



United Nations
Educational, Scientific and
Cultural Organization

Globalization and Women's Vulnerabilities to HIV and AIDS

GENDER EQUALITY **SERIES 2**

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II - Colleen O'Manique, Associate Professor at Trent University, Canada.

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GLOBALIZATION AND WOMEN'S VULNERABILITIES TO HIV AND AIDS

Our knowledge of HIV & AIDS is limited by the way in which we see and understand the multiple dimensions of the pandemic. A key dimension that is often ignored is how macro-economic frameworks, such as international trade policies, national economic reforms, and agriculture sector trends, and their inherent power structures contribute to the feminization of the pandemic and affect women at the micro-economic level.

Our inability to see this dimension is partly due to the fact that traditional frameworks used to conceptualize the pandemic – predominantly biomedical and epidemiological – have masked the role of macro-economic frameworks. Additionally, correlations between the macro and micro levels are difficult to isolate and identify and are therefore commonly overlooked and underestimated.

This Paper – largely inspired by Colleen O'Manique's analysis in her article "Globalization and gendered vulnerabilities to HIV and AIDS in sub-Saharan Africa" – seeks to uncover some of the effects of the global political economy on women's vulnerability to HIV and AIDS. Using as a base C. O'Manique's examination of structural adjustment programmes¹ and global trade regulations applying specifically to intellectual property and agriculture, this paper attempts to draw the readers' attention to some of the ways in which specific macro-economic frameworks can contribute to local risk contexts for women and capacities to respond to HIV and AIDS.



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A migrant laborer in Vadodara, India, washes clothes near the construction site where she works, as her daughter plays around her.

LIMITATIONS OF COMMON FRAMEWORKS

The understanding of women's vulnerability to HIV has evolved over the past thirty years (Schoepf, 1991a and 1991b; Barnett and Whiteside, 2002): from a focus in the late 1980s on women's unique biological risk factors and 'high-risk' sexual behaviours ("First Wave"), to biomedical approaches ("Second Wave") to broader socio-cultural, political, legal and economic conditions in the early 1990s ("Third Wave").

Table 1 below summarizes the main analytical frameworks commonly used over the years to

understand women's vulnerabilities to HIV and to design policy and programme responses. The table also presents the limitations of each response, which, while factually correct, look at the problem from only one angle. None of the approaches considers the overarching causes of women's vulnerability, which are shaped by processes of 'globalization' that exert constraints on the everyday lives and choices of women, men and children as they determine their ability to access medication, receive quality care, purchase affordable food, etc.

Table 1: Prominent analytical frameworks used to understand women's vulnerability to HIV and AIDS

Cause of Women's Vulnerability	Intervention Focus	Limitations
Women's unique biological risk factors and 'high-risk' sexual behaviours (high-risk behaviour).	Education and empowerment campaigns focusing on 'promiscuity' of 'high-risk groups', and the social-cultural factors contributing to high-risk sexual behaviour.	Approach sometimes based on biological and cultural explanations which are stigmatizing. Can be understood as racist and neglects to consider historical factors.
Limited income-earning options and low education levels of poor women (low capacity).	Economic empowerment of women, such as through micro-credit and micro-enterprise development.	Does not address the main causes of poverty or the inadequacy of health and social policies. Responsibility rests on women themselves.
Unequal access to property, land ownership and inheritance (low opportunity).	Changing discriminatory laws and practices that deny women access to income and property.	Limited impact because resources for collective action are often unavailable.

IMPACTS OF STRUCTURAL ADJUSTMENT PROGRAMMES (SAP) ON WOMEN IN THE CONTEXT OF THE HIV PANDEMIC

SAPs are conditions for obtaining loans from the World Bank or International Monetary Fund (IMF) and were introduced to sub-Saharan Africa in the 1970s. A body of research produced in the 1980s and 1990s indicated the role of SAPs in undermining health and education systems, local economies, and the social determinants of health (Schoepf, 1991b; Schoepf et al, 2000). According to these studies, SAPs negatively affected the ability of developing countries in sub-Saharan Africa to respond to HIV and AIDS (Gershman and Irwin, 2000; Poku, 2004; O'Manique, 2004), by:

- trimming State budgets and encouraging the reduction of public sector employees;
- encouraging the privatization and the establishment of user fees for public services;
- weakening ministries of health and education due to budget and human resource constraints.

The erosion of public services as a result of economic reform disproportionately affects women and girls as it notably increases the already unequal burden of unpaid subsistence and care labour borne by

women. Other effects include longer and more intense working days for women in both the productive and reproductive spheres to make up for the loss of income; increased household expenses due to the increased commodification of necessities; decreased participation of girls in school due to the rise of user fees as well as the need for their labour in the household.

