Health Transition Review, Supplement to Volume 5, 1995, 35-56

A high price to pay: for education, subsistence or a place in the job market

Christine Oppong

Formerly of the Development Policies Branch, Department of Development and Technical Cooperation, International Labour Office, Geneva.

This chapter cursorily reviews a variety of evidence, mainly from Sub-Saharan Africa, related to the current incidence and speed of spread of HIV/AIDS. It draws and builds upon an array of previous work.[1] It calls attention to some of the discussions and data-supporting hypotheses which link more rapid sexual transmission of the virus to the degree of prevalence of several documented, chang ing, gender-role attributes. The latter are involved in the economic, political, military and social crises transforming familial and non-familial institutions. They are associated with widespread social and spatial dislocation of populations; escalating impoverishment and increasingly sharp divergences in wealth and power. They concern aspects of what has been loosely termed in the past 'women's status'. These include on the one hand the degrees of inequality, subordination, dependence, neglect, deprivation, irresponsibility, coercion and even violence, suffered by girls and women in a variety of role relationships; for example as daughters, wives, community members, employees. On the other hand they include the types of socio-legal protection which they do or do not enjoy in their various capacities and their relative access to and control of resources required for sustainable livelihoods and human development.

These status attributes are associated in a number of ways with the types of sexual behaviour and relationships in which they are involved, especially the extent to which girls and women have to engage in sexual intercourse through necessity: to pass school examinations or obtain training places; to retain access to their children; to get access to farming land; to get money and food for daily subsistence; to get jobs and stay in them (see Ulin 1992). The text accordingly focuses attention on connections between escalating female socio-economic inequality, insecurity, poverty and powerlessness on the one hand and health outcomes on the other. It draws attention in particular to the evidence pointing to links between types of sexual behaviour and the incidence and spread of sexually transmitted disease and death including HIV/AIDS (cf. Gordon and Kanstrup 1992). The discussion thus takes up and documents a theme of the International Conference on Population and Development enunciated in Cairo in 1994, that is the need for health policies and programs to take sufficiently into account the economic, demographic, socio-cultural (and gender) dimensions of reproductive health protection. Already a number of countries in the region have begun to address HIV/AIDS in public discourse which goes beyond a purely medical approach and is gender-sensitive, and to develop programs which recognize the need for multifaceted approaches. In line with the current WHO (1995) global health report the discussion stresses the crucial links between poverty, inequality and morbidity and mortality. In the final analysis the latter rates are the prime indices of the former.

---

[1] For example Caldwell, Caldwell and Quiggin 1989; Caldwell, Orubuloye and Caldwell 1991; Caldwell, Caldwell and Orubuloye 1992; Ankrah 1991; Cleland and Way 1994; Anderson 1994.

Space constraints prevent a discussion of the effects of girls' and women's unequal access to education, training, agricultural resources and employment opportunities and the discounting and neglect of women's work in labour records, agricultural plans and policies; and this chapter does not describe the agricultural crises, the devastating terms of trade, the pervasive effects of the rapidly increasing supply of job-seekers, the effects of harsh retrenchments in the public sector, the informalization of employment and increases in precarious labour contracts, the apparent declines in recorded female employment and widespread feminization of unemployment and poverty. These issues have recently been addressed in several ILO and other publications (Oppong 1992; Singh and Tabatabai 1993; Mhone 1995; Date-Bah forthcoming).

The changes in gender roles and relationships referred to in this discussion and resulting from such processes are implicated in several transformations, even crises, occurring in demographic and socio-economic systems of production and social reproduction on the African continent. Among these are the weakening and relative disintegration of traditional, often descent-group and farm based, structures of subsistence and support and the consequent collapse or inadequacy of customary social safety nets and survival mechanisms including substitutability of actors in the domestic domain. Results include increasing streams of labour migration, both national and international[2]. An outcome is more people searching anxiously for often non-existent jobs, compelled to set up micro-enterprises in urban areas as survival strategies.

The spatial, social and familial dislocation of populations so entailed is immense. The suffering and degradation of the ceaseless to and fro of migrants is not well documented (Standing 1985:xl). Instead of being enmeshed in lifelong systems of morally binding transactions of kinship and affinity, ensuring group solidarity and some measure of security across the generations for young and old, individuals are forced more and more to rely upon precarious forms of livelihoods in strange environments. They are drawn to engage in forms of short-term, unprotected, deregulated, opportunistic, economic and sexual behaviour, which are entailed by such forms of survival and associated life styles and constraints when institutions and frameworks promoting and regulating employment and procreation are lacking or in their infancy. Both productive and reproductive (sexual) behaviour and relationships are being stripped of their moral, long-term, responsible contractual framework and being recast in daily, nightly, or hourly rated modes of operation, including exploitation, with consequent effects on the dignity of labour, individual security and the outcomes in terms of child survival and development (see Oppong 1993a).

Various macro-economic and legal policies and political as well as demographic phenomena are implicated in the micro-change processes discussed. They are shaping labour market demands, supplies and opportunities, the legal frameworks within which these operate and the public resource allocations and private patterns of expenditure affecting them. Lachaud (1994) has recently compared poverty levels and labour market issues in the region, stressing the rapid escalation of proportions and numbers in poverty through excess labour supply and little labour demand. For the region's socio-economic context is one of significant, if not catastrophic, economic deterioration during the past decade and a half, in which internal and international factors precipitating crises and decline have been aggravated by disastrous domestic policies, including Structural Adjustment Policies (SAPS), of which the gender dimensions and potential effects on social reproduction remain largely ignored and misunderstood. At the same time there is widespread recognition at the national level of the

---

[2] It has been estimated that Africa has 10 per cent of the world population and around half of the world's nationals abroad (Stalker 1994). In addition much migration is internal, either cyclical or one way (e.g. Collier et al. 1990 on Tanzania).

need for legal reform, to reconcile customary laws and contemporary practices, to promote the equality of citizens appropriate to modern states and to provide the kinds of legal redress and protection needed by the oppressed and wronged.

World Bank publications have argued that in the light of current knowledge, discussion of links between macro-economic adjustment policies and deteriorating health status, including vulnerability to HIV infection, is speculative (Elmendorf and Roseberry 1993). They have also propounded that there is much that reform-oriented public policies can do, within an adjustment framework, to address HIV risks. These include expenditure reallocations to ensure essential public and preventive care services, including STD screening and public education. However, some analysts of political economy and demographic trends in the African region view the macro-economic policy advice of SAPs as having observed and pervasive negative effects on survival and social reproduction in Africa and elsewhere, whether these effects are intended or unintended (see Singh and Tabatabai 1993).

Persuasive and well documented answers to such questions regarding the effects of macro-economic policies and legal reforms on human survival and development will ultimately depend upon the wider availability and analysis of demographic and health data, together with more systematic cross- cultural and comparative studies of the socio-economic, political, cultural and legal contexts of sexual behaviour and its outcomes, whether the outcomes are conception and procreation, or sickness or death.

This chapter merely adds more fuel by further juxtaposing some of the diverse materials which could be used in such debates. It first looks briefly at the incidence of HIV/AIDS and the kinds of approaches to documentation, analysis and forecasting used by scholars of different disciplines. It then concentrates on diagnosis of vulnerability, highlighting the ways in which individuals' sexual behaviour puts them at risk. This behaviour is seen to be moulded by their resources, power and decision-making ability. The latter largely stem from the resources accruing to occupations or provided by protective and supportive family members. At the same time the lifestyles, including sexual behaviour, associated with various key occupations of females and males are observed to be critical. Moreover places of education, training and employment are highlighted as key areas in which females are sexually at risk. This leads to the widely supported conclusion that approaches to sexually transmitted disease and death, which omit female empowerment and protection and male responsibility and which ignore the effects of poverty and inequality, are likely to be doomed to catastrophic failure.

In the light of the labour and training-related aspect of these discussions some recent evidence is cited from ILO meetings and analyses. These indicate the mounting recognition of the actual and potential implications for ILO's constituents. Simply put the discussion is meant to add more weight to those already advocating the necessity for more sophisticated design of multisectoral population and development policies.

The HIV/AIDS epidemic: incidence and approaches

Basic information about the global HIV/AIDS epidemic, the associated sexual behaviour patterns and the worldwide responses, continues to grow rapidly. Certain facts are apparent, such as that no community or country in the world already infected by AIDS can claim that HIV spread has stopped; that HIV is spreading, sometimes quite rapidly, to new communities and countries around the world; that the epidemic is becoming ever more complex as it matures and the major effects are yet to be felt (Mann, Tarantola and Netter 1992:2-3). Projections to the end of the century suggest that a minimum of 38 million adults will have become HIV infected, with a higher estimate of up to 110 million. In this scenario the cumulative number of AIDS cases by the year 2000 will reach 25 million and the majority of

infections will be in Asia and Oceania: 42 per cent, compared to 31 per cent in Sub-Saharan Africa and 14 per cent in Latin America and the Caribbean (Mann et al. 1992:4).

