

A CULTURAL APPROACH TO HIV/AIDS PREVENTION AND CARE

UNESCO/UNAIDS PROJECT

Women Migrants and HIV/AIDS: An Anthropological Approach

*Proceedings of the round table
held on 20 November 2004
at UNESCO - Paris*

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Foreword

The round table on “Migrant women and HIV/AIDS in the world: an anthropological approach”, held at UNESCO in Paris on 20 November 2004, afforded an opportunity to reflect on the social and cultural aspects of HIV/AIDS on the basis of two closely linked issues, namely women and migration.

The round table was part of the Joint United Nations Programme on HIV/AIDS (UNAIDS) World AIDS Campaign 2004 on women, girls, HIV and AIDS. UNAIDS chose the theme in order to draw attention to the growing feminization of the epidemic since it began: women now account for half of the people living with HIV/AIDS in the world, and the percentage is even higher (57%) in sub-Saharan Africa where the infection rate among women under 24 years old is a matter of particular concern. UNESCO, a co-sponsor of UNAIDS, has naturally made a point of being fully involved in this awareness-raising and prevention mission, with the aim of lessening the impact of the virus on both women and men.

Migration was the theme selected for all the events held by UNESCO in the run-up to World AIDS Day, expressing solidarity with Africa under the slogan “Africans united against AIDS”.¹ Migration is in fact a phenomenon of growing significance: in 2002 there were 175 million international migrants, that is, 2.9% of the world’s population, and 48% of them were women.² Migration increases vulnerability to HIV/AIDS, as the migrants are far away from their families and partners, living in poverty and all too often exploited, their status in the host country is precarious or even illegal, and they may have limited or no access to health services and appropriate medical information. In addition to these vulnerabilities, their lifestyles undergo change, they meet new people, modify their sexual practices and call relations between men and women into question – and all of these upheavals have a particular impact on migrant men and women.

The round table “Women migrants and HIV/AIDS in the world: an anthropological approach” brought high-level researchers in the social sciences together to promote an exchange of comparative analyses of case studies from different parts of the world: West Africa, South-East Asia, the Caucasus and Western Europe. The presentations addressed migration in all its complexity – economically-motivated migration by men and women, the situation of partners remaining in the country of origin, HIV-positive women migrants, second-generation daughters of immigrants, and so on – and identified ways and means of taking the specific needs of these population groups at the local, national and international levels better into consideration. On the basis of these very constructive contributions I should like to draw attention to what I regard as a crucial point, namely the need for a sociocultural approach to HIV/AIDS. There is indeed a pressing need to design, with and for migrants, HIV/AIDS programmes that are culturally and linguistically adapted to them, respect gender equality and rise to the specific challenges that women migrants may encounter. This is the contribution of the “anthropological approach” promoted by UNESCO, an approach that is sensitive to all social and cultural realities, the mechanisms of migration, and the practices and experiences of women in the HIV/AIDS era.

The anthropological approach has been used since 1998 by UNESCO’s Culture Sector as part of its joint project with UNAIDS entitled “A Cultural Approach to HIV/AIDS Prevention

¹ Organized jointly by UNESCO and Sida Info Services (AIDS Info Service), the day of solidarity was marked by three round tables (on the rights of the child, women migrants and the presentation of good practices), exhibitions of photographs, arts and crafts, and an evening show and concert with Rokia Traoré and Meïway.

² International Organization for Migration (IOM). *World Migration Report*. Geneva, IOM, 2003.

and Care”. The “cultural approach” stresses the sociocultural factors linked to HIV/AIDS: the specific features of the epidemic must be understood on the basis of local cultures, beliefs, myths and traditions, ways of life and so on. These cultural factors can be obstacles to open discussion and information about HIV/AIDS and to effective prevention. Nonetheless, each culture has an immense pool of appropriate responses to combating the disease – as long as culture is seen as an infinitely rich, diverse, multifarious and changing resource. In addition to promoting research, methodological tools and pilot projects, the project aims to create opportunities for theoretical reflection on HIV/AIDS themes and a platform for dialogue to improve the design of the programmes and activities of all stakeholders in the HIV/AIDS response.¹ The round table “Women migrants and HIV/AIDS in the world: an anthropological approach” has fully lived up to expectations by highlighting the practical relevance of all the studies submitted and carefully linking research and action, reflection and recommendation.

In conclusion, I should like to express my warmest thanks to the participants, many of whom have come from far and wide to take part in this round table and share their thoughts with us. I also thank the International Organization for Migration and the Centre Régional d’Information et de Prévention du Sida (Crips – Regional AIDS Information and Prevention Centre) Ile-de-France, which have joined UNESCO in organizing this round table. The pooling of efforts is vital to the HIV/AIDS response, and I am delighted that this event has been the outcome of excellent cooperation between the three institutions.

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¹ For instance, an anthropological debate on the issue of stigmatization and discrimination was also held at a round table organized by UNESCO in 2002. The proceedings of the round table have been published in a special series by the Division of Cultural Policies and Intercultural Dialogue: *HIV/AIDS, Stigma and Discrimination: An Anthropological Approach*. Studies and Reports, Issue No. 20, UNESCO, 2003 (available online at the following address: www.unesco.org/culture/aids).

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List of Acronyms

AIDS: Acquired Immunodeficiency Syndrome

ART: Antiretroviral Treatment

CSW: Commercial Sex Worker

ECOWAS: Economic Community of West African States

HIV: Human Immunodeficiency Virus

IDU : Intravenous Drug User

NGO: Non-Governmental Organization

OFW: Overseas Filipino Workers

PLWH: People Living With HIV

STD: Sexually Transmitted Disease

STI: Sexually Transmitted Infection

UNAIDS: Joint United Nations Programmes on HIV/AIDS

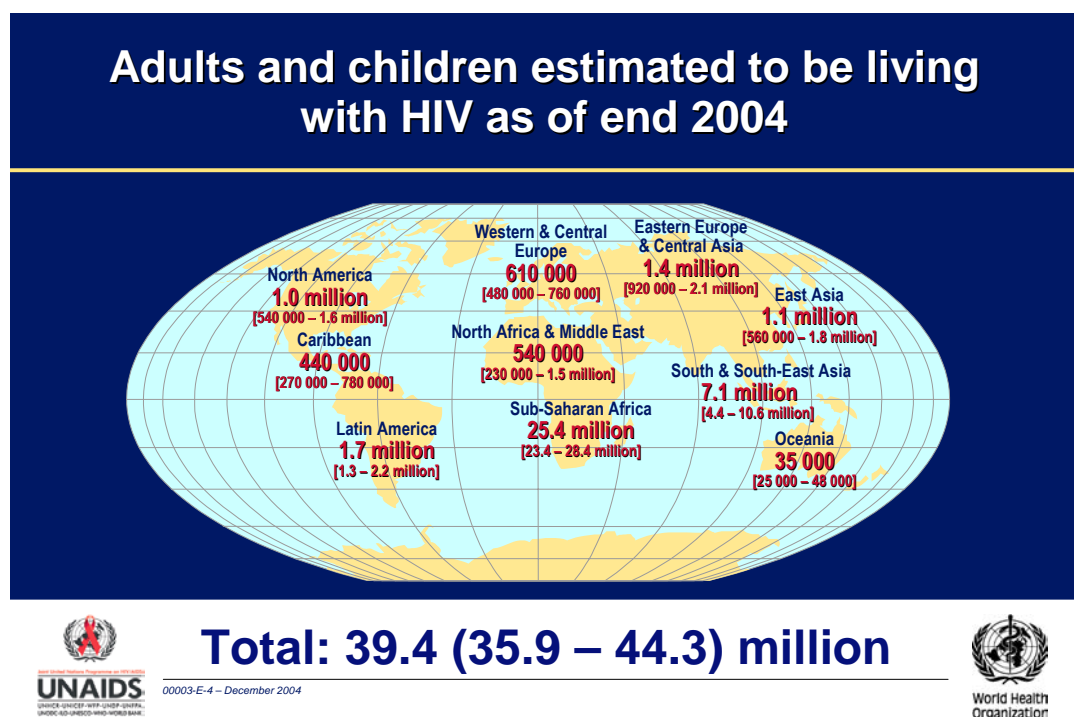
HIV/AIDS and Migration: Setting the Scene

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HIV and AIDS

At the end of 2004, approximately 39 million people were living with human immunodeficiency virus (HIV) or with acquired immunodeficiency syndrome (AIDS). Approximately 37 million of these were adults, and over 2 million were children under the age of 15. Some five million people became infected with HIV during the year 2004, including some 640,000 children, and some three million people died. About half a million of those who died of AIDS-related illnesses were children¹. HIV and AIDS are now present on every continent, as shown in UNAIDS/WHO figures:



A 2004 UNAIDS report outlines a number of significant trends in the global AIDS epidemic: Sub-Saharan Africa remains the hardest hit region, with extremely high prevalence among pregnant women aged 15 to 24 reported in a number of regions (UNAIDS, 2004). There is no reason for complacency elsewhere, however. Diverse epidemics are under way in Asia, in Eastern Europe and Central Asia, and in Latin America and the Caribbean. Even in the regions most able to afford them, current AIDS prevention efforts are clearly insufficient, as some 21,000 people were newly infected in Western Europe during the year 2004, and some 44,000 in North America².

¹ <http://www.unaids.org/en/resources/epidemiology/epicore.asp>

² <http://www.unaids.org/en/resources/epidemiology/epicore.asp>

As of the end of 2004 women accounted for nearly 50% of all people living with HIV worldwide, and the UNAIDS report stresses the way in which women's increased risk is a reflection of gender inequalities. In most societies, the rules governing sexual relationships differ for women and for men, with men holding most of the power. This means that for many women, including married women, their male partners' sexual behaviour is the most important risk factor. In Thailand, for example, a 1999 study found that 75% of HIV-infected women were likely infected by their husbands. Nearly half of these women reported sexual relations with their husbands as their only HIV-risk factor¹.

On a somewhat more optimistic note, world-wide response to the HIV epidemic has been significantly expanded, with increased spending for both prevention and treatment, and increased coordination among national and international bodies². Recent years have also brought increasingly effective treatment for HIV disease in the form of antiretroviral treatment (ART) and increased *access* to ART. Indeed, with the "Three by Five" initiative the World Health Organization has formulated the goal of providing three million people living with HIV/AIDS in developing and middle income countries with life-prolonging ART by the end of 2005³.

Migration

At the start of the 21st century, the International Organization for Migration estimates that one person out of every 35 worldwide, or some 175 million people, are international migrants (IOM, 2003). Eighty six million people migrated for reasons of work in 2003, of whom some 32 million are in developing countries (ILO, 2004). In addition, almost three quarters of a million highly qualified migrants have moved from Africa to Europe and North America (IOM, 2003).

Forced migration also continues: the year 2003 saw some 17 million refugees and internally displaced persons, the vast majority of whom also remain within developing countries (UNHCR, 2004). Partly as a result of tightening restrictions on immigration and on labour migration, recent years have also seen an increase in the numbers of persons smuggled and trafficked, with some 4 million persons thought to have been trafficked in the year 2002 (IOM, 2003).

The last ten years have seen an increased feminization of migration, with women currently representing about 50% of the estimated 175 million migrants worldwide. In Asia, in particular, women now make up the majority of expatriates working abroad: accounting for 65% of all Sri Lankan and 70% of Philippino migrant workers overseas. A growing number of rural-to-urban migrants within developing countries are also young women, attracted by the increasing availability of factory and services jobs available in large cities, including domestic service (IOM, 2003).

Numbers of migrant have increased, but migration patterns have also changed significantly over the past quarter of a century. What were formerly countries of origin are becoming countries of destination, migrant receiving countries are becoming migrant sending countries, and both sending and receiving countries are becoming countries of transit. The International Organization for Migration stresses the importance of seeing migration – or population movement - as a process, involving countries or regions of origin (where people are coming

¹ UNAIDS 2004 Report on the global AIDS epidemic: 4th global report, Geneva, June 2004, p 42.

² See for example "The three ones" principles, promoting: one agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners; one National AIDS Coordinating Authority, with a broad-based multisectoral mandate; and one agreed country-level Monitoring and Evaluation System.

<http://www.unaids.org/en/about+unaids/what+is+unaids/unaids+at+country+level/the+three+ones.asp>

³ <http://www.who.int/3by5/en/>

from), transit (the places through which they travel during their voyage, sometime stopping for lengthy stays), destination and return. The latter is particularly important to keep in mind as travel becomes cheaper and easier: many people migrate for relatively short periods of time, returning home between stays abroad, and others who may have migrated permanently nevertheless regularly return home for visits.

HIV/AIDS and mobility

A number of epidemiological studies have pointed to a link between population mobility and the spread of HIV, a link that should not be surprising. At the risk of stating the obvious, it is in the bodies of human beings that human immunodeficiency virus is carried from one place to another, as people move between different zones of HIV prevalence. Thus, at the beginning of the epidemic – and in countries or regions with adequate epidemiological monitoring – the first cases of HIV can sometimes be traced to individuals or groups passing through, such as truck drivers, people displaced by conflict, military personnel, or returning migrant workers. This stage is now passed, however: HIV is now present in every country of the world. At later stages in the epidemic, when HIV is already established in a particular area, migrants, refugees, internally displaced people and individuals in transit for professional or other reasons often find themselves in situations where they are at increased risk of becoming infected, thus, in turn, potentially carrying HIV to yet other places in transit, or back to their communities of origin.

Understanding of the complex and circular relationship between HIV and population mobility is gradually increasing¹. Several factors increase migrants' vulnerability to HIV. These include separation from families and partners, and also from the norms that guide behaviour in stable communities. They also include loneliness, and the alienation and despair that follow the stigma and discrimination experienced by many migrants. Factors of a more social nature particularly drive migrants' HIV risk and vulnerability. These include poverty, lack of legal protection, powerlessness and exploitation – all of which may drive people to engage in behaviours in which they would not otherwise engage. Sexual violence is a risk factor for many migrant and refugee women, especially. Finally, non-nationals and others in transit often lack of access to health promotion in general and AIDS prevention in specific, as well as to voluntary counselling and testing, and to HIV care and support. The presentations that follow will now explore in more depth these factors, and show the striking way in which such factors are similar across the world.

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1 See IOM, 2005, for a review of recent evidence.

Women's Migration, Livelihoods and HIV/AIDS in West Africa

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The migration process in West Africa

Massive mobility of people has been found to be a common feature of West Africa and has had historical pre-eminence over Eastern and Central Africa (Parkin, 1975). Two principal patterns of population movement have been established over the years. The first is the North-South movement within coastal countries of Côte d'Ivoire, Ghana, Togo, Benin and Nigeria, and the second is the movement over longer distance between the hinterland Sahelian countries in the North (Mali, Burkina Faso, Niger and Chad) and the coastal countries to the south.

The main feature of the migratory movements in West Africa is that they were male dominated. The migrants were more likely to be young unmarried males and if married, they were more likely to leave their wives behind. Women's participation in the movement is increasingly becoming important in recent times but as yet their movement seems to be towards a few places in the sub-region (Anarfi, 1990). Another feature is its periodic, seasonal nature. This massive, region-wide mobility is strongly linked to the effects of seasonality on the ability of rural dwellers in West Africa to earn the real income that their families need to survive and get ahead (Painter, 1992). A situation of seasonally limited opportunities and a scarcity, over a period of 7 to 8 months, related to the rainfall pattern of the Sahelian countries, prevails. Seasonal migration has therefore become a form of strategy to survive harsh conditions imposed by nature.

According to Painter (1992) each year, from September through December, hundreds of thousands of men leave their homes in the Sahelian countries in the North and travel to countries along the coast. These men may remain in the coastal countries from four to eight months looking for money, before they return home. It is estimated that from 6 to 16 per cent of the total population of Niger, for example, may be affected each year by seasonal migration. Other studies have observed that men from the Sahelian countries participate in this yearly migration from 10 to 15 years during their individual lifetimes (Painter, 1992). Participating in the migration process has become more or less a way of life for rural households in Sahelian West Africa.

Human mobility in the West African sub-region could be very tedious. From trans-Saharan trade times through the colonial era to the present, it has been done mainly by land. Painter has observed that the vast majority of migrants from Niger and Mali travel to Côte d'Ivoire in buses and small trucks (Painter, 1992). The distance covered by the migrants could also be very considerable. For example, the round trip from Niamey, Niger to Abidjan, Côte d'Ivoire, is about 3,500 kilometres. Journeys over such distances take days and cross several international boundaries. Despite the Economic Community of West African States' (ECOWAS) treaty of free movement of citizens in the sub-region, travellers experience a lot of harassment from law enforcement agents along the routes and the borders (Anarfi, 1990). Crossing over boundaries at unmanned posts, especially for those who carry goods, is often a preferred option and that too is not without its dangers. There is the danger of falling into the hands of occasional border patrols or being blackmailed by scouts who take unsuspecting travellers across for a fee (Anarfi, 1982). The element of physical fatigue is, therefore an important ingredient in migration in West Africa.

