66 The Impact of AIDS on Women's Social Life in a Mexican Rural Community

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66.1 Introduction

66.1.1 The Setting

According to the United Nations official statistics for 2002, there were one billion poor people in the world, 70 per cent of whom were women, a figure that reflects a serious problem of gender inequity and a harsh social inequality. Some 40 million of the world's poor live in Mexico, 26 per cent of them in conditions of extreme poverty. Given this panorama, there is a clear and urgent need not only for actions designed to achieve an understanding of the multiplicity of the causes of poverty but, more importantly, to generate interventions by different sectors that will bring about a gradual transformation of this reality. This entails adopting a posture that orients discussion and exposes basic aspects of poverty. In particular, there is a need to analyse elements that affect women in particular.[1]

We intend to show how economic, social, and psychological vulnerability impacts on women's capability to cope with adverse health conditions, such as having acquired HIV. The lack of resources critically heightens the subjective feeling of insecurity and perceived lack of coping strategies in situations of threat. Vulnerability, in this sense, is subjectively perceived defenselessness and negatively affects social integration and personal well-being.

This research on women's health and their associated social life was conducted in a rural community, Coatlán del Río, a municipality in the state of Morelos that is characterized by high indices of migration[2] that have specific repercussions on the dynamics of everyday life and the social relations that develop among people (figure 66.1).

According to data from the population census (INEGI 2005), this town has 4,523 male and 4,833 female inhabitants. The average age is relatively low, as the largest cohort is the 1 to 15 years age group. In Morelos, 15 per cent of migrant women and 14 per cent of non-migrant women are heads of households (Chávez Galindo 2008: 52). The most common illnesses in this jurisdiction are infectious diseases and parasitic infections of the digestive tract, mainly intestinal amebiasis, caused by the lack of clean drinking water and sewer systems. These ailments affect mostly children and young people from 5 to 14 years of age. Communicable diseases such as hemorrhagic dengue and sexually-transmitted diseases, especially the *Human Papillomavirus* (HPV) and HIV, are also present. The most common non-transmissible, chronic-degenerative diseases are arterial hypertension, diabetes mellitus, rheumatoid arthritis and, especially, cervical-uterine cancer. The latter is detected in 30 per cent of cases analysed and is the most common cause of death there; indicating clearly that women's health suffers from a lack of preventive measures and medical attention.

The community's economic activity is based on agriculture because of its favourable climate. Though located in a region rich in natural resources with broad extensions of arable land, residents live in somewhat precarious conditions mostly due to a lack of orientation, support systems, and official resources for developing programmes. Given the lack of employment opportunities, slow emigration has become a 'naturalized' phenomenon, as men – mostly – have assimilated

1 A perspective much in vogue in public policies during the 1990's that emerged from denunciations of male/female inequities in different contexts fostered by the women's liberation movement in the 1970's.

2 Among the states with high levels of migration registered by CONAPO in the 2000 Census, we find: Aguascalientes, Colima, Guerrero, Hidalgo, Jalisco, Morelos and San Luís Potosí. Morelos showed a migratory flow of 10,495 people in that year.

Figure 66.1: Location of the research: Coatlán del Río, Morelos, Mexico.

migratory processes and flows, leading to a consolidation of shared imaginaries and collective identities. Most of the women with whom the researchers had close contact have experienced the migration of their partners at some point in their relationship and assume that at any moment their family dynamics may have to be reoriented. This uncertainty propitiates a state of emotional alert related to their ambivalent feelings and this, in turn, generates tension as well as states of anxiety and contradiction.

Against this backdrop, our research represented an attempt to identify: 1) the psychosocial and gender indicators that are constructed through the subjective experiences of a group of women exposed to the migratory process in that setting; and, 2) how those women have come to signify HIV/AIDS in their condition.

