THE DUAL FEMINISATION OF HIV/AIDS

HIV/AIDS has increasingly been identified as a feminised epidemic by the governments, international organisations, donors, and non-governmental organisations that have come to constitute the global response to the problem. The socio-economic status of women in countries with high HIV/AIDS prevalence has heightened their vulnerability to HIV infection and limited their ability to negotiate safe sex practices. Combined with physiological factors that make the female body more susceptible to HIV infection, notions of female vulnerability and burden have precipitated multiple gender initiatives that seek to involve women within the response to the disease through direct funding of community projects, inclusion of women-based national non-governmental organisations (NGOs), and the articulation of numerous gender-based plans. In addition to these initiatives, women occupy positions at every level of HIV/AIDS governance, from the Director of the World Bank's Global HIV/AIDS Programme, the head of local HIV/AIDS authorities, to the front line of community aid workers. Yet the widespread recognition of these factors, and multiple policies developed to address them have not elicited a better situation for women's susceptibility to HIV infection, or their burden of care for friends and family living with the disease. It is this problem that the paper seeks to address by asking: why has the dual feminisation of the HIV/AIDS epidemic and its governance not led to more effective outcomes for women infected and affected by the disease?

The paper explores this question in the following manner. First, it defines what is meant by the feminisation of HIV/AIDS in regards to the epidemic and its governance. Second, the paper offers some explanations as to why recognition of gender issues within the HIV/AIDS response and the dual feminisation of the disease have not led to more effective outcomes. These explanations centre upon the mis-application of gender mainstreaming, the assumptions of gender roles within the response, the politics of presence, and the institutional sidelining of gender expertise. Third, the paper links these findings to wider problems of HIV/AIDS governance and what it means for women and gender. The findings of the paper are drawn from wider research on the governance of HIV/AIDS in Kenya, Tanzania and Uganda. Interviews were conducted with national and local government

officials and NGOs and community groups in these countries, as well as in-country and headquarters officials of the World Bank, UNAIDS, UNIFEM, WFP, UNICEF, WHO and the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria. The majority of research was conducted in 2005-2006 and 2009.

Defining the feminisation of HIV/AIDS

The feminisation of HIV/AIDS commonly refers to the number of women infected and affected by the epidemic as disproportional to that of men. That is the feminisation of HIV/AIDS can be understood in biomedical and social contexts. However, there is an additional element to this, the role of women as central actors within those structures of local and global organisations that are at the forefront of decision-making as to how the epidemic can best be addressed. Together these areas of political contestation explain how the epidemic has become 'feminised.' Each of which will be explained in more detail here.

Of the 40 million people projected to be infected with HIV in 2007, 48% were women over the age of 15. In sub-Saharan Africa, where in 2007 25 million people were living with HIV, 59% are women, and three out of four young people aged 15-24 living with HIV are female UNAIDS/WHO, 2008). The most common explanation for the disparity in infection rates between the sexes is the biological vulnerability of women in regard to exposure area and timing; the physiology of male and female sexual intercourse; and the increased inflammation of mucosal surfaces through cross-infection with other sexually transmitted infections (STIs) and possible trauma. The biological make-up of the female body only goes some way to explain the feminisation of the epidemic, the central meaning of the term derives from social and cultural explanations as to why women are more vulnerable to HIV infection and share the burden of care for those infected and affected by HIV/AIDS.

It is the structural socio-economic inequalities that underpin high prevalence rates and the burden of care apportioned to women that makes the feminisation of HIV/AIDS more about gender and less about female biology. HIV/AIDS has been identified as an exceptional disease because of its intrinsic link to poverty (Barnett and Whiteside, 2002). In practice because of their socio-economic position in the world, this makes women vulnerable to HIV infection in countries with high prevalence rates, particularly sub-Saharan

Africa. The nuances of the relationship between HIV/AIDS, poverty and gender, can be explained by the following factors. First, in many countries in sub-Saharan Africa women are economically dependent on men. Compounding the biological aspect of female vulnerability is the removal of female control of prevention. Women in developing countries, according to Ulin, have limited access to economic resources and thus do not believe they have equal status in decision-making concerning sex and sexuality. A lack of control of their sexual relationships and behaviour in this regard leaves women vulnerable to HIV infection (Ulin, 1992, 64). The ABC of prevention – *A*bstain, *B*e faithful, use a *C*ondom – is easier for some women to practice than others. In studies from India (Gangakhedar et al, 1997; Pallikadavath et al, 2004) to sub-Saharan Africa (Doyal, 1994; Gupta, 2002; Hamblin and Reid, 1991; Rankin et al, 2005) evidence has shown that a high percentage of women were infected with HIV by their husbands. Abstinence is problematic within a marriage for fear of being stigmatised as having something to protect against, or accusatory and thus inferring a lack of trust within the relationship. Women have minimal property rights and often lose their property when their husbands die. Women thus depend on men for property ownership. The lack of property rights and education among women reduces their ability to leave abusive relationships or partners that engage in polygamous activity, or negotiate safe sex (Lawson, 1999, 393). Second, girls are less likely than boys to attend school in poor families, and when a relative becomes sick or a parent dies it is girls that are more likely to leave school to care for the family (Barnett and Whiteside, 2002). Without an education girls face greater dependency on males for money for both themselves and their families, are uneducated about the risk of HIV and methods of prevention, and lack the resources to leave abusive relationships. The socio-economic position of women and girls makes it harder for them to negotiate safe sex with a partner, or abstain from sexual intercourse for fear of being accusatory or stigmatised, and the partner subsequently leaving them. Third, gender-based violence such as rape inside and outside of marriage increases female susceptibility to HIV infection, especially in instances where the husband has multiple partners. The predominance of stereotypes that blame women for the spread of HIV/AIDS extends the problem by accentuating the stigma attached to women speaking out about infection and their ability to negotiate safe sex (deBruyn, 1992, 249).

