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GPID Reflections

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Abstract

This paper discusses the broad impacts of AIDS on women in Uganda. An extensive literature review and analysis demonstrate that not only is the risk of HIV-infection and AIDS higher for women than for men in Uganda, individual and social impacts of the disease on Ugandan society disproportionately affect women. Both afflicted and nonafflicted women are greatly affected by the AIDS scourge through their multiple roles as individuals, caregivers, and mothers. Research demonstrates that AIDS in Uganda presents severe socioeconomic implications for women as well as a higher risk for infection due to cultural expectations, subordinate status, and patriarchy in the society.

Introduction

Illness and death caused by AIDS are taking a big toll on Ugandan society. The World Health Organization estimates that 20 to 30 percent of the adults in Kampala, the

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capital city of Uganda, are HIV infected (Van De Walle 1990). The national newspaper of Uganda, New Vision, reported in 1989 that of the country's 17 million inhabitants, 790,522 were infected with the HIV virus, while it is estimated that the actual number is closer to 1.3 million (Barnett and Blaikie 1992,23).

Until recently, the disease affected men and women equally with 50 percent of the cases reported for each gender. Current reports, however, show that the ratio of women to men with HIV infections and AIDS is 1.42 to 1 (Barnett and Blaikie 1992:33). Considering the changes in the demographics of AIDS in Uganda, it is necessary to focus on the forces increasing the risk and impact of the disease on women. Toward this end, I contend that women are at greater risk for infection because they face inequities within patriarchal relationships and society; Ugandan women are also disproportionately impacted by AIDS, I suggest, because they endure a "triple burden" as individuals, mothers, and caregivers (Storck 1992). Moreover, AIDS has damaging effects on the socioeconomic situation of women. In addition, the consequences of AIDS on the society as a whole disproportionately burden women by worsening their positions and survival capacity through their extended role expectations brought on by the biased character of the disease.

Literature Review

Because Uganda was among the countries where AIDS was first reported, as well as being one of the first countries in Africa to recognize and address HIV infection, the literature on HIV and AIDS in Uganda is extensive and broad. Research covers the AIDS spectrum of epidemiology, transmission factors, predictions, changes, and its effects on various components of society. Although the literature on AIDS in Uganda is considerable, a neglect of the impact of HIV on women is evident. Because in Africa, AIDS is primarily transmitted through heterosexual intercourse, discussion of AIDS in Uganda cannot avoid mention, or at least assume inclusion, of women. Some authors do address women specifically, but a comprehensive view covering the full impact of the disease on women is lacking.

Of primary interest in the study of AIDS in Uganda are the factors in society that facilitate and increase the spread of HIV. The economically disadvantaged situation of developing societies is demonstrated to be a fertile host for the transmission of the virus (Barnett and Blaikie 1992; Storck 1992). The social and political nature of developing countries, involving little availability and access to health care, low literacy and education rates, high stratification, limited resources for coping with the social fallout of HIV and dependency on developed nations (Ankrah 1991), serves to perpetuate a high-risk environment for HIV infection (Barnett and Blaikie 1992; Gould 1993). Few studies, however, address the stratification within developing countries that leaves women in the most impoverished and disadvantaged positions, thereby placing them in high risk conditions.

Other factors may better explain the spread of AIDS in Ugandan society. In discussing the transmission of the virus, J111derson (1992) argues that the heterogeneity, variance, and rate of partner change must be analyzed. Sexual practices elevating HIV

infection have cultural reinforcements (Storck 1992). Both men and women face cultural expectations influencing their sexual behavior; sexual activity with many partners is prevalent for men in Uganda (Ulin 1992). Male identity is often based on "sexual conquest and fecundity" (Barnett and Blaikie 1992) and therefore, men are often expected to have multiple partners both in and out of conjugal relationships (McGrath et al. 1993).