66.1.2 Social Representations in the Community

The present research takes social representation theory as the starting point. The concept of social representation refers to socio-cognitive processes by which social actors render their reality comprehensible and endow it with sense and meaning. By providing an everyday epistemology, social representations are the prerequisites for constructing and maintaining systems of communication among the members of communities. This approach allows conceptualizations of everyday thinking and experience within the frame of community discourse and personal communication.

A community is the place where personal communication intersects with the wider social setting and mass-mediated communication. A village or a city block has a size that allows villagers and residents to meet on a regular basis and to engage in personal contact that involves exchange of private matters as well as of societal and political ones (Jovchelovitch 1995, 2001; Moscovici 1976). The wider public sphere enters via the representations entertained and transported by the mass media, which provide topics for conversation and dispute among the members of the community. In this sense the community settings are pivotal in the generation, elaboration, and change of social representations that always emerge when discourse unfolds about some new phenomenon and some preconditions are met (Wagner/Hayes 2005).

Illness appears to be first and foremost a matter of private interest. Maintaining and re-establishing one's personal physical well-being depends on lifestyle and personal preferences. However, what counts as well-being and what counts as an adequate and preferred lifestyle is defined in the deeply social fabric of cultural and societal discourse. There is no private desire or behaviour that is not directly and indirectly informed by, and directed towards, other actors as well as towards the collectivity. Each person's subjectivity is the historical product of collective processes that converge in an individual as a member in families, social groups, communities, nations, and cultures.

The illness of AIDS or HIV-positivity is a case in point. People are affected by HIV infections as patients, as family members of patients, and as members of societies that are struggling to contain the societal consequences of this virus. The appearance of AIDS/HIV a few decades ago was shocking and serious enough to give rise to a full-fledged representational system. The emergence and development of how the public collectively coped with this issue showed all attributes that social representation theory postulates. First, it was an issue that immediately gained high significance in the media, thus setting AIDS on the agenda of the wider public discourse. Second, in the course of this developing discourse a multitude of images, metaphors, and stories emerged that anchored thinking about the novel illness in existing systems of everyday knowledge. Third, once objectified, the images and metaphors condensed into an amalgam of practical and symbolic public knowledge that, to a certain degree, contains the symbolic frames as well as the practical means of avoiding the infection, for example by the use of condoms. This representation, hence, is the prerequisite of people's participation in public, media, and personal discourse (Joffe 1995; Marková/Wilkie 1987; Marková 2003; Wagner/Kronberger/Seifert 2002).

Besides providing an example of the symbolic realm representing AIDS and HIV, this chapter also contributes to a more theoretical understanding of how the social sphere and the individual experience interact in community discourse about other issues such as public health and the implementation of health programmes (Joffe 2002, 2003). The social and psychological processes in all these realms do not differ significantly from each other since they all require forms of public and symbolic coping as well as individual responses to novel developments. Normal societal innovations as well as personal hazards are a threat to the security that one feels while following an established way of life as recognized in several UN documents (cf. Brauch 2008a).

66.2 Method

Our starting point is the fact that certain personality characteristics and features of the individuation process universally differentiate between the sexes, and that these, in their representation of themselves, articulate multiple representations that become current as a function of the situation. At some point, one of those variants is established circumstantially as constitutive of the subject in the 'centre' of her/his consciousness (Flores 2001).

Our first approach to this town was through informational talks and workshops focused on HIV/AIDS and *sexually transmitted infections* (STIs). These activities allowed us to detect certain needs that called for an urgent intervention due to the conditions of vulnerability to which the population is exposed. The intervention was designed using the perspective of communitarian psychology[3] in a series of stages that were carried out from April to November 2006. Ethnographic methodology included survey visits, contacting key informants, and organizing focus groups.