Beyond higher rates of infection, women deal with a quadruple burden of responsibility in their roles as Mothers to their immediate children, Grandmothers/carers for their deceased sibling/child's children, full-time employees, and home based-carers within the wider community in which they live. Since the origin of 'slim' – the name given to the epidemic in parts of East Africa because of the physical conditions of the infected, before communities came to know it as AIDS – women have organised to provide care and support for the sick, orphans and vulnerable children of their dead friends and family. With increased access to information, these women have educated and organised the communities in which they live about methods of infection and ways people can protect themselves. This organisation has translated into women occupying positions of power as opposed to positions of vulnerability that the feminisation of HIV/AIDS suggests. It is this position of power that suggests a dual aspect to the feminisation of the disease.

The position and role of women in relation to the HIV/AIDS epidemic has been recognised by international organisations, donors, governments and NGOs in the design and implementation of HIV/AIDS response strategies at the community, national, regional and international government levels. As the principle co-ordinator of the global AIDS response, the Joint United Nations Programme on HIV/AIDS (UNAIDS) has articulated multiple objectives and priorities in partnership with its co-sponsors to address gender and human rights, education, young people, male participation, conflict, microbicides, food security, and prevention of Mother to Child Transmission (UNAIDS, 2005). UNAIDS identifies its current gender priorities as: (i) top leadership must speak out against discrimination, stigma, and inequality; (ii) 'laws and policies that protect women and girls against sexual violence, disinheritance, and gender discrimination of all kinds'; (iii) 'women must be adequately represented in policy and decision-making on HIV/AIDS; (iv) laws that address gender inequalities must be enforced; (v) changes in laws and policies must be accompanied by adequately funded 'know your rights' campaigns (UNAIDS, 2008a). UNAIDS pursues these objectives in partnership with governments and through the work of its co-sponsors. UNAIDS and its co-sponsors use a combination of conditionalities attached to multilateral and bilateral aid that governments receiving the money have to adhere to and implement; global campaigns, often conducted in partnership with a range of civil society organisations (CSOs); United Nations (UN) missions; partnerships with governments in countries with

high HIV prevalence rates; and international commitments such as the UN General Assembly Special Session (UNGASS) on HIV/AIDS declaration of Commitment 2001 and 2006.[i] In stressing the need for co-ordination and co-operation, UNAIDS is able to transmit its approach to the feminization of HIV/AIDS to the widest aspect of society through multiple agencies and actors.

The response to the feminization of the HIV/AIDS epidemic has engendered widespread participation of women, specifically within the non-governmental sector. This has specifically been the case in regards to the funding of community groups led by women by multilateral organisations such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), and bilateral agencies such as the Department for International Development (DFID) in the UK (DFID, 2008, 62-66; Global Fund, 2008a). The stress upon community-led responses to HIV/AIDS has arisen in the last ten years under the rubric of 'multi-sectoral' approaches to addressing the disease. Multi-sectoralism refers to the involvement of multiple actors that go beyond the state and health-led initiatives to combat HIV/AIDS to recognise the epidemic as driven by socio-economic and rights-based factors that need to be addressed as well as the health aspects of the disease. Women's groups organised around providing care and education to communities affected by HIV/AIDS in sub-Saharan Africa existed prior to the unprecedented amount of financial commitment directed to them, however in providing them with money, they have become more formalised into loosely structured organisations that manage the minutia of international budgets and implement international directives. Prioritising community initiatives has indirectly positioned women as the main focus of global HIV/AIDS governance. The success of international objectives and programmes rests on the ability of women in areas of high HIV prevalence to conduct and be effective in the implementation of projects and delivery of services.

Recognition of the role of women has broadened the scope and space in which women operate. This is particularly the case in regard to their role within national and local authorities, nominally the National and District HIV/AIDS Councils that were established across sub-Saharan Africa as part of a wider process of governance reform through HIV/AIDS funding from 2000 onwards (Harman, 2009). In Kenya, Tanzania and Uganda, women occupied senior positions of authority within the National HIV/AIDS Councils.

