HIV/AIDS has reached pandemic proportions. With one African infected every twenty-five seconds (www.medilinks.org), it has been described as the ‘Black Death’ (Hunter, 2003, p.vi), and analogous to ‘one tsunami a month in Africa’ (Fanning, 2005, p. 24). Sub-Saharan Africa has had to bear the brunt of the pandemic. Though just more than ten per cent of the world’s population lives in this region, it is home to 63% of all adults and children living with HIV, globally (UNAIDS/WHO, 2006, p.3) and there are indications that this situation could escalate. Moreover, there is now an abundance of evidence showing that right across the globe, from sub-Saharan Africa to Europe, from Asia to Latin America and the Pacific, more women than men are being infected with HIV/AIDS (UNAIDS/WHO, 2006, p.3-4). In 2006, there were 17.7 million (15.1 million–20.9 million) women living with HIV, globally, representing an increase of over one million compared with 2004 (UNAIDS/WHO, 2006, p.4). 59% of people living with HIV in sub-Saharan Africa in 2006 were women. In this region, there are about 14 adult women who are infected with the virus for every ten adult men living with the virus (UNAIDS/WHO, 2006, p.3-4) and the ‘unevenness’ is even more pronounced among young women (the 15-24 age group), who are statistically three times more likely to be infected than men of the same age (UNAIDS/WHO, 2005, p.4).

As a sexually transmitted disease, it is widely accepted that sexual behavioural change is needed to lower HIV prevalence rates. The behavioural change paradigm of AIDS prevention is ubiquitous in sub-Saharan Africa where it continues to prevail in domestic national AIDS control agendas. It has been rejuvenated of late by the Bush administration’s commitment to the ‘ABC strategy: Abstain, Be faithful, use Condoms’ as its ‘dominant approach’ for fighting AIDS in Africa. The argument of this paper is that the apparent simplicity of this strategy masks its underlying complexity.

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Essentially, the behavioural change paradigm assumes, *a priori*, that people have the ability to change their behaviour at will, a presumption that simply cannot be made. This paper will argue that AIDS prevention programmes have tended not to take sufficient cognisance of the many factors that limit people’s behaviour and choices. Furthermore, the dilemmas behavioural change prescriptions pose for women are rarely considered.

A study carried out by myself and a research team in Mwanza region of Tanzania (2001-2003) showed that lack of information/knowledge about HIV/AIDS is no longer a major impediment to AIDS prevention in the country. On the contrary, the research revealed extremely high levels of awareness of AIDS/AIDS prevention media. Ignorance is not the problem as is sometimes implied. Indeed, both structured and unstructured interviews demonstrated that Tanzanians are well versed in the prophylactic value of the recommended sexual behavioural change. The problem, rather, ultimately lies in the mechanism by which this information might be translated into action.

In addressing the constraints to behavioural change in the country, the study considered the dilemmas women encounter in trying to ensure their safety from HIV infection, particularly when juxtaposed with the cultural rules of heterosexuality in the country and a material reality that constructs them as dependant on men. In so doing, it also identified a risk context for HIV/AIDS in Tanzania in which every Tanzanian is, currently, vulnerable and at risk.

**Sexual behavioural change: An ‘ideal type’ model of AIDS prevention.**

This paper argues that ‘one size fits all’ AIDS prevention simply does not work. The necessity to focus interventions in context-friendly terms is consequently stressed. The behavioural change model of AIDS prevention that revolves around the adoption of safer sex is, in essence, an ‘ideal type’. This ideal is very distant from the world most women inhabit. Moreover, as a model that is contingent upon individuals exerting control over their behaviour, it is utterly incapable of accounting for situations of sexual violence in which people are forced into risky situations that are totally outside of their control. The possibility that the ‘safe sex’ message may be quite ‘unsafe’ for millions of women is all too frequently overlooked.