66.3 Results and Discussion

66.3.1 First Stage: Approaching the Community

In this stage, survey visits were conducted and the search for key informants begun. We contacted individuals who exercise some degree of leadership in the community in order to facilitate access to the main features of local dynamics, though it also allowed us to publicize our planned activities. A talk called "Women, Health and Daily Life" was organized, dealing with some of the hardships associated with gender

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3 In this approach, the community is not seen as bereft of power because it is excluded from many social benefits. Rather, it naturalizes a situation in which the dispossessed, poor, excluded and, in general, all social groups that do not enjoy statutory power or adequate socio-economic conditions are seen as weak, incapable and deprived of any possibility of transforming their lives. In this view, community members participate actively in the search for solutions and transformations by potentializing their resources.

conditions and some aspects of STIs and HIV/AIDS in the context of migration.

The event was attended by 20 women and one man who were between 30 and 45 years old and had finished junior high school (*secundaria*). Seventeen had a life partner (married or common-law) and on average 3 minor children. Most were housewives. Family income, consisting mainly of remittances, was less than three minimum wages.[4] These data showed a somewhat higher economic income than those of a preliminary study, though perceptions were quite similar. This activity allowed us to enter the community in a favourable manner that paved the way for the next stage: a focus group designed to identifying people's needs.

66.3.2 Second Stage: Focus Group

The focus group employed 10 of the women from the first stage, all from the same municipality. We decided to use this technique because it is a productive tool in social psychology, especially in efforts to use group interaction to understand the meaning and attributions that people associate with their own existence. Also, it is an exploration method that focuses on culture (Marková 2003).

The focus group lasted three hours. Participants demonstrated their interest in being involved by signing an informed consent form. The following topics were explored: 1) the impact of migration on daily life; 2) health, HIV/AIDS and vulnerability; and 3) marital relations; themes chosen on the basis of women's contributions in the first stage.

The information obtained in this second phase was transcribed literally so it could be systematized using a 'content-type' analytical technique that makes it possible to draw valid, reliable inferences with respect to context (Bardin 1982; Krippendorf 1988). Given the nature of the study, this technique turned out to be pertinent as it combines the rigour of objectivity with the richness of subjectivity by generating revelations that precede the initial meanings.

66.3.3 Third Stage: Reinforcement

Eight women participated in this stage, all of whom had attended the other two sessions and stood out because of their great interest in the community and the leadership they exercised. This final stage of the intervention focused on the goals of reinforcing and consolidating the other two phases through a specific activity based on thematic guides taken from the women's own discourse. Once again, these women deliberated over the issue for three hours, speaking freely about their personal processes and meanings, and their life experiences in the town. Then, we presented all the information that had been systematized up to that point. The group's psychological contention was observed, several dynamics[5] were conducted, and the need to set up support networks among them was reinforced.

It must be noted that in this activity special attention was paid to reinforcement[6] as a strategy for developing and transforming communities through the members' own active participation. This potentializes their capacities and abilities so that they can achieve positive change that will improve their quality of life. Community-based support networks propitiate reinforcement in certain ways, as they constitute alternatives for political action and, at the same time, demonstrate their capacity to transform, to provide social support, and to exercise solidarity and power, as well as their reinforcing character. Finally, they are a source of leaders for the community (Montero 2003).

The results of this intervention revealed various aspects of women's life experience and that constitutes the specific meanings developed in the face of the particular adversity they confront.

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4 The daily minimum wage in the state of Morelos, which came into effect 1 January 2007, is $47.60 pesos (about 2.8 €), established by the *Comisión Nacional de los Salarios Mínimos* [National Minimum Wage Commission] in a resolution published in: *Diario Oficial de la Federación*, 29 December 2006.

5 In the first dynamic, participants were asked to complete a series of incomplete phrases alluding to their feelings and what they needed to fulfill their different roles (as women, partners, housewives, mothers, friends). The second was an exercise on imaginaries, the main objective of which was to have them reflect on how they cared for themselves (enjoyment, appropriation of their bodies, self-esteem). The third dynamic consisted in symbolizing a support network among participants as a means of creating an atmosphere of trust and mutual support.