The stark situation in Africa as recently estimated by WHO is that there are nearly six million HIV-infected adults and 800,000 AIDS cases in adults. Among infants and children there are about 900,000 HIV and almost 500,000 AIDS cases. The outcome is that in some urban centres of East, Central and Southern Africa up to one or more in five under 50 years of age are now estimated to be HIV-infected.

The pandemic has been described as composed of multiple epidemics interacting which each other, each developing at its own pace, depending on the size of the group at risk, the rate of contact between individuals and the efficiency of the mode of transmission (Fontanet and Piot 1994).

In the past, several approaches have been taken to document the epidemic and its correlates. These include the geographical approach, the temporal approach — using graphs to illustrate changes in numbers affected over time — and the population approach, describing the pandemic by focusing on apparent high-risk groups especially according to sex, age and occupation.

A number of possible spatial correlates of infection with HIV have been broadly defined in the African region and geographical and sero-epidemiological data have already been compared to assist in the formulation of hypotheses concerning the dynamics of the spread of the epidemic (e.g. Caldwell and Caldwell 1993). These include the location of routes of infection and the processes whereby the infection is distributed in different regions and communities. Important spatial variables are geographic barriers and international borders and their permeability and the location of communication routes and administrative centres. Airports, ports, international highways and railways are all singled out as being important factors, since they affect the flows of people, the intensity, volume and directions of movement.

National capitals and major secondary cities tend to have the highest sero-prevalence rates. Villages with intense relations with areas of high prevalence are more likely to have higher rates than isolated communities. Type of city is relevant, with new cases increasing more rapidly in regional centres of colonial origin and contacts, that is with more ethnically diverse and cosmopolitan populations than for example indigenous centres of West Africa.

Demographic factors associated with speed of spread include migratory movements, rapid urban growth and unbalanced sex ratios. Significant variations have been found in the different subgroups of single national populations, according to mobility and educational status as well as marital status (e.g. Rutenberg, Blanc and Kapiga 1994 on Tanzania).

The evidence considered in examining potential connections between several phenomena and speed of spread of HIV comes from several countries in West, East and Southern Africa. It is part of an accumulating body of socio-economic literature which is scattered and certainly much less rich than the bodies of medical evidence on the basic health issues involved. As Cara‘l (1993) has stressed, of the thousands of references on STDs and the relationship between sexuality and health in Africa, the majority focus on clinical aspects, laboratory techniques and problems of medical diagnosis. They are mainly based on data from clinic populations.

A serious drawback is that most of these works have no relevance to behavioural or sociocultural aspects of sexual relationships or marriage. Yet nuptiality, mobility, migration, inequality, and poverty are obviously crucial to the range and types of sexual experience of individuals. The proxies used in most studies to represent risk factors are weak in comparison: age, sex, income, education, marital status, often crudely defined. Surveys can scarcely capture the complexity, multiplicity and changes occurring in heterosexual relationships. Nor can they take cognizance of the fact that in one culture area there may be a

large number of recognized types of marital or sexual relationships, partly differentiated according to the degrees of economic dependency, seduction, power or coercion wielded.

Significantly among the countries with the highest and most recently estimated prevalence are those countries in Southern and Eastern Africa which have been most pervasively affected in diverse ways by labour migration, mobility and the marauding military. These factors have traumatically destabilized marriage and the family, by diminishing the protection resident men afford to their wives and daughters and by changing the norms, values and sanctions surrounding sexual encounters. They have also stimulated the commoditization of sexual services. The predictions are that if present trends continue there will be further large increases in numbers and proportions affected.

In view of the fact that heterosexual transmission is the major route of infection in the region a large amount of data has recently been gathered, analysed and published on the self-reported sexual behaviour and habits of women and men in relation to the incidence and spread of HIV. Attention has been drawn to the examination of correlated factors, including sexually transmitted diseases and 'sexual networking' which is in part associated with the stability and rate of marriage (Caldwell and Caldwell 1994). Thus while in the decade of the 1980s medical and public health approaches to sexual behaviour and diseases predominated, in the 1990s socio-demographic and even ethnographic perspectives have come more to the fore (e.g. Dyson 1992; Orubuloye, Caldwell and Caldwell 1994 a,b; Cleland and Way 1994). Numerous studies of the reported sexual behaviour patterns of samples of general populations have been undertaken, a topic surprisingly understudied in previous demographic and health surveys examining reproduction.

A large number of such surveys have been carried out under the sponsorship of WHO Global AIDS Programme (Cara'l, Cleland and Ingham 1994). They have focused on the levels of polygyny and multi-partner sex in different populations and subgroups, the levels of sexual activity before, within, outside and after marriage and the widespread evidence of more sexual partners among men than women. There are however calls to caution in the examination of such self-reported sexual behaviour; moreover there is sometimes very little capacity to link the sexual activity data to political, economic and social processes, transactions and relationships.

Clearly, improved knowledge of sexual behaviour and related practices and beliefs in different cultures and socio-economic and occupational groups is a prerequisite for the design and development of appropriate programs and strategies to combat the spread of HIV/AIDS. Accordingly, since 1989 the WHO Global Programme on AIDS has sponsored national surveys of sexual behaviour in more than 20 developing countries. The methodology has included the development of a standard population survey protocol for use by national AIDS programs. In each country the sample size has consisted of 3,000 adults randomly selected in 70 clusters. The questionnaire has included about 100 items, most of them on first sexual relations, the number and type of sexual partners and condom use in the last year. Analysis of surveys from 14 countries has revealed considerable international variation in patterns of sexual behaviour which have implications for the design of effective interventions. The usefulness of these data for national AIDS programs, their methodological implications and their relevance for cross-national comparisons have been discussed (Cara'l et al. 1993).

There is no doubt that migration, urbanization, education and the dislocation of customary forms of domestic organization, based on traditional systems of kinship and marriage, are having profound effects upon the sexual behaviour of both women and men. On the one hand declines in customary constraints allow more individual freedom. On the other hand economic constraints and insecurity, in the face of dwindling sources of customary maintenance and security, are providing pressures leading to commoditization of sexual services for the poor and relatively deprived. Dyson (1992) has reviewed anthropological and

socio-cultural evidence on sexual behaviour, networking and transmission of HIV, identifying factors probably linked to declines in customary constraints. Other researchers have viewed current multi-partner sex in the light of traditional sexual practices (e.g. Caldwell et al. 1989; Caldwell, Caldwell and Oruboloye 1992). Women's necessity, through impoverishment and high child dependency rates, to use sex as an economic resource is being widely documented (Ankrah 1991).

In view of its potential as a protection from disease and death there has also been considerable focus of attention on the condom (female or male) and possible negotiations regarding its use. Gender inequalities have also featured prominently in a number of such analyses, with much stress on the levels of ability of women to persuade partners to use condoms according to their relative conjugal or partner power (e.g. Mason 1994).

Vulnerability to infection: the risk assessment approach

Attempts continue to be made to identify those social, behavioural and biological factors which put individuals and populations most at risk, so that prevention programs can be designed specifically to combat them. However, there continues to be discussion and differences of opinion with regard to the major risk factors, leading to analyses noting with surprise high levels of seroprevalence in supposedly low-risk populations, for example Caldwell and Caldwell (1994) on Eastern and Southern Africa.

Sexual behaviour considered to be high-risk and associated practices have been the subject of systematic cross-cultural study by among others the WHO Global Programme on AIDS (Carballo et al. 1989); the study of sexual relations is encouraging the more widespread use of anthropological methods (Orubuloye, Caldwell and Caldwell 1991). Risk-prone occupational groups are being seriously targeted by studies; the extra risk involved in being female is also being documented.

New concepts now coming to the fore in this field to facilitate analysis and understanding of the dynamic processes involved in patterns of spread of infection are *vulnerability* and its opposite, *empowerment* (Mann et al. 1992:6; Tarantola, Mann and O'Malley 1993). At a popular level the message regarding the links between female empowerment and reproductive health was one of the loudest emanating from the Cairo International Conference on Population and Development.

