Spring 1996

The Condom Crisis: An Application of Feminist Legal Theory to AIDS Prevention in African Women

Anne N. Arbuckle

Indiana University School of Law

Follow this and additional works at: http://www.repository.law.indiana.edu/ijgls

Part of the Health Law and Policy Commons, and the International Law Commons

Recommended Citation

Available at: http://www.repository.law.indiana.edu/ijgls/vol3/iss2/4
The Condom Crisis: 
An Application of Feminist Legal Theory to AIDS Prevention in African Women

ANNE N. ARBUCKLE

INTRODUCTION

At the Tenth International Conference on AIDS held in Yokohama, Japan in August, 1994, one of the primary focuses was the urgent need for revised Acquired Immune Deficiency Syndrome (AIDS) prevention strategies for women around the world, particularly those in developing countries. In a speech to the opening plenary session, Dr. Michael Merson, chief of the World Health Organization's (WHO's) Global Programme on AIDS, asserted that for women to effectively confront the HIV epidemic, they need to be "empowered." Although empowering women globally is a necessary long-term goal, it will require a social revolution the course of which will not be complete in time to curtail the growing numbers of HIV/AIDS-infected women.

Accordingly, this paper suggests an alternative to the notion of empowering women as an AIDS prevention technique. It proposes applying feminist legal theory to more realistically effectuate HIV/AIDS prevention through condom promotion. This approach recognizes the history of gender inequality and the fact that women in most African cultures continue to be subordinate to men. But rather than attempt to overturn centuries of tradition, this approach accepts gender inequality in an effort to implement a more immediate solution vis-à-vis the condom. To date, the condom is one of the most effective methods for preventing sexual transmission of HIV, second only to abstinence.

AIDS is a "disease believed to be caused by a retrovirus called HIV and characterized by a deficiency in the immune system. [This deficiency] often leads to infections caused by opportunistic microorganisms in HIV-infected women."
Because of the depressed and weakened condition of the immune system, the body becomes unable to defend against viruses, bacteria, and fungi that commonly inhabit it without causing harm. AIDS is the most ubiquitous and tragic pandemic disease in recent history because there is no cure for the disease. It has had a profound impact on the social and economic infrastructure of the nations and communities suffering from it. Accordingly, it has caused the world to reassess its approach to prevention techniques.

As of December 1994, seventeen million people were infected with the HIV virus, seventy percent of them living in Sub-Saharan Africa. According to the WHO, approximately nine million adults have been infected with HIV in Sub-Saharan Africa. The WHO estimates that sixty-seven percent of the three million estimated AIDS cases have occurred in Africa.

Women are the fastest growing population of HIV infected persons. The virus “has infected more than seven million women worldwide and estimates show that thirteen million women may be infected by the year 2000.” Women made up one-half of the number of cases of HIV diagnosed in 1992. The rate of HIV infection in African women is increasing, particularly in Sub-Saharan Africa where four million women are believed to be infected. According to Dr. Eka-Esu Williams, president of the Society of Women and AIDS in Africa, the rate of HIV infection in African women is thirty-five times higher than in European women and eighteen times higher than in women in

4. Alan Riding, Paris Meeting Backs U.N. Program to Combat AIDS, N.Y. TIMES, Dec. 2, 1994, at A12. The statistics used throughout this paper were accurate as of March, 1995. Given the nature of the AIDS epidemic, the numbers have probably increased.
5. Many AIDS cases worldwide are unreported for numerous reasons that are beyond the scope of this paper. See PETER O. WAY & KAREN A. STANECKI, U.S. BUREAU OF THE CENSUS, THE IMPACT OF HIV/AIDS ON WORLD POPULATION 3 (1994). One reason cited is that the 1987 Centers for Disease Control (CDC)/WHO case definition of AIDS did not include diseases common to women, such as pelvic inflammatory disease. See STINE, supra note 3, at 40. Accordingly, the definition was expanded in 1993 “to include all people with CD4 lymphocyte count of less than 200/mm³.” Id. Two reasons were given for the revision. First, that the 1987 definition did not reflect the pandemic disease in women; and second, that those people with CD4 counts of less than 200/mm³ are more likely to be severely disabled or ill. Id.
9. Id.
the United States. Also, in the mid-1980s, the ratio of infected men to women in the Ivory Coast was four to one; in 1993, the ratio narrowed to two to one. Moreover, the rate of infection of pregnant women in Nairobi increased from 6.5 percent in 1989 to thirteen percent in 1991. In urban Rwanda, ninety percent of all deaths of women of childbearing age are caused by the HIV virus.

Despite awareness since the mid-1980s of the growing problem of AIDS in African women, these recent statistics have finally captured the attention of the world. Accordingly, AIDS prevention, particularly for women, became one of the focal points at the Tenth International AIDS Conference held in Yokohama. The participants recognized that the current global AIDS strategy has not been effective in preventing the spread of AIDS in women, despite widespread publicity and prevention programs. As the statistics have shown, the numbers continue to rise. The global AIDS strategy is proving to be ineffective and has become a source of false reassurance, especially in the developing world. Jonathan Mann, the director of the International AIDS Center at Harvard's School of Public Health, told the Conference participants: "The major societal risk factor for vulnerability to HIV is to belong to a group which is discriminated against, marginalised, stigmatised by and excluded from society." Zena Stein, co-director of the HIV Center for Clinical and Behavioral Studies at the New York State Psychiatric Institute, told the Conference:

We must induce [and] encourage communication of sexual matters between men and women. . . . The view held by men in many cultures [is] that they have the right to dominate sexual relationships, including the privilege of using or not using a condom . . . . The next possibility

---

15. Id.
is for the woman explicitly to take responsibility and for the man to accept to transfer the role.\textsuperscript{16}

The ability of African women to take the next step depends on the need for increased social, economic, and cultural opportunities for them so that they can better protect themselves against HIV/AIDS. Political and social reality indicates, however, that this is not happening, nor is it likely to happen soon enough to stop the AIDS epidemic that has become so catastrophic in Sub-Saharan Africa. To be sure, effectively changing the cultural and economic status of women all over the world, as well as in Africa, would require a kind of social revolution, a tall order that cannot be filled in time to stop the increasing destruction of HIV and AIDS. In essence, the problem of HIV infection among African women is an urgent problem needing a more immediate solution than a long-term social, cultural, or economic solution can provide.

The purpose of this paper is to suggest a different way of approaching the AIDS problem in African women, based on what feminists describe as the asymmetrical or difference model. In pursuit of this purpose, the paper is divided into five parts. Part I briefly discusses the current global AIDS pandemic disease and the AIDS crisis in Africa specifically. Part II examines the role of women in African society and its contribution to their vulnerability to HIV infection. Part III begins by discussing the condom as the most widely publicized and suggested prevention technique in Africa. It continues by outlining how African culture and certain misconceptions about the condom have contributed to its ineffectiveness in preventing the spread of AIDS among women in Africa. Part IV discusses the equal treatment/special treatment, or sameness/difference, debate in feminist theory and criticisms of each approach. Part V concludes by suggesting that the acceptance model be used as a way of approaching prevention methods and, ultimately, curbing the rising numbers of African women becoming infected with HIV.

\textsuperscript{16} Abi Sekimitsu, \textit{Women Urged to Take Control in AIDS Prevention}, Reuters, Aug. 8, 1994, \textit{available in WESTLAW, INT-NEWS Database}. 

I. THE GLOBAL AIDS PANDEMIC DISEASE AND ITS IMPACT IN AFRICA

"The total number of HIV infections worldwide increased from 14 million to 17 million in the past year" according to the WHO. 1.7 A July 1994 report by the WHO estimated that the global number of AIDS cases was four million, an increase from 2.5 million the previous year. 18 By the end of 1992, the WHO estimated that 1.75 million people in Sub-Saharan Africa had developed AIDS. 19 By mid-1993, the WHO "estimated that over eight million people in Sub-Saharan Africa were HIV-infected, representing more than half of all HIV infections in the world. WHO expects the number of AIDS cases [in Sub-Saharan Africa] to exceed five million by the end of the century." 20

The number of deaths caused by HIV/AIDS in the Sub-Saharan region has been growing steadily since the mid-to-late 1980s. Since 1987, AIDS has been the leading cause of adult death in Zaire. 21 As of 1990, studies from Uganda and the Ivory Coast showed AIDS to be the leading cause of adult death. 22 As of October, 1994, seventy-three percent of women and fifty-five percent of men in Kigali, Rwanda were HIV positive, including up to sixty percent of soldiers. In addition, one in three HIV-positive mothers in Kigali gives birth to an infected child. 23

The HIV/AIDS pandemic disease contains many separate epidemics that involve different risk behaviors and sexual practices. 24 Currently, there are three patterns of HIV transmission identified by the WHO. 25 In Pattern II, occurring in Africa, the Caribbean, and South America, HIV is spread mostly by heterosexual sexual intercourse. 26 The homosexual lifestyle is not prevalent in these areas; therefore, homosexual transmission is rare. Transmission via

17. Paul Cotton, Human Rights As Critical As Condoms Against HIV, 272 JAMA 758, 758 (1994).
19. WAY & STANECKI, supra note 5, at 7.
20. Id.
21. De Cock et al., supra note 12, at 481.
22. Id. at 481, 485 nn.4, 6.
24. WAY & STANECKI, supra note 5, at 3.
25. Pattern I occurs in industrialized nations such as the United States, Western Europe, and Australia. The primary mode of transmission in Pattern I is through homosexual sex, bisexual sex, prostitution, and drug use. Pattern III occurs in Eastern Europe, the Middle East, North Africa, Asia, and the Pacific, areas where the prevalence of HIV infection is growing but has not yet reached the proportions of infection in areas of patterns I and II. See STINE, supra note 3, at 162, 164.
26. Modes of transmission in Sub-Saharan Africa: heterosexual sex, 94%; transfusion, 4%; homo/bisexual sex/intravenous drug user, 1%; other, 1%. WAY & STANECKI, supra note 5, at 7.
intravenous drug use is also rare due to the lack of availability of drugs.\footnote{Stine, \textit{supra} note 3, at 164.} Thus, factors which have contributed to the rapid spread of HIV in Africa are multiple sex partners and untreated sexually transmitted diseases.