6 This is the Spanish term for "empowerment", a neologism that appeared in the USA as a homologous word. However, as Montero (2003: 61–63) notes, the Spanish words for "strengthening" (*fortalecimiento*) and "potentialization" (*potenciación*) have been used in Latin America since the late 1970's.

One of the first elements that caught our attention in the town were references to HIV/AIDS, mainly due to an increase in contagion in the November-January period, the time of year when male migrants to the USA return home to take part in Christmas festivities. During the first stages, it became clear that the system of social beliefs and representations regarding the origins of HIV were strongly based on the stigmas that attribute the causes of this pandemic to groups such as homosexuals, sex-trade workers, and people who have casual, unprotected sex.

Women also judged that adolescent boys and girls were especially vulnerable and, therefore, required information to avoid transmitting the virus. This shows how women shift their concern towards their adolescent children who could become infected; but this is a representational shift that impedes them to some degree from recognizing their own susceptibility to infection or from seeing themselves as potential victims of AIDS. This situation has been established as part of a social imaginary that holds that "the disease is present but doesn't affect us", a discourse similar to those found by other groups of researchers (Flores/ Leyva 2004).

Another observation was that though some women were aware of the importance of condoms as a form of protection and prevention, this did not necessarily translate into their use during sexual relations. This was attributed mainly to factors that might affect or impugn their spouses, as they specifically mentioned elements such as faithfulness and trust; however, in these negotiations, gender status puts women at a disadvantage.

In the focus group, we found that the impact of migration on women's everyday life was strongly marked by emotional states that reflected how gender conditioning operates through their daily activities.

The first significant element to emerge was that women often expressed a fear of dying, though they related this fear to how their absence would affect others, seeing it as a 'failure' on their part. This attitude indicates their feelings of total responsibility and devotion to the family that places them in a permanent state of anxiety, as the following extract shows: "... what really worries me is that I might leave this world and my children would be left alone with relatives..."

Here, the perspective of the social construction of feminine subjectivity suggests it would be extremely difficult to find a suitable substitute for a mother's care, much less someone who could take her place, a situation that has constituted a contradiction throughout history:

> "...I also worry about my children because I have a boy who's 16, one who's 10 and a baby of 11 months; so yes I worry that something might happen to me, like getting sick, because I'm their right arm, what worries me is getting sick ... or dying ..."

In the third stage, this anguished thinking about death led to discussions about the emotional links women have established with their children and how those links lead them to stop thinking about themselves and to live their lives through those children. Together with them, costs and benefits of this kind of relationship were analysed:

> ...and what if I die? What if I'm not around? That's the question day after day, every night... oh God, dear God, I don't want to die because my children need me. ... I think that's what worries us as mothers because whether you have a husband or not, death is the biggest worry, if we were to leave our children on their own. ...

The women in this group also said that they experienced feelings of loneliness and of not being understood, that they were left alone and unprotected by their partners and by their close family members. One participant said that her father told her: "... you chose your life, now you deal with it. ..." Another said:

> ...men don't worry about anything, they never say 'hey son, how'd things go at school today' or 'how're you doing', they do their part just by working; ... they get home and say 'come on, rub my feet and get me something to eat'... It's us, the women and mothers who worry, the father's job is just to work, bring home the money and, well, that's it...

The loneliness and lack of comprehension that mark these women's lives lead to poor self-esteem and to the idea that their feelings are of little importance in the conditions of poverty and migration in which they live. In the face of adversity, their feelings are relegated to 'second-place' and this contributes to the development of gender-related maladies that have repercussions for their mental health. Vulnerability that women in this group expressed with respect to HIV is intimately associated with their gender status, especially in view of their partners' activities and their own fear of contracting the virus due to men's behaviour, whether as migrants or living in the town:

> ... for example, in my case [my partner] lives with another woman in the United States. I'm careful not to have any other partner here, but it would be impossible anyway because [you know] he might come back tomorrow or maybe next year, and I'm his wife. I don't know

> how many other relationships or partners he may have had, but if he'd use condoms...