Behavioral changes lowering HIV risk include abstinence, monogamy (referred to as zero-grazing by many Ugandans), and condom use. Much of the research on HIV infection in Uganda addresses the implications of condoms for preventing AIDS. Inquiry into condom use demonstrates several obstacles to condom use including their unavailability (Griffiths 1988), the association of condoms with promiscuity and prostitution (Van De Walle 1990), the reluctance to use condoms due to lack of understanding and distrust of Western technologies (Nyonyintono 1991), and religious pressures (Lorch 1993a).

Though behavior change by both men and women is essential in order to reduce transmission, Ankrah (1991) identifies the importance for changes in men's attitudes and behaviors before HIV prevention can be effective. A study by McGrath et al. (1993) reinforces this idea. The authors show that Baganda women are changing their sexual behaviors to reduce their exposure to AIDS. Despite behavioral modifications, women still feel highly at risk because they see little to AIDS prevention in their partners' behaviors and have little influence in persuading partners to change. Although research encompasses some gender analysis of behavioral practices, few connections are made between the patriarchal structures that subordinate women and women's lack of control over their own or their partners' behavior.

Much of the research identifies the family as a key instrument in transmission. As well as being a medium through which HIV is spread, the family is also the core support system for dealing with AIDS (Ankrah 1991; Eberstein, Serow, and Ahrmad 1988; Onyango and Walji 1988). The social and economic pressures that families face because of AIDS, as well as demographic changes, impact the structure and functioning capacity of the family. While the research addresses the family as a whole, it fails to distinguish the disproportionate responsibility women bear in the caregiving and support roles of the family. In addition, women's lack of access to resources is another neglected area that severely impacts women's abilities to fulfill these unrecognized roles in AIDS care.

The repercussions of widespread AIDS affects not only those afflicted with the virus, but extends to all aspects of society. Research addresses the socioeconomic impacts of AIDS illness and death on demographics (Barnett and Blaikie 1992), orphans (Beer, Rose and Tont 1988; Black 1990; Lorch 1993b), agriculture and farming systems (Barnett and Blaikie 1992), food production (Abel et al. 1988), industry and occupational health (Sekimpi 1988), social organization (including age, rural and urban distributions), and family arrangement (Carballo and Carael 1988). The disruptive effects of AIDS on organizations and institutions within society deteriorate the economic conditions and exacerbate the impoverishment of the people (Ankrah 1991; Sekimpi 1988; Storck 1992). The neglect of women continues when assessing the social and eco-

nomic impact of AIDS on Ugandan society. Women bear much of the responsibility in subsistence and production, which is severely impacted by AIDS.

A small section of the literature does focus exclusively on the impact of the disease on women. According to de Bruyn (1992), women are neglected in AIDS research, prevention, and impact, yet are affected more than are men due to factors tied directly to their gender. Ulin (1992) focuses on the cultural, social, and economic factors which perpetuate and increase women's susceptibility to HIV infection and AIDS repercussions.

Despite research which suggests that women may be unfairly burdened due to their reproductive and caregiving roles, this acknowledgement is not carried over into adequate solutions and feasible prevention strategies. In addition, the consequences of AIDS on women's roles as economic producers and their domestic and social responsibilities have not been addressed. When women are addressed in the literature, it is often in discussions of prostitution, transfer of the virus from infected mothers to babies, or another fashion which places the blame of the spread of AIDS on them. This bias fails to address the vulnerability women face in trying to prevent the spread of AIDS and assure their own protection.

Considering the prevalence of AIDS in Uganda and women's higher infection rate than men's, the failure to address women has far reaching implications. Not only is personal infection a serious problem for women, but the larger social impacts which disproportionately affect them pose an added dimension to the difficulties.

