

'Bring us the female condom': HIV intervention, gender and political empowerment in two South African communities



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The quotation which heads this paper encapsulates two important issues in AIDS research in South Africa: the one is substantive, the other methodological. The link between them is the rapid spread of HIV/AIDS in the country and the indication not only that women are more at risk of infection than men, but that, as in many other parts of the world, much of their vulnerability is gender based. 'Bring us the female condom' sums up the response of one particular group of black South African women to AIDS education. Their demand was a reflection of their relative domestic and gender empowerment - and also a high degree of political mobilization. However, their position is not necessarily shared by other black women. But the call for the female condom went further: it was a challenge to rethink our position as researchers and particularly to face the implications of commitment to a participatory model of community based intervention research.

The interface between research and action

As the AIDS crisis looms ever larger on the South African public health horizon, the call is for research to be directed not only to understanding the dynamics of HIV transmission, but, virtually simultaneously, to piloting and launching intervention strategies. The perceived need among many researchers and certainly among health authorities, and often among funders, is for 'action' rather than 'pure' research. Combining these is a difficult and challenging task. As elsewhere in the world relatively little attention is paid in the local literature to the dynamics of sexual interaction and negotiation, or to the full range of factors impinging on sexual decision making. A serious commitment to action may, furthermore, result in the temptation to cut the time and resources available for good holistic ethnography on which to base solid interventions. While it is true that in the cases described below we were working against a background of considerable sociological knowledge of the major structural features of the communities concerned and, at a general level, we had a fair picture of gender relationships in them, in practice we learnt many important details of local circumstance 'on the job'. This related, in particular, to the possible effect of women's political empowerment and mobilization on their response to AIDS education.

Reflexive exercises such as this paper represents are important in that they contribute to the construction of a body of local ethnography about not only AIDS/HIV in general, but the complexities of HIV intervention in itself. The themes raised here have a wider resonance; what is reported echoes studies done elsewhere in Africa and also in other parts of the world. A growing body of international literature suggests that gender empowerment is the key to women's ability to protect themselves and their children from HIV infection. For women in traditional and transforming societies, political as well as domestic empowerment may necessarily have to precede or, go hand-in-hand with individual sexual empowerment.

Evidence is drawn from one of the first HIV/AIDS research and intervention projects to be carried out in KwaZulu-Natal, a geographical and political region situated on the eastern seaboard of South Africa. The majority of the population of the region speak Zulu as their home language and two contrasting Zulu-speaking communities were chosen for study, one largely rural and structurally traditional in organization, the other a far more rapidly transforming informal shack settlement abutting the largest urban-industrial area in the region. At the time of fieldwork KwaZulu-Natal was characterized by considerable social and economic change and was undergoing fundamental political transformations. In both the communities local support was overwhelmingly for the African National Congress which was to win the national elections and it was, indeed, through the ANC local structures that we gained entry to both communities. In terms of policy, the ANC had already come out strongly in favour of women's empowerment and their local representatives reacted to our focus on women both seriously and supportively.

In planning our intervention strategies we made mistakes and missed a number of opportunities, but we could not have acted very differently because our research was constrained in two important respects. First it was focused at the level of micro-interaction where the nature of domestic and neighbourhood relationships, not to mention the influence of dominant personalities, competing interpersonal loyalties, reciprocities and local power struggles, necessarily dominated the processes both of data collection and how we planned and conducted our intervention. Secondly and probably more critically, we were committed to an 'action' and, moreover, a consciously participatory model of research and intervention. We worked with and within two communities and we planned that our intervention was to be community rather than merely individually oriented. We set out to interact closely with, and respond to the unique circumstances of each community. We regarded the women (and to a lesser extent the men) as research partners, and we did our best to allow them to set the pace and actual direction of our intervention strategy. However, this approach presented us with a number of dilemmas which, in turn, raised the more general question of who sets the ultimate 'direction' and where the final 'ownership' lies in programs which are based on a participatory research model.

The problems raised by the micro-level focus and participatory nature of our research are not unconnected. What differentiated the two communities was the degree of local political and domestic empowerment enjoyed by the women in each. There is a possible connection between the degree of political mobilization of women, their ability to negotiate sex and HIV prevention (Susser forthcoming); also, a critical role was played in each case by the persons identified by us as community liaison persons. Here too, is an important item of local difference. In the case where we believe that our intervention has had most effect, the liaison person was herself a political activist and the platform from which she launched our program was that of the Woman's League of the African National Congress. Although both communities were ANC-dominated, in the first the women were not strongly organized on that political platform, while in the second our intervention went hand in hand with their political mobilization. There were, of course, other factors differentiating the two communities. They turn, however, very largely on the degree of domestic freedom and gender empowerment which the women in the two communities enjoyed or believed that they commanded in their relationships to the men who were their husbands, lovers - and their elected political leaders. These factors allowed the women in the second community to challenge us to bring the female condom to them. They firmly believed that they would be able to negotiate its use with their sexual partners and could persuade and empower other women in the community to follow suit.

