HIV/AIDS is now recognized as a global crisis, with young women emerging as the most vulnerable group. In both the industrialized and developing worlds, the rates of infection among women are increasing at a faster rate than men, with heterosexual contact as the main form of HIV transmission (Centre for Infectious Disease Prevention & Control, 2002a; Commonwealth Secretariat, 2002; Gomez & Meacham, 1998; UNAIDS, 2002a). In general, the rate of male-to-female transmission of HIV is 12 times more likely than female-to-male transmission (Gutiérrez, Oh Joo & Gillmore, 2000). Most explanations for this gender discrepancy focus on the ways young women’s greater biological vulnerability to HIV infection is increased when their sexual autonomy is compromised in heterosexual relationships. The factors associated with young women’s inability to control sexual encounters include sexual violence, female sexual passivity, the privileging of male penetrative sex and the sexual double standard (see, for example, De Oliveira, 2000; Holland & Thomson, 1998; Kumar, Larkin & Mitchell, 2001; Larkin, 2001; Mlamelli et al., 2001). As an overriding framework, young women’s disproportionate vulnerability to HIV infection is often attributed to universalist notions of masculinity and femininity that get played out in youth sexual behaviour (Holland et al., 1999). While this work has been a vital first step in acknowledging gender as a risk factor for HIV, our research with the Gendering Adolescent AIDS Prevention (GAAP) project has revealed some of the limitations of this analysis, most particularly, the focus on individual sexual practices, the essentializing of masculine and feminine identities and the homogenizing view of youth from different locales.

The anthropological response to the epidemic has done much to move analyses beyond such individual and universalist approaches to risk. In studying “the local”, researchers have identified the ways in which structural inequities embedded in processes related to “economic development, housing, labor, migration or immigration, health, education, and welfare (Parker, 2001, p. 169)” can drive the epidemic in specific populations. The work of Farmer (1996), in particular, has demonstrated how the political factors that create conditions of HIV risk are linked with gender and sexuality in ways that can help to explain the disproportionate vulnerability of girls and women. More recently, however, anthropologists such as Aihwa Ong (1999) have argued that many ethnographical studies have failed to capture the “relational nature of the contemporary economic, social and cultural processes that stream across spaces” (p. 4, emphasis in the original), a concept she sees as accounted for in the term “transnationality.” In a postmodern world, as Ong explains, “[t]rans denotes both moving through space or across lines, as well as changing the nature of something” (1999, p. 4) in a time when the global flows of people, products and information are increasing (Shohat, 1998).

The work of Ong and others (Alexander, 1994; Farmer, 1999; Freeman, 2001; Grewal & Kaplan, 2001; Kenway & Kelly, 2000; Mohanty, 1998; Perry & Obiora, 2002; Shohat, 1998) has raised new questions for our HIV work with Canadian and South African youth. How do we think about HIV/AIDS in an increasingly globalized world? How do transnational processes impact on HIV risk and the gendered dimensions of HIV vulnerability? What are the implications for HIV research and education with youth? In this research note, we consider these questions as a way of furthering our understanding of the complexities of gendered risks both within and across two countries at very different stages of the epidemic. South Africa with national prevalence rates around 20% (UNAIDS, 2002b) and Canada where infection rates are currently low (around 0.3%) but with worrying signs about the potential for the spread...
of the disease (Centre for the Infectious Disease & Control; 2002b; Patrick, Wong & Jordan, 2000; UNAIDS, 2004). In both countries, females are disproportionately affected. The infection rates of girls in South Africa are three-four times higher than boys (Human Rights Watch, 2001); in Canada, the rates are increasing in young women aged 15-29 years (Health Canada, 2003c).

With concerns that HIV infection rates in Canadian youth may be on the rise (Health Canada, 2003c; The Centre for Infectious Disease Prevention & Control, 2002b), we know we have much to learn from countries like South Africa who are experiencing the urgency of AIDS. In this paper we draw on HIV work in both countries to consider some of the concepts that may have value for gender-sensitive HIV prevention programming in a transnational world. We argue that the problem of first world/third world binaries, the transnational circulation of colonial and racist representations of AIDS, and the restructuring of gender systems through globalization processes are important considerations for HIV prevention work. We refer, also, to some preliminary results of our research with focus groups of youth in Ontario, Canada to make the case for situating prevention work with Canadian youth in a larger global context.