The Position of Women in Ugandan Society

One cannot begin a discussion on the effects of AIDS on women without first discussing women's subordinate position in Ugandan society. While a full review of the status of women in Uganda is beyond the scope of this paper, women's lack of access to resources, low levels of education, minimal political influence, and poor economic situation within the larger patriarchal context, demonstrate their low status in society (Watson 1988). The history of colonialism in Uganda established inequities against women through biased marriage customs and property rights, thus preventing women from gaining access to land and resources. This colonial stage was followed with the turmoil of years of civil war and unrest perpetuating and exacerbating inequalities (Barnett and Blaikie 1992). It is imperative to keep the prevailing forces of patriarchy and male dominance in mind, in order to understand the magnitude of the structural forces determining women's vulnerability to AIDS.

Finally, in any complete discussion of AIDS, two aspects of the disease must be considered: the impacts of the infection on carriers, and the socioeconomic implications of AIDS on society as a whole. Both facets strike women with greater force due to their secondary position in Uganda. Looking first at the members of the society who are not infected, the "survivors" (Beer, Rose and Tant 1988), I examine the socioeconomic effects of AIDS on women.

Socioeconomic Implications of AIDS on Women

In societies where AIDS is prevalent, issues raised by the disease affect not only those infected with HIV and AIDS, but they also affect the society and nation due to the Joss of productivity and demands placed on active members of the communities. Beer, Rose and Tant (1988:171) state,

> As full blown AIDS is fatal, sociologically the main impact will be felt by the survivors. Although we consider survivors as secondary victims it will be these survivors upon whom the full weight of sustaining a decimated, confused and demoralized community will fall.

Approximately 90 percent of Ugandan AIDS cases are found in people 15 to 59 years of age, who comprise the most productive: and economically active group in the society (Sekimpi 1988:242). In terms of the impacts on society, this demographic distribution translates into loss of labor force and declining production in all spheres of industry, agriculture and housework. In countries such as Uganda where one half of the population is below the age of 15, the loss of human potential in this group has profound effects. With fewer people to do work, which reduces subsistence and economic activity, the well-being of those affected on all levels from individual to household to community to nation is threatened.

The main point to consider here is that women provide a substantial contribution to production, particularly in the area of subsistence labor. The reduced work force does not result in lower expectations on women's labor, but instead increases the demands on their time. With heavy reliance on women's subsistence production in African societies, the impacts on the welfare of households and communities when women's roles are further overextended are tremendous.

Ugandan women also face a greater threat to social consequences of HIV infection than do men due to their impoverished and disadvantaged status in Ugandan society. These economic repercussions accentuate the impoverished conditions many women already face. While women face an increased burden with greater labor expectations and responsibilities, they also lack access to resources such as land and income-generating technologies that can ease the load and produce extra earnings for themselves and affected families (Obbo 1991). Without access to resources, women lack leverage in decision-making or protecting themselves and their possessions.

In some areas of Uganda, the rapid change due to increasing illness and death related labor loss is producing a major transformation in the nature of the labor communities. The structural adjustment occurring in Uganda to compensate for the changing labor force "disproportionately affects women through decreased employment opportunities; through austerity measures that have reduced purchasing power and removed subsidies on basic food; and through decreased social services" (Storck 1992:3). Anytime a major shift or disturbance, such as AIDS in Uganda, takes place, those in the most vulnerable positions—women and children—are the most affected.

In sum, the situations women face in their subordinate positions are aggravated by the AIDS epidemic. A cyclic effect is evident as the socioeconomic impact of AIDS

disproportionately encumbers women, and conditions of disadvantage and poverty encountered by women increase the probability of virus infection (Storck 1992).

The social impacts of AIDS affect women through increased social pressures and responsibilities, and also through increased likelihood of infection. On the individual level, the economic situation faced by women survivors is equally discouraging. With limited access to land and assets, widows face not only the loss of their partners' income and/or labor, but often their homes and property as well (Obbo 1991). There has been a noted decrease in widow inheritance with the increase of AIDS as brothers of husbands, who are supposed to take responsibility for the widow and children, fail to fulfill their obligations (Ankrah 1991). This burden is not shared by widowers, most obviously because access to their land is not threatened, but also because the care for children and household labor is often dispersed to female relatives or a new wife—options which generally are not available to women.