Vulnerability can be assessed at the individual level, the community level and the societal level. Such an approach is potentially invaluable for diagnosis and forecasting purposes. National vulnerability is being assessed through considering the individual factors which influence the risk of acquiring HIV or of being deprived of adequate care and support should the infection occur; the nature and quality of programs; the societal factors that increase, sustain or reduce empowerment. Three sets of criteria, 'vulnerability indices', have been developed. The first is a self-administered questionnaire intended to determine personal vulnerability; versions of such a tool are being effectively used in national AIDS Control programs to heighten individual awareness of risk. The second index was designed to evaluate the strength of collective efforts to prevent and control HIV/AIDS; the third evaluates the societal vulnerability to the pandemic.

The application of a 'vulnerability index' has led to the identification of countries most at risk (Tarantola et al. 1993), which include countries which have so far not appeared to be seriously affected[3]. Various kinds of risk-prone situations and behaviour make people

[3] Analysis so far has identified 57 countries at high risk of HIV spread including countries that have so far escaped the worst of the epidemic. These include Indonesia, Egypt, Pakistan, Bangladesh and Nigeria. A further 39 countries estimated to be at substantial risk include 11 Latin American countries, 8

vulnerable, thereby influencing the directions and speed of spread of HIV infection in different populations. In addition to sexual contact and blood transfusions, which may be the cause of up to 25 per cent of children and 10 per cent of adults with AIDS, perinatal transmission is also expected to have a significant negative effect on child survival in Africa. Situational and behavioural factors appear to be more important than biological factors in explaining the sex and age differences in incidence and spread . They also throw light on why and how demographic phenomena, employment-related issues and aspects of systems of kinship and marriage affect pathways of infection. These include such factors as patterns of labour migration, working conditions, types of occupations.

Evidence is accumulating of higher incidence of seropositivity among certain occupational groups. Other crucial factors include extent of kin dispersal, degrees of conjugal stability, forms of domestic organization and divisions of parental responsibilities. Such an approach also ultimately makes possible the highlighting of links between impoverishment, inequality, social breakdown, social justice and the potential rate of spread of HIV/AIDS.

Associations between labour migration and mobility and propensity to morbidity and mortality are clear and region-wide, as is the association between the vulnerability of people in certain especially mobile occupations. The latter include mobile professionals and those whose power and prestige emanating from their occupational roles give them access to a wide range of sexual partners, as well as seasonal workers, traders, and lorry drivers. The high levels of incidence and therefore risk in urban centres, which are poles of attraction for migrants who later return home, gives considerable cause for alarm with respect to the influence of spatial mobility. Historically labour migration is known to have facilitated the transmission of sexually transmitted disease. It has created markets for prostitution in mining towns and geographical networks of relationships between urban and rural communities (Jochelson, Mothibeli and Leger 1991). The major communication and travel axes and crossroads are typically found to be hubs of infection and risk-prone sites. Patterns of labour migration and associated health problems have accordingly been documented by, for example, Hamadou (1990) on Niger.

Female vulnerability and risky relationships

Certain population groups are already known to be particularly vulnerable and the epidemic has been categorized as increasingly affecting the youth and women, with proportions and numbers in these categories increasing rapidly and young women the most vulnerable group of all (Reid 1990). Data from AIDS prevalence surveys by sex and age have given disturbing and clear evidence that the prevalence of HIV infection is in many cases highest in women aged 15 to 25 but peaks in men ten years later in the 25 to 35 age group. It is a pattern which is consistently different between females and males (Reid 1992).

Women's risk is known to be compounded by a variety of socio-economic and cultural reasons both customary and modern. Thus important matters for study include the ways in which old behaviour patterns, such as conjugal separation and multiple-partner relationships, are continuing in modern guises and may have disastrous results for health and survival. For example the kinds of polygyny and multi-partner sex which were in the past partly by-products of late marriage and long periods of sexual abstinence of wives between births may now prove lethal to couples, as sexual networks become geographically far-flung, reaching

---

for the Southeast Mediterranean and 7 from Asia including China, 4 in the Caribbean and 9 in other regions. Communities which differ from the national aggregate in terms of vulnerability were also identified. These proposed indices underscore elements of remedial action needed to halt the course of the pandemic and to mitigate its impact (Tarantola et al. 1993).

distant centres of infection (Caldwell, Orubuloye and Caldwell 1991; Caldwell and Caldwell 1993).

Cara'l (1993) has examined some of the evidence linking labour mobility and increased propensity for STDs to develop and spread through separation of spouses and facilitation of brief sexual liaisons and commercial sexual contacts. Conjugal separation, whether to protect breast feeding or through labour migration, has been associated in several studies with greater vulnerability to STDs (Caldwell and Caldwell 1983). Accordingly, the evidence from a wide variety of sources to indicate that marriage is becoming less stable and that increasing numbers are not entering stable unions, implies greater vulnerability for women and men to sexually transmitted disease.

Customary practices such as the ritual cleansing of widows through sexual intercourse and the persistence of genital mutilation in all its forms add to the special vulnerability of females. They continue to be a cause for concern among health personnel and others, leading in extreme cases to mass demonstration protests (e.g. Ezeh 1990). Worldwide an estimated 84 million women and girls have been infibulated or circumcised causing genital conditions which put them at high risk of infection, and many of these are in Africa (Reid 1992). Reproduction-related disabilities, including the sequelae of abortion, are also common among poor women and increase the efficacy of HIV transmission. Reid (1992) stresses that many of their reproductive disabilities including sexually transmitted infections are treatable, but some will require changes in cultural practices, including child marriage and pregnancy, rape and incest and other sexual practices causing lesions or inflammation.

Factors recognized as associated with female vulnerability also include poverty, inequality, mobility, insecurity, lack of family support and protection, heavy parental responsibilities, and male dominance and aggression (e.g. Hamadou 1990; Cara'l 1993). At the same time seriously implicated are pressures pushing, pulling and allowing women to trade sexual favours for material considerations. These are linked on the one hand to the breakdown of familial forms of production and maintenance of family members, and on the other hand the failure of modern labour markets to offer opportunities for economic security and family maintenance.

Higher levels of premarital and extramarital sexual activity are reported for men than for women in a number of studies (e.g. Orubuloye et al., 1991). Accordingly the risks women face from their sexual partners are now an important topic of research (Orubuloye et al. 1994a). Relatively little was known until recently about the sexual rights of women and men inside and outside marriage, other than the prescribed rights and duties of marriage partners, and yet the degree of control individuals can exercise over their sexual relationships is obviously now a matter of life and death. This makes more valuable the small but growing number of relevant studies. It means that study of such topics as conjugal power and decision-making is crucial to understanding sexual negotiations, reproductive health outcomes and survival itself. 'Lack of access to and control of resources for decision-making, particularly in the sexual relationship appears to be one key to the vulnerability of women and children in the AIDS epidemic' (Ulin 1992; see also Ankrah 1991; Bassett and Mhloyi 1991). This has led to concern to examine the extent to which women can control the terms of their sexual relationships with their partners including husbands[4]. From a geographical perspective

[4] See for example a recent study of the rights of Ghanaian women over their own bodies. Studies of vulnerable and high-risk women were carried out in 1991 among purposively selected groups in four areas of Ghana (Awusabo-Asare, Anarfi and Agyeman, 1993). The groups selected included prostitutes, itinerant traders, and partners of policemen, soldiers, sailors and miners, long-distance drivers and AIDS/HIV seropositive men. Attention was focused on whether women had the right to refuse sexual relations with a philandering partner, who by this behaviour put them at risk of disease and death; and if they did refuse, what the consequences were.

attention has been called to apparent differences in women's power between West Africa and Eastern and Southern Africa. A hypothesis formulated is that women in the latter subregions have less power and suffer relatively greater disadvantages regarding decision making vis-^-vis partners than women in West Africa, owing to their more precarious rights in land, children, and property, and to the more widely documented propensity of men to violence against women (e.g. Orubuloye, Caldwell and Caldwell 1993).

The pervasive effects of urbanization and rural migration have included greater numbers of female-headed households: increasing numbers of impoverished women alone in urban communities, adopting various survival strategies, which typically include selling domestic or sexual services for survival[5]. Further correlates are comparatively high levels of commercial and casual sexual relations and treatment for STDs (Cara'l, 1993).

Escalating jeopardy

Just as changes in familial systems and relationships may be associated with increased jeopardy for women's health, so the number of women potentially sexually vulnerable to harassment and exploitation in workplaces is growing (Oppong 1993 b, c, d). They include migrant women workers spatially separated from kin, husbands and traditional sources of sustenance — land and family labour; lone, unaided mothers with economic pressures of dependent children to maintain and therefore desperate to obtain and keep employment; girls and women in poverty without income-earning skills, training or opportunities and therefore ready to take on any kind of income-earning opportunities they can find; women engaged in legally and socially unprotected, precarious economic activities, including trade, home workers, domestic servants; women in casual, daily rated or piece work in factories, plantations, etc.; women in refugee camps and squatter communities who have fled from political and other crises and have no source of sustenance[6]

In sum the result of the combined global, regional and national trends affecting the productive and reproductive roles of women is that there are increasing proportions of female workers who need cash income to support their families, and are in legally, economically and socially precarious conditions. They lack security of all kinds provided by both traditional and more modern institutions. The effects of economic crises are known to be making their situation worse. Meanwhile there is accumulating evidence for their bearing increasingly unequal burdens of responsibility for dependent children, as the numbers and proportions of domestic groups maintained by women continue to increase (Folbre 1991).