The virus tends to follow migration patterns and transport routes. It spreads fastest where men are living apart from their wives in search of employment (usually in the city). Due to these employment patterns, there are more men than women living in cities. Poor women in need of income often turn to prostitution to support themselves and their children.\footnote{Susan Okie, \textit{AIDS Devouring Africa Even as Awareness Grows}, \textit{WASH. POST}, Aug. 18, 1994, at A1.} Yet despite the central role that prostitutes and their clients play in the spread of HIV, most cases of HIV infection in African women result from heterosexual intercourse with regular partners (infected husbands).\footnote{Genevieve Mwale \& Philip Burnard, \textit{Women and AIDS in Rural Africa} 12 (1992).} In other words, most African women suffering from AIDS are married to and have contracted the disease from their husbands, who contracted HIV through extra-marital sexual relations.

As of 1992, the ratio of HIV-infected men to HIV-infected women in Africa as a whole was one to one.\footnote{See Peter Piot et al., \textit{World Health Organization, AIDS in Africa: A Manual for Physicians} 15 (1992) [hereinafter WHO, AIDS in Africa].} AIDS in Central and East Africa also has a ratio of one to one, most infected people being between the ages of twenty and thirty-nine. In contrast, the ratio of HIV-infected men to HIV-infected women in the United States is approximately nineteen to one.\footnote{Id. at A1.} As of 1993, in some African nations, the number of women diagnosed exceeded the number of men diagnosed.\footnote{Id. note 8, at A1.} In Sub-Saharan Africa, for example, the male to female ratio is ten to twelve.\footnote{Id. note 1, at 19.}

The growing numbers of HIV-positive women in Africa have been monitored since the mid-to-late 1980s. For example, the results of a study conducted in 1989 by the United Nations International Children's Emergency Fund (UNICEF) in the ten countries most seriously affected by AIDS, predicted that between 1.5 and 2.9 million women between the ages of fifteen and forty-nine in those countries will die of AIDS by the turn of the century.\footnote{Elizabeth A. Preble, \textit{Impact of HIV/AIDS on African Children}, \textit{31 SOC. SCI. \& MED.} 671, 675 (1990). The countries studied included: Central African Republic, Congo, Uganda, Rwanda, Burundi, Zaire, Kenya, Tanzania, Malawi, and Zambia. \textit{Id.} at 671.}
A team, led by Frank Plummer from the University of Manitoba, conducted a survey of pregnant women in Nairobi which found that these women considered AIDS to be the number one health concern.\textsuperscript{35} Half of them considered themselves to be personally at risk, despite their own low-risk behavior. It was their husbands' behavior that most concerned them.\textsuperscript{36}

Interestingly, despite virtually universal AIDS awareness in most African countries, little evidence suggests that sexual behavior has slowed or even changed.\textsuperscript{37} Many women in Africa cannot reduce their risk of HIV infection because they are already in monogamous relationships, and most lack the autonomy and bargaining power to introduce condoms or other preventative measures into sexual interactions. Therefore, the focus of AIDS prevention for African women must be on the "socio-economic and cultural conditions that predispose them to [the] risks" (polygamy, early marriage, and lack of empowerment within sexual relationships).\textsuperscript{38} Women's behavior need not be the primary target for change. That behavior must be understood, however, before AIDS prevention will be effective.

II. THE ROLE OF WOMEN IN AFRICAN SOCIETY

A. The Patriarchal Infrastructure and Its Contribution to Women's Vulnerability to HIV/AIDS

Women play a focal role in the African family. They are the "embodiment of care and nourishment for life."\textsuperscript{39} Women are the primary caretakers and are also responsible for the farming and housekeeping.\textsuperscript{40} Therefore, they take on additional responsibility and burden when they or another in their family becomes ill because most of the care of patients, including AIDS patients, is done in the home.\textsuperscript{41} Because women's traditional role in the family is based in the home, their access to medical care is more limited than that of their

\begin{itemize}
  \item \textsuperscript{35} Okie, \textit{supra} note 28.
  \item \textsuperscript{36} Id.
  \item \textsuperscript{37} Id.
  \item \textsuperscript{38} Mwiinga, \textit{supra} note 10.
  \item \textsuperscript{39} MWALE & BURNARD, \textit{supra} note 29 (citing E.M. Keirini, \textit{AIDS Impact on Women and Children in Africa}, 37 INT'L NURSING REV. (1990)).
  \item \textsuperscript{40} Id. (citing Keirini).
  \item \textsuperscript{41} Id.
\end{itemize}
husbands. In addition, they may not even have access to information about the ways HIV is transmitted. AIDS prevention materials are often distributed in public places, such as the workplace, schools, and via social organizations, places these women rarely enter.

Even married, middle class, and monogamous African women are becoming infected, despite their knowledge about AIDS, the way it is spread, and prevention methods.

Her role and status in society do not allow her to say no to unwanted, unprotected intercourse, even if she knows her husband is infected. There is no viable option for her to refuse unwanted, unprotected intercourse until that woman's rights, role, and status are changed. Then and only then will the potential value of condoms, sexual negotiation skills, peer counseling, brochures, and posters be realized.

Jonathan Mann, speaking at the Tenth International AIDS Conference, characterized condoms, clinics, and educational materials as "a Band-Aid over a deep wound." A recent Zambian study well illustrates his point. He interviewed women from three villages in an area called Chazaso (120 kilometers from Lusaka, the capital). Most respondents knew that the most common method of transmission was through sexual intercourse with an infected partner. A very small number did not know how the disease was transmitted. However, the respondents seemed to have no control over preventative measures, such as ensuring that men wear condoms. In fact, many of the respondents interviewed in the Zambia survey conveyed feelings of helplessness as well as awareness of the double standard in terms of sexual activity. They identified men and their own powerlessness as the problem. One respondent said, "Men are a problem . . . because men won't talk and they

43. MWALE & BURNARD, supra note 29, at 13.
44. Cotton, supra note 17.
45. Id. (quoting Jonathan Mann, M.D., director of the International AIDS Center at Harvard School of Public Health, speaking at the 10th International Conference on AIDS in Yokohama, Japan).
46. Id.
47. See MWALE & BURNARD, supra note 29, 20-25.
48. Id. at 26-28.
49. Id. at 54-56.
can’t say when they have been unfaithful and it might take up to six months before the disease is seen . . . and no one accepts the blame.***

B. Men’s Behavior as a Source of HIV Risk in Women

Many women are at risk for HIV infection due to the behavior of their regular sex partners. In Kigali, Rwanda, for example, twenty-five percent of women with one lifetime sex partner are infected with HIV.** A study conducted by the Rwandan Ministry of Health and the Center for AIDS Prevention Studies at the University of California at San Francisco, called the Projet San Francisco,*** followed the progress of 460 HIV-infected women ages eighteen to thirty-five and a comparison group of non-infected women. The follow-up study, the largest study of HIV-infected women in the world, revealed that of the 460 HIV-infected women, most were in a stable relationship, either in a legal marriage (thirty percent) or in a common law marriage (forty-seven percent).**** Fifty-three percent reported having only one lifetime sexual partner. Sixty-nine percent had no personal income and relied exclusively on their partner for financial support.*****

It is a common belief in West Africa that men are “naturally ‘polygamous.’ A variety of partners is considered to be necessary for health and well being . . . .” Further, a man’s status is often predicated upon the number of women with whom he maintains sexual relations.

Sexual promiscuity, whether labelled prostitution or concubinage, is not likely to ensure a stigma of disapproval or a stigma of evil in an African society, even if it is linked to the threat of AIDS. This

50. Id. at 56.
51. De Cock et al., supra note 12.
52. See infra text accompanying note 84 (describing the Projet San Francisco).
54. Lindan et al., supra note 13, at 321-22. Of the 38 HIV-positive women who died of AIDS, only 25% met the 1987 WHO criteria for AIDS. Id. at 323.
suggests that even with the problem of HIV/AIDS, unfaithfulness through concubines will continue as this seems to have been accepted as a norm in African society.\textsuperscript{56}

Moreover, the men who control more economic (and other) resources are able to maintain sexual relations with wives and mistresses, as well as with prostitutes and casual girlfriends.\textsuperscript{57} Thus, it seems that the people most at risk are the men who have money and the women who do not.

Women are forbidden from engaging in extramarital sexual relations. Although in some traditional African societies, women, like men, are considered to be promiscuous, their "'rights' to sexual satisfaction are subordinate to the social requirement of fidelity of wives."\textsuperscript{58}

C. Young African Women's Vulnerability to HIV Infection

Male dominance in these patriarchal societies also allows men to coerce women into sexual intercourse, regardless of the women's marital status. Early marriages are the norm in Africa.\textsuperscript{59} Moreover, unmarried young women have little power to resist unwanted sexual advances from older men, and even in cases of outright rape, few have remedies. Rape cases are often settled traditionally by the man paying a fine to the young girl's family.\textsuperscript{60} In fact, in many African countries, women are beaten if they say no to unwanted intercourse with an infected partner, and they have no recourse under the law.\textsuperscript{61} Recent studies by the WHO indicate that young women are several times more

\textsuperscript{56} MWALE & BURNARD, supra note 29, at 41-42 (quoting D. Mokhoba).