The irony of the situation is that the same factors increasing the potential for HIV infection in society, such as poverty, malnutrition, lack of access to resources, and power, serve to force or trap women in situations leading to behaviors which engender a high risk of infection. The destitute situations women face often force them into sexual liaisons or prostitution as the only viable money-making alternative (Van De Walle 1990). With the spread of AIDS being highly correlated with multiple sexual partners, participation in the sex industry is clearly a liability. An alarming study recently conducted in Rakai reported that five percent of orphaned girls are sexually active by the age of 10, 30 percent by the age of 12, and 85 percent by the age of 18 (Marum 1993). The very fact that women in an AIDS-infested society are forced into prostitution out of economic necessity points to their low status.

The low status of women becomes particularly important when discussing sexual behavior and AIDS. Women's inferior position results in fewer options available to them to prevent and cope with the disease along with their reduced influence in the family and community. Barnett and Blaikie (1992:64) observe, "The economic insecurity of women is a major factor, not only of the way in which AIDS impacts on Ganda society, but also in the pattern of sexual practice and the spread of the disease in the first place." In responding to the AIDS crisis, women in Uganda are caught in the paradox of high expectations for managing HIV infection in the community and lack of control over the factors which can reduce the spread of the disease.

Sexual Behaviors and Risk in HIV Infection

Although AIDS is generally regarded as a disease that can be controlled through behavioral changes, it is necessary that the disease also be considered within the larger environment and culture within which it exists (Barnett and Blaikie 1992). Larger cultural and social forces often dictate behaviors and leave women with little control over many of their own actions, which undoubtedly has severe consequences in light of sexual activities and the spread of AIDS.

In discussing AIDS, it is important to address the risk individual's face in acquiring the disease. Lacking immunization against HIV and a cure for AIDS, behavioral

changes are the only protection against HIV infection. Women's ability to exert influence or control over any of these areas is restricted by their subordinate position in the household and society.

Ankrah (1991) identifies women's low status and powerlessness as leading factors in their vulnerability to HIV infection. Several studies report the limited ability for women to make changes in their sexual behavior to reduce their risk of AIDS (e.g. Ankrah 1991; Black 1990; Hayward 1990; Mahmoud, Zaldvondo and Zewdie 1990; McGrath et al. 1993). Clearly, if women are unable to effect changes in sexual behaviors which result in exposure to HIV, their risk of infection remains high.

Because lack of access to resources makes women dependent on men, women often have little influence in decision-making regarding sexual activities (Newman 1984). There are several components to this: women fear challenging men (Ankrah 1991), they are socialized to assume passive roles in social and sexual relationships (Reid 1988), and there is poor communication across gender lines, especially regarding such a sensitive topic as sexual behavior (Caldwell, Orubuloye and Caldwell 1992).

Women's fear of challenging men is grounded in experience. Often women's insistence on safe or protected sex, even in response to AIDS, meets with violence or expulsion from the home (Hayward 1990; Storck 1992). Considering women's economic dependence on men, they are often left with little choice but to follow the desires of their partners. A larger facet of women's inability to effect behavioral changes involves their prostration in controlling male attitudes and behavior (Ulin 1992), which is required for protection of women themselves. At most, women can control their own behavior. For effective preventative measures, changes require the cooperation of both men and women. With little, if any, influence over men's actions, women remain vulnerable on two accounts: protecting themselves from infection, and potential recourse from partners upon request for change.

The request for change in itself is often problematic. Sexual matters are considered secret in Ugandan culture and are generally not discussed between the sexes, including husbands and wives. Problems arise because avoiding discussion of sexual topics precludes cooperating to take preventative measures against AIDS. Accordingly, it also obfuscates the link between sexual activity and HIV transmission (Onyango and Walji 1988). Because talk about sex is a cultural taboo, women who initiate the conversation are deemed promiscuous, especially when the topic is condoms.