The thinking that informs this paper comes out of our engagement with the work of transnational feminist scholars who have offered insights that have broadened our analysis of gender, risk and HIV prevention. Our attempt here is to push the discussion of the gendered dimensions of HIV risk beyond individual behaviour by considering the ways transnational processes are increasing the structural inequities that heighten vulnerability to HIV infection, particularly for young women.

The Gendering Adolescent AIDS Prevention (GAAP) Project

The Gendering Adolescent AIDS Prevention (GAAP) project includes a series of studies with Canadian and South African youth2 who face various degrees of HIV vulnerability that have much to do with their particular social location and the uneven impact of local and global factors of risk. Given these variations, our goal in GAAP, is to develop gender sensitive HIV prevention programs that go beyond a “one size fits all” approach to youth and HIV risk. Our focus on Canada and South Africa grows out of our work with the Canada South African Management Program (CSAEMP), a partnership of CIDA, McGill University, and the National Department of Education in South Africa. Through CSAEMP, we worked with South African educators and learners on the development of an educational model designed to educate teachers about issues related to gender-based violence. This project brought to light the link between gender and HIV, a connection we began to apply to our understanding of HIV risk in Canadian youth but one we now recognize as not nearly nuanced enough. While the situation in Canada is nowhere near the epidemic proportions in South Africa, we know that youth within each country are disproportionately affected, with youth from marginalized groups most at risk and marginalized girls the most vulnerable of all (see, for example, Albertyn, 2003; Health Canada, 2003a; Tharao & Massaquoi, 2001). A key task of our HIV prevention work is to identify the risk factors faced by differently situated youth.

Through GAAP, we have worked to unravel some of the problems associated with HIV prevention work with particular attention to issues related to gender. Although most education programs aim to change the views and behavior of individual youth, it is a general finding that knowledge about HIV/AIDS does not typically transfer to safer sex practices. As Campbell (1997) reminds us, “research has found that even people with relatively high levels of knowledge about HIV/AIDS often indulge in high-risk behaviours” (p. 274). Part of this disjuncture may have to do with the “anybody else but me” attitudes to HIV vulnerability supported by narratives of AIDS as a disease of “foreign” places and sexually deviant bodies (Patton, 1999, 2002; Treichler, 1999). Other factors may have to do with neo-liberal approaches to HIV prevention that view risk “as a result of lifestyle choices [and] thus an individual responsibility” (De Oliveira, 2000, p. 2) with little consideration of the structural inequities that can operate to limit individual choice. By ignoring the “social character” and “the diversity of meanings” (p. 2) attached to risk, De Oliveira (2000) argues that “health promotion has dealt with the complex problem of girl’s sexual risk-taking in a very simplistic way” (p. 2).

The concept of risk, in this historical period, is complicated further by the social and political transformations in the context of rapid globalization. In their study with youth in seven developing countries, Dowsett et al. (1998) identified some of the larger contemporary forces that impact on the HIV vulnerability of women and girls and the need for a more complex approach to gender and HIV prevention:
The growing practice of sex for cash, goods or favours; the increase in intermittent sex worker related to (sometimes transient) economic need and migration; an increasing recognition of women’s sexual pleasure; the widespread and undeniable experience of women in coerced sex; the impact of globalizing sexual cultures; these are as much an urgent part of the HIV/STD agenda as are condom promotion and sex education (p. 304).

In documenting the varied situations of youth, Dowsett et al., (1998) argue for a rethinking of HIV prevention programs based on dichotomous notions of aggressive-passive masculine and feminine sexual behaviour and visions of youth “as one, inevitably at-risk population” (p. 306). They propose that a good starting point to more complex understandings of gender and HIV vulnerability is to consider young people in relation to their “risk-in-context” (p. 307). In a transnational world, this means considering the forces that create uneven conditions of risk for youth across diverse populations and different geographical locations. Our particular concerns are the relevance of these forces for the rising infection rates in girls and for HIV prevention programming targeted at youth.