As this extract shows, it is considered natural and is widely tolerated for men to have relations with other partners. Thus any negotiations on the use of condoms that involved these women – who see themselves as distinct due to their identity as wives – centre on the danger of contracting the HIV virus and not on the condom as a naturalized practice in the exercise of their sexuality. It is assumed that *he* can be with other women but that *she* cannot be with other men, and it stamps the husband-wife relationship with an assumed inequality that clearly contributes to feelings of malaise.

Some of the participants in this group agreed that because of the sexual behaviour and absences – short or prolonged – of their men, it is the women who are in greater danger of exposure to HIV, as the following testimony from an interviewee reflects:

> ...we run a greater risk, because if a husband goes to bars, drinks and has relations with *individuals* who don't always get checked or who pay the doctors not to check them ... it's really dangerous, I knew of a case of one *individual* who worked there and never had any supervision or didn't go where she was supposed to; she just kept hanging around the bars... then he comes home to me and he's not going to use a condom, I mean if he doesn't use one with that *individual*, there's no way he's going to use one with me, so that's why we need to be more careful than other people. ...

As mentioned above, in this community the stigma against sex-workers is deeply-rooted and it is an element that differentiates among social groups. Also, it is a central aspect of the social representation that people have of AIDS as a disease. Paradoxically, this centrality actually promotes preventative actions in the non-stigmatized population, as in the case of these women, though what they really need is more information, more means of prevention, and a change of attitude on the part of both men and women in relation to AIDS.

Another finding was that although these women spend long periods alone and assume complete responsibility for their households, which they resolve through a diverse repertoire of survival strategies that includes selling food and consumer products, this is not sufficient to counteract a certain imaginary subjection or to give them a greater sense of self-worth. One woman, for example, said:

> ...the place of my children's father is respected, though he's not around, we know he'll be back... but meanwhile I have to work and make sure my children can get ahead.

During our observation period another feeling of contradiction in the exercise of this dual role as mother *and* father became clear. On the one hand, this was due to satisfaction women feel when they are recognized by their families and society for their strength, and on the other, due to the emotional malaise they are never quite able to explain but is reflected in the physical weariness caused by daily tensions. This often leads them to turn to self-medication as a way of reducing their suffering and keeping up with their daily activities. Also, it helps them to avoid feeling that they may be losing control, a sentiment they expressed constantly.

On another topic, participants also referred to problems of violence and expressed feelings of vulnerability and loneliness in a world full of hostility towards them because of their condition as women. They said they had been victims of sexual harassment by men in their hometowns, as this extract shows:

> ... often when I have to go out alone on some errand, men's looks and comments really bother me [but] because I'm a woman I never say anything ... but they just have the right to annoy [us]. ...

In addition, they mentioned feelings of insecurity and a lack of protection, especially when they spoke of the situation of their daughters in the town, another important source of latent fears that women and daughters discuss and share with each other because of their common condition as women.

This aspect is central to the analysis of the construction of subjectivities characterized by situations that are reflected among mothers and daughters because of their gender status. They may be a constitutive element of a certain social and psychological defencelessness that will be very difficult to change in their lifetime. As Chodorow writes (2003), while subjectivities are being constructed they are anchored in lived processes of gender.

As mentioned above, self-medicating is a common practice among women in taking care of their own physical and mental health. Almost all of them, at some point in their lives, have taken non-prescribed anti-depressants or anxiety-reducing drugs; a finding that supports data from the National Psychiatric Epidemiology Survey (*Encuesta Nacional de Epidemiología Psiquiátrica*).[7] When we asked them about the reasons for self-medication in our study, women said that while they knew it was not advisable to take such

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7 See: Medina-Mora/Borges/Lara/Benjet/Blanco/Fleiz/Villatoro/Rojas/Zambrano/Casanova/Aguilar (2003).

drugs, it was one of the few alternatives they have to make themselves feel better and keep up with their heavy daily workload. They also reflected unease with respect to the future, as one said: "...there's no good medical service here, so you just have to take whatever you can. ..."