The link between condom use and promiscuity has negative implications for women. Unlike other forms of contraception which women can use without the knowledge of men, prevention against AIDS requires the use of condoms. Because use of condoms requires cooperation from male partners, women are not only put in the position of having to request the use of condoms, but upon request are often subjected to stigmatization (such as being labelled prostitutes) (Van De Walle 1990). In part, this label is because condoms are most widely used by prostitutes. Due to this association between condoms and prostitutes, people frequently avoid the use of condoms in emotional relationships. Reid (1988) points out that even prostitutes who use condoms in working sexual relationships refuse to use them in sexual activities with their boyfriends to separate personal relationships from work relationships.

In identifying the obstacles to condom use, a serious flaw in much of the literature and research on AIDS in Africa emerges. Many researchers and policy makers fail to recognize that the expectation and burden of change is placed on women. Despite women's restricted influence, many of the preventive programs are targeted at women. This strategy has a double impact on women, first, by placing responsibility for preventing the spread of AIDS on their shoulders, and second, by indirectly placing the blame for HIV transmission on women.

Prevention targeted at women may be ignoring the larger reality of women's repressed ability to directly effect change (Ulin 1992). There are certain individual behaviors that women can control, such as the number of sexual partners they have. However, behavioral changes are ineffective without joint participation by both men and women in resisting exposure to AIDS. Changes must be directed at the relationship and decision-making within the relationship. Until both men and women feel the need to alter behavior, the AIDS situation will continue to be a great threat. Cultural expectations also disproportionately render women potential AIDS victims. Male sexual behaviors, in particular, deserve more examination. A major barrier to male behavior change is the status attached to male sexuality and "conquest" (Barnett and Blaikie 1992). As Ankrah (1991:972) states, "The mental fixation that glorifies tradition of male sexuality now hinders behavior to stop the spread of AIDS."

For example, de Bruyn (1992) points out that marriage norms in developing countries' cultures often require women to be monogamous while men are expected to have multiple partners. Potential transmission of AIDS is further exaggerated by the tendency for men to wait longer before marriage. This practice generally accommodates more pre marital partners, thereby putting the woman at risk once she is married (de Bruyn 1992). Making matters worse, multiple partners for men in the formal pattern of polygamy is still prevalent in African society today (O'Donohue 1991). A culture that encourages multiple partners for men in a society permeated with AIDS creates a perilous situation for women.

Marriage customs in Uganda involve an age differential between men and women that results in earlier infection and death for women than for men. It is common for older men to marry younger women. For this and other reasons, girls begin sexual activity at a younger age than do boys (Marum 1993). The trend is evident in AIDS infection and mortality rates for men and women. Girls in the 15 to 19 age group show twice as many HIV cases as boys in the same age group. The most affected groups are 20 to 30 year old women and 30 to 40 year old men (Perkz 1990). The onset of infection and death at younger ages for women affect both the family and the society through reduced childbearing, family support, and production capabilities.

Impacting the whole arena of the behavioral aspects of AIDS are the biological conditions that increase the risk of women. First, men are much more "efficient" transmitters of the virus (Van De Walle 1990). Anderson (1992) reported that men are physiologically three times as likely as women to transmit the virus to a partner. Second, sexually-transmitted diseases (STDs), common in African women, provide increased susceptibility to HIV infection (Ronald et al. 1991).