\textsuperscript{57} Edward C. Green, AIDS in Africa: An Agenda for Behavioral Scientists, in AIDS IN AFRICA: THE SOCIAL AND POLITICAL IMPACT 175, 180 (Norman Miller & Richard C. Rockwell eds., 1988).

\textsuperscript{58} KEMP, supra note 55, at 31.

\textsuperscript{59} Preble, supra note 42, at 960.

\textsuperscript{60} Green, supra note 57.

\textsuperscript{61} Moffett, supra note 14. In Uganda, however, rape has recently been made a crime as a result of the AIDS epidemic. See Collins, supra note 8. Uganda has also created, educated, and empowered village political action committees (part of the National Resistance Movement) to enforce existing laws protecting young girls who are increasingly abused by older men seeking un-infected partners. These laws are designed to protect girls from premarital sex, to discourage prostitution, and to prevent children under age 18 from drinking alcohol or frequenting bars. In addition, the Ugandan army has established a code of conduct that forbids sexual relations with unmarried girls. The effect of these measures remains to be seen. See Preble, supra note 42, at 971.
vulnerable to HIV infection than men because they are infected by older men
and at a much earlier age (ten years earlier). 62

In Uganda, for example, girls ages fifteen to nineteen are six times more
at risk than boys of corresponding age. 63 The medical explanation for this
increased risk is that the tissue lining the vagina is very thin in adolescent
girls. 64 It reaches its thickest about two years after the first menstrual period.
The vaginal mucous, which contains protectants, also thickens at this time. In
addition, the cells that surround the opening of the cervix are exposed in young
adults. 65 Moreover, girls who become pregnant at young ages have a higher
risk of becoming infected with HIV. For example, more than twenty-five
percent of pregnant women in Rwanda younger than eighteen years of age are
HIV positive. 66

The Dipo ceremony is a ritual believed to contribute to the spread of HIV
among African women because it confers sexual permissiveness on girls at a
young age. 67 It is an initiation ceremony that used to be practiced all over
Ghana on girls between the ages of fourteen and twenty. Once a girl has
undertaken Dipo, she may begin sexual activity. The ritual used to last a year;
at the end of such time the girls would emerge ready to be courted. The girls
received a series of marks on their wrists and on the back of their waist
indicating to men that they had finished Dipo and could be courted.

Today, the ceremony is practiced primarily by the Krobo people. 68 It is
purely symbolic, lasts only five days, and can involve girls as young as eight
years old. Thus, it has been suggested that Dipo leads to greater sexual
permissiveness because puberty rights are bestowed on these girls often before
they reach puberty. As a result, girls become pregnant at very young ages. 69

63. Id.
64. Boyce Rensberger, AIDS Spreads Fastest Among Young Women: U.N. Study Finds Adolescents
65. Id.
66. Id.
67. JANNIE HAMPTON, MEETING AIDS WITH COMPASSION: AIDS CARE AND PREVENTION IN
AGOMANYA, GHANA 4-7 (1991).
68. Id. The Krobo district is in the eastern region of Ghana, which has reported the largest number
of HIV/AIDS cases. In 1988, 455 people in the Eastern region were HIV positive. In 1989, that number
increased to 889, and in 1990, to 1222. Id. at 2.
69. Id. It used to be that girls who had not undertaken Dipo and who became pregnant were banished
from the tribe. This threat helped to protect these girls from early pregnancy. Id. at 7.
Moreover, because these girls are so young, they either do not know about condoms or are not inclined to introduce them to their (often older) partners. These young girls are not in a position, either socially or economically, to refuse unwanted sex or to negotiate condom use because of their youth and inferior status in African society.

D. Poverty

Women’s dependence on their husbands for financial support also contributes to the spread of HIV/AIDS among them. When their husbands’ income is not enough, many women find that their employment prospects are few and thus must turn to the “sex industry” to earn money. An example of this is found in the Manya-Krobo district of Ghana, an area of economic poverty, which has a population of fifteen thousand and an agricultural economy. The literacy rate among women there is forty percent, the lowest in Ghana. In need of money to support their families, many women went to the Ivory Coast during the 1970s and 1980s to work in the sex industry and contracted HIV.70 Because HIV tests in many parts of Africa are not readily available, affordable, or in demand, these women, among others, did not know they were HIV infected, and that they had a one in three chance of infecting children born to them.71 Therefore, more often than not, the AIDS diagnosis of her infant is what alerted the woman that she, and most likely her husband, were HIV infected.72

The prevalence of HIV in many cities increases the risk of HIV infection of all men and women with more than one sex partner.73 In Zaire, women look to “spare tires” (men to whom they offer sexual services) when they need cash.74 These women are not prostitutes but are usually traders or those with professional and clerical jobs who need the economic protection that high

---

70. *Id.* at 2-3.

71. HIV has been found in blood, semen, saliva, urine, tears, breast milk, vaginal secretions, lung fluid, and cerebrospinal fluid. A woman can infect her child either in utero, during delivery (by the child ingesting blood or other infected maternal fluids), or by breastfeeding. *See* WHO, *AIDS IN AFRICA*, supra note 30, at ch. 6.


73. *Id.* at 961.

status men can provide.73 Thus, most female sexual behavior in Africa can be traced to economic survival and adaption to patterns of male dominance.

In summary, the nature of the patriarchal infrastructure of African society and the role women play in that society have largely contributed to their vulnerability to HIV/AIDS. Men are allowed, even expected, to be polygamous; whereas, women are labeled promiscuous if they engage in extramarital sexual relations. Young women, regardless of marital status, remain vulnerable to sexual abuse and, consequently, to HIV infection. Mature women, who are dependent upon their husbands’ meager wages and forced to resort to the sex industry to support their families, place themselves and their families at great risk of HIV infection.

75. Id.
III. THE CONDOM AS A PREVENTION TECHNIQUE IN AFRICA

The current agenda of the global AIDS prevention programs is promoting the use of condoms, primarily to women. However, this strategy presupposes that these women have the bargaining power and the ability to introduce condoms to their male partners. In particular, the success of this global agenda is dependent upon three existing factors: first, the existence of relative sexual equality between men and women; second, the possibility that other sex partners can be acknowledged without seriously threatening a relationship; and finally, the existence of alternative roles for women, other than motherhood, that define their sense of self and self-esteem. Only the second of these is currently applicable to African women. The first does not apply because the average African woman is subservient to her husband or lover. The result of this traditional gender-role behavior is that these women lack power over sexual decisionmaking within their traditional sex role. The third factor does not apply because in many African societies women’s “identity, status and self esteem depend on children.” Therefore:

Programs promoting condom use related to AIDS prevention, if they are to be successful, have to ascertain whether [the above mentioned] conditions exist, and what the implications are if they do not. They have to examine the power dimensions of sexual decision-making, sexual exchanges, and the social and cultural values that support such decision-making and exchanges.

---

77. Id.
78. KEMP, supra note 55, at 59.
79. Worth, supra note 76.
A. General Knowledge About the Condom

Condom marketing programs in many African countries have shown the potential to change sexual behavior. According to the WHO, condom sales in Sub-Saharan Africa have increased from less than two million in 1986 to more than seventy million in 1993. Condom use among Kenyan men, for example, has increased from zero to twelve percent since condom marketing began in Kenya in the mid-1980s.

In 1986, the Rwandan Ministry of Health and the Center for AIDS Prevention Studies at the University of California at San Francisco conducted a condom study. These two institutions collaborated to establish the Projet San Francisco. At the start of the two year study in Kigali, Rwanda, only seven percent of the women had ever used condoms. But after participating in the program for one year, twenty-two percent were using condoms regularly.

The author of the study suggests that one reason the Projet San Francisco successfully changed behavior was because the participants knew of their exceptionally high risk status. According to the author, "Individuals who know they are at high risk [of contracting HIV] are more receptive to interventions . . . ." This notion of risk perception may help to explain why, despite knowledge about the condom as a method of HIV protection, studies in East and Central Africa have revealed that knowledge alone has not had a significant impact on behavioral change in general. Unfortunately, a twelve percent condom use rate among men in Kenya will not prevent the spread of HIV to any meaningful degree. Although radio and print prevention messages emphasizing monogamy and limiting sexual partners have mentioned . . .

80. Latex condoms block the passage of HIV in intercourse and reduce the incidence of sexually transmitted diseases (STDs) which appear to act as co-factors. Schoepf et al., supra note 74, at 218. To be effective, the condom must be worn on the penis for the entire time that it is in contact with the genital area, mouth, or anus. It should be worn prior to any penetration and care must be taken to ensure that it does not slip off. STINE, supra note 3, at 201.
82. Id.
83. Allen et al., supra note 53, at 1657. The goal of the project was to study the incidence and predictors of HIV in cohorts of HIV-infected and uninfected women. An educational program and a study of the acceptability and efficacy of condom use were developed. The subjects of the sample were 460 infected and 998 uninfected women between the ages of 18 and 35 who were attending the outpatient and prenatal clinics at the Centre Hospitalier de Kigali. Lindan et al., supra note 13, at 321.
85. Id. at 3342.
condoms, they still are not widely used. For example, in 1990, a survey of sexually active adults in Kigali revealed that ninety-seven percent of the respondents were aware that AIDS can be sexually transmitted. Sixty-nine percent of the men and forty-seven percent of the women knew what a condom was. Yet despite these statistics, none of the respondents reported that they had used condoms during intercourse.

