an uproar—the local community organizer, a woman, had brought in copies of the ANC constitution, newly translated into Zulu. The transition from White domination of South Africa to a multiracial government was about to take place. (In 1994, South Africa held its first multiracial election, and the ANC won by an overwhelming margin.)

Dr Nkosasana Zuma, who later became the Minister of Health (1994–1999), was a member of the research team at the time and the ANC representative from the area. She spoke to the group in Zulu about the importance of HIV and the need for women to protect themselves. Next, a representative from the US foundation that funded the community education research project spoke briefly in English, and then American researchers mentioned the development of the female condom.

At this meeting, the women were very outspoken in front of the men. Women in the audience stood up and argued with the men in the back of the room who claimed that the young girls hanging around the harbor were "asking for it [sex]." The women talked about the lack of economic alternatives that led women to sell sex. One woman explained that a woman who had spent the entire day in Durban unsuccessfully looking for work and returned to the settlement with no money might exchange sex for 10 rand to buy sugar for her children that night. The women did not see these situations as being restricted to a group of "sex workers" or "prostitutes" but rather talked about the sale of sex as one last option available to women whose families were in desperate need of money and food.

The women were explicit about economic needs and said that the best method they could imagine for preventing HIV in the settlement was to provide work for women. They requested that the project consider funding a candle-making factory. They pointed out that since there was no electricity in the settlement, this would be an extremely profitable concern.

When asked if they would use the female condom, the women became enthusiastic. They said that they would definitely use something like that, over which the woman had control. They asked when the female condom might be available and asked that the researchers provide them samples as soon as possible.

Thus, only a few miles removed from their previous existence in the rural areas, women's experiences and their perspectives on sexuality—as well as their willingness to speak in public—were dramatically altered.

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In 1995, Eleanor Preston-Whyte and I.S. returned to the informal settlement with the community liaison person from the 1992 project. At the meeting convened by the liaison person, we found that the women were well aware of the threat that HIV infection held for them and their children. When asked who was most at risk, they immediately replied that it was women; they said that this was because their partners had other women, and they themselves were dependent on men for support. As before, they made the point that if they had jobs, they would be able to refuse sex to men who refused to use condoms. The point was also made, without prompting, that women should be able to avoid unprotected sex with a number of men. "Poverty makes prostitutes of us," they said. The connection between sex, particularly sex with more than one partner, and HIV infection was made again and again. Also repeated was the fact that condom use prevents infection.

Although the women at the meeting demonstrated a knowledge of HIV risk and of the role of male condoms in protection, when we asked if their partners were using male condoms, no woman said yes. When we asked why not, one woman commented, "It is good to have women's groups to help us, but there is no group to support you when you are alone with your husband." Another woman said, "It might be better if we had a

female condom," and this comment led to an excited discussion.

The women asked to see a female condom, and when we returned a few days later, we brought a demonstration kit with us. The reaction was immediate and positive. About 25 women had collected in the community hall to meet us, and after the demonstration, they eagerly handled the condoms and jokingly practiced using them with the dildo provided by the liaison person. When we cautioned that men might reject their use, as they did the male condom, the women overrode our hesitation. "We can use it and teach other people to use it. It is better that you bring it quickly and that it is free."

This opened the way for a discussion once again of the problems women faced in the area, the lack of adequate housing and employment being paramount. One woman said, "In these small 2-roomed shacks the children can hear everything . . . maybe it will be difficult to talk about this new kind of condom. . . . What we need is better houses." Another noted, "It will be easy to use the female condom if you are working. You just say to your husband that you must not get pregnant or you lose the job. Even a woman can stay alone with her children if she has a job. So we need jobs." Still another commented, "If we have this new condom, we will get our men to use it. . . . It will help us a lot." Finally, a woman said, "We are mostly relying on our husbands because of unemployment. The only way of leaving them is employment. If we earn money, we have power. . . . If we can wear them, we will be free."

Although they are available in some pharmacies in South Africa, female condoms are extremely expensive, even for relatively wealthy middle-class women. The national AIDS program and the Ministry of Health intended to make them available free through clinic services. However, there was to be a delay of at least 3 months before female condoms might become available. (Five years later, at the time of writing, the program is still facing barriers to implementation.) When we relayed this information to the women at the meeting they were indignant. "You must tell the minister [of health] to send us female condoms first. . . . We need them here, and we will show they can work," said one. Another said, "Tell the minister to bring the female condom quickly. . . . If it should have come before, we would have limited our families more easily." We ended the meeting by writing a letter to the minister. The women signed their names in an exercise book and spoke into our tape recorder so that "she [the minister] can know that no lies are being told."

