



Gendered Epidemics and Systems of Power in Africa: A Feminist Perspective on Public Health Governance

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Abstract

This article is about systems of power, and the way different power systems – global, local, patriarchal and family – interconnect and create vulnerability to epidemic and infectious diseases among those with less power, mostly poor, resource-limited rural African women. The main argument is that to understand gendered epidemics in Africa, we need to examine the systems of power that create and perpetuate African women's vulnerabilities at local, national and global levels. The article uses case studies, extracted from published epidemic stories and interprets these cases from a feminist and power analytical framework. The results suggest that while a disease or an epidemic affect a group of individuals, systemic factors regarding responsible governance and the role of national politics and policies; the role of global systems that control knowledge production and sharing; as well as patriarchy and culture all contribute to creating an environment that increases women's vulnerability to epidemics. The article concludes by advocating for strengthening practical ways that can make hierarchical power less attractive and equitable distribution of power more attractive. Since current systems of power cannot be eliminated, they need to be challenged and transformed. The article has various limitations. It relies on a small number of case studies and though the literature refers to gender, the analysis is predominantly of women. Notwithstanding these limitations however, the article aims to contribute to the ongoing scholarly debate on governance of public health in Africa as well as to the growing field of African feminist epidemiology.

Résumé

Cet article porte sur les systèmes de pouvoir et la manière dont différents systèmes de pouvoir – mondial, local, patriarcal et familial – sont interconnectés

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et créent une vulnérabilité aux maladies épidémiques et infectieuses chez ceux qui ont moins de pouvoir, essentiellement les femmes rurales pauvres aux ressources limitées. L'argument principal est que pour comprendre les épidémies à dimension genrée en Afrique, nous devons examiner les systèmes de pouvoir qui créent et perpétuent les vulnérabilités des femmes africaines aux niveaux local, national et mondial. L'article se sert d'études de cas tirées de publications d'histoires d'épidémies, et les interprète à partir d'un cadre d'analyse féministe et de pouvoir. Les résultats indiquent qu'alors qu'une maladie ou une épidémie affecte un groupe d'individus, des facteurs systémiques concernant la gouvernance responsable et le rôle de la politique et des stratégies nationales, le rôle des systèmes mondiaux qui contrôlent la production et le partage des connaissances, ainsi que le patriarcat et la culture, contribuent tous à créer un environnement qui accroît la vulnérabilité des femmes aux épidémies. L'article conclut en préconisant le renforcement des moyens pratiques qui peuvent rendre le pouvoir hiérarchique moins attrayant et la distribution équitable du pouvoir plus attrayant. Étant donné que les systèmes de pouvoir actuels ne peuvent pas être éliminés, il est impératif qu'ils soient remis en question et transformés. L'article comporte diverses limites. Il s'appuie sur un petit nombre d'études de cas et bien que la documentation se réfère au genre, l'analyse porte essentiellement sur les femmes. Cependant, en dépit de ces limites, l'article vise à contribuer au débat scientifique en cours sur la gouvernance de la santé publique en Afrique, ainsi qu'au domaine en expansion de l'épidémiologie féministe africaine.

Introduction

Research on the gender dimensions of health in Africa is not new. There is a long history of scholarly work exploring the relationship between gender and health in both social and health sciences. As Vlassoff (2007:49) stated 'gender has been shown to influence how health policies are conceived and improved, how biomedical and contraceptive technologies are developed and how health systems respond to male and female clients'. Understanding the role of gender in health is key to improving both women's and men's health in Africa.

In recent years, epidemic prone infectious diseases have become an increasing challenge to Africa's public health. Yet surprisingly few studies have focused on the gender dimensions of epidemic prone infectious diseases. In 2007, the World Health Organization produced a long and detailed report entitled 'Addressing sex and gender in epidemic prone infectious diseases'. This report looked at gender differences in incidence, severity and mortality due to dengue fever, Ebola haemorrhagic fever (EHF) and severe acute respiratory syndrome (SARS). The report took a life cycle approach and examined gender differences that account for differential infection in infancy, adulthood and old age. Other causes of vulnerability to infection, for example pregnancy and lactation, as well as traditional cultural behaviour, are also discussed.

While the WHO report is to be applauded for putting the spotlight on the gendered nature of African epidemics, there is little, if any, discussion on what might cause or increase women's vulnerability to epidemic prone infections even for diseases that are not sexually transmitted. Without addressing the source of vulnerability, it is difficult to suggest ways in which the gendered nature of epidemics can be challenged and transformed.

This article aims to push the debate on from how African epidemics are gendered, to why women become vulnerable to these epidemics. The aim is to discuss the sources of vulnerability to epidemics through a systemic approach and then to highlight, using feminist perspectives, what makes these systems detrimental to women. In rural African settings, among poorly resourced populations, women are disadvantaged by various hierarchies that arise from patriarchal structures, community level power structures, national political systems, and global systems of power. This does not mean in any way that men are not vulnerable to epidemics; it simply means that in this article it is taken as a given that women are more vulnerable to epidemics than men and the task is to provide evidence as to why this is so.