To better understand the reasons why condoms have not been a particularly effective AIDS prevention method, in spite of knowledge about them, it is necessary to briefly examine the cultural values and power differential which influences African women’s sexual decision making, affects their risk perception, and, in turn, makes them vulnerable to HIV. “[F]or in order to devise culturally appropriate methods of dealing with AIDS... we need to take implicit cultural constructs seriously...”

B. Tradition and Culture

Women who are most vulnerable to HIV infection are those who have the least control over their sexual decision making, whether because of lack of economic power or culturally sanctioned gender role behavior. Accordingly, certain socio-cultural aspects of African culture contribute to lack of condom use, and to the correlative increase of African women’s risk of HIV infection. “Culture is the intricate process by humans of sharing language, utilizing symbols, and organizing and giving meaning to behavior... AIDS can be understood as a cultural phenomenon...” Understanding AIDS in terms of culture means understanding AIDS in terms of risk assessment and in terms of the relationship between cultural values and sexual behavior. One example of such a relationship is the Rwandan notion of the “fractal person.”

---

86. Id. at 3338.
88. Id.
89. Worth, supra note 76, at 306.
1. The "Fractal Person"

Rwandans believe the interaction and passage of fluids between persons creates an essential social bond by which individuals are socially constructed. Traditionally, Rwandans believed that any blockage of this flow was pathological. This fundamental cultural notion has contributed to Rwandans' reluctance to use condoms. They believe that condoms block this essential flow of fluids.91

Rwandans' view of risk is influenced by and consistent with their beliefs concerning the moral person. The Rwandan perception of risk is filtered through the eyes of the "fractal person."92 Fractality is expressed primarily through the media of liquids and their passage from one body to another.93 These liquids are blood, semen, maternal milk, vaginal secretions, and saliva. Other liquids include those involved in social exchanges, such as cow's milk, sorghum beer, sorghum porridge, banana wine, honey, and rainfall (the primary fluid of terrestrial fertility).94

In pre-colonial Rwandan society, well-being was dependent upon the movement, or flow, of fluids.95 Blockage of the flow of fluids between bodies was considered pathological. For instance, young girls who had not yet developed breasts (thereby considered to lack the capacity to produce milk), or who had never menstruated (considered to lack the capacity to produce blood) by a certain time were considered to have "blockage" that could drain the fertility of the land by bringing on draught.96 To prevent such a draught, the king would either put these girls to death or banish them. The condition was believed to be contagious, one that sorcerers inflicted on their victims, which could then be transmitted to destroy the entire community.97

This emphasis on the flow/blockage of bodily fluids continues today. Indeed, social relations are affirmed and reinforced in all acts of drinking which involve alcoholic beverages or milk. Choice beverages include beer,

91. Taylor, supra note 87, at 1027.
92. Id. at 1024. The term "fractal person" means a "dimensionality that cannot be expressed in whole numbers." Id. The fractal person "perceives his social universe not in terms of monadic individuals, but in terms of holistic structures of meaning whose patterns repeat themselves in slightly varying forms like the contours of a fractal topography..." Id. at 1024-25.
93. Id. at 1025.
94. Id.
95. Id.
96. Id.
97. Id.
sorghum beer, banana wine, milk, and sorghum porridge.\textsuperscript{98} Rwandans place a great deal of emphasis on the reciprocal flow of secretions between two partners and the female’s response to that interaction.\textsuperscript{99} They enjoy a form of sex called kunyaza (to make urinate) or “wet sex” whereby the man causes the female to generate profuse vaginal excretions before he ejaculates. He does this by tapping his penis against the woman’s clitoris and stimulating it externally.\textsuperscript{100} This form of sex is consistent with the Rwandan ideal of flow/blockage and reciprocity.\textsuperscript{101}

Sexuality and human fertility are related to the notions of reciprocity and gift. New life is produced when the man’s semen fuses with the female’s intanga (gift of self), which is contained in her blood. The most ideal time for this to occur is during the first week following menstruation, after the couple both have had orgasms. Sexual relations between partners become more frequent once the woman is pregnant because conception is believed to be a process, dependent upon the continued mixture of male semen and female blood.\textsuperscript{102}

A condom would interrupt the reciprocal flow of secretions between two partners and would render the woman “blocked.” This explains why over half of Rwandan women are aware of condoms but are reluctant to use them for fear that they will remain lodged in the vagina after intercourse, thereby blocking them.\textsuperscript{103} In addition to their belief that condoms are blocking devices and unsafe, Rwandan women are also reluctant to use condoms for the following additional reasons: (1) diminished pleasure, because the reciprocal movement of fluids is the emphasis in kunyaza, women do not believe this can be done with a condom; and (2) diminished fertility (traditionally, blockage was associated with infertility).\textsuperscript{104}
2. Other Rituals

Certain other African rituals also contribute to the spread of HIV in women because of the alcohol consumption and promiscuous activity they encourage, both of which tend to reduce the incidence and likelihood of condom use. Respondents in the Zambia study believe the Nkolola ceremony contributes to the spread of AIDS. This is an initiation ceremony for young girls who have matured during the past year and usually lasts a week during August or September. An elderly woman, responsible for teaching the young girl, carries her on her back into the bush. Animals are slaughtered and beer is brewed especially for the ceremony. There is much singing and dancing, which used to be done primarily by women and children but the men now take part as well. Moreover, there is also much drinking and eating; the young participants get drunk and, accordingly, tend to act very "mischievous." Indeed, Nkolola has been identified as a source of promiscuous activity, an occasion where young people often engage in unprotected intercourse as a rite of passage. "Initiation, which for most African societies took place at puberty, marked entry into adulthood . . . . The initiation ceremonies were marked with songs and dances by adult women which, in normal circumstances, would be considered highly obscene." Yet despite the potential for mischievous behavior that takes place during Nkolola, it continues to be a revered ritual, left by ancestors to be carried on. It is not likely to be discontinued any time soon.

Makogo is another ritual in which alcohol plays a central role, and thereby reduces the likelihood of condom use. Beer is brewed six months to a year after a person dies. After six months, people gather to drink and dance to release the dead person's spirit. One respondent characterized the Makogo as well as the Nkolola as "big gatherings" where "they cook and eat and dance . . . and when they are drunk, there is also adultery . . . this is where the problem is." Because the areas where the Makogo is practiced are so underdeveloped, it is one of the only means of recreation. Moreover, the correlation between alcohol and reduced reasoning power explains not only the

105. See generally MWALE & BURNARD, supra note 29.
106. Id. at 45.
107. Id.
108. Id. at 46 (citation omitted).
109. Id. at 47-48.
110. Id. at 48.
111. Id. at 49.
tendency to engage in sexual relations but also the tendency not to use a condom.

3. Polygamy and Multiple Partners

Polygamy is yet another aspect of African tradition and culture that exacerbates the power imbalance between men and women. It contributes to women's low socio-economic status and their inability to control their sexual health vis-à-vis using condoms during every sexual encounter, thereby making them more vulnerable to HIV infection.

The history of polygamy dates back thousands of years. One of its purposes was to regulate child spacing and sexual abstinence during pregnancy. Among the Tongas, for example, it is taboo to have sex during periods of pregnancy, menses, lactation, mourning, and ritual ceremony periods. Therefore, during this time, the husband will have sex with one of his other wives. Polygamy also gave some security to childless women. Instead of sending her away, as was the custom, her husband simply married another wife. Today, polygamy continues to be accepted among many Africans despite urbanization, migration, and other aspects of modern life that have affected tribal customs.

Women who are in polygamous marriages are often unable to ensure that their husbands use a condom with their other wives. Bearing in mind that it is the man who must wear the condom, women who do not engage in the risky behavior of having multiple sexual partners are still at risk because their partners engage in such behavior. Indeed, having multiple partners places both the unfaithful husband and all of his partners at risk.

4. The Significance of Children to Women

In West Africa, children are important to women as a means of self-esteem and a way of improving their social status. In addition, children enable women to form the necessary bond between themselves and their husbands. This bond

112. *Id.* at 39-40.
113. *Id.* at 40.
114. *Id.* at 39.
115. *Id.* at 41.
116. *Id.* at 70-71.
then gives them access to money, clothes, and other necessities. In much of Africa, infertile women are treated negatively. In one rural community, barren women are believed to be witches who are isolated to avoid contaminating the children and pregnant women in the community. Further, in some African societies, a woman is not considered an adult until she has produced children. Therefore, women understandably consider unrestricted fertility to be their right.

The high economic and social rewards that come from having children significantly reduce the chances that a woman will be receptive to condom use, even if her partner suggests it. Because a woman's livelihood is predicated upon the leverage she is able to use to obtain economic support from her husband, children are the link to a woman's elevated social status and to her well-being. Condom use would prevent her from achieving these rewards of fertility. Depending on her own risk assessment, she is more likely to choose money and clothes, those things needed for her survival over using a condom (and reducing her risk of HIV infection). In essence, because many women depend on their husbands for financial and social support, they may be forced to engage in unprotected sexual intercourse, especially when the alternative is having all financial and social support cut off.