The decrease of public services further affects women by jeopardizing their access to services and resources that are necessary for coping with HIV and AIDS, including easy, confidential and safe HIV-related health care centers; safe drinking water and nutritious food; primary health care; sexual and reproductive health services; and treatment for other common opportunistic health conditionsⁱⁱ. Lack of access to these services exacerbates the additional, psychological barriers that women face to health care, such as sexual coercion and fear of retaliatory violence in the case of a positive HIV test, and socio-economic barriers such as unequal access to education, property and income (Cohen, Kass and Beyrer, 2007, p. 384).

EFFECTS OF THE AGREEMENT ON TRADE-RELATED ASPECTS OF INTELLECTUAL PROPERTY RIGHTS (TRIPS) ON WOMEN AND THEIR ACCESS TO HIV TREATMENT

SAPs have not been the only global, economic strategy that has had an impact on the response to the pandemic. The global market is governed by a number of World Trade Organization (WTO) agreements that are specifically affecting women's ability to cope with the pandemic, such as the agreement on Trade-related Aspects of Intellectual Property Rights (TRIPS), which calls upon WTO members to strengthen and enforce intellectual property rights.

Under TRIPS, patent-holders have exclusive rights to their invention for a period of no less than 20 years, leading to a situation in which drug companies hold a monopoly on price setting for patent-protected antiretroviral medication (ART) and are able to overprice drugs that are vital for HIV treatment. Civil society groups, including Treatment Action Campaign in South Africa, the Third World Network, and Médecins Sans Frontières, have alerted the public about the detrimental impacts of a legal framework that seeks to protect intellectual property rights at the expense of providing public access to affordable treatment. Despite global protest and the Ministerial Declaration on the TRIPS Agreement and Public Health adopted at the Doha Ministerial Conference

in 2001, which allowed for the granting of compulsory licenses in 'national emergencies', permitting countries to override drug company's monopolistic prices (Heywood, 2004), the basic framework has remained unchanged since TRIPS came into effect in 1995 (Thomas, 2003).

As a result, providing affordable access to antiretroviral medication has become a priority item on the HIV agenda for international donors. Numerous donor projects aimed at increasing the production and distribution of generic drugs have surfaced, such as the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria, '(Product) RED' and UNITAID. These initiatives have been able to help raise the percentage of persons in sub-Saharan Africa who access antiretroviral treatment (ART) from 21 percent in 2006 to 30 percent, according to recent data (WHO, 2009b)ⁱⁱⁱ. While women have been among the first to receive antiretroviral treatment, notably because of campaigns to prevent mother-to-child transmission, ART roll out programs often fail to address the range of social and economic factors that impede many women from accessing quality care, treatment and support throughout life, before and after pregnancy.

THE GENDER DIMENSIONS OF DRUG RESEARCH AGENDAS

The current intellectual property architecture has also had a gendered impact on responses to the HIV pandemic by shaping drug research agendas. Research on female-controlled prevention technologies – such as microbicides, pre-exposure prophylaxis and preventive vaccines – happens slowly and depends on a broad-based advocacy campaign. Furthermore, as the main beneficiaries of ART and female controlled prevention technologies live in the global South and are usually unable to afford HIV treatment and prevention services, the drugs and technologies are simply not profitable

for private industry to develop. Research on these technologies therefore depends on funding from donors, governments and multilateral institutions, since it is “not in the economic self-interest of pharmaceutical companies to fill this R&D gap” (Global Campaign for Microbicides, 2009). A case in point is the recently announced (20 July 2010) results of the Caprisa 004 study that confirmed the effectiveness of an antiretroviral microbicide gel. The research is funded by USAID and the South African Department of Science Technology.^{iv}

TRADE POLICIES, FOOD SECURITY AND WOMEN'S VULNERABILITY TO HIV

There is a complicated, but increasingly clear, relationship between trade policies, the food security crisis in certain parts of sub-Saharan Africa, and women's vulnerability to HIV. In 2000, Alex de Waal put forth the 'new variant famine' hypothesis, which posits that due to loss of human capacity in agriculture from HIV and AIDS related illness, caregiving, and death, sub-Saharan Africa is experiencing an episode of acute food insecurity. The 'new variant famine' is a new kind of acute food crisis in which there is no expectation of a return to sustainable livelihoods, unlike past acute food crises in which families and communities could withstand famine and drought and a return to 'normalcy' was expected.

The relationship between HIV & AIDS and household food security is connected to overarching macroeconomic frameworks and conditionalities that shape agricultural policy; yet, this relationship is poorly understood, even by the mechanisms put in place to regulate trade in agriculture. For example, the WTO Agreement on Agriculture, which favours policies that recognize monetized transactions, ignores the impacts of such policies on subsistence agriculture, indigenous labour practices, seed saving and other forms of commons' management (McMichael, 2004). For this reason, it has been argued that the agreement undermines self-sufficiency in sub-Saharan Africa.