High-risk strategies

Migration by women for work can be a high-risk strategy involving many problems compounded by their sexual vulnerability. The body of evidence on the movements of female

---

[5] Lesotho is an example of a situation in which massive male emigration for employment in South Africa has led to the absence of a large proportion of the adult male population. The resulting sex imbalances in population composition have been associated with late marriage, decline of polygyny, increase in divorce and frequent extramarital relationships (Timaeus and Graham 1989).

[6]Attempts have been made to rally resources to design research tools to document the sexual vulnerability of women in workplaces, based on elements in a seven-roles framework which would include such indicators as degree of security of employment contract; alternative job opportunities available; level of economic family responsibilities shouldered alone; availability of protection from male family members; type of community protection afforded. The purpose would be to call more urgent attention to those locations and subpopulations of women workers most at risk, in order to target preventive and remedial policies.

migrant workers, though relatively sparse and biased in the past, is currently growing apace (Findlay and Williams 1990). As well as increasing feminization of labour streams there is widespread evidence of discrimination and need for protection. Women's and girls' search for jobs in far-away places is often part of a family coping strategy in households in poverty. Internal migrants provide many of the workers employed in seasonal, insecure, agricultural jobs in plantations and the manufacturing industries (e.g. food and drinks processing, textiles, including export promotion zones); they are also absorbed into the new service sectors, including the hotels and tourism.

There is consequently in many countries a rapidly growing number of female migrant workers, girls and women in seasonal, insecure, casual, part-time, piece-rate work; they are often unprotected either by labour laws and workplace mechanisms or by family members and community sanctions. Their workplaces outside the home are almost entirely controlled by men: their livelihood and that of their families may depend entirely upon the favour of male managers. Fear, and lack of alternative sources of livelihood in situations of high unemployment rates, may be effective in promoting docility and silencing potential complaints. The position of girls and women in Export Processing Zones is known to be particularly acute. This situation is potentially conducive to vulnerability of larger numbers of female workers, girls and women, to sexual as well as economic abuse. A recent report of the Workers' Education Branch on Equal Opportunity and Women's Participation in Unions has highlighted the concern for vulnerable migrant women workers' reproductive health in Africa, if they remain unprotected from both the spread of AIDS and unwanted pregnancies. Their vulnerability to sexual harassment and these consequences was noted to result from their economic desperation to get work to feed their families (ILO 1993).

Female sexual vulnerability at work and school

There is an accumulating body of information concerning sexual harassment of girls and women in places of training and work in the African region and other parts of the developing world.

> Numerous women state that they are required to extend sexual services to employers as a condition of employment and promotion. Some husbands refuse to allow their wives to work for wages because of this. Their refusal renders vulnerable many women who might otherwise have been able to earn a living without resorting to sexual strategies upon finding themselves divorced or widowed (Schoepf et al. 1991:191).

Studies in a number of countries have uncovered the dimensions of the problems involved and highlighted the means to combat them (e.g. ILO 1993). Campaigns to raise awareness of sexual harassment have been recommended or conducted in several countries.

It is already known that problems of sexual abuse can be particularly severe in countries in which community and workplace environments lack protective laws, norms, and practices and effective sanctions, which would serve to deter the worst kinds of abuse and their economic, demographic, social and psychological sequelae. Men may have only worked before in close contact with women who are their wives; sexual harassment may serve to perpetuate the expected exchange of sexual favours for economic support, which underlies the conjugal relationship (e.g. Caines 1992). Sexual harassment is also recognized as being one of the ways of reminding women continually of their inferior position in the workplace, and prevents them from being treated as workers on the same terms as men.

Girls in school are not immune. Reid (1992) has restated the question: why do girls and young women (15-25) have such significantly higher rates of infection, when in fact young men are more sexually active than girls and have more STDs? One response to this question

is that they are clearly becoming more and more frequent sexual targets of old infected men, who view school-girls as safe partners. The economic vulnerability of girls is often also linked to their sexual vulnerability.[7]

Documentation of well publicized, individual cases from schools and workplaces, the gradual accumulation of anecdotal evidence and several surveys have begun to show that the problems are not rare or individual. They may in fact be revealing only the tip of an iceberg and be describing a problem which is part of a whole syndrome of discrimination and exploitation to which women are subjected.

The economic consequences for women and their families are clear. Victims report serious effects on their job security and prospects. Effects on victims' health are cited, including depression and physical ailments thought to result from stress; cases of nervous breakdown and hospitalization have been documented. For the women who do not want to be victimized the pressure is not to offer themselves for employment in such hazardous conditions. A recent ILO (1992) compendium of evidence on sexual harassment and sexual protection in the work place in 23 industrialized countries showed that it is becoming increasingly recognized as a serious problem for both victims and employers. Informal as well as formal-sector workers are vulnerable often through isolation and dependency upon male links to formal systems, for example police, customs officials, and middlemen. Informal-sector workers do not have available to them the legal redress which may be available to women in formal-sector employment.

Export processing zones are among the locations where girls and women are potentially at greatest risk. During the past twenty years there has been a rapid increase in such zones (EPZs) in Africa and elsewhere. The majority of workers in such zones tend to be girls and women, in particular unmarried girls. There are reports of insecurity, marginalization and economic and sexual exploitation. Oodit et al. (1993) in a two-year research project examined the HIV-AIDS risk related behaviour of young women 15 to 25 working in the EPZ of Mauritius which had expanded from 10,000 workers in 1978 to 100,000 workers in 1992: this is ten per cent of the total population of the island. For the first time young women are working outside the home unsupervised by relatives, have earned income and may have relationships with men outside the family context. These relationships are a source of risks of pregnancies and AIDS which have recently been studied in collaboration with the Mauritian Family Planning Association..

ILO constituents' responses

A working group in a recent ILO (1994) meeting in Uganda on HIV/AIDS and the workplace noted that sexual harassment in the workplace is an abuse of power, which increases the risk of exposure to AIDS and calls for counselling and disciplinary action. Protection from sexual harassment and coercion is increasingly recognized as a legitimate concern for employers and trade unions, at least for women members.[8] However, as the ILO *Digest of Information* admits, given that the majority of trade union members and the majority of office bearers are

---

[7] E.g. Sharpe et al. (1993). By age 12, 30 per cent of girls in a study were recorded as sexually active and by age 18, 85 per cent were active. Of boys, by age 14 ten per cent were active rising to 70 per cent by age 18, showing a sharp difference in the experiences of girls and boys. Reasons for entering sexual relations included poverty as well as rape, lack of parental supervision and peer pressures.

[8] See, for example, FIET Regional Women's Seminar for English-Speaking Africa, Lusaka, Zambia, Nov. 1991. In a resolution on sexual harassment it was resolved that unions should develop policies and negotiate grievance procedures as part of collective bargaining agreements, and that they should develop and distribute educational materials and raise awareness through trade union newsletters and discussions in meetings.

male, the whole trade union movement is not yet fully at ease with the subject and much yet remains to be done, to raise the awareness of trade union members themselves and to strengthen the attempts of women members to publicize these issues.

In some countries and regions failure to take the issue seriously is more marked. 'To date unions in Africa have not taken the seriousness of sexual harassment sufficiently into their programmes as an issue which their members are faced with' (Caines 1992). Moreover only a small proportion of women workers in the African region have opportunities for union membership but this number is likely to grow as women's work based organizations are strengthened to unionize. Furthermore current moves for an increase in the components of workers' education syllabuses on reproductive health and sexual protection issues are clearly strategically important.

As ILO reports have noted, unions themselves have to decide whether they are ready to practise sexual equality and share power and positions between women and men and whether they will tackle issues such as sexual harassment in their negotiations. In this regard information and education will be critical, as will organization of union meetings to ensure active female participation and leadership, as well as education and sensitization of male members.