A good part of the people who move in the West African sub-region end up in urban concentrations. In most cities of the sub-region, therefore, there is a large concentration of young men in their active years. As stated earlier, they are usually unmarried, or if they are married they are unaccompanied by their wives. If the migrant is an autonomous female she is usually young, unattached and lacks basic skills to compete for jobs in the new destination. The situation is thus created for migrants to be involved in activities which expose them to multiple social contacts and possibilities of sexual encounters in a social context where sexual access is open and extremely fluid.

Côte d'Ivoire has for decades been the most important destination for migrants in West Africa. Until the recent conflicts it enjoyed a stable political climate and its economy performed better than most of the countries in the sub-region. Côte d'Ivoire, therefore, offered a number of opportunities to populations in the neighbouring countries. Large numbers of male migrants from the Sahelian countries were attracted to the country annually. Census estimates made between 1989 and 1991 put the number of Malians in Côte d'Ivoire at somewhere over 1 million. Burkina Faso alone had about 3 million of its nationals living in Côte d'Ivoire (Painter, 1992). The country's capital, Abidjan, receives a large share of the migrants creating a large male surplus in the city. The serious sex imbalance has created the condition for large-scale commercial sex with international dimensions.

Migration and vulnerability to HIV/AIDS

The advent of AIDS in West Africa, and in Côte d'Ivoire in particular, has made migration as a survival strategy for both men and women in the sub-region an increasingly risky enterprise. AIDS is now established in almost every country in the sub-region. Côte d'Ivoire ranks first in West Africa in the number of recorded AIDS cases. In Abidjan, the capital city, AIDS is the leading cause of death among males aged 20-35 and the second most important cause of death among women in the same age bracket (De Cock et al., 1991). About 12 per cent of blood donors and an estimated 50-90 per cent of commercial sex workers were already reckoned to be HIV-positive a decade ago (Painter, 1992, p. 7). Given that African population movements are mainly circulatory, a link between the pool of HIV/AIDS in Abidjan in particular and Côte d'Ivoire in general, and the spread of the disease in the neighbouring countries may be easily established.

Although current available data do not permit drawing neat cause/effect relationships between migrations to the coastal countries in general and to Côte d'Ivoire in particular, and AIDS among migrants, the evidence available leads to an interesting observation. Ever since records have been kept on AIDS in Ghana the numbers have been dominated by females, the majority of whom have a history of travelling to other countries especially Côte d'Ivoire. An interesting relationship is that the Ghana/Côte d'Ivoire migration stream is predominantly female (Anarfi, 1990). In Niger, for example, 70 per cent of all AIDS cases registered at the central hospital in Niamey have a history of migrating to the coast, particularly to Côte d'Ivoire. Again two of the major emigration areas in Niger, Tohoua and Niamey, together accounted for 90 per cent of all known AIDS cases in Niger in 1991 (Painter, 1992, p. 8). A similar situation could be observed in other emigrating countries in West Africa. There is now some evidence about what migrants do at their destinations, which put them at risk of contracting HIV infection.

Females are increasingly taking part in migratory movement as a way of enhancing their livelihoods, just like their male counterparts. Unlike them, however, they tend to be funnelled

into few easy entry jobs because of their disadvantaged position. Commercial sex has become one of the easy entry jobs, especially in Côte d'Ivoire where a large influx of male migrants from neighbouring countries has led to a large excess of males over females. It must be explained that Ghanaian women in commercial sex are more visible in Abidjan than in any city in Ghana. Within Ghana as elsewhere in West Africa, women who practice commercial sex always do so far away from their home areas. Entry into commercial sex

is not the result of female weakness, but rather is evidence of a breakdown in normal sexual morality brought about by economic pressure, social isolation and the anonymity afforded by urban conditions. (Acquah, 1972)

Writing on Nigeria Pittin remarks,

the reasons for the Hausa (and the Yoruba, and any other given group's) occupational choices must be sought within the context of specific socio-cultural provisions and constraints, as well as within the wider socio-economic framework. (Pittin, 1984, p. 1302)

Quite simply, women turn to commercial sex as one of a limited range of options they have of making a living away from their home areas (Bujra, 1977; Pittin, 1984). It is always away from home because the local society abhors the practice and does not accord the prostitute much respect. The Ghanaian women for example, are therefore hiding behind the anonymity provided by distant Abidjan to practice what they know is not very acceptable in their home areas.

For some women practicing commercial sex is a way of manipulating certain male ideologies. Lacking out the skills and education which might afford them a niche in the modern economy, the women act out the roles traditionally accorded to and expected of them (see for example Pittin, 1984). In a study of Ghanaian women in Abidjan, a young woman who was asked why she entered into commercial sex replied, "In Ghana men were using me for free so what is wrong with it if I come to do it here for money" (Anarfi, 1990). In Ghana the traditional *mpena* relationship or concubinage had in it some elements of transaction. Generally the *mpena* relationship was a prelude to marriage. As such the male was expected to approach the parents of the girl to declare his interest. In return, the parents accord the man the recognition of a prospective suitor (i.e. if they agree with the relationship) and give him a certain measure of protection by ensuring that their daughter remains faithful to him. The man reciprocates by presenting gifts to both the girlfriend and the parents occasionally. The gift was more in kind than in cash – a farmer would send the best of his farm produce and a hunter, game. Others would rather buy cloth and other tangible gifts on occasions. The essence of the gifts is for the prospective husband to demonstrate to the would-be in-laws that when eventually their daughter got into his custody, he would be capable of taking care of her.

In recent times, most men are not living up to their responsibilities in the *mpena* relationships. Yet they still demand sex from their female counterparts. This has compelled some women to put a price on their bodies in line with a local maxim in pidgin English: *Cash na hand, back na ground* – meaning: "money in my hand before I lie down for you" (pay before sex). This explains the statement made by the young woman interviewed in Abidjan.

Pittin (1984) has observed a similar manipulation of popular ideology in the *karuwanci* or courtesanship practice among the Hausa of northern Nigeria. In this part of Nigeria where polygamy is highly prevalent, there is the practice of putting all wives in the part of the house called females compound. Such places are often areas of seclusion and are often out-of-bounds to male strangers.

Women who are either tired of marriage or want to assert their independence, ran into the towns and join others in a “house of women”. Pittin has observed that in this part of Nigeria changes in women’s status throughout their lives tend to be marked by spatial movement, to or from marital or natal home, or away from both and into the practice of *karuwanci*. She explains that entrance into *karuwanci* is usually clear-cut, both spatially and temporally: the woman leaves her family or marital home, usually precipitously, and heads for the city. From the houses of women men go to pick sexual partners and take them either to their homes or elsewhere for sex. Strictly, sexual relationship does not take place in the “house of women”. In that respect it cannot be described as a brothel in the strict sense of the word. Thus the arrangement allows the women to assert their independence while at the same time exercising some power over the men since they come to them. Hausa women live together in houses of women, and expect to be “courted” by a prospective client. After sexual intercourse the man will give the woman a sum of money decided by himself, rather than preliminary bargaining. Thus the procedure duplicates that of a man wooing a prospective girlfriend or wife and thereby adheres to one facet of the appropriate behaviour demanded by dominant Hausa ideology, which assumes for women a passive, and for men an active role, in establishing sexual relationships.

Itinerant Women Traders

Itinerant trading is a time-tested means of distributing both imported and locally produced goods in West Africa. It has a long history dating into pre-colonial times. Early writers emphasised the vigour of trading activities both across the desert and within the Sudan (Leo Africanus, 1896; Mungo Park, 1816). Almost all the writers highlighted the peaceful nature of these movements. They involved the movement of products from one ecological region for exchange with others from another. Thus long before colonisation, migratory movements in West Africa were strongly determined by the distribution of economic opportunities and itinerant trading has been an important feature of the phenomenon.

Commercial migration continued to gain momentum in the colonial era as it was given a tacit approval by the colonial administrations. At this stage, however, it became more voluntary and was dominated by unskilled migrant labour mainly of young men. Most of the migrants in Ghana during the period, including many from Niger, Mali and Nigeria, were self-employed traders rather than wage labourers (Rouch, 1956). A 1948 census of Ghana showed that among male traders tribes from outside the country provided the greatest proportion of occupied persons in that sector. The situation was different with females, however. The same census figures show that of all the 18,672 employed women in Accra, 89 per cent were traders. Writing in 1853, Cruikshank states that

The commercial spirit is very strong in the African. The whole population are traders to a certain extent. It is the delight of African women to sit in the market places under the trees exposing their wares for sale, or to hawk them through the streets from door to door, and from village to village. (Cruikshank, 1853, p. 28)

The above shows that women have played a leading role in trading in the sub-region and have contributed to the distribution of items from place to place from time immemorial.

While the international dimension of itinerant trading has gone down considerably in the post-independence times due to restrictive policies by governments in West Africa, trade-related internal movements are still important. A substantial number of females have been known to be part of this movement since the 1960’s (UNECA, 1994). It has been estimated that in Ghana, about half the rural/urban migrants in the 1960 census were women. There is evidence that the

proportion either remains the same or has gone up in recent times. Itinerant women traders are important segments of these movements as they move goods from one part of the country to the other.

The association between movement of people and spread of disease has been long observed. Through population movements of many different types people may be subjected to a variety of health hazards (Prothero, 1977), as well as engaging in social and risk behaviours likely to enhance the spread of HIV (Anarfi, 1993). Moving across different ecological conditions may expose movers to diseases transmitted by strange insect vectors. Movements also bring different group of people into contact with one another and may thus enhance the possibilities of disease transmission. Sheer fatigue, which may result from travel especially if it is over a long distance or if it is repeated often, could lower a person's resistance and so increase their susceptibility to infection. Added to this is the psychological stress which can result from having to adjust to new environments (Porthero, 1977). People involved in trade-related movements in contemporary times appear more susceptible to the hazardous situations described above because their movements are more temporary, repeated more often and have to make do with makeshift arrangements for their persons and the large amount of money they often carry. Female itinerant traders are more vulnerable because they are the objects of masculine sexual desire, which may lead to some form of sexual violence.

A Ghanaian study observed that the itinerant woman trader could be relatively young, likely to be between 25 and 44 years with very low education or basic employable skills. Most claimed they were married and almost all of them had children (Anarfi et al., 1997). They played a major role in the upbringing and maintenance of their children in line with the society's expectation that women should develop careers of their own to support themselves and their children (Peil, 1979, p. 485). The majority of the people studied travel to the markets weekly, each trip lasting an average of three days. It must be added that those who go to farm gates to buy direct from the farmers spend a much longer time. Also those who go to the markets to sell actually hurry from one market to the other which makes the overall travel routine of some of them very intensive. The need to get transportation timely and at reasonable cost compels some of the itinerant traders to strike a permanent acquaintance with drivers which could develop into love relationship with time. The danger here is that most drivers take advantage of similar situations concerning several other women to engage in multiple sexual relationships with them thereby putting them at risk of contracting HIV.

The conditions at the market places add to the general insecurity and hence the vulnerability of the itinerant women traders. Accommodation is a serious problem for the itinerant women traders since it is not the usual practice for many Africans to lodge in hotels. It has been the practice of migrants to seek and stay with relations or people from their areas of origin (Caldwell, 1969; Nabila, 1974; Anarfi, 1993). Given the highly fluid nature of trade-related movements in contemporary times, such inter-personal arrangements are not possible. Studies have also observed that local men who may enter into such relationships do so with the view to exploiting the women traders' vulnerability (Anarfi et al., 1997). Those who are forced to sleep in trucks and in the open also face the danger of being assaulted or losing their working capital through attacks by criminals. The need for security for themselves and for the large sums of money they carry, compels most of the itinerant women traders to strike acquaintance with local men, which often develops into a love relationship. The evidence suggests that through circumstances beyond their control, some itinerant women traders are compelled to get involved in sexual activities while out on business. Public opinion about the sexual behaviour of itinerant women traders in Ghana now is very disapproving indeed. The men who come into contact with

these women exploit their state of vulnerability, which is the product of the extremely difficult conditions in which they work.

Concluding remarks and suggested actions

It has been established that the very disadvantaged position of women which makes them opt for migration as a survival strategy also compels them to undertake certain risky behaviours in migration that expose them to HIV infection. Their mobile nature and the environments in which they operate impose structural factors such as inadequate health infrastructure and poor access to treatment on them. In addition to these individual risk factors, some societal, cultural, and economic factors beyond the control of individuals further deepen the vulnerability of migrant women to HIV/AIDS. These bring into focus the three levels at which vulnerability exists as identified by Mann and Tarantola (1996), individual, societal and programme-related vulnerabilities.

They explain that personal (individual) vulnerability has two components, namely cognitive and behavioural factors. Cognitive factors involve informational needs and the ability to utilize information. Behavioural factors, on the other hand, include personal characteristics such as emotional development, perception of risk and attitudes toward risk-taking, personal attitude to sex and sexuality. They also include personal skills, that is, the ability to negotiate for a wide range of risk-reduction behaviours such as abstinence or condom use.

Societal vulnerability on its part involves the socio-cultural, economic, political and environmental factors that make a society or group within that society particularly susceptible of adverse effects of any event. The subordinate position of women in certain African societies is a case in point.

Finally, programmatic vulnerability encompasses the processes and activities that are available for reducing or resolving personal vulnerability. This involves the provision of information and education, counselling and peer support and skill training in sexual issues. However, many efforts to prevent STIs and HIV/AIDS infections urge people to insist that their sexual partners use condoms, but the concept relies on the mistaken assumption that women and men share power equally in negotiating sex and therefore condom use. In addition, although we now have female condom, female-controlled methods of preventing HIV/AIDS are not readily available or affordable in many parts of Africa.

From the foregoing it follows that for individual women migrants to change their behaviour, they need basic knowledge of HIV and their risk of infection. They need to learn how to protect themselves and must have access to appropriate services and products, such as condoms. They must also perceive their environment as being supportive of safe behaviours.

It also follows from the above that preventing infections involves more than avoiding risky behaviour, it also requires changing the socio-economic and political conditions that make some people more vulnerable to infection. For all the activities to succeed, there must be adequate allocation of resources by national governments, greater support from the private sector and substantial increases in international assistance, bilateral funding programmes, and allocations by international organisations.

Involving Migrant Women

Migrant women could be made both the objects and subjects of HIV/AIDS intervention programmes. That is, they could be reached with the necessary information that will enable them change their behaviour as well as making them agents of change. Given that migration in Africa is mainly circulatory, the migrant woman equipped with the relevant information could influence both the last community and the origin community. UNFPA (2002) suggests that the areas for action should include the following:

1. Promote the scale-up of reproductive and sexual health programmes
 - To make available to women, particularly rural women, the information and services they need on reproductive health and HIV/AIDS;
 - To help prevent STIs, which increase the risks of HIV in women; and
 - To provide access to resources for promoting social and behavioural changes necessary to slow the spread of HIV/AIDS.

2. Advocate measures to eliminate barriers to women's access to health care, including
 - A reduction of high fees for health care services;
 - Removing the requirement for authorization by a spouse, parent or hospital authorities;
 - Promoting respect for confidentiality; and
 - Removing all forms of coercion, including mandatory testing for pregnancy or sexually transmitted diseases, and non-consensual sterilisation or other treatment.

Programme Locations

Migrants have always been a rare sample so programmes meant for them must target specific environments if many of them are to be captured. Three of such environments are suggested:

- Major migration corridors

These must be identified and an international programme put in place. This segment of the programme will target women in motion. Drivers should be made partners in this programme. They could be made educators, equipped with the necessary information and they pass it on to their passengers while travelling. The messages could also be put on cassettes and drivers play them while on the move.

- Focal points

Focal points along the corridors could be identified and HIV/AIDS programmes established there. The programme would target all populations but with emphasis on migrant women.

- Major market centres

Since a section of women migrants are actually traders who hop from one market to the other some of the programmes should be located in the major ones. The programme will operate just like the one at the focal points.

In all the locations migrant women should be identified and used as peer educators.

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Sexual Scripts and Shifting Spaces: Women Migrants and HIV/AIDS

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Introduction

I was a domestic worker for almost eight years, but due to HIV infection I was forced to come home. Without my knowledge, my employer booked my flight back to the Philippines forcing me to leave Malaysia three hours after they told me I was infected. (Samonte, 2002)

In recent years, the number of migrant workers in the Philippines who have been diagnosed with HIV/AIDS has steadily increased. Of the total number of people living with HIV/AIDS in the National HIV/AIDS Registry in September 2004, 32% are migrant workers. Of these, 17% are domestic workers, 5% are nurses and 4% are entertainers.