Under these conditions, farming households cannot earn enough income to send their children to school, to buy basic necessities or to feed their families. While seemingly removed from the HIV & AIDS epidemic, global trade policies determine sustainable livelihoods in rural agricultural households, and their associated resilience and capacity to deal with health and food security emergencies.

The promotion of export crops has reinforced the bias against the subsistence sector and, as a result, women. It has been long recognized that, in most African countries, women form the backbone of subsistence food provision and that their contribution to household food security has suffered disproportionately from the drive to export products at the expense of food production for domestic consumption. Women farmers have been neglected in terms of access to credit and extension services, labour- and time-saving technologies and transport facilities, all of which play a role in women's ability to benefit from and participate in global trade and the liberalization of the economy and to access quality health care services, treatment and support.



Jerry Riley © IRIN

A young girl tends to chores at a makeshift internally displaced persons (IDP) camp. Life must go on.

The 'new variant famine' is "an episode of acute food insecurity fuelled by the loss of human capacity in agriculture," which has resulted from the HIV & AIDS pandemic and is "threatening a social calamity on a scale not witnessed before in the continent" (de Waal and Tumushabe, 2003, p. 2).

LEARNINGS

1. The response to HIV and AIDS is not simply a public health issue. In the areas hardest hit by HIV & AIDS, it is those most socially, politically and economically marginalized who are often the most vulnerable to HIV infection. More often than not, this is women and girls, as they bear the brunt of poverty. Women's well-being and capacity to mitigate the impact of HIV and AIDS depends upon well functioning public services that address women's needs.
2. While it is very clear that some economic policies, such as SAPs and TRIP, have negatively impacted HIV prevention and treatment for women, the alternatives to such policies are less clear. The scale-up of HIV prevention strategies and antiretroviral therapy must be matched by policies that address the structural factors that contribute to the transmission of HIV and place women, in particular, at greater risk. To do so, the following is required:
 - a) A better understanding of the gendered impact of global economic policies and frameworks is needed to improve country responses to HIV and AIDS. Current policies and institutional cultures that shape responses mask the structural power that will continue to condition the gendered and political geography of the pandemic and undermine local and national responses.
 - b) An understanding on how local realities relate to meso- and macro-level analyses of global political economic frameworks and HIV responses.
 - c) Collaboration and interdisciplinary research which brings together specialist knowledge of biomedicine, anthropology, public health, political economy, human rights and feminist and gender analyses will inform mainstream technical approaches and can draw attention to the structural powers within which HIV epidemics are embedded.
3. The way in which the HIV & AIDS epidemic is understood is important as it shapes how responses are conceptualized and implemented. Integrating an understanding of the gendered nature of globalization into analyses of the pandemic in sub-Saharan Africa and elsewhere will help to clarify what approaches need to change and where pressure needs to be directed in a macropolicy framework. A gender lens can be a galvanizing force to bring about systemic change.



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1 **Structural adjustment programmes** (SAPs) are “economic policies for developing countries that have been promoted by the World Bank and International Monetary Fund (IMF) since the early 1980s by the provision of loans conditional on the adoption of such policies. Structural adjustment loans are loans made by the World Bank. They are designed to encourage the structural adjustment of an economy by, for example, removing “excess” government controls and promoting market competition as part of the neo-liberal agenda followed by the Bank. The Enhanced Structural Adjustment Facility is an IMF financing mechanism to support of macroeconomic policies and SAPs in low-income countries through loans or low interest subsidies.” (WHO accessed 11 October 2010: <http://www.who.int/trade/glossary/story084/en/index.html>).

2 **Opportunistic conditions** are illnesses that appear when the immune system is weakened. Examples of such conditions are tuberculosis, *Pneumocystis carinii* pneumonia, cytomegalovirus retinitis, various oral diseases and complications, changes in bone mass and increased risk of bone disease, and cervical cancer.

3 WHO data show that in low- and middle-income countries overall, adult women are slightly advantaged compared with adult men in accessing antiretroviral therapy. About 45% of women in need and 37% of men in need received antiretroviral therapy at the end of 2008. (WHO 2009b).

4 www.caprisa.org/joomla/index.php/component/content/article/1/225 (accessed 9 August 2010).

GLOBALIZATION AND GENDERED VULNERABILITIES TO HIV AND AIDS IN SUB-SAHARAN AFRICA

Colleen O'Maniqueⁱ

in "The Fourth Wave: Violence, Gender, Culture & HIV in the 21st Century",
UNESCO/SSRC

Available online at: <http://blogs.ssrc.org/fourthwave/>

Globalization and gendered vulnerabilities to HIV and AIDS in sub-Saharan Africa

Colleen O'Manique

The connections between global structural economic arrangements and vulnerabilities to HIV and AIDS at the local level are non-linear and complex. However, there is little doubt that these global structural transformations have played an important role in shaping the HIV and AIDS pandemic in sub-Saharan Africa, as well as the policy responses that have been formulated to combat the pandemic. Macro-structural arrangements determine who receives treatment once infected as well as who shoulders the burden of care of people living with HIV and AIDS, children orphaned by AIDS, and much else. Yet, despite the profound impact of global economic structures on local communities, the policy implications of these macro-structural arrangements remain under-explored.