SITUATING CANADIAN YOUTH

Although there is a large body of work on youth and HIV risk focused on the developing world, the Centre for the Infectious Disease Prevention and Control (2002b) reports that, “few Canadian studies have examined HIV prevalence among youth, and almost all research has involved high risk populations” (p. 13). To address this concern, we want to expand on the work of Dowsett et al., (1998) by making the case for the urgency of HIV prevention work with youth in Canada and the importance of situating prevention work with Canadian youth in a larger global context. Although the Canadian HIV infection is nowhere near the epidemic proportion of South Africa (UNAIDS, 2002b; UNAIDS, 2004), the number of reported HIV infections is on the rise (Health Canada, 2003b). In youth, the rate is increasing most rapidly in young women (Centre for the Infectious Disease and Prevention Control, 2002b; Health Canada, 2003c) with females from marginalized groups most at risk (Health Canada, 2003a, Thaora & Massaquoi, 2001). Rising infection rates, coupled with a recent surge in STDs, are signs of the potential for the spread of AIDS in Canadian youth (Patrick, Wong & Jordan, 2000). As reported in the Toronto Globe and Mail (August 21, 2001), the findings from a study by Patrick, Wong & Jordan (2000) are disturbing:

Just when we thought today’s teenagers were a whole breed of sexually savvy sophisticates, reality intrudes in the form of a new study on sexually transmitted diseases...Teenagers (in Canada) from 15 to 19 have the highest infection rates, demonstrating that they are either ignorant of or blasé about Chlamydia, gonorrhea [and other STDs]...This latest study of sexually transmitted diseases has other implications. If teenagers are not using condoms, there is a growing risk that AIDS will spread to this age group (A12).

The recent rise in STD rates of Canadian youth signals an increase in HIV risk, most particularly for females who are more likely than males to have an undetected STD (Centre for the Infectious Disease and Control, 2002b; Kumar, Larkin & Mitchell, 2001; Patrick, Wong & Jordan, 2000). The Canadian AIDS society also states that “Because young people with HIV progress to AIDS much more slowly than older persons, AIDS statistics are bound to disproportionately under-represent youth” (Canadian AIDS Society, 2003, np). Despite this worrying situation, many Canadian youth connected with GAAP tell us they know very little about AIDS and do not consider themselves to be at risk (Larkin & Mitchell, 2003). Their comments support the findings of a national study conducted with 11, 074 grade seven, nine and eleven Canadian youth (Boyce et. al., 2003) which showed “a marked decline in knowledge about HIV, AIDS and other sexual diseases when compared to a similar study conducted in 1989 (Branswell, 2003, F4).” For example, in the recent survey, fifty percent of grade nine students thought there was a cure for HIV/AIDS and half of grade 11 students did not know that a person could have an STI without showing visible signs of illness. In the context of rising STI rates, Paul Cappon, director-general of the Council of Ministers of Education and commissioner of the report, describes this lack of knowledge as the most worrisome finding of the study (Branswell, 2003, F4).

In general, Health Canada (2003b) reports that recent studies “reveal the complacency, lack of information, and misinformation about HIV/AIDS in Canada” (p. 2). UNAIDS (2002a) has warned that, “[t]he prospect of larger HIV/AIDS epidemics cannot be ruled out if widespread complacency is not addressed” (p 39). Complacency about Canadian infection rates may have much to do with dominant narratives for representing AIDS. Drawing on colonial history, the tropical disease model associates HIV/AIDS with particular places, most particularly, the Third World (Patton, 2002). The face of HIV as a disease of the developing world can place Canadian youth at risk, particularly when statistics show...
a sudden rise in the STD rates of adolescents (Patrick, Wong & Jordan, 2000). To illustrate this risk, we offer excerpts from the transcripts of our conversations with groups of youth in Ontario, Canada. These conversations are part of a GAAP project in which we have set up focus groups of 10-15 youth as a space for young women and men to discuss a cluster of questions that explore their interpretation of terms such as safe-sex, risk, condom negotiation and their knowledge and sources of HIV/AIDS information. To this point, we have conducted twelve focus groups with 139 youth in Canada. The groups include students in three Toronto area schools, youth from community groups in three small Ontario towns, three groups of Aboriginal youth and a group of Black youth from a community organization in Toronto.