In looking at the issue of migration and HIV/AIDS, it is important to examine the risk and protective factors that influence HIV vulnerability of women within the context of migration.¹

Beginning in the 1990s, the feminization of labor migration in Asia has taken on a more predominant turn. In 1976, women migrants from Asia accounted for 15% of the migrant labor force; in 1987, 27%; and in 2000, 47.5% (CARAM-Asia, 2004). In Sri Lanka alone, 80-90% of migrant workers are women; in the Philippines, 64% of new hires are women, while in Indonesia, female migrants comprise over 70% of total migrants. Most of these migrants are from the reproductive ages of 15-35. (Marin and Quesada, 2002)

Why do women migrate? There are various push factors that facilitate the movement of women:

- *Economic and political factors*

I wanted to go abroad because I saw our neighbors going abroad. They would come home with jewelry and lots of money. Their lives were improving. That was what I knew... My mother said I should finish my fourth year in high school so I could graduate. I [told her], "you can't handle it anymore, you even complain about my allowance for school. Don't you want ... our life [to] improve?" (Marin et al., 2004)

Macro level push factors such as economic disparities and political instability strongly influence the movement of people across borders. In the Philippines, about 40% of people live below the poverty line, with about 30% living on P50.00 (about US 90 cents) on a daily basis (ISSA, 2003). In Indonesia, there are about 30.15 million underemployed people and about 7.8 million without jobs. Other push factors include landlessness, domestic or community conflicts, labor export policies, low and variable agriculture productivity, and natural calamities, among

¹ Because there are many categories of migrant women all throughout Asia, this paper will focus primarily on the experiences of women migrant workers mostly coming from the Philippines.

others (CARAM-Asia, 2004). Women in these economies are often the hardest hit because of their low status, illiteracy and political disempowerment.

Socially constructed gender roles ascribe the productive and public sphere to men and the reproductive and private sphere to women. This definitive division has resulted in women having less access and control over productive resources, e.g. in terms of income, land, credit and education (CARAM-Asia, 2004). With decreasing opportunities and choices for women, migration has become a means of survival rather than an option.

Abroad, there is a growing demand for cheap labor among richer, industrially-developed countries. It is this cheap, available labor reserve that is required to do the 3D jobs, i.e., dirty, dangerous and demeaning. Women migrants often fall under these categories, especially those who end up in the service sector such as domestic workers and caregivers.

- *Socio-cultural factors*

Gender selective policies of receiving countries are a result of changing socio-economic conditions, either as more women in richer countries join the workforce or because of higher incomes and affluent lifestyles. Women in the industrialized countries, having higher educational attainments and social aspirations, have entered technically superior jobs leaving a vacuum for domestic work at home. Women from poorer economies are therefore mobilized to take on these roles (CARAM-Asia, 2004).

Women's ascribed traditional role in society is reproduced in the migration sphere. Women migrants are largely concentrated in reproductive work such as domestic work, child rearing and care giving, which are part of the informal sector of many receiving countries. Because this work is not recognized as paid and productive work, women migrants are predisposed to abuses, exploitation and health vulnerabilities (Marin and Quesada, 2002).

Migrating to work abroad may be a personal decision but the family plays a critical role in the implementation of this decision. In most cases, women are forced to migrate by their families in order to provide for the family's financial needs. They have also shown better performance in remitting income (Marin and Quesada, 2003).

Experiences of abuse and violence within the home and the inability to change their situation also push women to leave. Being abroad renders them unreachable from the abusive hands of husbands and partners and affords them a relative sense of safety and security.

Women Migrants and HIV: Risk Factors

In 1997, the Coordination of Action Research on AIDS and Mobility in Asia (CARAM-Asia) began a participatory action research to determine HIV vulnerability of migrant workers in seven Asian countries. This program was implemented in Bangladesh, Cambodia, Indonesia, Malaysia, Philippines, Vietnam and Thailand. In 2000, CARAM expanded its reach to include other countries in South Asia, such as India, Nepal, Pakistan, and Sri Lanka. In the Philippines, five studies have since been generated: knowledge, attitudes, behavior and practices of first time departing Overseas Filipino Workers (OFWs); on-site qualitative research on HIV vulnerability of Filipino domestic workers in Hong Kong; qualitative research on HIV vulnerability of female spouses of OFWs; qualitative research on HIV vulnerability of returning migrant workers; and lastly, life stories of Filipino migrant workers living with HIV/AIDS. The researches covered the

different phases of the migration cycle, from pre-departure, post-arrival or onsite and reintegration.

Pre-departure

There are factors that predispose women migrant workers to HIV/AIDS at the pre-departure phase:

- *Taboos on sexuality*

Existing societal taboos on sexuality hinder women from getting access to information about sexuality and reproductive health issues, including HIV/AIDS.

While awareness on HIV/AIDS is high, actual knowledge about the disease is low. In the research by CARAM-Philippines, migrant workers still correlate HIV/AIDS with certain “high-risk” groups such as sex workers and gay men. Sexuality education, especially among young people, is not openly promoted because of the belief that it will encourage people to engage in sexual activities.

Sharon, one of the participants of the research with HIV+ migrant workers says:

I did not know anything. Not a single thing, even from the radio, I did not hear anything. There was nothing, nothing at all. All I heard of was rape, but not HIV. (Marin et al., 2004)

- *Low Condom Use*

While information about sexuality is withheld, information against the condoms is aggressively pushed. Till today, the use of condoms is seen more as a form of contraception rather than a safer sex method. In a predominantly Catholic country with a very high population growth rate, all forms of contraception are regarded as synonymous to abortion and therefore discouraged. Apart from this, men generally dislike the use of condoms and do not make it easy for women to demand or negotiate its use.

- *Poor health seeking behavior*

Due to economic and socio-cultural factors, migrant workers are predisposed to poor health seeking behavior. Aside from having a tendency to self-medicate, there is also a fatalistic attitude about health and sickness that pervades, even in the advent of actual illness. For women migrants, this has direct bearing on their reproductive health, especially when they are in the jobsite. Fear of losing their jobs and the prohibitive cost of health care services are some of the reasons why migrant workers hesitate to inform their employers about their health condition.

- *Conduct of Mandatory HIV Testing*

Today, HIV testing of migrant workers is increasingly being imposed by receiving countries as a precondition for foreign employment. While HIV testing is important for epidemiological surveillance and as a basis for treatment, mandatory HIV testing focusing on migrant workers violates human rights, reinforces stigma and discrimination and creates a false sense of security among nationals of the host country. The conduct of mandatory testing, oftentimes without pre- and post-test counseling, leads to an attitude of invincibility among migrant workers who test negative for HIV.

Onsite

Once women migrant workers are at the jobsite, they are exposed to actual conditions and situations which render them vulnerable to HIV/AIDS.

Many women migrant workers lead so-called “parallel lives” when they are abroad. Being away from their family, friends and community affords them with a certain degree of personal space and freedom which, if explored or taken advantage of, could lead to many possibilities, including sexual activities or involvements. The narratives of the women migrants involved in the research evidence this:

I wanted to have fun...I wanted something different... Because when I was growing up, I did not enjoy myself, that's why I was looking for it. I was looking for something but I couldn't find it. (Marin et al., 2004)

[I] was also seeking companionship at that time... also wanted someone to lean on whenever [I] had problems. It was not just for sex that [I] entered into a relationship. But sex is a temptation “especially when [one is] lonely.” (Marin et al., 2004)

We are only human beings in need of warmth and comfort. We need to be able to share our experiences with somebody that's why some OFWs cope by getting into intimate relationships with other OFWs or with the nationals of the receiving country. Sometimes they even get into relationships with married men in order to lessen the loneliness and homesickness. However, these relationships can make migrant workers vulnerable to STIs and HIV/AIDS. (Samonte, 2002)

It became very lonely for me being away from home. I felt the need for the closeness and warmth of a family. Then I met and fell in love with a Malaysian man. He courted me and I felt that he really wanted me. He even helped me financially so I could regularly send money home to my mother. I got pregnant eventually but I found out that my boyfriend was already married. I thought of having an abortion but I didn't go through with it. (Marin et al., 2004)

Among the factors influencing overseas workers to get involved in relationships are:

- they are homesick and lonely;
- they are mostly sexually active even prior to working abroad;
- there are no social shackles to “check” their behavior;
- there are peer pressures to get involved in relationships;
- they have a need for sexual gratification;
- a relationship may be economically beneficial to them;
- they are socially isolated and in need of companionship;
- they need respite from the rigors of their work;
- they see marriage to foreigners as a form of upward mobility;
- they actually fall in love (Ybanez et al., 2000).

Underlying all these factors is the social construction of gender and sexuality, which invariably impact on the decisions that women make within the context of migration. The meanings attached to masculinity and femininity and the norms that prescribe women to exhibit passive behavior and restrict them from expressing their thoughts, feelings and attitudes have also pushed them to seek the freedom and the space to express themselves in places away from home. For women migrants, this could mean exploring relationships which they normally would not engage in, e.g. extra-marital relationships or homosexual relationships.

Migrant workers who have preexisting relationships or are married, are confronted with the conflict of remaining faithful to their partners but at the same time responding to their sexual needs (Marin, 2001). This engagement may further entail construction of new or parallel identities which govern the migrant's temporary overseas existence. In cases where migrants need to return to the country of origin on a regular basis, this shifting of identities may at times, create internal dilemmas and conflicts, especially since this inevitably affects the relationships they left behind prior to leaving for abroad.

The experience of being away from situations and conditions that one is accustomed to opens a whole new world of possibilities. However, this new world is also fraught with limitations and restrictions. There are countries where public expression of sexual desires or intentions is not encouraged among migrants, especially women. Policies that forbid migrant women workers to get pregnant, contract a sexually transmitted infection or marry a national of the State impact on their sexual behavior and attitudes. Thus they learn to negotiate their sexuality in these settings. The narratives of male migrant workers attest to the intricate and complicated arrangements that they make with women migrants in order for them to establish physical contact and interaction. Some even go to the extent of getting fake marriage licenses just so they can "legitimize" their otherwise illicit relationships.

Because they have been socially conditioned and oriented to behave and think in certain ways at the country of origin, they cannot easily discard these attitudes and behavior in the foreign country. For example, the expectation for women to be monogamous and men to be "promiscuous" is still the norm even in their relationships abroad. Lovely, one of the participants of the research with HIV+ migrant workers says:

[I was] ... not sure if Robert was really faithful to me since he could not go out every week. Maybe he had a different girl for every week... I'm not really sure. There were times when I saw other girls clinging on to him and his friends would say it's just a friendly gesture. On those occasions, Robert didn't hear anything from me. I would just look at him instead and he would voluntarily get away from them. (Marin et al., 2004)

- *Lack of access to health information and services*

Most migrant workers lack access to health information and services. For women, this is particularly true in the area of reproductive and sexual health. In some countries, seeking these types of information may lead others to suspect their activities and stigmatize them as "immoral" or "loose women" (CARAM-Asia, 2004). Even though they may already be afflicted with reproductive tract infections or sexually transmitted infections, they are restrained from doing so. In many countries, medication and health care are more expensive but not necessarily available and accessible to migrant workers.

In a survey conducted by the Women in Development Foundation, a NGO in the Philippines with 110 Filipino domestic workers in Hongkong in 2002, 44% of the respondents identified genito-urinary infection as the leading reproductive concern. This was followed by pelvic inflammatory disorder (RTD): 17%; unintended/unplanned pregnancy: 13%; and, abortion: 10%. In a subsequent medical mission that involved 376 female patients, 49% were suffering from menstrual disorders; 23% had urinary tract infections; 22% experienced vaginal discharge; and, 15% had cysts/mass in the breast (Marin and Quesada, 2002).

- *Undocumented Status*

Immigration policies are often biased against migrant workers. In many countries, access to justice or legal redress remain limited, even in situations where migrant workers are unjustly terminated from work. Because of family obligations and the prohibitions in finding another foreign employment, many migrant workers end up staying in the country without proper documentation. Most of them take up part-time work or get into sexual relationships in order to survive. Others end up doing “sideline” work, i.e., sex work.

Daisy found out that there were many women, mostly Filipinas who had “sidelines”... The “sideline job” meant going to clubs and bars at night, sitting with customers, entertaining them, and getting a percentage from the drinks the customers buy for the women. A lady’s drink worth HK\$65.00 would fetch HK\$35.00 for a woman. In other clubs, a woman could get as much as HK\$50.00 from a drink worth HK\$80.00. Other bars listed the women’s commissions and distributed the money at the end of the month.

Most of the Filipinas were domestic workers by day, but some, like Daisy, were jobless. They would cruise the bars starting 11 in the evening, would stay briefly in one club and transfer to another, in search of customers, most of whom were Americans and Nepalese. Some of the women would go out with their customers after their barhopping. “I did not know what else they did, I did not want to think [about it],” Daisy explained. (Marin et al., 2004)

- *Women migrants’ vulnerability to sexual exploitation and abuse*

Women migrants are vulnerable to sexual exploitation and abuse. For service workers such as domestic workers, caretakers, nannies, or caregivers, their employment site is in the private realm. Thus, their workplaces do not facilitate monitoring or supervision by concerned authorities and this sets the stage for the occurrence of sexual and physical abuse and violence against them.

Coping Mechanisms

While these coping mechanisms may enable migrant workers to survive the realities of migration and alienation from their families of origin, these are also the same factors that may contribute to their vulnerability.

Establishing social networks

One of the first things that migrant workers do when they arrive is to establish ties with their compatriots. In some cases, they may have family members or relatives to count on but this is not always the case. There are many forms of social networks that exist and they are grouped according to ethnic origins, religious affiliation, occupation, etc. In countries where migrant support NGOs and associations of migrants are allowed to exist, these networks function as virtual support systems and lifelines for migrant workers especially in times of crisis situations.

Communicating with families

Many migrant workers survive their difficult existence abroad when their families communicate with them on a regular basis. In the previous decade, communication with families back home was very difficult, causing significant changes in interpersonal relationships. With the advent of information and communication technology, the distance between the migrant and the family has become shorter. Internet connectivity and mobile phone communication are

becoming more common among migrant workers seeking to maintain ties with their families, for instance enabling them to even actively exercise parental duties. While this is indeed a welcome change, it also has a negative impact for those who have no wish to maintain family ties. This is especially true for migrant workers who complain that it has become easier for their families to nag them about sending more money or material things.

Engaging in sexual relationships

Whether in the context of transactional sex or within a romantic/emotional relationship, women migrants turn to their partners for reasons that have been enumerated above. A positive sexual experience results to an improve sense of self and well-being but a negative sexual experience may cause trauma and anguish. It is worth noting that preferences in terms of partnerships, and the number, timing, duration and choice of partners are influenced by the particular context of the migrant. While Filipino men prefer to have relationships with Filipina women abroad (because they perceive them to be “cleaner” and “safer”) they also have no qualms in having sexual relations with other foreign women. Others get into relationships with the notion that these are fleeting engagements that they would terminate once they go back to the country of origin.

Impact of HIV infection

It's like the moon exploded in your face... [or] a bomb blew off ...Your mind is severed from your body, that's how I felt. My god, what will I do? It's a good thing my friend was there, advising me, helping me... I was shocked, I couldn't accept it. I didn't want to go home. I wanted to be alone. I wanted to be up in the mountains. I cried. I told the doctor I wish that [the result] would change. Because I remembered, I would not be able to work if I was sick. (Marin et al., 2004)

I cried and cried. It did not matter anymore that there were other people in the room. How would I tell my husband? What if I transmitted it to him? How would I tell my family? I thought about my baby. How did this happen? (Marin et al., 2004)

These were some of the accounts of the women migrants who participated in the research of ACHIEVE/CARAM-Philippines. Among the impact that they shared included:

- *Economic Impact*

The most severe impact of HIV infection among migrant workers is economic. Because of mandatory HIV testing, HIV+ migrant workers can no longer work abroad. This is worsened by the lack of local employment and their inability to find jobs that would suit the skills they learned abroad. The high cost of living, coupled with increasing cost of health care due to privatization result to heavy economic burdens. For women migrants who are the primary breadwinners in their families, being HIV+ could mean the end of their dreams and hopes of a better life. Whatever savings they may have managed to stash away, are depleted slowly to support their families and their medication.

- *Social Impact*

Migrant workers diagnosed positive with HIV experience a sudden fall from grace. While previously they were considered as “heroes”, they suddenly find themselves isolated, marginalized and discriminated. The stigma on women migrants living with HIV/AIDS is often greater due to societal perceptions and beliefs about HIV/AIDS as a curse and a consequence of sinful acts. Migrant women are thus perceived to have engaged in “immoral” and “improper” behavior when they were abroad. Such prejudices impact on the social relationships that migrant women living

with HIV/AIDS have with their families, friends and even their communities. Many make the painful choice to not go home and stay away from their families, leading to their further isolation. Some make the conscious decision to not anymore engage in sexual relationships, believing that their HIV positive status has stripped them of that right.

- *Psychological and Emotional Impact*

The impact of HIV/AIDS on migrant workers cannot be measured on economics alone, emotional and psychological adjustments are even more difficult for former migrant workers who have not yet disclosed their condition. The pressure to still provide for their families, the fear of being found out and stigmatized, and the uncertainties about their physical health and well-being, affect the psychological state of migrant workers living with HIV/AIDS. For women, their fear of being judged or stigmatized because of “immoral” behavior adds another layer of distress. On the other hand, migrant men who get infected with HIV, for example seafarers, are more “tolerated” or accepted because it is just “natural or normal” for them to engage in sexual activities.