What is the magnitude of the HIV/AIDS crisis in South Africa, and particularly in KwaZulu, and who is most at risk? To answer this will explain why the projects described

here focused on Black South African women and on issues of gender and empowerment. A brief sketch of the nature, organization and methodology of the study is followed by a contextual description of the communities with which we worked; the paper concludes with analysis of the course which our intervention took in each community.

The KwaZulu women and AIDS project

The original motivation for the Women and AIDS Project was the need to identify the factors which might prevent black women in KwaZulu from adopting preventive measures against HIV infection. We also aimed to test general knowledge of HIV/AIDS in the areas studied and, at an early stage of the research, we decided to offer information and advice as well as any practical assistance we could, to the communities. The core of our research team were women and the project drew together academics, members of the health profession and community representatives in a co-operative response to the threat presented by the spread of HIV/AIDS in KwaZulu. Our team consisted of epidemiologists, anthropologists, and a medical doctor working as a researcher for the Medical Research Council. We recruited other health workers and graduate students to assist in the fieldwork and, where possible, we drew on the support and assistance of clinic staff working near, and used by, the two communities studied. Once established, our link with the communities was, however, through a number of community liaison workers who were paid by the project¹.

Rooting AIDS information in the community: the role of the liaison people

We hoped to root AIDS information and awareness in the two communities through a continuing and interactive combination of 'pure' and participatory research in which the academics and health practitioners on the core team would be linked to each community through the liaison people chosen by the communities themselves. There were three reasons for having community liaison workers on the research team: first to create direct and two-way access to the communities through which we could communicate the AIDS message and through which the community could communicate their ideas and needs, as well as their reactions to our message and activities; second, to facilitate the collection of research material which we believed should inform our intervention practice; and third, to develop a local and, it was hoped, long-term resource for raising and sustaining AIDS awareness and providing AIDS information within the community members.

So they could be an informational resource for the communities, we gave each liaison person an AIDS education course. This took place at the Medical Research Council's Durban office to which they came on average once a week to begin with, and about once in two weeks as the project matured and they needed less support. The object of these visits was also to debrief them regularly on what people were thinking and saying about AIDS in the community. We encouraged them to keep field notes either in English or Zulu and, as they got used to the idea of research, we gave them topics to pursue in discussions with some of the groups they set up, or even simply with friends and acquaintances. Examples of such topics are the issue of sex for money or how AIDS was being interpreted and fitted into the meaning system of the communities concerned. These notes, which, with the exception of the specific topics mentioned above, we encouraged to be as open and undirected as possible, proved to be an invaluable source of guidance on what was going on in the communities and the effect we were having on AIDS awareness. When the first AIDS death occurred we tracked its repercussions through these diaries, and they warned us of potential pitfalls in our

¹ The study was facilitated by the International Centre for the Study of Women, Washington DC with funding from the Health Office of the US Agency for International Development.

original research strategy. The diaries and the regular meetings with the liaison people were vital for the qualitative side of the research.

The liaison people also provided a welcome and relatively inconspicuous source of condoms to the community. In the first area studied, although the local clinic dispensed condoms freely and easily, the supply ran out on occasion and some people were embarrassed to be seen going to the clinic for condoms 'too often'. Youngsters who were intimately known to the more mature locally based clinic staff were not surprisingly reluctant about such clinic visits. Although they worked closely with local clinic sisters, the liaison people were 'of the community' rather than part of the formal health care structure of the area; in this lay the prime 'participatory' and 'action' component of the project as well as its hopes of sustainability. As it turned out things worked out rather differently in the two communities.

The communities studied

The two communities which were the target of our research are situated on the outskirts of Durban, the largest city and source of employment in the KwaZulu region. Durban is the most important port on the east coast of South Africa and is the centre of a rapidly growing and diversifying urban conurbation. The business and industrial hub of the region is surrounded by sprawling black settlements made up on the one hand of the 'townships' in which the previous government provided limited low-cost housing for black families, and on the other, large informal shack settlements which have mushroomed as people have moved to the city in search of employment. In the latter, recent rural migrants live cheek-by-jowl with second and third generation urbanites who have been unable to secure settled accommodation either in the white-dominated city or the townships. In this heterogeneous and volatile environment the second of our research communities was located.