What is emerging from our data is the extent to which youth see HIV as a disease of the “other”. Whether talking about the developing world, city or small town dwellers in Canada, or poor people worldwide, the youth tend to distance themselves from the disease by claiming that HIV is a problem elsewhere, but not in their own communities. Most striking is the perception of AIDS as an African problem. In the following discussion, for example, students participating in a focus group from a suburban Toronto high school appeal to the discourse of African AIDS (Patton, 1999) to account for the discrepancy in Canadian and South African HIV infection rates. We can read such comments as evidence of the need for pedagogies and curricula that situate HIV/AIDS in a broader ‘global awareness’ framework. An additional concern, however, is the students’ belief that the risk of HIV infection is ‘somewhere else’:

Nellie: …if I were living in South Africa right now, I would probably be quite afraid of getting AIDS, like it’s got such a high rate. …Because it’s such a big deal there…we see it as…not a huge problem for us living in Toronto right now…

3 The eight working group questions are: 1) If someone your age says that they are sexually active, what do you think that means? Is this different for guys than girls (and vice versa)? 2) We are always hearing that youth feel pressured to be sexually active. Is this the case? What are some of the pressures? Do you think that they are different for guys and girls? 3) Where do people your age get their information about STDs and HIV/AIDS? What kinds of information are available? 4) Do you think young people worry about getting HIV/AIDS? 5) How many of you have seen a male condom? How many of you have seen a female condom? How might young women (girls) feel about male condom use? How might young women (girls) feel about female condom use? How might young men (guys) feel about male condom use? 6) There’s a lot of talk about people “negotiating” around using condoms. What do you think that means? Is it the same for guys and girls? 7) When you hear the phrase risky behaviour when it comes to sex what do you think it means? Does it mean the same thing for young men and young women? 8) What messages do you get about HIV/AIDS in the media? If you had to create an ad for television or a magazine, what message would you give to young men? To young women? Would they be the same or different?

4 The focus group included 10 students with an equal number of males and females. The group was racially mixed with students self-identifying as Korean (1), Caucasian (3), Sri Lankan (1), Lebanese (1), French Canadian (1), and African-Indian (2).

Evan: …I disagree…if I lived in South Africa…I would most likely be poor and I would most likely not have an education. So I’d be ignorant to the risk…of contracting AIDS if I have sex. So I won’t have a problem in having sex, and that’s something that I won’t think about.

Rosalee: Obviously they’re not ignorant now because of research, right?

Evan: Like…it’s totally different there than it is here when you have people that live in huts and don’t have radios and listen to the latest science report.

Razeena: …I think the main problem there was…lack of education. I was watching this report and they said that…education was a major impact on why a lot of people were being infected…because people couldn’t read the signs being put up and warning them of it, so they had to put pictures and even then some people had trouble understanding…

The students’ appeal to the tropical narrative of African AIDS involves a recycling of racist ideas of African people as backward and illiterate (Patton, 2002, Raimondo, 2003) and a sharp first world-third world division separated by education. In her further comments, Razeena draws on the colonial discourse of a benevolent, modern first world charged with the responsibility of saving “primitive” peoples from their own ignorance, a perspective stripped of an analysis of the colonial history, inadequate health care and other global inequities that heighten HIV risk in Africa:

Razeena: I think they needed more people to educate people in the village…someone with experience to go around and talk to people more so than just putting up signs, cause…while you’re doing your daily chores and what not, from what I know of Africa…you might look at the pictures, pretty pictures and walk off…I think it was a lack of communication on our part if we’re still trying to help them…