This chapter highlights some of the ways in which the governance of the global political economy contributes to vulnerability to HIV and AIDS in sub-Saharan Africa, particularly among women and girls. By vulnerability, I mean the ways in which women or men are at risk of being exposed to HIV and of being stigmatized and marginalized in terms of care and support once infected. Vulnerability also refers to the many ways in which the livelihoods of women and men are undermined and their resilience weakened in HIV-affected households and communities.

The rules of global governance are a form of structural power that imposes constraints on political and economic interactions, from within local communities and at the global level. Though seemingly remote from local

communities, structural power plays a role in shaping risk environments and circumscribing the range of possibilities in national and local responses, including the responses of an increasingly diverse group of civil society and private actors. This chapter will especially focus on international laws governing intellectual property; trade, investment and subsidy regimes; and the conditions attached to national debt and development assistance, all of which contribute to the contexts within which the pandemic unfolds and to local capacities to respond to HIV and AIDS.

One clear lesson of the pandemic is that those most socially, politically and economically marginalized are often the most vulnerable to HIV infection. In the areas hardest hit by HIV and AIDS, these people are increasingly women. The UNAIDS annual report on the epidemic for 2007 (UNAIDS, 2008) points to the continuing and hugely disproportionate impact of HIV and AIDS on sub-Saharan Africa. The statistics are alarming: 68 per cent of adults and 90 per cent of children infected with HIV live in this region; 76 per cent of all AIDS deaths have occurred here; infection rates in the 15–49 age group exceed 15 per cent in most southern African countries; and in 2007, almost 61 per cent of adults living with HIV in sub-Saharan Africa were women.

Our knowledge of the HIV and AIDS pandemic has been limited by ways of seeing and knowing that leave out important pieces of the puzzle. A key piece that is often left out is how structural power, in its present configuration, has contributed to the growing feminization of the pandemic. Feminist political economists have recognized that the rules governing the global political economy are inscribed with gendered meanings (Marchand and Sisson Runyan, 2000). Gender here refers to the varied and shifting understandings of what it means to be a man or a woman in specific historical and social contexts. Gender relations are constantly negotiated in relation to other relational divides, such as class, race, ethnicity and sexuality. Gender relations, thus, not only shape relationships between individuals but also cultural and institutional practices from the very local to the global level.

One of the reasons why the links between the global political economy and the feminization of the HIV and AIDS epidemic are seldom made has to do with existing dominant frameworks for understanding the epidemic. The main frameworks for conceptualizing the pandemic are still predominantly biomedical and epidemiological. For instance, within mainstream accounts of risk and vulnerability, gender relations have been largely understood through a focus on individual sexual behaviour, which is perceived to be amenable to change through education and empowerment campaigns. The central role of

women in formal, informal and caring economies has been neglected, as have the implications of gender relations in the links between poverty and HIV and AIDS. Many similar examples illustrate how biomedical frameworks can mask the impacts of the past thirty years of neoliberal economic restructuring on the feminization of the pandemic.

The term 'neoliberalism' here is understood as the political and economic doctrine that proposes that collective human interest is best advanced by unleashing entrepreneurial freedom within a governing framework characterized by strong individual property rights, free markets and free trade. The application of this doctrine has resulted in deregulated global financial markets, weakened institutions for social and labour protection, and diminished government services. It has cut top tax rates and liberalized capital markets and the trade of international goods and services. The necessities of life – water, health care, education – have become increasingly privatized and commodified (Harvey, 2005). The gender dimensions of neoliberal ideology are reflected in the devaluation of subsistence, informal and unpaid household labour – labour that is critical to human survival and that is largely shouldered by women (Bakker and Gill, 2003; Mohanty, 2004).

This chapter will argue that the neoliberal rules governing the global political economy are not simply a backdrop but a key contributor to the pandemic and its increasing feminization. It will examine the connections between globalization and the feminization of HIV and AIDS by focusing on the impacts of structural adjustment programmes, international intellectual property laws and agricultural trade policies. All of the above are seemingly removed from the day-to-day hardships faced by people who have been affected by the AIDS epidemic, but I will try to show that these macro-level policies have a gender-specific impact on the AIDS epidemic.