At its periphery the formal urban area of Durban shades into what was once its peri-urban and rural hinterland. Here both formal and informal urban spread meets and intermingles with predominantly rural areas inhabited by either white or black farmers, the former being substantial landowners and the latter subsistence peasants living in areas designated first as 'reserves', and later as part of the 'Bantustan' territory of KwaZulu, where authority is vested in hereditary chiefs and their chosen councillors and functionaries. Recently political parties and particularly the structures of the ANC have begun to influence the political process in some of these areas, but others are strongholds of traditionalism and support the major opposition party to the ANC. Land is held under communal tenure and is allocated largely to married men (Preston-Whyte and Sibisi 1975). In most of these areas it is still possible to obtain enough land to cultivate on a small scale and many households subsist on a combination of migrant wages brought in by men and some women, supplemented during the summer months by the fruits of indigenous crops such as maize and increasingly vegetables. The latter are, however, often sold locally rather than eaten by the household and there is a vibrant, if low, income-generating informal sector operating in most of these areas. This provides women who have few local sources of wage employment with some possibility of making money. In such an area, some 80 kilometres from the centre of Durban, KwaXimba, our first research area, is situated.

In formal terms the social structure of KwaXimba is male-dominated with men not only wielding political authority, but dominating in the domestic sphere as well. Members of the research team witnessed the election of office bearers to the newly formed civic structures and found that the majority of married women, although clearly well respected and influential in the community, would not allow their names to go forward for election because they had not got the prior permission of their husbands.

In contrast to rural KwaXimba, it is more than 20 kilometres from the centre of Durban to the second area studied, Nhlungwane, at the junction of what was originally one of the

largest of the city's formal black townships, and the informal shack area which has sprung up alongside it. The residents of Nhlungwane do not have fields or gardens and they pay high rents to local landlords for the small plots on which their shacks are built. Both men and women commute to work daily and the chances of either formal employment or informal money-making are far better than at KwaXimba. On the debit side, many women at Nhlungwane are not permanently supported by men. This is an area where single, divorced and widowed women have been able to establish households and it is widely known as an area where both older and younger women run their own households, giving them the independence which the married women in KwaXimba appear to lack. A number of outside organizations as well as the local ANC have run women's groups in Nhlungwane for some years: women were well versed in politics. Indeed, at one of our meetings, copies of the newly translated Freedom Charter was being distributed and eagerly discussed.

KwaXimba: working through community structures

At the time of fieldwork the KwaXimba Chief, who was a staunch member of the ANC, was in the process of democratizing the authority system of the community. A number of civic associations, commonly referred to as 'democratic structures', had been formed, including some focused on the youth and, at least theoretically, on women also. In order to gain entry to the community we worked through and sought the co-operation of all of these bodies. We began by explaining the purpose of our research to the Chief who was fortunately known to one of the core research team; he passed us on to the community-based structures and allowed us to address an open meeting of the whole community. Referred to in Zulu as an *imbizo*, this was not set up only for our message: it was one of the regular occasions for communication between community members and their leaders and happened to be one at which important elections to the civic structures were held. We thus met, and were met by, many of the key people in the community and we believed that agreement to our project was ratified, and the story of our work would begin to filter into the community through those present. In this we were largely correct and we are grateful to the KwaXimba male youth leaders, who arranged to meet our team over weekends in their precious free time and took a personal interest in our research. While it is true that these men facilitated our work, their involvement to the virtual exclusion of local women, with the exception of the clinic sisters, appeared to us problematic.

Male permission to study women?

In the early phases of setting up our research it was noticeable that, although the members of the research team were women, and the focus of the study was on women, it was men to whom we were talking and men whom we appeared to have to persuade. The clinic staff are women, and we visited them and solicited their co-operation, but the real permission came from male dominated community structures. Had these been threatened by our proposals we believe that we would not have been able to proceed, let alone put into operation any participatory research.

Choice of liaison people

Following the *imbizo* we began a series of smaller meetings with civic organizations and, in order to set these up and to root ourselves firmly in the community, we asked the Chief and civic association to provide us with a liaison person who would be paid by the project. Since the project focused on women, we thought that a mature local woman with a good profile in

women's organizations would be a good choice. It was suggested to us, however, that such women are very busy and that the position might be better filled by two people on a part-time basis. In the end, the names of two young women were put to us. Both spoke English well and one was already working as a secretary to the Chief, but, we were assured, had time to spare to assist us. Because she worked at the courthouse which was situated just beyond the local clinic, she was already at the centre of important civic and health related activities. The other had recently left school and was waiting to further her education. She was, however, the daughter of an influential middle-aged married woman who was active in local church circles and in her own right she was the centre of a considerable local youth network. The exact negotiations by which these candidates were decided upon was a 'community' matter organized through the local authority and power structures. The liaison people were, therefore, community appointees. As it turned out they were good choices and contributed greatly to the research and intervention: unfortunately one has now left the community to further her education and the other, now that the project funding has run out, is once more fully occupied with civic duties.