5. Common Misconceptions About the Condom

Common misconceptions about the condom and its safety have also contributed to its lack of effectiveness as a prevention technique. In Zaire, for example, condoms are viewed as a form of western imperialism; they are linked with western control strategies. There is also a widely held belief in Zaire that semen makes women healthy. Accordingly, many people in Zaire believe that a condom inhibits semen's contribution to a woman's health, that condoms are injurious to women, and that they cause sterility. In Rwanda, there is a similar common misconception that condoms cause sterility or illness by becoming lodged in the vagina after intercourse. In fact, sixty-eight percent of urban Rwandan women think condoms are dangerous.

118. Id.
119. Mwale & Burnard, supra note 29, at 70.
120. Schoepf et al., supra note 74, at 218.
121. Id. at 219.
122. Allen et al., supra note 84, at 3342.
123. Kemp, supra note 55, at 54.
Men in Zaire also complain that condoms reduce their penile sensation and the gratification of knowing that they are depositing semen inside the woman, thereby contributing to her fertility. They also believe that the semen contained in the condom after ejaculation might be used for sorcery or would make them unable to ejaculate in the future.

African women's subservient role in these male-dominated societies serves as the backdrop against which the above social forces operate to make it difficult for them to challenge their partners' behavior. This traditional gender role behavior affects women's ability to take an active part in the prevention and control of the virus, by insisting on condom use, because they lack the control necessary for effective sexual decision making.

As indicated in the previous three sections of this paper, condoms are the most effective HIV/AIDS prevention technique currently available. However, the condom's effectiveness in preventing the spread of HIV in African women is significantly hampered by the social and cultural forces perpetuating their inferior status in society. The notion of empowering these women so that they may effectively introduce condoms into sexual relations and reduce their risk of HIV infection is a daunting task in light of the current AIDS crisis in Africa. Realistically, these women may not be sufficiently empowered for many years or even decades. This paper proposes, then, that feminist legal theory offers a more workable strategy that focuses on the consequences of gender inequality, not only on its sources.

IV. THE EQUAL TREATMENT/SPECIAL TREATMENT DEBATE

A. An Overview of the Sameness and Difference Models of Feminist Legal Theory

The modern legal debate over gender equality began in the United States in the 1970s. The case of Miller-Wohl Company, Inc. v. Commissioner of Labor and Industry brought the conflicting views of feminists over the equal

124. Schoepf et al., supra note 74, at 219.
125. Id.
treatment of women into sharper focus.128 Wendy Williams refers to this conflict as the "Equal Treatment/Special Treatment Debate."129 Joan Williams and others characterize it as the "Sameness/Difference Debate."130 Whatever its label, the debate has been one of the focal points of feminist literature for over two decades. In this paper, I will refer to the two sides of this conflict as "equal treatment" and "special treatment."

The debate is best understood in terms of its application to the workplace. The structure of the workplace assumes that child rearing duties are allocated according to sex-based tradition. Based on this assumption, employment is tailored to fit the needs of men who are able to work long, uninterrupted hours. Women are assumed to be in a "secondary, segregated, marginal work force, engaged in the dual careers of worker and mother, in jobs where turnover is assumed . . . ."131

The equal treatment model of gender equality focuses on the elimination of laws or social practices whose effect is to treat women differently from men because of their sex. This view suggests that equality between the sexes can

128. Id. In that case, the Miller-Wohl company sought to invalidate a Montana statute that made it illegal for an employer to terminate a woman’s employment or refuse to grant her a reasonable leave of absence because of pregnancy. The plaintiff, Ms. Tamara Buley, was pregnant when hired by the Miller-Wohl Company on August 1, 1979. Her pregnancy caused her severe morning sickness because of which she missed several days of work.

The Miller-Wohl sick leave policy provided its employees no sick leave until they had completed one year of employment. The company fired Ms. Buley on August 27 for having taken sick days, due to her pregnancy, before her one year anniversary. Miller-Wohl argued that the Montana statute conflicted with Title VII’s Pregnancy Discrimination Act (PDA). The 1978 Act requires that “women affected by pregnancy, childbirth, or related medical conditions . . . be treated the same for all employment related purposes . . . as other persons not so affected but similar in their ability or inability to work.” See 42 U.S.C. § 2000e(k) (1983). Specifically, the company asserted that, because its sick leave policy treated all employees the same, it had complied with the PDA. Moreover, Miller-Wohl argued that the Montana statute was invalid under the Supremacy Clause of the Constitution because it required preferential treatment of pregnant workers. The Ninth Circuit dismissed the case on jurisdictional grounds and failed to rule on the merits.

Two other cases fundamental to the equal treatment/special treatment or sameness/difference debate are Geduldig v. Aiello, 417 U.S. 484 (1974) and California Federal Savings and Loan v. Guerra, 479 U.S. 272 (1987). In Geduldig, the Supreme Court held that classifications based on pregnancy are not classifications based on sex because not all women can be classified as pregnant. The facts in California Federal were similar to those in Miller-Wohl. An employer challenged a California mandatory pregnancy leave statute arguing that it conflicted with the PDA. The Court held that the statute was not pre-empted by PDA. This case raised the issue of the dangers of recognizing difference. Many feminists have argued that the promise of job security offered by mandatory pregnancy leave statutes such as this one come at the price of drawing gender lines, which exacerbates workplace inequality between the sexes.

129. See generally Equality’s Riddle, supra note 126.

130. Joan C. Williams, Deconstructing Gender, in FEMINIST LEGAL THEORY 95 (Katherine T. Bartlett & Rosanne Kennedy eds., 1991).

131. Equality’s Riddle, supra note 126, at 353.
be achieved through individual competition in the workplace. But before that can happen, equal treatment advocates assert that women must be treated the same as men. In short, proponents of this view believe that women can be just like men if given the chance. This equal treatment view or liberal view of equality was the touchstone of the women’s movement in the 1960s and 1970s.

The special treatment paradigm asserts that differences between men and women should not be ignored or eradicated but, rather, society should acknowledge that the sexes are different and accommodate those differences. Assuming men are the norm, any difference from that norm is located in women. Special treatment advocates maintain that women should not be punished for their differences. They should be given special rights based on their special needs, particularly those needs rooted in reproduction. This, in turn, will permit equality of effect. This view does not require that women assimilate into a labor market based on the male norm. Instead, it avers that women can be on equal footing with men, without having to be like them, provided that societal institutions accommodate women’s differences.

For example, in the Miller-Wohl situation, the Montana statute provided women a special right to unpaid leave, a right not given to men for the obvious reason that men do not become pregnant. In this regard, special treatment advocates would argue that the statute is merely a reasonable accommodation statute that alleviates a burden on women, one that a man will never have to bear. The statute promotes equality by recognizing and accommodating difference whereas equal treatment would ignore difference, thereby furthering inequality.

B. Criticisms of the Equal Treatment Model

Linda J. Krieger and Patricia N. Cooney, both critics of the equal treatment model, argue that the equal treatment model, or the liberal model, of sexual equality ignores the fact that there are real differences between men and women. They assert that the equal treatment approach seeks to eradicate
gender differences instead of addressing the implications of those differences.\textsuperscript{137}

The liberal model of sexual equality is based on two fundamental assumptions. The first is that there are no "real" differences between the sexes; that is, no differences that cannot be dismissed as illusory sex-stereotypes or... which cannot be effectively compared to and treated the same as some cross-sex analogous condition. The second is that once all vestiges of disparate treatment are removed, men and women, by virtue of their inherent similarity, will achieve equal status through individual freedom of choice and equal competition in the marketplace. The dangers and limitations of the liberal view stem from these two basic assumptions.\textsuperscript{138}

Both assumptions work together to further the notion that treating men and women the same will lead to equality. Both are flawed. The first assumption suggests that male values, characteristics, and priorities are the norm. It does not suggest that the rules and structures governing the male norm be changed to accommodate the needs, values, and priorities of women. Rather, this first assumption of the equal treatment approach suggests that women's differences be molded to fit neatly into the confines of those male rules instead of trying to change the sexist nature of male-dominated institutions.

By virtue of the second assumption, only women who are able to conform to the male norm will benefit from the equal treatment approach. These are the women who are willing and able to take a less active role in raising their children, among other things.\textsuperscript{139} The inherent flaw of the second assumption is illustrated by the fact that working class mothers who deviate from the male norm by not working long hours because they do not have the financial resources available to them to hire childcare, need the special treatment that a statute like Montana's could provide. These women simply will not benefit from the equal treatment model because their differences cannot be manipulated to fit within the male rules. In short, this is because the equal treatment approach fails to address women's need to balance their dual roles as working mothers. It forces them into a workplace structure designed for

\textsuperscript{137} Id. at 544-45.
\textsuperscript{138} Id. at 538.
\textsuperscript{139} Id. at 545.
men, failing to adequately respond to the realities of their lives. The end result is that women are given theoretical rights and opportunities which they cannot really use.

To be sure, there are characteristics that are exclusive to one sex. The obvious example is the capacity to become pregnant. In this situation, the special treatment model would recognize the difference where the equal treatment model would analogize pregnancy to some male characteristic. These analogies are often strained. For example, the plaintiff in the Geduldig case discussed above, analogized pregnancy to a prostatectomy and argued that the two should be treated the same. The Supreme Court rejected this argument. By analogizing pregnancy to a condition unique to men, the equal treatment model does not focus on the effect on women of this very real sex difference. In this sense, it "elevates equality of treatment over equality of effect."

Equality is better characterized as a social policy aimed at furthering an equality of effect rather than an individual right to equal treatment. The practical effect of the special treatment theory is exemplified in the following illustration: A mother has two children, both of them have a disease. One is dying while the other is merely uncomfortable. The mother has one remaining dose of medicine. Instead of dividing it up equally, she gives the remaining dose to the dying child in the hope of keeping both children alive. Here, the focus is not on the equal treatment but on the equal effect. To achieve this end, proponents of the special treatment model suggest that equality of treatment often must be sacrificed. The end is actually more important than the means to that end, which may actually yield very unequal treatment.