These positions were principally in the areas of community organisation and district support. Women such as Rustica Tembele, the Director of Community Response in the Tanzania Commission for HIV/AIDS (TACAIDS) and Ursula Bahati, Deputy Director of Co-ordination and Support for the National AIDS Control Council (NACC) Kenya are responsible for decisions affecting community support and co-ordination of activities at the District level. They play a pivotal role as the interlocutors between donor objectives, national priorities and district and community activity, and manage a significant aspect of the national strategic plans for Kenya and Tanzania. Presence of women within senior positions within the Uganda AIDS Commission (UAC) is less obvious; with men fulfilling the majority of senior posts and positions of responsibility and decision-making. The head of the NACC in Kenya is a woman – Miriam Were – whereas in Tanzania and Uganda both Chairs of the commissions are men. The roles of women as District and Community co-ordinators within the NACs reflects their positioning within governance structures of the HIV/AIDS response as community organisers and facilitators. At the time of conducting research, roles in finance, procurement, strategic planning, and donor co-ordination were filled by men.

Of the District HIV/AIDS Councils considered within the research project, there was an even split between male and female focal points. The difference between their roles, however, was that female focal points maintained the quadruple burden seen by those women organising at the community level. This quadruple burden refers to women who worked full-time within the District HIV/AIDS Councils, had principle responsibility for childcare in the family, were responsible for the welfare of deceased siblings' children, and acted as carers for the sick within the wider community in which they lived. For example, one woman, Mina Nakawuka, the head of Kampala's District AIDS Committee (2005), was working full time at the Kampala District AIDS Committee having just given birth, looked after her family, and was in the process of completing her MA degree in public health (*Int.* Nakawuka, 28th October 2005). Community groups led by women are encouraged to work with local authorities in formulating the District and Community HIV/AIDS strategic plans, as well as to co-ordinate the activities of other community groups and CSO activity in the area. Participation of this kind leads to a transition of women's participation from implementation to direct influence upon local decision-making and agenda-setting.

The presence of women within HIV/AIDS governance is not only evident at the national and community levels of decision-making and implementation. Women feature highly within international structures of HIV/AIDS governance. Women are present on the boards and committees of international co-ordinating agencies such as UNAIDS and the Global Fund. The most senior woman within the global HIV/AIDS response is Debrework Zewdie, the Director of the World Bank's Global HIV/AIDS Program. Zewdie's role within the global AIDS response should not be underestimated; as head of the Bank's operations, she designed the Multi-Country AIDS Program (MAP) that has since been adopted in twenty-nine countries in sub-Saharan Africa and forms the template for the current form of HIV/AIDS funding, co-ordination and structures of governance (Harman, 2007; World Bank, 2008). Further to Zewdie's role within the Bank, she is Director of Operations at the Global Fund and was one of the last three nominations for the position of Executive Director of UNAIDS in 2008. According to multiple sources, it was Zewdie who single-handedly put HIV/AIDS at the centre of the Bank's activity (*Int.* deRegt, 20th April 2006), this activity has since set the framework for HIV/AIDS governance.

The prominence of female activity at the community level and subsequent inclusion in District decision-making is reflected in the formation of women-based NGOs at the national level. Organisations such as Kenya Network of Women with AIDS (KENWA), Women Fighting AIDS in Kenya (WOFAK) and WAMATA (Walio katika Mapambano ya AIDS, Tanzania – Those in the struggle against AIDS in Tanzania) are well recognised by their governments, bilateral and multilateral donors as leaders in the field of care, treatment, and support of both men and women affected or infected by HIV/AIDS. This recognition results in donors targeting them for funding, participation in planning initiatives, national, and global conferences and meetings, any organised dialogue or consultation between the government, donors and civil society, and positions on the board within every form of AIDS Council – community, district, regional and national. The most obvious explanation for the inclusion of women-based NGOs is that their inclusion presents the simplest way of governments, donors, and international organisations implementing a gender component to their work. However, the prominence of women-based organisations can also be seen as a result of their longevity, close contacts with women working and living within the furthest

reaches of a specific country, national coverage, and the ability of key women in getting their agenda heard. For example Elizabeth Ngugi of Kenya Voluntary Women's Rehabilitation Centre (K-VWORC) is a significant figure within the Kenyan AIDS response. Ngugi has used her professional expertise in public health to place the issue of commercial sex workers – a taboo in Kenya and with HIV/AIDS donors – within the wider agenda of the Kenyan National AIDS Control Council (NACC) and international organisations such as the World Bank and UNAIDS (*Int.* Lagerstedt, 16th November 2005). This kind of female trouble-shooting is evident throughout the response to HIV/AIDS in East Africa, with women acting in community groups and national NGOs pursuing multiple avenues of influence in the realisation of their organisation's goals and objectives. Thus despite the inclusion of women-based groups as an easy way for governments and international organisations to add-on a gender policy to a specific country's HIV/AIDS response, some women and organisations have used the political space this opens up to access decision-making and promote their agenda.