A. Abstinence

The abstinence strategy is based on the principle that by refraining from sex, one avoids the potential risks inherent in heterosexual sexual intercourse. The reality is far more complex than
this simple premise suggests. In the first instance, many African countries construct abstinence as ‘unnatural’ because sex is regarded fundamentally as something that makes life worth living. Our research project found that abstinence, though cited as a general AIDS prevention strategy by a number of respondents, was considered to be largely ‘inapplicable’ in a Tanzanian context. The role of sex in procreation, so highly treasured in almost all African communities, is one of the principle reasons why abstinence remains an anathema to its peoples. Since sexual abstinence and fertility do not go together, many in sub-Saharan Africa will simply dismiss the abstinence strategy as moral and westocentric rhetoric.

In short, the abstinence strategy is simply not a practicable one in many parts of sub-Saharan Africa where decisions about sex are complicated and informed by a diverse range of motivations and needs. The precarious balancing act that accompanies sexual decision-making in sub-Saharan Africa is often misunderstood by prevention agencies prescribing abstinence in the region. For some women, suggesting abstinence may meet with a violent and/or suspicious reaction. Needless to say, for those women who are raped or coerced into having non-consensual sex, the abstinence strategy is totally inapplicable.

B. ‘Be faithful’

Monogamy

Monogamy, or ‘zero grazing’, as it is commonly referred to in parts of Africa, advocates sexual fidelity, or faithfulness, as a means of reducing the possibility of HIV infection. As a strategy, its simplicity suggests not only a certain social and cultural naiveté, but also a disregard for the rules governing heterosexual relations in Africa, as well as the material context in which these relationships take place. Most of the world’s women, UNAIDS reveal, are infected with HIV by the high-risk behaviour of their partner over which they have little control (UNAIDS/WHO, 2004, p.4). For them, being faithful to one partner does not protect them against infection; rather ‘they run the risk of being infected by that very partner’ (UNAIDS/WHO, 2004, p.28). UNAIDS cite a number of studies where women had been infected ‘despite staying faithful to one partner’ (2005, p. 9). Furthermore, UNAIDS/WHO record that, in many cases, ‘the main HIV risk factor for a woman is the fact that she is faithful to a husband with previous or current other sex partners’ (UNAIDS/WHO, 2004, p.10). This effectively eliminates the efficacy of monogamy as an AIDS prevention strategy for women in sub-Saharan Africa (Elias and Heise, 1993, p.15). The situation has generated concern among socially enlightened theorists, that AIDS prevention discourse has paid little attention to the needs of ‘the majority of women, whose risk derives from
sex with their husbands’ (Bujra and Baylies, 2000, p.47-8 citing Baylies and Bujra, 1995). In many respects, it could be further argued that because of the proclivity to focus on ‘risk groups’, a false sense of immunity has been instilled in those women who are in ‘regular’, monogamous, heterosexual relationships. Another cultural norm that limits the feasibility of the monogamy strategy is the sexual ‘double standard’, which forms an integral part of the rules of heterosexuality in many sub-Saharan African cultures. Here, men are given sexual licence whilst female sexuality is restricted. In Africa, this sexual double standard is internalised by both boys and girls at an early age so that many ‘[m]en feel pressured to ‘prove their masculinity’ by being dominant and having many sexual partners’ (Mgalla, Wambura and de Bruyn, 1997, p.89).

Statements by women in Tanzania illustrate the difficulty this poses in intimate relations. One woman reported, ‘faithfulness is something that is not in their [men’s] vocabulary’...they cannot stick to one wife because their tradition favours them’ (Mwanachawa Hamisi with Stella Mpuya, December 2002). Another woman remarked ‘...unfortunately, some of our husbands are not faithful. They ‘preach what they do not practice’ and in most cases it is men who bring diseases [sexually transmitted diseases] to their wives ...’ (Tabu Abdullah with Stella Mpuya, December 2002). Baylies and Bujra found that even within the partner reduction message disseminated by AIDS prevention agencies, there seems to be a tacit acceptance that ‘men’s multiple partnering cannot be eliminated altogether...’ (2000, p.176).