This article uses cases studies, a key methodological tool in epidemiology and applies feminist analysis to highlight the role of systems of power and how they influence vulnerability to epidemic prone infections.

Organisation of the Article

The article begins with a brief theoretical grounding. This is followed by a literature review looking at gender and epidemics. The methodology section is then presented with two organizing frameworks for looking at hierarchical as opposed to cyclical systems of power. Case studies are then presented and analysed. Finally, a conclusion and way forward advocating transformation of the systems of power is provided followed by acknowledgements and a declaration of the author's pre-existing biases.

Theoretical Grounding

The article is grounded in African feminisms. My perspective on African feminisms has been and continues to be strongly influenced by liberation war politics, based on both historical and literary accounts of women's roles in various liberation struggles in Africa. I have gained insight from feminist analysis of historical accounts surrounding the role of Mbuya Nehanda in the Zimbabwe liberation struggle (Zimbabwe Daily 2015); the works of Albertina Sisulu in the South African liberation struggle (Sisulu 2002) and from the works of women's empowerment in protecting the earth (Maathai 2003).

I have also been greatly influenced by literary works and many readings of recent African female writers, most of whom do not deliberately declare themselves as feminist in their writing yet provide some strong insights into African feminisms. These are the works of Tsitsi Dangarembwa and Adichie (2006). Feminist academics have provided me with the academic frameworks for understanding feminism in a scholarly manner. These are mostly the works of Tsikata (1997), McFadden (2001), Gaidzanwa (1992), and Imam, Mama and Sow (1997). My interest and understanding of intersectionality has been strongly influenced by critical race theorists like Crenshaw (1993), Ladson-Billings (1998) and Delgado and Stafencic (2001). The concept of *African feminist epidemiology* is adapted and strongly aligned with the work of Kaufert (1988).

Although still a largely contested research area, feminism is devoted to the tasks of critiquing women's subordination (Allen 2014). Feminists are also interested in the relations of power rather than power as an individual activity. So here I argue that to understand gendered epidemics we must put on feminist lenses and evaluate the role that different systems of power play in disease epidemics within African contexts. In this approach it is important to understand that power works through systems that impact on the relations between people creating hierarchies of those with more power and those who have less power, irrespective of gender. It is however the case in most instances in African countries that women tend to hold less power and men more power hence the default position in most feminist work is understanding and critiquing gender-based relations of domination and subordination (Allen 2014).

With respect to power, my work is influenced mostly by Foucault (2000) and Russell (1938). I argue that no understanding of African epidemics can be achieved without understanding the systems of power, how these systems define the relations of power between individuals, and how this ultimately contributes to the vulnerability of women. We need to understand women's interaction and interdependence with systems of power and how that influences their vulnerability to epidemics.

What exactly is power? I begin with a concept of power based on the work of Bertrand Russell (1938:25) who defined power as 'the capacity of some persons to produce intended and foreseen effects on others'. So a system is created and then gains its own momentum sustained by interactions and interdependencies (relations) among people. What is key in this definition for understanding power is that it involves relations where there is *intentional and effective influence*, not only on individuals but on other sub-systems.

The aim here is to examine and discuss from a feminist perspective the various pathways through which systems of power intersect and create

multiple vulnerabilities to disease exposure and mortality among poor African women. I argue that to understand vulnerability to epidemics among the poorest of our communities, we must follow the fault lines taken by the systems of power at every level and understand the intended, though sometimes unstated, effects which work through intersectionality. I argue that one cannot understand the gendered nature of African epidemics, unless and until one understands the way in which power is systemically organized, used/abused and shared/withheld. I also propose that for poor women, their vulnerable positions in society are rarely the result of one disadvantage but an intersection of multiple vulnerabilities which may involve some or all of the following; poverty, lack of education, belonging to a minority group, lack of information, lack of financial resources, age, patriarchy, culture and oppressive political systems. It is for this reason that a feminist analysis becomes key. For many years now, feminist scholars have highlighted the importance of recognizing multiple disadvantages when dealing with women's issues in Africa. This article emphasises this point further. The use of intersectionality as a research paradigm is based on work of Crenshaw (1993) as well as the work Carastathis (2014) and Hill Collins (2008). What these authors highlight in various ways is that powerlessness creates its own networks of increased vulnerability which sometimes intersect in one individual; power creates its own protective networks.

Literature Review

Gender and Epidemics

Research on the gendered nature of African infectious diseases has a long history in the sociology of health, anthropology and epidemiology. Social determinants of health research have highlighted gender roles and how these influence vulnerability to infection. Govender and Penn-Kekana (2007) highlighted how in most African communities, women take responsibilities for caring for the sick which increases their exposure to infectious diseases. These researchers argue that gender roles are also taken into hospital settings where women tend to occupy less senior positions thereby replicating their roles in the households, which further exposes them to higher risks of infections as health workers. This tendency towards the heteronormativity of women as care givers can work detrimentally for women, by increasing their exposure to infectious epidemics.