This raises serious questions as to whether the project is having any long-term effect, and it is possible that we did not manage, except in a marginal sense, to provide the community with a resource for dealing with the AIDS crisis as it developed. Whatever the case may be, working on the project was personally beneficial for both women. They developed their linguistic and writing skills, gained confidence in dealing with people and structures outside their own community and one earned the money to further her studies. At one level it could be argued that these are achievements in their own right, and that in broadening the base of experience and expertise of these young women and, in particular, through giving them experience of working on an AIDS program, we have added to the general capacity of the community, both in KwaXimba and elsewhere in KwaZulu-Natal, to cope with the coming crisis in health management.

The further, and more problematic, question must be posed of whether, and in what sense, the project was truly participatory, as opposed to being merely community based in that we were careful to work through the (male dominated) political structures. After all, gaining acceptance in the community is a basic *sine qua non* of most field-based social science. Was this project any different and did it have the elements of true 'action research' associated with it? Here we are more sanguine. The liaison people set up numerous meetings for the rest of the research team to speak to local groups: more important, in the first seven months of research we received no fewer than eight spontaneous requests for meetings. Had we had a larger team we might have been able to cope with more. Eventually the liaison people were able to address many of these meetings: an indication of the success of our training of them to take over the role of AIDS educators. Of course there were some failures. As is inevitable where telephonic communication is problematic some meetings did not materialize, to the frustration of those who had initiated them, whether research team or community group. Thirty-eight formal meetings with some 979 people were held in addition to the numerous one-on-one discussions and informal consultations with the research team which occurred when they were visiting the area. On the whole our public meetings were well attended and discussion enthusiastic, concerned and critical. We were called upon when crises occurred in the AIDS field, for instance when the clinic sister felt the need for counselling for the family of the first girl to sicken and die of AIDS; and we were invited to community events such as the celebration held to commemorate the heroes of the community who had sacrificed their lives for liberation. We believe that had the project been able to continue, these occasions for involvement and reinforcement of the AIDS message would have increased.

The reasons why this was not possible need to be seriously addressed. Like all externally funded aid programs, the project had a finite life span. When the funding ran out the liaison people found other employment and the academic members of the research team moved on to other tasks. At this point the project should have become self-perpetuating and self-sustaining. The work of the liaison workers should, perhaps, have been absorbed into the routine responsibilities of the clinic staff, and to some extent this was the case. The request by the sister for assistance indicated her awareness of the larger picture of the impact of AIDS/HIV on the community she served. Ideally funds should have been available from the state or the health structures of local government for retaining the services of the liaison people or for putting such a service onto a permanent footing. With its emphasis on primary health care and the training of grass-roots health personnel, the new government's National Health Plan is, indeed, a move in this direction. In this connection it may be noted that the medical doctor on the research team is now the Minister of Health and the epidemiologist has been appointed the National AIDS Director in the new Department of Health (AIDS Analysis Africa, 5/6/95).

Locally, the picture is less good. One of the reasons why it became difficult for team members to continue to interact with the KwaXimba community is the violence which engulfed the area soon after the national elections. Outsiders were at times no longer safe nor welcome and even the clinic staff were beleaguered for periods and the health services curtailed. When the first two authors of this paper attempted to visit KwaXimba in 1995 it proved to be impossible because of the instability of the political situation leading up to the local elections. Robust local structures need to be in place to carry the burden of continuing AIDS awareness work.

Combining intervention and survey work with qualitative research techniques

Returning to the course of the Woman and AIDS research project, we comment now on the way we were able to combine AIDS education with the gathering of research data. The academics and medical specialists on the research team were often called on to speak on AIDS/HIV at many functions in KwaXimba: when this occurred we took the opportunity for data gathering. From the questions asked on these occasions we learned about local attitudes to sex, condoms and, indirectly, the position of women and gender relations. These discussions constituted the qualitative side of our research and on that basis we developed a questionnaire which was administered to women in a sample of some 100 households. Although the interviews were conducted by trained outside interviewers on the research team, the liaison people accompanied them to each home, introduced the survey and facilitated the interview. They got discussion going on the problematic issues of youthful and non-marital sex as well as knowledge and attitudes to HIV and AIDS. Although care was taken that the chosen respondent answered the questions alone, the rest of the informal team chatted to others in the household while this was going on and the occasions of the interview often resulted in informal and intimate discussion sessions. Women and sometimes men took part and, in this way, wide participation in the project was achieved at the household level. Subsequently, a second questionnaire was designed for men and administered in much the same manner with the same widespread result. Although we recruited outside male interviewers, the liaison women facilitated the interviews, thus, indicating clearly and publicly that AIDS is not divided on gender lines.