The special treatment model allows women to be treated differently than men to better effectuate the goal of ending women's subordination. Men and women, regardless of their differences, must be treated as full members of society. To achieve this end, women may need special treatment to give them a leg up in certain arenas such as the labor market. Simply empowering women and not taking into account their differences from men only gives them

140. Equality's Riddle, supra note 126, at 327.
141. Krieger & Cooney, supra note 132, at 539-40.
142. Id. at 546.
143. Id. at 553 (citing RONALD DWORKIN, TAKING RIGHTS SERIOUSLY (1978)).
144. Littleton, supra note 134, at 1299.
145. To give official authority or legal power to. WEBSTER'S NINTH NEW COLLEGIATE DICTIONARY 408 (1989).
the opportunity, in theory, to share male power, but in reality gives them none of their own.

C. Criticisms of the Special Treatment Model

According to advocates of the equal treatment model, the object of equal treatment is to minimize employer and government rule making that is predicated on a traditional gender-based structure. The equal treatment approach is designed to encourage employers "to respond to pregnancy as within the normal range of events which temporarily affect workers." Proponents of the equal treatment model view pregnancy as just another of the physical conditions that affect workplace participation for both men and women. Their concern is that workplace disabilities of all employees are dealt with fairly and adequately.

Pregnancy is another example of the need for an adequate fringe benefit structure, but it does not create special needs. Thus, pregnancy should not be a basis for termination any more than any other non-disabling condition should be. When pregnancy is a disabling condition, certain benefits available for other disabled workers should also be available to pregnant workers.

Wendy Williams suggests that special treatment provisions are a double-edged sword because, although they help to ease the burden of women's dual role as mother and worker, they cause employers to spend additional money and incur certain obligations for pregnant workers. Accordingly, she argues, the special rules actually create an incentive for employers to discriminate against these less desirable employees.

Equal treatment proponents further argue that pregnancy leave and reinstatement reinforce stereotypical assumptions that women do not belong in the labor market because they need help from the law to keep their jobs. In short, they need special help to compete. Male workers, on the other hand, do not expect nor are they given this legal protection because society presumes they will not leave when their children are born. Equal treatment proponents believe that allowing sex differences to dictate special rights for women may

147. *Id.* at 327.
148. *Id.* at 356.
149. *Id.* at 367.
in fact lead to a reinforcement and perpetuation of stereotypical attitudes and sex roles.  

[Protective labor legislation] does describe the reality of many women’s lives, but it also assumes the inevitability of that reality and, more deeply, the desirability of traditional family roles for women. It promotes and reinforces the traditional asymmetrical family model, with father as chief breadwinner and mother as child tender and housekeeper—except that today the woman also holds a job in the labor market. It is designed to provide unquestionably needed help to assist women in coping with dual responsibilities. The problem is, the special treatment approach not only gives recognition to one type of family structure, it actively discourages and thwarts alternative models. It ensures the continuance of women’s dual burden.

D. The Acceptance View of Special Treatment

Christine Littleton responds to critics of the special treatment model by suggesting an alternative way to understand it. She suggests that special treatment be viewed through the lens of acceptance. Acceptance, she argues, does not view sex differences as problematic per se, but rather focuses on ways in which differences are permitted to justify inequality. It asserts that eliminating the unequal consequences of sex differences is more important than debating whether such differences are “real” or even trying to eliminate them altogether. The goal of the acceptance model is to deal with gender asymmetry (i.e., biological and social differences) in a way that creates symmetry in the reality of women’s and men’s lives. In other words, acceptance is primarily concerned with the consequences of gender differences and not their sources. For example, the fact that most women have the primary responsibility for

---

151. Krieger & Cooney, supra note 132, at 563.
152. Equality’s Riddle, supra note 126, at 377.
153. Littleton, supra note 134, at 1296.
154. Id. at 1297.
155. As Littleton states, it does not matter “whether differences are natural or not . . . differences are created by the interaction of person with person or person with institution; they inhere in the relationship, not in the person.” Id.
childrearing should not be ignored in an attempt to aim for the time when this duty is shared equally. Instead, reality should be accepted to help assure that "equal resources, status and social decisionmaking flow to those women (and few men) who engage in this socially female behavior." Ideally, "[t]he difference between human beings, whether perceived or real, and whether biologically or socially based, should not be permitted to make a difference in the lived-out equality of those persons." The acceptance approach offers a way of avoiding the critics' double-edged sword. Special treatment does rely on traditional stereotypes and images of women, allowing their differences to determine their special needs, like pregnancy. Acceptance suggests a broader approach. It looks to equality of result without relying on traditional models of gender roles. The remedy of acceptance is quite similar to the special treatment remedy but is preferable because it seeks to structure institutions so that all people, men or women, get equal results, regardless of where they fall on the gender role and power continuum.

Acceptance does not mean accommodation. In other words, unlike the special treatment approach, it does not suggest that "male" institutions should deal with women's differences by accommodating them. Instead, they should seek to accept them. One example Littleton uses to illustrate this point is that of a female lawyer giving a speech at a podium which is too high to enable her to reach the microphone. Accommodation, pursuant to the special treatment model, would be a step platform specially placed for women to stand on to reach the microphone, or a podium with just two heights, one for men and one for women. Alternatively, acceptance would be a podium adjustable to a range of heights, none of which would be labeled male or female.

Extending the podium example to the workplace helps underscore the difference between acceptance and special treatment. Just as the "acceptance podium" offers a broad range of heights to accommodate any height, acceptance in the workplace would offer child care, flex time, time off after birth, or any combination thereof to any worker, male or female. Whereas the special treatment approach would be to offer maternity leave to those women who might need it, there is no gender role attached to the broad range of

156. Id.
157. Id. at 1284-85.
158. Id. at 1314.
acceptance remedies. They do not resemble maternity leave but are more like the differing heights of the podium.

Unlike acceptance, both the equal treatment and the special treatment models can be cast as reinforcements of the status quo because neither directly challenges the underlying social and economic structures that disadvantage women. As discussed above, equal treatment ignores the differences between the sexes. It seeks to eradicate the power differential between men and women in society, instead of addressing the consequences of those differences. It posits that treating women and men the same will enable women to achieve equal status with men. In terms of AIDS prevention, equal treatment advocates would suggest that providing both women and men access to condoms will protect them equally from contracting HIV. This approach is less preferable to either special treatment and acceptance approaches because it ignores women's deficient bargaining power in negotiating safe sex.

Although not the preferred model, special treatment is a compromise to the acceptance model when acceptance would not be an effective approach. This situation is explained in more detail below. Special treatment posits that women's differences should not be ignored, but accommodated, to further an equality of effect. However, the assertion of this model, that women be treated differently, tends to further perpetuate their subordinate position to men. In terms of preventing HIV in African women, special treatment advocates would suggest that women be the primary target of condom promotion, in the belief that providing condoms to women will empower them, thereby effectuating their treatment as full members of society. This approach is less preferable than the acceptance approach because it ignores the possibility that men may not actually wear the condoms.

The acceptance model seeks to structure institutions so that everyone is able to get equal results, no matter where they fall on the power continuum. The acceptance model is the preferred approach to addressing the AIDS crisis in African women because it recognizes gender differences while arguing that equality can be applied to those differences. It differs from special treatment in that, rather than suggesting that women's differences be accommodated, it seeks equality of effect, despite those differences. Unlike equal treatment,

159. See Krieger & Cooney, supra note 132, at 538.
160. See generally Littleton, supra note 134.
162. Id. at 1058.
it is not a 'leveling' proposal. Rather, equality as acceptance calls only for the application of equalizing analysis across . . . differences. . . . It requires social institutions to adjust to the fact that people come in two sexes.¹⁶³

The equal treatment/special treatment debate, as it relates to pregnancy, is centered around the issue of how to structure employment rules so that pregnant and non-pregnant workers can be equally accepted, with neither placed at a disadvantage in the workplace. Similarly, the approach to alleviating the AIDS crisis in African women should be how to structure condom promotion and other AIDS prevention programs so as to ensure that women subject to inequality in general, and certain disparate cultural forces in particular, are as able as men to obtain the necessary HIV protection. To that end, the acceptance model of equality "recognizes that women and men frequently stand in asymmetrical positions to a particular social institution, and insists that such asymmetries justify equalizing efforts, rather than justifying the perpetuation of inequality."¹⁶⁴ Acceptance locates and recognizes social and cultural differences between men and women, seeking to remedy the result of those differences, not the differences themselves.

V. APPLYING THE ACCEPTANCE MODEL TO CONDOM PROMOTION AS AN AIDS PREVENTION METHOD

A. The Condom Crisis and the Current Global Agenda

The World Bank's World Development Report asserts that improving the education, employment opportunities, and social status of women is absolutely necessary to the control of HIV and AIDS in developing countries.¹⁶⁵ Women's vulnerability to HIV/AIDS infection and the need to eliminate the adverse social, economic, and cultural barriers which stymie prevention programs has become the current global focus. Patricia Fleming, the Clinton Administration's interim AIDS Policy Coordinator speaking at the Tenth International AIDS Conference in Yokohama, Japan concluded: "Women too often lack the power to protect themselves from infection because of their historic inequality around the . . . world. . . . The battle against AIDS is inextricably linked to the battle for women's rights . . . ."¹⁶⁶

¹⁶³. Id. at 1056.
¹⁶⁴. Id. at 1058.
¹⁶⁵. De Cock et al., supra note 12.
¹⁶⁶. Cotton, supra note 17.
Women need to be educated about the AIDS prevention options available to them. The invention of the birth control pill in the United States helped shift the focus of responsibility for contraceptive decision making to women. Similarly, current AIDS prevention programs in Africa based on condom distribution are attempting to shift responsibility to women. This shift in responsibility, however, cannot meet with the same success that the birth control pill has enjoyed in the United States. Bearing in mind that men are the ones who wear condoms, we must recognize that distributing them to African women wrongly presupposes that these women have the bargaining power to insist on their use. “It’s an enormous problem. We can’t just pass out condoms. I hear it everywhere, from Africa to Asia: Women don’t have the power to demand condoms.”