Once again, here it remains clear that women do not consider their own health as a matter of high priority. In fact, their prime concern is their responsibility to care for others; hence, they tend to trivialize their feelings of malaise and symptoms or illnesses that may manifest themselves.

For most women in the group the meaning of their bodies has basically been annulled: i.e., the body does not exist to feel pleasure or to be cared for. A defence mechanism operates here that leads them to somaticize their tensions and therefore turn their bodies into recipients for their emotional states.

The symptomatology of depression in the group was also connected to their role as caregivers and the person responsible for their households. This immerses them in a condition of personal and social vulnerability arising mostly from their obligation to confront life's travails practically bereft of support, a burden that tends to leave them physically and emotionally spent, as one interviewee described: "... I often get depressed, I feel a sadness invading me, the only thing that keeps me going is ... my children."

This situation of abandonment, perceived loneliness, the absence of their partners, and the minimal personal compensating resources they have at hand, all combine to keep these women in a tension-filled state that often leads them to commit acts of violence against their children. Of course, such incidents almost immediately engulf women in feelings of guilt, a recurrent situation that turns into a form of family coexistence that is recursive and accepted as a result of abandonment. In this situation, their sexuality is obviously forgotten and enjoyment or pleasure does not exist in their immediate subjective register, a fact that also contributes to the gender-related maladies they suffer, which with time can become illnesses.

In addition, we observed that though these women share the common experience of being migrants' wives, they have been unable to build support networks, a fact they explain by referring to the difficulty of trusting people, their isolation, and their almost non-existent mutual recognition. Here, the intervention group emphasized the importance of several elements: 1) consolidating support networks; 2) recognizing and accepting themselves *and* their peers as women, in spite of their individual differences; and, 3), the importance for their subjectivity of having their actions and desires validated as strategies of change oriented to a process of reconstruction that would valorize them as people and offer new representations that support their capacity to exercise power and thus raise their self-esteem.

In the final stage of the intervention –'reinforcement'– we sought to conduct a process in which the women would deconstruct-reconstruct the gender-based systems of representation that have psychosocial referents in the subjective constitution of the group. Our hope was that this analysis of their practices would allow us to extract highly significant non-verbalized symbolic elements related to the signification of a representation (Flores 2001).

In that phase of our work, we conducted an analysis of their discourse and narratives using certain group dynamics and techniques designed to isolate significant elements that reflected some of the tensions identified in the previous stages. This analysis centred on the relation between the meanings women attribute to their surroundings and their personal experiences. It revealed emotional ambivalences related to their double role as female heads of households and as women. What stood out was their need to feel loved, protected, and cared for by a masculine figure, a finding that agrees with González (1993: 78), who reported that "throughout their lifetime women do not obtain the amorous nourishment that they provide [to others]." As one participant said: "...when he calls me from the US, he never asks me how I'm doing ... instead he's surprised to hear I'm working and says I'll probably get fired before long."

When asked about their life projects, these women reached the conclusion that no such thing existed or, if it did, that it was centred exclusively on the family, a situation causing feelings of frustration. They feel insecure about undertaking any other project outside the family context, and this attitude limits their search for new possibilities and contributes to their low self-esteem. It proved very difficult for them to identify with the ability to carry out a life project of their own; one that would benefit them and proffer them some degree of comfort. The following comments illustrate this: "... I always wanted to study, but didn't have the chance, I've always had to work ...", and "... I'd really like to be someone, to study, but I don't know how."