Does the inclusion of women in structures of HIV/AIDS governance lead to effective outcomes?

The presence of women in state and international agencies at the centre of HIV/AIDS governance suggests a general recognition of women's role in combating the epidemic, the importance of presence, and the importance of women's agency within structures and processes of global decision-making. Yet, this form of feminisation of HIV/AIDS governance has not necessarily led to effective outcomes for addressing the central issue of the feminisation of the HIV/AIDS epidemic. As of 2009, HIV prevalence around the world has declined from 40 million in 2006/7 to 33.4 million in 2008, of which 22.4 million people live in sub-Saharan Africa. Women still occupy 60% of all HIV infections in sub-Saharan Africa (UNAIDS/WHO, 2009). There has been a significant increase in prevention of mother to child transmission initiatives and coverage being up 35% from 10% in 2004 to 45% in 2008 (UNAIDS/WHO, 2009), yet research and development is yet to concentrate of women-based interventions or strategies to protect themselves from HIV services, and the introduction of difference within major health services remain unresolved. Female condoms, femidoms, were initially promoted as a mechanism in which such women could take responsibility for protection as a form of HIV prevention. Yet they have had limited success

in this regard, with some women claiming them to be 'noisy' and that they only work when a man is too drunk to notice.[ii] The social and economic factors that stimulate high HIV/AIDS prevalence rates amongst females remain despite an increased involvement of women and gender within the response to the epidemic. This can be explained by the following factors: the problem of gender mainstreaming, the politics of presence, and the sidelining of gender expertise.

The Problem of Gender Mainstreaming

In Kenya, Tanzania and Uganda the commitment of the National HIV/AIDS Councils to address the issue of gender is mixed with the only commonality being the emphasis placed on gender mainstreaming. Women and gender are included in the flagship National Strategic HIV/AIDS Plan of each of these countries to a lesser or greater degree. In Kenya and Uganda, the women and gender are mentioned within the strategic plan but other than an emphasis upon mainstreaming gender throughout the national strategy the issues are not articulated as a main priority area, or even specifically addressed within the breakdown of the plan's principle aims (UAC, 2007; NACC, 2005). The 2000-2005 Kenyan National Strategic HIV/AIDS Plan (KNASP) introduced a Gender and HIV/AIDS Technical sub-Committee formed to mainstream gender throughout the national response. The emphasis here was upon the promotion of gender sensitive policies and protection of rights of women and men affected by HIV/AIDS (NACC, 2005). The Uganda AIDS Commission similarly commissioned a technical report by the international development consultancy Futures Group on mainstreaming gender as part of its National HIV/AIDS Strategic Plan. Current measures within Uganda to address the issue were identified as inadequate, but other than stipulating the key issues that effect how HIV and AIDS impact upon men and women differently and emphasising the need for in-country data disaggregated by sex, there was little emphasis upon how to address this issue (UAC, 2007). Tanzania and the Tanzanian HIV/AIDS Commission (TACAIDS) are similar to Uganda and Kenya in the emphasis placed on gender mainstreaming within the National HIV/AIDS Strategic Plan, but go further in articulating specific measures as to how the issue of women and gender should be addressed throughout the Plan based on a 'gender responsive approach' to the country's epidemic (TACAIDS, 2007). This gender-responsive approach articulates the following short-term measures to promote effective outcomes for women infected and affected by

HIV/AIDS: user and gender friendly HIV/AIDS services; review laws pertaining to marriage and gender-based violence; introduce gender indicators and outcomes to data sets; reduce risk of infection arising from inequality and sexual abuse; promote awareness about gender inequalities; and help implement strategic plan on protection of women and children, including commercial sex workers, intravenous drug users, men who have sex with men, and single mothers - in partnership with the Ministry of Community Development, Gender and Children (TACAIDS, 2007).

The Tanzanian approach presents clear short and long term goals in tackling issues that impact upon women infected and affected by HIV/AIDS. This differs significantly from the Kenya and Uganda that re-assert mainstreaming without a concrete commitment to targets and outcomes. The problem with these approaches is the projection of the concept of gender mainstreaming to align with wider commitments within the international community without articulating what such mainstreaming means in the context of a country's specific epidemic and how it can be done. This points to a wider problem within the governance of the epidemic: that most initiatives are articulated and developed by international organisations such as the World Bank, UNAIDS and the Global Fund, and then implemented or transposed to the national governmental level. Since the introduction of the National HIV/AIDS Councils under funding from the World Bank's Multi-Country HIV/AIDS Project (MAP), governments have had to align with the policies and directives of international initiatives and funding earmarked to address the problem of HIV/AIDS as a means of receiving much-needed funds to combat the epidemic. As such, national and local governmental agencies have come to 'own' those agendas for HIV/AIDS articulated by the World Bank, UNAIDS, and increasingly the Global Fund. The issue of gender presents an interesting case in this regard. As Hafner-Burton and Pollack argue, gender mainstreaming as the 'systematic incorporation of gender issues throughout all governmental institutions and policies' has become generally accepted within international organisations and development policies (Hafner-Burton and Pollack, 2002, 342). Hafner-Burton and Pollack consider two variables to openness and input structures in implementing gender mainstreaming initiatives: the existence of multiple points of access in policy-making and the 'presence of allies among the elites of that organization'; and the output structure by internal change and external compliance (Hafner-Burton and Pollack, 2002, 343). These types of input and output

