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development - gender

Report No 13

Gender and HIV/AIDS in Sub-Saharan Africa: the cases of Uganda and Malawi

Report prepared for Centre for Development Studies, University College Swansea

by Rachel Marcus

September 1993

The authors gratefully acknowledge support for the preparation of this report from the Centre for Development Studies (CDS), University College Swansea. However, the views expressed and any errors or omissions are those of the authors and not of CDS.

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ISBN: 1 85864 148 9

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1. INTRODUCTION*

This report discusses the gender dimensions of the impact of HIV/AIDS in Sub-Saharan Africa, with a particular focus on Uganda and some reference to Malawi. The Ugandan Government has, from early on in its recognition of HIV/AIDS as a serious health, social and economic problem for the country, been relatively open about the scale of the problem and has allowed considerable indigenous and foreign research into HIV/AIDS. As a result there is substantially more material on HIV/AIDS in Uganda than any other African country. The limited existing material available on HIV/AIDS in Malawi consists mainly of seroprevalence surveys; discussion of social or gender aspects is absent. Inferences drawn for Malawi, therefore, are based partly on the experience of other African countries, particularly Uganda, and to a lesser extent Zambia and Zaire.

The primary focus of this report is the heterosexual transmission of HIV and its prevention, raising issues of gender and sexuality, on which there is a large literature. The focus on heterosexual transmission is not intended to further invisibilise male and female homosexuality, often presumed to be non-existent in Africa, but which a few studies have documented (Shepherd, 1987; Standing and Kisekka, 1989; Pellow, 1990). However, heterosexual transmission is thought to account for 90 percent of HIV/AIDS transmission in Sub-Saharan Africa. Moreover, most women and men in Uganda and other African countries marry at least once and/or may engage in heterosexual relations before, during and after marriage. Thus even the small minority of men and women who engage in same-sex relationships, or are celibate, may well be exposed to risk of HIV/AIDS through a heterosexual relationship at some point in their lives.

Increasingly activists from communities heavily affected by HIV/AIDS are stressing that prevention strategies are not enough - support needs to be directed to people already affected by HIV/AIDS. In the context of caring for people with HIV/AIDS a number of gender issues also arise which are tentatively explored in this report (Williams and Tamale, 1991).

The report is structured as follows. Section 2 provides an overview of the social epidemiology of HIV/AIDS in Uganda and Malawi, with a particular focus on gender disparities in prevalence rates. Section 3 discusses gender issues in vulnerability to HIV infection. Section 4 analyses prevention and control strategies and their gender implications, particularly in Uganda, and Malawi, but also with illustrations from other contexts. Section 5 discusses gender dimensions of care strategies in the countries concerned. The report concludes with recommendations on sensitising prevention and care programmes to gender considerations. An appendix listing the HIV/AIDS-related work of international and national organisations in Uganda and Malawi is attached, as is a bibliography, statistical data, and some information about the activities of TASO (The AIDS Support Organisation), prominent Ugandan NGO involved in HIV/AIDS work.

* This report was compiled by Rachel Marcus, Research Assistant, BRIDGE, in conjunction with Sally Baden, BRIDGE Manager. Assistance and advice from Alison Evans and Christine Kisamba-Mugerwa are gratefully acknowledged.

2. SOCIAL EPIDEMIOLOGY OF HIV/AIDS IN UGANDA AND MALAWI

2.1 Major transmission routes

In Sub-Saharan Africa, heterosexual sex is generally agreed to constitute the major route (approximately 90 percent) of HIV/AIDS transmission (RoU/UNDP, 1992). With adult[1] HIV prevalence between 4 percent and 30 percent in different parts of Uganda (RoU/UNDP, 1992:3; Wawer et al, 1991), unprotected heterosexual relations are clearly pervaded with risk.

However, perinatal transmission is of growing significance, as seropositivity rates rise and the number of HIV positive women bearing children increases. The significance of HIV infection through mixing of blood products varies between and within countries and is estimated to account for approximately 6 percent of HIV transmission in Uganda (RoU/UNDP, 1992:22). Mixing of blood products occurs mainly through transfusions, although ritual scarification and circumcision or infibulation may also be significant.[2] Intravenous drug use in Sub-Saharan Africa is apparently confined to large cities in West Africa, and appears to be a relatively insignificant source of HIV infection, at least in the countries discussed here.

2.2 Current prevalence

HIV/AIDS surveillance activities have been implemented by most African governments, including those of Malawi and Uganda, and several serosurveys to determine HIV prevalence have been conducted. However, figures for HIV/AIDS infection are generally understood to underestimate the scale of the pandemic. Tumwebaze et al (1992) suggest that the Ugandan Government AIDS Control Programme (ACP) figure of 3.4 million people living with HIV/AIDS in 1992 underestimates actual numbers by a factor of three.

This discrepancy arises due to the failure of reporting systems to include people outside the formal health care system, and also from the diagnosis of specific diseases, rather than AIDS, when people do attempt to get health care from the formal system (*ibid*). In Uganda, most HIV/AIDS diagnoses rest on the presence of clinical symptoms rather than blood tests, since even with donor assistance, these remain, for

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1 The age boundaries of the category 'adult' are not given.

2 There is no consensus on the degree of risk of HIV transmission through ritual blood sharing practices. Clearly, there is a greater potential danger in areas of high HIV prevalence and where knives cannot be disinfected.

the most part, outside the scope of Government budgets.[3]

Table 1. Overview of HIV Prevalence in Uganda, Malawi and other African countries. [4]

Country	Population (millions), 1991[5]	Seroprevalence
Malawi	9	20% sexually active population 23% pregnant women in Blantyre[6] 8% in rural areas[7]
Tanzania	25.2	11% urban and rural 'low-risk populations' 15-20% sexually active population
Uganda	17	8% in large rural survey; 20 - 30% in urban areas
Zambia	8.3	18-20% sexually active population

2.3 Gender disparities in HIV/AIDS prevalence

The WHO classifies Sub-Saharan Africa as a Pattern II region, where transmission is mainly heterosexual, observing that men and women are approximately equally infected with HIV. This is presented as a contrast to the higher rates of male infection in Pattern I regions, where male homosexual intercourse acts as a major transmission route. However, this obscures significant differentials in male: female infection rates across different ages, and in certain geographical areas and the existence of other

[3] A counterargument suggests that HIV/AIDS figures in Uganda and other parts of Africa are exaggerated due to misdiagnoses and use of the ELISA HIV antibody test (cheaper than the apparently more accurate Western blot test), which produces more false positives. This argument was presented in Channel 4's Dispatches programme, 'AIDS and Africa' on Wednesday 25 March 1993.

[4] All statistics from Panos Institute WorldAIDS Datafile, May (1993:7) except where otherwise indicated. This datafile draws mainly on WHO 1992 figures. Except where the sample population is made clear, it is unspecified whether surveys include people under 15 or not.

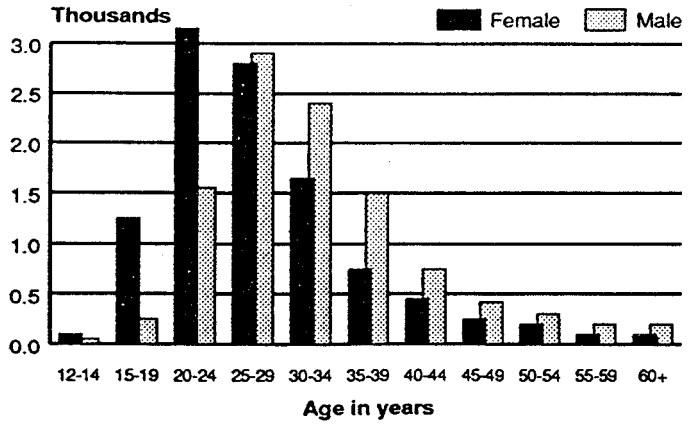
[5] Source: World Bank (1993a:288)

[6] Source: Dallabetta et al (1993)

[7] Source: Personal Communication, Geraldine Carr, British High Commission, Lilongwe, 4 August 1993

patterns of transmission besides the main ones cited.[8] Figure 2 illustrates the breakdown of AIDS cases by age and gender in Uganda.

Figure 1. Breakdown of AIDS by Gender and Age in Uganda



Source UNDP (n.d.: 5)

In various African countries, including Uganda, rates of infection are approximately equal for young male and female children, who have been infected perinatally. Children under 10 now constitute approximately 10 percent of recorded persons with HIV/AIDS in Uganda (RoU/UNDP, 1992). However, for young women, up to approximately age 25, rates of infection are far higher than for men of the same age-group. For example, recent official statistics from Uganda show that five times as many women aged 15-19 are infected with HIV/AIDS as men of the same age (AIDS Newsletter, 8 (7/8), 1993) and recently released statistics suggest that this may now have increased to seven times as many (Alison Evans, personal communication).

The startling increase in the female to male ratio of seroprevalence in this age group may represent an unintended effect of raising awareness about HIV/AIDS. Many men are now known to seek very young partners, assuming that they will be virgins and hence HIV negative (Kaleeba, 1991), as well as less assertive and thus less likely to insist on condom usage. 'Traditional cultural practices' are frequently invoked as a justification for the increasingly early marriage of girls (at around age 12), which may also help account for the disparity in infection rates (Alison Evans, personal communication). In this context, reports of sexual abuse of girls under 10 are particularly worrying. This constitutes an important issue for research and mobilisation.

Few details are available relating to the gender/age distribution of HIV/AIDS in Malawi. Reeve (1989:568) observes that in his study conducted at Zomba Hospital,

[8] WHO's classification system has been severely criticised by Seidel (1993), among others, for contributing to the stereotyping of 'African AIDS' as different from HIV/AIDS in other regions. This has been construed both as racist and as an attempt to render HIV/AIDS in Africa a different and isolated problem, rather than part of a global HIV/AIDS pandemic with major implications for Northern countries.

similar numbers of women and men were seropositive and that the peak age at infection was 20 to 30. Whether the women comprised the bulk of the younger patients was not noted.

2.4 Geographical variation in HIV/AIDS prevalence

Appendix 1 illustrates geographical variation in HIV prevalence in Uganda. Figures for the North of the country should be interpreted with caution, given the continuing instability in those regions.

The most heavily affected areas outside Kampala - Masaka and Rakai - are located on the main highway from Kenya through Kampala to Tanzania and Rwanda. A 1991 HIV seroprevalence survey conducted in Rakai (Wawer et al, 1991) showed a clear differential in male and female infection rates, illustrated in Table 2.

Table 2. Rates of HIV seroprevalence in Rakai by gender and distance from main road trading centre

Location	Seroprevalence Rate (percent)	
	Women	Men
Main road trading centre	47	26
Rural trading village on secondary road	29	22
Rural agricultural village (Low road access)	9	8

Source: Compiled from Wawer et al (1991)

Barnett and Blaikie (1992) suggest that rates of HIV/AIDS infection may be particularly high in this part of Uganda as the growth of the illegal trade (*magendo*) economy during the Amin and Obote periods created economic opportunities along the Kampala - Rwanda/Tanzania highway and that truck stops, bars and brothels were established to service the wealthy transient population in these areas. The combination of migrating men with wealth and poor women may have resulted in a high rate of sexual contact in this area, and the spreading of HIV before the existence of the disease was recognised.

Additionally, civil war and unrest may have contributed to an increase in sexual contact, as local controls over sexuality declined (*ibid*, 1992). Rape appears to have been extremely common - as Barnett and Blaikie were told, during wartime,

> 'soldiers took money and sometimes killed men, but they always took money and sex from women' (1992:81).