These comments may be informed by media representations of Africa as a place of poverty, ignorance, and hopelessness to be salvaged only by first world interventions, a perspective resent by youth in our
The ideas expressed by many of the youth in our Canadian focus groups point to the need for developing a more transnational understanding of risk and prevention, one that takes up Ong’s argument for viewing countries not as “hermetically sealed entities” (Shohat, 1998, p. 1) but relationally, particularly in a world increasingly characterized by movement. Within this expanded framework, Canadian youth are not seen to be exempt from “the disruptions of globalization” (Ong, 1999, p. 109) or apart from the “matrix of domination” (Collins, 1990, p. 229) that creates uneven conditions of risk both within and beyond Canadian borders. Given the rising infection rates among youth, HIV/AIDS researchers such as Paul Farmer (1996) argue that young people throughout the world need to learn about the relationship between HIV transmission and the social forces of inequity. In an increasingly globalized world, this means situating HIV awareness education in a global equity framework that acknowledges the complexities and unevenness of risk. Grewal & Kaplan’s (2001) arguments for bringing “questions of transnationalism into conversation with the feminist study of sexuality (p. 666)” may be an important step to achieving this goal and advancing our understanding of what it means to do gender and HIV prevention work in a world where AIDS has become a global moving target.

TRANSNATIONALIZING HIV PREVENTION

‘Transnational’ is an imprecise term invested with such multiple and disparate meanings as global linkages and connections in some cases and unequal and uneven relationships in others (Grewal & Kaplan, 2001; Trotz, 2004). So, for example, while addressing the asymmetries of globalization, transnational feminism is also an activist project that works towards alliances across differences (Mohanty, 1998, p. 486). Central to most articulations of ‘transnational’ is the concept of movement across borders. While the dominant foci of transnational studies have been migration and finance capital, the capacity of diseases to “completely defeat national boundaries” (Patton, 2002, p. 28) gives HIV/AIDS a transnational character (Patton, 2002, Farmer, 1999), its uneven impact subject to fluctuating globalization processes. Within this changing context, as Grewal & Kaplan (2001) have argued, “ignoring transnational formations has left studies of sexualities without the tools to address questions of globalization, race, political economy, immigration, migration and geopolitics (p. 666)”, forces we now recognize as important determinants of HIV risk. What follows is a discussion of some of the transnational concepts that have helped us to incorporate these
In Canada, the erosion of Medicare and the threat of a two-tier health care system pose grave concerns for the health status of women and girls who lack the income required to access private health care services (Larkin, 2000; Maher & Riutort, 1998). The increasing poverty of some nations and the persistence of poverty through the inequitable distribution of resources within the wealthy nations are taking a toll on the health and development of many youth throughout the world (Call et al., 2002). Moreover, if we take seriously Stromquist & Monkman’s (2000) point that “the tidal wave of globalization has impacted the lives of citizens of all countries with different degrees and a mix of positive and negative directions (p. 19)” it seems a first world/third world binary is off the mark in the study of AIDS. This is something Paul Farmer acknowledges in his important book, Infections and Inequalities, where he claims that the “lack of a systemic and critical analysis permits… global ties to be obscured” (1999, p. 281). In writing on his research and clinical work on AIDS in Haiti, he argues:

... the intense suffering of many of the people described in these pages cannot be understood as divorced from the suffering and surplus documented within the borders of countries like the United States and Britain. The sick of rural Haiti, urban Peru, and sub-Saharan Africa may be invisible to those tallying the victims of modern inequality, but they are, in many senses, casualties of the very same processes that have led to crime and decreased social cohesion “at home” (p. 280).

We are not suggesting that the nation-state is inconsequential in the study of HIV risk. As Farmer (1999) reminds us while “infections pass easily across borders”, medical resources, “are blocked at customs” (p. 54). The differing access to anti-retroviral drugs in Canada and South Africa is a startling example. But given the uneven impact of globalization forces, we know the conditions of HIV vulnerability vary both across and within national boundaries with youth in marginalized positions disproportionately affected and female youth the most vulnerable of all. In South Africa, Albertyn (2003) notes that HIV infection patterns follow the biases of poverty and race with the highest prevalence among young African women. The pattern is similar in Canada. For example, Aboriginal women are over-represented in HIV/AIDS statistics with the rates of infection rising most alarmingly in women under 30 (Loppie & Gahagan, 2001; Ship & Norton, 2002).