Understanding the vulnerability of women to HIV and AIDS: Some common approaches

The pandemic in sub-Saharan Africa, including its gender dimensions, has been understood primarily through narrow cultural and biomedical perspectives. In the late 1980s, the first accounts of women's particular vulnerability to HIV focused on their unique biological risk factors, as well as on the 'high-risk' sexual behaviours of both men and women that placed women at greater risk. The focus was on the 'promiscuity' of 'high-risk groups', such as

sex workers, migrating men and long-distance lorry drivers, and the factors contributing to high-risk sexual behaviour, such as the breakdown of traditional cultural codes governing sexuality, increased rural-to-urban migration, alcohol consumption and deeply entrenched patriarchal cultures that placed men in control of women's sexuality and labour (see, for example, Killewo et al., 1989; Piot et al., 1987; Serwadda, 1985).

However, by the early 1990s, this individual behaviour paradigm was challenged. Critics pointed to the sometimes stigmatizing, racist and ahistorical biases in biological and cultural explanations. Instead of offering cultural or biological explanations for individual behaviour, they drew attention to the influence of broader sociocultural, political, legal and economic conditions that increased the risk and vulnerability of women (Barnett and Whiteside, 2002; Schoepf, 1991*a* and 1991*b*). These factors included the limited income-earning options of impoverished women in both formal and informal economies, which, coupled with their central roles in domestic labour, forced them to resort to 'survival' sex to provide for their families. They also referred to women's disadvantaged sociocultural and legal position with respect to property, land ownership and inheritance (Izumi, 2006) and to the impact of the increasing informalization of economies and related migration and household mobility (Hunter, 2007; O'Manique, 2004).

The critique of the individual biomedical approach additionally pointed out that women could not be 'empowered' to have safer sex without also taking into consideration the behaviour of men. What was relevant was the local context shaping gendered power relations, such as the asymmetrical economic and legal standing of men and women within the household.

In line with these critiques, an important 2001 World Bank Policy Research Report, *Engendering Development Through Gender Equality in Rights, Resources and Voice* (2001), advocated programmes to strengthen the empowerment of women by focusing on their centrality to family survival, economic growth, poverty reduction and household well-being, particularly in contexts where public health care systems and social safety nets were weak or non-existent. This analysis pointed to the need for the economic empowerment of women and refocused attention on microcredit and microenterprise development for women in HIV-affected communities; this development approach rapidly became ubiquitous as an empowerment strategy for women. However, this approach sometimes masked the fact that a lack of credit was not the main cause of poverty, nor could credit stand in for decent health and social policies or access to secure employment (Bond, 2007; Rankin, 2001).

At the same time that microcredit and microenterprise programmes for women were becoming popular, campaigns by civil society and women's organizations were directed at changing discriminatory laws and practices that denied women access to income and property, thereby exposing the injustices faced not only by women but also by the majority of the poor in various local settings (Izumi, 2006). However, these kinds of interventions had a limited impact because resources for collective action were often unavailable (Baylies and Burja, 2000).

The critiques of individual behavioural approaches also drew attention to structural factors that frame risk. Research has shed light on the connections between national political economies, state responses and the broader macro-structural factors that shape risk environments, such as debt, structural adjustment programmes (SAPs), intellectual property and trade law, and investment patterns (Barnett and Whiteside, 2002; Nattrass, 2003; Poku and Whiteside, 2004). Scholars have modeled the effects of HIV epidemics on governance and democracy, national security and the economy (Fourie, 2004; Ostergard, 2004, Price-Smith, 2003). However, these critiques have seldom shed light on the impact of structural power on the everyday lives and choices of women, men and children.

Structural adjustment programmes and their implications for HIV and AIDS

Recent changes in the political economy of sub-Saharan Africa are important in explaining the distribution and scale of the pandemic. The spread of HIV in the Great Lakes region of Africa, beginning in the late 1970s, roughly corresponded to the advent of neoliberal SAPs, which contributed to weakening of the capacity of states to provide adequate health services. We cannot know with certainty whether the course of the HIV pandemic would have been different had it not emerged alongside Africa's debt crisis and the introduction of SAPs, but a body of research produced in the 1980s and 1990s pointed to the role of SAPs in undermining health systems, local economies and the social determinants of health (Schoepf, 1991*b*; Schoepf et al., 2000). Structural adjustment policies represented a shift in control of social and economic policy away from the nation-state and towards global institutions, such as the World Bank and the International Monetary Fund. The basic prescriptions of SAPs focused on currency devaluation, the diversion of production and trade towards export

markets, the trimming of state budgets and the retrenchment of public sector employees, and privatization and the establishment of user fees for public services (Gershman and Irwin, 2000; Poku, 2004).