- *Physical Impact*

Access to healthcare, treatment and support remain limited for people living with HIV/AIDS, including migrant workers. In the Philippines, most PLWH are unable to afford ARV as well as medication for opportunistic infections. Most hospitals are ill equipped to treat and care for PLWH. For migrant workers, the compendium of economic, social and psychological problems impacts greatly on their physical health.

Recommendations

Intervention programs addressing HIV vulnerability of migrant workers require a thorough understanding of the issues that migrant workers face. This can be facilitated by directly involving migrant workers and their families and communities who are affected by the pandemic. For women migrants living with HIV/AIDS, this requires increasing their awareness and knowledge and deepening their perspective in understanding the issues around gender, sexuality, HIV/AIDS and migration. It also entails skills building so that they can meaningfully engage in the responses to HIV, whether in the form of advocacy, education and awareness-raising, care and support activities or capacity building of institutions dealing with migrant workers.

In the Philippines, interventions with the direct involvement of women migrant workers have been undertaken – notably by ACHIEVE/CARAM-Philippines:

- **Institutional advocacy** with national and local institutions to generate policies and programs that address various concerns and needs of its partner communities, particularly in the area of HIV/AIDS response. To accomplish this, ACHIEVE contributes to **building capacities** and enhancing skills of various stakeholders and key players in handling issues and cases related to migration, gender, sexuality and health/HIV/AIDS issues.
- **Information management** on migration, health, gender and sexuality. This entails operating a resource center, development and maintenance of a website and monitoring of media information. ACHIEVE produces information with and for migrant workers for purposes of policy and program advocacy.
- **Spouses and partners empowerment program:** capacity development of female spouses and partners of migrant workers by 1) providing education opportunities on gender

issues, reproductive health, sexuality, migration and HIV/AIDS; 2) building and enhancing life skills, assertive communication, safer sex practices, home management, among others; and 3) supporting community organizing and mobilization efforts.

- **Community-based pre-migration program on health, sexuality and HIV/AIDS**, with the local government and community organizations of migrant worker returnees. Such intervention equips and enables communities of prospective migrants to recognize and address any actual or potential vulnerability that they face as future migrant workers.
- **Empowering spouses and migrant workers living with HIV/AIDS**, in order to enhance their involvement in education, advocacy and networking activities, through knowledge and skills building activities.
- **Regional advocacy and campaigns**: campaign against mandatory HIV antibody testing, campaign for access to treatment and greater involvement of migrant workers living with HIV/AIDS, campaigns on issues and concerns faced by foreign migrant domestic workers.

In the implementation of these interventions, ACHIEVE promotes the following principles and approaches:

- Rights-based approach;
- Participatory and based on migrant worker's realities;
- Enabling and empowering;
- Gender Sensitive and respects diversity;
- Holistic and integrated;
- Research-based;
- Must be sustainable and long term;
- Must involve key players and stakeholders in the migration arena.

Conclusion

Migration for overseas employment is expected to increase, along with the rise in numbers of people living with HIV/AIDS. The challenge brought about by HIV/AIDS within the context of gender and migration realities requires immediate responses. Joy Samonte, a former migrant worker and activist says it clearly and succinctly:

When we are healthy, we are heroes. But when we get sick, what happens to us? The time to act is now. Together, let us empower migrant workers against HIV/AIDS. Save lives. Stop AIDS. (Samonte, 2002)

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HIV in the Caucasus: The Importance of Family Networks in Understanding Women's Risk Settings¹

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The independent states of the southern Caucasus – Armenia, Azerbaijan and Georgia – play an increasingly important role in global energy markets, in international labor flows and in international efforts to combat narcotic trafficking. Located between the Black and Caspian Seas and bordering Russia to the north and Turkey and Iran to the south, the region struggles with persistent poverty, collapsing public health infrastructure, on-going ethnic tensions, and significant concerns over the porous nature of their borders. While recent economic and political developments such as Georgia's "Rose Revolution" in 2004 support positive future development trajectories, the inclusion of the region within the coming "second wave" countries in the HIV/AIDS pandemic raises serious threats to social stability, economic development and governance. HIV prevalence is presently low across the region but steep increases in the number of reported cases and shifting transmission modes (from intravenous drug use to sexual transmission) are a clear cause for concern. The recent rise of HIV infection rates in countries such as Ukraine and the Russian Federation illustrates both the rapidity with which HIV infection can spread within national populations and the emergence of a potentially important mechanism of transmission, temporary labor migration. Across the southern Caucasus hundreds of thousands of migrants, mostly men, travel to countries such as Ukraine and Russia as temporary laborers, generating important alterations in risk related behavior among themselves and their families.

This paper examines temporary migration flows out of the southern Caucasus in historical and cultural context in order to better assess their influence on the transmission pathways and growth trajectory of HIV in Georgia, Azerbaijan and Armenia. What are the direct and indirect effects of large scale labor migration from the region on HIV risk related behaviors? Can the socio-cultural context of the region extend and expand our understanding of the ways in which male out migration directly and indirectly alters the risks faced by migrant families generally and wives specifically? The paper is divided into four sections designed to address these questions. The first section provides an overview of the HIV/AIDS pandemic in the region, focusing on the changes in transmission routes and risk groups over time as well as the specific cultural and social norms underpinning HIV risk related behaviors. The following section examines labor out-migration in the region. The third section then turns to an expansion of the way in which the link between HIV risk related behaviors and migration is theorized, focusing on potential behavior changes within migrant families. Lastly, I discuss programs focusing on HIV/AIDS education, prevention and treatment targeting migrant families, emphasizing the importance of shaping interventions to suit the socio-cultural context of the south Caucasus.

¹ This paper partly stems from a UNESCO/FLANDERS Funds-In-Trust project: "Culturally Appropriate IEC for HIV Prevention in the South Caucasus Countries".

HIV/AIDS in the southern Caucasus

The first cases of HIV infection in the southern Caucasus were registered in the late 1980s, when the region was part of the Soviet Union. As in many regions of the former Soviet Union, massive testing was conducted in Armenia, Azerbaijan, and Georgia during the early 1990s, including all pregnant women, hospital patients, and men enlisting in the armed forces. The total number of reported HIV infections however, remained very low, until the late 1990s, when the number of cases began to rise markedly each year as seen in Figure One. In 2003, the number of officially reported cases in the region totaled 1,220. Local reports point out that many of those infected had traveled abroad, or been with foreigners, adding to the perception of HIV/AIDS as an “outsiders” disease.

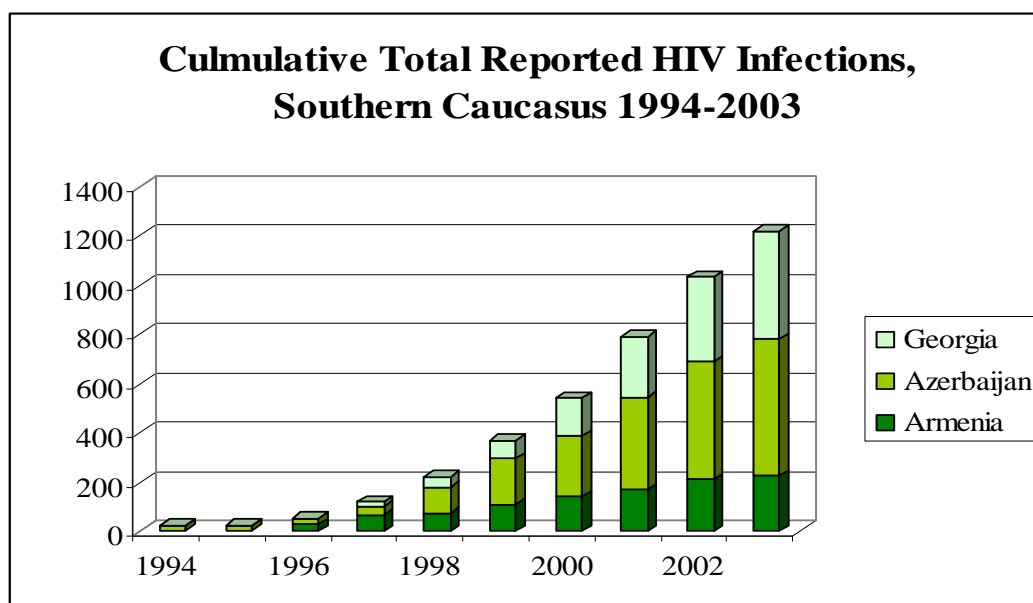


Figure One

Source: WHO/CISID <http://data.euro.who.int/cisid/?TabID=39145>

The number of adults reported to be HIV positive per 100,000 in Azerbaijan was 1.93 in 2003, in Georgia 1.42, and in Armenia 0.76. Contrastingly, HIV rates per 100,000 adults in the Russian Federation were 27.64 and in Ukraine 20.77 in 2003¹ (WHO/CISID). As other Eurasian countries, people living with HIV tend to be young, urban, and male. Official statistics identify 127 total AIDS-related deaths in the region since 1989. However, changing patterns in the modes of HIV transmission and co-morbidity with tuberculosis point to a potentially rapid expansion of HIV infection and AIDS-related illnesses.

The main transmission route for HIV infection in the southern Caucasus is intravenous drug use, but patterns are shifting. Specific cases of contracting HIV through medical procedures have occurred, but they remain rare even though over 20 of every 100,000 blood donors in Azerbaijan and Georgia, (where donations have been traditionally paid) is HIV positive (Euro HIV, 2003, p.13). Men who have sex with other men remain highly stigmatized in the region, with identities kept secret. Most reported sexual transmissions of HIV are classified as heterosexual, and recent trends suggest a shift away from transmissions linked to commercial sex workers. Increasing number of new HIV infections attributed to sexual transmission indicates

¹ While overall HIV prevalence is higher in the Russian Federation, AIDS prevalence is highest in Ukraine.

that intravenous drug users (IDUs) may be serving as a bridge population to sexual transmission of HIV, similar to the experience of Ukraine in the early period of rapid growth of HIV infections (Euro HIV, 2004, p.8; CEEHRN, 2002). The growing importance of sexual transmission marks an expansion beyond traditional core risk groups and an increase in the number of women living with HIV in the region. As sexual transmission of HIV gains importance, infection rates are likely to grow rapidly. The impact of such increases may well be compounded by the relatively high rate of tuberculosis in countries such as Georgia. Tuberculosis increases the odds of HIV infection once exposed, and appears to hasten the development of AIDS among those who are HIV positive (WHO, 2004).

Across the region cultural practices, social norms and economic coping strategies create an enabling environment for the transmission of HIV and the development of AIDS. Culturally and religiously distinct, Armenia, Georgia, and Azerbaijan each adhere to deeply ingrained norms concerning gender roles and sexuality. Sexual activity outside of marriage, increasingly common, is nonetheless strongly stigmatizing for women. Within marriage, men retain household authority and responsibility for material provision. In spite of significant strides in educational attainment and employment outside the home for women during the Soviet period, the post independence period has witnessed disproportionate female unemployment and increasing emphasis on traditional gender norms and roles, often supported by increasing religious identification and stress placed on ethnic traditions. Social norms discourage the discussion of sexual health, even within families. The adoption of comprehensive sexual health education in schools has not occurred in any of the countries. As a result, young women are especially reluctant to seek information concerning sexual health, and many young people are unaware of reproductive and sexual health issues at the time of sexual debut. Numerous national and regional studies centering on reproductive health have found extremely low levels of knowledge concerning the transmission, symptoms, and treatment of HIV/AIDS.

Over taxed public health infrastructure, resource constrained government budgets and widespread poverty are often cited limiting influences on the ability of Armenia, Azerbaijan and Georgia to unilaterally launch large scale educational, prevention or treatment programs targeting HIV/AIDS. Since independent in 1991, state-provided universal health care has crumbled. Treatment for pay in private clinics has emerged across the health sector but remains out of the reach of many citizens. Some state run clinics are functioning, but the quality of care varies and according to some studies the informal payments expected for services rendered put many out of the market for “free” health care (Lewis, 2000). Funds to bolster the public health system are not likely to come from state budgets. Future income from oil sales in Azerbaijan and pipeline construction and maintenance in Georgia may be on the horizon, but at present government budgets are tightly stretched. Long term investments in public health compete, often unsuccessfully, with security interests, public transfer programs and economic development projects for limited state funds.

Widespread poverty in the southern Caucasus amplifies emergent public health concerns in the region, such as HIV/AIDS. Estimated poverty rates vary dramatically by the methodology employed, but most survey estimates indicate approximately 50% of each of the three populations live below their national poverty threshold. Poverty elevates HIV risk indirectly, by decreasing access to health care, accentuating the negative physiological effects of stress and leading to increased rates of negative health behaviors such as smoking, alcohol and drug use. Antidotal evidence indicates a more direct link between financial hardship and HIV-risk, as some women report begin pushed into commercial sex work in order to provide support for their families (Babayan, 2002). The economic dislocation and poverty of the 1990s also intensified reliance upon temporary labor out-migration. Destination countries have expanded, but most

migration flows remain directed towards the Russian Federation, and in some cases Ukraine (UNICEF, 2004). This factor will most likely play an important role in determining the trajectory of HIV transmission in the region, as migration serves as an important mechanism for the spread of HIV infection in several countries and context (Quinn, 1994).

Labor migration from the southern Caucasus

There is a long standing tradition of temporary labor out migration from the countries of the southern Caucasus into Russia. Economic forces continue to generate substantial out migration from the southern Caucasus, enabled by Soviet era networks for both registered and unregistered migration flows. Soviet era labor brigades from the region, often specializing in seasonal construction work, both lessened the negative effects of labor shortages in Russia and provided important opportunities for migrants to gain financial resources for weddings, home construction, and other capital intensive activities (Shabanova, 1991). Such brigades often originated from a single region of origin and worked with farm and enterprise managers on request, using a wide variety of formal and informal labor agreements. Migrants involved in small- to mid-scale agricultural marketing provided another element of population transfers between the southern Caucasus and Russia and Ukraine. In spite of the economic dislocations experienced by all of the Soviet successor states during the 1991 transition, labor market opportunities in Russia and Ukraine remained relatively attractive to individuals in the southern Caucasus, while preexisting network linkages and migration experiences served to diminish the uncertainty in the migration decision making process.

Since 1991, emigration from the region has been especially high. Much of the population movement has been unregistered and estimates vary widely. Gagik Yeganyan, the director of the Department of Migration in Armenia estimates that at least 800,000 Armenians left the country during the 1990s (Pope, 2002). Minimum estimates for out migration from Georgia and Azerbaijan during the same period are approximately 500,000, and the entire region continues to lose population through negative net migration. In Moscow alone, there are an estimated 250,000 migrants from the southern Caucasus, although only 100 of them are properly registered with the tax authorities (Migration News, 2002).

Structural incentives to avoid registration, either upon leaving the origin location or arriving at the destination are significant. Individuals leaving a region are likely to maintain registration in anticipation of return or in order to protect ownership rights to housing. Registration at destination can be costly or hindered by visa restrictions. Although the Russian Federation presently mandates the use of migration registration cards among all migrants, it remains extremely difficult to obtain legal registration in Russia (ITAR/TASS, 2003). Migration networks can assist individuals in circumventing or engaging in legal requirements by providing information, assistance networks and social support during and after migration (Massey et al., 1998). As during the Soviet period, socially bounded and regionally concentrated networks facilitate migration, leading to concentrated areas of out-migration.

The global feminization of international migration has been noted by several scholars, but the migration flows from the southern Caucasus remain predominantly male. Social and cultural norms emphasizing the importance of the male breadwinner role and male economic responsibility for the family are strong throughout the region, making men more likely to migrate in hopes of finding worthwhile employment. Correspondingly, embedded practices emphasizing female responsibility for the instrumental needs of the family may act to decrease the likelihood of moving for women. Of even greater importance are the influences of pre-existing networks,

focused on male occupations, and labor market demands for physically demanding low skilled labor at the destination. Migration networks and social ties can facilitate migration, destination labor demands significantly influence who is most likely to utilize networks. Labor migration across the Caucasus remains a primarily male activity. Various studies indicate that men comprise somewhere between 65 and 90% of estimated economic migrants in the region. Additionally the majority of migrants leave spouses and dependent children at the place of origin (UNICEF, 2004).