Structural factors leave women at increased risk of HIV infection due to discrimination which limits their access to information. High levels of female illiteracy and lower levels of education for women in Uganda demonstrate their inferior status (Watson 1988). There is a definite link between proper knowledge and understanding of AIDS and its prevention. O'Donohue (1991:54) states that illiteracy among women is reported as "specifically contributing to the spread of AIDS" as their lack of knowledge leaves them vulnerable to infection. Women lack information due to educational discrepancies and also, as noted by de Bruyn (1992), through lack of access to radios which denies them information via public announcements and news. Behavior changes cannot be identified or attempted without information regarding appropriate behaviors to adapt. Once again, the peripheral position of women in society, reflected by low levels of literacy and information, contributes to their increased susceptibility to AIDS. The marginality of women is also evident in their limited access to health care. Women receive less health care than do men (Black 1990). Studies have demonstrated that women are less likely than men to show symptoms, be diagnosed, and seek treatment for AIDS (Ulin 1992). Some of this difference can be attributed to the failure of the medical system to accurately diagnose AIDS in women (de Bruyn 1992), but the responsibility partly falls on the secondary status women receive with regard to health care. Economic and social reasons prevent women from seeking and obtaining adequate health care for themselves.

Despite recognition of the AIDS problem by the Ugandan government, Goodgame (1990) reports a lack of attention to treatment of patients. Limited financial resources are exhausted as health facilities are increasingly overburdened with AIDS victims. Given the over-extension of health care services and limited resources in Uganda, women are the first to be excluded. A clear indication of this is the ratio of hospital beds given to men and women AIDS patients in some areas of Southern Uganda, where women have 14 beds compared to men's 40 (Black 1990). The impact of limited health care is most evident in the shorter life span of women with AIDS than of men with AIDS.

A mother's health is critical to family health. As the primary caregivers in the Ugandan family, women are responsible for the care of all family members, especially children. When women lack ways to protect their own health, it impedes their ability to provide a healthy environment and care for family members, particularly their children. Indeed, a woman's role as mother and childbearer is a crucial factor in her exposure to HIV and the impact by AIDS.

Implications of Women's Roles as Mothers

Women's reproductive roles increase their likelihood of infection with HIV. The risk occurs partly with their subordinate position in the marriage relationship obligating their participation in sexual activities as discussed earlier. Black (1990:9) states, "Most cases of infection in women in the developing world result from straightforward sexual relations within regular partnerships, usually between an infected husband and wife." This risk is increased by the expectation and requisite that women bear chil-

dren. In considering the implication of women's reproductive role on their susceptibility to the mv virus, it is necessary to examine fertility patterns and expectations in Ugandan society and their relationship to AIDS.

A good indicator of the importance of children and limited use of family planning in Uganda is the fertility rate of 6.9 children per woman (United Nations 1991). These high fertility rates remained steady from 1970 to 1990 despite the AIDS scourge rampant in Uganda since the early 1980's. In understanding social forces behind these high fertility rates, the patriarchal context in which they occur must be taken into account. The subordination of women (Greenhalgh 1988) and male control over reproductive activities (Crapo 1990) characteristic of patriarchal societies in developing countries demonstrate the need for analyzing gender differentials in fertility (Vock 1988).

The patriarchal structure strongly influences male power in decision-making regarding fertility manifest through contraception usage, the timing of children, and the number of children in the household. Huston (1979) illustrates that women can, and do, use birth control in various forms against the desires and without the knowledge of their husbands. However, the use of condoms (the only form of birth control other than abstinence that is also effective in preventing AIDS) requires accordance from husbands.

Even more important in consideration of fertility and AIDS is the desire for children by both men and women. Children provide labor, economic contributions, emotional benefits, and other values to the family. When looking at women specifically, however, the significance of childbearing goes beyond conditions of the household. Childbearing renders "the most important means to an acceptable social position for women" (Jensen 1991:72). Storck (1991:4) reinforces this assertion, "A major obstacle for women who wish to protect themselves against HIV infection is the desire for children . . . In many cultures, childless women face stigma; sometimes the penalty is desertion of divorce." Clearly, if women are dependent on their ability to produce children for status and economic security, AIDS poses a serious threat. When a woman is confronted with the decision of whether to have a child or avoid possible HIV infection, the child is preferred.