Similarly, it is possible that the very high rate of HIV/AIDS in Gulu may be related to rape during the war. Extremely high seroprevalence rates in the army, estimated at

40-45 percent (Alison Evans, personal communication), continue to have serious implications for the further spread of HIV/AIDS, particularly as large numbers of former soldiers will return to rural areas on demobilisation.

Again, there is little detail available about the geographical distribution of HIV/AIDS in Malawi. The importance to the Malawian economy of male migrant labour to South Africa may have facilitated the spread of HIV/AIDS. Similarly, the disruption of local land tenure systems and the growth of migrant labour working on plantations during the colonial and post-colonial periods in both Uganda and Malawi may have increased the potential for multiple sexual contacts by migrant men, and of women surviving from servicing this demand. Men who have had sexual relationships with women other than wives or girlfriends may increase the risk to all their women partners of HIV/AIDS infection; the poverty of female-headed households lacking adult male labour and awaiting remittances may precipitate women into sexual relationships for survival, thus increasing risk through increasing sexual contacts.

3. GENDER AND VULNERABILITY TO HIV/AIDS

Gender differentials in the risk of contracting HIV can be broadly divided into three categories: firstly, those ensuing from physiological differences between women and men; secondly, those deriving from cultural constructions of what constitutes appropriate feminine and masculine behaviour in heterosexual relations; thirdly, those relating to inequalities in access to economic resources, particularly during generalised economic crisis, which may lead to increasing commoditisation of sexual relations as a survival strategy especially for women (Schoepf, 1988). These categories are by no means discrete and several of these factors may be involved in any particular sexual relationship. However, they will be employed in order to facilitate discussion of particular kinds of risk.

3.1 Biologically related risk

Most discussions of the efficacy of HIV transmission suggest that women are physiologically more susceptible than men to HIV infection through heterosexual intercourse (Gordon and Kanstrup, 1992:29), as they are to other STDs. This may be because quantities of HIV present in semen are higher than those in vaginal mucus, because vaginal membranes allow transmission of the virus more quickly than do penile tissues, and because semen may remain inside a woman's body for longer than vaginal mucus remains on a penis (Berer, 1993). Higher order pregnancy and possibly breastfeeding may decrease the incubation period of HIV positive women, effectively shortening their expected lifetime relative to infected males (Palloni and Lee, 1990). This is clearly a factor exacerbating women's risk of developing AIDS in much of Sub-Saharan Africa, where eight or more pregnancies per woman may be common, as in Uganda (UNDP, 1992:137) and Malawi (Government of Malawi/UNICEF, 1987:23).

The presence of STDs causing genital warts, ulcers or lesions is an important co-factor in HIV transmission since this facilitates the direct mixing of blood, the most effective route of HIV infection. Since symptoms of STDs such as genital ulcers and lesions are more likely to be internal to women, they, and other manifestations of STDs, such as vaginal discharge, may be either unknown, or accepted as a normal part of women's experience and no treatment sought (Schoepf, 1993). Ssali et al (1992) report that in rural Masaka, Uganda, 25 percent of the population admitted to having suffered from an STD. However, only 20 percent of those who reported an STD were women. Women's access to curative health care for STDs is further diminished by the greater stigmatisation of STDs among women than among men. For women they represent a label of 'impurity' and are assumed to constitute evidence of illicit sexual activity even though they may be acquired from a sole sexual partner. For men, on the contrary, they represent a demonstration, in part, of their sexual prowess (Kaleeba, 1991).

Partly for reasons given above, accurate statistics on STD prevalence are hard to obtain. However, overall rates of STD infection are considerably higher for women

than men in Sub-Saharan Africa - in 1990 approximately 45 million women compared to 28.9 million men were reported as suffering from an STD, excluding HIV/AIDS (World Bank, 1993a:216-8).

In Uganda, treatment facilities for STDs are extremely limited. There are two specialised STD clinics both in Kampala, one at Mulago Hospital and another run by Kampala City Council (Hitchins, 1992). Because of the links between STDs and HIV transmission and the lack of specialised STD treatment, expanded control of STDs is frequently cited as a priority area for donor assistance in curbing the spread of HIV/AIDS (RoU/UNDP, 1992; RoU/UNICEF, 1991; World Bank, 1993a). No information is available on STD prevalence or treatment facilities in Malawi.

3.2 Masculinity, femininity and sexuality

Cultural expectations of sexual satisfaction are closely related to norms of appropriate male and female behaviour. In much of Africa, heterosexual intercourse is widely believed to be essential to both women's and men's physical and emotional wellbeing (Ssali et al, 1992; de Bruyn, 1992). Whilst some societies permit women, in practice, though not usually normatively, to the satisfaction of sexual needs through non-marital sexual encounters, in most societies women's normative and real freedom to engage in multiple sexual relationships is much more constrained than that of men (Standing and Kisekka, 1989). In the context of HIV transmission, women are thus particularly vulnerable to infection by non-monogamous men, raising significant questions for AIDS prevention strategies based purely on 'stick to one partner' messages. RoU/UNDP (1992) estimate that 60-80 percent of women with HIV/AIDS in Africa contracted the virus whilst sticking to one partner.

Kisekka (in Standing and Kisekka, 1989) and Kaleeba (1991) further notes that within heterosexual relationships, and particularly within marriage, women do not have the right to refuse sex with their partners:

> ' ... we live in cultures where men control sex. In these cultures, even if you turn to your mother and return to her beaten and swollen saying you won't go back to your husband because you refuse to sleep with him, she will tell you to go home, to get out. How can you not have sex when he wants to have sex ? ... ' (Kaleeba, 1991:50).

HIV/AIDS education campaigns which advocate abstinence as a major prevention strategy may thus be offering women no viable means for self-protection.

In many cultures, in Africa and other parts of the world, 'proper' or satisfying sex is defined in relation to a male-centred experience of sexual pleasure resulting from penetration (Ssali et al, 1992 for Uganda; de Bruyn, 1992 for Sub-Saharan Africa in general). Kisekka (in Standing and Kisekka, 1989:210) researched local perceptions of sexuality among twelve ethnic groups in different parts of Uganda, and found that very frequent penetrative sex was expected by both men and women. On average two rounds per night constituted a desired and expected norm. Whilst it is difficult to

ascertain the extent to which these norms are met, informal conversations in Kampala suggest that penetrative sex does indeed occur with approximately this frequency (Anne Marie Goetz, personal communication).

The extent to which penetration constitutes the central or sole component of a sexual encounter differs between societies. For example, some Ugandan groups, such as the Baganda or Busoga, emphasize pleasure of both male and female partners and, in addition to penetration, engage in other practices giving pleasure to both women and men. Other groups, such as the Acholi and Lugbara expect sex to be rough and to consist almost entirely of penetration. The risk of HIV transmission in rough sexual encounters is increased, particularly if the woman also suffers from an STD, as violent penetration may cause tearing and bleeding. In much of Zambia, Zaire and parts of Uganda, a male preference for sex with women who have dried their vaginas using herbs is noted (Bledsoe, 1991; Standing and Kisekka, 1989). This increases the potential for abrasions during intercourse and, particularly in the presence of STDs, may further increase the risk of HIV transmission.

Where HIV seropositivity rates are high, rape presents a doubly traumatic and dangerous violation of women. The violence with which penetration takes place during rape makes women especially vulnerable to vaginal tearing and hence to HIV transmission. Knowledge of the potential for HIV transmission through this route may be particularly traumatic psychologically. Schoepf for Zaire (1988) and Kaleeba for Uganda (1991) have noted the phenomenon of men, who on discovering their HIV positive status have reacted by raping women, either in the belief that to have sex with a 'clean' woman will rid them of the virus, or, in anger and frustration, so that if they die of AIDS they will take others to the grave with them. The extent of sexual coercion of girls and women in Uganda was tacitly acknowledged by the Government in laws passed in 1991 which made the rape of girls under 14 a capital offence and which raised the age of consent for heterosexual intercourse from 14 to 18 (Williams and Tamale, 1991).

It is common, but unhelpful, to dichotomise women as sexually passive and men as active sexual initiators, and may represent an attempt to transfer a normative construct of Western sexual relations to Africa. Standing and Kisekka's (1989) review reveals that women are expected to initiate certain kinds of sexual activity. However, this norm does not extend to suggesting activities that compromise male pleasure, such as using a condom, often compared to 'eating a sweet with the wrapper on' or 'having a shower with your clothes on' (Forster and Furley, 1989). For women to suggest or demand condom use thus transcends the boundaries of appropriate femininity and risks arousing male anger and violence. As one Zairean woman told Schoepf (1988:634):

> 'If a wife were to suggest - and I emphasize the word suggest because a married woman cannot insist in such matters - her husband immediately would react unfavourably'.

Other women in this study and in Uganda (Kaleeba, 1991) have reported being beaten by their husbands for suggesting condom use.

Male resistance to condom usage lies also in the association of condoms with multiple partners and prostitution. As such, a request to use one can be interpreted as evidence that a woman has acquired HIV or is unfaithful, or that she thinks her male partner is involved in other sexual liaisons. Additionally, as condoms prevent conception as well as HIV infection, they are strongly associated with non-committed relationships, since bearing children often signifies woman's commitment to a man (Bledsoe, 1991). It is notable in this context that commercial sex workers (CSWs)[10] are often more able to insist on condom usage with clients where an emotional relationship is not involved, than they are with male partners where condoms imply a lack of commitment and trust (Worth, 1989).

For men and women, demonstration of sexual potency through bearing or fathering children symbolises adulthood and responsible membership of society (Standing and Kisekka, 1989). The desirability of fertility from both women's and men's perspectives, though their motivations and desired numbers of children may differ, presents a particular problem for HIV/AIDS prevention strategies based on the usage of condoms or of other barrier methods. As Carovano (1991: 136) notes,

> 'to provide women exclusively with HIV prevention methods which contradict most societies' fertility norms is to provide many women with no options at all.'

This points to the urgent need to develop protection methods such as virucides which allow conception whilst destroying HIV and other agents of STDs (Elias and Heise, 1993; Stein, 1990). Currently there are no virucides which destroy HIV without causing painful and possibly dangerous side-effects to women. Female condoms, whilst controlled by women, are still visible to, and can be felt by men; they also prevent pregnancy, are more expensive than male condoms and shift the onus for HIV/AIDS prevention on to women. Further, they may be unacceptable in cultures such as the Acholi in Uganda (Standing and Kisekka, 1989:214) where women are not supposed to insert things into their vaginas.

These formidable barriers to condom use, particularly, but not exclusively where initiated by women, raise serious problems for strategies relying on women to change their partners' behaviour in this respect (Worth, 1989; Bledsoe, 1991). Strategies for condom usage which concentrate on male motivation (in addition to female) have a greater chance of success. This is discussed further in Section 4.5.1.

Anal sex between women and men, whilst stigmatised and generally not freely talked about, may also take place and may be perceived as a more acceptable alternative to vaginal intercourse than condoms, in spite of the high HIV transmission risk associated with anal intercourse.

[10] To avoid the stigma attached to the word prostitute in English, and the East Africa equivalent 'malaya', the term Commercial Sex Worker (CSW) is preferred.