Partner reduction
The partner reduction message, clearly, is aimed at those who are not monogamous, and have more than one sexual partner. However, this advice rarely considers the crucial material component of sexuality for many poor women. In many sub-Saharan countries, ‘under conditions of scarcity and competition for survival’ (Ulin, 1992, p.67), the commodification of sex has become an economic survival strategy. A transactional dimension within the discourse of heterosexuality, where, in many instances, ‘both women and men believe that women should receive something in return for granting sex to their partners’ (Mgalla, Lambura, and de Bruyn, 1997, p.93) has facilitated the commodification of sex in sub-Saharan Africa. Such relations range from regular relationships where women provide sexual favours quid pro co financial assistance, to women exchanging sex for gifts a job or promotion, to the ‘sugar daddy’ phenomenon. In each instance, women have little leverage to insist on protective measures, regardless of how ‘informed’ they are.
C. Condom Use

Given that ‘[t]he male latex condom is the most efficient available technology to reduce the sexual transmission of HIV and other sexually transmitted [i]nfections’ (UNAIDS/WHO, 2005, p.12 citing UNAIDS/UNFPA/WHO, 2004), condom usage is widely advocated as part of the safer sex message disseminated by AIDS prevention programmes aimed at curbing the heterosexual spread of HIV infection. It is also the main preventive strategy of the Tanzanian government’s National AIDS Control Programme (Mbilinyi and Kaihula, 2000, p.94). The scientific orthodoxy, as expounded by the Centre for Disease Control and Prevention, is clear and unambiguous - latex condoms are highly effective against the sexual transmission of HIV when used consistently, and correctly, during sexual intercourse. This, tenet however, is by no means as ‘simple’ or straightforward as it appears.

The condom conundrum

Apart from the prohibitive financial cost of long-term consistent condom use, there are other levels, too, on which the use of condoms as an AIDS prophylactic is fraught with difficulties. The dislike of condoms, which I will refer to as condomodium, is grounded not only in deep-seated lay beliefs, but is crucially informed by social and cultural norms regarding their symbolism. A number of sociologists and commentators underlining the social side of HIV/AIDS have identified powerful lay beliefs about condoms. Maria de Bruyn, for example, records that within popular discourse, sexual intercourse with a condom is ‘likened to undesirable things like ‘bananas with chocolate’, ‘taking a shower with a raincoat on’ and ‘eating candy with the wrapper still on’” (1992, p.256). In Uganda, Obbo reports that ‘the use of condoms is fraught with many pitfalls’ (1995, p.83). These include fears that ‘condoms would fall off and get lodged in the woman’s vagina, with a harmful effect on the womb’ (ibid.). In Zaire, Brooke Grundfest Schoepf discovered similar fears that ‘condoms may injure women and even cause sterility’ (1988 (a), p.178).