Although the particular social and economic conditions vary
across the world, more and more young women are linked by their subordination within a global economy that has created conditions of female impoverishment (Farmer & Kim, 1996). For young women worldwide, the HIV risk practices of drug use and transactional sex are often a direct consequence of trying to cope with limited economic resources (Connors, 1996). Sinha (1999) uses the term “structural violence” to refer to poverty and other social forces that operate to create conditions of HIV risk.

Bringing the uneven impact of structural forces to the fore has implications for designing prevention interventions and strategies that work for particular communities. Given that youth are not a heterogeneous group their involvement in the creation of prevention messages is crucial. The move towards more participatory approaches to HIV research and prevention is something Parker (2001) sees as an important outcome of the growing awareness of the structural components of risk:

In some of the most innovative work currently being carried out, HIV/AIDS interventions research has drawn on theories of “social transformation” and “collective empowerment” in order to examine issues related to power and oppression. The research has increasingly turned from the psychological theorists of reasoned decision-making to the work of community activists and popular educators in seeking the basis for a transformative or dialogical educational process in which participants explore and question their own lives and realities. Through this exploration and questioning, the participants begin to undergo a process of collective empowerment and transformation in order to respond to the forces that threaten and oppress them (p. 172).

Our own recent work examines the ways popular modes of youth culture can be used to involve youth in the creation of gendered education messages that reflect the realities of their lives. In both Canada and South Africa we are working with a cross-section of youth activists, writers, artists, dancers, entertainers, health workers and educators to develop arts activities that provide a space for discussion and action projects around gender and HIV prevention. We see such localized work as a forum in which to develop more situated understandings of HIV risk and to provide youth with a space to create prevention messages and strategies that have real meaning for them. In keeping with transnational feminism’s project of building of solidarities and alliances (Mohanty, 1998; Park, 2002), the materials produced5 are being used to create conversations with youth about the forces that impact on gendered relations and HIV risk across geographical spaces.

Race, Representation & Border Crossings

Growing population movements across the globe as part of the fallout of colonial legacies and contemporary global restructuring are accompanied by discrimination against people considered to be “the face of AIDS.” Anxieties that the third world is now moving into the first world have led to tighter regulatory borders erected to defend against the pollution of the ‘Other.’ In the western world, efforts to reinforce national borders to defend against the invasion of AIDS have marked particular bodies as outside the parameters of the rights of citizenship (Raimondo, 2003). Fear that an HIV positive test will affect immigration status and the ability to sponsor family members are reasons that HIV testing and health services are underutilized by some marginalized groups in Canada (Tharao & Massaquoi, 2001). Health workers at Women’s Health in Women’s Hands, a community health centre for women of diverse backgrounds in the Toronto area, have found that the stigma and stereotypes associated with AIDS can operate to increase infection rates in communities marked as the originator of the disease:

The racist discourse that dominated the first decade of HIV/AIDS and personal experiences with racism remain major factors in the continuing silence and the increase in HIV infection among Black women in their communities. Once diagnosed with HIV/AIDS one cannot escape the socio-cultural interpretations attached to it creating negative implications for the individual, for their social interactions and for their relationships. Commonly believed images, stereotypes, and attitudes about the disease itself, compounded by constant anxiety about what others think or feel about them determines whether people seek or access services (Tharao & Massaquoi, 2001, p. 72).

Racist conceptions of HIV/AIDS move across borders. The stigma associated with African AIDS6 is commonly expressed through

5 Materials produced to date include the videos, Taking Action (Canada) and Fire and Hope, (South Africa) as well as the book, In My Life: Youth Stories and Poems about HIV and AIDS (South Africa) and a photo exhibit (Canada).

6 As Raimondo (2003) describes it, The African-origin theory of AIDS “proposes that HIV developed out of an animal host series in central Africa and spread all over the globe, with the Caribbean serving as a way station for the virus’s trip to North America” (p. 392). Critics argue that the theory relies on racist and colonialist stereotypes of Africa.
descriptions of black women’s alleged hyper sexuality, a key feature in the representation of the disease (Raimondo, 2003). In the discourse of ‘AIDS and accusation’ (Farmer, 1992), black women have been represented as “the other” of the “other,” the deviant of the deviants” (Hammonds, 2001, p. 390), exempt from the discourse of “violated innocence” (Raimondo, 2003, p. 393) associated with white women’s sexuality.