The field work done at KwaXimba was, an example of community research and intervention in action: the study was talked about, the message debated and the presence of the liaison people working with and leading the outside researchers helped to make it participatory, at least in some important senses.

Gender again - but age as well

In the meetings at which only women were present and in many of the small groups formed during the administration of the survey, the informal participation of the liaison people who were themselves women gave other women the opportunity to speak and debate what are essentially gender issues in real depth. Often in the larger meetings at which women were present with men, only a few local women, if any, spoke. The community is still sufficiently patriarchal for men, even if there are only a few present in relation to many women, to dominate discussion. If the men concerned are, furthermore, older or members of the senior 'tribal' establishment, the passivity of women and particularly young women, was even more pronounced. In contrast, in groups in which only women were present, they spoke out forcefully, although where there was an age difference, younger women were more silent than older women. In the groups in which young women and girls predominated, lively discussions emerged in which all took part. The fact that these sessions were presided over by the liaison people, who were themselves young, allowed for questioning and possibly, real learning in these groups through the discussion of shared experiences; so much of what we learned about the potential problem of HIV and AIDS in KwaXimba was refracted through youthful eyes. The choice of the particular liaison people was, as we have seen, a community one, and if it had drawbacks, we believed we had to accept them. Research which is participatory is led as much by the community and its internal dynamics as by the researcher.

In the long term we believe that the focus on youth is an expression, whether conscious or unconscious, of the KwaXimba community's response to AIDS and the questions which AIDS and HIV raise about youthful sex and sexuality. Indeed, a frequent concern voiced at our meetings focused on teenage pregnancy and the implication often seemed to be that we would be better occupied trying to deal with this long-standing problem than merely with the more recent AIDS problem.

AIDS is a woman's problem

Although men were often present at our meetings and we had had to get their permission to do the research, the decision to develop a male questionnaire, to involve men as well as women actively in our work and to include men in our research team, was made well into fieldwork. It was done at the suggestion of the liaison people. When a young woman died of AIDS — the first death in the community — they warned us that AIDS was being construed as a woman's problem and disease. The fact that our whole research team were women and most of our activity appeared to be directed to women, had only served to reinforce this perception. We were not doing true community-based participatory research because, in our concern about women and our own gender-based interests, we were excluding men. Paradoxically it was a lesson that confirmed what women were telling us about the constraints on their ability to say 'no' to unsafe sex.

Financial dependence on men

Much has been written on the unequal position in which most women, and especially those who are poor, find themselves *vis-à-vis* men in sexual relationships. As the KwaXimba women gained confidence in 'answering the experts back', an eloquent spokeswoman summed up:

It is all very well for you to tell us to protect ourselves against AIDS by sticking to one partner or using the condom. What if we and our children are hungry and we have no other way to get money? ...some local women who accept money for quick sex are not simply casual prostitutes. They are mothers and people with stomachs ... sometimes these women are young and sometimes old. Even married women are dependent on their husbands for money .

Her suggestion was that the project did a lot of talking but would be more helpful if it offered women some practical suggestions about how to solve their economic problems. Here the implication was clear that the research team did have well filled stomachs and were not participating in any sense in the life common to many KwaXimba women. Worse, we were not doing anything about it, or even attempting to do so. In her terms the research was neither participatory nor action oriented. Looked at in these terms she was right. Stung by these strictures and their implications we hoped to do better the next time around.

Nhlungwane: working through women's groups

People living in rural areas in South Africa are used to a certain lack of facilities. By no stretch of imagination is Nhlungwane rural: it is clearly part of the ever-growing conurbation of greater Durban. It offends, however, because it offers none of the usual amenities expected of urban life. In fact Nhlungwane has simply mushroomed as people who have been dispossessed of their land and homes in other places have sought refuge in what was once a rural backwater. They have built their own houses and shacks wherever they could beg or rent a small piece of land. There is a clinic at some distance but, save for the main highway leading past the area, there are no properly tarred internal roads. There is no regular refuse removal nor a postal delivery service to individual houses. Electricity is rare and has been installed at great cost by those wealthy enough to do so. One landmark dominates and this is the three-story ANC-built community hall which towers over the surrounding shacks. It is surrounded by a high fence and the key of the sturdy gate is kept by a caretaker who lives next door. Within the wire fence is a bank of post office boxes, witness to the failure of the post office to cope with either the rapid spread of shacks or the violence which is endemic in the area.