Ironically sexual harassment is one of the very factors noted as preventing women from fully participating in trade union activities in some countries. At a seminar on workers' education for women members of rural workers' organizations, organized by the International Federation of Plantation, Agricultural and Allied Workers in Harare in 1992, participants identified five major obstacles to women's full participation in trade union activities. Among them was sexual harassment; the others were lack of education, women's multiple conflicting role responsibilities, their lack of self-confidence and discrimination against women because of cultural and societal attitudes. Given the salience of gender issues as obstacles to equality in trade unions the ILO has been active in providing assistance in this regard, as in the project RAF/88/M09/NOR — Workers' education for women members of rural workers' organizations in Ghana, Uganda and Zimbabwe. There are, however, indications that through lack of awareness only a few unions take the matter very seriously. The problem is still widely considered to be a personal problem and not a general labour issue. This situation is supported by the unwillingness of victims to file formal complaints even with their own unions. Some unions, while including sexual harassment in the list of women workers' problems, keep no records and take little action; however an increasing number of unions are beginning to include it on the list of women workers' problems. The Malaysian Trade Union Congress has promoted the collection and dissemination of data and has published a guidebook on sexual harassment at the workplace which provides guidance for both employers and employees. This was part of a women's section campaign for legislation on sexual harassment; it has stepped up its campaign to create awareness. Victims will need to identify sexual harassment as a violation of their rights as workers and to know what personal and legal action they can take to have the support of social opinion for their actions.

Recognition of the close links between speed and directions of spread of HIV/AIDS and the prevalence of sexual harassment in schools and workplaces is likely to increase the urgency of research and action in this sphere in the near future.

The ILO Meeting of Experts on Special Protective Measures for Women and Equality of Opportunity and Treatment concluded in 1989 that sexual harassment is a safety and health problem and this element is beginning to surface in the deliberations of concerned women's organizations. Studies have generally underlined the fact that these are real problems for a considerable number of women workers. So far results of those studies which have been disseminated in the media have stimulated political and legal debate on how to proceed. They have also in many cases paved the way for action (see ILO 1992: 286-289).

Poverty and prostitution

Statistics are lacking but observers have called attention to indications that multiple-partner situations involving various forms of sexual patron-client relationships appear to be increasing as a result of the economic crisis (e.g. Schoepf et al. 1991, on Zaire). Harsh economic conditions have also forced into long-distance trading women who are not customarily involved in such activities. Women traders, especially itinerant traders, are often perceived as promiscuous and with their sexual behaviour beyond male control. A study of sexual relations of market women in Benin City Bendel State Nigeria indicated that the majority had been involved in non-marital sexual relationships, some of this with strangers, and accordingly a high proportion had been susceptible to STDs (Omorodion, 1993). Traders may use sexual strategies to economic advantage (Schoepf et al. 1991.). Regular relationships with officials may facilitate transactions and casual sex can help meet travel and trading expenses.

Faltering economies, widespread unemployment and lack of conjugal and kin support, as well as the kind of 'development' policies which cause migration are recognized as linked to the expansion of prostitution and have turned growing numbers of girls and women to temporary and casual sale of sexual services, as the only means they know of surviving in the city (Ulin 1992), with consequent effects on the spread of STDs (Cara'l 1993). This is happening at a time when there has been a cutback in the very medical services needed to stem the tide of sexually transmitted disease (Caldwell and Caldwell 1993).

As yet there are not enough reliable data from which to estimate how many people are involved or how great is their risk, though the literature on prostitution and HIV/AIDS in the region is growing apace. Indeed various data suggest that relationships with prostitutes play a significant role in the spread of STDs and HIV/AIDS in urban and rural areas, and a third to a half or more of prostitutes are judged to be infected with a sexually transmitted disease at any time, with their customers infecting both other prostitutes and their other sexual partners including wives.

Commercial sex has already figured prominently in HIV/AIDS studies, since while there is apparently little evidence to date of its relevance in industrialized countries to speed of spread, in Africa and parts of Asia prostitutes and their customers were among the first groups to experience high levels of HIV infection and are considered to have fuelled the early stages of national epidemics. However, information bases are sex-biased, with the bulk of information from prostitutes and not their clients (Cleland and Way 1994). Only a few studies have examined the multiple relationships obtaining with clients, employers, family members etc. (e.g. Podhista et al. 1994 on Thailand).

Important findings of such studies and highly pertinent to future research and action programs are the facts that prostitutes constitute a very heterogeneous category of workers and that there are marked variations in their behaviour and clientele in different country contexts and sub-regions. Moreover in a number of cases and especially in the African region there is considerable fluidity of sexual and occupational identities (Cleland and Way 1994). Many women selling sexual services do not consider themselves as prostitutes, nor are such sales necessarily their main form of employment or source of sustenance. Life cycle periods of commoditization of sexual services may be interspersed with marriage or may be mixed on a daily and nightly basis.

For many poor women it is not a profession sought after but simply a temporary or longer term survival strategy resorted to when other strategies fail (Schoepf et al. 1991). It may be a strategy temporarily adopted at certain life stages in between more stable conjugal relationships (e.g. Pittin 1983 on Northern Nigeria; Dinan 1983 on Accra in the eighties). Accordingly the form taken by relationships categorized as prostitution varies considerably,

not only by class but by culture. The sexual exchanges which are given this label include a wide variety of relationships and levels of living (Pickering and Wilkins, 1993).

Women in this category of self employment full time are typically highly mobile, seldom practising their trade in their home areas.[9] Many are married or formerly married and ply the trade for financial reasons, including child support, a responsibility increasingly left to mothers (Chikwem et al. 1988; Onyango et al. 1993). Indeed some reports show that the majority of prostitutes have high burdens of family dependency, whether from parents or children, and few if any other sources of security or income. A study in a Kenyan clinic showed that 70 per cent of the women had three or more dependents and but no access to resources or home other than rented accommodation. The majority depend upon prostitution as their only source of income. The majority were young and most of their clients were truck drivers. They had no access to land and little education. The conclusion of those carrying out the study was that 'they therefore are bound to engage continuously in unrestricted sexual behaviour with unattached men such as truck drivers unless provided with economic power' (Gathiqi et al. 1993).

Prostitutes often return home to their place of birth with the intention of marrying and settling down: this return migration is itself a serious and significant factor in the heightened spread of HIV infections. This pattern of cyclical migration and infection of rural areas is by now well documented in a number of regions, as caused by both internal and international migrant workers; see Anarfi (1993) on the Akan and Krobo of Southern Ghana and Dada et al. (1993) on high-class Lagos callgirls with an international clientele.

Ghana provides an example of a country in which at first the majority of diagnosed cases were female migrants returning from neighbouring African countries who were believed to be involved in the sex trade (Anarfi, 1990). These women have come predominantly from two ethnic groups in which women are noted for their relative autonomy, mobility and materialism (see Anarfi 1990; Awusabo-Asare et al. 1993).

Approaches to the phenomenon of trade in sexual services frequently neglect the possible macro socio-economic and political factors involved. These include the existence of criminal syndicates trafficking in women. They include the fact that rapid socio-economic and political transformations are taking place which are greatly influenced by macro-economic policies, by international trade flows, by consequent pauperization of whole communities and the presence of large military bases, and tourist industries, creating demands for sexual trade.

Violence and coercion

International and regional attention has recently turned more and more to instances of violence against women by men. Recently the UN Commission on Human Rights has appointed a special rapporteur to look into what is described as 'the alarming situation of violence against women throughout the world', including its causes and consequences. The violence examined includes violence in the workplace, sexual assault and harassment, and commercialized violence such as trafficking in women, prostitution, labour exploitation and pornography. Violence was firmly placed on the international agenda in December 1993 when the General Assembly adopted resolution 48/104 in which it proclaimed the Declaration on the Elimination of Violence against Women. Cross cultural analyses have demonstrated that economic inequality is a key factor associated with violence.

---

[9] Two decades ago a study in Mombasa indicated that they came from 40 different ethnic groups including seven countries of West Africa and 40 per cent had lived in the city for less than a year. See Verhaeghen and Gemert 1972.

The spread of sexually transmitted disease and death through sexual coercion and rape has recently surfaced as a matter of serious concern in the African region, especially in the south. In South Africa the incidence of rape is one of the highest in the world. The incidence and prevalence in the whole region has yet to be systematically documented and examined but the AIDS epidemic is urging in this direction. Dr. Eka Esu-Williams, the Nigeria-based General Secretary of the Society of Women and AIDs in Africa (SWAA), has noted that if there were data to show rape is an important route of HIV transmission then some headway could be made to challenge this serious abuse of human rights (World AIDS 1992:2).