A WHO report highlighted five key gender-related differences that account for the increased vulnerability in exposure and outcomes to epidemic prone infections among women. These include the fact that there are gender differences in time spent at home. Men tend to spend more time away from

home and typically face greater exposure to infectious agents outside home, while women tend to face greater exposure inside the home. Anecdotal evidence from reports of those working in the field suggest that in the case of Ebola, many men were exposed due to contact with wild animals during hunting, but the disease ultimately took hold in the home, where women faced even higher exposures because they took care of sick men and sometimes had the responsibility of preparing infected animals for consumption. In most African households, food preparation is mainly a woman's role.

In doing a thorough literature search on gendered epidemics, it is clear that a major limitation in addressing gender and epidemics in Africa is the lack of good quality data. The WHO (2007) publication addressing sex and gender in epidemic prone infectious diseases used a lot of WHO unpublished data which is not available on public platforms for many researchers. With the exception of HIV/AIDS, good quality data on epidemic prone infectious diseases by gender is scarce. The Ebola data provided in Figure 1 highlights the paucity of the current data.

Figure 1 shows the distribution of confirmed Ebola cases for different countries in West Africa. The data was downloaded from the Statista website but the graphs were plotted by the author. As can be seen from this data, except for Liberia, there are more female confirmed cases of Ebola than male. However, statistical analysis of these figures (Z test for differences in proportions) indicated that these gender differences in the proportions of Ebola cases are not statistically significant, hence these figures only provide suggestive rather than confirmatory evidence of gender differences.

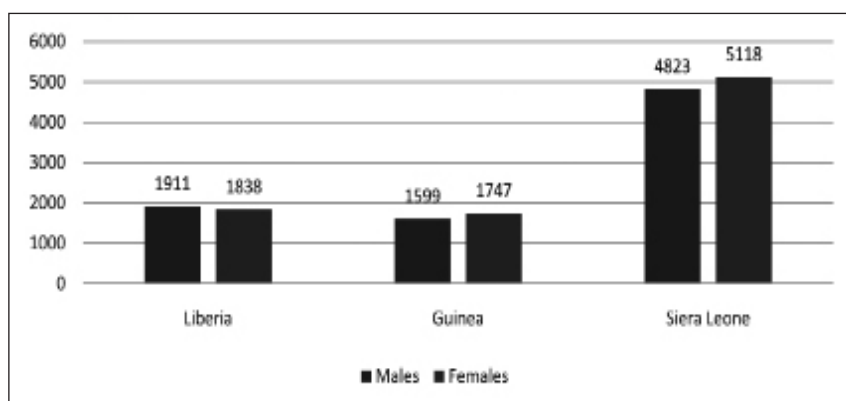


Figure 1: Number of confirmed Ebola cases in West African countries by gender (novembre 2015)

Data source: www.statista.com/statistics/379484/west-african-countries-ebola-cases-by-gender, Accessed 8 January 2016.

A clearer case of the gendered nature of African epidemics is provided by AIDS statistics for the Southern African countries with the highest deaths from HIV/AIDS in 2015. Figure 2 shows HIV prevalence for the five Southern African countries with the highest prevalence of HIV in the world. Additional information from the World Bank, UNAIDS and WHO suggests that out of Africa’s 23 million adults infected with HIV/AIDS, 57 per cent are adult women. Gender disparities in HIV/AIDS among fifteen to nineteen year-olds are even wider. For every one fifteen to nineteen year-old boy who is infected, five or six girls in the same age group are (World Bank 2005).

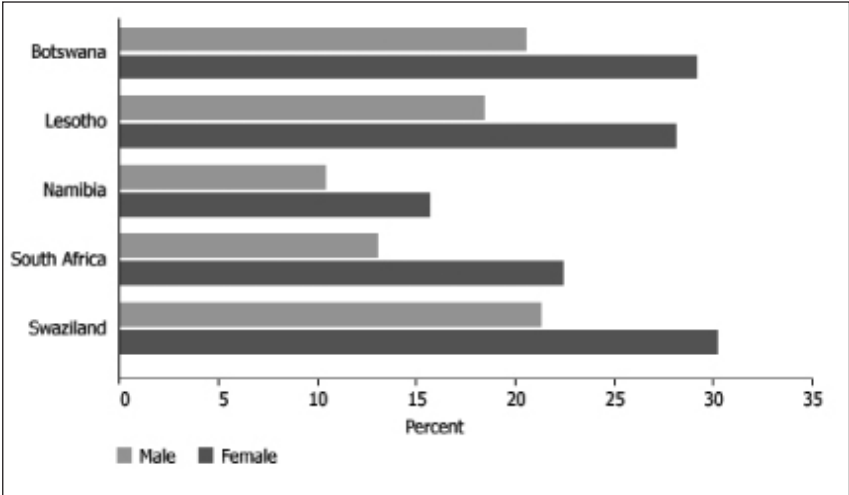


Figure 2: HIV prevalence by gender in five Southern African countries, 2011
Data source: www.prb.org/Publications/Articles/2011/gender-based-violence-hiv.aspx.