Bisexual and homosexual practices are often presumed not to exist on a large scale in Africa, there is some evidence of such encounters among men.[11] De Bruyn (1992:253) cites studies in Eastern Uganda and Botswana where 16 percent and 15 percent of male respondents respectively reported having sex with other men. However, these studies do not indicate whether or not anal penetration constitutes normal practice in such encounters, and thus the risk of HIV transmission is difficult to determine. Where anal sex has occurred, the risk of HIV transmission both between men, and with their female sexual partners, may be greatly increased.

3.3 Poverty, gender and HIV/AIDS

Exchanging sexual favours for material support constitutes a widely documented survival strategy of women in Sub-Saharan Africa (Kaleeba, 1991; Schoepf, 1988).[12] Barnett and Blaikie (1992) suggest that economic decline in Uganda from the early 1970s may have increased the dependence of large numbers of women on such activities. This may also be the case in Malawi, where per capita income has grown at a rate of only 0.1 percent per year in 1980-91, whilst inflation has increased by 14 percent annually over the same period (World Bank, 1993a:238). In Uganda, the economic and social policies of the Amin and Obote periods, combined with the subsequent years of civil war, have resulted in serious damage to the economy. This is reflected in declining incomes, coupled with consumer price inflation, and declining coverage and quality of social services (World Bank, 1993b; Banugire, 1989).

For example, the purchasing power of wages in Uganda fell so severely between 1983 and 1987 that most workers could meet only one third of their basic needs (Banugire, 1989). The structural adjustment programme (SAP) instituted in 1986/7 may have further contributed to increasing poverty; cost-sharing schemes introduced in clinics and hospitals further reduce the possibility for poor people, especially women, of obtaining basic health care. At the same time, the growth of the *magendo* (illegal trade) economy in the 1970s and 80s created a stratum of wealthy men, on whom many women depended for material support (Barnett and Blaikie, 1992). This dependence continues in present-day Uganda (Kaleeba, 1991) and may have increased with structural adjustment.

For such women, present-day survival may take precedence over an apparently distant risk of contracting HIV/AIDS. In the words of market traders, cultivators, waitresses and barmaids in South West Uganda who supplement their income with occasional sex with customers when times are particularly hard (Nakuti, et al, 1992), 'If we fear AIDS, what shall we eat?' (*ibid:* 3). Or as Kaleeba (1991:52) puts it,

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[11] There do not appear to be any estimates of the prevalence of sexual encounters between women. Most of the HIV/AIDS literature is silent on issues of risk and prevention for lesbians.

[12] There is no statistical evidence of an increase in such exchanges, but there is a strong probability that they have increased.

> 'If we tell people [men] who have a number of stable partners to love faithfully, what will happen to the other women?'

Whilst the (generally older) wealthier partner may occasionally be a woman (Shepherd, 1987; RoU, 1988), since women's access to and control over resources is generally more limited than men's and their chances to escape poverty lower, the vast majority of 'benefactors' are probably male 'sugar daddies'. It is not uncommon for girls and young women to engage in a sexual relationship with older men in order to finance their schooling or to augment household income (Bledsoe, 1991).

As well as increasing the likelihood of sexual contact for material gain, poverty may increase the risk of HIV transmission in sexual encounters. As Gordon argues,

> [i]ncreasingly difficult living conditions imply growing tension in relationships. Low income and sharply rising prices cause extreme uncertainty and a vulnerability which makes it very difficult for people to feel in control of their lives in any way. Self-esteem, assertive behaviour and effective decision-making are undermined, making it more difficult for women to protect themselves and for men to take responsibility for their actions.
>
> A deterioration in housing conditions, water supplies and sanitation make it more difficult to practice sexual hygiene and to use barrier methods of contraception. A lack of privacy and energy to try out new sexual practices; and no suitable place to keep and dispose of condoms or to wash off the smell of spermicide are serious practical barriers to change. Unless condoms are free, many people will be unable to afford them every time they have sex - "the man with the torn shirt is likely to be the man with the torn condom" (1990: 208).

In Uganda, condoms are priced at a level deemed compatible with incomes of the urban poor. This may, however, be beyond the budget of many rural people (Alison Evans, personal communication). Schoepf's (1988) work with commercial sex workers (CSWs) in Kinshasa suggests that poorer workers who need as many clients as possible in a brief time period, are much less likely to demand condom usage than richer workers. However, collective refusal by groups of CSWs to have sex without a condom has proved a very effective strategy in some other African contexts (Berer, 1993).

4. PREVENTION AND CONTROL STRATEGIES IN UGANDA AND MALAWI

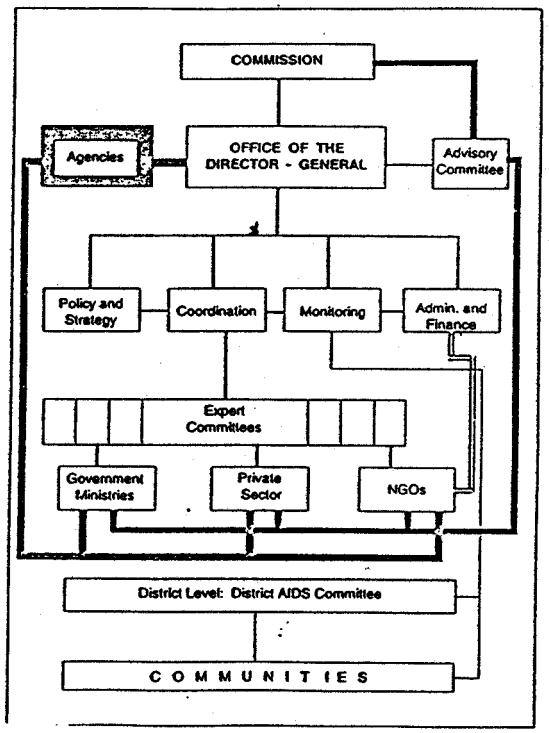
4.1 Structure of HIV/AIDS prevention activities in Uganda[13]

The development of official HIV/AIDS-related activities in Uganda is summarised by RoU/UNDP (1992):

'In 1986 the National Resistance Movement Government responded to the AIDS epidemic by establishing a National Committee for the Prevention of AIDS (NCPA) and the AIDS Control Programme (ACP) in the Ministry of Health. Besides these, a number of AIDS activities were initiated throughout the country, particularly in the districts of Rakai, Masaka and Kampala. In August 1990 a national task force on AIDS was appointed to review all work in the field of AIDS and to suggest how a multi-sectoral AIDS control programme might be implemented, The task force's proposals led to the setting up of the Uganda AIDS Commission (UAC) in April 1991.'

The structure of these bodies and their interaction with other agencies is illustrated in Figure 2 below:

Figure 2. Structure of Ugandan HIV/AIDS-related activities



Source: RoU/UNDP (1992:11).

[13] Similar details are not available for Malawi.

The UAC aims to coordinate a national programme of interventions with contributions from Government, NGOs, religious groups and the private sector. The UAC also provides :'the overall direction and coordinating framework for the donor community to ensure that their activities complement each other and fit in with national priorities' (*ibid*:12)

The main focus of activity is prevention, with a secondary focus on care of people with HIV and support to those affected. Around 60 percent of the planned expenditure for the ACP in 1992 was devoted to prevention activities, with health education constituting 34 percent alone. Direct support to care of people with HIV/AIDS accounted for only 15 percent of expenditure (*ibid*: 13). A full breakdown of the planned expenditure for 1992 is given in Table 3.

Table 3. Uganda Ministry of Health AIDS Control Programme planned expenditure summary 1992

Item	Planned Expenditure (USD)	Percentage
Health Education (IEC)	1.558.500	34
Patient Care	662.250	15
Sexually Transmitted Diseases	577.419	13
National Blood Transfusion Service	641.000	14
Laboratory Support	291.600	6
Epidemiology/Research/ Evaluation	303.500	7
Programme Management	523.163	12
Total	4.557.432	100

Adapted from ACP Report - Ministry of Health Plan: 1992.
Source: RoU/UNDP, 1992: 13

NGOs, religious organisations and private sector bodies are also involved both in prevention and care activities in Uganda. The prominent prevention campaigns of the Christian churches are detailed in section 4.4 below. However, little information on specific projects run by Christian churches or organisations, is available. In Iganga district, Eastern Uganda, lay workers have been trained by Muslim elders and have been provided with transport by donors to carry out HIV/AIDS awareness work in the Muslim community. Apparently all these outreach workers are men (Alison Evans, personal communication). There is no other information on prevention work initiated by Muslim organisations. Details of other NGO and private sector organisations involved in HIV/AIDS prevention and care are given in Appendix 2.

4.2 National AIDS Control Programme (NACP) in Malawi[14]

Malawi's NACP has been in existence since 1986. A 5-year Medium Term Plan was drawn up by the Ministry of Health with assistance from the WHO Global Programme on AIDS and runs until the end of December, 1993. The focus is on the reduction of HIV and STD transmission and on providing care and support for people with HIV/AIDS and STDs. Phase 1 of the programme ran from January 1989 to July 1990, but little activity took place due to delays in setting up the programme and overcentralisation.

Phase 2 ran from August 1990 until July 1991 and aimed to decentralise activities to regional and district levels, to increase involvement with NGOs, to improve counselling services and to target truck drivers, barmaids, STD patients and young people. However, the second Annual review reported little progress due to funding difficulties, staffing constraints, and the slow development of guidelines on HIV/STD management. Phase 3, which is currently in operation, attempts to strengthen the priorities set out in Phase 2.

4.3 Coordination, consultation and targeting in national AIDS programmes

The main state organisations implementing HIV/AIDS activities in Uganda are the Ministry of Health, the Ministry of Education and the Resistance Committee network. Very little specific information is available on the spheres of operation of these different bodies or the extent to which they work in conjunction with one another. HIV/AIDS advice may be given during visits to clinics or hospitals, but this appears not to be widely integrated into family planning or MCH services. (However, see Appendix 2 for details of CARE's project in Rukungiri assisting the integration of family planning and HIV/AIDS services at local and district level).

In addition, it is difficult to assess the nature or degree of cooperation between state bodies, and private, NGO and religious organisations. In particular, no information was found whether official Women's Affairs Departments of Ministries, or non-government women's organisations (or indeed other NGOs) are represented on the Uganda AIDS Commission or consulted by the ACP, or whether they are represented on Malawi's NACP. Clearly significant involvement of women's organisations in the bodies co-ordinating AIDS policy and activities, could help promote more gender-aware policy and interventions on HIV/AIDS.

There is also limited information is available on the extent to which official HIV/AIDS awareness and care provision is targeted to particular segments of the population. In Uganda, it is clear that young people (in and out of school) constitute an important target group (RoU/UNICEF, 1991). UNICEF is assisting the Government to target seropositive women to reduce numbers of pregnancies. They are also supporting the Government to promote condoms nationwide (*ibid*). In

[14] This section is based on a personal communication from Geraldine Carr, Project Assistant, British High Commission, Lilongwe

Malawi, the focus seems to be on particular high risk groups (as mentioned above), as well as on younger people through the schools programme.

Whilst targeting groups especially vulnerable to HIV infection is necessary, where seroprevalence rates are between 8 and 20 percent as in most of Malawi, and much of Uganda, it is important that all sexually active people receive accurate information and assistance in changing risky practices.

4.4 Gender issues in access to information on HIV/AIDS

This section is based on two questionnaire surveys of knowledge, attitudes and practices towards HIV/AIDS, one by Anderson et al (1990) in Kabale, in the south of Kigezi District, South West Uganda, and the other by Forster and Furley (1989) in Kabale, villages in the north of Kigezi District and Kampala. Some results from Forster and Furley's survey are summarised in Table 3.