Comparative global studies of male violence against women have demonstrated that it is a pervasive and prevalent problem worldwide, touching all aspects of women's lives including their places of work (e.g. Schuler, 1992). The study of this phenomenon on any meaningful scale is recent and expanding rapidly. The debates arising have helped to put the matter onto international and national agendas. There is comparative evidence to suggest that women are most vulnerable to violent actions from men when they are dependent on them and have no alternative options for survival. Important factors diminishing expressions of violence are greater relative autonomy and equality of women and men, and techniques to deal with aggressive feelings as well as mutual respect. Schuler (1992:17) cites a comparative ethnographic analysis by Levinson (1989) which indicates that female economic inequality appears to be the strongest factor linked to wife abuse in the home in addition to male domestic control and female inability to divorce.

Women are most vulnerable to violence and coercion in times of civil strife. Massive dislocations of people from their normal lives in wars, which have been continual in a number of countries, have been clearly associated with the speed of spread of disease. Evidence of this comes from East, West and Southern Africa and indicates many practical, epidemiological and ethical problems (WorldAIDS 1992:5). AIDS is already reputed to have seriously affected some armies in the region and many civilians view soldiers as prime agents of spread of the disease, whether by coercion or through the commercial sex which is typically provided near their camps (see Cliff and Smallman 1991). The plight of women refugees has been poignantly highlighted; they are vulnerable to a variety of traumas affecting their health, including rape (Martin, 1991).

Adolescent girls are especially at risk of sexual coercion as well as economic pressures and seduction by males old enough to be their fathers. Evidence comes from several countries (e.g. Lema 1990 on Kenya). This evidence has led UNICEF to focus special attention and resources on the protection of the youth, especially adolescent girls, as for example in Uganda's Safeguard Youth from AIDS program aimed specially at girls.

In spite of these issues systematic evidence of sexual coercion is scarce, but in some countries evidence is beginning to accumulate because of the added fear regarding potential mortality.

Research on sex and gender: developing advocacy tools and spurs to action

Scholars prolific in the field admit that a great deal is being written on HIV transmission and sex but that much of it is based on the continuous circulation of a small number of research findings (Caldwell et al. 1993). The seriousness of the issues involved and their effects, actual and potential, make it urgently necessary to design and promote social science research which can meet the demand and provide evidence and insights on which to design appropriate strategies to respond to the crisis.

In designing advocacy tools to change behaviour in order to promote reproductive health and protect human development, it is absolutely necessary to understand the cultural, social, economic, and political as well as biological and demographic factors shaping gender roles

and sexual behaviour. In some instances it may be hypothesized that female dependence and subordination are crucial factors in the spread of AIDS. In other cases it may be female autonomy, mobility and sexual freedom which are associated with their vulnerability. We need to know what makes human behaviour high-risk in different contexts, or what puts individuals in high-risk situations and how these risk factors can be overcome. More attention needs to be paid to the changing roles of women and men in labour markets (and the family), which are leading to the increasing vulnerability of girls and women and their dependence together with their children on insecure, precarious and inadequate sources of support and incomes.

Researchers have already emphasized the need for studies of sexual behaviour to be carried out within the context of social institutions and other forms of behaviour. They have also stressed the need for a broad definition of risk behaviour and sensitive gender considerations and emphasized the urgent need for alternative methods of research (Cara‘l et al. 1994). The value of ethnographic studies through participant observation of beliefs, concepts, sexual practices and power relations has already been well demonstrated in a number of locations (e.g. Orubuloye in Ekiti; Oostvogels and Karanade in Bombay).

With regard to sexual harassment and coercion in places of work and training, the Report of the ILO Committee of Experts on Equality in Employment and Occupations noted the difficulties involved in getting information. It stressed the need to carry out surveys which, while very unpleasant, in view of the kinds of information they reveal, yet are necessary to achieve adequate recognition of the existence of the phenomenon, for they will play an important part in the elimination of the problem.

Effort is also needed to develop more scientific research and theory on sexual harassment, to design and develop practical research tools which can be used to identify where, against whom and in what circumstances it is most likely to occur, who are the victims in greatest need of protection, who benefits from it and how, and the human and economic costs. Such studies would help to raise public consciousness. They would help to convince those government policy makers, law makers, employers and unionists who require it, that it is worth formulating real strategies for its prevention. They would help programs to aim protective measures at those most in need; diagnostic tools could be designed to speed analysis of the extent of vulnerability and so to underline the need for protection.

Reid (1992) has argued persuasively and with good evidence that gender biases have pervaded much of the research and program agendas hitherto. Yet since much of the research on HIV impinges on the culturally prescribed roles of females and males and the gender issues — biases, inequalities— involved, it needs to be always in touch with the lives of women as well as men. A striking feature of the responses to the epidemic to date is how few of the policies and programs developed have really taken into account the women's true-life situations (Reid 1992). This has been called a failure of epistemic responsibility, which is a moral imperative, since knowledge of women's experience is especially essential to effective HIV-related research and policy development. Women's sexual relations put them at risk but strategies proposed give them little or no protection: educational messages stressing reduction of numbers of partners, use of condoms and treatment of STDs are designed with males in mind and are inadequate to protect women who mainly only have one partner; if they have more it is frequently through economic pressure or coercion, not necessarily desire.

Woman's faithfulness does not protect her as it has been estimated that half to 80 per cent of infected women in Africa have no other sexual partner than their husband. Moreover women's relative lack of power or alternative sources of social and economic support means they have little ability to negotiate safer sex or abstinence. Cross-cultural studies of sexual relations and the commoditization of services have demonstrated clearly that sexual identities, roles and behaviour are changeable and quite diverse. So it is necessary to

understand local sexual culture to ensure that prevention programs are relevant and practicable (Gillies and Parker 1994).

In this chapter the focus has been on gender issues, concerning inequalities between females and males in access to resources and opportunities, and the consequent vulnerability of the female. The special topics for consideration have included the effects of impoverishment and family dispersal upon the security of females as trainees or workers and the pervasive pressures towards increasing commoditization of both labour and sexual relationships, as opportunities for exploitation increase.

High-risk behaviour may be preceded by poverty, extensive labour migration and consequent dispersal of families, sexual inequality, male dominance, female dependence and regional military instability; if so, then health or population strategies which ignore these factors are not likely to be successful. Efforts to promote individual behaviour change are likely to founder if the broader socio-economic and political issues are not addressed (e.g. Bassett 1993).

As scholars addressing the AIDS crisis for women in the continent have already emphasized, dealing with health issues will not be enough (Ankrah 1991). Strategies will also have to be developed at the national, community and individual level to reverse the deteriorating socio-economic conditions of women's lives. National policies are needed which will help to stem the floods of labour migration, as rural impoverishment affects increasing millions of families. Community and work-place based institutions, laws and effective sanctions are required which will provide adequate sexual protection for individual girls and women attending schools, or working in markets, plantations and factories.

Girls and women need equal access to education, training in entrepreneurial opportunities, skills and employment, so that if married their conjugal relationships may be more egalitarian. If they are not married they will not depend upon sexual relationships for access to needed resources (see du Guerny and Sjoberg 1992).

Family Planning services must take on the wider implications of sexual and reproductive health promotion. Family Planning programs can provide the appropriate contexts for the prevention activities required to stop HIV transmission. These include STD prevention and control programs, condom promotion and IEC programs directed at changing behaviour which facilitates HIV transmission. Many FP programs are accepting such changes with undoubted benefits for both female and male clients. It will be important to find out what elements can be realistically integrated within programs of varying organizational capacity without compromising their effectiveness (Pachauri 1994).

A major challenge already identified is that of sustaining the impact of modest pilot projects, as demand for services and inputs escalates rapidly although available resources are often static or declining. The real problem is one of replicability of successful initiatives to larger and larger groups of people (Mann et al. 1992:4)

Given the facts that poverty and coercion are seriously implicated in risky behaviour patterns these factors need to be taken into account in any programs promoted to counteract them. For school girls Family Life Education alone is not likely to be sufficient. In view of the many charges of sexual impropriety directed at male teachers, schoolgirls need sexual protection as well as Family Life Education in places of education and training. Indeed greater, more active recognition is necessary of the economic and sexual vulnerability of adolescent girls (See African Rights 1994 and Yeboah 1993).

Accordingly regarding policies and programs a clear message of much of the evidence is that ‘central to the battle against AIDS is the need to empower women’ (Caldwell et al. 1993: 11; see also WHO 1992). This will involve in many cases changing dramatically the nature of relationships between women and men inside and outside the family, in places of work and schooling and the community.

References

African Rights. 1994. Crimes without punishment: sexual harassment and violence against female students in schools and universities in Africa, Discussion Paper No. 4. London.

Anarfi, J.K. 1990. Female migration, occupation and disease linkages: the Abidjan case study. Paper presented at workshop on Researching Sexual Networking in West Africa, Ibadan, March.