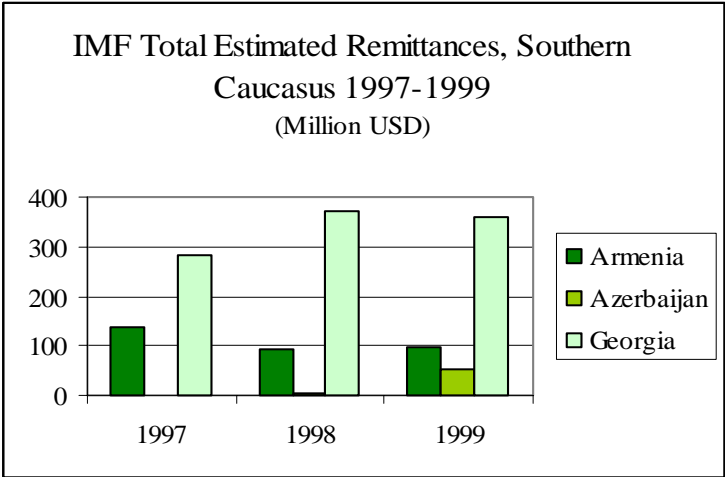


Figure Two.
Source: IMF

<http://migration.ucdavis.edu/mn/data/remittances/remittances.html>

Migrant remittances are extraordinarily important to the economies of Armenia, Azerbaijan and Georgia. They also highlight the persistence of ties between individuals migrating and their families remaining at the origin. Remittances back to the region are extremely difficult to access due to the poor financial infrastructure in the region and the incentives to keep remittances under cover linked to taxation policies. Developments within the commercial banking sector and the advent of commercial wire transfer services are promising, but much of the remittance flows are still carried out through hand to hand transfer, escaping capture in most approaches to remittance measurement. The existence of estimable remittances shown in Figure Two, especially on the large scale observed in Georgia; indicate that the migration process includes more than just the individual migrant. The implications and challenges of migration, and the potential financial benefits, are experienced across the family systems of migrants.

Migration, Families, and HIV/AIDS-Related Risk

A sizable literature links the process and challenges of migration to various mechanisms leading to elevated HIV risk for migrants and, secondarily, their spouses. Most of the literature focuses upon attitudinal and behavioral changes likely to occur among migrants, emphasizing that it is the migrant who must adapt to new socio-economic roles, decreased social control and altered social contexts, while maintaining obligations to social networks that may be far away. These processes are amplified by the need to strategize behavioral choices in light of anticipated duration of residence at destination. Yet, within family systems, do these migration effects differ significantly between those who move and those who remain at the origin? Spouses and children of migrants also must adapt to new roles, decreased social control and altered social setting.

Moreover, these choices also vary by the expected and experienced duration of migrant absence. The adaptation choices made within migrant families at the origin may have direct and indirect implications for HIV risk, reflecting and expanding the risks faced by individual migrants.

Migration is clearly linked with elevated risk for contracting HIV, for both men and women and across a number of socio-economic settings (UNAIDS/IOM, 1998). Recent research indicates that migrants actively renegotiate and reconstruct sexuality as they adapt to new socio-economic roles in the settlement process, as seen in Ghana (Anarfi, 1993). Evidence from India indicates decreased social monitoring and control can increase the likelihood of migrants engaging in commercial sex work or employing professional sex workers (Mishra, 2004). Similarly, migrants may tend to have more partners than non-migrants due to issues of exposure, altered social settings and decreased social monitoring, as found in Mexico (Magis-Rodriguez et al., 2004). Within the countries of the former Soviet Union, migrants may seek to diminish the stress of resettlement through the use of drugs or alcohol, behaviors that impede responsible decision making at best, and directly expose migrants to HIV infection at worst (CEEHRN, 2002). Lastly, migrants typically exhibited lower levels of health care utilization and medical treatment, linked to a lack of knowledge concerning health services availability at destination, issues of access and expense (Decosas et al., 1995). Many studies examining the link between migration and HIV risk stress the adaptation and decision making processes among migrants. The elevation of HIV risk for migrant partners is acknowledged, but primarily attributed to secondary exposure by their partners high risk activity. Suggestions for effective policy interventions to decrease HIV risk tend to focus on the destination and are aimed at migrants individually (Dawson and Gifford, 2003). Expanding theoretical approaches to include members of migrant family networks as active decision makers enables a more comprehensive examination of sexual health risk factors within migrant sending communities generally and is particularly well suited to the context of the southern Caucasus, where migration of household members influences various indirect and direct behavioral and relational risk factors associated with HIV/AIDS.

Members of migrant family systems face challenges similar to those of migrants in adjusting to changes in their cultural, social and economic context. This is especially true among the adult female partners and spouses of migrants. The influence of migration on women generally, and their risk for HIV/AIDS specifically, cannot be fully understood through the analysis of individual women migrants alone. The migration of household members, especially partners or spouses, can profoundly influence women's behavioral and relational HIV risks as well as influence the likelihood of familial communication concerning sexual and reproductive health between parents and children.

Out-migration of household members can motivate the reconsideration and rebalancing of familial and in some cases gender roles within family systems. Such renegotiation may be beneficial to female spouses and partners, as male out-migration is often associated with increased autonomy for women. Although the permanence of such expanded autonomy after the return of male migrants is poorly understood, increased autonomy may expand the behavioral choices open to women in migrant family systems during the migration process. Alternatively, the temporary labor migration of adult men can lead to an increase in "hidden" female headed households, which throughout the region are more vulnerable to a variety of social ills. This vulnerability may manifest indirectly through the poverty associated with remittance interruptions. Reliance upon remittances provides a fragile path of economic support and stability for families, a fragility compounded by difficulties with the banking system in the southern Caucasus. Direct manifestations of vulnerability can appear via decreased community standing, social marginalization, and susceptibility to male relatives or neighbors. Lastly, women

maintaining migrant households at the origin shoulder an increased burden in terms of child rearing and health education.

Previous studies in the area of migration and HIV highlight the risks of male labor migration for non-migrating spouses in terms of the latter's diminished capacity for negotiation and their dependence upon the migrant socially and economically. The non-migrating spouse is often seen as subject to *relational risk*, which operates through her relationship to a migrating spouse or partner. Such relational risk may operate directly through sexual contact with a migrating spouse or partner. Studies in a variety of settings indicate that men engaged in migration are more likely to engage in behaviors associated with elevated HIV risk. When temporary male migrants return home, they transfer their elevated risk to female spouses and partners, who due to cultural norms, economic dependence, and social practices are unlikely to question male fidelity, or initiate condom negotiation.

Relational risk also operates indirectly, as the absence of a male spouse or partner can signify or amplify the relatively powerless position of women. Women without a resident spouse or partner may be seen as targets for exploitation by others, either economically or sexually. In regions with high rates of temporary out-migration, women may band together in order to minimize opportunities for exploitation, but in areas in which female headed households are seldom seen or viewed as transgressing social norms, women may be at increased exploitation risk. Lastly, even though large scale survey data are lacking, antidotal evidence indicates that men engaged in traditional forms of temporary labor migration within the southern Caucasus are often more traditional than non migrating men in terms of cultural norms. Informal interviews support the interpretation that temporary male migrants often deem violence towards wives as acceptable. Victims of domestic violence, male or female, face indirect relational risks with their partners. The risks of initiating discussions concerning condom use or fidelity often out weight the potential benefits.

The appreciation of both direct and indirect relationship risk factors is critical for understanding the ways in which male out-migration influences the HIV risk for female spouses and partners. However, in viewing women's social and economic context primarily in relation to male migration, relational risk approaches tend to minimize female autonomy and agency. Migration is an inherently social process, altering the context for the calculation of priorities, process of decision making and behavior. As migration is best conceptualized as taking place within family systems, greater attention to the ways migration influences the decision making and behaviors of women who remain at the origin is of significant importance. Expanding our understanding of the effects of migration on women within family systems to include *behavioral risk* factors highlights women's agency and extends our understanding of the links between migration and HIV risk.

Women within migrant household may elevate their HIV risk through the pursuit of risk related behaviors, or through their prioritization of health care and investments for the household, including the education of children in the areas of reproductive and sexual health. Female spouses or partners of male migrants, similar to the migrants themselves, may turn to HIV risk related coping behaviors such as alcohol or drug use to cope with the challenges for migration within the family system. The absence of a spouse may signal a decline in social monitoring and control, leading to increased opportunities to pursue a variety of coping strategies. Long term spousal absence may also be associated with additional sexual partners for women. While throughout the region, professed sexual mores for women are quite restrictive, national surveys and expert interviews indicate that some women are sexually active prior to marriage and outside of marriage once wed, a topic in clear need of further research. Within

family migrant networks, the behavioral choices of the non-migrating spouse or partner should also be taken into consideration.

Similarly, the decision making processes women in migrant household employ regarding health care access and investment significantly influences the health of the family system. Throughout the southern Caucasus, women are responsible for their health as well as the well being of children and their spouse but do not always possess the concurrent economic authority to invest in health care. The precarious economic support represented by remittances can lead to brittle household budgets, constraining health related choices. Seeking medical care, increasing expensive throughout the region, may be viewed as an expense best avoided. Even when needed, questions regarding economic authority may diminish the likelihood that women within migrant families will seek health care, especially for themselves. As diminished access to health care is associated with increased HIV risk, health care decision making processes take on added importance.

Finally, parental responsibility within households is altered during the process of temporary labor migration. Migration changes the context for making health education decisions concerning young adults. When, as in the southern Caucasus, labor migration tends to be predominantly male, *de facto* female headed households face increased burdens regarding child care and child rearing. While studies to date in the region indicate that familial transmission of reproductive and sexual health information to young adults is low, the transmission that does occur is strongly gender specific. Mothers and sisters discuss reproductive and sexual health with daughters, fathers or brothers with sons. In such a context the familial transmission of reproductive and sexual health information may be hindered, particularly among young men with migrant fathers. In the absence of national reproductive and sexual health education programs in the region, family transmission of information can become increasingly import. Migrant families, due to gendered norms regarding the transmission of information, are less able to rely upon family channels for sexual or reproductive health information. Mothers in migrant households face difficult decisions concerning the transmission of reproductive and sexual health information to young males within their households. While cultural norms make such discussions very unlikely, deciding not to discuss reproductive and sexual health issues with all young adults in the household increases the likelihood that overall sexual health knowledge levels will remain low, elevating HIV risk.

Implications and Discussion

Labor migration flows from the southern Caucasus have been sizable, predominantly male, and directed towards regions such as Russia, with substantially higher HIV prevalence. While the inclusion of the region in the HIV/AIDS pandemic is recent, increasing prevalence rates, low knowledge levels, and shifting transmission patterns from intravenous drug users to sexual transmission combine with these migration patterns to raise serious concerns regarding the future spread of HIV/AIDS in the region. In accessing the ways temporary labor migration will influence risk patterns and behaviors associated with elevated HIV risk, this paper attempts to highlight the importance of including the potential relational and behavioral risks experiences by the female spouses and partners of migrants. The effect of migration within families alters the decision making context for women who remain at origin. The social, behavioral, and economic decisions of these women, often acting as heads of households, are shaped by the influences of migration but also reflect autonomy and agency, often masked by approaches focusing upon relational risk alone. Examining women's actions and adjustments to temporary labor migration

lends insight into how family networks cope and how these coping mechanisms relate to potential HIV risk.

Focusing upon migrant families, both women and children, provides a promising entry point for programs and educational efforts relating to sexual health. Increased efforts to address the needs of migrant families, through the targeting to remittance transfer points, post offices, and international telephone exchanges can be effective in addressing the needs of not only the mover, but the entire family. Attempts to improve family transmission of sexual and reproductive health information, keeping in mind cultural norms, may be of great assistance to young women. However, such programs will fail to address the needs of young men in migrant families, who will need alternative interventions. Programmatic efforts including increased education, targeting individual migrants can be effective, but fail to address the needs of women heading migrant families living in sending regions. An increased appreciation of the relational and behavioral risks of women in migrant families is vital.

Over the past decades, migration scholars have increasingly shifted analytical frames away from standard neo-classical evaluations of individual migrants towards a greater appreciation of, and reliance upon, families and migration networks (Massey et al., 1998; Castles and Miller, 2003). These approaches have reframed the answer to the question “Who migrates?” beyond individual experiences in order to include the direct and indirect influences migration exerts within networks, such as family systems. In order to accurately assess the influence of migration and gender on HIV risk, the analytical focus should strive to capture the influence of migration upon those actors who physically move, as well as actors who experience significant alterations in their life situations, contexts, and decision making opportunities due to their relationship to the mover. Put another way, in societies with strong familial bonds such as the southern Caucasus, it is not only individuals who migrate, but family networks as a whole.

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The Fifth H: The Question of Women Immigrants and AIDS in France

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In 1988, the magazine *Cosmopolitan* published an article by a psychiatrist “who endorsed the theory that women whose vagina was in good health did not have to worry about AIDS, even if they had had sexual relations with an infected person” (Elbaz, 2004, p. 68). The article did say, though, that certain women were particularly vulnerable – “African women” – and linked heterosexual transmission of AIDS in Africa to “the existence of sexual practices based essentially on violence (...) which we would consider to be rape but which constitute ‘normal sexuality’ over there” (Crimp, 1990). In the days following publication of the article, members of the ACT UP New York women’s caucus demonstrated in front of the magazine’s offices, condemning the author and demanding the publication of a counterclaim. It marked the birth of activism focused on women in the epidemic. In New York in the late 1980s, AIDS was the main cause of death of 25-34 year-old women, most of them “black or Latin American, with no access to clinical trials or, more generally, medical care” (Elbaz, 2004).

The story might seem rather bizarre if it did not highlight a basic issue in the social concerns and customs of women as a category in the history of AIDS, namely, that of combating invisibility.

A few years later, in 1993, President Clinton signed the NIH Revitalization Act which, among other things, required the inclusion of women and minorities “as subjects” in clinical trials which had theretofore been almost exclusively reserved for white, homosexual middle-class men (Epstein, 2004). That same year, certain female cancers were included in the list of AIDS-defining pathologies, thus dramatically increasing the number of AIDS cases among women in the United States of America (Elbaz, 2004).

Elsewhere, in countries of the South, women’s access to anti-retroviral drugs has long been confined to treatment during pregnancy to prevent transmission to the unborn child. It is only as “reproducers”, then, that women were taken into consideration and given health care. Today, specifically women’s issues – such as the social implications of not breastfeeding and of caring for the sick, are still mostly ignored. For instance, there has been practically no study of strategies for the replacement of maternal breastfeeding. As Alice Desclaux (2004) has stressed, the “gendered” nature of legitimate research subjects results in selective blindness. This is also the case in France where, until 1995, women were seen as a specific group only “in two particular situations, pregnancy and prostitution”.² It is only since 1997 that public prevention policies have targeted “women” and not merely “mothers” or “prostitutes”.

These seemingly disparate factors illustrate the belated realization of the epidemic’s implications for women and the recurrent constructed images of women as subjects of prevention and/or treatment policies.

¹ Many thanks to Alice Desclaux for her criticism and remarks on an initial version of this text, to the Sciences de l’Homme group and to the French National AIDS Research Agency (ANRS).

² Conseil national de l’évaluation, Commissariat général du plan [National Evaluation Council, French Planning Office]. *La politique de lutte contre le sida, 1994-2000*. Report of the body chaired by Christian Rollet, 2004.

The story in the introductory paragraph also sheds light, through the reference to African women on another aspect of the public health approach to AIDS. The arguments about “African sexual behaviour” may be offensive, but they nevertheless fit into the particular historic sequence of what constitutes “African AIDS” (Dozon and Fassin, 1989). It is therefore the theme of “promiscuity” and the practically obsessive and “over-culturalizing” focus on particularly “loose” sexual behaviour (Fassin, 1999) which constitute the framework for appraising the epidemic’s implications in that part of the world, thereby obscuring not only other ways by which the infection is transmitted but also the political economy on which the unequal distribution of AIDS is based (Fassin, 2004). Owing to the prevalence of heterosexual transmission in Africa, African women were very early on included in social constructions of AIDS (Le Palec, 1997).

For that reason, on the whole, the question of women in the epidemic oscillates paradoxically between invisibility and visibility (or blame) and is not set within a univocal framework. The first part of this article will endeavour to describe and explain this paradox, drawing on anthropological analytical factors that highlight the invariables within which the social implications of sexuality and the constructions of masculinity and femininity are confined.

Two main features stand out in the analysis of this paradox. The first concerns the history of the epidemic and the second, more broadly, the implications and impact of male domination and inequalities in gender relations that are revealed by representations of women’s bodies – from lay or scientific theories of “conception” in the history of medicine to popular assumptions that “sexually transmitted diseases” are “women’s problems”.

Within this general framework, the question of foreign and/or immigrant women and AIDS in France will be addressed specifically and particular emigrant/immigrant groups will be used as examples in placing the issue in its social and historical context. Today in France the issue of foreign and/or immigrant women and AIDS is related to the high prominence of sub-Saharan African women in the epidemiological statistics on new infections. This trend is to be found far beyond the borders of France, being a major trend in the epidemic in Western Europe, and is due in part to problems of access to treatment in most European States. The example examined here, however, will be that of emigrant/immigrant women from the Maghreb because they are historically the first “category” of women to have been the subject of research. As early as 1991, the *Conseil National du Sida* (French National AIDS Council), a national ethics body set up specifically to deal with AIDS, commissioned research on “Muslim women and AIDS” from two anthropologists (Marzouk, 1991; Shabou, 1991). At a time when there was a remarkable dearth of research on women, it was the theme of “Muslim women” that predominated, and this is mirrored by the fact that the term “migrants” in AIDS prevention and/or treatment in France has long “meant people from the Maghreb living in the outskirts of major cities in tower blocks built in the 1960s and 1970s” (Haour-Knipe, 1998, p. 162).