Clearly, this is a limited base from which to draw conclusions about the dissemination of HIV/AIDS information and its gender implications in Uganda as a whole, or more generally. Further, questionnaire surveys may have limitations in their capacity to elicit sensitive and personal information on sexual practices. Also, while analysis of gender differentials in access to information is important in assessing possible gender bias in prevention strategies, the ideological content of HIV/AIDS prevention messages and the translation of information to knowledge and behaviour change are also crucial. In particular, the extent to which HIV/AIDS education materials reassert traditional gender inequalities - or present empowering alternatives - influences the likelihood of their inducing behavioural change which increases protection against HIV infection.

Table 4. First sources of information on HIV/AIDS in Uganda (1988).

	Villages		Kabale		Kampala	
	Men	Women	Men	Women	Men	Women
First heard of						
AIDS (%)						
< 1 year ago	63	84	38	68	6	22
2-3 years ago	20	13	45	26	22	44
3 years +	17	3	17	6	72	34
How first heard						
Other people	49	72	38	62	47	50
Public rallies	23	25	24	26	13	9
Newspapers	17	6	34	9	38	19
Radio	20	9	31	0	22	6
Television	0	0	0	0	3	3
Posters/pamphlets	6	6	0	0	0	6
Church	6	12	14	24	3	0
Aware of government campaign						
Yes	79	77	79	38	97	94
Aware of church						
campaign						
Yes	83	91	83	71	75	81

Source: Forster and Furley (1989:149).

Both Anderson et al's study carried out in rural South-West Uganda and Forster and Furley's, in villages in the same region, Kabale town and Kampala, revealed that informal channels (friends and relatives) constituted the most important overall means of dissemination of HIV/AIDS information. Forster and Furley's study, which disaggregated information sources by gender, found that discussion with friends and relatives was a significant source of information for women and men but more important for women than men in rural areas. Seventy two percent of rural women compared to 49 percent of rural men first heard of HIV/AIDS through relatives and friends. In Kampala too, this remained the first information source, for 50 percent of women and 47 percent of men. This points to the potential for community level peer HIV/AIDS education in both rural and urban communities.

In both surveys, churches were the only formal or institutional channel of information more important to women than to men. Forster and Furley found that in Kabale and the villages twice as many women as men first heard of HIV/AIDS through the churches. Also, while levels of awareness of both church and government campaigns are high among women and men in all areas, it is only in Kampala that both women and men were more aware of the Government campaign than of the churches' messages.

The influence of the churches (particularly the Catholic church) in spreading HIV/AIDS related messages, particularly in rural areas, and particularly in reaching women with these messages, gives some cause for concern, given their tendency to emphasise marital fidelity, abstinence and celibacy. As stressed in Section 3, these may not always be viable options for women, and thus such messages present women with no feasible alternatives to protect themselves from HIV infection.

Newspapers and radio were a significant source of information for men in all areas, ranging from one fifth of men in rural areas to 38 percent of men in Kampala first hearing of AIDS in newspapers and 22 percent on the radio. For women media sources were insignificant, except in Kampala. Fifteen percent of women in villages and in 9 percent in Kabale had heard of AIDS from newspapers and radio. In Kampala, newspapers were the primary source of information for only 19 percent of women. This gender imbalance probably partly reflects women's lower levels of education and literacy, and hence access to newspapers and ability to read in any language, but particularly in a foreign one, English. The greater likelihood of women (particularly in female headed households) living in poverty may also mean that they cannot afford newspapers or radios Where households do possess radios, women are less likely than men to control their use.

Public rallies (presumably organised through the Government campaign), and posters and pamphlets had provided first information about AIDS for roughly equal numbers of men and women. The latter, however, were a relatively minor source overall (reaching less than 10 percent of the sample), whereas the former had reached up to one quarter of the sample, at least outside Kampala.

Another striking feature of this survey is that men in all locations had first heard of AIDS before women. Except in Kampala, the vast majority of women had first heard of AIDS less than one year before the survey (conducted in 1988), whereas most men had been aware for at least two years. This suggests limited discussion or communication about HIV/AIDS between male and female sexual partners, and also reinforces the evidence noted above, that women, to a greater extent than men, are getting access to information about HIV/AIDS indirectly through friends and relatives. Indirect means of acquiring information are quite likely to promote inaccurate knowledge or stereotypes. It is also worrying in that women have clearly been exposed to risk of HIV transmission for long periods with no knowledge of the need for, or means to protect themselves.

One major implication from the survey results is that HIV/AIDS education messages need to be specifically targeted at women, through outreach work and the use of informal channels, rather than hoping that women will be reached through mass media campaigns. Peer education, or discussion groups, at locations where women congregate, such as water points, family planning and MCH facilities, or markets, are one possibility. Radio listening groups organised around programmes specifically made for women on HIV/AIDS, and including some directed discussion, may be another. Such activities also have the advantage of being able to test and correct the accuracy of knowledge about HIV/AIDS, and share experiences and strategies.

Forster and Furley's survey also tested the accuracy of respondents knowledge on HIV/AIDS and whether any changes in behaviour were reported since knowledge about HIV/AIDS had been acquired. Particularly in rural areas, knowledge tended to be inaccurate about transmission routes (with some unaware of the risks involved in all unprotected sex; others holding erroneous beliefs about transmission through sharing of utensils etc.); about symptoms of AIDS; and about the degree of risk attached to their own behaviour. Only a minority of respondents - almost none in rural areas - mentioned condom use as a prevention strategy, whereas almost all stressed fidelity.

Some behaviour change was reported by respondents (although the reliability may be questionable and the categories used - 'love everybody (LE),' 'love carefully (LC)' and 'love faithfully (LF)' - are somewhat subjective and ambiguous), but more so by the men, and more so in urban areas for both women and men. For women the main change was a shift from LC to LF (in any case practised by the majority - 65 percent - of women), with little change in the smaller high risk LE (from 11 to 8 percent). This reinforces the point made earlier, that in many instances, the options for women are limited, in that they already practice monogamy, or that where they do not it is often because they rely on sex for economic survival. For men, the 'love everybody' category was reduced considerably (from 30 to 17 percent), although 'love faithfully' still remained considerably lower than for women, at 58 percent compared to 77 percent.

Both for young adults who have attended school since 1988 and for other family members, particularly women, who gain access to AIDS information through school-going children, as in rural Zambia (Mwale and Burnard, 1992), school represents an important source of dissemination of HIV/AIDS information. Despite controversies over HIV/AIDS and sex education in schools, HIV/AIDS awareness has been integrated into the curricula of all Ugandan and Malawian primary and secondary schools.

The geographical coverage of HIV/AIDS education in Ugandan schools varies. Kampala schools have engaged in intensive HIV/AIDS awareness work with students. However, many students in rural Eastern Uganda had received no HIV/AIDS information at school. This may be due to lack of training on the part of teachers or problems in the distribution of the Ministry of Education's HIV/AIDS information packs for teachers, and/or resistance from teachers or headteachers to HIV/AIDS education (Alison Evans, personal communication).

Whilst the following figures are probably overestimates, given the incentives to overreport school attendance in Uganda (RoU/UNICEF, 1989), overall approximately 89 percent of children attend primary school for some period, 8 percent secondary school and 1.25 percent any post-secondary education. Of these, at primary school level approximately 44 percent of pupils are girls, but only 26 percent secondary students and 16 percent university students are female (*ibid*). In Malawi, in 1990, 71 percent of children in the appropriate age group were enrolled in primary school with 64 percent of girls enrolled. At secondary level, however, only 4 percent of the appropriate age group were enrolled, and 3 percent of the relevant cohort of girls (World Bank, 1993a:294).

The low school attendance overall, and the persisting gender gap, particularly at post primary levels, clearly have serious implications for the coverage of schools based programmes. Apart from a longer term attempt to raise attendance and narrow the gender gap, requiring considerable public investment and incentives to educate children, particularly girls, in the shorter term, the implications are that primary schools will be the major mechanism to reach young people and thus that resources should be concentrated there; and also that there is a need for out of school, as well as school based, HIV/AIDS education aimed at youth, and particularly at post-primary age girls.

Faul-Doyle (1990) cited in Kristensen (1991) warns against expecting a school system geared to passing examinations to help students develop skills for behaviour change. Other experiences in HIV/AIDS education, and more generally in health education (BRIDGE, 1992) have also shown that didactic models have limited effectiveness in bringing about behaviour change. Both the manner in which information is disseminated and its content are critical in this respect. There is little information about the way in which HIV/AIDS education has been integrated into the curriculum in Uganda or Malawi, and whether it is linked to more general sex education, or the development of life and social skills, particularly negotiation skills and assertiveness for girls.

Neither Anderson et al's or Forster and Furley's surveys found posters a significant source of information. Increasingly posters and leaflets are being produced in vernacular languages. However, for the 65 percent of women and 38 percent of men in Uganda (UNDP, 1992:137, 1990 statistics) and 80-85 percent of women and 44-52 percent of men in Malawi (UNECA, 1984: 5) who are illiterate, even posters in local languages may fail to convey the desired message.

This points to the importance of research into visual literacy and designing materials with specific communities and populations. Illiterate rural people may well interpret images in a different order and construct an alternative meaning from that intended by the literate poster designer. Further, posters presenting glamorised or standardised images of Ugandans or Malawians, who may be construed by rural or poor urban people as elite city dwellers, having little connection to their lives, will probably be ineffective. A similar point is noted by Waterkeyn (1991) in relation to hygiene education in Kenya - merely presenting "African" characters proved insufficient for messages to be interpreted as relevant. Specific details distinguishing a Luo household from, for example, a Digo household were necessary.

The denial of relevance of posters presenting people who appear different may be particularly marked in the case of a stigmatising and fatal disease such as AIDS. Perceiving oneself as 'not at risk', even where risk to others in the community with similar behaviour is acknowledged, may constitute an important and common psychological defence mechanism (Anderson et al, 1990: Barnett and Blaikie, 1992).

Also, it appears that in Uganda outside Kampala, and areas of intense HIV/AIDS-related work, such as Masaka and Rakai, publicity materials may be limited to institutions such as hospitals, which may be very infrequently visited (Alison Evans,

personal communication). Similarly in Malawi, apart from in Government offices, very few HIV/AIDS awareness posters are displayed.

Little information is available on alternative methods of promotion of HIV/AIDS awareness such as song, dance, drama, puppet plays etc. However, a Ugandan woman whose husband died of AIDS, Julliet Awino, has developed a play called 'Strings Attached' about the struggle of a widow to retain her property when her deceased husband's family try to claim it. She and the other women in her play have travelled around, acting in villages (AIDS Health Promotion Exchange, 1991). Similar activities have been initiated in Zimbabwe through the Women and AIDS Support Network (WASN) (Berer, 1993). Puppets have been used effectively by AREPP (African Research and Educational Puppet Programme) in South Africa (AIDS Health Promotion Exchange, *op. cit*.), though in some areas, including parts of Malawi, these may be ineffective for work with adults as they may be considered childish (Mda, 1993).

4.5 Gender issues in HIV/AIDS prevention messages - control or empowerment?

Seidel (1993) argues that prevention strategies can be divided broadly into those that seek to control and those that aim to empower. These are not mutually exclusive categories, and elements of both approaches are often combined in one message. However, they serve as a device for analysing HIV/AIDS prevention campaigns in Uganda and other Sub-Saharan African countries.