In discussing what the World Bank, WHO and UNAIDS calls the *gender dynamic* of HIV/AIDS in Africa, three key factors are provided to explain the gendered nature of the HIV/AIDS epidemic. The first factor is that risk and vulnerability to HIV/AIDS are substantially different for men and for women. The second factor, which closely ties in with the argument of this article, is that the impact of HIV/AIDS differs markedly along gender lines, reflecting men’s and women’s different roles and responsibilities in household and market activities, and critical gender differences in access to and control of resources. This strongly suggests that tackling the AIDS pandemic is fundamentally about radical change in gender relations in sub-Saharan Africa through behaviour change.

Further evidence on the contribution of gender to exposure and epidemics suggests that gender roles also matter in addition to gender relations. The World Health Organization (2002) suggested that in most African

communities, women and men take care of different domestic animals. Most women tend to take care of smaller livestock like chickens, rabbits, guinea pigs, pigs and poultry. These smaller animals usually get less attention from veterinary and extension programmes when sick, thus increasing women's risk to zoonotic diseases. They also require close proximity during feeding thus increasing women's exposure to disease. Men tend to look after larger animals like cattle, donkeys and/or horses which do not require direct contact during feeding. In some Southern African countries, larger animals are more likely to be the focus of government sponsored veterinary services.

Research has also shown gender differences in care received by males and females. In India and Pakistan, studies have shown that parents tend to take care of sick male children more quickly than female children. In addition, there is evidence showing that doctor – patient relationships differ markedly by gender of the patient, with men receiving more technical explanations for their illnesses than women, as well as men receiving more optimistic prognoses. This was largely due to the fact that most of the doctors assumed that male patients understood technical information more than female patients. In addition, more doctors are men and find it easier to communicate in more straightforward ways to and with other men. Yuen – man Yiu (2015:2) states that a kind of 'medical patriarchy' exists, with male doctors giving female patients minimum information under the pretence that female patients lack the capacity to understand their own diseases. The WHO (2007) also suggests that there may be differences in scientific knowledge provided about appropriate treatment for females and for males. Many clinical trials have included male subjects, or have failed to analyse or present data by gender.

Using the determinants of health approach, Rathgeber and Vlassoff (1993) provided and tested a gender framework for tropical diseases research which highlighted the direct importance of the gendered division of labour, as well as the social/reproductive roles of women and personal factors relating to knowledge about disease to disease outcomes. Their main aim was to show that there is a need to expand gender dynamics beyond the context of reproductive roles in order to understand African women's health, particularly in the context of epidemics.

This work aims to contribute to current debates by focusing on a model that attempts to explain the role of systems of power in increasing the vulnerabilities of African women to epidemics. What the article tries to show is that the gendered nature of epidemics is a reflection of the fault lines created by power systems that disadvantage women. This approach highlights the complexity of how gender influences susceptibility to epidemics in Africa.

Methods

Organising Frameworks of Various Systems of Power

Two frameworks for analyzing the role of systems of power on female vulnerability to epidemics are presented. The first (Figure 3) is a representation of hierarchical systems of power and the pathways through which they increase women’s vulnerability. This is not an analytical framework but an organising framework which shows how things exist currently. The thick arrows in the diagram show the one directional hierarchical flow of global, political and community systems of power. The first to experience epidemics are usually the last to know how to protect themselves. The first to experience the epidemic are usually the last to be considered in allocation of resources. I then introduce very small bidirectional arrows suggesting that the systems of power that are lower on the framework have very little impact on the higher systems. The lower one is on the systems of power, the harder it is to intentionally influence the systems above. The lower you are, the higher your vulnerabilities to epidemics. The flow of power is from top to bottom.