Upon becoming conscious of their role as caregivers, they began to critically question the survival strategies they had constructed, which also centred on others. Eventually, they came to realize that this process *is* reversible and constrains their personal growth

Table 66.1: Summary of the results by objective factors and subjective expression.

Objective factors	Subjective expression	Discourse
Migration	Fear due to the spouse's absence and the lack of his social support	"When he went ... I was left completely alone."
HIV, AIDS	Fear of dying and leaving the children	"What disturbs me most is that my kids remain alone."
	Loneliness and depression	"When I can't continue anymore I take a pill."
Community	Low self-esteem	"I am nobody."
	Continuing dependency on spouse	"Even though he is not here, his space is being respected."
	Helplessness, lack of recognition and power	"Nobody understands me. I am alone with my kids."

to a considerable degree. Malaise, pain, and sadness were expressed time and time again as the feelings they associate with the context of migration and, clearly, with their poverty, low self-esteem, feelings of guilt, self-censorship and feelings of dependence.

Recognizing and revalidating these feelings, necessities, and thoughts supported the process of becoming more sensible that led to an analysis of the dynamics of visual imagery related to their death. The pain they manifested in this context – one that all of us must face sooner or later – oriented them more towards the 'here and now' when they spoke of the things they needed for their physical and emotional well-being: taking control of their bodies, recovering lost pleasures and their sexuality, generating a life project that will strengthen and give them a new dimension as women.

Table 66.1 summarizes the overall results in a grid contrasting the objective situational factors, the subjective expression of the stressors and examples of the women's discourse as illustration.

66.4 Conclusion

The results obtained in this research allowed us to see subjective processes, social representations, and the sense and meaning that these women give to their existence in a context of migration and conditions of poverty and vulnerability. The women's statements and contributions to the focus group and intervention reveal a deep emotional undercurrent in subjectivity and sense making that colour all discursive production. We think that most realms of life, including general health-related behaviour as well as behaviour implied by the lack of critical resources show a similar structure. Also in these areas of everyday life and coping with the novel, affective underpinnings have a crucial effect upon cognition, action, and language use.

Besides, the present study on women and HIV reveals how public knowledge is displayed in the conversations of people affected and their family members. It illustrates the finding that the stable core of social representations comprises primarily affective and emotional elements (Wagner/Valencia/Elejabarrieta 1996). In this study, we find concern for the well-being of one's beloved children, fear of the unknown future of living with HIV, distress about the husbands' absence for work in a foreign country and their extramarital relationships there, and the desire for community support. All these are 'hot' ideas linking the general societal discourse about AIDS to one's private subjectivity. The subjective weight of women's own experience of HIV in the light of their dialogues is also reflected by the fact that they do not hesitate to openly talk about deeply sexual issues in their private lives, while sexuality usually falls prey to rules of decency and prudishness in most other conversations.

On a more general level, the research highlights that "to be secure is to feel free from threats, anxiety or danger. Security is (...) a state of the mind in which an individual (...) feels safe from harm by others" as stated in the Report of the UN Secretary-General's High Level Panel on Threats Challenges and Change, 2 December 2004. Such a subjective state of security, however, does not only depend on identifiable others, but also on structural characteristics of a social system. These characteristics have to do with the social status of their gender and the associated lack of power which are central constituents of the women's subjectivity. Consequently, the risks entailed by migration and HIV become overwhelming for a single person.

The study also illustrates that the pillars of human security, particularly the 'freedom of want' and the

'freedom of hazard impact' as defined in United Nations documents (Brauch 2008a), are crucially interconnected. The ability to cope with the impact of potentially lethal health hazards depends on a nation's public health infrastructure as well as on the economic and, even more so, on the social resources available to the individual. The stories of the women recounted in the focus groups vividly illustrate the plight of HIV positives to realign their life in the community under their changed condition. Even though purely existential fears in the face of a serious disease can never be completely alleviated, a general feeling of security can very well be achieved through community resources backed by a nation's social and gender policy.