This section demonstrates how the three main messages of Uganda's and other AIDS Control Programmes, 'Love Faithfully' or 'Zero Grazing', 'No Sex Before Marriage' and 'Avoid prostitutes' can be delivered either so as to control sexuality, particularly women's sexuality, or to empower people to change sexual behaviour. Whether messages are 'controlling' or 'empowering' may have a critical influence on the effectiveness of HIV/AIDS education campaigns.

4.5.1 "Love Faithfully"

In Uganda, the ACP has been characterized by several shifts of perspective on AIDS prevention, particularly surrounding the importance of fidelity and abstinence on one hand, and condom use on the other. Initially condoms were vigorously promoted as the major method of HIV/AIDS prevention, encapsulated in the slogan 'Love

Carefully'.[15] Sexual fidelity and abstinence initially held a fairly low profile in public education messages and their relative unimportance in the ACP's view was underlined by a poster which declaimed

> 'The Bible [i.e. sexual fidelity and/or abstinence] may save your soul, but this [a condom] will save your life'.

This poster provoked enormous criticism from the clerical establishment. As Seidel (1990:63) points out, in Uganda, and to a lesser extent in other countries, such as Zambia, Christian-inspired and church-based NGOs are significant providers of health care and

> 'Christian intervention in the AIDS pandemic is crucial. For this reason it is seen as unacceptable to criticize the churches in public'.

In deference to the strength of Christian and 'traditional moralistic' sentiment, 'Love Carefully' was superseded by 'Love Faithfully' or 'Zero Graze', i.e. sexual fidelity, preferably within marriage, as the primary AIDS control messages. Church posters, such as those of the Uganda Catholic Medical Bureau prominently advocate Christian marriage as the only acceptable context for the expression of sexuality.

Condoms were subsequently so downplayed by the Government that by 1988 Uganda's Guidelines for Resistance Committees (RoU, n.d.) on the Control of AIDS devote only two pages to condom usage (out of 48), and stress that it is possible to get AIDS even if using condoms.[16] Although in 1990-1 large-scale efforts were made by the Government to market the 'Protector' condom, these now appear to have faded in significance and 'Zero Grazing' appears the most prominent message.

Condoms are available in rural dispensaries, but often appear to remain unsold, both due to prices, set at feasible prices for the urban poor, but beyond rural incomes, and because of other obstacles, detailed in Sections 3.3 and 3.4 (Alison Evans, personal communication). Whilst there are, indeed, many problems associated with condom use, a failure to vigorously promote this prevention method, is to deny the only widespread means of protection against HIV infection. As a Ugandan nurse observed in reaction to President Museveni's comment at the 1991 International Conference on AIDS that condoms are 'non-Ugandan', 'Ugandans will have to change their culture - or they'll die' (cited in Seidel, 1993:179).

The advice to limit sexual contact opposes the male norm of multiple partners, and moreover, the message relies on fear, rather than helping provide any tools to change

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[15] The association of condoms with being careful has been criticised by The AIDS Support Organisation (TASO), the primary Ugandan NGO working on HIV/AIDS issues, who consider that this message stigmatises people with AIDS as careless (Williams and Tamale, 1990).Similarly, government posters which proclaim 'I said NO to AIDS' are criticised as implying a lack of will power on the part of people with HIV/AIDS. As TASO clients point out, no one said 'YES' to AIDS (Hampton, 1990).

[16] The stress on fidelity can be interpreted in part as a realistic reaction to the limited availability of condoms in Uganda and their widespread misuse (as is made clear in RoU, 1988: 32-3) as well as in deference to the discourses of traditional and Christian morality.

behaviour. In this regard a training package produced by TASO (1992a) is starting to address this problem. It presents scenarios where a man who fears being derided by his peers for monogamy is supported by other men who have decided to accept this advice and change their behaviour. This package has been used by TASO's Community Initiatives project since September 1990, first in Kampala and subsequently in Mbarara, Masaka and Tororo to train groups from local communities (of which the composition is not specified) in HIV/AIDS awareness training. TASO has also trained other organisations in HIV/AIDS awareness training and this package was developed in response to requests for training of trainers activity. Whilst depicting such changes in male behaviour may seem rather utopian, similar work on a larger scale might help men develop attitudes of greater responsibility towards their partners.

As noted in Sections 3.2 and 3.3, for many women, partner reduction is unfeasible, either because they are already monogamous or because they cannot afford monogamy. If such messages are to be widely advocated, they need to be coupled with alternative opportunities for women which reduce their economic dependence on men. (See Section 4.5.4).

The dominant association of male virility with unprotected sex and multiple partners has prompted national and NGO campaigns to attempt to promote condom use as manly and macho. In Uganda, for example, the brand name 'Protector' was chosen for these associations; in Jamaica, condoms are known as 'Panther' (Berer 1993). To address male fears of derision by other men, projects such as the promotion of condoms at construction sites in rural Malawi, or among farm labourers in one area of Zimbabwe, attempt to create a climate of peer acceptance of condoms. TASO counsellors offer suggestions to clients on ways in which the issue of condom use can be raised by women or men with their sexual partners (Kaleeba, 1991).

4.5.2 Chastity for Youth

More controversial than the issue of fidelity within marriage is that of adolescent non-marital sexual activity. Frequently interpreted as a sign of moral decay, young people's sexual relations have become one of the most politicized issues in HIV/AIDS prevention strategies. Chastity is strongly advocated, with information about condoms downplayed.

Governments and NGOs are under pressure, particularly from religious lobbies, to avoid accusations of promoting 'promiscuity' among young people, but to deny young (or older) people accurate information on protecting themselves from HIV/AIDS is unlikely to prevent sexual relationships (Seidel, 1993; Carovano, 1991) and thus may only compound the problem. Studies of the provision of family planning and contraceptive information to teenagers show no evidence of young people engaging in sexual activity at a lower age than their peers, but have meant that when they do so, they are better able to protect themselves from risk (Carovano, 1991).

Uganda's Guidelines for Resistance Committees (RoU, n.d.:30) emphasise the need to 'protect' young women from the advances of older men:

> * Protect young girls from older men. Make all members of the community responsible to protect young girls. We must make a special effort to protect young girls because they are the future mothers of the next generation.
> * Discuss traditional laws you have in your area to protect girls from getting pregnant outside of marriage. Can these laws be used to stop AIDS?'
> and 'Prevent school personnel and other adults from having sex with school children. Be very vigilant. Anyone found having sex with students should be prosecuted.'(*ibid*:46).

The emphasis is on protecting girls from the advances of older men, rather than on working with men to stop them exploiting girls and young women sexually. Concentrating solely on female sexual exploitation by older men, whilst a growing problem, and one which requires innovative and empowering solutions, can also obscure peer pressure to engage in sexual relationships with boys of similar age, and power relations in relationships with same-age boyfriends.

An important initiative in this field is the Anti-AIDS Project in Zambia, which works primarily with young people both in school and out of school, and supports the development of Anti-AIDS clubs. Members of these clubs, initially only boys, but now only slightly more boys than girls, promise to: abstain from sex before marriage; to discuss HIV/AIDS prevention with friends and relatives; and to care for people with HIV/AIDS (Panos Institute, 1988:68). Although the focus on sexual abstinence may be criticised as unrealistic, it was the decision of the members, and thus represents young men and women taking control over their sexuality in order to prevent HIV transmission. Also, as Seidel (1993) observes, for many young people, and particularly for young women under constant pressure to have sex, Christian chastity, legitimised through membership of an Anti-AIDS club, may provide a useful way in which to frame refusal.

Recognising the social pressure girls may be under to have sex, the Anti-AIDS Project in Zambia, in conjunction with the Copperbelt Health Education Project has produced a poster with 19 different responses girls and young women could give to men who harass them for sex. It suggests that girls practice saying these things with one another so as to enhance their confidence in refusing sex with men. Several of the responses justify refusal on the moral basis of premarital chastity as desirable; others do so more through the notion of women's right to sexual self-determination as a fundamental human right.

For example, one young woman says:
'NO. Don't you know that girls have the right to say no?'. Another:
'NO. It's my body. I'm the one to decide, not you', and a third:
'NO. Can't you be understanding enough to respect my decision?'.
Other responses contextualise this refusal giving possible responses for girls pressured by teachers or bosses:
'NO. I came for education, not for sex!' or:
'I just came for an interview - NO'.

Empowering women to 'say no' is extremely important, both in HIV/AIDS prevention and in providing women with assertion skills which can be used more widely.

However, it becomes problematic when presented as the only strategy, in that it denies both women's sexual desire and the economic need of some women to engage in sex to support themselves or their children. It may result in girls and women feeling that 'good girls' do not have sex, thus inducing feelings of guilt when they do. Further, targeting of HIV/AIDS prevention messages mainly or exclusively to women and girls (Carovano, 1991; Seidel, 1990/1993) may serve to reproduce the widespread belief that women are the primary vectors of HIV/AIDS (Barnett and Blaikie, 1992). There is a general lack of material targeted at young men, aiming to empower them to find demonstrations of masculinity other than sexual prowess. However, the work of the Anti-AIDS clubs goes some way to counteract this. The Zambian Government's 'AIDS Information for Secondary Schools' (1988:13) tells boys to 'have the strength not to ask' as well as stressing girls' right to refuse sex, also begins to address this issue.

4.5.3 "Avoid Prostitutes"

A preoccupation with identifying and quarantining "high risk groups" has permeated HIV/AIDS prevention campaigns both in the North and in Africa. British colonial treatment of "free women" throughout Anglophone Africa stigmatized them heavily as pools of STDs waiting to transmit infection to innocent men. This approach has continued into post-colonial STD and AIDS prevention campaigns in Uganda and elsewhere (Berer, 1993), which advise men to avoid CSWs. This serves, as Carovano (1991) has pointed out, to create two categories of women - the 'virtuous wife', held to be monogamous, and the 'whore', responsible for the spread of HIV/AIDS, widely held stereotypes in Uganda, both among men and elite women (Obbo, 1980). Male responsibility not to infect their wives is downplayed and male vulnerability stressed.

For example, Uganda's 'Guidelines for Resistance Committees', (RoU, n.d.: 26) whilst acknowledging the risk that CSWs face from their clients, stresses that 'Prostitutes who have the AIDS germ can then give AIDS to each customer with whom they have sex'. An illustration in this pamphlet (*ibid*) portrays a man walking away from three CSWs saying 'No thanks. I can live without AIDS' (See Figure 3 below).

Figure 3: "I Can Live Without AIDS"

Source: RoU (n.d.:26)

The greater stress on discouraging men from using CSWs than on safer sex, including condom use, represents a missed opportunity. It may be considerably easier for CSWs to use condoms with their clients, in what is clearly a commercial transaction, than it is for women (including CSWs) to do so with their lovers and husbands (Worth, 1989; Schoepf, 1988).

Some NGO projects are, however, attempting to make commercialised sex safer. AMREF (African Medical Research and Education Foundation) in Tanzania has initiated a project with truck drivers and CSWs at truck stops, educating them on condom usage on the major transit route to Zambia (Muizarubi et al, 1991). In addressing both women and men, it attempts to overcome the problems of promoting condoms with one sex, only for them to be rejected by the other. In Yaounde, Cameroon, a group of CSWs were trained in AIDS education and condom promotion. They travelled around bars educating other CSWs and their clients through skits and short plays about AIDS. This is widely believed to have been a very successful and empowering initiative and to have increased the rate of condom usage considerably, thus addressing male and female sexual health without damaging women's livelihoods.