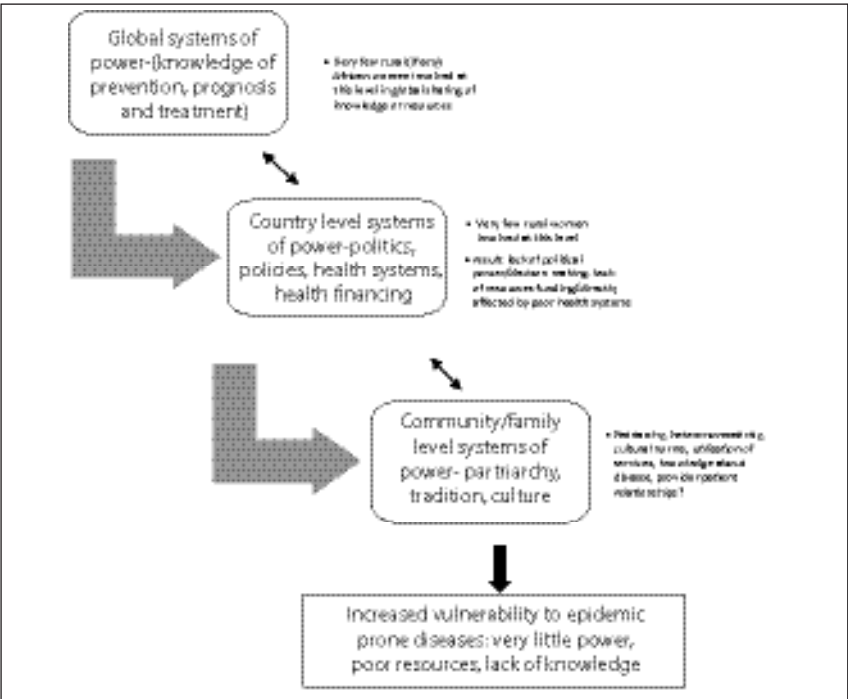


Figure 3: A hierarchical model of the various systems and levels of power and pathways of vulnerability to epidemics of village women

The second framework (Figure 4) is theoretically based on Kaufert (1988) concept of feminist epidemiology, translated into a diagrammatical framework by the author. This framework presents how an equitable sharing of power, resources and knowledge on epidemics could work to reduce women's vulnerability. Kaufert (1988) calls for the need to take women's experiential knowledge of their situation as valid knowledge. In addition, she states the importance of not using women as objects of research but as fellow participants for whom results are provided in timely manner and in a form that is usable. The flow is cyclical, depending on need.

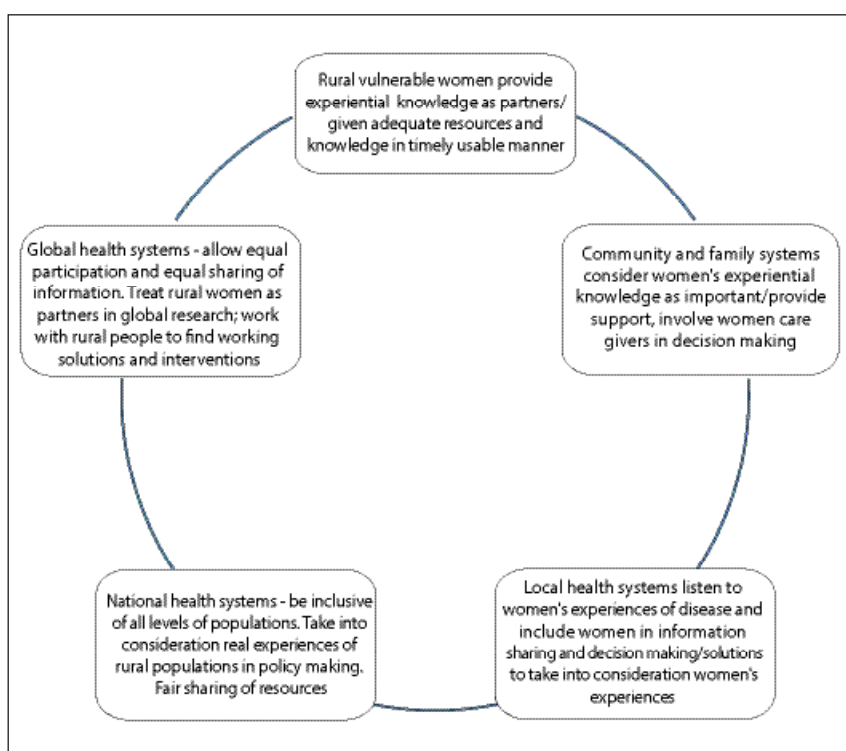


Figure 4: Author's diagrammatical representation of a cyclical framework influenced by Kaufert's (1988) feminist epidemiology to explain women's vulnerability to epidemic prone infectious diseases

Figure 4 suggests equality rather than hierarchy in the process of resources allocation, information and knowledge sharing and inclusion of women as participants. It begins with a clear recognition of rural women's own life experiences of epidemics as valid knowledge in the prevention of epidemic prone infections. Kaufert (1988:11) suggests 'the need to see women as legitimate priority for scientific endeavour'. Recognition of this means that

reasonable resources would be allocated to deal with epidemics at this stage. It also means that women's experiential information will drive and inform both local and global responses to epidemic prone infectious diseases.

Data Sources

The main sources of data are various medical stories published on health websites. I refer to these stories as 'African epidemic stories'. The analysis is not country based nor is the individual the focus. My interest is in the meaning of the story from a feminist and power analysis approach. I acknowledge and accept that the approach of using publicly available stories has serious limitations. The stories are posted online by various workers from various NGOs but their truth cannot be verified. The stories presented here are typical of most of the stories posted but even though sometimes country information is provided, they cannot really be used to represent country studies.

Case Study One

The individual is a young twenty-three year-old woman named Fifi who has been married for a year and half to a young man she has known since childhood. She has always lived in the current village where she was born and was reported by friends and neighbours as having been a young happy active woman before she became ill. She was not highly educated, was not employed and is a member of a minority population group in her country. She was not reported as having had any life threatening disease before and had had no reported history of family life threatening disease. She was reported to having been looking forward to having children with her husband. Her death was described as an unfortunate tragedy by those who knew her.