The significance of fertility in AIDS rates is indisputable. Studies show that 28 percent of pregnant mothers attending the prenatal clinic at a Ugandan hospital are HIV infected (McGrath et al. 1993). Still more alarming is the suggestion by Hayward (1990) that the HIV rate in pregnant women (15 to 40 percent) is beginning to match the infection rate of prostitutes (40 to 60 percent). The sheer numbers of pregnant women with AIDS, combined with the percentage of the adult population infected with HIV, underscores the dangerous situation for sexually active individuals in Uganda.

The number of pregnant women with HIV infection poses another somber threat to the eradication of HIV and AIDS mortality because there is a great potential for mothers to pass the virus on to their babies. The likelihood of an HIV-infected mother passing the infection to her unborn child is estimated at approximately 40 percent (McGrath et al. 1993). Cases of pediatric AIDS are easily attributed to the mother's infection. The general result is the unfair placement of blame for the child's condition,

and eventual death, on the mother. While this may seem like a logical association, the infection is not traced further than the mother; the source of the mother's infection is rarely questioned. Therefore, the stigma may lead to violence, abuse, or abandonment from the husband, worsening the economic deprivation the mother already experiences. In addition, it places a grave psychological burden on the mother over the death of her children (Black 1991).

On a larger scale, the transfer of AIDS from mother to baby, as well as the association of AIDS with prostitutes, contributes to the use of women as scapegoats for the spread of HIV by men (Barnett and Blaikie 1992). The blame of prostitutes and mothers transcends to women as a collective. STDs are already commonly known as "women's diseases" (Barnett and Blaikie 1992; de Bruyn 1992). Taking this line of reasoning one step further unjustly positions the responsibility for HIV and the spread of AIDS on women instead of men in the society.

Both the focus on mothers and prostitutes ignores the involvement of men in sexual activities that facilitate the spread of the virus. Placing blame on groups of women, who are undeniably sexually active, provides an easy scapegoat for a disease that creates a stigma and socially questionable condition for the family. At the same time, it unfairly burdens women with responsibility where, at most, they were only partially responsible. Rarely does one hear of a condom campaign directed at clients of prostitutes, because they can easily remain anonymous. And although pregnancy involves a man and a woman, rarely is the HIV status of the father called into question in direct relationship to an AIDS baby.

Because the family is an active transmission site for HIV in Uganda, the focus on the family is a logical succession. Hayward (1990) suggests that the scope of the disease is extending from the individual to the family because the family as a whole feels the effect of the disease even if only one member is afflicted. The family feels the stigma attached to the disease, as well as suffers the economic hardships the loss of a family member incurs. These effects are particularly damaging if the father dies first, leaving the mother, with weaker economic footing and resources, to provide for the family. The scenario only gets worse considering she is most likely infected herself. However, regardless of whether one or both parents is afflicted and no matter which parent it is, women must bear the stigma of AIDS in the family. As previously stated, in their role as primary caregivers, women must bear the brunt of the responsibility for family health and maintenance.

Women as Caregivers

Part of a woman's role as reproductive agent is the responsibility of household maintenance and caregiving. These duties are expected of women regardless of their own health condition. Mothers are expected to care for children, husbands, and themselves. The caregiving function places further demands on the time and resources of women vis-a-vis AIDS. As AIDS is an expensive and time-consuming disease, those charged with care of the sick bear a heavy responsibility. Of even greater consequence is the presumption that caregiving obligations will be born without remuneration

or compensation for expenses incurred as part of their charge as mothers, which includes "pressure to give up paid labor" in order to render care to family members (Ankrah 1991, 973).

Women's responsibilities as caregivers extend much further than immediate family members. Women also face the expectation to provide care for extended family members on both sides of the family. The role of women as household producers assumes the care of the afflicted with little regard for actual resources. This expectation places further demands on women's limited resources, and the resources needed for coping with AIDS; labor, land, cash, income-generation, and household/family skills all reflect a gender differential, mostly in favor of men.

Because the virus is often transmitted between family members, the devastation of widespread AIDS often results in the breakdown of the extended family structure. As developing countries rely on families for health care and social services, the collapse of the family system incurs larger problems for the society and government. However, these problems are diverted back to the communities as governments are incapable of providing these services. Once again, the burden falls on women.