structures do not exist within state-level responses to HIV/AIDS. Instead what we see is the application of this general acceptance to the state level without the existing will of government structures to fully address the issues of women and gender. These factors point to a central problem within the wider governance of HIV/AIDS, the lack of political will on the part of the state to address some of the structural constraints to combating the epidemic, and the poverty that drives it, and the problem of international institutions such as the World Bank and supporting UN system implementing governance structures and directives within the state as a means of eliciting political will.

This issue is compounded in the context of gender by the tendency to homogenise women and seeing women and gender as an 'issue' to be added or mainstreamed within the HIV/AIDS response. Shepherd's work on United Nations Security Council Resolution 1325 can be applied here when considering the tendency to homogenise women and the systematic deferral to the notion that the inclusion of women is assumed to equate to a focus on gender (Shepherd, 2008, 162-163). In a similar way to what we have seen with HIV/AIDS, the incorporation of gender as an additional add-on to programmes where women were once add-ons re-enforces the notion that organisations such as the UN are not already gendered. International organisations take on a global authority that is gender sensitive, free of structural sexism that can promote a form of gender mainstreaming throughout HIV/AIDS responses at the national and community level, with little regard to the structural inequalities that heighten the vulnerability of women from the grandmothers caring for orphans and vulnerable children in rural Kenya to the women manoeuvring within the political climates of international organisations. As Reanda suggests, women's concerns are compartmentalized within the systemic structure of the UN with rhetoric of gender development failing to be converted into policy. Issues of women and gender are ghettoized into frameworks on human rights and international development and often excluded from the 'hardcore' elements of international politics, i.e. war and security (Reanda, 1999, 51-58). The response to HIV/AIDS differs to this understanding in the respect that it has been related in some respect to issues of 'hardcore' international politics through its inclusion as a security concern in the UN General Assembly Special Session on HIV/AIDS in 2001; however the issue of gender has not. The feminisation of HIV/AIDS is understood within the remit of HIV/AIDS as a development issue where gender is permitted to exist,

abstracted from the wider machinations of UN activity and international politics as a whole, and considered in isolation of the feminization of HIV/AIDS governance.

The Politics of Presence

The second issue of why greater inclusion of women within the HIV/AIDS response has not elicited better outcomes for women infected and affected by the epidemic pertains to the problem of the politics of presence and how women are included. When conducting research, the majority of CSOs interviewed replied to questions of how they are tackling gender by saying they promoted a 50/50 gender split on their boards, and staff. This rhetoric did not necessarily correlate to practice, and when it did, participant observation of several community group meetings would suggest that the women play a passive role within these organisations. Men dominate proceedings, and their thoughts and opinions were often prioritised over that of their female counterparts. Women within the community continue to be pigeon-holed into positions of implementation, care, and primary education, and are only able to gain leverage in decision-making by re-asserting their caring function and close links with the community. Despite negotiating political space through engagement with 'global' processes of decision-making, they remain positioned within a 'local' level of governance that promotes their role as primary carers. The unpaid role of women as carers underpins the core priorities of the global HIV/AIDS response as they are at the forefront of prevention, treatment and care. It is in the interests of those actors at multiple levels of governance to maintain this care role of women to perform these key functions within the response. The corollary of this is that in the case of community support groups instigated and run by women, women are very much the focal point of decision-making, leverage towards national and international agenda setting, and the implementation of projects. Within many organisations it is women that are the trouble-shooters for getting things done. Yet this often exists in relation to their wider role in care and *community* based decision-making and inclusion. For example, in Kenya, the inclusion of KENWA and WOFAK in national decision-making forums is because they represent women, specifically women within local communities, and thus provide token forms of inclusion and voice within these meetings. However, this inclusion often takes the form of consensual, process-based dialogue or feedback, to little outcome of gender-based policy. This reflects a wider trend of community

or NGO-based inclusion in decision-making, that there is a high emphasis upon presence yet to little outcome.