Other socio-cultural beliefs have also been found to obstruct the implementation of the condom usage strategy in intimate relations. The association of condoms with promiscuity militates against the adoption of the condom usage strategy in stable sexual relationships. In Tanzania, our research confirmed that condom usage is not considered applicable in a committed long-term relationship, particularly marriage. This paper supports the call by Liddell, Barrett, and Bydawell (2005) for more research into the influence of such beliefs on condom use, on the basis that such information could be an effective AIDS prevention tool.
Studies have consistently shown that condoms are used less frequently in cultures where fertility is highly esteemed, confirming Ulin’s argument that ‘in African societies, the greatest deterrent to the use of condoms may be their contraceptive effect’ (1992, p.68). The centrality of fertility and childbearing in Africa is often misunderstood by western society. In Africa, as Elias and Heise remind us, ‘pregnancy is often the primary motivation for sex’ (1993, p.32). Schoepf et al. found that in many parts of Africa, bodily fluids such as blood and semen are freighted with ‘symbolic significance and emotional impact’ (1988(a), p.178) and are regard as magical substances by many (1988(b), p.638). Indeed a more recent analysis by Liddell, Barrett, and Bydawell (2005) confirms that such beliefs remain widespread in sub-Saharan Africa, where in many cases suggest that sexual intercourse is ‘imbued with mystical as well as earthly value’ (2005, p.4 citing Meyer-Weitz et al., 1998). Moreover, since the potential of personal fertility in terms of the furtherance of lineage is highly esteemed in many African societies (Liddell, Barrett, and Bydawell, 2005, p.4), condom use is often regarded as wasting and ‘showing disrespect for’ a ‘treasured’, life-giving ‘resource’ (ibid, p.11 citing Meyer-Weitz et al. 1998). Indeed the ‘fertility conundrum’ (Preston-Whyte, 1999, cited in Barnett and Whiteside, 2002, p.21) may arguably be the single greatest impediment to the adoption of condom usage in sub-Saharan Africa. Due to the potency of the motherhood discourse for so many women in sub-Saharan Africa, forcing women to ‘choose between motherhood and safe sex’ (Doyal, 1994, p.20) creates a huge dilemma for them. The situation is exacerbated further when a woman’s status and identity is contingent upon childbearing. An even bigger dilemma confronts women in those cultures where ‘there is no social place for women who are unable or choose not to have children’ (Carovona, 1991, p.136). AIDS prevention programmes that promote the condom usage strategy, ‘without serious thought concerning their interference with women’s childbearing’ (Elias and Heise 1993, p.1), will always meet with resistance in an African context.

The role of condomodium in frustrating AIDS prevention/ behavioural change has not been adequately explored. The results of our research confirmed findings from all over Africa, that the fact that condoms prevent conception remains a powerful barrier to their acceptability as an AIDS prevention strategy. As long as fertility continues to be so culturally esteemed, and indeed, continues to construct women’s subjectivities, condom use is a profoundly challenging concept for Africa.

For women who are financially/economically dependent on their male partner, the room for (wo)manoeuvre vis-à-vis condom use is even more restricted. For these women, implementing


the safer sex strategy by suggesting a man wear a condom (something that they are not used to doing anyway, since it is men who primarily control sexual decision-making) may result in rejection, abandonment, starvation and ultimately, death.

**Conclusion**

Sexual behavioural change is a complex concept. The behavioural change paradigm assumes, *a priori*, that people have the ability to change their behaviour at will, a presumption that simply cannot be made. Women who are subordinated, poor and disadvantaged have few ‘choices’ available to them, fewer choices about the number of sexual partners, the nature of sexual relations engaged in, and even less choice in terms of the type of prevention, if any, used. Their subjugated risk location dictates that they must engage in a precarious balancing act of weighing up one ‘risk’ against another. Exporting containers of condoms and leaflets calling for safer sex, though useful, is not the long-term solution to this quandary.

The existence of a risk milieu is thus central to an appreciation of the many ‘risks’ that are confronted daily in sub-Saharan Africa and the complex process of decision-making and cost/benefit analyses that must take place on a daily basis. Understanding the architecture of HIV/AIDS is a *sine qua non* of effectual prevention. Rather than the narrow risk group approach to AIDS prevention, then, this paper trenchantly supports a risk ecology (Barnett and Blaikie, 1992, Baylies, 2000, Lidell, Barrett and Bydawell, 2005) approach to AIDS intervention. This perspective considers multiple structural aetiologies of risk that are, generally, outside of individuals’ immediate control and puts them back on the AIDS prevention agenda. While there has been a distinct shift in the AIDS literature towards the appreciation of those risk factors that heighten the risk status of individuals, variously described as an ‘expanded response’ (UNAIDS, 1998, cited in Baylies, 2000, p.15), these are still in their infancy. For this reason, it is still too early to gauge their impact.