From our point of view Nhlungwane was an attractive site for research because there had been a fair amount of mobilization among women and many of the residents were single and running their own homes. This made them very vulnerable in economic terms, but also fairly independent and militant. A number of non-governmental organizations dedicated to economic upliftment, to 'development' and to political and social transformation, as well as the structures of the African National Congress, have been active in the area and it was possible to call a meeting of women without formally going through any male authority structures as we had done in KwaXimba. On our side was once again the fact that one of our research team was a high ranking member of the local ANC Women's League; her influence and presence at the initial meeting facilitated our entry to the community. Through her initial intervention the first community meeting focused on AIDS was called in the area. It was held in the recently completed community hall and people were informed of its time and purpose through the local ANC network. Although some men were present, the majority of the audience were women.

Having explained our project and intention we asked the women who had assembled to propose a liaison person to work with both us and themselves in AIDS education. The person who emerged was a mature woman with years of experience in community activism. Her command of English was not as good as that of the KwaXimba liaison people, but her

networking within the community was excellent and she had a wide range of contacts with older women and, incidentally, with men as well. In herself she is a community personage. She has also been and is seen in the community as being committed to 'community' work. In this sense her personality and personal history had much to do with the response to our intervention and to the course it took. Another lesson here for participatory intervention research: how much is the success of the method due to the luck of personality mix and personal initiative on the part of critical role-players?

Empowerment - the female condom or jobs

After the initial gathering our *modus operandi* in Nhlunwane was for the liaison person to call large women's meetings which drew on existing voluntary organizations and other informal groupings. At these one or more of the research team explained the purpose of the research, and introduced the critical issue of AIDS, HIV and the need for women to protect themselves; she then asked for comments and questions. The response was immediate and challenging. The existence of multi-partner sex was acknowledged without hesitation, but the women quickly analysed the barriers to protecting themselves. 'Bring us a female condom', they insisted, 'or give us jobs so we are not dependent on men'. They also pointed out that they had many problems to contend with: inadequate housing and shelter, no running water or electricity, few health care facilities, no vote or power to change this. It is not only in our perception that the answer to gender constraints on 'safe sex' lies in empowerment: they were only too aware of this as they are of the wider political struggle in which black South Africans are engaged. At the practical level, however, they spelled out the financial constraints governing their lives and came up with a few simple and practical suggestions: help with the purchase of sewing machines or a candle-making machine so that they could make money; and, of course, the female condom. The idea was to form co-operative working associations which would seek training together, and co-operate in the purchase of materials and possibly marketing. The project's liaison person was to be their facilitator.

The candle-making project

In the end, all that the group asked of the AIDS project was a small grant to buy materials and cover the costs of transport to make the necessary purchases to start the candlemaking project. The liaison person, using her considerable initiative, identified a local woman who owned a candle-making machine and who was willing to lend it for a few days, and to teach the new group how to use it. It was decided that the women would each pay a small sum into a common pool when they joined the group, but that they would get this back if they left the group. Those who could not afford this sum, but who wanted to join, were allowed 'credit' until such time as they made some money from the sale of communally produced candles. A small committee was formed but the major responsibility for arrangements fell on the shoulders of the liaison person who saw herself as working both for the AIDS project and generally for 'community development'. In fact her salary from the AIDS project covered some but not all of the time and energy she expended on the candle-making project.

The making of candles is not difficult: having got the money to begin and after a demonstration and the loan of a machine, the project progressed well and began to generate some income for a core group of between ten and twenty women. Looked at in one way, this is, of course, a drop in the ocean of 'development' and, had the AIDS project continued we would surely have been approached with other similar requests. Other groups or lobbies would have emerged with their own demands and priorities. We have then to ask to what extent we could possibly have met these, or should have felt an obligation to do so.

The challenge to a participatory research model

In retrospect it is clear that the suggestions for forming a candle making-group, and the route that was taken in establishing the group, did not materialize from nowhere: the processes involved were part of the empowerment strategy and rhetoric of many development agencies which have been working in the region for some time. We were, in fact, being treated as another potential donor (virtually as an NGO) and as a resource to be tapped for money to enable some women to gain access to the skills and material base which would facilitate, if not 'jobs' exactly, at least the possibility of income generation. The challenge which this represented for the project was to sanction the use of research funds for a type of practical initiative never envisaged in the funding proposal; and one, moreover, with no direct link to either AIDS or health promotion in even the broadest sense. This move, however, was where community involvement, and through that particular liaison person, participatory and action research, had led.