4.5.4 Promotion of alternative livelihoods for women

For poor women, who rely on selling sex regularly or sporadically, an increase in their material security could represent important protection against HIV/AIDS. In Uganda, TASO and various church-based and other organisations (Williams and Tamale, 1991) support women's micro-enterprise and other projects and initiatives which give women an increased independent income and reduce their dependence on relationships with men for survival. In Zambia, the Copperbelt Health Education Project has, since early 1992, organised five-day 'crash courses' in survival skills for out of school girls, to enable them to find ways of earning a living which do not put them at risk of HIV infection. Similar courses, which discuss health, including

HIV/AIDS, the law, agriculture, micro-enterprise and training opportunities have been held for young men since 1990 (Mouli, 1993).

The Uganda Association of Women Lawyers (a branch of FIDA, the International Association of Women Lawyers) provides legal support to women who refuse to have sex with their husband, an increasingly common phenomenon in the context of rising HIV prevalence. The Association assists women in attempting to claim or retain their property and land rights if they divorce or if relatives attempt to acquire their property on the death of their husband. This can help women gain control of the material resources they need in order not to depend on sexual relationships for survival.

Although poverty may increase the likelihood of engaging in risky sexual relations, heterosexual relationships cannot be understood as solely a response to poverty. Sexual relationships involve complex emotions and desires and economic empowerment is thus insufficient to eliminate risk. Specific work with women and men around safer sex and condom usage remain necessary to reduce risk of HIV transmission.

5. GENDER ISSUES IN CARING FOR PEOPLE WITH AIDS[17]

5.1 Home based care

De Bruyn (1992) notes that in general the task of caring for people with AIDS falls upon women, in congruence with women's traditional roles of caring for sick people and for the household. Seeley et al's (1993) study of carers in Masaka, Southern Uganda, indicates that overall women constituted more of the principle and assistant carers (56 percent) than men (44 percent). However, the small sample size of 30 means that only limited conclusions can be drawn. Based on observations among TASO clients, Kaleeba (1991) observes that people with AIDS whose mothers are still living tend to live longest whilst those without a female relative are likely to survive for a much shorter period.

Currently in Uganda, men who have contracted HIV first tend to get sick and die, leaving wives who may or may not be HIV positive. Thus sick women may themselves be caring for their partner, and/or children, further jeopardising their own health. In parts of Eastern Uganda, it appears that people with AIDS, particularly migrant men, may come home to die, placing severe burdens on rural households (Alison Evans, personal communication).

Care of people with HIV/AIDS by friends and relatives is often advocated as fitting in best with 'African tradition'. However, it should not be assumed that extended families have the capacity or the will to care for relatives with AIDS, especially where there may be more than one sick person in a family (Seeley et al, 1993). Further, the responsibility may not be spread evenly between family members, but may devolve onto just one or two people. The impact and caring capacity clearly depend also on the prior asset position of the family and the numbers of dependent persons.

The ACP in Uganda has produced posters advising carers of the best methods of looking after sick friends and relatives. TASO also provides such advice, while recognising that poverty may seriously impede the provision of the necessary care for patients. TASO therefore supplies home care kits consisting of bedsheets, laundry soap and plastic sheeting to people who cannot afford them. They also distribute food, since good nutrition enhances peoples' chances of recovering from opportunistic infections, and provide free drugs for treatment of such infections. To obtain TASO support, it is necessary for a person to register as HIV positive at one of the organisation's centres in towns in the South and East of the country. This may mean that people who are too poor or too sick to travel, are unlikely to be able to obtain

[17] No information on hospital or hospice care for people with AIDS in Uganda or Malawi was available. Gender disparities in hospital admission, treatment and care are undocumented but may exist. Nurses and other caring staff, who are mainly women, may be at high risk of HIV infection through accidental contact with the blood of seropositive patients, where protective clothing is lacking. In any case, the health infrastructure in both countries is heavily under-resourced. No statistics on the availability of health care in Uganda are available. In Malawi, currently, the ratio of doctors to people is 1: 45, 740, and of nurses to people is 1: 1,800, indicating a severe lack of medical personnel to provide health care (World Bank, 1993a:292).

such assistance. Due to resource constraints on TASO, such services can be provided only in urban and peri-urban areas (Alison Evans, personal communication).

A gender bias in numbers of TASO clients has not been documented, but it is possible that the undervaluation of women's health may mean that they are less likely to go to the expense and effort required to register at a TASO office. Similarly, it may be more difficult for women than men to avail themselves of such Government and church-run care facilities as are available, both in Uganda and Malawi.

5.2 Orphans

In Uganda, orphans are considered to be children who have lost one or both parents. In the context of HIV/AIDS, the probability is high that if one parent has died of the disease, the other may also die fairly shortly. Estimates of the overall number of orphans vary from 620,000 to 1,200,000 (Hunter, 1990)[18]. It is increasingly clear that extended families cannot be relied upon to care for orphans, due to a combination of factors such as poverty, death and illness of adult carers and increasing feelings that in the context of such a generalised problem, family responsibility does not extend so far. Similarly there is evidence (Barnett and Blaikie, 1992) that orphans incorporated into extended families may receive less care than other children of that family or those in institutional care (Hunter, 1990; Muyinda and Barton, 1992 cited in World Bank, 1993b:38). The strain on a foster family may be particularly acute where only elderly adults, particularly women, are left. As Barnett and Blaikie (1992) observe, such women are often poorer, depend more on friendship and goodwill, and generally are less entitled to community labour than elderly men.

Girl orphans in particular may be disadvantaged, especially in school attendance. Barnett and Blaikie (1992) note that the single greatest problem cited by carers, particularly grandparents of orphans, was paying for school fees. Where resources do not permit sending of all children to school, it is possible that girls rather than boys will not attend since female education is often considered a lower priority than male education (World Bank, 1993b). However, it appears that in many cases strenuous efforts are made to keep children in school and often all children have to leave, particularly where several orphans join a family, due to the increased costs that this places on household.

The Government initially pledged to pay for the school fees of AIDS orphans, but this has since been retracted since, given the numbers involved, and the severe constraints on Government expenditure, it would clearly be financially unfeasible. In certain cases, organisations such as TASO or the small neighbourhood associations, *bubondo*, described in Williams and Tamale (1991) pay school fees where carers cannot afford to do so, In some areas local-level Resistance Committees (RC1s) have pooled money to support carers of orphans and people with HIV/AIDS (Christine Kisamba-Mugerwa, personal communication).

[18] More recent estimates are not available

Barnett and Blaikie (1992) observe that the gender of the eldest child in a wholly orphan household has a considerable impact on those children's well-being and survival; because girls traditionally learn domestic and agricultural skills, they are better equipped than boys to head households and care for other children. In spite of kin or community-based efforts to support such families so that children do not experience the disruption of moving to a new home, such structures are probably not sustainable over the longer term. They therefore recommend community-based care for orphans by professionals with experience in child-care, nutrition and health (*ibid*). What this would actually consist of, is, however, not detailed. Whilst several NGOs are providing support to foster families to care for orphans, many people in rural areas are unaware of the possibility of obtaining such assistance. People tend to be most aware of TASO support programmes, since TASO has regular radio slots (Alison Evans, personal communication).

5.3 Counselling

No information is available either on Government counselling services in Uganda or Malawi nor on NGO counselling work in Malawi. Nor are statistics available on the numbers, gender and social composition of people counselled by different organisations. The ratio of women to men counsellors is also not known. Approximately equal numbers of male and female counsellors are desirable in that counselling on HIV/AIDS and sexual issues may be more acceptable when counsellors and clients are of the same gender. Development of such a database would provide an important contribution to ensuring the gender-sensitivity of counselling services.

In Uganda TASO has been particularly active in counselling people affected by HIV/AIDS and in training counsellors. People with HIV/AIDS are particularly welcomed as counsellors. As of January 1992, TASO had opened counselling centres in Kampala (at Mulago Hospital), Masaka, Mbarara, Tororo, Mbale, Entebbe, and Jinja. There are plans to open further centres in other districts. In Kampala and Masaka, TASO has opened drop-in centres where people with HIV/AIDS and their families can meet and take part in income-generating and social activities (TASO, 1992b). As well as disseminating information on the care of people with HIV/AIDS and the prevention of HIV transmission, much of TASO's work centres around reducing the stigma attached to the disease and promoting feelings of acceptance of people affected by HIV/AIDS.

6. CONCLUSIONS AND POLICY RECOMMENDATIONS

6.1 Uganda

There is a need to extend HIV/AIDS prevention and care activities in Uganda beyond Kampala, Rakai and Masaka, to the whole country and particularly to rural areas. The North has probably been particularly neglected. This implies support to organisations engaged in rural outreach work.

Apart from NGOs, two possible other sets of institutional structures are the Resistance Committees (RCs) and rural health infrastructure, which are already involved in both prevention and care work. They could be strengthened through training in gender-sensitive awareness work, and in explaining HIV transmission and the development of AIDS in clear terminology, based on an understanding of local concepts and in local vernacular. PRA methods to ascertain how rural communities perceive HIV/AIDS and attitudes towards sexual behaviour could be of value here. Schools, too, have large potential to reach young people in rural areas, and their efforts could be strengthened by supporting the training of teachers or other resource persons in HIV/AIDS awareness work, and the development and dissemination of training materials for their use.

The imminent demobilisation of the army poses a major threat in terms of the potential for further spread of HIV infection, given high seroprevalence rates in the army, and the likely dispersion of personnel across rural areas. Specific work with these men to promote safer sexual behaviour before demobilisation is necessary to help to reduce the spread of HIV/AIDS into populations of currently low prevalence. HIV/AIDS programmes with military personnel in other contexts (e.g. Nigeria - see Ford, 1993) might provide valuable insights here.

6.2 Malawi

The limited information on HIV/AIDS and on prevention and care activities in Malawi precludes the drawing of anything beyond preliminary and tentative policy conclusions. In general, it appears that there is a lack of indigenous NGOs with which external NGOs can develop programmes and/or through which official programmes can be decentralised. Institutional development, including training with a strong participatory component, would thus appear to be a major requirement. Gender-awareness training, and support to women's NGOs should form be a central feature of such work.

The density of population in Malawi may facilitate outreach work among rural people, and mean that problems of reaching dispersed communities do not arise to the same extent as in Uganda. However, the inaccessibility of lakeside communities in the North and of island communities may need special attention.

6.3 General

Some organisations in Sub-Saharan Africa, and particularly in Uganda, are implementing innovative prevention and care projects on a small-scale (see main text and Appendix 2). These projects are often highly resource intensive with extremely high project staffing ratios, relying on one-to-one or small group support approaches in training and mobilising for HIV/AIDS prevention, or in counselling and supporting persons with AIDS and their carers. Strategies for scaling up such initiatives should be examined carefully and donor resources committed to supporting this process, in the cause of eventual cost savings.

Further work is needed to investigate the extent to which women's organisations (governmental and non-governmental) are able to influence National AIDS Programmes and/or the degree to which gender issues are taken into account at this level. Mechanisms for strengthening the participation of women's organisations in National AIDS Programmes need to be examined, where this is lacking.

The patterns of expenditure on HIV/AIDS activities may need to be examined in the light of the increasing need to support people with AIDS, their carers and dependent relatives, and of the current low levels of expenditure on care compared to prevention and other activities.