The problem of community presence with little outcome limits women's position further in the fact that their position of power is located firmly within the community and care roles with little influence in government or international organisations, re-enforcing development orthodoxy that locates women and development within the 'local' sphere of activity based on implementation of projects and caring support-only roles whilst binding them into structures and processes of global decision-making. Similar to other studies into development processes and gender directives by international organisations such as the World Bank, 'women' are characterised as marginalized, vulnerable and in need of assistance, wherein their subordination is a result of their exclusion from the market and modern economic thinking (Bergeron, 2003, 408   410). This focus on vulnerability obscures any wider understanding of the presence of women within HIV/AIDS governance and activity. As argued in Bedford's research into World Bank gender initiatives in Ecuador, where women are afforded any power within the HIV/AIDS response it is a form of limited autonomy 'with frequent references to neo-classical household models' as well as debate over the shifting focus towards men arising from the constraints of complementarity between the sexes in addressing issues of gender (Bedford, 2008, 101; Bedford, 2007). The Bank recognises women in relation to the caring role for people affected and infected by HIV/AIDS and their position in the family as a determinant factor of infection susceptibility. Yet this recognition does not translate into policy, with women being rolled into the social aspect of HIV/AIDS as an 'issue' as opposed to addressing the feminization of the epidemic as a structural issue that transcends distinction between the global/national/local dichotomies of decision-making and provision. Where gender is considered in the context of HIV/AIDS, the complementarity constraint discussed by Bedford often comes into play, with the focus switching to men and ways to address their polygamous, violent and sexist behaviour as a means of female emancipation from their relationships and familial constraints. In identifying women infected and affected by HIV/AIDS as victims, they are seen as passive recipients of international aid, which is far from the case.

The politics of presence and the role of women within the feminisation of HIV/AIDS governance are particularly pertinent within those international organisations that have set and sustained the global agenda for HIV/AIDS. With the exception of Debrework Zewdie, female presence is not proportional to the number of male employees and participants within international organisations such as UNAIDS or the Global Fund, or translated into central leadership roles. For example, in UNAIDS the previous and current Executive Directors have been men, with a woman only recently appointed to the position of Deputy Executive Director (UNAIDS, 2009a). With regard to the Global Fund, fifteen members of the Board are men, and only five are women. Two of these five women occupy the NGO quota-seats on the board (Global Fund, 2008b). Women tend to be located within community outreach, in-country or gender-based positions within international organisations and there is a lack of women in senior, non-gender specific roles within international organisations.

Furthermore, women in positions of power do not necessarily correlate to beneficial outcomes for women infected and affected by HIV/AIDS. This would wholly assume that all women are the same and that all women will engage in issues of gender politics. Of the women interviewed within international organisations such as UNAIDS, the World Bank, UNFEM and the World Food Programme, approaches to and thoughts on the feminisation of the epidemic differed. Some acknowledged it was an issue, stipulating that it was increasingly becoming a central focus of their operations. Others had a more systematic view of what their particular organisation was doing. The level of detail depended on whether the woman was working in-country or at headquarters and upon the personal interest of the woman involved. For example, Kristan Schoultz, the Country Director of UNAIDS, Kenya at the time of conducting research, discussed in detail the practical, structural and emerging issues facing women and HIV/AIDS that suggested a significant personal interest in the subject; whereas Purnima Kashyap, a programme officer of the World Food Programme (WFP) was more pragmatic as to the gender programmes the WFP implemented, key to which was support to prevention of mother to child transmission initiatives (*Int.* Schoultz, 5th April 2005; *Int.* Kashyap, 7th October 2005). Representatives of UNIFEM were similar to Schoultz in the level of understanding of the feminization of the HIV/AIDS epidemic, but were limited in impact because of the institutional constraints. Women were aware of

various approaches to gender but they did not necessarily prioritise the issue over others, or if they did there was nothing to suggest this was because they were active feminists – with the exception in some cases of those working within gender-specific units or programmes - or women.

Sidelining Expertise

Beyond the common problems of mainstreaming and presence, there is evidence to suggest that international organisations that promote gender equality are sidelined within the global response to HIV/AIDS. This is most apparent when considering the role of the United Nations Development Fund for Women (UNIFEM). Co-ordination of international organisations committed to the global response to HIV/AIDS is done by UNAIDS. UNAIDS is made up of ten co-sponsors – UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, World Bank and WHO – who are involved in the governance, division of labour, individual efforts, and resources for the maintenance of the global response to the epidemic. UNIFEM is represented by UNDP within the organisation, with issues of women and gender also represented by the Gender Programme Team, within the Social and Economic Development Group within UNDP. Both the Gender Programme Team and UNIFEM have a strong focus on HIV/AIDS, and collaborate through the UN Inter-agency Network on Women and Gender Equality (UNDP, 2008). However, UNDP's representation of UNIFEM suggests a sidelining of gender expertise in a number of ways. First, that UNIFEM as the UN representing women and gender either does not represent an issue of importance to UNAIDS or does not have the institutional clout to be a co-sponsor in its own right. Second, those actors representing issues of women and gender are not necessarily feminists or experts on women and gender, specifically the politics of mainstreaming and inclusion. Third, co-sponsorship of UNAIDS confers a degree of legitimacy for institutions to be present in wider decision-making forums both in-country and at the global level. UNIFEM lacks this legitimacy. It is therefore possible for UNIFEM and thus women and gender to be excluded from certain decision-making forums, which can lead to the sidelining of any critical engagement with the concepts of women and gender and how they pertain to the global HIV/AIDS response. As Nazneen Damji, Programme Specialist, Gender and HIV/AIDS, UNIFEM, describes the process