According to health-care workers Tharao and Massaquoi (2001), “fear of the spread of HIV/AIDS across borders...has numerous implications for Black women living in Canada (p. 72).” As the discourse of HIV/AIDS unfolded, they argue that:

... African women living in Canada, were not so much concerned with contracting the HIV virus as we were the racist undertones of media reports depicting HIV/AIDS as just another tragedy that was plaguing the poor, the powerless, and those living on the margins of society, namely Africans, drug users, and gay men... (p. 72).

In their study, racist attitudes within the healthcare system were found to be “one of the primary reasons Black woman reported a reluctance to access healthcare services including HIV/AIDS education, prevention, treatment, support and care” (Tharao & Massaquoi, 2001, p. 75), a situation that can heighten vulnerability to HIV infection for girls and women of African and Caribbean descent. Here gender and race intersect to create conditions of risk specific to a particular population of girls. Such specificities can be lost if youth are viewed as a homogenized group in HIV research and prevention programming and young women’s vulnerability is attributed solely to their subordination in heterosexual relations.

Disrupting the racialization of AIDS will call for prevention strategies that apply an intersectional approach to HIV risk, inscribing race into discussions of gender and sexuality. Jacquie Alexander’s appeal for us to “become fluent in each other’s histories” (cited in Mohanty, 1998, p. 486) is important if young people are to understand the colonial myths behind the construction of “African AIDS” and the connection to racist stereotypes of female sexuality. Prevention efforts that attempt to decolonize representations of AIDS will help to challenge the stigma that negatively impact on some youth populations while allowing others to distance themselves from the disease. Understanding the ways diverse histories and cultures parallel and intersect (Shohat, 1998) will help to forge connections among youth that can challenge the “othering” of AIDS by working towards the “non-colonized dialogue” (Mohanty, 1998, p. 486) that is the project of transnational feminism.

Globalization & the Restructuring of Existing Gender Systems

Transnational feminist scholars work against essentialized identities of race, gender, class and sexuality (Park, 2002) and consider “the central role of both local history and contemporary global restructuring in creating existing gender systems” (Perry & Obiora, 2002, p. 257).” At this moment in time, one feature of globalizing processes is the destabilizing of class and gender identities to the extent that masculinities and femininities are being reconstructed in ways that both reinforce and transform unequal gender relations (Alexander, 1994; Freeman, 2001; Gross, McMurray & Swedenburg, 1996; Kenway & Kelly, 2000, Mohanty, 2003; Nagar et. al., 2002), a key social determinant in HIV risk for women and girls. A significant effect of global economic restructuring is a change in labour patterns with the heightened exploitation and feminization of the workforce and a demise of the ‘male breadwinner’ role (Alexander, 1994). With the decline of heavy manufacturing in the industrialized world, jobs in traditionally male labour markets are shrinking, particularly as factories move south where wages are lower and workplace regulations are more lax. At the same time, a rise of the retail and service sectors means that traditionally female markets are expanding (Kenway & Kelly, 2000). In the north, women may appear to be the winners of globalized production but their employment advantages are in low-income, precarious jobs (Wichterick, 1999). While industrial jobs are disappearing for males, females are seen as cheap and exploitable labour. As Nagar et. al., (2002) point out, the discourse of “deferential femininity” (p. 268) embedded in the current global labour market “constructs young men as unsuitable workers, disadvantaged by their gender and a specific embodied performance of a macho working-class masculinity” (p. 268). The impact is perhaps greatest in poor countries hit hardest by structural adjustment programs and poor and working class communities in North America. In what ways might a change in gendered labour patterns intensify gender inequalities in heterosexual relationships?