Fifi, a young healthy African woman is happily married to a young man from her traditional village. When one of her husband's female relatives falls sick, Fifi found herself with the responsibilities of taking care of this older relative. Having seen stories of Ebola on TV during a visit to the city, and talking to her friends in the village, Fifi goes to the local clinic to request gloves. Unfortunately, she is told by the staff there that the clinic does not have gloves. The clinic staff told her that there has been very little funding at the clinic because the clinic is in a part of the country where there are political rebels. This has led the government to offer as little support to the clinic as possible. In addition the clinic is in a remote part of the country, where access is not easy. This also means there is sometimes a long time before supplies are delivered.

On return from the clinic Fifi goes to the traditional healer in the village hoping for some kind of protection against getting the disease her husband's older relative has. But she is warned severely that using gloves will show disrespect for an older relative. When the older woman dies, Fifi washes the body herself without wearing gloves to avoid disrespecting the dead and also because she didn't have the gloves. Fifi gets infected with Ebola. She dies from the disease.

Case Analysis

It is easy to understand Fifi as a direct victim of a tradition that we can define as an inhuman patriarchal system that forces women to obey tradition even if the tradition kills them; or as a victim of traditional healers who use their power to control those who are powerless; or that Fifi's limited source of power comes from her unquestioning respect of her husband's family, and how at an individual level these factors put her at risk and led to her ultimately mortality.

Fifi is a victim of the heteronormative assumption that as a woman it was her role within her culture to take care of older relatives and to do so in a way determined by patriarchal norms of the family. The victim hood does not necessarily arise from her having to take up the role of care giving, but rather from the fact her culture and the health care system did not adequately train her to do so properly. She had only access to old ways of dealing with new epidemics. There need not be a conflict between heteronormativity of care giving roles and epidemics, if adequate training, resources and information is given to care givers about self-protection against infectious diseases and if the roles of these care givers is properly valued.

But from a feminist power analysis we must also allow ourselves to raise other issues of concern.

Failure of the National Political System

Many hospitals and clinics operate with adequate sanitary basics like gloves, needles and cleaning materials. Yet in some African rural hospitals, it is also common that hospitals lack basics like gloves, clean needles and cleaning materials. In most cases, availability of hospital materials differs by region with the most remote and poorest regions usually having the poorest resources compared to the urban facilities and easily accessible regions. How are decisions to equip hospitals made? What accounts for the differential development within many African countries? Morrock (1973) suggested that the divide and rule strategy applied to colonized people by the colonisers

may account for differential development in many African countries. He defines this strategy as 'a conscious effort of an imperialist power to create and or turn to its own advantage the ethnic, linguistic, cultural tribal and religious differences within the population of the subjugated colony' (Morrock 1973:129).

Fanon's (2005 [1961]) class analysis of the ruling African elite as an individual who tends to copy their colonial masters and Obadina's (2005:2) definition of the current African ruling classes as the 'predictor class who have dominated African politics since independence, support the argument that current differential development in many African countries may be explained by the perpetuation of colonial legacies. This strategy, when used in the independent African country, influences how resources are shared.

Michalopoulos and Papaioannous (2011) challenged the colonial legacy argument by using geographical information systems and statistical analysis to show that the extent of colonial influences in African development may have been largely urban-based and differential regional development may be explained by pre-colonial ethnic differences which simply resurfaced in the newly independent countries. Supportive data comes from regional similarities in development among the same ethnic groupings even when these groups live under different national governments. Whatever the explanation may be, whether we choose to believe in ethnic profiling or the predictor class, differential development is a reality in many African countries and it leads to differential allocation of health resources which increases vulnerability of care givers to epidemics.

Failure of Global Systems of Power Controlling Knowledge of Epidemics

Most of the new epidemics start among men and women in rural settings, yet these are the people (specifically the women) who are usually the last to know about basic disease prevention strategies. This is because technical information follows an invisible hierarchy determined by systems of power. Individuals with access to education and financial resources are likely to know about new diseases earlier and in more detail than those who live in faraway places away from the sources of power. Why is there funding for international and global health meetings and conferences but not enough funding for local conferences for monitoring new outbreaks of disease? Why is it so difficult for experts to provide knowledge on epidemic control that is easy to understand and integrate into the lives of poor rural Africans? The answer is that global and local systems of knowledge are structured in such a way that the status core decides what should be funded, what relevant scientific knowledge is and how it should be shared. Research and academic

careers are built on research far removed from the grassroots. Solutions to reduce epidemics among rural populations through participatory knowledge sharing are not easily funded. Marindo-Ranganai (1997) argued that this could be because African rural populations are on the fringes of power and are used as objects of research rather than participants.