Condom use has to be renegotiated with every sexual contact. Women must address the issue of control over sexual decision-making every time they ask a male partner to use a condom. This leaves women vulnerable to the emotional, sexual, physical, or economic vicissitudes of their relationships at the moment of use.

Condoms are not just viewed as contraceptives or protection against sexually transmitted diseases; they carry with them the same cultural and social implications that intercourse does. First, a woman who suggests condom use may be perceived as deviating from the cultural norm, resulting in a loss of social status. Second, because a woman’s fertility often defines her social role and self-esteem, she may be reluctant or unwilling to suggest condom use. Third, a man who suggests condom use may be perceived as a failure or as refusing to fulfill the male role as impregnator of women. Fourth, introducing condoms into a long-term relationship where they have been absent may threaten implied trust. Finally, many women view condoms as a symbol of extra-relationship activity (often extra-marital). Women do not want to be reminded of this because it may raise uncomfortable issues and questions. Thus, avoiding condoms enables them to avoid these feelings of pain.

168. Worth, supra note 76, at 304.
169. Id. at 303.
170. Id. at 303-04.
This vulnerability underscores the need for the development of prevention measures under a woman’s direct control, such as the female condom and vaginal microbicides. However, there is no evidence thus far that the female condom prevents HIV infection. Moreover, female-controlled methods and the condom should be complementary. Women should not be the sole target of AIDS prevention messages. On the contrary, messages need to be targeted at the behavior of both sexes, and they should not lose sight of the relevance of the African woman’s interaction with her male counterpart.

B. The Current Global Focus

Increasing women’s awareness of their risks through AIDS prevention programs may actually run counter to traditional values, attitudes, and behaviors, thus resulting in the inability of women to consider or to undertake the sexual behavioral change necessary to reduce or remove the risk of contracting HIV. Suggestions voiced at the Tenth International AIDS Conference that steps must be undertaken to improve women's social, economic, and cultural status for AIDS prevention programs to be effective are certainly well taken. Given the political reality, however, this is not likely to happen anytime soon for the following reasons.

First, AIDS prevention and control efforts are subject to many obstacles like famine, war, civil unrest, lack of sufficient funding, weak government infrastructure, and competing demands from other projects. The resources required to effectively give women the economic, social, and political power they need are either insufficient or unavailable.

Second, laws aimed at improving the status of women have also been ineffective. “Currently, the legal structures and economic policies that purport to empower women actually exacerbate existing distinctions between male, public-political control and female, domestic-familial involvement. In essence, these reforms have not really drawn women into the development process.”

171. Collins, supra note 8. The female condom is “a 15 cm polyurethane sheath with rings at each end.” It covers “the base of the penis and . . . the area of tissue between the [female] anus and the beginning of the vaginal opening.” See STINE, supra note 3, at 203.

172. Preble, supra note 42, at 677.

Third, AIDS education programs targeted primarily at women through women's groups, print media, radio, religious leaders, and active political groups have been unsuccessful in changing sexual behavior. For example, although seventy percent of all Rwandans are aware of the dangers of AIDS and the ways to prevent it (due in large part to radio education), this knowledge has not led to significant behavioral change.

These laudable education and prevention aims are misdirected. They seem to be operating under the premise that giving women the laws necessary for economic empowerment and the tools necessary for social empowerment (condoms) will effectively reduce HIV infection. Moreover, this is itself rooted in the notion that giving women "power," either through the law or education, will put them on par with men. Further, being on par with men means being in complete control over sexual decision making, which translates into effective bargaining leverage, enabling women to successfully introduce the condom and to ensure its use. This premise is misguided because it is fashioned with the male norm in mind, an approach criticized in the context of employment rules discussed in Part IV. Like the equal treatment model, the premise does not attempt to suggest that the rules and structures which govern the male norm be changed to accommodate the needs of women.

The current AIDS prevention strategies in Africa borrow from both the equal treatment and the special treatment models of feminist legal theory. This combination of models is unworkable and has resulted in an inadequate answer to the AIDS prevention problem in Africa. Just as the equal treatment model fails to respond to the needs of women to balance their dual roles of worker and mother, the current condom promotion agenda aimed at the education of African women fails to respond to the realities of their lives. Specifically, it fails to account for the reality that years of deeply ingrained, centuries-old tradition tends to dictate behavior, behavior which cannot be changed so readily. It makes an erroneous leap from education to behavioral change, skipping over the reality that gender inequality has significant impact on risk behavior.

The current agenda is similar to the equal treatment approach in that it assumes that patriarchy is the norm, and indeed it must. But attempting to simply give women power without taking into account their differences from men and their existing unequal status in society confers no real power upon

---

174. Preble, supra note 42, at 973.
175. Green, supra note 57, at 184.
them. They may be given the tools, but they are unable to use them until they actually have social and economic power. The goal of equal treatment, which advocates elimination of social practices that treat women unequally, is an enormous task that may not be fulfilled for many decades, if ever. Conversely, these social practices could be used creatively to further more effective condom promotion and AIDS prevention.

Like the special treatment model, the current AIDS prevention aim in Africa has been to single out women for education and awareness (i.e., special treatment). However, as mentioned above, it seeks to empower women in a vacuum, without factoring in the underlying reality that women are subordinate to men and therefore may not be able to successfully negotiate for the use of a condom. Special treatment by itself is an inadequate approach to addressing AIDS prevention in Africa. Furthermore, the current approach is arguably just window dressing in that it uses a special treatment approach as a means of effectuating equal treatment. Women are being treated differently in order to eliminate their differences so they can be more like men. In the workplace, special treatment recognizes that pregnant women have special needs that must be accommodated. In African society, women, as the linchpins of the family, have special needs that also must be accommodated. However, their needs are not truly accommodated in the way that the needs of pregnant women in the workplace are effectively accommodated by way of maternity leave. The special treatment of African women is motivated by the equal treatment goal of sameness. It attempts to bring women to a point where they will no longer need special treatment because condoms will dissolve their vulnerability.

Actions, such as educating women and passing laws to improve their economic and social status, although crucial, cannot be relied on to stop the spread of HIV/AIDS simply because it will take too long for women to be fully empowered. The spread of HIV/AIDS is an urgent problem needing a more immediate solution than a social overhaul can provide. Clearly, we can no longer rely on the notion of empowering women to thwart its spread.

C. Acceptance: A New Approach to AIDS Prevention and Condom Promotion

A more effective strategy must focus on the consequences of gender inequality, not only on its sources. However, its sources must not be ignored; rather, they must be utilized to encourage and effectuate behavioral change “by
furthering women's awareness . . . based on the understanding of who decides how, why and when to have sexual intercourse.\textsuperscript{176} Returning to the podium example in Part IV, the podium here is HIV avoidance, the variable is power. The essence of the acceptance angle, theoretically and practically, is that no matter where men or women may fall on the power continuum, they all can be HIV free.

\textsuperscript{176} Eltahawy, supra note 7.
1. Education and Acceptance

Education must continue to be a part of the new agenda, as it is part of the current agenda, but its focus should not only be on women but on men as well. Furthermore, education programs for both men and women need to be geared toward the current reality of women's sex roles. The subservient nature of women's roles in patriarchal African society should not be ignored by aiming for the day when these roles are more "equal." For example, if a woman is involved in a polygamous marriage, she should be encouraged to introduce the condom into sexual relations with her husband, with the understanding that she is dependent upon him for her economic well-being. Accordingly, the consequences of not using a condom should be emphasized to both partners by underscoring the fact that wealth is irrelevant if potential partners are dead. This tactic may be most effective if directed to men who equate numerous sexual partners with high social status. By emphasizing the enormity of contracting HIV (i.e. inevitable death), education and awareness programs may be more effective at influencing and altering risk assessment and risk behavior. Videotape, where available, could be an effective tool in motivating women and men to use condoms.

Like the current approach, education must continue to be used to allay common misconceptions of both sexes about the condom: that it causes sterility in women or is harmful to women if ever lodged in the vagina, that the semen within the condom will be used for sorcery, and that a condom will prevent men from ejaculating. Educators should place an emphasis on the condom's use in other geographic regions to show that none of these fears are grounded in reality. Although knowledge does not necessarily lead to a change in behavior, it could lead to a change in belief. If women and men start to believe that these misconceptions are exactly that, their behavior is more likely to conform accordingly. By dispelling these myths, men may be more willing to use condoms and women may be less likely to fear becoming barren, another characteristic often linked to their social and economic status. This acceptance approach to education differs from the current approach in that it recognizes that polygamy and infidelity are accepted aspects of culture in some African countries. Instead of threatening to upset the power imbalance at the root of most traditional African marriages, this alternative approach attempts to educate both women and men about condoms by playing into that power imbalance. It posits that recognizing gender asymmetry, and using that imbalance to effectuate condom promotion and education to both sexes could
more immediately and effectively reduce the numbers of HIV-infected women and men.