Namibia: The Ovambo-Speaking Region (1996)

In 1996, Richard Lee and I.S. visited the University of Namibia in Windhoek to work with Namibian students in sociocultural research on HIV. Two students, a man and a woman from the Ovambo area, then accompanied us to their home region, serving as guides, informants, translators, and, by the end of the project, interviewers and researchers.

In the Ovambo-speaking region, we interviewed hospital administrators, nurses and doctors, church leaders and counselors, and men and women in their homesteads in the communities along the road north. We visited the homestead of one student and he introduced us to his mother, his aunt, his brothers and sisters, and neighbors in the farming area. His father and older brothers were away, working in a town about 2 days' drive distant. Most of the families in this area relied for cash on the men's work in the towns, particularly Windhoek. The men traveled the 700 km from Windhoek to their homes in minibuses Friday night and returned in the minibuses and public buses that began the drive back to Windhoek Sunday morning and continued all day Sunday.

Families who owned homesteads cultivated the fields surrounding their homes. Men and women who had no land and lived in the shanty areas might find temporary work, often unpaid but providing food and shelter, as laborers on the land. The women, responsible for children and with few options for employment, might also sell home-brewed beer in little shacks along the highway, especially at the major bus stops for the journey down to Windhoek. Such stops were also places where women could exchange sex for money.

"Tell the minister [of health] to bring the female condom quickly."

The church and the hospital were major institutions that helped to define the treatment of HIV/AIDS in the region. We learned from hospital administrators that many elite members of the Namibian government and their staffs had received medical care for AIDS but that the government kept this information confidential. Nurses at the hospital said that community members did not believe in AIDS because illnesses were not given that name, and the doctors would say someone died of one of the opportunistic diseases, such as diarrhea or tuberculosis.

A pastor in the area told us that people did not believe in AIDS because "no one has died of it." He claimed, "You'll never know if somebody died of AIDS, only maybe after somebody is buried it is a rumor." He added that the church "can't ask what the sickness is, even for your own child. . . . They have codes for sicknesses, one will never find out what the person died of. . . . It is a heterosexual matter, and the church doesn't know how or what to do. . . . It is not discussed because there is not evidence that the person died of AIDS." Like the doctors and nurses, the pastor claimed that people did not talk about AIDS openly or admit to others that they had the disease, even when they might be dying from it.

The pastor also said that he was opposed to the distribution of condoms, which was based on the assumption that people did not practice chastity before marriage and monogamy within it. In his words, "Our church does not support the case of condoms to be used, especially by unmarried persons. They are based on the issue of woman and man—a condom, it's like you get rid of principle and breaking it and giving freedom for people to go around." He would not discuss AIDS with his congregation except in terms of sin and chastity.

Although it was a progressive force for African freedom and a strong supporter of the South West African People's Organization (SWAPO) in the war for African independence, the church in Namibia has developed constraining views of family norms that do not directly correspond to the lives of migrant workers, who have a history of polygamous living on homesteads. Many Namibian ministers, including those we interviewed, have been trained in the United States and reflect some of the fundamentalist moral trends that are strong in certain sectors of the US population. In some ways—for example, in its opposition to the distribution of condoms—the church has contributed to the silence about and stigmatization of AIDS. AIDS counselors at the hospital said they believed many religious leaders initially opposed the government's program for the distribution of condoms and made effective prevention difficult. However, as the following cases demonstrate, such ideas were not always expressed by rank-and-file members of church congregations.

In one homestead close to the church grounds, in the midst of harvested fields that resembled a desert because of the overgrazing in the densely populated region, we found women who knew of and talked openly about people with AIDS. Similarly, when we visited a devout church worker and her sister and children in another homestead several

miles down the highway, we found women who were concerned and knowledgeable about the AIDS epidemic in their midst.

In the middle of a hot, dusty day we were brought to the first interview by our student, who had gone to a religious school with one of the daughters in this homestead. Inside the compound of mud shacks and shanties made of corrugated iron, we were greeted by a woman carrying a small boy and surrounded by many other children. We began talking to the woman, and she called in her sisters, who then called in their teenaged daughters to join the discussion. Although both of our students were with us, which meant we were 2 men and 2 women, the women did not seem reluctant to discuss contraception or AIDS.