Powerlessness of Local Disease/Epidemic Experts

There is a wealth of research and knowledge on African culture as well as research on health and anthropology which could be useful for epidemic control in Africa. Increasingly, participatory research in health has shown that there are disease prevention methods that work, when local knowledge is taken into account. Yet very rarely are African medical anthropologists, sociologists and health researchers the lead researchers in surveillance and research of epidemics in their own countries. In most cases, epidemics are treated as if there is no pre-existing knowledge in disease prevention in Africa. Funding organizations bring their own experts, most of whom do not necessarily build on existing knowledge particularly from the rural populations. This sometimes leads to interventions that are not sustainable. This is done at the expense of poor locals, who could have been reached and helped by their own people earlier if only the locals had been empowered to do so. The problem is that most local knowledge and disease prevention strategies are ignored in preference for imported ones. Those imported ones are supported by donor funding and gain credibility.

But why is it not possible to provide basic information on disease prevention in a manner that a village woman can understand? How do we, as women's health researchers and experts, ensure that knowledge and information about epidemics is shared timeously especially to those who are affected first?

Because the systems of power and knowledge demand that knowledge only becomes relevant if one collaborates with the right people, if one quotes experts in the field (even if they have no clue about the village) and if the system recognizes the work as relevant. So knowledge is not useful and does not exist until systems of power that control knowledge decide it is so. Local knowledge is contaminated by systems of power. So Fifi's death was caused by global and local systems that control knowledge of epidemics.

The Importance of Using a Feminist Intersectional Approach

Fifi is controlled by patriarchy and heteronormativity. She is let down by problems of differential regional development, she has no access to financial

resources which could have enabled her to purchase gloves and other sanitary basics, or even to employ a nurse, and she lacks recent and detailed and useable knowledge of disease prevention. It is the intersection of all these factors which caused her death. Her life was caught up in multiple disadvantages. Feminist research has for a long time highlighted the importance of an intersectional approach to policies and practices aimed at empowering women. This is also emphasised in this article. An intersectional analysis is critical in making policy decisions about reducing women's vulnerability to epidemics because rarely, if ever, does a single reason account for their vulnerability. Most are victims of intersecting sources of vulnerability.

Case Study Two – Maggie's Story

I am a 43-year-old woman and I discovered my [HIV] status on 15 September 2009. I am not sure when I contracted the disease. In my early twenties, in order not to let down the organization that funded my scholarship, the last thing I wanted was to get pregnant so I used the pill. So I had unprotected sex because I knew I wouldn't get pregnant. But when I turned thirty, although I was now successful and had passed my degree, I experienced a lot of pressure to get married and have children from my family. It was as if all the success meant nothing to my family and relatives as long as I did not have a husband and a child. Each time I went home to visit my parents expecting a celebration. But all they wanted to know was when I was getting married and when I was having a child.

I felt I was a failure as long as I was not married and a mother. So during two years between 2007 and 2009 I stopped using any contraception because I wanted to fall pregnant so that the man I was with would marry me. When that didn't work out I moved on to another relationship and so on.

Now I am positive and sick all the time. All my babies did not survive, I am still not married – nobody wants to marry me now and I am sure I will also die soon. My parents are embarrassed of what I have become. I am angry that I did everything that I thought was right but I still ended part of this epidemic.

Systems of Power and the Control of African Women's Wombs

African wombs have been grounds for a clash of power, between global systems of power encouraging population control through contraception and patriarchal power fighting for propagation of the species. Hartman (2009) argued that the motivation behind global population control is targeted racism towards third-world women. She argued that it is a deliberate strategy

of blaming the most vulnerable people for the world's problems. A key disturbing feature is how the global push for contraceptive use in developing countries is occurring at the same time as the expansion of assisted fertility programmes like IVF and surrogacy in developed countries. Isn't there some kind of global inconsistency in this approach?

Feminists have also questioned the way in which patriarchy controls various aspects of womanhood. Simone de Beauvoir (1997 [1949]) wrote about a 'myth of patriarchy' which defined proper womanhood. Ogundipe-Leslie (1985), in an interesting article about the Yoruba, stated that marriage turned women into property belonging to their husband's lineages. Among the Karanga's of Zimbabwe, a daughter in law is a '*mutogwa*', the word means a stranger but the ancient meaning referred to a 'stranger brought in to provide a womb'.¹ Both of these systems exert control on women's bodies, one under the guise of empowering women, another under the guise of culture.

The issue of population control is about controlling women's bodies in the same way that the excessive privileging of marriage and having children is about controlling women. This interference of power in women's wombs creates a lot of vulnerability for African women; partly because they want to feel that they are part of global movement of empowered women who control their reproduction, but on the other hand, they want to be part of their culture and have families and children. Although African men also experience these conflicts to some extent, women tend to experience these pulls more strongly.