From the start of the epidemic, National AIDS Programmes (NAPs) were implemented through weak ministries of health, which were already subject to budgetary and human resource constraints and had been further weakened by SAPs (O'Manique, 2004). Again, there are variations from one country to another, but generally speaking, the health and social systems inherited from colonial administrations were already beleaguered and primarily served the urban middle classes. Structural adjustment policies linked to debt rescheduling foreclosed the possibility of providing and extending basic health care and other social necessities (Cheru, 2002; Green, 1989). Neoliberal restructuring undermined the capacity of individual states to restrain financial markets and control the investments and activities of economic enterprises for developmental purposes. Today, political authority and the protection of citizenship rights are conceded to 'sovereign' states, but the state system is inseparable from the rules governing the global market economy (Brysk, 2002). The SAPs of the 1980s and 1990s served to entrench the notion that it is not the responsibility of states to provide services; government accountability tilted towards external financiers, with local and international non-governmental organizations and the private sector becoming subcontractors in the delivery of basic services where the state had opted out (Stewart, 1997). The World Bank and related communities of experts – dominated by economists – became central to the design of health systems and also HIV and AIDS policies (Lee and Goodman, 2002).

The erosion of public services due to the implementation of SAPs disproportionately affected women. The impacts of SAPs on women and gender relations have been extensively documented and include the intensification and lengthening of the work day in both the productive and reproductive spheres to make up for income loss; increased household expenses due to the increased commodification of necessities; decreased participation of girls in school due to user fees as well as the need for their labour in the household; the deterioration in the health status of women and girls, particularly among the poorest, who cannot afford health services; the rise in women's participation in licit and illicit informal sector activities; and increased acts of violence against women (Petchesky, 2003; Peterson, 2003). In contexts where HIV was prevalent and spreading, SAPs removed the social support structures needed by individuals caring for sick family members and paying for necessities and diverted their labour towards income-generating strategies to pay for medicines, food and funerals (Barnett and Whiteside, 2002; Baylies, 2002).

In many parts of sub-Saharan Africa, women are responsible for subsistence and smallholder food production and securing access to water and fuel, as well as household chores, such as cooking, cleaning, caring for and socializing children and the care of older people. The HIV and AIDS pandemic, with its growing numbers of sick adults and children and orphans, increased the burdens that many women had to shoulder. This increased workload sometimes obliged women to give up waged labour or, conversely, to increase their working hours to meet AIDS-related expenses. Girls are also drawn into the care or wage economies in times of economic need. Yet, the very categories that are used by most macroeconomic models exclude consideration of the unpaid labour routinely done by women. By not problematizing them nor accounting for them in economic analyses, existing gender relations that disfavour women are often further reinforced (Bakker and Gill, 2003). These silences in macroeconomics are especially problematic in the context of the AIDS pandemic, which has created disproportionately large care burdens for women in countless communities across sub-Saharan Africa.

Trade, TRIPS and AIDS: Access to treatment for HIV in the global market

SAPs have not been the only global issue that has had a gendered impact on the unfolding of the response to the pandemic. The global market is governed by a number of World Trade Organization (WTO) trade agreements. Trade-Related Aspects of Intellectual Property Rights (TRIPS), which requires WTO members to increase and enforce intellectual property rights, has been perhaps the most controversial WTO agreement in relation to the HIV and AIDS pandemic. Under TRIPS, patent-holders have exclusive rights to their inventions for a period of no less than twenty years, which has led to a monopoly on setting prices for patent-protected antiretroviral drugs. Civil society groups, including Treatment Action Campaign in South Africa, the Third World Network, and Médecins Sans Frontières, have brought the injustice of this legal framework that privileges private profit over human life to the world's attention. But the basic framework has remained unchanged since TRIPS came into effect in 1995 (Thomas, 2003) despite the Ministerial Declaration on the TRIPS Agreement and Public Health adopted at the Doha Ministerial Conference in 2001, which allowed for the granting of compulsory licenses in 'national emergencies' (Heywood, 2004).

Implications of TRIPS are especially salient since the treatment of AIDS through antiretroviral drugs has become the most popular item on the HIV agenda for international donors. Recent data from the World Health

Organization puts access to antiretroviral therapy (ART) in sub-Saharan Africa at 30 per cent, up from 21 per cent in 2006 (WHO, 2009). With the increase in the production and distribution of generic drugs, life-extending treatment has been supplied through a range of mechanisms: brokered country-specific price breaks for individual drugs or combinations, corporate donations, the United States President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria. 'Saving African Lives' through the provision of ART has also become a marketing strategy for a range of Western corporations through (PRODUCT) RED, which is discussed by Lisa Ann Richey elsewhere in this volume. In these marketing campaigns, shoppers in the North are told that they can keep their 'African brothers and sisters alive' with just '2 pills a day' through their purchases of specific products that channel resources to the Global Fund (<http://www.joinred.com/Home.aspx>). These acts of 'compassionate consumption' mask and silence the relationship between overconsumption in the North and the grim state of public health in the South (Labonte and O'Manique, 2008).