Given the limitations of the approach to AIDS prevention thus far, this paper suggest that a paradigm shift may be necessary in terms of how HIV/AIDS risk and vulnerability are conceptualised and where prevention interventions are focused. To put it bluntly, a ‘back to basics’ approach may be required in terms of re-imagining AIDS, not just as a medical condition (medical gaze), but also as a socially created syndrome (social gaze). By (re) focusing on the aetiology of AIDS in this way, those factors that have acted as social pre-cursors for HIV/AIDS in various milieus can be more fully understood, and ultimately, more practically addressed.
Empowerment appears to be the way forward if we are to have any long-lasting impact on the HIV/AIDS pandemic. As the only plausible antidote for powerlessness, the empowerment of women needs to become an essential component of any enlightened AIDS prevention agenda. I use the term in a broad sense to include a multi-level process of empowerment, on a number of critical levels.

Economic empowerment

There is an immediate need for survival strategies that truly ensure survival. This analysis has tried to depict a contradictory situation whereby, for many women, the need for subsistence i.e. material security, can often conflict with the corollary need to secure protection from HIV i.e. physical security. Thus, there appears to be a tension between maximising the odds of survival by ensuring subsistence needs are met, and maximising survival odds by ensuring protection against a fatal and virulent virus. This is a strategic gender issue that requires long-term structural engagement. It is essential that the concept of economic empowerment avoids the charge of rhetoric and translates into real and concrete policy priorities. The new and expanded critical model of AIDS prevention I propose involves an engagement with the structural and political forces and may ultimately necessitate structural/material reform. It will require, *a priori*, that women’s strategic gender needs be incorporated into an ethical, global AIDS prevention agenda.

Cultural empowerment

Given the cultural impediments to behavioural change cultural empowerment is a crucial ingredient in the empowerment project. Obbo (1995) was one of the original theorists to suggest that the AIDS pandemic has provided an opportunity to rethink many of the ‘taken for granted’ cultural and gender axioms (ibid 94) particularly those around female subordination. Another cultural practice that will need critical reconsideration is the sexual double standard that informs heterosexuality in many African countries that is currently endangering men and women in the continent. The Tanzanian case illustrated that hegemonic notions of male sexuality, particularly those that sanction multiple sexual relationships and taken for granted by individual men and women and governments alike, urgently need to be challenged, for both men and women’s sake. Cultural empowerment also involves a process of engagement with other cultural rules that organise heterosexuality to facilitate dialogue and the evolution of ‘protection-friendly’ cultural sexual mores.
Gender Empowerment

This analysis has tried to emphasise that, as it currently stands, many women in sub-Saharan Africa inhabit a risk space that is not only ideal for the flourishing of the pandemic, but is utterly antithetical to the achievement of sexual safety. The economic empowerment of women is but one step in this direction. Discriminatory gender-based norms that have resulted in women’s subordinated position in so many sub-Saharan African countries also needs to be considered part of the risk milieu that is increasing women’s vulnerability to HIV/AIDS and challenged and dealt with on this basis. Moreover, since certain definitions and practices around masculinity are currently imperilling both men and women’s health (Doyal, 2001, p.1063) that there have been welcome calls for a remodelling of the discourse of masculinity and its construction within the broader framework of heterosexuality. This would involve a redefinition of ‘what it means to be male’ (Elias and Heise 1993, p.36) in ways that are far more conducive to sexual safety.

HIV protection poses many challenges for women. Whilst it is important that education continues, those involved must appreciate the dilemmas that the behavioural change model poses for women. These dilemmas must be recognised if they are to be addressed. Though women may seem powerless in the face of such mammoth obstacles, they are not without ‘power, influence or capabilities’ (Baylies and Bujra 1995, cited in Baylies and Bujra, 2000, p.15). In 1997, I cited the tremendous potential of women’s ‘power within’ (Callanan, 1997, p.171). The women of Africa have held steadfast in the face of all kinds of adversity. In Tanzania, patience is not just a virtue—it is a verb. ‘Kuvumilia’ is the verb to be patient; it is an action word, something women actively do on a daily basis. HIV/AIDS is another challenge for them, though it may be the greatest one they have ever had to face. Viable, practicable, and ultimately, effective AIDS prevention in the long term may well depend upon building the structural support to allow women meet the challenges that AIDS awareness presents in their lives.