Maggie was a victim of this complex interplay of systems of power that exert control over women's bodies and individual choice. As a young woman, it was drummed into her not to become pregnant, so the use of contraception sounded like the best strategy that would allow her to achieve her goals while still enjoying her life as a young woman. Contraception gave her freedom from pregnancy but not from infection. Lack of knowledge during the early days of HIV/AIDS also made her assume that simply because she was protected from pregnancy it meant she was protected from disease. But after achieving educational accolades, she still found that culturally she was not a success: she still needed to have a husband and children in order to be a proper woman. These are systems of power controlling women's sexuality and reproduction. Global systems of population control tell us it is not good to have children; traditional systems tell us that we only become something when we have children. She found herself at the intersection of various forces of modernity, patriarchy, the myth of individual power, male-driven heterosexuality and biological reproduction.

Male Dominance in Heterosexuality

But why did Maggie feel that it was her responsibility to take contraception? Why are young men not taking responsibility for their own sexual behaviour by using condoms? Because many young African men are not prepared to use condoms all the time, because young men have the power to walk away from a relationship without being pregnant; because the negative effects of pregnancy will affect the young woman and not the young man. Because young men have the power to explore their sexuality without responsibility while young women carry the responsibility for contraception because unwanted pregnancies are more devastating to their lives than those of young men. Because heterosexuality is about male dominance and women's subordination (Rich 1996).

Failure of Educational Systems to Teach Young People about Real Empowerment

What is the role of our educational system in teaching, mentoring and strengthening women? Who decides on what we teach our children in schools? What is success for women in the African context? We support local and national systems that create conflicting and disempowering systems for women; on the one level, our educational systems give us the impression that our daughters can be anything they want. Meanwhile our family and traditional cultures teach them that in spite of all that success they are nothing unless they are married and have children.

Conclusion, A Way Forward and Advocating for Change

I do not claim to have the answers to the conundrum of systems of power and disease vulnerability. But no drop of ink should be wasted fighting for the removal of any system. It is impossible to remove a system completely and entirely. The only solution is to come up with alternative new paths of least resistance that will transform the systems that we are dealing with. I am advocating for a new way of engaging with systems of power in ways that challenge the status quo.

The frameworks presented in this article have shown us two dimensions; where we are and where we would like to be with systems of power if a feminist epidemiology is to be achieved. But to get to where we want to be from where we are, we need to work with what we have and transform it. So I advocate the following.

- i. Let us come up with a new approach to our cultures and tradition and celebrate the success of our women by recognizing their contributions

in various fields. Let us come up with a system that recognizes that some women will not be married or have children and that it is okay in our societies for this to happen. It does not make them any less our daughters or sisters. Let's make patriarchy as it currently exists a less attractive option. If we can take away the vulnerability created by the fear of being culturally not good enough, perhaps we can move towards making disease epidemics less gendered. If we move towards cultural traditions that equally value men and women, perhaps epidemic prone diseases will be less gendered. Resistance comes from making what we no longer like/what we want to remove the least attractive option in any situation. We can achieve this by ensuring that our family and cultural values align with the global values that we have adopted. We cannot expect our daughters to be globally successful and at the same time poor, powerless and kitchen-bound.

- ii. Let us redefine new governance systems and become a continent known for having the smallest armies but the most equitable healthcare. How can we do this? By putting into place systems that enable us to change governments without fear, by developing new political parties and strengthening the role of civil society. Let us create new governance structures which do not replicate the entrenched divisive history of many African countries. Let us be able to change governments without destroying what we have built already. Let us be inclusive when making policy by forging equally balanced partnerships between unlikely groups for politicians and feminists, agricultural experts and eco-warriors, rural experts and professors, to name but a few.
- iii. Let us begin by redefining and accepting that knowledge about diseases and epidemics does not only come from Western education. Let us find the paths that allow knowledge from our communities, and from our own researchers, to be real knowledge. Let us begin to put resources into understanding our continent and our people and how they live and how they deal with epidemics. How can we achieve this? As scholars, by supporting African institutions that are working to build credible research in Africa. Those of us with resources: by funding African research, establishing academic chairs, by funding rural-based research to provide localized solutions through our own research funds rather than waiting for funds from elsewhere. If we can find the least path of resistance that allows all knowledge of epidemics to be integrated and shared quickly where it is needed; if we can find a path of least resistance that acknowledges all levels of knowledge from all communities and countries openly, then perhaps we will redefine new ways of making epidemics less gendered.

- iv. Let us fight for inclusive societies. No country can ever develop unless its people are united.

Acknowledgements and Declaration of my own Biases

I would like to offer my sincere thanks to CODESRIA for funding the conference on Governance of Public Health in Africa. I am not a poor powerless resource-limited African woman. And yet, I experience levels of powerless arising from being homeless. I sincerely hope that my analysis in this article does not in any way reproduce and reinforce certain systems of power and knowledge that create vulnerabilities in other women.

As an African female academic, struggling for relevance in a global scientific world, dealing with homelessness and political challenges from my own birth country, I have found myself at the intersection of racism, ageism and gender issues. I have no doubt that these multiple struggles with power/powerlessness have influenced both the emotional and analytical focus of this article. Systems of power play a crucial role in my life.

I am an unapologetic feminist and a critical race scholar. I offer no apologies for my beliefs.

Note

1. Personal communication with Karanga elders.

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