It was only after much discussion within our research team that we decided to accede to the request for 'seed money' to start the candle-making group. Reservations were expressed about what, to the medical people on the team, appeared to be an initiative only tangentially linked either to the objectives of the project or, indeed, to general health concerns. The anthropologists on the team were used to wide-ranging requests from research participants for practical assistance and, in keeping with their personal and professional belief in both the ethics and concrete advantages of reciprocity in research, they argued for the proposition. Their reservations lay in the doubt that, with the possible exception of the liaison person, any of the team had sufficient experience in development, and in applied work in the development field, to make the project a resounding success. They were persuaded, however, that if this was the way their community partners wished to proceed, the research team should accede to the request. In the end the logic of the participatory model persuaded all concerned. It was a judgement call, and even in the light of the fact that the group did not survive more than a year, we still believe that it was the right decision.

Reviewing the Woman and AIDS project

In mid 1995 two members of the research team returned to Nhlungwane. In contrast to what happened in KwaXimba, after the end of the Woman and AIDS project the liaison person at Nhlungwane has been employed by another non-governmental funded AIDS project. She has remained living near the community hall and has maintained her position in the ANC local political structures. Both her personal commitment to the role of community activist and the expectations of her new job take her into the homes of many of the local people. She is now a counsellor for people and the families of people with AIDS, but it is clear that she also still regards herself as an AIDS prevention educator. At a meeting which we held to demonstrate the female condom to Nhlungwane women she arrived with a dildo and graphically took over demonstrations of the differences between male and female condoms. It is fortunate that her new job has carried on and deepened both her understanding of HIV/AIDS and, because her brief is to deal largely with the families of people living at Nhlungwane who are diagnosed as HIV positive by the largest referral hospital in Durban, she is heavily committed to AIDS as a continuing problem and is still associated with it in the minds of the community. The problem is that, as in the case of the Woman and AIDS project, her current employment is

only on a temporary contract. She is looking for another job and would clearly be attracted to one which is permanent, even if it were not in the AIDS field. Her undoubted skills as a community organizer and facilitator — which she has honed in her last two positions with AIDS education and care — will probably make her eligible for a number of positions which are in the Development rather than the AIDS and Health field. As at KwaXimba, this raises the problem of project sustainability in the face of a lack of civil service establishment posts for health personnel at the community level.

It might well be asked if her work over the last four years in the AIDS field has not served its purpose; are people, and particularly women, at Hlungwane not fully aware of the threat which HIV constitutes for them? We think that this may well be so. Certainly we found that women at the meeting which the liaison person convened for us were well aware of the threat which HIV infection holds for them and their children. When asked who was most at risk, they immediately replied that it was women, and commented that this was because their partners had other women and they, themselves, were dependent on men for support. As before they made the point that if they had jobs they would be able to refuse sex to men who refused to use condoms. The point was also made without prompting that women should be able to avoid unprotected sex with a number of men. 'Poverty makes us to be prostitutes', they said. Although most were not completely clear about the distinction between HIV positivity and full blown AIDS, this is by no means uncommon the world over. The connection between sex and particularly multi-partner sex and HIV infection was reiterated again and again. So was the fact that condom use prevents infection.

While, however, knowledge of risk and also of the role of male condoms in protection was generally present, when we asked if their partners were using male condoms, it was clear that very few were. This created some embarrassment as this response was clearly seen as reflecting poorly on them and on the liaison person. It led to a discussion of what are essentially the wider political problems of the area: poor housing and lack of employment. The point was made that there were numerous development projects in the area but they did not go to the heart of the problem. 'They do not get us jobs... it is good to have women's groups to help us but there is no group to support you when you are alone with your husband...'. One woman said then 'it might be better if we had a female condom...' and this led immediately to an excited discussion of the topic. One of us who has been active in promoting the female condom in the United States was able to describe the mechanism in some detail but the call was to 'see one'. Hence the reiterated demand that we return with the female condom for them to see. On our next visit we did just that.

Although they are not readily available in Durban, we managed to borrow the demonstration kit issued by a well known brand of American manufactured female condoms from another researcher. The reaction was immediate and positive. About twenty-five women had collected in the Hlungwane community hall to meet us and after the demonstration they eagerly handled the condoms and jokingly practised using them on the dildo provided by the liaison person. When we cautioned that men might reject their use as they did the male condom, the women overrode our hesitation: '...we can use it and teach other people to use it ...it is better that you bring it quickly...and that it is free..'. This opened the way for a discussion once again of the problems which women face in the area, the lack of adequate housing and employment being paramount:

In these small two roomed shacks the children can hear everything...maybe it will be difficult to talk about this new kind of condom ...what we need is better houses.