An open question is what will happen when pilot projects and existing funds, such as PEPFAR, for the scaling-up of ART come to an end. What will happen when those receiving ART require different formulations than those currently under WTO patent protection or for which price breaks have not been negotiated? After all, people living with HIV and AIDS need to be treated throughout the course of their lives and will need new formulations when they develop resistance to the current combination of drugs (MSF, 2009). The drugs that are effective today will not be tomorrow. Kenneth Shalden (2007) has argued that TRIPS has engendered changes that threaten the future supply of high-quality, generic antiretroviral drugs needed for AIDS treatment, which in turn creates a challenge for the scaling-up and the long-term maintenance of treatment regimens. According to such arguments, TRIPS has transformed market structures by dramatically reducing incentives to invest in the production of generic versions of new antiretroviral drugs that are known as 'hybrid generics' – drugs that have high production costs but low prices. Shalden hypothesized that there will be little economic incentive to produce such new drugs, regardless of existing intellectual property provisions that allow firms to do so. Similarly, there will be little incentive to grant compulsory licenses or use parallel imports in the case of a 'health emergency.' The costs of reverse-engineering, producing and marketing these new drugs are quite high, as are the transaction costs that derive from the legal environment. It is therefore 'an activity with exceptionally thin [profit] margins' (p. 571).

Efforts to scale-up treatment are also hampered by bottlenecks, such as the inadequate human and physical capacity in relevant health sectors and the absence of other conditions necessary to the health of people living with HIV and AIDS, such as access to nutritious food, primary health care and treatment for other endemic health conditions (Schoepf et al., 2000; Stillwaggon, 2006). Moreover, the focus on ART has diverted attention from some of the other factors that contribute to poor health, either alongside HIV or on their own. The social determinants of health are equally neglected. Laurie Garrett (2007) recently reported that while many HIV-positive mothers are given ART to manage their infection and prevent the transmission of the virus to their babies, some of them still cannot obtain even the most basic obstetric and gynecological care or immunization for their infants. Although women have been among the first to receive ART in certain contexts because of campaigns to prevent mother-to-child transmission and their more frequent contact with the health care system, this may change as treatment programmes move into the general population (Cohen et al., 2007, p. 383). Cohen et al. speak to the range of factors that may impede the access of women to ART unless the systemic barriers to health care are addressed, including sexual coercion and fear of retaliatory violence in the case of a positive HIV test, and unequal access to education, property and income (p. 384).

Much analysis of TRIPS and the HIV and AIDS epidemic has focused on the issue of affordability of ART. Less attention has been paid to the manner in which the current intellectual property architecture shapes drug research agendas. The only common prevention technology that exists – a full three decades into the pandemic – is condoms, which, if used consistently, eliminate the possibility of pregnancy and are often difficult for women to use without the consent of male partners. Microbicides are being developed, some of which are non-contraceptive tools, a technology that would give women the power to protect themselves from infection. But research has moved at a snail's pace and depended on a broad-based advocacy campaign and funding from donors, governments and multilateral institutions since it is 'not in the economic self-interest of pharmaceutical companies to fill this R&D gap' (Global Campaign for Microbicides, 2009). According to the Global Campaign for Microbicides, there are currently nine clinical trials being undertaken around the world, but it could be more than a decade before any microbicides are approved for use. Therapeutic or preventive vaccines and pediatric formulations of ART fall into the same category, as the main beneficiaries live in the global South, and are simply not profitable for private industry to develop. At the centre of the debate

are the contradictions of a global market-based system that puts profit before the interests of people who could benefit from these drugs.

This is not to say that the scale-up of ART is not critically important, nor that vertical programmes focusing exclusively on HIV and AIDS are not needed. However, it is important to point out that these programmes are often skewed by the priorities of Western donors, who are attracted to technological ‘quick fixes’ with results that can be easily measured in quantifiable terms, which are easy to market to their national constituencies. Some argue that the scale-up of ART will encourage investment in the infrastructure and human resources needed to run the programmes: states and donors will dedicate resources to the health sector in order to shore up the capacity to deliver ART, with potentially positive spin-off effects for health services in general (UNAIDS, 2008, p. 154). However, it remains to be seen whether this can happen. The provision of ART is critically important. But it is not enough.

Agriculture, trade and the risk environment for HIV

Access to drugs and intellectual property laws is just one aspect of the complicated relationship between trade and HIV and AIDS. An understanding of the links between trade policies and the food security crisis in certain parts of sub-Saharan Africa and between these elements and local epidemics lies much further out on the margins of AIDS research and policy. In early 2000, Alex de Waal put forth the ‘new variant famine’ hypothesis. New variant famine is ‘an episode of acute food insecurity fuelled by the loss of human capacity in agriculture’ that has resulted from the HIV and AIDS pandemic and that, according to de Waal and Tumushabe, is ‘threatening a social calamity on a scale not witnessed before in the continent’ (de Waal and Tumushabe, 2003, p. 2). The hypothesis posits a new kind of acute food crisis in which there is no expectation of a return to sustainable livelihoods. In the past, households and communities were able to withstand periodic drought or a food emergency, and once the crisis was over, there was a return to a ‘normal’ situation. However, agrarian households that are affected by HIV and AIDS are more susceptible and less resilient to external shocks. When family members are dying or too ill to farm and bring in the harvest, acute food crises have more permanent effects. AIDS-related mortality and morbidity have the potential to permanently undermine household subsistence in many areas of high HIV prevalence.