Freeman (2001) argues that the new forms of global femininity and the shift in gender roles have been accompanied by an increase in violence against women, a key factor in the higher HIV infection rates for women and girls (Doyal, 2002, Garcia- Moreno & Watts, 2000; Gomez & Meacham, 1998; Human Rights Watch, 1995; Larkin, 2000; Mlamelli et al., 2001). The strong association between masculinity and paid work can be disrupted when young men face a bleak employment future (Kenway & Kelly, 2000; Morrell et. al., 2001). Threatened by the loss of power in the
public sphere, the attempt to assert a male identity may be transferred to personal relationships. As sexual dominance has traditionally been a central feature of manhood, a return to more conventional forms of masculinity may reduce young women’s sexual autonomy and increase their HIV risk (Kenway & Kelly, 2000; Morrell et al., 2001). This is the current situation in South Africa, where a history of oppressive political practices under apartheid has resulted in heightened forms of masculinity that are often directed at women (Albertyn, 2003; Mlamlelli et al., 2001). In fact, the high incidence of rape in South Africa has been linked to the rapid spread of the HIV virus, particularly in youth (Human Rights Watch, 1995; Mlamlelli et al., 2001). As a number of South African scholars have noted, when faced with a future of poverty and hopelessness, young men may use sex to gain control in their lives (Klugman, 2000; Morrell et al., 2001). We are not suggesting that the correlation between poverty and AIDS is a causal one, a position that can reinforce racial stereotypes and pathologize people who are poor. Our aim, following from Patton (1999), is to consider the impoverished conditions of differently-situated youth in the larger context of uneven global processes that cut across national boundaries, a perspective that can disrupt a first world/third world division in framing the disease. As she puts it:

Linking disease and poverty in a simple way leaves the way open to the unconscious of Westerners to relate poverty as well as disease to some transcendent racial/ethnic difference rather than situating both in larger and historically specific patterns of colonialism, capitalist statism, and a global economy increasingly controlled by supranational corporations (p. 390).

In the context of the AIDS pandemic, shifting gender relations and the link to sexual violence, we need to pay attention to concerns that sexual health programs targeted at youth have inadvertently reinforced essentialist notions of aggressive masculinity (DiCenso et al., 2002; Langille, Gahagan & Flowerdew, 2002; Bay-Cheng, 2001). If a key aim in HIV prevention education is a renegotiation of high-risk behavioral norms, prevention programs should provide youth with the possibility of renegotiating traditional forms of gender behavior. South African AIDS prevention educators, Campbell & MacPhail (2002), argue that HIV prevention education should provide youth with the opportunities to consider how particular versions of masculinity and femininity place their sexual health at risk, as well as “the belief in the possibility of alternative gender relations” (p. 341). In our work with Canadian and South African youth, we are analyzing our focus group data to identify alternative forms of masculinity and femininity that could be used to fashion a broader framework for exploring gender relations in sexual practices (Andrews & Larkin, 2002a, 2002b; Larkin, Andrews & Mitchell, forthcoming). In a related project we are using photography to document multiple forms of masculinity and femininity through the images produced by youth themselves. Our goal is to explore what images of masculinity and femininity look like from the perspectives of differently situated youth and to determine the connections to HIV risk, particularly for girls.

CONCLUSION

In the fight to halt the spread of the pandemic, UNAIDS (2002a) has declared that “prevention efforts must be tailored to developments in the epidemic...Like society itself, the epidemic is in constant flux as it adapts to surrounding factors and circumstances” (p. 80). In the context of the uneven processes of globalization, however, the “messy reality of complex processes of societal transformation” (Doyal, 2002) can be difficult to assess, particularly with economic, political and cultural transformations shifting the optics through which we understand gender (Mohab & Manicom, 2004). Developing a ‘transnational literacy’, as Spivak (1993) puts it, may help to address these transformations in our HIV prevention work with youth. From a transnational perspective, we may come to understand the increasing vulnerability of girls in the context of a more nuanced understanding of the complex relationship between gender, youth and HIV infection in a world increasingly connected across national borders. Our work in Canada and South Africa has shown that a questioning of first world/third world binaries, the decolonizing of representations of AIDS, and the restructuring of existing gender systems are important components to be added to the expanded HIV/AIDS agenda proposed by researchers such as Dowsett et al., (1998). In transnationalizing our thinking about the character of the disease, we may be better equipped to develop prevention and awareness programming that will have more force in reducing youth infection rates and, most particularly, the spiraling rates for girls.
REFERENCES