There are therefore two aspects to the “immigrant question” in AIDS policies in France. Under its immigration policies, labour immigration was officially halted in 1974 leading, through the encouragement of family reunification, to the lasting settlement of immigrants from the Maghreb, linked to French colonial history, thus “swelling the ranks of the deprived” (Fassin 2002, p. 15). In the second place, the toughening of entry and residency conditions in the 1990s led to the “production of irregulars”, that is the rise in the numbers of persons without official papers, whether new arrivals or people who had not renewed or even obtained a residence permit even after many years’ residence in the country. In this scheme of things, two questions arise when immigration is linked to AIDS. The first concerns persons without official papers and at the same time forms part of the political economics of North/South inequalities and the toughening of the repressive laws regulating entry and the right to stay on the national territory,

which has made it considerably harder for foreign nationals in a precarious administrative situation to gain access to health care. Since 1998, when France adopted measures prohibiting the deportation of foreign nationals afflicted with a serious disease and then allowed them to have a temporary residence permit,¹ disease has afforded access, on compassionate grounds, to recognition of a status in France. The second question relates to what many countries, especially Anglo-Saxon countries, call “ethnic minorities” (Fassin, 2002), in particular regard to the over-representation, in terms of levels of infection and problems of access to health care (borne out in part by official figures but also by the observations of social and health workers), of emigrants/immigrants from the Maghreb, most of whom hold French nationality. Although the most recent figures on new infections relate primarily to a more recent migration inflow which is duly highlighted,² the example of post-colonial waves of migration from the Maghreb given in the second part of this article has a double heuristic value.

This example may be used first to place the question of gender and the social status of immigrant women within a longer time-frame to elucidate the link between societal macro-phenomena and the women’s experiences which will be examined. Secondly, it will be used to throw light on contexts in which the epidemiological situation in the societies of origin is not comparable with that in some sub-Saharan African countries. In fact, the epidemiological situation in the Maghreb is one of low prevalence of AIDS, even though local actors fear that the epidemic will develop in the years ahead (Jenkins and Robalino, 2004). In addition, the history of the epidemic in that part of the world has from the outset been consistent with its colonial history in that, in the case of Algeria, Morocco or Tunisia, the first AIDS cases in the latter half of the 1980s were overwhelmingly linked to persons who had lived in Europe and been deported to their parents’ country of origin and who often had a history of intravenous drug use and imprisonment. Thus, as the epidemic took hold in the societies of origin, in addition to the image of “foreigners” universally seen as the “original importers of the virus”, they were regarded as “emigrants”, “at risk” or responsible for importing the epidemic (*Le Journal du sida*, [AIDS Journal] 1997; Dialmy, 1998).

Women between invisibility and blame

The social effects of origin theories

In Gmerck’s history of AIDS (1986), it is recalled that there is sometimes a fifth H in the 4-H theory developed by epidemiologists in the United States of America on the basis of a “small series of cases” (Pollack, 1991). Thus, while Homosexuals, Heroin-users, Haemophiliacs and Haitians were designated the basic groups at risk, a fifth, namely Hookers, could be added to the list. It has been stressed that “the disease has been perceived essentially as a male disease and the

¹ France is the only country in Europe to have legally defined a category of “foreign national afflicted with a serious illness requiring treatment whose unavailability in the country of origin would have extremely serious consequences”, (Article 12bis 11 of the 1945 order). See Musso-Dimitrijevic, S. L’ “étranger malade” : éléments d’histoire sociale d’une cause [The “sick foreigner”: Elements of the Social History of a Cause], in Fassin, D. (ed.) *Un traitement inégal, les discriminations dans l’accès aux soins* [Unequal treatment, discrimination in access to health care]. Report of the *Centre de Recherche sur les Enjeux Contemporains en Santé Publique* (CRESP – Centre for Research into Contemporary Public Health Issues), 2001.

² On 8 June 2004, the French Minister of Health wrote in a major daily newspaper on the occasion of the publication of the figures of new HIV infections: “One of the major lessons of the new epidemiological table is that it may be misleading and disastrous to think that, as far as epidemics transmitted from person-to-person are concerned, we are unaffected by contagion in other countries. SARS has brought this back to mind, and so has AIDS. We should have no fear of speaking out on the subject. The epidemic in France mirrors the epidemic that is spreading unchecked in the countries of the South and in particular Africa.”

famous 4H series is understood to refer to men (...) this occultation series in itself constitutes for anthropologists a data series that draws attention to relations of domination and inequality, analysis of which inevitably refers to social gender relations” (*Journal des anthropologues*, [Anthropologists’ Journal], 1997), but there have been few comments on the fifth H in the series.¹ It is nevertheless the category used in most stereotypes incriminating women.

Laurent Vidal, referring to his fieldwork on AIDS in Africa, questions the definition of prostitution:

“We know in this respect that the term covers a wide range of behaviour and individual social situations (depending on the number of partners, the price of the sexual relation, the use or not of condoms). Consequently, observing prostitution practices only to hold forth about ‘prostitution’ amounts to equating unlike analytical and empirical categories.” (Vidal, 2000).

The social use of the word “prostitution” may encompass a set of signs (clothing, make-up, and so on), leading to the stigmatization of all unmarried women of child-bearing age. Whereas in the countries of the North AIDS was primarily a male (and peculiarly homosexual) disease in the early years of its development, in many African societies, “women featured from the outset in the social construction of the epidemic”.² As AIDS is always “other people’s disease”, the elsewhere and otherness conveyed by the categories of “gay” and “drug addict” in the North mirror the categories of “prostitute” and “migrant” in the South (Taverne, 1995).

Women’s problems

In many languages and societies, sexually transmitted diseases are known as “women’s problems”. Researchers working in contexts ranging from Kanak societies³ to Burkina Faso⁴ have looked at popular classifications and descriptions of disease concerning these “women’s problems”.

In Morocco, the term “*el berd*”, which means “the cold”, tends to designate all sexually transmitted diseases, which are also described as “women’s problems”. Gonorrhoea can also be attributed to the cold. A large number of prescriptions and proscriptions relate to the need for women’s bodies to combat the cold by which they are ontologically characterized. So, when a woman cannot become pregnant, she is given decoctions which are supposed to “warm her womb”, but which are proscribed during pregnancy, particularly in the first few months when care must be taken to avoid overheating – heat being characteristic of the pregnant woman who no longer loses blood every month.

For Françoise Héritier, using the heat/cold duality to characterize male and female bodies is a result of what she calls “the differential valence of the sexes”. It is the desire to control the extraordinary power of women’s bodies, that is, the power to give birth not only to that which is

¹ Apart from work by Laurent Vidal (2000) which, with regard to Africa, shows how the category of prostitution may not be understood as a category in itself.

² Le Palec, A. Un virus au cœur des rapports sociaux de sexe. [A Virus at the Heart of Social Relations between the Sexes] *Le journal des anthropologues*, Femmes et sida, [Anthropologists’ Journal, Women and AIDS] No. 68-69, 1997, p. 111.

³ Salomon-Nékiriari, C. Le sida dans les sociétés kanakes : maladie des femmes et/ou maladie des blancs. [AIDS in Kanak Societies: Women’s problem and/or Whites’ Problem] *Le journal des anthropologues*, *op.cit.*, pp. 129-141.

⁴ Taverne, B; Egrot, M. Les maladies de femmes. [Women’s Problems] In: Jaffré, Y.; Bonnet, D. *Les maladies de passage*. [Diseases in Passing] Paris, PUF, 2003.

the same (girls) but also to that which is different (boys), which establishes, with what is considered to be “natural” legitimacy, the transformation of differences noted empirically in a hierarchical framework:

“It is important to bear in mind that other elements also form part of the primordial hard core of observations made by our distant ancestors: life comes together with death; the heat of blood connotes life, and the blood lost by women indicates lower heat in relation to men; copulation is necessary for birth; not all sexual acts are necessarily fertile; parents come before children and older children before younger children; women reproduce themselves but also have the extraordinary capacity to produce bodies different from their own” (Héritier, 1998, p. 25).

It is this last remark that, according to Françoise Héritier, contains the engine and seed of hierarchical thinking. In many societies, conception theories hold that only sperm and blood govern the development of the foetus, which grows and feeds on the seed issued during sexual relations into a womb that may be regarded as a mere receptacle.¹ For the Yoruba, it is again sperm that enables women to have milk to give their children, but many other societies observe strict sexual prohibitions in the post-natal period, believing that sperm can “turn the milk bad” (Héritier, 1986).

Beyond representations of conception and rites of passage in which boys accede to the status of manhood through a “social birth” from which women are excluded (Godelier, 1984), it is the issue of biological reproduction, specific to women, which is central and the basis of male domination.

Consequently, with “humanity making sexuality a matter of social policy” (Balandier, 1986), standards relating to sexuality refer to the way in which the cosmic, moral and social order must be preserved. In this context, control of women’s sexuality rests on the need to preserve order in the world, as Pierre Bourdieu has shown in relation to the Kabyl creation myth (Bourdieu, 1998).

Furthermore, beyond the danger of sexuality as expressed by empirical data, ethnology has also pointed to the link between the danger attributed to female sexuality and the power of fertility. Thus, the menses, a period that symbolises the power of fertility, are almost universally a period when women are excluded from certain ritual and social activities. Only the menopause, pre-puberty and sterility (always attributed to women) give access to certain social or symbolically important activities.

Closer to home, Monique Plaza has used a study of a corpus of medical texts published between 1983 and 1990 on the Medline database to show how medical discourse had reproduced the imagery of the “infective woman”, as women were sometimes described as “reservoirs of virus” (Plaza, 1997).

It is against this general background that the “woman question” is raised: between invisibility and too much visibility, or even blame. This backdrop, with the invariables described above, provide the setting for the local assumptions and personal histories to which consideration will now be given.

¹ This proposal must however be viewed in relative terms as the substances which are held to play a decisive role in the creation of the foetus differ from one society to another. For a synthesis of the differing theories of conception, see Godelier, M., 2004.

“Why were things not judged equally from the beginning, and why did we look primarily at the case of infected men (with AIDS)? Well, that is because only men are really regarded as individuals, while women are viewed as a group, an interchangeable collective at that”, said Françoise Héritier in 1997 in an interview for the *Journal des anthropologues*. While the social implications of the construction of “masculinity” cannot be denied, this hypothesis nevertheless has the merit of calling to mind the perplexing difficulties linked to the category of “women” or the notion of a universal “feminineness”.

It is, then, important to put into context which “women” are under consideration here, since as will be seen, emigrant/immigrant Maghrebi women in France have to face differing AIDS situations and circumstances. It will therefore be necessary to show the interconnections between the social, economic, geopolitical and cultural processes by which these women are affected and to highlight the place of women in social responses to the epidemic.

Women, migration and AIDS in France: the example of emigration/immigration from the Maghreb

More than 20 years after the first AIDS cases, the main watchwords of World AIDS Day 2004 concerned “women and girls”. Before 1993, women accounted for 16% of AIDS cases in France. Ten years on, when new provisions were introduced in 2003 making HIV/AIDS a notifiable disease, women accounted for 29% of *new AIDS cases* reported and for 43% of *new infections* (Institut National de Veille Sanitaire – INVS, [National Health Watch Institute], November 2004). Of those infected through heterosexual relations, 60% were women and 47% of them came from sub-Saharan Africa. In 2001, two-thirds of women diagnosed during pregnancy were foreign nationals. It must be pointed out that this situation is not confined to France and, on the evidence, now obtains at the European level:

“... experiences, analyses and convictions all show that the time has come to take account of women’s interests and desires, and of the particularly great threats that they face from AIDS” (Vidal, 2000, p. 183).

As part of HIV/AIDS prevention in France, the “migrant” category has long been confined to the image of the single man living in a workers’ hostel (Goudjo, 2003), while the “immigrant question” was more generally the “blind spot” of French public policy (Fassin, 1999; 2003).

Far from relating only to the implications of the epidemic, the definition of the “universal migrant” as a male person/worker, has long dominated perceptions of the realities and implications of migration. For instance, in regard to a recent book on “women in migration”, Nicole Fouché has noted that “linkages between the scientific fields of research on gender, migration and ethnicity were still unthinkable in the France of the early 1990s” (Fouché, 2000).

That said, the theme of immigrant women and AIDS in France must be placed in its broader social and historic context. For, as Cindy Patton stressed a decade ago, any attempt to think about “women” without looking closely at how identities and groups are formed leads to another sort of aporia (Patton, 1994). A number of explanations will be given to account for the diversity of social responses and the personal experience of immigrant women in order to show how, in a given socio-political and historical context, gender inequalities are linked to inequalities in foreign and/or immigrant women’s social status. These clarifications, while not designed as an exhaustive description of the overall issue of immigrant women and AIDS in France, will avoid the pitfalls of a culturalist interpretation by considering the example of emigration/immigration

from the Maghreb. In reasserting the importance of taking migratory journeys and their social and historic timescale into account, the principal challenge is to reveal the relativity and interconnections of the definitions of ethnicity and gender and their impact on prevention and treatment.

It would, however, be misleading to look at “women” without bringing into the picture the more global dynamics of the epidemic and the way in which emigrants/immigrants from the Maghreb came into contact with it. This can be gleaned piecemeal from epidemiological statistics that only reflect the experience of foreign nationals, from the work of voluntary organizations and from field interviews. The macro-phenomena illustrated by this social history must be linked to several major aspects of the history of the epidemic in France, such as the extent of the “heroin epidemic” that preceded the advent of HIV (infection linked to intravenous drug use, then the belated introduction of a damage-reduction programme in this field), the lack of prevention policies “targeting” foreign and/or immigrant communities (an “embarrassed silence” on such matters was characteristic of public policy until the late 1990s) and, lastly, the problematic nature of relations between the society of origin and the host society (marked by its colonial history and the rise of xenophobia and discrimination, which led to the politicization of sexuality as a symbol of “identity”).

Research into AIDS and immigration in France¹

As Abdelmalek Sayad has stressed (1999), the phenomenon of migration is a total social event, not only because it is always part of a relation of domination, but also because the two terms of the phenomenon – “emigration” and “immigration” – must be examined in depth and taken into consideration. “Immigration”, as a category of public debate, is always addressed in terms of “problems”, “harm” and “difficulties”, with the host society taking an omnipotent position in defining these various “problems”.

With regard to emigration/immigration from Maghrebi societies to France, the question of women is posed in many ways, as will now be seen. The question must be placed in the more general context of the epidemic in France and what is usually known as the “vulnerability” (Delaunay, 1999) of women and of foreign nationals and/or immigrants – a challenge at last considered to be relevant today.

Foreign nationals in France make up 6% of the population but account for 18% of people living with HIV (Lert and Obadia, 2004). Almost one in three HIV-positive women is a foreign national. The distribution of AIDS cases by gender is not the same “among French nationals and among immigrants” (Lert and Obadia, 2004): for instance, women account for 23% of AIDS cases among persons born in France, but 51% of cases among people born in the Maghreb and 60% of cases among people born in sub-Saharan Africa. In addition, socio-economic data also differ by nationality: foreign women are thus more systematically unemployed and/or living in precarious social conditions.

¹ The facts detailed here have been derived from research carried out initially as part of action-research by Arcat Sida (see Chérabi, K.; Fanget, D. *Le VIH/SIDA en milieu arabo-musulman en France. Synthèse bibliographique et rapport d'enquête*. [HIV/AIDS in the Arab-Muslim Environment in France. Bibliographical Synthesis and Survey Report] Arcat Sida, 1997), and subsequently with pre-doctoral funding from the National AIDS Research Agency. The research, on “migrant” issues in AIDS policies in France, was carried out in several places in France, with a small comparative component in Morocco. I should like at this point to thank Professor Hakima Himmich, founder of the first association established to combat AIDS in the Maghreb, who allowed me to conduct surveys in her Infectious Disease Unit at the Ibn Rochd Teaching University in Casablanca. It was indeed absolutely necessary to observe in one of the societies of origin the contextual constraints on the formulation of prevention strategies and the local epidemiology and implications of the disease.

Politics of AIDS

The “politics of AIDS” concept was first used by political scientists in the United States of America trying to describe the “exceptionalism” of HIV prevention and treatment policies. It was then taken up by social science researchers¹ to qualify the specific “arena” of AIDS, in which a reaffirmation of “traditionalist” or “dominant” values coexisted with a revolt against exclusion policies by those who suffered from such policies. AIDS policies are as likely to tend towards a return to a “moral order” as to open up a subversive space in which identities doomed to opprobrium before the epidemic can express themselves and make demands, and in which debates are held publicly on themes that had previously been neglected or “avoided”.

The concept has also enabled researchers belonging to the school of critical medical anthropology in the United States of America to introduce a “constructivist” perspective as to how epidemiology, biomedicine and medical anthropology had each constructed the “subject” of AIDS (Scheper-Hugues, 1994).