in some cases our officers have no problem, they can have a meeting, everyone will be there, things are collaborative and then suddenly you'll be like ok everyone else leave, only co-sponsors. It's only (a problem) if you feel an issue is not going to be raised if you're not in the room, but unfortunately in some cases issues do not get raised if UNIFEM is not in the room and that's the difficult part (*Int.* Damji, 10th May 2005).

The exclusion of UNIFEM from wider forms of decision-making within the global response to HIV/AIDS does not necessarily lead to a sidelining of gender expertise. Expertise exists within the wider organisational structures of many of UNAIDS co-sponsors. A key example of which would be the World Bank. The core directors and managers of the Bank's flagship HIV/AIDS project, the MAP, emphasise the importance of gender at both the in-country level (*Int.* Voetberg, 7th April 2005) and in the Bank's headquarters in Washington. Yet, there are no gender experts within the Bank's AIDS Campaign Team for Africa (ACT Africa). Gender mainstreaming has been adopted within the Bank since 2001, and the Gender and Development Group 'promotes a gender-specific response to HIV/AIDS' (World Bank, 2009) through successful 'best practice' in-country models such as the Tanzanian National Strategic HIV/AIDS Plan, and more specific projects organised around topics such as gender-based violence and nutrition (World Bank, 2009). The Gender and Development Group within the Bank was involved in aspects of MAP implementation, ideas, and priorities, and was consulted in aspects of ACT Africa's operations guide *Turning Bureaucrats into Warriors* (World Bank, 2004). However beyond these incidents of consultation there is little overlap between ACT Africa and the Gender and Development Group. As Waafas Ofoso-Amaah, Senior Gender Specialist describes, the Bank's approach to gender is very much a work in progress that addresses gender in a systematic way as opposed to a structural development issue (*Int.* Ofoso-Amaah, 28th April 2006). Gender units within international organisations such as the Bank are relegated to consultation for gender inclusion without thinking structurally about the feminisation of HIV/AIDS.

The institutional arrangements within international organisations such as the Bank that add-on gender to the wider organisational structures limit any structural thinking about women and/or gender. 'Women and gender' become a single development issue, to be engaged with in specific projects when they are affecting successful project outcomes in the 'other' of

developing countries, specifically those with high HIV/AIDS prevalence rates, as opposed to seeing women *and* gender as part of wider structural inequalities within the institutions themselves. In constructing HIV/AIDS as a non-health specific, development issue, the role of women's higher infection and impact becomes subsumed in wider trends of male bias within the development policy process (Elson, 1991). Male bias in this regard refers to development outcomes that are preferential to men and the perpetuation of such bias through an upbringing in which women have less perception as to their needs, interests or rights because of the perpetuation of such bias and the prioritisation of male needs (Elson, 1991). The nature of such bias cannot be overcome by the add women and stir nature of development planning in which women are added as afterthoughts to the development process or sidelined as an issue or topic for HIV/AIDS interventions.

Feminisation and the Governance of HIV/AIDS
The dual feminisation of the HIV/AIDS epidemic and its governance does not lead to better outcomes for women infected and affected by HIV/AIDS. Attempts to promote gendered responses to international development issues are addressed within international institutions through the use of add-ons: from adding women to adding gender. These approaches fundamentally ignore the male bias and structured gender dynamic within the institutions themselves, and perpetuate a notion that organisations operating globally are somehow politically neutral and gender-free. These patterns and structured inequalities are not particular to HIV/AIDS, as existing feminist research would suggest they mirror certain trends within development initiatives. However these inequalities and patterns are heightened by wider trends within the global HIV/AIDS response. The first of which is the framing of the disease as a non-health development issue. The consequence of which is the use of women and gender as an additional topic to the multi-faceted or 'multi-sectoral' approach to combating the disease. The primary element of women's health is often sidelined but for their role as carers and Mothers and subsequent efforts to prevent mother-to-child-transmission. Ill women and the care role they occupy within the HIV/AIDS response allows women to be portrayed as more vulnerable and in need of external assistance. As a development issue, the objectives of addressing women's needs are bounded within rhetoric on addressing socio-economic inequalities, the result of which is little

outcome or awareness as to how these socio-economic inequalities can be addressed beyond gender mainstreaming throughout the response.