Rehabilitation and further development of health infrastructure, particularly in under-served rural areas, is a vital prerequisite to the strengthening of HIV/AIDS work. Increased integration of HIV/AIDS activities with STD treatment facilities, MCH and Family Planning activities would be of great value in this regard and may facilitate reaching larger numbers of women. In the longer term, improved treatment of STDs and increased birth spacing could substantially reduce women's vulnerability to HIV infection and the early development of AIDS. However, there are a number of sensitive issues here, which require careful handling, due, in particular, to the stigma attached to HIV/AIDS and STDs, especially for women. Moreover, this should also be seen as an opportunity to involve men more in reproductive health issues generally, rather than a way to target prevention activities on women.

Further research, development and trialling (on a safe and ethical basis) is needed with alternative technologies for HIV/AIDS prevention, which are affordable and appropriate for women.

6.4 Towards more effective prevention strategies

Targeting

Current patterns of targeting in HIV/AIDS prevention are not seem very clear in either Uganda or Malawi. Given the extremely high seroprevalence rates in both countries, it is vital that prevention messages are not limited to perceived 'high risk' groups, but made accessible across the sexually active population, including young adolescents and also even younger people whose behaviour can be influenced before they are

exposed to risk. However, untargeted mass media campaigns may be of limited value in reaching certain groups (particularly women), and generally in influencing individuals to transform information into knowledge or behaviour change. Thus, what appears to be needed is increased support and extension of resource intensive, local level programmes which have a clear understanding of the requirements of all the particular groups at whom programmes are aimed.

Specific strategies and messages are needed to reach different segments of the population, which should be based on a clear understanding of differences in their access to information, and also of the feasible options for behaviour change open to different groups. In particular, the limited value of exhorting women to change their behaviour should be recognised, when the majority are already monogamous or are dependent on sex with multiple partners for survival, but still remain at risk through the reluctance of their partners to change behaviour. Much greater attention needs to be paid to ways of influencing male sexual behaviour, and to creating economic alternatives for women to reduce their dependence on men.

Condom promotion

In the absence of alternative technologies preventing HIV transmission, condom promotion remains essential. The failure of the majority of respondents in the Ugandan survey cited to mention condom use as a method of HIV/AIDS protection is particularly worrying in this regard.

Efforts to encourage condom use and to set their retail prices at affordable levels for rural people need to be strengthened. Innovative marketing and distribution methods need to be employed in this respect.

However, condom promotion alone is insufficient and needs to be accompanied by education and awareness raising if use is to be increased. More efforts need to be concentrated on increasing male motivation to use condoms. (See below.)

Women and prevention campaigns

The limited evidence from Uganda shows that women are reached with information on HIV/AIDS later than men, more often through indirect channels, and also that churches are more influential in reaching women. This suggests a gender bias in access to information, which needs to be addressed in the planning and implementation of information campaigns.

Specific measures are needed to ensure that women receive timely and accurate information about HIV/AIDS and about possible means of protecting themselves. More intensive outreach work targeting locations where women congregate, and use of peer education and other community based campaigns would seem to be most valuable in this respect. Such activities also have the advantage of allowing the accuracy of knowledge about HIV/AIDS to be tested, and facilitating the sharing of experiences and strategies. The use of mass media such as newspapers and radio has limited impact unless backed up by community based activity.

The messages in HIV/AIDS prevention campaigns - especially those of religious bodies - often tend to be moralistic, based on recommending abstinence or fidelity.

As such they tend to reinforce gender based power in sexual relationships, and/or fail to challenge economic and ideological inequalities which undermine effective protection. Thus, women are often left with a sense of frustration and powerlessness to take any action against HIV/AIDS.

HIV/AIDS prevention work among women needs to address issues of men's attitudes and behaviour, to protect women's legal rights (in respect of property and inheritance particularly), and in the longer term, to create alternative economic opportunities for women reducing their dependence on exchanging sexual favours with men. Both non-gender specific anti-poverty programmes and those focusing on women should be supported. However, the overall climate of economic decline and deteriorating infrastructure in much of Sub-Saharan Africa, including Uganda and Malawi, is clearly a major structural constraint in this regard.

Communities need to be mobilised around the issues of sexual abuse, sexual violence and sexual exploitation/early marriage of young women, which is increasing with HIV seroprevalence, particularly by older men. Further work is needed to increase girls' school attendance at post-primary levels and to provide them with skills and employment opportunities; in many situations community level mobilisation seems to be crucial in raising educational enrollment and attendance among girls. (Brook and Cammish, 1993.)

Men and HIV/AIDS prevention

Men are generally better informed than women about HIV/AIDS, although they may still have serious misconceptions about various aspects of HIV transmission and also about the risks attached to their own behaviour, particularly in rural areas. less so in rural communities. A major barrier to prevention campaigns is men's resistance to using condoms, and, in general, a lack of sense of responsibility for their sexual behaviour. Peer education seems the most likely approach to be effective. Here, the work of TASO with groups of men (see main text, section 4.5.1) is extremely valuable and needs to be extended.

Youth and HIV/AIDS prevention

Schools programmes are of immense potential value but are currently limited by: poor overall attendance at post primary level and gender gaps in enrollment; lack of resources (human and material); lack of expertise/experience in introducing HIV/AIDS education; resistance on the part of school management or teachers to delivering HIV/AIDS education. Schools programmes need to start early (i.e. at primary level) to capture the majority and have a chance of changing behaviour. There is a need for training and materials support for teachers involved in HIV/AIDS education, particularly those in isolated rural areas where awareness is lower and resistance to change may be greater.

Out of schools programmes are also vital (and perhaps more flexible) in reaching young people. The Anti-AIDS clubs in Zambia provide an useful model. Equal participation of girls and boys in such activities should be aimed for, as well as

activities which stress the responsibility of boys for their sexual behaviour, and empower girls to refuse unwanted sexual advances.

Other groups
Work with CSWs and their clients is clearly valuable and should be continued. However, the emphasis needs to be shifted away from one of simply discouraging men from using CSWs, to the promotion of safer sexual practices between CSWs and their clients. Parallel work is clearly needed with both sides. Issues of morality and legality means that this work can only be effectively carried out by NGOs or self-help groups which are not pursuing a moral agenda. (Self)-organisation of CSWs to enforce or promote condom use has been successful in other contexts. Poorer CSWs may be more vulnerable to pressure from clients and thus need special attention.

Design and evaluation of prevention messages/campaigns
Processes of translation of information into knowledge and behaviour change are poorly understood, but didactic methods of delivering information are increasingly thought to be ineffective. The specificity of sexual behaviour and norms in particular contexts means that understanding of local conditions is vital for effective intervention. Awareness of this heterogeneity and/research into variation in local understandings of HIV and AIDS and local sexual behaviour and norms needs to be strengthened. This should enable the development of prevention messages with greater clarity and help reduce misconceptions about the disease. Participatory approaches may be particularly valuable in this field. Related to this, research into visual literacy would help understand the images deemed most meaningful by illiterate people. Other participatory methods of raising HIV/AIDS awareness (e.g. drama) may also have potential; but little is known about the relative effectiveness of different approaches, media and messages and this needs to be carefully monitored.

6.5 Towards larger scale care

Initiatives providing assistance to people with HIV/AIDS and those caring for them need further support. This may become increasingly important as the capacity of households, and particularly of women to cope with several terminally ill people or to meet the needs of orphaned children becomes progressively strained.

Professional support for home and community based care needs to be stepped up, particularly in rural areas where the strain of caring for returning migrants and the distance from existing facilities are currently causing great stress.

Adult female carers, and particularly female heads of household, may require particular support, in that they are more likely to be doing the bulk of caring; where caring for partners they may be ill themselves; they are more likely to be poor and/or have less claim on family and community resources; they are vulnerable to dispossession of the death of a partner.

Increased support is needed for those caring for orphans and for orphan households in the community, which may be headed by very young women. Particular attention is needed to ensure that the school attendance of orphans and other children in foster families does not suffer, especially that of girls, through a more systematic provision of subsidies, exemptions or incentives. Some degree of government/donor financing is clearly required here.

Research into the gender (and class, ethnic, geographical and educational) composition of recipients of counselling and care services should be carried out and the results used to examine (and if necessary address) any apparent gender biases in such provision.

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APPENDIX 1: ORGANISATIONS INVOLVED IN AIDS PREVENTION AND CARE PROGRAMMES IN MALAWI AND/OR UGANDA

1. Regional Organisations

Society for Women and AIDS in Africa (SWAA)
c/o Secretary General SWAA
UTH, P. O. Box 50110
Lusaka, Zambia
Tel: (260-1) 264864/254809
Contact: Dr. Nkandu P. Luo, Secretary

Undertakes safer sex workshops, counselling, public education, support services. Aims to collaborate with governments, NGOs and women's organisations throughout Africa and globally. Helps empower women to insist on safer sexual practices. Working in Uganda (see Uganda section). A branch has recently opened in Malawi, but no details are available (Berer, 1993:312).

Southern African Network of AIDS Support Organisations (SANASO) (links in Malawi)
PO Box 6690
Harare, Zimbabwe
Contact: Farai Mugweni
Currently moving but can be contacted through the AIDS Counselling Trust
Tel: (263 4) 792340

No details available

2. Malawi

Christian Hospital Association of Malawi
Contact: Percy Kantunda
Telex: 44558 Health MI or 43148 CHAM MI

Large organisation promoting HIV/AIDS awareness and care. Supported by Oxfam (UK).

National AIDS Control Programme
PO Box 30662, Lilongwe 3
Fax: (265) 784247
Tel: (265) 781040/ 781198/ 781344/ 781080

No details available

3. Uganda

Action for Development (Acfode)
Tel: (256) 41 245936

Ugandan women's NGO, which concentrates on publicising gender inequality, political and legal advocacy work, networking and awareness raising with women. (Christine Kisamba-Mugerwa, personal communication). Has incorporated HIV/AIDS awareness into its outreach work with women since 1990 (Ankrah et al, 1992). Special programme training senior women teachers in sex education for girls (Hitchins, 1992).

AIDS Information Centre
Baumann House
7 Parliament Ave
P.O. Box 10446
Kampala
Tel (256-41) 231528

'HIV testing, counselling for individuals, couples and groups; post-test clubs; education; research projects in coordination with university researchers and referral services. Plan to open satellite clinics in several rural areas.' (Berer, 1993:315)

Experiment in International Living (EIL)
AIDS Education and Control Project
P.O. Box 9007, Kampala
Tel: (265-41) 242429/234900/233237
Fax: (265-41) 231743

'Support referrals and education for women. Emphasize sexual practice, STDs and pregnancy-related transmission. Target adolescents and rural women. Training guides for HIV/AIDS workers' (Berer, 1993:315)

Uganda Women Lawyers' Association
(branch of FIDA - International Federation of Women Lawyers)
No contact details available

Provides legal advice to women and men and conducts legal awareness workshops throughout Uganda (Christine Kisamba-Mugerwa, personal communication). Supports women in property disputes, increasingly arising among women widowed or divorced through AIDS. Also supports women who refuse to have sex with their husbands (Berer, 1993).

Society for Women and AIDS in Africa (Uganda)
c/o Ministry of Health, MCH/FP Division
P.O. Box 8
Entebbe
Tel: (256-42) 20537

Plans to provide HIV testing and counselling, sex education, conduct condom distribution, training for community-based women and youth counsellors, traditional birth attendants and healers. Also to examine whether traditions and socio-cultural practices put women at risk or make coping with HIV/AIDS difficult. Aim to use songs and drama to communicate on HIV/AIDS issues (Berer, 1993:315).