Though AIDS prevention is necessarily a long-term mission, this paper suggests a number of interim measures. Among other things, this could include a regeneration of interest in the promotion of income generating [micro finance/micro enterprise] projects for women, or the establishment of revolving funds that allow women to borrow from each other to start their own particular projects, as a potential route for empowering women in the short-term. The ‘majiko sanifu’ [economic stoves] seminars which Magu Community Development Department conducted with village women’s groups while I was a volunteer in the area proved to be a genuine success in reducing the time women spent cooking, thereby freeing up their time for
other activities. Similarly, tree-planting initiatives by the local forestry department helped to address the shortage of firewood that caused women to have to travel farther and farther in search of firewood for cooking and boiling water. Addressing practical gender needs such as these at grassroots level can yield important short-term benefits for women as well as men. Another useful suggestion is that, where they exist, local coping experiments (Barnett and Blaikie, 1993, p.288) need to be supported with immediate effect, rather than imposing external formulations on negatively affected communities (ibid.). For the sub-Saharan region in particular, any progress towards meeting the Millennium Development Goals is a step in the right direction in terms of long-term HIV/AIDS prevention. However, it is vital that none of these endeavours compromise the long-term project.

Baylies and Bujra argue that ‘the very depth of the crisis entails a liberatory moment through the collective struggle required if the causes of the epidemic are to be overturned’ (2000, p.xi). Only time will tell whether AIDS prevention agencies seize this opportunity, to create something positive out of the greatest catastrophe humankind has ever faced. In the meantime, however, many of Africa’s women continue to be positioned between a rock and a hard place; they are damned if they do (protect themselves) and damned if they don’t. Their dilemmas are far more than a matter of academic interest. For millions of women living in sub-Saharan Africa, this dilemma has become, quite literally, a matter of life and death.
Aengus Fanning’s article appeared in the Sunday Independent, Jan. 9th 2005. Fanning is one of a small number of Irish journalists who have used the tsunami disaster to highlight the more hidden tragedy of HIV/AIDS in Africa. Indeed, one week after the publication of Fanning’s analysis, Gene Kerrigan of the Sunday Independent referred to HIV/AIDS as one of the world’s ‘less fashionable disasters’ (Jan.16th, 2005, p.38). In a critical article, Kerrigan argues that while the ‘global outpouring of generosity’ in the aftermath of the Asian tsunami ‘creates a feel good event, in which we all take pleasure-almost regardless of the tragedy that spawned it…the vast majority of diseases and famines that afflict the world need more than outbursts of generosity’ (ibid.).

These are not their real names. Pseudonyms have been used to protect the identity of both the interviewee and interviewers.

**Bibliography**


**Author Information**

**Patricia Callanan** was awarded her PhD in University College Cork in 2006 for her thesis entitled “Damned if I do and damned if I don’t”: women’s dilemmas in the face of HIV/AIDS in sub-Saharan Africa”. She has a particular interest in development and was awarded the Vincent Tucker Memorial Scholarship for excellence in the field of development by the Sociology Department of University College Cork in 1998. She has been involved in temporary/part-time teaching on a continuous basis mainly (though not exclusively) with the Sociology Department in University College Cork, since 1998, and has taught a variety of courses including first year sociology on the BSc in Nursing and the BSc in the Public Health and Health Promotion, the Second Year BA/Social Science Social Structure Inequality and Stratification module and the Globalisation and Development module on the Third Year BA/Social Science Course. She also teaches a course, based on her PhD thesis in the first year Diploma in Development for the Adult Education Department.