Second, as a consequence of the structures of HIV/AIDS governance, there is little meaning to such mainstreaming or awareness of women and gender at the state and community level. HIV/AIDS governance is located within the objectives and directives of international donors, whether multilateral donors such as the World Bank and increasingly the Global Fund, or bilateral donors such as the US government's President's Emergency Plan for HIV/AIDS Relief (PEPFAR). Previous to large scale commitments to HIV/AIDS funding, there was little political will within the state in sub-Saharan Africa (perhaps with the exception of Uganda) to acknowledge or address the epidemic. Hence, programmes for intervention were initiated through economic incentive by donors such as the World Bank, with an emphasis upon states 'owning' their response. The problem with such ownership, however, is that state structures such as the National HIV/AIDS Councils manage competing donor demands, and adopt the requisite language of HIV/AIDS as a means of proving their success in targeting key issue areas highlighted by the international community. Women and gender fall into this, specifically in terms of gender mainstreaming. There is a tendency for state structures, national NGOs and communities to say they are implementing or prioritising certain issues or terms, with little awareness to what they mean or commitment to them. This is particularly acute with highlighting the affect of HIV/AIDS upon women, as though there is an awareness of the issues, to challenge or confront the structural issues that stimulate this impact would require a wider reconstruction of cultural, social and political systems within these countries. There is a willingness to include women and sympathise with their experiences, but there is a lack of willing to engage with the wider structural drivers of their position.

The third trend within HIV/AIDS governance that impacts upon women's experiences and infections rates is the homogenous nature of the response to the epidemic and its governance. Since 2004, in-country responses to HIV/AIDS have become organised around 'the three ones' principles – one strategic plan, one co-ordinating body, and one monitoring and evaluation framework (UNAIDS, 2005) – which have come to consolidate and co-ordinate the global response to the epidemic. The application of the three ones and projects

such as the World Bank's MAP and the Global Fund has seen the introduction of core elements to every national response throughout the world. The majority of countries throughout the world with a high HIV prevalence rate have a National HIV/AIDS Council system, underpinned by a wider commitment to multi-sectoral interventions that prioritise the inclusion of community groups and multiple stakeholders in the implementation of HIV/AIDS programmes. The result of which has been a homogenous approach to HIV/AIDS that takes best practice from specific 'successful' countries such as Brazil and Uganda as a model for HIV/AIDS interventions to be applied throughout the world. The implications of this is that 'women and gender' become constituted as a single issue and homogenous entity subject to similar experiences and impact of the disease within a cohesive and blueprint global agenda for how best to conduct HIV/AIDS interventions. The space for acknowledgement of difference and country-specific let alone gender-specific lenses becomes increasingly narrowed within policy-making.

Conclusion

This paper has argued that there has been a dual feminisation of HIV/AIDS. The most common understanding of which has been in regard to the feminisation of the epidemic; the impact it has upon women, and the structural socio-economic factors that makes them more vulnerable. What this depiction ignores, however, is the other side of the feminisation of HIV/AIDS: that of governance. Women are involved at every level of what has come to be known as the global HIV/AIDS response. Women form the majority of community organisers and carers, they work within the District and National AIDS Councils, they are present in international organisations, and have in some cases articulated and implemented global plans to bring relief to those infected and affected with the disease. Despite the presence of women within the feminisation of the governance of HIV/AIDS, gender-based policies to effectively address the feminisation of the epidemic have not occurred. This is fundamentally because the gender-based policies are based on the add women and/or gender and stir approaches advocated by international organisations both within and beyond the UN system. Within such a system, women are characterised as a single vulnerable, marginalised and local entity, isolated from global forums of decision-making. As the feminisation of HIV/AIDS governance suggests, this is not necessarily the case.

In positioning women as vulnerable, global HIV/AIDS policy misconceives the role of women in responding to the epidemic. The relationship between women and HIV/AIDS thus needs to be re-formulated to understand them as leaders of the response at every level of governance. Their role as community organisers has come to the forefront of global priorities and national agendas. In maintaining the idea of women as vulnerable they remain in that position; in seeing them as leaders, in recognising gender, and attributing significance to their role within the governance of HIV/AIDS, the feminisation of HIV/AIDS governance can come to effectively address the feminization of the epidemic. Recognising the dual feminisation of HIV/AIDS unravels the gendered inequalities that exist within those international organisations that constitute the global HIV/AIDS response, and that 'the response' is not somehow separate from the epidemic or wider processes of development practice. In leaving this relationship unacknowledged, the feminisation of every aspect of the epidemic will continue unabashed to the detriment of the lives of women infected and affected by HIV/AIDS.

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ⁱ Further declarations to address the issue of gender and HIV/AIDS include: Goal 3 and 6 of the Millennium Development Goals, the World Education Forum, the Fourth World Conference on Women "Beijing" Declaration and Platform for Action, the International Conference on Population and Development Programme of Action, the World Conference on Human Rights Declaration and Programme of Action, Convention on the Rights of the Child, Convention on the Elimination of all Forms of Discrimination Against Women

ⁱⁱ This was made clear to the author when discussing femidoms on home visits with St John's Ambulance in Kisumu, Western Kenya.