The caregiving role falls on women regardless of age. One problem arising from the high death toll in Uganda is a reliance on the older generation to care for the orphans of AIDS victims. Due to the caregiving role of women and their longer life expectancy, grandmothers become the primary caregivers. This creates a "double burden" on elderly women who may be unhealthy themselves and had expected to be provided for in their old age by their children. Instead, they are given the burden of raising their grandchildren (Beer, Rose and Tant 1988).

Caregiving is paramount in a society where disease and death are prevalent, especially considering the overload of the existing insufficient health services. Yet little research examines the effects of aiding the sick and, consequently, the function of women in this role. When caregiving is reported in studies, it is mentioned almost as an assumption rather than being part of the assessment of social and economic consequences for society, family, and women in particular.

Conclusion and Recommendations

Clearly, the vulnerability of women in the environment of AIDS in Uganda remains a significant obstacle to development and equality. The discrepancies in the examination of HIV and AIDS in Uganda not only perpetuate women's risk to infection, but also unfairly place the blame of transmission and burden of responsibility for prevention of AIDS on women in Uganda.

When addressing the AIDS situation in Uganda, it is imperative to include women at all levels. AIDS issues that directly affect women are being brought to the attention of policy-makers. Until the significance of its impact on women is understood by those in power (predominantly men), however, AIDS strategies will continue to neglect the disparate roles and consequences men and women will encounter. The pervasiveness of patriarchy in Uganda society must be considered both in understanding AIDS impacts and in working toward preventative and coping measures. The

greater risk and burden women face in HIV infection, tied directly to their status as women, necessitate gender differentiation in research and policies that incorporate the extended roles of women. There is currently a tendency for agencies in Uganda to focus prevention strategies on women. On one hand, investing in women as agents of change by directing prevention approaches at them suggests that agencies have confidence in women's resourcefulness and responsibility. On the other hand, it may illustrate the failure on the part of agencies to recognize patriarchal and structural forces impeding women's ability to enact suggested changes. Agencies and governments must target prevention strategies at both men and women in order for these strategies to succeed. Promotion of programs directed at men is a necessity, not only. to affect infection reducing behaviors, but to ease the transfer of blame on women.

Targeting information and prevention at women provides an easy scapegoat for men. This is particularly true when men are excluded from programs. Focusing on high risk groups of women such as prostitutes and pregnant mothers relocates the locus of spread unfairly on women. Indeed, spread of AIDS. can no longer be connected to high risk groups or even high risk behaviors, but "risk situations" (Obbo 1993:949). What situation could be more risky than the subordination and domination of women within the patriarchal context?

Paramount to women's ability to cope with AIDS and defend themselves against infection is empowering women with access to resources. Control over material resources is fundamental in promoting women's influence in decision-making within the relationship, their access to health care and social services, and men's and women's shared responsibility in dealing with the destruction and devastation of AIDS on the community. Before prevention strategies can be effective, the stratification and inequities of the trends of the disease must be recognized and contained. Both the higher rate of HIV-infection in women, and the greater impacts AIDS has on them, emanate from the subordination and economic deprivation of women. Even more consequential, AIDS care drains women of the limited resources they have, further weakening their position in society.

The impact of AIDS is raising questions about women's responsibilities and rights. There is potential for a redistribution of power and resources to help women who are struggling with the AIDS situation in Uganda. Recognition that efforts necessary to curb AIDS transmission clash with current cultural norms is necessary in effective coping measures. Behavioral changes must occur within current cultural, social, economic, and political settings that may not be easily malleable. Perhaps the repercussions of AIDS will continue to inflict devastating consequences on society's most disadvantaged. Paradoxically, the severity and relentlessness of AIDS devastation will promote an environment that necessitates change.

Note

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the National Institutes of Health, the Department of Health and Human Services, or the United States government.

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