The AIDS Support Organisation (TASO)
P.O. Box 10443
Kampala
Tel. (256-41) 231138
Fax: (256-41) 244642

Counselling and support for positive living including provision of food and drugs to registered clients. Pays school fees of AIDS orphans. Conducts awareness training in communities.
(See main text)

4. International NGOs

ACORD
Francis House
3rd Floor, Francis St
London, SW1P 1DQ
071 828 7611
Contact: Chris Batchelor

Has supported integrated rural development programmes in Uganda, Rwanda and Kagera Region of Tanzania for approximately 12 years. In response to community request, assistance on AIDS-related issues has been integrated into these programmes. ACORD supports the development of community-identified coping mechanisms, such as AIDS committees and burial groups in severely AIDS-affected areas. Have supported training of counselling volunteers and have sponsored AIDS awareness competitions in schools in Gulu, Uganda (Chris Batchelor, personal communication).

Action Aid
Hamlyn House
Macdonald Road
LONDON N19 5PG
Tel: 071 281 4101
Fax: 071 272 0899
Contact: Catherine Pluman

Supported production of Strategies for Hope series of booklets. Currently giving technical and financial support to NGOs involved in HIV/AIDS awareness and care, including a 'seed assistance to community-based organisations' programme, working with 19 groups in Uganda and 8 in Malawi (Catherine Pluman, personal communication).

AHRTAG (Appropriate Health Resources and Technology Action Group)
1 London Bridge St
LONDON, SE1
071 378 1403
Contact: Chris Castle, HIV/AIDS Officer

Produces AIDS Action, published in five languages. Planning to decentralise production of the English edition to Southern Africa and investigating the possibility of supporting the development of AIDS information/resource centres in Africa. Supports and funds project partners involved in AIDS prevention and care work, such as the Township AIDS Project in South Africa. Will support production in French and Spanish of M. Berer (1993) Women and HIV/AIDS: An International Resource Book, which is already published in English (Chris Castle, personal communication).

CARE
32-39 Southampton St
London WC1
071 379 5247
Contact: Jo Munro (HIV/AIDS specialist) or Shoa Asfaha (East Africa Desk Officer)

Supports HIV/AIDS and STD Information, Education and Communication (IEC) component of reproductive health project in Rukungiri, Uganda. Also support an education project for youth in western Kenya and fund production of Pied Crow, a primary school environmental education magazine which, like Action, a similar magazine produced in Zimbabwe, regularly features articles related to sexuality, including a whole issue on HIV/AIDS. Articles often consist of picture stories in simple English with young male and female characters in everyday situations. Pied Crow also challenges traditional gender relations by portraying boys and men in stereotypically female activities and expressing traditionally 'feminine' emotions and vice versa (Jo Munro, personal communication).

Christian Aid
P.O. Box 100
Interchurch House
35 Lower Marsh
London, SE1 7RL
071 620 4444
Contact: Catherine O'Neill

One programme in Malawi supporting drama group to tour schools, churches, community centres etc doing AIDS awareness plays. Also supports the Anti-AIDS project which supports Anti-AIDS clubs in schools in Zambia and a home-based care programme in Zambia (Catherine O'Neill, personal communication).

Marie Stopes International
129 Whitefield St
London, W1P 5RT
071 388 3740
Contact: Catherine Howard (Malawi),
Emma Blackman (Uganda)

In Malawi, support the Man to Man programme, primarily a family planning programme, but which also addresses HIV/AIDS, motivating men to accept condoms, particularly through workplace groups and training people in family planning motivation. Based in Blantyre and working in neighbouring townships (Catherine Howard, personal communication).

Details for Uganda are not available

OXFAM
Oxfam House
274 Banbury Road
OXFORD
0865 311311
Contact: Claudia Garcia Moreno

Supports Christian Hospital Association of Malawi (see above) and various other projects with HIV/AIDS foci or components in Uganda (Claudia Garcia Moreno, personal communication).

Scottish Catholic International Aid Fund (SCIAF)
5 Oswald St
Glasgow, G1 4QR
Tel: 041 221 4447
Fax: 041 221 2373

Supports 3 programmes in Uganda. Education for Youth for Life in Western Isle involves dissemination of information on AIDS and STDs through the peer educators working with the Diocesan Youth Service. Supports similar seminars for youth in Kampala. Has supported training and refresher courses for counsellors in the mission hospital in Kitovu (Africa Desk Officer, personal communication).

World Vision UK
Dychurch House
8 Abington St
Northampton
NN1 2AJ
0604 22964
Contact: Nicola Wilkinson

Pilot project in Luwero, Mpigi, Mukono and Mubende training Resistance Committee leaders and school teachers to educate children and adults about HIV/AIDS. Also assist in provision of health care supplies to people with HIV/AIDS. This project has a strong focus on women and discussion and development of coping strategies is taking place in the context of small existing community women's groups.

Also supporting programme caring for orphans in Rakai, Masaka and Gulu. This project is supporting the care of children in extended family and foster care networks. Inputs to communities in this project include educational assistance to orphans and school rehabilitation, the development of vocational centres, skills training, agricultural loans, HIV/AIDS and bereavement counselling, the rehabilitation of health facilities and training of health workers.

In Malawi, HIV/AIDS components are integrated into existing community development projects. Further details are not available. (C. Symes, personal communication).

Uganda AIDS Action Fund
57 Old Kent Road
London SE1 4RF
Tel: 071 231 4862
Contact: Rose Ntege

No details available

5. International Organisations

UNDP
304 E. 45th St
9th Floor
New York, NY 10017
USA
Tel: (1) 212 906 6019/5860/6977
Fax: (1) 212 906 6366/6350
Contact: Gail Lerner

Field Office:
P.O. Box 7184
Kampala
Uganda
Tel: (256) 41 3344012/324634

Has provided financial assistance to the Ugandan Ministry of Health to develop training and Information, Education and Communication (IEC) materials; also to a microproject programme to combat HIV/AIDS and for research on the socio-economic impact of AIDS. 1992-6 Plan aims for flexibility in resource allocation and to identify areas where assistance can be most productive. Possible areas include IEC in districts such as Apac and Lira where awareness is very low, collaboration to support programme development on behaviour change, addressing gender issues through supporting the ACP and UAC to become more gender-sensitive and women's NGOs such as ACFODE and the National Council of Women. Suggest also special work on STDs, with the military, prisoners and refugees (RoU/UNDP, 1992)

UNDP
P.O. Box 30135
Lilongwe 3
Tel: (265) 30566
No details available

UNICEF (Kampala)
P.O. Box 7047
Kampala
Tel: (256) 41 234591/2
259146.

Supporting expanded programme of communications on HIV/AIDS, particularly through production of posters and assistance to Radio Uganda to produce AIDS prevention programmes. Intend to focus on condom promotion, reduction of STDs, intensive work with youth through schools and reduction in pregnancies by seropositive mothers (RoU/UNICEF, 1991).

UNICEF (Lilongwe)
P.O. Box 30375
Lilongwe 3
Tel: (265) 732755/732127/732714/732393

No details available.

WHO
P.O. Box 6
Entebbe
Uganda
Contact: WHO Representative
Tel : (256) 42 20572/20750

No details available

WHO
P.O. Box 30390
Capital Hill
Capital City
Lilongwe 3
Malawi
Contact: WHO Representative
Tel: (265) 782755/782450

No details available

APPENDIX 2: EXTERNAL SUPPORT FOR UGANDAN OFFICIAL AIDS PROGRAMME

In 1989 **UNDP** granted funds towards the national AIDS Training and Information Materials project within the MOH. UNDP has granted USD 614,000 from its Indicative Planning Figure for the 1992/96 Country programme in support of the Uganda AIDS Commission secretariat (UGA/91/003). By mid 1992, USD 173,000 has been spent on vehicles and office equipment. In November 1991 UNDP granted USD 700,000 for a micro project programme to combat AIDS (UGA/91/005). Uganda is also benefitting from a regional UNDP grant for studies on the socio-economic impact of AIDS (RAF/91/004).

Since 1988, **USAID** has been assisting the Government's AIDS programmes. In 1991, it provided a USD 12 million grant to be administered by the NGO Experiment in International Living (EIL). This grant fully funds the AIDS Information Centre (AIC), which provides free HIV testing and counselling. USAID is providing approximately 50% of the operational budget of The AIDS Support Organisation (TASO). It also provides funds for AIDS activities by the Federation of Ugandan Employers and Uganda's army, the National Resistance Army (NRA). Most of the funding goes towards training professional and lay personnel in HIV prevention; training counsellors; HIV testing and counselling; community awareness and outreach; peer education, and HIV prevention in the military. **USAID** is concerned about the need for additional research and programme evaluation and about the technical and professional human resource gaps in those fields.

GTZ, the German international aid organization, has also been involved in AIDS interventions in Uganda since 1988, initially through assistance to the primary health care programme. It has concentrated on providing comprehensive interventions in Bundibugyo and Kabarole districts. Future initiatives are planned in support of the UAC and AIC; control of STDs; provision of health care supplies, including condoms; and expanded programmes of health education. The GTZ intends to give more support to home-based care and to NGOs and women's groups.

DANIDA has also worked to strengthen NGOs involved in AIDS interventions and has recently redirected its programme to ensure district and community-level service through "area development programmes". It also supports the essential drugs programme and, with UNICEF, the training of teachers in health education. DANIDA has identified the need for a framework to coordinate NGOs working in AIDS.

EEC financed the rehabilitation of the blood transfusion service and will continue to support it. The EEC may fund more AIDS interventions, depending on the priorities emerging from the national plan.

UNFPA is supporting the strengthening of health information systems and is addressing AIDS in the information component of all its projects, among them the safe motherhood initiative, the MCH/FP programme, the integration of family life education into school curricula, and the integrated district population programme. It is also training health care workers and providing supplies to protect them from

infection. It is considering support for Makerere University for research into the socio-economic and demographic impact of AIDS. With UNFPA, FAO is introducing AIDS/health education into all extension and farmer education programmes.

UNICEF has identified intervention opportunities in the communication field. To date UNICEF has been a key supporter of the UAC, school health and development of a health education network. It is also assisting community-based groups which care for orphans and other vulnerable children and is preparing a health education programme geared towards youth, Safeguard Youth from AIDS (SYFA).

WHO has largely supported the management and administration of the ACP and IEC activities. It has also provided assistance to patient care; laboratory support and blood screening activities; STD control, and epidemiology and surveillance. Future assistance of WHO/GPA includes expansion of present activities with potential redirection following the preparation of the successor Medium Term Plan scheduled for 1992.

The World Bank responded in 1990 to a request from the Government for assistance (with UNDP, WHO and UNICEF) in formulating a multi-sectoral approach to addressing the epidemic and has undertaken a number of missions to identify areas for Bank cooperation. As a major donor supporting the establishment and maintenance of the UAC (approximately USD 3 million over 3 years), the Bank has provided salary assistance, staff training and operating costs. The Bank has also been active in financing consultancies for studies and the establishment of an AIDS Action Evaluation Fund to monitor and evaluate the cost-effectiveness of various interventions. Areas for potential support include continued strengthening of the UAC; IEC and STD programme development; and activities aimed at assessing the potential socio-economic impact of the epidemic and developing programmes particularly in the agricultural sector.