The synergies between HIV and AIDS, household food security and the overarching macroeconomic frameworks and conditionalities that shape agricultural sector policies are poorly understood. The WTO Agreement on Agriculture poses a challenge for self-sufficiency in the South since only monetized transactions are counted as productive, whereas subsistence agriculture, indigenous labour practices, seed saving and other forms of commons management lie outside of the model (McMichael, 2004). It has been long recognized that, in most African countries, women form the backbone of subsistence food provision and that their contribution to household food security has suffered disproportionately from the drive to export products, at the expense of food production for domestic consumption. The promotion of export crops has reinforced the bias against the subsistence sector, and women farmers have been neglected in terms of access to credit and extension services, labour-saving technologies and transport facilities.

The billions of dollars in farm subsidies and price supports provided by the United States and European Union countries place African exporters at a competitive disadvantage and undermine the potential gains that might result from trade liberalization. Subsidies keep global prices artificially low, undermine rural livelihoods and food security through unfair competition in local markets and result in lost market share in export markets, particularly as African countries cannot compete with the prices of dumped or subsidized commodities (Oxfam, 2006). Donna Lee's (2007) recent analysis of domestic subsidies for cotton producers in the United States puts the cost to Central and West African cotton farmers at an estimated US\$1 billion in lost export revenues. While cotton production in Africa increased by 14 per cent between 1999 and 2002, export earnings fell by 31 per cent. Single commodity producers are the hardest hit. As Lee states, 'cotton production and exports play a vital strategic role in the ... continued underdevelopment of the 33 net cotton export countries' (p. 141). The impacts on farming households could not be more profound: they cannot earn enough income to send their children to school, to buy basic necessities or to feed their families. While seemingly removed from the HIV and AIDS epidemic, these issues determine sustainable livelihoods in rural agricultural households and the associated resilience and capacity of those households to deal with health emergencies.

Conclusion

The scale-up of HIV prevention strategies and antiretroviral therapy has not been matched by policies that address the structural factors that contribute to the transmission of HIV and place certain people at greater risk. Indeed, some of the current policies and institutional cultures that shape responses serve to mask the structural power that will continue to condition the political geography of the pandemic and undermine local and national responses. Despite the vast and complex web of private and public initiatives, the growing list of foundations and celebrities embracing the cause, and the exponential growth in the production of scientific knowledge about HIV and AIDS, the pandemic continues to exact a devastating toll and will likely do so for many decades to come.

What does this mean for research and policy? Our construction of the disease and the epidemic matters as it shapes how responses are conceptualized and implemented. Integrating an understanding of the gendered nature of globalization into analyses of the pandemic in sub-Saharan Africa and elsewhere will help to demystify global processes and clarify what needs to change and where pressure needs to be directed in a macro-policy framework.

The response to HIV and AIDS is not just a question of health policy. Claims that globalization has produced higher standards of living and well-being across the board (Wolf, 2004) are contradicted by realities on the ground, as reflected in the persistence of inequalities and human rights abuses that are shaping individual epidemics within the global pandemic. We therefore need analyses that relate local understandings with meso- and macro-level analyses of global political economic frameworks and HIV and AIDS responses. Collaboration and interdisciplinary research that bring together specialist knowledge of biomedicine, anthropology, public health, political economy, human rights and feminist and gender analysis will usefully inform mainstream technical approaches and draw attention to the structural violence within which HIV epidemics are embedded. A gender lens can be a galvanizing force to bring about systemic change.

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Division for Gender Equality
Office of the Director-General
7, place de Fontenoy
75007 Paris, France
Tel: 33 (0)1 45 68 16 54
Fax: 33 (0)1 45 68 55 58
Email: gender.equality@unesco.org

Globalization and Women's Vulnerabilities to HIV and AIDS

This Issues Paper is part of a series produced by UNESCO's Division for Gender Equality in the Office of the Director-General within the context of its UBW funded project "*Transforming the Mainstream: Addressing Structural Gender-related Vulnerabilities to HIV and AIDS*" that seeks to strengthen national and international capacities to adopt gender-transformative strategies in order to help eliminate the gender inequalities that are driving the AIDS pandemic. These Papers all address structural issues affecting women's and girls' vulnerability to HIV and the gendered response to the AIDS pandemic.

This Paper was developed with the financial support of **UNIFEM**.