Women in this compound were very aware of the issue of AIDS and also knew people with AIDS. To quote one of the women, "People know that there is AIDS and they talk about it. They are not hiding it any more, because they know people are getting it. They know people that have AIDS and they talk to them. People in the community are taking care of AIDS victims." One of the sisters took up the discussion. She said they were all concerned about AIDS: "Women are very open. They talk to each other about AIDS. . . . Yes, they acknowledge that it is possible they have it. They are very afraid."

These women knew that AIDS was sexually transmitted, and they wanted their husbands to use condoms but they could not insist. "It's different," said one. "There are some women who ask men to use condoms but some women don't say it." Later another said, "A husband will not agree to use condoms with his wife. . . . He says he sleeps around but will use condoms outside, but she can't be sure." They said they were worried that they would get AIDS and die.

Eventually, we showed the women the female condom. They became very animated and said it was what they needed: "We want the female condom today." One woman noted, "It is important that the semen will remain in the woman because men don't like to take the semen out." Another woman said, "You can bring it [the condom] here."

The women asked where female condoms were available and discussed the cost of the condoms at the local pharmacy. They were eager to use female condoms; they said that although they could not say anything to their husbands, they could use anything they chose. They said definitely that it did not matter that the men could see the female condom; if it was theirs, they had the right to use it: "A woman can make her own decision." One woman said, "This will be protective from the woman's side." When we pointed out that we could not provide female condoms and that they were expensive, one woman insisted, like the women in Durban, "Go to the ministry [of health] and tell them to order female condoms. . . . Maybe it's better if we have this report [that we said we were writing] and write them a letter."

We then interviewed a man and his girlfriend in the shanties along the edge of the road, which housed the poorest laborers of the region. The man and the woman said they knew people who had died of AIDS and they knew about the male condom, but they were not willing to talk to us for long.

The next significant interview was with our student's mother and aunt. Since he thought his mother would be more comfortable talking with women, he and Richard Lee went to interview a neighbor while the woman student and I.S. stayed to talk with his mother and her sister. Both women were in their 40s. They showed us around the homestead. The small buildings were made of mud with straw roofs and were separated by bamboo screens. Each son and daughter over a certain age had his or her own hut, and the entire compound was surrounded by a bamboo wall. Outside the wall were dried-out fields where cattle grazed. The student's mother showed us the beer she had brewed, alcoholic for adults, nonalcoholic for children, and the enclosed but roofless area where she and her sister cooked in huge iron pots over an open fire, using spoons and other instruments made from local material. Four little children, dusty and dressed in rags, played around our feet as we all sat down on the ground under the trees for the interviews.

"We want the female condom today."

However, lest this homestead sound like an unchanged traditional setting, it should be noted that the son who was working with us was a college student (the first in the family), the husband had a civil service job far away, and in the teenaged son's hut, next to his bed, was a pack of condoms. The mother worked as a liaison for the church, helping to identify children with disabilities. The student who was working with us had run away as a teenager to join SWAPO in Angola when the South African army occupied Namibia, returning only after Namibia had won its independence.

In this "traditional" compound in a rural area in the far north of Namibia—where water had to be fetched from a faucet a mile away, most of the food was prepared from subsistence crops, and the utensils in the enclosed patch of sand that served as a kitchen were fashioned from local materials—we found extensive knowledge about AIDS. Both women talked about people they had known who died of AIDS. A couple who lived across the highway had both died recently; the wife had asked her neighbor to visit her so that she could tell her neighbor she had AIDS and that others should know. The 2 women also told us about a member of their church who had been in the hospital and had written a letter to be read during the Sunday service. He said he was dying of AIDS and he wanted people to know. He did not want to die in secret but wanted to warn other people about the disease. The women told us that everyone thought his girlfriend and her baby must have AIDS and that she had left the district and disappeared. They were also wondering whether her next boyfriend, who now had another girlfriend, might be infected.

As this example demonstrates, people were very aware of the possibility for heterosexual and perinatal transmission of AIDS. Although this awareness sometimes led to stigmatization (which might explain why the girlfriend left the area), people knew very well the mode of transmission. Devout, respectable churchwomen told us that women had no say in an Ovambo bedroom—they could not ask a man to use a condom or discuss any other sexual issue. However, they were extremely enthusiastic about the female condom, saying that this was something women could use. It would be under their control. They said explicitly that if they used a female condom they would not be inviting a beating, as they would if they dared to ask a man to use a condom.