It will be easy to use the female condom if you are working. You just say to your husband that you must not get pregnant or you lose the job. Even a woman can stay alone with her children if she has a job. So we need jobs.

...if we have this new condom we will get our men to use it ...it will help us a lot.

We are mostly relying on our husbands because of unemployment . The only way of leaving them is employment. If we earn money we have power if we can wear them we will be free.

Clearly the support for the idea of female condoms went hand in hand with notions of employment and independence from men. The fact that the women at Hlungwane were so responsive to the idea of female condoms was not unrelated to fact that they were already mobilized on the political front. Although they acknowledged very clearly their financial dependence on men, they believed that, given money, they would be in a position to call the tune in terms of HIV protection. Whether they are right or wrong, they believe that a different future and a different kind of relationship with men is possible. Although we could not revisit KwaXimba because of the violence in the area, we had never on our previous visits been made aware of a similar optimism and confidence. Nor did the field notes of any of our research team reflect such perceptions. While the KwaXimba women also called for jobs and money, they did not overtly take the next step in envisaging the possibility of a different gender dispensation in which these things might provide the basis for independence from male control, nor did they see the possibilities of the female condom in this respect. Cautious readers may believe that we are stretching our evidence too far, but they have not been present at meetings such as those held at Hlungwane where women demonstrate confidence in their ability to equal men — or live without them. Herein lie, we believe, the roots and evidence of gender empowerment.

It is, however, not only emerging empowerment with which we are dealing at Hlungwane. As suggested above, the women are seasoned political troopers. Female condoms, although available in some pharmacies in South Africa, are extremely expensive even for relatively wealthy middle-class women. The national AIDS program and the Ministry of Health intend to make them available free through clinic services, but there will be a delay of at least three months before this will occur. When we relayed this to the women at Hlungwane they were indignant:

You must tell the Minister (of Health) to send us female condoms first ... we need them here and we will show they can work.

Tell the Minister (of Health) to bring the female condom quickly ... if it should have come before we would have limited our families more easily...

After this they turned to another practical issue: the felt need for local women to be trained as community health workers. This is, in fact, part of the recently announced Health plan for the country and so, once again, we believe that the idea did not surface on its own. It is part of the political rhetoric of the ANC structures. In addition, of course, the women see the liaison person achieving well-paid employment as a result of her expertise and experience in the field of community based AIDS education, and these would like to be able to follow suit. A bone of contention in this respect concerned the age limit which is apparently being suggested for these workers — they have to be under forty:

There are lots of us who are older and who have much experience and are not too old to work hard.

Lessons from Hlungwane

What can we learn from the experiences recounted above? Most important, the women at Hlungwane felt able to make representations to government and we ended the meeting by writing a letter to the Minister. The women signed their names in an exercise book and spoke into our tape recorder so that 'she (the Minister) can know that no lies are being told'. While many of the women knew the Minister from her days in the local branch of the ANC, and the influence and leadership of the community liaison person was very clear, the women in the group were well aware of the fact that a political strategy was being played out. They had had experience of similar situations, and had been the beneficiaries of political mobilization before. In fact a concrete expression of the power of local political manoeuvring had been the building of the very hall in which we were meeting. At Hlungwane we suggest that political mobilization and gender empowerment reinforce each other. In the instance we have described, HIV/AIDS protection has been added to the equation. 'Bring us the female condom' might be taken as a symbolic statement of the social and structural transformation which is characteristic of some local shack areas where the space is available, both actually and figuratively, for women to create a 'New South Africa'.

The question arises, of course, why the same active response and willingness to try the female condom did not surface in KwaXimba. The main reason is that in that community the women, while active in women's organizations, had not made the move to active participation in the wider political arena. They had not been actively mobilized by the ANC, as shown by their reluctance to take public office without the permission of their husbands. In addition, most were living under the domestic control of husbands, fathers or other male guardians. Few had experienced great opportunities for independent money-making and, as they acknowledged, their main source of 'private' income was often in the field of either casual sex or longer-term sexual relationships. While the latter was also true of many of the women at Hlungwane, the geographical situation of the area so near to Durban means that there are more formal-sector jobs available to women and the informal sector is certainly more lively than at KwaXimba. Also, the fact that many women have no husband means that they must enter the labour market in some form. No doubt this experience is, in itself, liberating to a certain degree. Overall the positions of women in the two areas are qualitatively different.