Of course, the danger of this technique is that it does not attempt to equalize gender roles in African marriages and could be considered an impediment to African women's emancipation from those roles. It can be argued that the acceptance model actually does impede the long-term goal of eradicating African women's inferior social status by focusing on the short-term solution of immediate AIDS prevention. Viewed differently, however, acceptance can be seen as decoupling AIDS prevention from notions of social, political, and economic empowerment, thereby encouraging African women to approach those issues on independent terms.

It is important to note that condom education by itself may not carry both men and women the same distance in terms of behavioral modification. For example, the adjustable podium, which can be likened to HIV prevention, despite its various heights, still might not enable all women and men to stand at the most comfortable position. Similarly, educating both sexes about the condom might not always lead to condom use, as we have seen. Under the acceptance theory, however, progress has been made if factors other than gender determine how close individuals get to effective condom use. In terms of the podium, those other factors might be a microphone, which could be adjusted, or a step, located beneath the podium for very short people. Other factors affecting access to AIDS/condom education might be wealth and power. Nevertheless, attempting to equalize educational opportunities for all women and men, notwithstanding their socio-economic position, is a step forward.

2. Social Marketing

To approach social marketing only in terms of an acceptance model of equality would be difficult. Advertising is most effective when its message is aimed at a particular group of people. Accordingly, targeting condom advertising to women and men together cannot be as effective as singling out each group individually because the messages would have to reach all women and men, regardless of their various positions on the power continuum. Indeed, to attempt this would be both impractical and impossible. Therefore, the compromise is to utilize the special treatment model for formulating different messages that are reflective of unequal gender roles and the resulting power imbalance. To effectively reach both sexes, marketing programs must
first recognize the reality of traditional gender roles and the power imbalance they create. They can then target women and men in some power positions, but not *all* women and men in *every* position on the power continuum.

To do this effectively, social marketing programs must address women and men using different strategies. For example, the programs could be designed to make condoms seem empowering and macho to men. Instead of attempting to limit men’s sexual partners, condoms could be marketed to men in a way that equates condoms with the prestige and elevated social status men acquire by amassing numerous sexual partners. Assuming it blocks HIV transmission, perhaps the female condom could be marketed to men in such a way as to downplay its symbolism as an empowering tool for women. Instead, it could be promoted as a more sexually satisfying complement or alternative to the male condom.

Social marketing programs directed at women could be used to emphasize their traditional societal role as caregiver by portraying the condom as a meaningful extension of that role. By introducing a condom to her partner, the message would suggest that the woman is simply fulfilling her role as caregiver by seeking to prevent the transmission of HIV.

Again, this approach to condom marketing differs from the current approach, which seems to ignore the gender power differential altogether. For example, the Ghana Social Marketing Programme offers prizes such as electric fans, radios, and televisions to anyone who buys ten condoms and can successfully complete the sentence, “Modern contraceptives help me to...” This approach is flawed because it assumes the people it reaches are literate and televisions or electric fans are enticing enough to risk threatening their own and their children’s long-term social and economic well-being.

In accordance with the acceptance model, the acceptance marketing strategy contains elements of both the special treatment and the acceptance models. Like the special treatment model, it recognizes that to effectively reach both sexes, marketing techniques must recognize the reality of traditional gender roles and the power imbalance they create. It accepts that reality by formulating different messages for women and men that are reflective of those unequal gender roles and the resulting power imbalance.

The danger of using the special treatment model for purposes of marketing condoms is that it tends to reify potentially destructive stereotypes, thereby perpetuating women’s stereotypical role as subservient to men. Using these
stereotypes in an effort to reach each group may actually decrease the possibility that men will use condoms. Rather, it may increase the probability that men will take advantage of their superior power position by refusing to wear them. Yet, despite the dangers of using the special treatment approach, it is worth the risk. Contracting HIV and AIDS is a far graver consequence.

3. African Culture

The acceptance model of equality is an effective approach to incorporating African culture into condom access and education. By recognizing the power differential in terms of the differing roles men/boys and women/girls assume in certain ceremonies where intercourse is often considered a rite of passage into adulthood, the acceptance approach attempts to remedy the results of those differences. Too frequently, the result of the differences is that men and women increase their risk of contracting HIV by engaging in unprotected sex.

Where healthcare workers are an integral part of AIDS prevention programs, they could help to encourage the implementation of a form of sex education in the initiation ceremonies and rituals, like the Nkolola, the Makogo, and the Dipo. Where older women are given the task of educating the younger women, healthcare workers could suggest that HIV/AIDS prevention be incorporated into the ceremony. The elder women could take this opportunity to educate the young girls about the dangers of alcohol use involved in the ceremonies by encouraging them not to drink or to drink in moderation. Perhaps eventually the condom could be used as a part of the ceremony itself, as the symbol of good health and sexual well-being.

Moreover, the male participants in the ceremonies and post-ceremony celebrations could become informed of the importance of using a condom during this time, especially since excessive amounts of alcohol are consumed. Perhaps healthcare workers or older men in the community could provide access to and information about condoms prior to, or in conjunction with, the ceremony. Ideally, however, the men and women participating in these ceremonies should be informed together about the importance of using a condom for HIV prevention.178

178. The author is aware that financial resources for this type of intervention are limited, a topic this paper does not attempt to address. Therefore, discussion here is premised on the assumption of adequate funding.
The “acceptance as equality” approach to AIDS prevention does not call for an end to the Makogo, the Nkolola, or any other type of African ceremony or ritual. Neither does it suggest that women’s traditional, subordinate role continue. Its concern is with the consequences of gender inequality with respect to its effect on African women’s heightened vulnerability to HIV. Accordingly, acceptance attempts to structure ceremonies so as to create opportunities for both women and men to have equal access to HIV/AIDS protection, regardless of where they fall on the power continuum.

Bearing in mind that cultural patterns shape women’s access to services and their responses to prevention techniques, the acceptance tactic might not always be successful. In fact, condom usage encounters the most resistance in the context of culture and tradition. Moreover, the culture and traditions of each country in Africa are numerous. Acknowledging and accepting that initiation rituals for young women in certain rural African regions are still practiced will reveal their potential as useful avenues for AIDS education.

AIDS prevention and condom promotion could also be implemented with the Rwandan notion of the “fractal person” in mind. Kunyaza (wet sex) could be encouraged as a step toward non-penetrative sex. It could be promoted as a way of incorporating the condom into an already existing traditional practice. First, the condom would not interfere with external clitoral stimulation. Second, the condom could be used to enhance male stimulation and pleasure, without penetration. Of course, these suggestions presuppose that either party will accept non-penetrative sex as a viable option.

If children are women’s link to monetary support and self-esteem, AIDS prevention educators must recognize this and understand that it may not be enough to stop women from accepting the condom as a workable prevention method. Considering the increasing number of children orphaned because of HIV/AIDS, perhaps adoption could be encouraged as an alternative for HIV-positive women. These women could then use a condom without sacrificing their social and economic status as a mother. This approach accepts that women may continue to link their self-esteem to having children, and it does not suggest that they obtain some other means of attaining that self-fulfillment grounded in economic empowerment. Certainly, economic self-fulfillment is a sensible long-term goal, but not one that should be a precursor to reducing the number of HIV-infected women.

The acceptance approach to condom promotion is not without its disadvantages. As Christine Littleton admits, “equal acceptance as a legal norm does not automatically produce one and only one ‘right’ answer to
difficult questions of equality. Instead, it provides support for new remedial strategies . . .”179 The biggest drawback of this approach is that it may hinder the short-term improvement of women’s social and economic status in Africa by discouraging it as a means to the end of the AIDS crisis. Indeed, this approach actually uses the inferior status of women as a sort of springboard for condom promotion and other types of AIDS prevention. However, this is the price that must be paid today to curtail the growing numbers of HIV-positive African women. The current global agenda of empowering women as a way of preventing the spread of HIV is daunting. It is an issue of almost the same magnitude as the AIDS crisis itself. It is a reachable goal, but one that will not be reached soon enough to stop the rampant spread of HIV in Sub-Saharan African women. The AIDS epidemic in African women is an urgent problem needing an urgent, even radical, solution.

CONCLUSION

Despite the fact that HIV/AIDS prevention strategies in Africa have been in place since the 1980s, the number of HIV-infected people continues to increase. As the speakers at the Tenth International AIDS Conference emphasized, previous and current global AIDS prevention strategies have been unsuccessful in curtailing the devastating, continual increase in the numbers of HIV-positive people in Africa, especially women. Accordingly, the notion of empowering women socially, legally, and economically is now the current focus of the global AIDS prevention agenda. Although this is a laudable goal, women in Africa simply will not become sufficiently empowered before AIDS destroys them.

This paper has suggested applying the acceptance method of feminist legal theory to condom promotion as an AIDS prevention strategy. In general, the acceptance method seeks to prevent gender differences from furthering sexual inequality. In particular, the acceptance method seeks to diminish, and ideally eliminate, the effect that sexual differences, whether biological or cultural, have on African women’s opportunites for maximum protection from HIV and AIDS. This may not be a wholly successful approach, or provide “one right answer.”180 Indeed, the relationship between theory and practice is often tenuous. But accepting the reality that women are subordinate to men in most,

179. Littleton, supra note 134, at 1313.
180. Id.
if not all, African cultures, instead of trying to put women on more equal footing with men, allows for a more urgent and effective strategy in condom promotion, and, ultimately, AIDS prevention.