These cases give a sense of the dynamics between women and men in Ovambo society. They suggest areas for mobilization for the treatment and prevention of HIV infection and demonstrate the significant agency, open-mindedness, concern, and knowledge to be found among women who might at first appear to be most constrained by church and family.

Namibia: Rundu, a Kavango-Speaking Region (1997)

In July 1997, Richard Lee and I.S. returned to Namibia with Karen Brodkin to conduct interviews among the Kavango people, the second largest population in northern Namibia. At Rundu, a regional center on the border between Namibia and Angola, we met with health workers, workers from non-

governmental organizations, and the head of the health district (an extremely articulate and knowledgeable nurse trained by the community health movement in South Africa), who took us to talk with some women in a sewing cooperative.

The sewing factory, which employed about 60 women, had been started at the suggestion of Oxfam Canada workers and was now an active concern run by the women themselves. They worked on their sewing machines at the back of a large shop. Their products were displayed in the front of the store, with no division between the seamstresses and the customers.

We walked into the store and started talking to the women at their sewing machines. Since it was an impromptu meeting, rising out of our request to be introduced informally to local women, we did not start by talking about HIV/AIDS. We asked the women about their sewing and the materials they used. They asked us what we did, and we told them we were concerned with AIDS. The women said they knew about HIV/AIDS. They had been told the modes of transmission by nongovernmental organization workers. They seemed somewhat bored by the topic.

At the end of the conversation I (I.S.) casually mentioned the female condom. One of the women, who had been listening in a desultory way, turned around and said, "Oh! I've seen one of those in the drugstore here." Another woman said, "Do you have one, can we see it?" I said I had not brought one with me, but I asked, "Would you use it?" The women said, "Yes, yes, tell us about it." I started to talk about the female condom as one method that women could use, and several women left their sewing machines and moved closer to listen.

We drove back to our rooms for the demonstration materials. When we returned about an hour later, the women were waiting for us. They left their sewing machines, looked at the books and pictures we had brought, handed the female condom around, and asked us to give them some. They said they were too expensive for them to buy. I said they would have to get their own government to provide them, and that this would be possible only if they mobilized collectively, as they had for the sewing cooperative, to make this a government priority.

These women wanted the condoms and were positive they could use them. They wanted to make a political demand for women's condoms—a reaction almost identical to that of the women in the Durban informal settlement and the women in the Ovambo region. Once again it became clear that given the resources, people would act to protect themselves, even if it meant changing sexual mores. The women in the sewing cooperative were familiar with AIDS. They had seen people die. They knew that they or their friends could easily be next. With appropriate resources and support, they said, they were ready to act.

The Kalahari Desert (Namibia, 1996; Botswana, 1999): The Ju/'hoansi

Next we visited the Ju/'hoansi of the Kalahari Desert, who were first contacted 30 years ago by Richard Lee. At that time, they were gatherers and hunters living in seminomadic band societies, with egalitarian relations between men and women.[11–13] The Ju/'hoansi now live in settled villages around government-supplied water sources. They support their households on a combination of government food supplements, temporary government-sponsored work groups, gathering, and infrequent hunting.

Here, we got a different response. As at our other sites, men and women knew about HIV/AIDS. They knew people who had died of the disease. However, the Ju/'hoansi women's description of their sexual negotiations differed from those of our other informants. One single woman, expressing the group's view, said, "If he won't wear a condom, I won't have sex with him." Another woman, exhibiting the autonomy of women described by Eleanor Burke Leacock, Richard Lee, and others,[11–14] said, "He can't control me. I will do what I want, and if he doesn't do what I want, I don't have to have sex."

The young Ju/'hoansi men also talked of their relations with Ju/'hoansi women as negotiations with equal agents whose opinions had to be taken into account. In fact, the young men said they hoped that a girl who became a sexual partner would agree to be the man's wife.

Discussion

The 5 sites we visited offer contrasting opportunities through which women might be helped to protect themselves against HIV infection; no methods are currently in use or playing effective roles. At the first site, a rural village in what is now Natal/Kwazulu, South Africa, women were, in 1992, reluctant to discuss HIV infection or contraception and tended to remain silent in the presence of men. They were poorly informed about sexually transmitted diseases in general and about HIV in particular. They had a small role in community organizations, appeared to be subservient to men outside as well as within the home, and were the only group visited that displayed the passive response and disempowered demeanor sometimes ascribed to African women in the literature.