Anarfi, J. K. 1993. Sexuality, migration and AIDS in Ghana — a socio-behavioural study. Pp. 45-67 in *Sexual Networking and HIV/AIDS in West Africa*, ed. J. C. Caldwell et al. Supplement to *Health Transition Review* 3. Canberra: Australian National University.

Anarfi, J. K. and K. Awusabo-Asare. 1991. Sexual networking and its implications for the spread of AIDS in Ghana. Health Transition Working Paper No 15. Canberra: Australian National University.

Anarfi, J. K. and K. Awusabo-Asare. 1993. Experimental research in sexual networking in some selected areas of Ghana. Pp. 29-43 in *Sexual Networking and HIV/AIDS in West Africa*, ed. J.C. Caldwell et al. Supplement to *Health Transition Review* 3. Canberra: Australian National University.

Anderson, D. 1994. Towards a more effective policy response to AIDS. In *Policy and Research Papers.* Li•ge: IUSSP.

Ankrah, E.M. 1991. AIDS: Socio-economic decline and health: a double crisis for the African women. Paper presented at UNFPA workshop on Population, Health and Development in Sub-Saharan Africa, Kasese, Uganda.

Awusabo-Asare, K., J.K. Anarfi and D.K. Agyeman. 1993. Women's control over their sexuality and the spread of STDs and HIV/AIDS in Ghana. Pp. 69-84 in *Sexual Networking and HIV/AIDS in West Africa*, ed. J.C. Caldwell et al. Supplement to *Health Transition Review* 3. Canberra: Australian National University.

Bassett, M.J. and M. Mhloyi. 1991. Women and AIDS in Zimbabwe: the making of an epidemic. *International Journal of Health Services* 2:143-156.

Bassett, M.T. 1993. Social and economic determinants of vulnerability to HIV. Paper presented at Ninth International Conference on AIDS in affiliation with Fourth STD World Congress.

Caines, K. M. 1992. Women in rural workers' organizations in Africa. Paper presented at ILO Workshop on Advancement of Women in Rural Workers' Organizations in Africa, Arusha, 18-23 May.

Caldwell, J. C. and Pat Caldwell. 1983. The demographic evidence for the incidence and cause of abnormally low fertility in Tropical Africa. *PHN Technical* Note 85-16. Washington DC: World Bank.

Caldwell, J. C. and Pat Caldwell. 1993. The nature and limits of the Sub-Saharan African AIDS epidemic: evidence from geographic and other patterns. *Population and Development Review* 19: 817-848.

Caldwell, J. C. and Pat Caldwell. 1994. The neglect of an epidemiological explanation for the distribution of HIV/AIDS in Sub-Saharan Africa: exploring the male circumcision hypothesis. Pp. 11-22 in *Aids Impact and Prevention in the Developed World*, ed. J. Cleland and P. Way. Supplement to *Health Transition Review* 4. Canberra: Australian National University.

Caldwell, J. C., P. Caldwell, E.M. Ankrah, J.K.Anarfi, D.K. Agyeman, K. Awusabo-Asare and I.O. Orubuloye. 1993. African families and AIDS: context, reactions and potential interventions. Pp. 1-16 in *Sexual Networking and HIV/AIDS in West Africa*, ed. J.C. Caldwell et al. Supplement to *Health Transition Review* 3. Canberra: Australian National University.

Caldwell, J. C., P. Caldwell and I. O. Orubuloye. 1992. The family and sexual networking in Sub-Saharan Africa: historical regional differences and present day implications. *Population Studies* 46: 385-410.

Caldwell, J. C., P. Caldwell and P. Quiggin. 1989. The social context of AIDS in Sub-Saharan Africa. *Population and Development Review* 15:185-234.

Caldwell, J. C., I.O. Orubuloye and P. Caldwell. 1991. The destabilization of the traditional Yoruba sexual system. *Population and Development Review* 17:229-262.

Caldwell, J. C., I.O. Orubuloye and P. Caldwell. 1994. Methodological advances in studying the social context of AIDS in West Africa. Pp. 1-12 in *Sexual Networking and AIDS in Sub-Saharan Africa: Behavioural Research and the Social Context*, ed. I.O. Orubuloye et al. Canberra: Australian National University.

Cara'l, M. 1993. Women's vulnerability to STD/HIV in Sub-Saharan Africa: an increasing evidence. Paper presented to IUSSP seminar on Women and Demographic Change in Sub-Saharan Africa, Dakar, 3-6 March.

Cara'l M., J. Cleland, J. C.Deheneffe and L. Adeokun. 1990. Research on sexual behaviour that transmits HIV: the GPA/WHO collaborative surveys. Preliminary findings. Paper presented at IUSSP Seminar, Sonderborg, November.

Cara'l M., J. Cleland and R. Ingham.1994. Extramarital sex: implications of survey results for STD/HIV transmission. Pp. 153-172 in *Aids Impact and Prevention in the Developed World*, ed. J. Cleland and P. Way. Supplement to *Health Transition Review* 4. Canberra: Australian National University.

Carballo, M., J. Cleland, M. Cara'l and G. Albrecht. 1989. Research agenda: a cross national study of patterns of sexual behaviour. *Journal of Sex Research* 26,3:287-299.

Chikwem, J.O. et al. 1988. Impact of health education on prostitutes' awareness and attitudes to Acquired Immune Deficiency Syndrome. *Public Health* 102,5:439-445.

Cleland J. and P. Way. 1994. Social and demographic dimensions of AIDS: an introduction. Pp. 1-10 in *Aids Impact and Prevention in the Developed World*, ed. J. Cleland and P. Way. Supplement to *Health Transition Review* 4. Canberra: Australian National University.

Cliff, A.D. and M. R. Smallman. 1991. Civil war and the spread of AIDS in Central Africa. *Epidemiological Infections* 107.

Collier, P., S. Radwan, Wangwe and A. Wagner. 1990. *Labour and Poverty in Rural Tanzania*. Oxford: Clarendon Press.

Dada, A., J. Oyewolo, F.R. Onofowokan et al. 1993. *Lagos Nigeria - New Delhi India HIV-1 Connection Among High Class Prostitutes.* Poster at Ninth International Conference on AIDS in affiliation with the Fourth STD World Congress, Berlin, June.

Date-Bah, E. (ed.). Forthcoming. *Women Workers*. Geneva: ILO.

Dinan, C. 1983. Sugar daddies and gold diggers: the white collar single woman in Accra. Pp. 344-366 in *Female and Male in West Africa*, ed. C.Oppong. London: Allen and Unwin.

Dyson, T. (ed.). 1992. *Sexual Behaviour and Networking: Anthropological and Socio-Cultural Studies on the Transmission of HIV*. Li•ge: Derouaux-Ordina.

du Guerny, J. and E. Sjoberg. 1992. Inter-relationship between gender relations and HIV/AIDS epidemic: some possible considerations for policies and programmes. Vienna: United Nations.

Elmendorf, A. and E.W.L. Roseberry. 1993. Structural adjustment: what effect on health? On vulnerability to HIV infection. Paper presented to Ninth International Conference on AIDS in affiliation with the Fourth STD World Congress, Berlin, June.

Ezeh, P. 1990. *Nigeria: Female Circumcision*. Row New Africa.

Findley, S.E. and L. Williams. 1990. Women who go and women who stay: reflections on family migration processes in a changing world. World Employment Programme Working Paper No 176. Geneva: ILO.

Folbre, N. 1991. *Mothers on Their Own: Policy Issues for Developing Countries*. Washington DC: ICRW.

Fontanet, A. and P. Piot. 1994. State of our knowledge: the epidemiology of HIV/AIDS. Pp. 11-22 in *Aids Impact and Prevention in the Developed World*, ed. J. Cleland and P. Way. Supplement to *Health Transition Review* 4. Canberra: Australian National University.

Gathiqi, H.W., J. Bwayo, P.M. Karuga, A.N. Kihara, M.A.Omari and F.A. Plummer. 1993. *The Socio Economic Status of Prostitutes at a Truck Drivers Stop and Their Interaction with Male Clients*. Poster at Ninth International Conference on AIDS in affiliation with the Fourth STD World Congress, Berlin, June.

Gillies, P.A. and R.G. Parker. 1994. Cross-cultural perspectives on sexual behaviour and prostitution. Pp. 257-272 in *Aids Impact and Prevention in the Developed World*, ed. J. Cleland and P. Way. Supplement to *Health Transition Review* 4. Canberra: Australian National University.

Gordon, G. and Kanstrup. 1992. Sexuality, the missing link in women's health. *IDS Bulletin* 23,1:29-37.

Hamadou, O. 1990. Le SIDA ˆ l'H™pital National de Niamey (Niger). *Bulletin de la SociŽtŽ de Pathologie Exotique et de Ses Filiales* 83,1:117-119.