In France, Didier Fassin has taken up the term “politics of AIDS” which, in his opinion, was a “reminder that policies to combat AIDS may only be formulated in relation to the problems it posed to society and the solutions to those problems”.² For the expression does not merely designate a type of public action and the public forum in which political implications and the social responses to the epidemic are debated. In an anthropological approach, the study of the politics of AIDS tends to reconcile three requirements: that “of ethnographical work in which as much attention is paid to the words of patients and healers as to those of decision-makers and doctors”; that of “overall interpretation in order to understand the symbolic and physical setting in which AIDS and the social agents involved come into contact”, and, lastly, the need to “consider, and to refrain from discrediting, the totality of words and deeds, even when they do not correspond to usual or dominant forms of perception and behaviour”.³

My work falls within that theoretical and methodological perspective. Accordingly, I interviewed different groups of “respondents”, ranging from activist associations to doctors involved in treatment, from HIV-positive people or AIDS patients to their family and friends, and community and religious leaders, neighbourhood associations, officials responsible for applying public policies – all in various contexts.

The critical anthropological perspective on public health differentiates between culture as “political subject” and culture as “subject of policies” (Dozon and Fassin, 2001). Likewise, AIDS and immigration, which are interrelated, must be dissociated as “political subjects” and “subjects of policies”. The impact of these two elements on the forms that social responses to the epidemic take in social networks in immigrant circles must also be considered.

It is around the “catch-all” category of “migrants” that debates on the implications of AIDS prevention and treatment in France have crystallized. My work has, among other things, aimed to deconstruct the basic assumptions of this category, what it highlights and what it conceals, and also its history and social customs.

¹ Singer, M. *The Politics of AIDS*. Introduction. *Social Science and Medicine*, Vol. 38, No. 10, May 1994, pp. 1321-1324: “Indeed AIDS has become probably the most political affliction visited upon the human species in modern times”, p. 1322.

² Fassin, D. *Les enjeux politiques de la santé*. [The political implications of health] Paris, Karthala, 1999, p. 265.

³ *Ibid.*

Women usually find out that they are HIV-positive during pregnancy because a screening test is routinely performed in the monitoring of pregnancies. In France and Europe, the dominant image of foreign women who are HIV-positive or living with AIDS is that of a sub-Saharan African woman. The figures for newly diagnosed HIV infections in 2003 and the first half of 2004 show a rate of 51% for sub-Saharan African women and 2% for women of “North African” nationality. The magnitudes involved must obviously be construed as meaning that AIDS is an “imported pathology”, thus concealing the complexity of the interconnections between migratory journeys and AIDS.

This text proposes to “sidestep” this dominant body of ideas.

Aspects of the social history of the epidemic among emigrants/immigrants from the Maghreb: the historical importance of infection linked to intravenous drug use

In 1999, a report by the Institut National de Veille Sanitaire (Lot and others, 1999) was the first to reveal the AIDS situation of the foreign nationals living in France.

The figures had until then been released only in part, and then only by a few associations combating AIDS, out of fear that broader publicity would lead to stigmatization (de Villepin, 1997; Migrants against AIDS, 1998). The report showed that foreign nationals accounted for 14% of all AIDS cases between 1978 and 1998, which was more than twice their statistical share of the total population (6% according to INSEE). In relation to all nationalities, the report spoke of late screening and problems in gaining access to care owing to an array of administrative, socio-economic and sociocultural difficulties.

Beyond these common features, the rates of prevalence in the societies of origin may play a role, and specific characteristics may be noted in “epidemiological profiles”. For instance, the gender ratio and modes of infection can differ according to the type of “nationality”.¹ Since the beginning of the AIDS epidemic, sub-Saharan African women have been affected by AIDS as much as men of the same “nationality”, while Haitian women have been about half as affected as men, women from “North Africa” about four times less than men, women from Europe and France five times less, women from Asia about ten times less and women from the Americas (excluding Haiti) twenty times less.

With regard to “modes of infection by gender”, in 1997 heterosexual infection became predominant among women of North African “nationality” (83% of cases diagnosed in 1997, while drug use concerned 17% of cases diagnosed in 1997). Heterosexual transmission is still predominant among women of Haitian nationality or from another country in the Americas or from sub-Saharan Africa.

The main mode of infection for men of North African “nationality” continues to be drug use (35% of AIDS cases diagnosed in 1997). Heterosexual infection, on the rise, concerned 26% of cases diagnosed in 1997 and homosexual relations 16% of cases. Heterosexual transmission is still predominant among Haitians and sub-Saharan African men (89% and 76% respectively of cases diagnosed in 1997).

¹ It should be borne in mind that as it was not compulsory to notify HIV-positive status, the number of “reported AIDS cases” gave the impression that infection had occurred in the previous decade.

Factors explaining the over-representation of cases linked to intravenous drug use

With regard to the history of the spread of heroin injection (Toufik, 1999), France's experience has been unique, closer to that of the United States of America than to that of other European countries. Owing to a series of factors ranging from the quality of the product available to its cost, and the modes of socialization of its administration, France had the highest rate of intravenous drug users infected with HIV in Europe.

Several founding paradigms of public policy on the subject must also be noted in this brief overview of the situation. The 1970 law criminalized intravenous drug use and established a general "objective of abstinence" in the treatment of drug addiction in which psychoanalysis was the dominant paradigm (Bergeron, 1999). It was not until 1987 that the unrestricted sale of needles was authorized, and not until the 1990s that an injection risk and damage reduction policy (access to injection equipment and substitution products) was introduced.

At the level of policies on immigration and discrimination against foreigners (or persons presumed to be foreigners), there is a demonstrable link between the penalization of drug users and nationality.¹ The frequency of imprisonment is one consequence of this, but the prison environment is itself a significant place of exposure to risk.²

However, discrimination of a judicial nature must also be mentioned: for instance, the common practice of the courts to deny foreign nationals the right to stay in France meant, until 1997, deportation or illegal residency and, as a result, some who have suffered from such practices are now in inextricable situations in which they can neither have their situation regularized nor be deported (Musso-Dimitrijevic, 2000). Some of the people concerned by these measures described as "double punishment" are young, born in France before 1962 when their parents were of Algerian nationality, or had arrived there as children under family reunification schemes in waves of migration from the Maghreb in the 1960s.

The third factor has an extremely important place in this picture: the sociology of customs and their differentiated impact on social environments. The heroin "epidemic" in the 1980s did in fact affect young people in deprived neighbourhoods in a context of widespread academic failure³ and in an environment of discrimination that often began in school and then continued in contacts with institutions responsible for job placements and for justice.⁴

It is against this general backdrop that the visibility of the epidemic in the isolated estates and neighbourhoods where foreign nationals and/or immigrants from the Maghreb are largely segregated must be set. It is also in such areas that the first association of Maghrebi "mums" was established in Marseille in the mid-1980s with the objective of "breaking the taboos" on drug injection.

¹ 55.8% of foreign nationals as against 23.3% of French nationals serve prison terms for illicit narcotic use (Mary and Tournier, 1997).

² For example, intravenous drug users report the sharing of needles in prisons.

³ Such failure, while similar to that of children in the same socio-economic category, equally concerns immigrant children, over-represented in these categories.

⁴ The question of racism and discrimination against those who would be called "beurs" [meaning second-generation] in the public arena was thrown into relief by the first "beurs march" in 1983, followed by a second march in 1984.

Mothers and the "hecatomb"

Hadda Berrebou was a 50 year-old mother of ten children when she decided "to do something". She had arrived at the age of five from Algeria and had lived for 20 years in an estate in the "northern suburbs" of the city, characteristic of the

"[...] strengthening of isolates that spring up around some estates. In spite of the stated intention of encouraging the various groups to mix, is it not a fact that council housing allocation schemes eventually have the effect of increasing the concentration, and thus the segregation, of immigrant communities?"
(Temime, 1991, p. 190)

This situation of isolation maintained certain forms of sociability but increased the influence of other people's perception: "It's like a village: everybody knows everybody else." The early 1980s were characterized by the great impact of unemployment. The heroin epidemic spread and with it came the first cases of overdose, and the first AIDS-related deaths:

"Yes, it's a long story, I'll have been on the estate for 24 years soon, I've seen lots of young people die. Nobody used to talk about drugs and AIDS. The drugs were already hard to talk about but AIDS was even harder. One day I said to myself that I had to do something, say to the other mothers: 'We must do something. We can't just stand by idly.' And so we started to get things moving. There weren't many of us, just two or three. We went from door to door, I did it myself, going from door to door, walking up eight floors."¹

Hadda is well known and "respected" in the neighbourhood. She had a small shop for a long time until her husband died. She knows about the "shame" of having a child who is "doing drugs":

"I think it's a shame to begin with. Before, people used to be scared when they had a child who was a drug addict. That was what most of them used to say at the beginning... they thought that if a child in the family was a drug addict, then everyone, or the police, would accuse the family of dealing. So they were afraid that if they said that a child was an addict then they might be suspected of drug trafficking. I think they were more scared of the law than anything else."

In addition to fear arising from the illegality of drug use and possession, the care taken to keep the "secret" is also part of the social context linked to migratory journeys and the sociology of the place of abode.

This is because the migrant's plan is very often one of social betterment and success.² The migrant and the migrant's family therefore feel obliged or bound to succeed or at least to engage in discourse that legitimizes and sets a value on departure and settlement elsewhere, for instance through talk of building a "nice" house or going back with a "nice" car. In this context, the disease symbolizes par excellence the failure of the migrant's plan:

"Sometimes mums ... then all those who have lost their children, well they say 'After all, if we had known that our children would end up dying from drugs, we would have stayed in our country, even if it meant starving to death'. Well, that sort of language,

¹ Interviews held in 1996 and 1997.

² Of course, many people are forced into exile after being subjected to violence in their society of origin, but the situation here relates to family reunification in a labour immigration context.

unfortunately, we call it '*mektoub*',¹ we came to France and what has happened, has happened, you can't turn the clock back."

"Do you feel that people are sorry they came here?"

"Oh, the ones who've lost their children, they do. I often hear mothers saying 'well if I'd known, I'd have stayed at home, even if it meant eating grass from the hillside, at least I'd still have my children'. There are quite a lot of them, more than you'd think, because really you have to understand, some of them have lost more than two, three children.² Oh, it is really, really hard because look, I have come to France, I haven't gained a thing, and in the end I'm going back with coffins.³ It's tough, it's really tough."

On the other hand, keeping the secret is also indicative of the links between information flows "here" and "there". It is not only in the neighbourhood that honour and reputation are at stake, thus making it necessary to "hide" certain facts, it is also because people from the same region live in the same places: facts are kept secret to prevent the information from circulating in the country of origin, in particular within the extended family.

By deciding to break the silence, mothers are trying to recast these social norms and rationales:

"Well, it's been hard on mothers. It really had to come to young people dying on the estate for them to start talking, because they did feel concerned. Maybe they were scared it would happen to them, so I think they thought it was better to talk about it, to try and hold on to our children rather than hide and end up like other people, losing their children for stupid reasons."

By becoming "acculturative play makers", these women are changing those standards of respect between generations that made it difficult for parents and children to discuss certain subjects together. The association that they have formed, which first met in the founder's home, is now being visited by children and parents together, "whereas at first they were playing a cat and mouse game". The women have contacted professionals, doctors, psychologists and associations to obtain documents on drug use, AIDS, prevention and treatment. The initiative is an example of the "recasting" of gender relations engendered by migration which in this instance have crystallized around AIDS.

These "mums" however also draw on standards that may be described as "traditional": it is primarily on the basis of their social identity as "mothers" that they can talk as "women" about AIDS. Only their children, and in particular their sons, are perceived as being at "risk".

Lastly, their experience of the disease as recounted is strongly connected to the history of the epidemic that they have experienced in their own environment. As a result, attention is being given almost exclusively to intravenous drug injection as a category of AIDS transmission, which does indeed correspond to the epidemiology they see around them:

"Question: And in general, people with AIDS, is it because they're drug addicts?"

H.B.: Yes, yes, most of them, yes. They all used to be drug addicts.

Question: Do you know anybody who has never been an addict but who has it?

H.B.: No, the ones I know used to be addicts. No, I don't know of anyone who has caught AIDS by any other means.

Question: And do you think there are any?

¹ "It is written", fate.

² I have heard, from a social worker in a Marseille hospital located near the urban outskirts known locally as the "northern suburbs", several accounts of several members of a group of siblings being infected. Similar accounts are heard in hospitals in the greater Paris region.

³ For the current, and changing, practice of repatriating bodies to the country of origin, see Chaïb, 1998.

H.B.: I don't know, there might be ... I don't know, like I just said, all the ones I know, they really are young people that I've known. Well, the ones I know about were drug addicts. I don't know of any others. Some of them are dead, a few are still hanging on ..."

So, not only does the epidemic concern "young drug addicts", but also it is practically "ancient history" ("a few of them are still hanging on").

All of these factors lead to the notion of "representations of the disease". As Yannick Jaffré and J.P. Olivier de Sardan (1994) have stressed, descriptions

"of indigenous conceptions, based on popular discourse on a particular 'disease', are generally implicitly or explicitly at odds with biomedical knowledge. The gap between the two meaning systems is then used to explain many forms of health behaviour".

It is undeniable, though, that the prevalence of the disease and certain associated symptoms contribute to the construction of a "representation of the disease". For that reason, to avoid the culturalist assumptions that may arise from the notion of "representations" and the latent dualism between "knowledge" and "belief" on which it rests, the authors recommend recourse to the notion of "pattern", meaning the set of variables (prevalence, effectiveness of treatment and modes of clinical expression) that define what could be called the "pattern of a disease".

Moreover, the advent of drug addiction and AIDS is to be placed within the context of the recasting of gender relations in the migration process in which it has crystallized. For instance, work on the Romany community in France, within which "HIV was almost always the result of heroin injection in the 1980s", has also shown the extent to which it is part of that recasting: as a result of AIDS-related illnesses and deaths, the mothers decided to mourn by wearing black, a practice that is traditionally prohibited (Tarrus, 2000, p. 176).

The way in which "women drug addicts" are passed over in silence will now be considered.

Invisibility of women drug addicts

All the actors interviewed during fieldwork – hospital doctors, social workers, HIV-positive people and their families – have underlined the special social status of immigrant women drug addicts. Accordingly, the founder of the above-mentioned mothers' movement said:

"In the families, it's as if they were dead; no one talks about them and they often go away. Well, you couldn't say that there's a lot of them, there aren't that many girls. In the neighbouring districts you might see one in passing on an estate, but there aren't many, they're not in the majority.

(...) We don't have any girls. They never come. Having a druggie son is hard, but for us, mothers from the Maghreb, a druggie daughter is twice as hard.

You know, we think that girls are sheltered from everything. You don't imagine that one day she'll end up doing drugs ..."

Generally speaking, whatever the person's origin, the treatment statistics of drug users show a difference in the gender ratio: there are far more men attending centres for drug users. Interviews with immigrant women drug users, in such centres or elsewhere, highlight a wider experience of breaking up with the family. The break with the family is always more "radical" for

these young women.¹ The reason for this may be the attitude of some family members, and the woman's internalization of the shame, dishonour and failure that "getting into drugs" entails socially. This is especially true when one of the most common ways for women to obtain the "product" is prostitution. The frequency of family break-up also has consequences in terms of maintaining an insecure administrative status in the country: it can be extremely difficult to get hold of one's birth certificate and other official documents after a complete break with the family.

The situation generally changes when drug use is stopped, when stability is restored and sometimes when children are born. In a migratory context, the behavioural demands of emigrant/immigrant parents on their children are strong, sometimes inflexible, but they are not the same for boys as for girls.

"Maghrebi culture in its entirety is marked by the division between the private sphere, that of women, and the public arena, that of men. That said, the father is responsible for the privacy of the family sphere, he is guarantor of the honour of the group, and must consequently ensure that the behaviour of each family member does not threaten the public image of the house" (Bouamama and Sad Saoud, 1996).

Owing to the supremacy of women in the domestic sphere, mothers play a central role in the reproduction of gender norms, as shown by Camille Lacoste-Dujardin's reference to a system of "mothers against women" in an analysis of the links between motherhood and patriarchy in the Maghreb. For example, girls are responsible for, or holders of, the family honour. A woman, and particularly a girl, holds in her hand the honour of the group, which can be tarnished as a whole if she behaves dishonourably.

"For us, a daughter is the family diamond, she must be pure".² Although these are still formative norms, particularly in discourse concerning girls' "virginity", they have been affected by migration in two ways. On the one hand, it has involved interaction between the host society's colonial approach, which "focuses on the issue of the oppression of women by regarding it as an essential feature of the Maghreb", and the stereotyped group, "which views the original purity as a positive stigma" (Tersigni, 2002). On the other hand, migration itself has led to the "recasting" of gender relations, which has been linked in particular to changes in the interaction between the public and private spheres caused by more women going out to work.