The situation was very different in the urban settlement on the outskirts of Durban. Although they had only recently come from rural areas, the women here were articulate and politicized; they showed no hesitation in speaking up in the presence of men, contradicting the men when moved to do so. They were open and explicit about their experiences with men, equating their bargaining power with their need for money and resources: "Poverty makes prostitutes of us." Jobs would buy them independence. They were familiar with the male condom but were unable to insist that men use it. The female condom was just what they wanted; it would give them the control they sought. How can we demand that the government give us the female condom, they asked.

The women from Rundu, Namibia, also saw the need for political action; they wanted to mobilize and insist on their rights. Namibian women from both Rundu and the Ovambo region, like the women in Durban, did not believe that they could ask a man to use a male condom. Although they were just as emphatic about their wish to protect themselves from HIV/AIDS as the women in Durban, the Namibian women expressed a similar sense of cultural limits in their approach to sexual negotiation.

A complex cultural distinction underlay the demands of the women from Durban and Namibia. In their system of thought, women have rights over their own bodies, as men have over theirs. It is a man's prerogative to use or not use a male condom. However, although women cannot control men's actions in many situations outside the home, within the bedroom a man cannot prevent a woman from making decisions that affect her own body. Hence, when told about the female condom, the women became extremely enthusiastic. They could and would use this device, because it would be within their accepted domain of autonomy.

This point was confirmed independently by an ANC man who visited one of our meetings in 1995 at the informal settlement in Durban. He said, explicitly with reference to the female condom, "If it's in her room and it is her condom, she can use it." Well aware of AIDS, the women wanted desperately to be helped to acquire this single possibility for protection. They knew that they could not control what their men did—seeking other partners when they were away from home, for instance. Men might use the male condom on such occasions, but not with their wives.

It is striking that both the women in the urban setting in Durban and those in the rural sites of northern Namibia knew about AIDS but felt quite unable to preserve a monogamous relationship or to insist that their men use condoms. Yet both groups of women were quite confident that they could and would use the female condom, and they urged us to help them obtain some.

Quite different were the Ju/'hoansi women, who assured us that they would stand no nonsense from their men. Either the men would follow instructions to use condoms or the women would withhold sex. The young Ju/'hoansi men confirmed this view of relations between Ju/'hoansi men and women as negotiations between equals. We must add that although AIDS has certainly hit Ju/ 'hoansi villages, we have little evidence that the male condom was actually used. In addition, many of the sexual partners of young Ju/'hoansi women today are not Ju/'hoansi men but men from neighboring populations who are working in the Ju/ 'hoansi region. Ju/'hoansi women may not have the same autonomy in their relations with such partners, who have greater access to work and money than the Ju/'hoansi women or the Ju/'hoansi men.

At least 3 generalizations can be made from these studies. First, with the exception of those in the South African rural village, our respondents were by no means passive or submissive, and they were well aware of their vulnerability to HIV infection. Second, although they are well aware of the hazards of unprotected sex, women in southern Africa do not have access to methods they believe they could use. Faces brightened at our demonstration of the female condom, and the women responded eagerly to the suggestion that these condoms might be made available to them. Unlike some women in the developed world, but similar to women studied in Mexico, Senegal, and Costa Rica, they saw the female condom as a serious option.[8] Third, the women understood that in order to obtain this protective device, they would have to take political action, probably by collective organization. They did not expect that women's needs would be recognized or understood by the government.

Conclusions

Contrary to the view of African women as helpless victims, most of the women we spoke to saw themselves as active participants in the search for a way to protect themselves in sexual situations. Nevertheless, their methods of sexual negotiation are shaped by cultural and historical perceptions of the bounds of the human body. Among some groups, the Ju/ 'hoansi for instance, a woman can insist that a man use a male condom, and she can withhold sex if he refuses. Among other groups, a woman's request that her partner use a male condom is seen as a challenge to his authority. A woman controls her own body, however, and has the right to use a female condom. In our interviews in these various settings, both urban and rural, the women demanded that the female condom be provided to them.

Woman-controlled methods of protection, such as the female condom, are regarded as culturally appropriate among many men and women in Southern Africa and are crucial to the future of HIV/AIDS prevention. Since women have been clearly asking for such methods, political and economic concerns, combined with historically powerful patterns of gender discrimination and neglect of women's sexuality, must be considered the main barriers to the development and distribution of methods women can control. □

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