International Labour Office (ILO). 1992. Combating sexual harassment at work. *Conditions of Work Digest* 11, 1. Geneva.

International Labour Office (ILO). 1993. *Report of Workshop on Advancement of Women in Rural Workers' Organizations in Africa, Arusha, Tanzania, 18-23 May 1992*. Geneva.

International Labour Office (ILO). 1994. *The Role of the Organized Sector in Reproductive Health and AIDS Prevention, Report of a Tripartite Workshop for Anglophone Africa, Held in Kampala, Uganda*. Geneva.

Jochelson, K., M. Mothibeli and J.P. Leger. 1991. Human immunodeficiency and migrant labour in South Africa. *International Journal of Health Services* 21,1:157-173.

Lachaud, J-P., 1994, *The Labour Market in Africa*, International Institute for Labour Studies, ILO, Geneva.

Lema, V.M. 1990. The determinants of sexuality among adolescent schoolgirls in Kenya. *East African Medical Journal* 67,3:191-200.

Levinson, D.. 1989. *Family Violence in Cross-Cultural Perspective*. Newbury Park: Sage Publications.

Mann, J. M., D. J. M. Tarantola and T. W. Netter (eds). 1992. *AIDS in the World*. Cambridge MA: Harvard University Press.

Martin, S.F. 1991. Women refugees face special health problems. *People* 18,4:13-15.

Mason, K. O. 1994. HIV transmission and the balance of power between women and men: a global view. Pp. 217-240 in *Aids Impact and Prevention in the Developed World*, ed. J. Cleland and P. Way. Supplement to *Health Transition Review* 4. Canberra: Australian National University.

Mhone, G. 1995. *African Women Workers, Economic Reform, Globalization, AIDS and Civil Strife*. Equality for Women in Employment Working Paper. Geneva: ILO.

Oodit, G., S.L. Schensul, J.J. Schensul, and U. Bhowon. 1993. Young Mauritian women working in the industrial sector and their AIDS related risk behaviour. Paper presented at Ninth International Conference on AIDS in affiliation with the Fourth STD World Congress, Berlin, June.

Omorodion, F.I. 1993. Sexual networking among market women in Benin City, Bendel State Nigeria. Pp. 159-169 in *Sexual Networking and HIV/AIDS in West Africa*, ed. J.C. Caldwell et al. Supplement to *Health Transition Review* 3. Canberra: Australian National University.

Onyango, D., L. Lewcadia, A. Awuor, N. Nkaangi and M. Tapwak. 1993. *Marriage and AIDS in One Kenyan Society*. Poster at Ninth International Conference on AIDS in affiliation with the Fourth STD World Congress, Berlin, June.

Oppong, C. 1992. African family systems in the context of socio-economic change. Paper presented at Third African Regional Population Conference, Dakar, December.

Oppong, C. 1993a. Occupational and conjugal inequalities and insecurity: effects on family organization and size. In *Women's Position and Demographic Change*, ed. S.N. Federici, K. O. Mason and S. Sogner. Oxford University Press.

Oppong, C. 1993b. *ILO Standard Setting Policy Studies and Technical Cooperation Relating to Population Issues and Women.* World Employment Programme Working Paper No. 185. Geneva: ILO.

Oppong, C.1993c. Socio-economic aspects of sex roles and reproductive health. Paper presented at UAPS Conference on Reproductive and Family Health in Africa, Abidjan.

Oppong, C. 1993d. Sexual coercion in the workplace: the need for protection.*VENA Journal* 5, 1.

Orubuloye, I.O., J.C. Caldwell and P. Caldwell. 1991. Sexual networking in the Ekiti District of Nigeria. *Studies in Family Planning* 22:61-73.

Orubuloye, I.O., J.C. Caldwell and P. Caldwell. 1994a. Diffusion and focus in sexual networking: identifying partners and partners' partners. Pp. 33-34 in *Sexual Networking and AIDS in Sub-Saharan Africa: Behavioural Research and the Social Context*, ed. I.O. Orubuloye et al. Canberra: Australian National University.

Orubuloye, I.O., P. Caldwell and J. C. Caldwell. 1993. African women's control over their sexuality in an era of AIDS. *Social Science and Medicine* 37,7:854-872.

Orubuloye, I.O., P. Caldwell and J. C. Caldwell. 1994b. Commercial sex workers in Nigeria in the shadow of AIDS. Pp. 101-116 in *Sexual Networking and AIDS in Sub-Saharan Africa: Behavioural Research and the Social Context*, ed. I. O. Orubuloye et al. Canberra: Australian National University.

Pachauri, S. 1994. Relationship between AIDS and family planning programmes: a rationale for developing integrated reproductive health services. Pp. 321-348 in *Aids Impact and Prevention in the Developed World*, ed. J. Cleland and P. Way. Supplement to *Health Transition Review* 4. Canberra: Australian National University.

Pickering, H. and H.A. Wilkins. 1993. Do unmarried women in African towns have to sell sex or is it a matter of choice? Pp. 17-27 in *Sexual Networking and HIV/AIDS in West Africa*, ed. J.C. Caldwell et al. Supplement to *Health Transition Review* 3. Canberra: Australian National University.

Pittin, R.. 1983. Houses of women: a focus on alternative life styles in Katsina City. Pp. 291-302 in *Female and Male in West Africa*, ed. C. Oppong. London: Allen and Unwin.

Podhisita, C., A. Pramualratana, U. Kanunsukkasem, M. J. Wawer and R. McNamara. 1994. Socio-cultural context of sex workers in Thailand: an analysis of their family, employer and client relations. Pp. 297-320 in *Aids Impact and Prevention in the Developed World*, ed. J. Cleland and P. Way. Supplement to *Health Transition Review* 4. Canberra: Australian National University.

Reid, E. 1990. Young women and the HIV epidemic development. *International Journal of SID*.

Reid, E. 1992. Gender, knowledge and responsibility. In *AIDS in the World*, ed. J. M. Mann et al. Cambridge MA: Harvard University Press.

Reutenberg, N., A. K. Blanc and S. Kapiga. 1994. Sexual behaviour, social change and family planning among men and women in Tanzania. Pp. 173-196 in *Aids Impact and Prevention in the Developed World*, ed. J. Cleland and P. Way. Supplement to *Health Transition Review* 4. Canberra: Australian National University.

Schoepf, B.G., W. Engundu, R. W. Nkera, P. Ntsomo and C. Schoepf. 1991. Gender, power and risk of AIDS in Zaire. In *Women and Health in Africa*, ed. M. Turshen. Trenton: Africa World Press, Inc.

Schuler, M. 1992. Violence against women: an international perspective. In *Freedom from Violence: Women's Strategies from around the World*, ed. M. Schuler. New York: United Nations.

Sharpe, U., R. Ssentongo, A. Ssenyonga and B. Ssamula. 1993. Orphans' sexual behaviour in Masaka Diocese, Uganda. Paper presented at Ninth International Conference on AIDS in affiliation with the Fourth STD World Congress, Berlin, June.

Singh, A. and H. Tabatabai (eds.). 1993. *The World Economic Crisis and Third World Agriculture in the 1980s*. Cambridge University Press.

Stalker, P. 1994. *The Work of Strangers: A Survey of International Labour Migration*. Geneva: ILO.

Standing, G. (ed.). 1985. *Labour Circulation and the Labour Process*. London: Croom Helm.

Tarantola, D., J. Mann, and J. O'Malley. 1993. Assessing the world's vulnerability to HIV/AIDS. Paper presented at Ninth International Conference on AIDS in affiliation with the Fourth STD World Congress, Berlin, June.

Timaeus, J. and W. Graham. 1989. Labour circulation, marriage and fertility in Southern Africa. In *Reproduction and Social Organization in Sub-Saharan Africa*, ed. R. Lesthaeghe. Berkeley: University of California Press.

Ulin, P.R. 1992. African women and AIDS: negotiating behavioural change. *Social Science and Medicine* 34,1:63-73.

Verhaeghen, A.R. and W. Gemert. 1972. Social and epidemiological determinants of gonorrhoea in an East African country. *British Journal of Venereal Disease* 48:277-286.

WorldAIDS. 1992. *Condoms and Conflict: AIDS and the Military.* London: Panos Institute.

World Health Organization (WHO). 1995. *Seminar on Women and AIDS* . Geneva.

Yeboah, Y. 1993. *Equal Opportunities for Women: The Implications of Adolescent Pregnancy and Childbirth in Sub-Saharan Africa for ILO Policies and Programmes*. World Employment Programme Working Paper No. 186. Geneva: ILO.