Moreover, the existence of, or adherence to, a norm does not imply that it is absolutely respected. Women devise tactics (de Certeau, 1986) to circumvent norms discreetly, taking social control into account. However, with regard to women's experience of intravenous drug use, possibly involving prostitution, it is easy to see how the practices that crystallize all the attributes of dishonour and the dangers of exile (in the eyes of the relevant social group and in the eyes of the women themselves) must be kept out of sight, thus leading to break-up and distancing.

Accordingly, a young woman with AIDS, deported to Morocco in 1994, who had been living in France since the age of four, explains:

"It took me a long time to get back in touch with my father, understand him ... To realize that living here in the context he was brought up in, but also the image of the

¹ This is not intended to characterize all situations: families have also been noted to show solidarity with women infected through intravenous drug use. Nevertheless, women generally do not feature in statements made by the associations, or only do when particularly significant problems encountered by women are addressed.

² Quoted by Cuha, M. Le surgissement de groupes de jeunes croyants musulmans dans les quartiers. [The Emergence of Groups of Young Muslim Believers in Deprived Neighbourhoods] *Migrants Formation*, No. 15, June 1996, pp. 70-110.

country he gave us. He didn't see the country change, it was a shock for me to see the difference between what he'd told me about it and daily life here. And then it was impossible for me, for ages, after what I'd done, to pluck up the courage to get in touch."

Family prevention strategies: "weddings back home"

In interviews with associations against AIDS, drug addiction prevention and treatment, and organizations of HIV-positive people, a recurrent typical situation is mentioned whenever the question of specifically Maghrebi, and especially Algerian, characteristics arise:

"To get a druggie son off drugs, he's sent to Algeria, Morocco and Tunisia. He's sent back home to marry a virgin, because they say that marrying a virgin is purifying. So they send them there and they get off the drugs alright, but they infect the young bride, who is usually pregnant within the month. All three of them come back to France and when she gives birth, she finds out that she's HIV-positive and the kid too. And in general, the three [women] who are being monitored have been infected because of their husbands' drug addiction. And N., she's the typical case of the virgin, the son who was sent to Algeria to marry a virgin and then when she came here three years ago and then gave birth, she found out at the same time that she, her son and her husband were HIV-positive. She didn't have a clue, so she found out ... Then she went back to Algeria and she's been back for a year now. A year ago she saw what dire straits she's in ... She found out everything, all at once."

"Were the three [women] you're monitoring all infected in the same way?"

"Yes, the husband was a drug addict. No, the two others weren't virgins, but the husband was a drug addict, yes." (Volunteer patient assistant in an anti-AIDS association)

A former intravenous drug user, a 40-year-old Algerian woman, said:

"At one point it was almost a fashion in the neighbourhood; there were a few, mothers, who went back home to find wives for their sons. They thought that it would calm them down, stabilize them and stop them from doing drugs. And inevitably some of them had been infected."

Data from the survey carried out by Michèle Tribalat show that for young people of Algerian origin born in France, less than 5% of weddings have been arranged by the family. For men born in Algeria and Morocco, the percentage is 29% and 32% respectively (Tribalat, 1995).

It is not rare to find, in the family histories collected, that in the case of immigrants of long standing (the father arrived alone in the 1950s and was joined by the mother a few years later, often with children) the oldest daughter goes back to live in the country of origin after an arranged marriage. The variable of time, the transformation of gender relations in the family, changes in education between the oldest child and the youngest (an age difference of up to 20 years, and with differing legal statuses) and the settlement of the question of return are all factors that make that kind of strategy increasingly unthinkable and improbable.

The choice of a marriage in the country of origin for one of the children is not therefore solely related to drug addiction, but may nevertheless appear as a way of "solving" the problem, for once drug addiction is in the open, strategies devised with allies or relatives living in France may fail. Thus:

"It is true that the ones who are, or used to be drug addicts have burnt their boats in the neighbourhood. It's a bit hard for them to find a wife here, so they too may go back

there to find someone because it's become too difficult here.” (Algerian voluntary worker in a neighbourhood association).

Amina Shabou's survey on a sample of 72 people has yielded much information about HIV-positive people of Maghrebi nationality or origin in France. Among the respondents, 27 were men who had been infected through intravenous drug use, among whom she identified three “groups”: those who had used “hard” drugs between 1985 and 1990 and had stopped once they were married, those who were occasional users and those who were still drug users (most of them single):

“It seems that a recurrent marriage scenario may be deduced from these data: the trend towards endogamous marriages within the family strengthens when a young man runs the risk of drug addiction. The silence observed within the extended family on the drug addiction episode has effects on both members of the couple: first, it is impossible for the wife to perceive any danger and, second, the possibility of transmitting the virus is concealed by the man (...). The notion of risk situation or behaviour is not therefore relevant to these women” (Shabou, 1998).

Drug addiction proves to be a paradigm of a pathology linked to the host society. There was no intravenous drug use in the Maghreb when the parents emigrated. Persistent symptoms of drug addiction may lead to the “drug withdrawal back home” strategy, a popular practice consistent with the ideal of abstinence which has long dominated French drug addiction treatment policy. Moreover, this line of thought, far from being specific to young immigrant drug addicts from the Maghreb is also prevalent among associations for alcoholics for instance: the aim is always to remove the person from a relational environment that is blamed for the practice.

The “Maghrebi” specific strategy of “drug withdrawal back home” therefore rests on the mobilization of specific resources, the presence of relatives or allies in the country of origin where it is thought that the troubles will end because no psychotropic substances are available and distance from the relational network. If these resources can be considered to be specific, it is because they are mobilized in the framework of an anthropological rationale that transcends the question of cultural specificity. That which is sometimes portrayed as irrational behaviour based wholly on the person's culture therefore falls within a line of thought determined by given contextual constraints which, in regard to “drug withdrawal back home”, applies a principle of prevention and treatment of drug dependence that is used in other environments and for other addictions (Fainzang, 1998).

However, the complex elements that determine such social reasoning are often effaced, relegated to the status of beliefs about the virtues of virginity or culturalized as referring solely to “cultural” rationales. Inverse situations may be observed in the countries of origin, which show the extent to which any linkage of the epidemic and immigration means departing from the “official line”. The first cases of women infected with HIV in the Maghreb did in fact involve the wives of men who had lived or were still living in Europe. The history of the epidemic in that part of the world was from the outset following in the tracks of colonial history and reflected the topicality of interactions between societies that produce emigrants and societies that produce immigrants (Sayad, 1991).

Accordingly, an article on AIDS in a Tunisian weekly ends with these words:

“Lastly, our foreign residents sometimes bring back from their solitude overseas a solid case of HIV infection together with the return bonus. Infection of the wife and then neonatal transmission set the seal on the family reunion.”¹

Experience of independent women

It is more than necessary to include women in the discussion on immigration because migration by women is an unavoidable issue at the start of the twenty-first century. Until recently, they have largely been excluded from statements and opinions on population movements (Green, 2002).

In research on Moroccan women who came to France on their own, Nassima Moujoud has stressed that the statistical data are silent on the very existence of the active female migration, which is seen only as part of family reunification. The dominant image is therefore that of a female minor who has been granted family status. In fact, they often leave because of the stigmatized status of widows and divorced women in the society of origin and, in addition to exclusion in the society of origin, often endured discrimination as illegal immigrants: “These women, mostly illiterate and with no established political awareness, develop a will for emancipation and choose to remain immigrants in order to ‘escape’, as they put it, openly or in different ways, from constraints” (Moujoud, 2003). While women leave their countries of origin because of factors linked to their social status as women there, they nonetheless face considerable administrative and economic difficulties as migrants. The risk of exposure to AIDS thus forms part of that experience, together with many other risks. For instance, Yasmina, who works on prevention with prostitutes from the Maghreb who do not have official papers, said that “they would rather run the risk of being infected than be deported. That’s not their priority”. In addition, non-protection can also be adopted as part of a matrimonial strategy “because insisting on a condom is perceived as being characteristic of groups of women considered to be at risk, namely, prostitutes” (Moujoud, 2003). This is a context in which women play a major economic role in regard to their children and family left behind in the country of origin who know nothing of their actual living conditions, especially when prostitution is involved.

For some ten years now, the “vulnerability of women” has been an increasingly frequent theme for discussion. It tends to group highly differing challenges together in a standard category, amalgamating physiological susceptibilities and social, political and cultural rationales (Vidal, 1999). Furthermore, it tends to convey the image of “passivity” of people who are described as “vulnerable” (Delaunay, 1999).

There is no denying the fragilities caused by accumulated discrimination: women’s identity, the social status of foreign and/or immigrant women in a society, with the attendant problems of access to the labour and resources markets, and tensions between the membership group and the host society which may increase or strengthen gender inequalities within the group.² The aim here, however, is to identify the plurality of identities of individuals and situations which can give rise to collective mobilization or tactics that are themselves varied.

In France, as in many societies of origin, women have spearheaded emerging social responses to the disease. Thus, the first association established to combat AIDS in the Maghreb

¹ Omrane, N. Branle-bas contre le sida [National Fight against AIDS]. *Réalité* (Tunisian weekly), No. 476, 2-8 December 1994. See also Himmich and Imane, 1995.

² For instance, a residence permit cannot be obtained for a second wife in the context of polygamy, which leads to women being kept in clandestinity prejudicial to their autonomy.

was founded by a woman, Professor Hakima Himmich, in Morocco in 1988, and the first association of persons who are HIV-positive and/or AIDS sufferers in Algeria was also founded by a woman. The first association to help Africans in France who are HIV-positive or AIDS sufferers, Ikambere, was also founded by a woman, Bernadette Rwegeera. More recently, a forum specifically for women was opened on the Internet site “Survivre au sida”, targeting HIV-positive Maghrebi and African immigrant women.¹ If, as this text has endeavoured to show, AIDS is singularly part of the collective memory and oral history of emigrants/immigrants from the Maghreb, the new forms of solidarity and mobilization that it has generated are also part of the future of prevention.

Anthropology has given pride of place to social and cultural rationales (Le Palec, 1997) which provide the setting for the risk of HIV exposure, ranging from polygamy to the impossibility of negotiating condom use. It has also shown how “structural violence”, that is, the dynamics of exposure to risk and HIV transmission, determined by economic, social, geopolitical and cultural rationales, has formed the backdrop to courses of action by women that lead to contact with the virus; whether they be peasant women from a Haitian village or Afro-American women from the underclass, poverty and the desire for economic security are the main ingredients of their encounter with the virus (Farmer, 1998; Farmer and Furin, 1997).

The social sciences have stressed the importance of taking gender relations into account in prevention, and they have also highlighted how much preventive discourse has been formulated by and for a subject whose social identity falls within the WASP paradigm: a white, middle-class man with a rational and responsible attitude in a society of abundance (Scheper-Hugues, 1994). In fact the risk of infection is always one among many other risks.

After an inquiry into the notion of “deviancy”, the epidemic has now been placed at the heart of the notion of “norms”, particularly those that govern the political economy and social construction of masculinity and femininity. If abstract universalism leads to the perception of male domination as an invariable, then practical universalism (Dozon, 1997) must lead to account being taken of the overall social conditions in which particular social and cultural norms exist. Recourse to the notion of culture must involve setting it in its historical and political context (Fassin, 2004) to avoid the risk of fuelling the “culturalization of social exclusion”. Nor must efforts be spared to stand back and look at the cultural norms of the prevention ideologies that provide a globalized structure for the struggle against AIDS (Dozon, 2005), all too often reducing the challenges linked to inequalities in a global world and contemporary forms of inhospitality to necessary “changes in behaviour”.

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¹ Forum “Women plus”: www.survivreausida.net

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Conclusions

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Using anthropological approaches, this Roundtable explored the impact of HIV/AIDS on migrant women and their responses to the pandemic. It addressed the gender dimensions of migration and of HIV/AIDS, and the socio-cultural factors shaping the way migrant women are both infected and affected by the disease, as well as their access to prevention, care and treatment.

The discussion addressed various “push and pull” factors driving women’s migration, while noting that HIV/AIDS interventions are less likely to address these structural causes. “Push” factors include armed conflicts, natural disasters, household violence, poverty, political instability, landlessness and forced marriage; while “pull” factors include family reunification, security, and education, health, social and employment opportunities. Women also migrate for different periods of time (seasonal, temporary, generational), and across different locations (local, national, regional and international). Migration can be forced, coerced and/or voluntary. The Roundtable did not focus on issues pertaining to forced displacement and sex trafficking.

Migration and HIV/AIDS

Migration was identified as a significant catalyst for HIV transmission, especially when prevalence is high among concentrated populations considered high risk such as truck drivers and sex workers. It was noted, however, that women migrants are often less visible than their male counterparts in analyses of both high risk groups and migrant populations, mainly because they predominate in the “invisible” service sectors. In recent years however, the feminization of migration, notably in Asia, Latin America and Africa, has increased attention to the special needs of migrant women and to their contributions in fighting the pandemic.

A notable pattern of female labor migration can be seen in the global health care industry where women dominate as low paid or unpaid caregivers. As HIV and AIDS increase the demand for care givers and health professionals globally, market forces are being seen to influence the migration patterns of female health workers in search of better paid employment, particularly those from South Africa, the Philippines and the Caribbean. This has implications not only for the individual health of caregivers, but also for the health needs of their families and communities left behind.

Panel speakers spoke to the numerous ways in which migration disrupts traditional social and sexual networks. In situations of political, social and economic insecurity, migrant women may be at higher risk of being coerced, exploited or forced to exchange sex for transportation, protection, housing, legal status, income and other basic needs during migration or in their destination areas. When migration increases the number of concurrent partners over short and long periods (in both sending and receiving communities) the risks of HIV also increase, some argue exponentially. Whether they are infected or affected by HIV/AIDS within their families, myriad socio-cultural, political and economic factors will inevitably shape both the impact of

HIV/AIDS on migrant women and their responses to it. Much more empirical research is needed to specify and understand these impacts and to increase migrant women's access to HIV/AIDS prevention, care and treatment. Priorities for research and action are summarized below:

Priorities for Research and Action:

1. Mapping the trajectory: Mapping the migration corridors along which women travel can help identify the specific situations that increase women's risk of HIV and limit or facilitate their access to prevention, care and treatment. As migrants cross borders, it becomes critically important to take regional and international approaches to social and geographic mapping exercises. Particularly important are border areas, transportation routes, shelters and marketplaces.

2. Assessing changing family, gender and intergenerational relations: Much more needs to be understood about the impact of migration (in both sending and receiving communities) on family structure, gender and intergenerational relations and social and sexual networks. Specific areas of impact that need further social scientific exploration include the impact of HIV/AIDS and migration on gender roles and relations, household income, sexual networks and child development.

3. Protecting sexual and reproductive health: Migration may affect women's sexual and reproductive health, their health seeking behaviors and their access to HIV/AIDS treatment, information and health services. Policy and programs need to consider the legal frameworks governing migrant entitlements to health care in receiving areas and the cultural relevance and accessibility of services to migrant communities. The circumstances under which migration increases the risk of sexual violence and exploitation – or be a response to it – need to be better understood and considered in the design of HIV/AIDS interventions.

4. Economy and livelihood approaches to HIV/AIDS and migrant women: Both push and pull factors influencing women's migration patterns (across age, nationality and sector) must be considered in the design of HIV/AIDS responses. Specifying patterns of migrant women's participation in the formal and informal sectors and understanding the gendered nature of livelihoods can help identify points of risk, vulnerability, and response.

5. Strengthening legal protections for women migrants: HIV/AIDS responses need to consider a range of legal and regulatory aspects of migration policy, ranging from HIV/AIDS testing to the implications of HIV status for citizenship, deportation and employment, and laws regulating migrant access to health services.

6. Supporting social mobilization among migrant women: Migrant women have effectively mobilized within their communities and across the diasporas across the social, cultural, economic and political arenas. Research and action can identify ways to support various forms social mobilization and activism to increase migrant women's protection from HIV, their access to prevention, care and treatment, their linkages with national and global HIV/AIDS and women's movements.

7. Developing cultural approaches to HIV/AIDS: Cultural approaches to HIV/AIDS mean adapting interventions to constantly changing and diverse traditions, habits and customs regarding sexuality, gender relations and traditional practices, and recognizing the heterogeneous

composition of migrant communities. Treatment and research literacy as well as information and communication technologies can play important roles in supporting the social networks that develop and sustain migration flows.

Annex

Indicative Bibliography “Migrant Women and HIV/AIDS in the World”

This bibliography has been compiled by the CRIPS (Centre Régional d’Information et de Prévention Sida) Ile-de-France and by IOM (International Organization for Migration).

All the documents published under the project “A Cultural Approach to HIV/AIDS Prevention and Care” are available on the project’s webpage:

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Selection of websites

www.genderandaids.org/

United Nations Development Fund for Women

http://portal.unesco.org/unesco/ev.php?URL_ID=1134&URL_DO=DO_TOPIC
UNESCO

www.iom.int/

IOM (International Organisation for Migrations)

www.aidsmobility.org

European Network AIDS & Mobility